Cofton Medical Centre

Safeguarding Adults Policy 99

Practice Lead:	**Dr V Lloyd**
Implementation Date:	**Dec 2016**
Policy Review Period:	**Annual**
Policy Review Due:	**Dec 2019**

*This policy relates to patients over the age of 18 only. For information about the safeguarding procedures for children please refer directly to the safeguarding children policy.

Introduction

Cofton Medical Centre is committed to ensuring that vulnerable adults who are in our care are kept safe from all types of harm and abuse. We recognise that we have a responsibility to act on behalf of our vulnerable adult patients, reporting abuse when suspicions are raised.

The aim of this policy is to raise awareness amongst all clinical and non-clinical staff about adult safeguarding and how to act when abuse is suspected.

This policy is informed by the following sources:

http://gp.dh.gov.uk/2011/09/27/bma-toolkit-to-help-doctors-protect-vulnerable-adults/

https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

http://www.bsab.org/publications/policy-procedures-and-guidance/

Who is at risk?*

The definition of a vulnerable adult can be very wide ranging but the most widely used definition is taken from the Government consultation paper 1997 *Who decides?* which informed the *No Secrets* guidance which suggests anyone over the age of 18:

> *Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*

Factors that could be considered to increase the vulnerability of an adult could include:

- Frailty
- A history of mental disorder including dementia or drug and alcohol problems
- A physical, learning or sensory disability or with a severe medical illness
- A homeless adult
- A carer under particular stress
- A person who is socially or culturally naive or isolated

*card 4 of the Safeguarding Adults Toolkit for GPs

Forms of abuse*

Abuse can take on many forms the following being the most well recognised:

- Physical
    - This could be hitting, restraining, misusing medications
- Sexual
    - Any non consensual sexual act
- Psychological
    - Verbal or emotional abuse, humiliation, isolation, bullying
- Financial
    - Coercion to change legal documents, stealing, fraud or misuse of property
- Neglect and acts of omission
    - Probably the most common; failure to meet basic needs such as not assisting feeding washing or dressing, neglecting health needs.
- Discriminatory
    - Due to race, gender, age, sexuality, religion or disability

The severity of these may trigger different actions please see Appendix I for more details.
*card 5 of the Adult Safeguarding Toolkit for GPs

Special Considerations for Adult Safeguarding*

<u>Mental Capacity</u>
It cannot be assumed that a person who is vulnerable lacks capacity to make decisions for themselves. It can be seen as abusive if a person's right to make decisions is removed where they still have capacity. Indeed a person is assumed to have capacity to make decision unless proved otherwise. Our role in these circumstances is to ensure that the patient is assisted in making their decision by being adequately informed, to ensure that there are no other vulnerable adult involved in the situation (care home) and to assist that person to be independent.
Where there are doubts about a person's capacity, where possible a formal assessment should be made and done with regard to the specific area of decision making in question at the time the decision needs to be made. (A person may have capacity in one area and not another and capacity may fluctuate)
The Mental Capacity Act 2005 advises that where capacity is lacking then we must act in the best interests of the patient trying to engage them in decision making where possible. Any Lasting Power of Attorney should be considered if it is appropriate to the decision being made and it is possible to engage an independent Mental Capacity Advocate where there is potential for dispute such as withholding treatment or moving a patient to a new place of residence.
*card 7 and 8 of the Adult Safeguarding Toolkit for GPs

<u>Deprivation of Liberty</u>
It is understood that at times patients who lack capacity may have to have their liberty infringed upon in order to keep them safe or provide specific care in their best interests. The least restrictive option must be chosen in this case. The MCA suggests that there are 3 circumstances where Deprivation of Liberty may be authorised:

- By the court of protection making welfare decisions under the MCA
- Where it is necessary in order to give life sustaining treatment while a decision is being made by the court
- In accordance with the DOL scheme

If you have any concerns that you or a care facility or family are depriving someone of their liberty in order to care for them then a referral can be made to the safeguarding team who will perform a 'deprivation of liberty' assessment
*card 8 Adult Safeguarding Toolkit for GPs

