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Safeguarding adults at risk of harm

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What is safeguarding adults?

Safeguarding adults is about protecting those at risk of harm. It involves identifying abuse and acting where harm is occurring. The **UK Department of Health's No Secrets guidance** defines a vulnerable adult as a person aged 18 years or over "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."¹

In the United Kingdom awareness of safeguarding adults has been raised in recent years through some high profile events. In May 2011, the BBC *Panorama* programme "Undercover care, the abuse exposed" (www.bbc.co.uk/programmes/b011pwt6) revealed the abuse of people with learning disabilities at Winterbourne View Hospital.² More recently, the Francis inquiry into the care provided at Mid Staffordshire NHS Foundation Trust highlighted standard care that resulted in harm to patients.³

Abuse is not just about an act against someone, such as physical abuse, but can also be about acts of omission and neglect, such as not listening or acting on the concerns of patients and carers, neglecting those in need, and allowing institutional harm to occur (box 1 summarises different types of abuse). This article reviews what constitutes abuse, who is at risk, and how to identify and manage suspected abuse in adults.

Who is considered an adult at risk of harm?

Many patients who use health services may be vulnerable (or "at risk of harm"⁴) in one way or another, but defining the core concept of vulnerability is a challenge. A frail elderly person and a blind adult may both be at risk, but the nature and impact of their vulnerabilities are likely to be different. Frailty or blindness, however, is not synonymous with being at risk. In both circumstances individuals may well be at liberty to make informed choices about their

SOURCES AND SELECTION CRITERIA

In preparing this review we have used our personal experience and personal archives and conducted searches of the Cochrane Collaboration, PubMed, and *Clinical Evidence* using search terms including "safeguarding adults" and "vulnerable adults". In addition we have drawn on information about safeguarding investigations reported to the Health and Social Care Information Centre, as well as government publications and "serious case reviews" of safeguarding events.

lives and be able to protect themselves. Rather, these factors may present additional challenges to keeping safe in particular situations, such as being in receipt of care that is substandard.

In clinical practice, be that primary or secondary care or partner agencies, adults at risk of harm can present in a variety of ways. Examples include:

- An elderly person who is frail, physically unwell, disabled, or has cognitive impairment
- A person with a severe mental illness who is in a nursing home or residential care
- A person with a learning disability
- People who lack capacity to make decisions about the care that they receive
- Somebody with drug or alcohol problems
- Someone with a physical disability, blindness, or deafness.

When should a health professional suspect abuse?

Given its nature, potential or actual abuse is not always obvious. For example, a general practitioner may visit a care home and notice that a patient seems withdrawn, unkempt, has lost weight, and has poor skin care. This should raise concerns for the general practitioner and stimulate further inquiries. Such a presentation could be due to disease that has led to deterioration, and treatment is needed. It could, however, mean that the patient is not being provided with the level of care that he or she requires and is being neglected. Points that the general practitioner might consider are whether the patient can reach a drink, can feed him or herself, and is able to ask for help and whether fluid and food intake are being monitored.

Good clinical skills can uncover abuse, but the clinician needs to be alert to this in order to recognise it. Doctors should consider not only the patient, but also the wider context, including environment, family, social networks, and culture. It is the space between the individual and the world around them where abuse can occur.

Doctors should be aware of the various "red flags" that initiate suspicions of abuse. Unexplained injuries may be discovered on examination or reported by a third party. These should be followed up and the cause of injury clari-

SUMMARY POINTS

Doctors have a key role in safeguarding adults at risk from harm. Identifying and reporting safeguarding events is the duty of all clinicians, and doctors need to familiarise themselves with how to do this

Preventing abuse is a key component of any effective safeguarding system. Listening to concerns, promoting self determination, and offering choice supports people in protecting themselves

Be sensitive to the challenges of inquiring about abuse. Does the patient want the support of a trusted person? Have you made sure the abuser is not present at the assessment?

