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<thead>
<tr>
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<tbody>
<tr>
<td><strong>Approving Body</strong></td>
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</tr>
<tr>
<td><strong>Date Approved</strong></td>
<td>5 May 2011</td>
</tr>
<tr>
<td><strong>Implementation Date</strong></td>
<td>11 May 2011</td>
</tr>
<tr>
<td><strong>Version</strong></td>
<td>2</td>
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<td><strong>Supersedes</strong></td>
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<tr>
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</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>All staff who are likely to have contact with vulnerable adults</td>
</tr>
<tr>
<td><strong>Supporting Documents and References</strong></td>
<td>See Paragraph 7</td>
</tr>
<tr>
<td><strong>Review Date</strong></td>
<td>April 2014</td>
</tr>
<tr>
<td><strong>Lead Executive</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Author/Lead Manager</strong></td>
<td>Safeguarding Vulnerable Adults and Consent Matron</td>
</tr>
<tr>
<td><strong>Further Guidance/Information</strong></td>
<td>Safeguarding Vulnerable Adults and Consent Matron Ext. 61627</td>
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<tr>
<td>Paragraph</td>
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<tr>
<td>1</td>
<td>Policy Statement</td>
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<td>2</td>
<td>Introduction</td>
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<td>3</td>
<td>Definitions</td>
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<td>Aims</td>
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<td>5</td>
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<td>6</td>
<td>Training and Education</td>
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<td>7</td>
<td>Supporting Staff</td>
</tr>
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<td>8</td>
<td>Summary of the procedure</td>
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<tr>
<td>9</td>
<td>Linked policies</td>
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<tr>
<td>10</td>
<td>Equality and Diversity Statement</td>
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<tr>
<td>11</td>
<td>Equality Impact Assessment Statement</td>
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<td>12</td>
<td>Environmental Impact Assessment Statement</td>
</tr>
<tr>
<td>13</td>
<td>Health and Safety</td>
</tr>
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<td>14</td>
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</tr>
<tr>
<td>15</td>
<td>We are here for you</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Equality and Environmental Impact Assessment Report</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>We Are Here For You Toolkit Assessment</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Defining vulnerable adults and abuse</td>
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<td>------------</td>
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<tr>
<td>Appendix 3</td>
<td>Potential indicators of abuse</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Action for the admitting team when there are concerns about adult abuse or neglect</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Decision to invoke safeguarding adults procedures for reported stage 3 and 4 pressure ulcers</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Safeguarding adults training plan</td>
</tr>
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**SAFEGUARDING VULNERABLE ADULTS AT NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST**

1.0 **Policy Statement**

Nottingham University Hospitals (NUH) recognises its responsibility to ensure the safety and welfare of vulnerable adults in its direct care and in its premises. This policy supports its discharge of this responsibility to protect the social and physical wellbeing of vulnerable adults and to promote their empowerment and welfare, through working practices in NUH, practices in its partnership working, and its assurance framework.

Vulnerable adults will enjoy the same rights as other patients in respect of access to care and treatment.

2.0 **Introduction**

2.1 After the publication of ‘No Secrets’ (DH, 2000), in which it was described that “There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults”, a legal framework, including statutory and non-statutory elements, has been created to regulate the way in which those responsible for care inter-relate, and to specify the multi-agency approach required in working with vulnerable adults.

2.2 This policy defines the way in which Nottingham University Hospitals NHS Trust will ensure that its working practices and procedures will discharge statutory responsibilities and will comply with best-practice framework based on the guidance contained in No Secrets (2000 Department of Health, Home Office) and Safeguarding Adults (2005 Association of Directors of Social Services) and as published by the established responsible local multi-agency groups, notably the Nottingham and Nottinghamshire Safeguarding Adults Boards.

2.3 The Mental Capacity Act 2005 places further duties on the Trust and on individual employees that are of great importance when working with vulnerable adults [see Mental Capacity Act 2005 Policy (2011)]

2.4 Information about Safeguarding Adults including Deprivation of Liberty Safeguards, Domestic Violence and Safeguarding Children can be
found on the Trust intranet on the Safeguarding Vulnerable Adults and Children's and Young Peoples Websites.