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/ - provides good information about this area.
https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1327 as does this for carers

Communication and Consent
It is generally accepted that it is reasonable to share information with health professionals involved in the care of a patient. That information is confidential however and the patient may decide not to share information with certain parties.
Confidentiality is to be upheld unless there is significant risk to others.
In cases where the person has lost capacity, information can be shared where it is considered to be in the best interests of the patient. It is therefore assumed that information can be shared with family members unless there has been information to suggest otherwise in the past.
*card 9 Adult Safeguarding Toolkit for GPs

Practice Lead for Adult Safeguarding
The Practice Safeguarding Adults Lead is **Dr Victoria Lloyd**

The Practice recognises that it is the role of the practice to be aware of maltreatment and share concerns but not to investigate or to decide whether or not a vulnerable adult has been abused.

Our responsibilities

All who work at the practice should take part in training and if appropriate significant event discussion regarding safeguarding adults. Following guidance from the BMA Safeguarding Adults Toolkit:

- Health professionals should be able to identify adults whose physical, psychological or social conditions are likely to render them vulnerable
- Health professionals should be able to recognise signs of abuse and neglect, including institutional neglect
- Health professionals need to familiarise themselves with local procedures and protocols for supporting and protecting vulnerable adults

The practice lead will be responsible for

- implementing the safeguarding adults policy
- advising practice staff with regard to any issues they have surrounding safeguarding adults
- Regular analysis of relevant significant events
- making recommendations for change or improvements in practice procedural policy
- will be the lead when dealing with outside agencies in this regard
- keeping up to date the vulnerable adult register (kept on spoke in the safeguarding folder)

The practice recognises that it has a duty to act on reports, or suspicions of abuse or neglect.

How to respond if you receive an allegation:

- Listen to the complaint and offer reassurance
- Record as accurately as you can what you have been told/witnessed as soon as possible
- Do not show any shock or disbelief
- Tell them that the information will be treated seriously
- Don't start to investigate or ask detailed or probing questions
- Don't promise to keep it a secret

If you witness abuse or abuse has just taken place the priorities will be:

- To call an ambulance if required
- To call the police if a crime has been committed
- To preserve evidence
- To keep yourself, staff, volunteers and service users safe
- To inform the patient's GP or the Practice Adult Safeguarding Lead
- To record what happened in the medical records

Stepped Approach to Adult Safeguarding

1. Prevention
    a. Being aware of patient who may be at risk of abuse
    b. Patients should be assisted to protect themselves
2. Assessing needs
    a. where an individual has been identified as at risk it is important to assess their needs and if they are at imminent risk or have already been subject to harm discussions should take place about and interagency referral
3. Assessing competence
    a. Where someone has been assessed at being subject to harm a capacity assessment needs to be performed
4. Responding to harm or abuse
    a. Identify all the agencies that could assist that person
    b. Response to harm of abuse should be the least restrictive for the patient to avoid deprivation of liberty
5. Coordinate with all the agencies involved
    a. It is important to liaise between all the agencies involved in safeguarding adults
    b. Regular assessment and audit of the safeguarding measures at the practice should be performed.

*Card 1 and 2 Adult Safeguarding Toolkit for GPs

Local Area Information on How to Report Abuse

See Appendix I for information about thresholds for referral.

In an emergency phone 999

If you think that there has been a crime committed contact the police straightaway
Call West Midlands Police on 0345 113 5000 or 101

If it is not an emergency and you want to report adult abuse please call the *Adults and Communities Access Point* (ACAP) on 0121 303 1234 and press option '1' on your telephone keypad or out of hours 675 4806

For an IMCA (independent mental capacity advocate send to local social services through the usual e-mail or telephone number 303 1234.