Information sharing and reporting are necessary to protect adults at risk. Be aware of when the need to share information outweighs the right to confidentiality

Working in partnership with other agencies and organisations is recognised as good practice and fundamental to ensuring that services provided are safe and of a high quality. Adults at risk may receive care from several different providers, and so a coordinated approach is most effective in safeguarding adults

Box 1 | Summary of types of abuse of vulnerable adults*

Physical abuse—including hitting; slapping; pushing; kicking; misuse of medication, restraint, or sanctions

Sexual abuse—including rape and sexual assault or sexual acts to which the adult at risk has not consented, could not consent, or was pressured into consenting

Psychological abuse—including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks

Financial or material abuse—including theft; fraud; exploitation; pressure in connection with wills, property, inheritance, or financial transactions; misuse or misappropriation of property, possessions, or benefits

Neglect and acts of omission—including ignoring medical or physical care needs; failure to provide access to appropriate health, social care, or educational services; the withholding of the necessities of life such as medication, adequate nutrition, and heating

Discriminatory abuse—including racist, sexist, that based on a person's disability, and other forms of harassment, slurs, or similar treatment

*Adapted from Department of Health. *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*¹

fied to understand whether abuse may have occurred. Behavioural change, such as becoming withdrawn, aggressive, irritable, or emotionally labile, may be a direct result of distress caused by harm. A patient mentioning a change in personal circumstances may lead the doctor to consider the possibility of exploitation by another. For example, a person with a learning disability who was previously financially independent may talk about his or her family “stopping” the money and not allowing the person to make choices. In all such cases, doctors must assess the risk to the individuals and whether there is a need for immediate intervention. Circumstances that would require immediate action would include when someone's life is in immediate danger or there is significant risk of serious harm. Doctors assessing risk should also think about any risk posed to adults at risk other than the patient, to members of the public, or to children.

The primary aim of safeguarding is to keep an individual safe and prevent further abuse from occurring. When assessing abuse, doctors should seek to establish the circumstances surrounding the concerns in an unbiased, objective way. It is important to be mindful of the difficulties the abused person may have in reporting abuse. The person may be frightened that the abuse will become worse if it is revealed and worried that it may leave them vulnerable to other types of harm. Making sure the potential abuser is not present when asking about concerns should help the abused person talk frankly about his or her experiences. Being accompanied by a trusted person may help a vulnerable adult feel supported and more confident in sharing information. For a summary of points to consider during assessment see boxes 2 and 3.

How common is abuse of adults?

Concerns about allegations of abuse are known to be under-reported—with issues about identification, stigma,

Box 2 | Factors to consider when inquiring about abuse*

- The vulnerability of the individual
- The nature and extent of the abuse
- The length of time it has been occurring
- The impact on the individual
- The risk of repeated or increasingly serious acts involving this or other vulnerable adults

*Adapted from Department of Health. *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*¹

Box 3 | Managing the conversation with an individual when abuse is suspected

- Make sure the abuser is not present
- Allow the victim to be accompanied by a trusted person if they wish
- Vulnerable people can have particular difficulties with communication. Ensure they have appropriate support to express themselves clearly (such as a foreign language interpreter or British Sign Language interpreter)
- Be clear what will happen with the information that the victim discloses
- Establish the facts of the allegation of abuse and acknowledge the impact of the abuse on the victim

and institutional systems^{5–6}—and so prevalence is difficult to identify. The Health and Social Care Information Centre reports that there were over 95 000 referrals for adult safeguarding in 2010–11 in England.⁷ Of these, 62% were for women and 61% for adults aged 65 years or older. People with a significant health need constituted a large proportion of the total referrals, including people with a physical disability (49%), with mental health difficulties (23%), with learning disabilities (20%), and with substance misuse problems (7%). International comparisons are difficult to draw given national variations in definitions of abuse and safeguarding.