2.5 In seeking to protect a vulnerable adult staff may be in conflict with that individual’s right to make decisions for themselves, even if those decisions carry the risk of harm. The proper balance of protection and autonomy is not well understood by the media and members of the public, nor indeed by many people involved in the care of vulnerable adults. Vulnerable adults choosing to accept risks may, as a result, remain in ‘less-than-ideal’ circumstances with professionals and carers undertaking a monitoring role.

2.6 The Trust recognises that employees and volunteers may be involved in distressing cases of abuse or neglect. Employees and volunteers can expect appropriate professional support from line management to support them in their roles and responsibilities.

3. Definitions

3.1 A ‘Vulnerable Adult’ is defined by No Secrets (Department of Health, 2000) as:

‘A person aged 18 years or over who is or maybe in need of community care services by reason of mental or other disability, age or illness’

AND

‘Who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.’

3.2.1 A significant proportion of the Trust’s patients meet this definition and are, therefore, vulnerable.

3.2.2 This vulnerability may extend from the one vulnerable person into their relationships, notably with carers (eg an elder carer may themselves become vulnerable because of their caring)

3.3 ‘Abuse’ encompasses any ‘violation of an individual's human and civil rights by another person or persons...’ It may take many forms [Appendix A].
3.4 **Disclosure** is the process by which someone is made aware of a situation of vulnerability or abuse.

3.5 **Safeguarding Adults** is a national framework of standards for good practice and outcomes in adult protection work.

3.6 **Safeguarding Vulnerable Adults Partnerships** are local eg. Nottingham and Nottinghamshire multi-agency partnerships responsible for steering and developing safeguarding adults work.

3.7 A **Perpetrator** is a person who abuses another person.

3.8 **Deprivation of Liberty Safeguards** (DoLS) are a provision of the Mental Capacity Act 2005 aimed at those who, for their own safety and best interests, need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty.

4.0 **Aims**

To ensure that the Trust meets its statutory obligations and demonstrates effective partnership-working with other agencies to protect vulnerable adults.

4.1 To bring about better outcomes for vulnerable adults.

4.2 To promote Trust-wide staff awareness of safeguarding vulnerable adult issues.

4.3 To develop effective processes by which NUH can ensure the safety and welfare of vulnerable adults.

4.4 To work with other agencies within the local safeguarding adults partnerships to ensure arrangements are in place to manage the risks associated with Safeguarding Adults.

4.5 To protect vulnerable adults in as sensitive and just a manner as possible.

4.6 To support the rights of the individual vulnerable adult to lead an independent life, based on self-determination and personal choice.
4.3 To ensure that lessons learnt from serious case reviews and other scrutiny reports are embedded into practice.

4.4 To ensure that staff understand that safeguarding vulnerable adults awareness/ training is mandatory.

4.5 To clarify the role and responsibilities of staff with regard to safeguarding adults and for the liaison with other statutory agencies.

4.6 The process for supporting staff involved in safeguarding adults.

4.7 The process for monitoring compliance with all of the above.

This policy applies to all areas of the Trust where vulnerable adults may attend or visit.

5.0 Responsibilities

5.1 All Trust staff including volunteers

5.1.2 All NUH staff must act to safeguard the health and welfare of vulnerable adults.

5.1.3 All NUH staff must be familiar with the principles described in this policy, notably its broad scope and the sources of advice should they have concerns regarding a vulnerable adult’s welfare or safety. See Appendix x for levels of training.

5.1.4 All NUH staff should;

- be alert to potential indicators of abuse and/or neglect,
- be alert to risks posed by individual abusers or potential abusers,
- share information and assist with its analysis in order for an informed assessment to be made of the vulnerable adult’s needs and circumstances,
- actively contribute to whatever actions are needed to safeguard, promote, and review the welfare of the vulnerable adult.

5.2 Safeguarding Adults and Consent Matron (Named Nurse for Adult Safeguarding)

The Safeguarding Adults and Consent Matron has responsibility for the development and implementation of Trust policy and procedures for
adult safeguarding. The SAC Matron is also responsible for providing advice to Trust staff and for liaison with the appropriate Local Authority Social Services Department once Safeguarding procedures have been invoked and for maintaining records of the number and nature of alerts raised. Trust Nurse Lead to also liaise with Directorate Safeguarding Adults and Mental Capacity Act Champions to provide support and relevant training.

