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## **SAFEGUARDING ADULTS**

### **A CONSULTATION ON THE REVIEW OF THE “NO SECRETS” GUIDANCE**

#### **Response by British Society of Rehabilitation Medicine (BSRM)**

Vulnerable adults who require safeguarding have a range of impairments including physical cognitive and behavioural, and in addition may lack mental capacity or have communication difficulties that threaten their autonomy.

The BSRM welcomes this consultation and the opportunity to voice concerns about the current process to protect vulnerable adults. The experience of our members is that there is often inertia in initiating the safeguarding process resulting in harm or a crisis which could have been averted. There is lack of explicit leadership, particularly for people with these needs for safeguarding who are living in the community, who are only seen in outpatient clinics, where more than one health Trust may be involved, in addition to social services. Ensuring the “safety” of the vulnerable adult is often a more costly and time consuming option than remaining indifferent and maintaining the status quo and there may be conflicts of interest. Cost is also a problem in acute hospitals where provision of safe levels of care may require additional staffing.

#### **The BSRM view is that**

- there must be a **clear framework** for safeguarding vulnerable adults
- there should be an **independent lead agency** with no conflict of interest
- the lead agency must be **empowered** to make decisions and act
- these arrangements must be **universal** without freedom for “local interpretation” because currently legislative powers appear to be weak and allow ad hoc interpretations.

#### **The following are the BSRM’s responses to the consultation questions:**

##### **1. Leadership**

This should be determined by the specific situation. There are potential conflicts of interest dependent upon who is the lead agency for the provision or funding of the individual’s care. The lead agency on safeguarding for an individual must be independent of financial concerns and must act in the best interests of the individual. This is best determined at a national level rather than locally, such that there is a robust process for determining the most appropriate lead agency, with systems in place for monitoring and accountability.

## **2. Prevention**

More needs to be done on the raising of awareness of adult abuse, and the process for raising concerns. There is ignorance with regards to what is acceptable to our society, which has resulted in complacency and indifference. Abuse may be a simple error of omission, failing to assist with feeding, failing to provide a safe level of care or may be a deliberate act of neglect or aggression. Situations can arise where vulnerable adults continue to be abused in a variety of ways, this is tolerated due to fears of accusations of prejudice because of diverse cultural issues. This could be resolved by links with the human rights agenda.

## **3. Outcomes**

The safeguarding agenda requires development based on experience, coordinated at local and national level with formal audit and regular review, with statutory obligation to record and report incidents and case reviews. Training of all health, social and care staff is essential. There should be national guidance or standards to direct multi-agency training.

## **6. Health Services and Safeguarding**

Unfortunately a culture of complacency and indifference is sometimes tolerated within institutions. In acute hospitals pressures to reduce length of stay may prevent assessment and investigation of potential adult safeguarding needs with premature discharge back into the “abusing” environment.

There is a tendency to allow relatives/carers to make decisions which may adversely affect the health of an individual who lacks capacity, without challenging that decision or seeking legal advice. The reasons for this may be the beliefs of the carer, or that they do not agree with the recommendations of healthcare professionals. Common examples include failure to administer medication for seizures with potential life threatening consequences, failure to adhere to specific dietary recommendations to prevent aspiration of food and/or fluids into the lungs resulting in malnutrition and recurrent pneumonia, failure to follow moving and handling advice resulting in musculo-skeletal damage.

Consultants in Rehabilitation Medicine, and the teams in which they work, repeatedly find inconsistencies in the way safeguarding issues are dealt with in people with acquired brain injuries due to trauma or illness who have cognitive impairments, who may have reduced mental capacity for some decision making. There needs to be greater understanding of these sometimes subtle impairments. It is anticipated that knowledge of the Mental Capacity Act and its application to all decision making will reduce individual vulnerability.

Education, training and the development of skills and awareness are key to recognition of the need for safeguarding. Systems within the Health Service (both NHS and independent sector) and institutions like residential and nursing homes that provide care, and companies that provide care services to people at home, are far from robust. Some are excellent but others are slow and non-responsive. Investigation of serious safeguarding incidents are protracted, there appears to be no formal reporting system, and whether “lessons are learnt” is dependent upon the priorities of individual organisations and their willingness to engage in the process.

There must be a consistent and co-ordinated approach in every organisation that provides health and care needs with locally monitored standards and accountability. This must be set within and report to a national framework.

## **8. Access to the Criminal Justice System**

The police and criminal justice system will be involved in some cases. Clarification is required to ensure consistency across the country. Information is already shared across agencies with regards to vulnerable adults, but there are concerns about confidentiality within the legal context. A more robust framework for investigation is required with deployment of multi-agency investigation teams.

## **9. Guidance and Legislation**

There is a need for updated *No Secrets* guidance, which is supported by legislation and has power. The details of this need to be debated, although this consultation will assist in that process.

With the recent implementation of the Mental Capacity Act, we believe that this is an appropriate time to review and revise guidance, processes and legislation with regards to adult safeguarding. The BSRM would be willing to assist in the progression of this review and the development of robust guidance.

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