One systematic review of studies of elder abuse has found that about a quarter of vulnerable elderly people are at risk of abuse, with only a small proportion of these currently detected, and it recommends that adequate standards for abuse measures are developed.⁸ In Hong Kong a study of Chinese elderly people found that 2.5% reported physical abuse,⁹ while in a US study women with disabilities were found to be four times more likely to experience sexual assault than other women.¹⁰ Accounts from carers also shed light on the prevalence of abuse. In the UK a cross sectional survey of family carers for people with dementia found around a third reported important levels of abuse,¹¹ and a Japanese study found 30% of care givers reported potentially harmful behaviour towards an elderly disabled family member.¹² Threshold inconsistencies in determining abuse are just one of the difficulties in safeguarding research.¹³

Who is responsible for protecting vulnerable adults?

The General Medical Council has highlighted the central role of doctors in protecting patients: “Good Medical Practice says that the safety of patients must come first at all times. If you believe that patient safety is or may be seriously compromised ... you should put the matter right if that is possible. In all other cases you should raise your

concern with the organisation you have a contract with or which employs you.”¹⁴

Safeguarding is the responsibility of all clinicians, and anyone can raise a safeguarding concern. All allegations of abuse need to be taken seriously whether made by a patient, carer, healthcare professional, or other service provider. If a third party reports concerns to a general practitioner, the doctor should make inquiries about the nature and circumstances of the allegation. It is particularly important to ask about the safety of the individual at the time the allegation is raised and any support the person has sought.

In addressing abuse, the Department of Health for England and Wales has described six safeguarding principles. Their aim is to inform how safeguarding matters should be approached (see box 4).¹⁵ These recommendations capture the essence of good safeguarding practice and would be of use to a clinician working in any country.

What factors influence the likelihood of abuse?

Certain personal characteristics of adults at risk can increase their vulnerability, and thus susceptibility to abuse (see box 5). A lack of mental capacity to make decisions about their own safety can place individuals at the mercy of others. Those who are unable to make such decisions have impaired ability to protect themselves from bad decisions and may be impaired in asking for help if they experience an abusive act.

Capacity may be impaired permanently, as in some cases of learning disability or brain injury. Temporary incapacity can also arise if conditions such as mental illness or physical illness involving the brain affect decision making sufficiently to disturb capacity. By contrast, people with communication difficulties may have recognised that an abusive act has taken place but are unable to com-

municate that it has occurred. In England and Wales, the Mental Capacity Act¹⁶ makes it clear that a person is assumed to have capacity unless established otherwise. Where people lack capacity to make decisions to protect themselves from abuse, then any acts done or decisions made must be in their best interests. Clinicians must consider if any matters to be resolved can be deferred until capacity returns (such as when mental illness resolves), but this needs to be balanced against ongoing risk of harm. Doctors should also think about whether capacity can be supported in any way, such as through simplifying communication.

Feelings of low self worth in victims can mean that abuse goes unreported. A prior history of abuse, including abuse in childhood, can shape an individual's response to current abuse. Stigma and discrimination of vulnerable people can increase the chance of their becoming a target for abusive types of behaviour.

How should we prevent and respond to abuse?

Abuse can be prevented through services ensuring that they provide safe and effective care. Staff must be supported in raising concerns about practice and action needs to be taken in response. Organisations need to have systems in place to monitor incidents, complaints, and feedback in order to understand what is happening, and should act as early warning systems to identify systemic problems as quickly as possible.³ Staff should be trained and supervised in safeguarding matters to raise awareness and ensure they have the necessary skills to identify abuse and respond.

GPs need to raise awareness of safeguarding in their communities and forge links with other services and stakeholders including local service user and carer groups (such as those offered through organisations like the Alzheimer's Society or National Autistic Society). Interventions should be aimed at making life easier, such as providing mobility aids or treating physical and mental illness to help individuals maintain independence. Such actions reduce barriers to patients making their own choices and reduce their reliance on others. Even when a person requires a high level of personal care, it is important to ensure that services are organised around the individual. The person's choices need to be heard and where possible form part of the plan. Compassion, dignity, and respect are fundamental to all aspects of care. The introduction of personal budgets for social care¹⁷ is one key way that individuals are being helped to take control of the care that they receive. Personal health budgets are to be rolled out in 2013.¹⁸