5.3 Safeguarding Adults Lead Doctor (Pathway Lead clinician for older people)

Has day-to-day medical responsibility for adult safeguarding and Chairs the Trust’s Safeguarding Vulnerable Adults Committee.

5.4 Safeguarding Vulnerable Adults Corporate Lead (Associate Director of Assurance)

Has day-to-day corporate responsibility for ensuring that NUH meets its safeguarding commitments as a multi-agency partner, and the legal responsibilities deriving from the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009, is delegated to the Associate Director of Assurance (SVAC Vice-Chair).

5.5 Independent Mental Capacity Advocate (IMCA)

Someone appointed to support a person who lacks capacity but who has no one to speak/act for them. The MCA regulations extend powers to instruct an IMCA in certain cases where safeguarding adults is concerned.

5.6 The NUH Safeguarding Vulnerable Adults Committee (SVAC)

The Committee will, through its terms of reference;

- Receive recommendations from any relevant statutory body including the both Safeguarding Vulnerable Adults Boards and consider their implications for NUH practice.

- Develop policies and procedures to ensure that Vulnerable Adults are safeguarded whilst in the care of NUH.

- Monitor that staff understand the full scope of their responsibilities for safeguarding vulnerable adults.
• Ensure implementation of legislation and guidance (statutory or non-statutory) relevant to Safeguarding Vulnerable Adults.

• Work in partnership with Health Agencies and other relevant agencies in the local community to Safeguard Vulnerable Adults.

• Support Directorates and Corporate Functions in implementing and monitoring processes and procedures relevant to safeguarding, and in the development of a culture which recognises the individual needs of Vulnerable Adults.

• Agree quality standards, develop audit tools, and develop a training strategy for Vulnerable Adults.

• Receive and disseminate the outcomes of Case Reviews (DH 2006).

• Through its membership ensure that robust mechanisms exist to;
  ➢ provide feedback of relevant information to their Directorates and Corporate Functions via an agreed communication process.
  ➢ actively seek the views of colleagues, and ensure that these views are represented at meetings.

• The Committee will also make appropriate links with other systems designed to protect other groups (e.g. Domestic Violence and Safeguarding Children and Young People).

5.7 Clinical Directors and Executive Directors (as Heads of Corporate Functions)

Clinical Directors and Executive Directors (as Heads of Corporate Functions) will;

• ensure that this Policy is communicated and implemented across the Directorate / Corporate Function.
• incorporate relevant aspects of the Policy into local induction arrangements.
• nominate a representative to sit on the Trust’s Safeguarding Vulnerable Adults Committee (Directorates only)
implement and monitor action plans generated to support the work of the Safeguarding Committee.
ensure that staff involved in Safeguarding vulnerable adults have access to appropriate training, advice and support.
Undertake risk assessments and develop local plans (including patient specific plans) to mitigate and/or manage the risks relating to vulnerable adults.
The named professional will in conjunction with Occupational Health provide appropriate advice and support to staff exposed to sensitive and distressing situations

5.8 The Medical Director

The Medical Director has executive responsibility for safeguarding adults, children and young people. He will convene the Safeguarding Vulnerable Adults Committee to oversee and discharge the Chief Executive’s responsibility.

5.9 The Chief Executive

The Chief Executive is responsible for ensuring that the Board is aware of and discharges its statutory responsibilities for safeguarding.

5.10 The Trust Board

The Trust Board has overall responsibility for ensuring that the Trust makes an effective contribution towards inter-agency working with partner agencies and for appropriately prioritising safeguarding vulnerable adults in its allocation of resources for services and professional training and development.

The Trust Board has nominated the Medical Director as being responsible for assuring the safety and welfare of vulnerable adults, for updating the relevant policies and for ensuring that necessary procedures and processes are available for all relevant staff.

5.11 Safeguarding Vulnerable Adults Boards

The multi-agency bodies in Nottinghamshire that oversee the Safeguarding of Vulnerable Adults are The Nottinghamshire Safeguarding Adults Board and The Nottingham City Safeguarding Adults Board.. Copies of the shared approved / pertinent policies can be obtained via their website: www.nottsadultprotection.org.
Readers are specifically directed to ‘The Nottingham and Nottinghamshire (Nottinghamshire) Safeguarding Adults Policy, Procedure and Guidance’ at www.nottsadultprotection.org for detailed advice.