Email acap@birmingham.gov.uk (please put the header 'safeguarding' in the subject box
You can fax a copy of the multi agency alert form to 0121 303 6245

If your enquiry if about someone who is in a 'position of trust' please phone 303 6906

Multiagency Alert form link

http://www.bsab.org/media/Birminghams-Local-practice-Guidance-Notes-19.pdf

APPENDIX I

Type of Abuse	Lower level of harm Could be addressed via referral to ancillary agencies. A safeguarding referral may however need to be made		Significant to Very significant Harm Addressed under Safeguarding Procedures – referral to safeguarding to be made		Critical Addressed as a potential criminal matter
Physical	• Staff error causing no/little harm e.g. skin friction mark due to ill-fitting hoist sling • Minor events that still meet criteria for incident reporting	• Isolated incident involving service user on service user • In explicable very light marking found on one occasion	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions	• Inappropriate restraint • Withholding of food drinks or aids to independence • Inexplicable fractures/injuries • assault	• grievous bodily harm or assault with a weapon leading to irreversible damage or death
Medication	• Adult does not receive prescribed medication on one occasion no harm occurs	• Recurring missed medication or administration errors that cause harm	• Recurring missed medication or errors that affect more than one adult and/or results in harm	• Deliberate maladministration without proper medical authorisation	• Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
Sexual	Isolated incident of treasing or low-level unwanted sexualised attention (verbal or by gestures) directed at one adult by another whether or not capacity exists	• Verbal sexualised teasing or harrassment	• Sexualised touch or masturbation without valid consent • Being subject to indecent exposure • Contact or non-contact sexualised behaviour which causes distress to the person at risk	• Attempted penetration by any means without valid consent • Being made to look at pornographic material against will/where valid consent cannot be given	• Sex in a relationship characterised by authority, inequality or exploitation • Sex without valid consent • Voyeurism
Psychological	• Isolated incident where adult is spoken to in a rude or inappropriate way but no distress is	• Occasional taunts or verbal outbursts which cause distress • The withholding of	• Treatment that undermines dignity and damages esteem • Denying or failing to recognise	• Humiliation • Emotional blackmail • Frequent and frightening verbal outbursts	• Denial of basic human rights/civil liberties over riding advance directives or forced marriage • Prolonged

	caused	information to dis empower	an adult's choice or opinion • Frequent verbal outbursts		intimidation • Verbal attacks
Financial	• Money is not recorded safely or properly	• Adult not routinely involved in decisions about how their money is spent or kept safe	• Adult monies kept in a joint bank account – unclear arrangements for equitable sharing of interest • Adult denied access to his/her funds or possessions	• Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards • Personal finances removed from adult's control	• Fraud/exploitation relating to benefits, income or will • theft
Neglect	• Isolated missed home care visit – no harm occurs • Adult is not assisted with a meal/drink on one occasion and no harm occurs	• Inadequate care provision leading to discomfort – no significant harm • No access to aids for independence	• Recurrent missed home care visits where risk of harm escalates or on miss where harm occurs • Hospital discharge, no adequate planning and harm occurs	• Ongoing lack of care to extent that health and well-being deteriorates significantly	• Failure to arrange access to life saving services or medicl care • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
Discriminatory or Hate Crime	• Isolated incident of teasing motivated by prejudicial attitudes towards an adults' individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period • Recurring taunts	• Inequitable access to service provision as a result of diversity issues • Recurring failure to meet specific care/support needs associated with diversity	• Being refused access to essential services • Denial of civil liberties • Humiliation or threats on a regular basis	• Hate crime resulting in injury/emergency medical treatment /fear for life • Hate crime resulting in serious injury/attempted murder/honour based violence
Institutional	• Lack of stimulation/opportunities to engage in social/leisure	• Denial of individuality and opportunities to make informed	• Rigid/inflexible routines • Service users dignity is	• Bad practice not being reported and going unchecked • Unsafe and unhygienic	• Staff misusing position of power over service users • Over-medication

	activities • SU not enabled to be involved in the running of service	choices and take responsible risk • Care-planning documentation not person centred	undermined	living environments	and/or inappropriate restraint • Widespread consistent ill treatment
Professional	• Service design where groups of service users living together are incompatible	• Poor, ill informed or outmoded care practices no significant harm • Denying access to professional support and services such as advocacy	• Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted • Failure to refer disclosure to abuse	• Failure to support vulnerable adult to access health, care, treatments • Punitive responses to challenging behaviours	• Entering into a sexual relationship with a patient/client