In England and Wales, statutory requirements for safeguarding adults are set out in the Department of Health document *No Secrets*,¹ and they continue to inform safeguarding practice. This establishes the principles of multiagency working and sets out how this should be achieved locally. In Scotland, the Adult Support and Protection (Scotland) Act 2007¹⁹ describes the function of adult protection committees and sets out the requirements for multiagency working. For Northern Ireland, procedures are described by the Department of Health, Social Services, and Public Safety.²⁰

Box 4 | Six principles of good safeguarding practice*

Empowerment—Presumption of person-led decisions and informed consent

Protection—Support and representation for those in greatest need

Prevention—It is better to take action before harm occurs

Proportionality—Proportionate and least intrusive response appropriate to the risk presented

Partnership—Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse

Accountability—Accountability and transparency in delivering safeguarding

*Taken from Department of Health for England and Wales. Statement of government policy on adult safeguarding.¹⁵

Box 5 | Risk factors for abuse in vulnerable adults

- Lack of mental capacity
- Being physically dependent on others
- Low self esteem
- Previous history of abuse
- Negative experiences of disclosing abuse
- Social isolation
- Lack of access to health and social services or high quality information

EDUCATIONAL RESOURCES

British Medical Association. *Safeguarding vulnerable adults—a tool kit for general practitioners*. BMA, 2011. <http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/safeguardingvulnerableadults.pdf>

General Medical Council. *Raising and acting on concerns about patient safety*. GMC, 2012. www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf

Care Quality Commission. *Raising a concern with CQC: A quick guide for health and care staff about whistleblowing*. www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final_0.pdf

Flynn M. *South Gloucestershire Safeguarding Adults Board. Winterbourne View Hospital. A Serious Case Review*. Available from <http://hosted.southglos.gov.uk/wv/report.pdf>

The Care Quality Commission has a central role in overseeing safeguarding practice for England and Wales through its role in eliminating poor quality care and protecting the rights of individuals.²¹ It emphasises that a central pillar in safeguarding practice is the principle of safe and proportionate information sharing to protect people at risk, to work in partnership with other agencies, and to promote adherence to standards. This can present particular challenges for clinicians, who are used to protecting confidentiality.

Serious case reviews often identify lack of information sharing between agencies as an issue. Doctors must therefore ensure that they share information about their concerns while respecting individuals' right to confidentiality. Patients and carers need to be informed that their right to confidentiality is not absolute and that information may be shared in some circumstances where there is a significant risk of harm to others and in cases where it is in the public interest.²² An example might be that a patient tells their doctor that their mother has been physically abused by a nurse in hospital, but says she does not want to report it. The doctor should explain that this is a serious allegation and that patients other than their relative may be at risk of harm, therefore further inquiries are needed.

When should I refer?

Doctors and health professionals need to familiarise themselves with the policies and procedures concerning safeguarding in their region. There is international variation depending on the law of the country. The United Nations Declaration on Human Rights informs the development of law for the protection of individuals throughout the world (www.un.org/en/documents/udhr/index.shtml).

All concerns regarding significant risk of abuse should be reported to the local services responsible for safeguarding. In England and Wales this would be the local safeguarding investigating team, the lead agency for safeguarding being the local authority.¹ Under section 75 of the Health and Social Care Act 2012,²³ the local authority is able to delegate this authority to other statutory organisations such as NHS partnerships. Doctors need to be aware of how and where to report in their local area. Most safeguarding boards have contact details and information on their websites.

In the UK there is a well established network of named professionals with experience in safeguarding for children and young people, as laid out in an intercollegiate docu-

ment on safeguarding children and young adults.²⁴ Similar roles for safeguarding adults are currently not statutory requirements but are being introduced across the country and becoming part of provider contracts. These can be a valuable source of support and expertise where available. If unsure, doctors should always make a referral for investigation. There is no predetermined threshold for intervention where there are safeguarding concerns. All responses are bespoke and depend on the circumstances of the case.

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