In keeping with this Policy NUH NHS Trust will adopt the following local arrangements;

5.11.1 endeavour to provide safe and effective delivery of services that facilitate the prevention and early detection of abuse
5.11.2 maintain effective dialogue to ensure co-operation between agencies, including sharing information as appropriate in line with the *Nottinghamshire* Information Sharing Protocol to safeguard vulnerable adults
5.11.3 fully contribute to safeguarding assessments and concerns of abuse in accordance with this policy and procedure
5.11.4 recognise its ongoing duty of care to all service users and facilitate any necessary action to address abusive behaviour
5.11.5 adhere to rigorous recruitment practices to deter those who actively seek vulnerable people to exploit or abuse
5.11.6 provide appropriate advocacy, advice and support when a vulnerable adult’s right to an independent lifestyle and choice is at risk
5.11.7 contribute fully to serious case reviews as necessary or required by the Safeguarding Adults Boards
5.11.8 provide appropriate resources to contribute to the development of the multi-agency framework

6.0 Training & Education

6.1 The Trust accepts that all members of staff who have contact with vulnerable adults must be trained in the relevant Trust policy and procedures. The specific training requirements and implementation plans will be assessed annually by means of the Trust’s Statutory and Mandatory Training Policy and supporting Training Needs Analysis.

6.2 The Trust will, through the Safeguarding Vulnerable Adults Committee, ensure that the necessary training is made available. This will be monitored by the production of monthly Directorate mandatory training reports provided by the Learning and Organisational Development Department.
6.3 All Multi-Agency policies and procedures adopted by the Trust will be available to staff via the Trust Intranet.

6.4 Please refer to Appendix X for Safeguarding Adults Training strategy.

7.0 Supporting Staff

7.1 Adult Abuse can be a particularly challenging area of clinical practice. Those who are involved in an adult protection case can be subjected to very distressing circumstances, potentially outside of their normal remit.

7.2 In the event of a staff member being involved in an adult safeguarding investigation, supervision and support will be provided, in the first instance through their line manager/clinical supervisor.

7.3 If more formal support is required, this can be accessed through the Occupational Health Department or the Employee Assistance Programme.

*Please refer to policy and procedures for Supporting staff involved in incidents contained within the Psychological Wellbeing at work policy.*

8.0 Summary of the Procedure

Anyone who is told of or suspects abuse/ neglect/ deprivation of liberty of any vulnerable adult should report the incident in line with the attached procedures.

When suspecting abuse/ neglect/ deprivation of liberty or on receipt of a disclosure.

8.1 Where necessary contact the Trust’s Safeguarding Adults and Consent Matron or one of the individual Directorate Safeguarding Adults and Mental Capacity Act Champions for any clarification or advice on invoking the procedures. See Appendix X for contact details.

8.2 Where applicable, in line with best practice for management of Domestic Violence, make available contact details for local Domestic Violence services. Additional information on domestic violence can be found in the Trust’s Domestic Violence Policy.

8.3 Where there are concerns regarding the health and welfare of children and young people linked to a safeguarding adult issue, where applicable, invoke safeguarding children’s procedures ensuring that
this is communicated in the vulnerable adults referral. Please see NUH Safeguarding Children and Young People's Policy.

8.4 Telephone referral through to relevant social care department. (see Appendix 4

8.5 Send proforma form to Safeguarding Adults and Consent Matron see Appendix 4

8.6 Record in the vulnerable adults medical notes that a safeguarding adults referral has been invoked and the nature of the concerns.

8.7 Inform Line Manager of situation

8.8 When dealing with a confirmed or suspected abuse or neglect incident, all relevant findings and conversations must be fully and clearly documented in the patient’s notes.

8.9 Staff must not initiate their own investigations.

8.10 Where appropriate, in accordance with the Mental Capacity Act, an Independent Mental capacity Advocate should be appointed where the abused person lacks mental capacity and the appointment of an IMCA will benefit the abused person.

8.11 Staff who feel that concerns are not being addressed appropriately have the right to use the Trust’s Whistleblowing procedures.

8.12 Where there is concern that the interagency arrangements are not working successfully, the Safeguarding Adults and Consent Matron should be contacted.

9.0 Linked Policies

9.1 This Policy should be read in conjunction with the following Trust Policies:

- Discharge and Transfer of Patients from Hospital Policy
- Assessment and Management of Individuals who Pose a Risk to Children Policy and Procedure
- Multi-agency Mental capacity Act Policy
Multi-agency Deprivation of Liberty Safeguards Policy
Managing Domestic Abuse in a Healthcare Setting Policy
Criminal Records Bureau (CRB) Checking Policy

10.0 Equality and Diversity Statement

10.1 All patients, employees and members of the public should be treated fairly and with respect, regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social & employment status, HIV status, or gender re-assignment.

10.2 All trust polices and trust wide procedures must comply with the relevant legislation (non-exhaustive list) where applicable:

- Sex Discrimination Act (1975 amended 1986)
- Race Relations (Amendment) Act 2000
- Disability Discrimination Act (1995)
- Employment Relations Act (1999)
- Rehabilitation of Offenders Act (1974)
- Trade Union and Labour Relations (Consolidation) Act 1999
- Code of Practice on Age Diversity in Employment (1999)
- Civil Partnership Act 2004
- Fixed Term Employees - Prevention of Less Favourable Treatment Regulations (2001)
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003
- Employment Equality (Age) Regulations 2006
- Equality Act (Sexual Orientation) Regulations 2007

11.0 Equality Impact Assessment Statement

11.1 NUH is committed to ensuring that none of its policies, procedures, services, projects or functions discriminate unlawfully. In order to ensure this commitment all policies, procedures, services, projects or functions will undergo an Equality Impact Assessment.
12.0 Environmental Impact Assessments

12.1 The purpose of an Environmental Impact Assessment is to make sure that when carrying out its public functions (or implementing policies and practices related to those functions) the trust considers the likely impact of the policy in causing change to the environment, and whether this change is harmful or helpful. This may involve direct effects such as changes in the use of resources, waste levels, or energy, (as some examples). Further guidance on environmental impacts may be found in: Sustainable Development - Environmental Strategy for the National Health Service (www.dh.gov.uk) and Sustainable Operations on the Government Estate (www.defra.gov.uk).

13.0 Health and Safety

13.1 The Trust accepts that it has a responsibility to ensure that the environment in which its staff work and patients are treated is safe. The procedures attached to this policy are designed to ensure the security of the working environment. The Trust also acknowledges its responsibility for the safety of members of the public who are on Trust premises for a legitimate reason.

14.0 Monitoring and Review

14.1 The effectiveness of this Policy will be monitored by the Trust’s Safeguarding Committee, who will audit and evaluate incidents and practice and provide reports as required to demonstrate how the Trust is performing against the policy and best practice.

14.2 The Safeguarding Committee will produce a bi-monthly update to the Clinical Effectiveness Committee on the work being undertaken against it’s Terms of Reference and detailing any key risks / issues identified that require higher level discussion / action.

14.3 The Safeguarding Committee will produce an annual report to the Trust Board detailing the Trust’s performance against Safeguarding Vulnerable Adults policy and practices.
<table>
<thead>
<tr>
<th>Monitoring Requirement</th>
<th>To determine the degree of compliance with the minimum requirements contained within the policy/ procedures by:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Identification of the number and nature of safeguarding adults’ referrals made including requests for deprivation of liberty safeguards.</td>
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<tr>
<td></td>
<td>• Identification of any concerns in the completion of the referrals, including the timing of referrals made</td>
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<tr>
<td></td>
<td>• To advise the Trust of local arrangements implemented for managing risks associated with safeguarding adults.</td>
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<tr>
<td></td>
<td>• To advise the Trust of any changes required to the policy/ procedures</td>
</tr>
<tr>
<td></td>
<td>• To advise the Trust of training opportunities available and those taken up by staff.</td>
</tr>
<tr>
<td></td>
<td>• To advise the Trust of any remedial actions/ action plans required in response to disclosures and or results of serious case reviews</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring Method</th>
<th>• Identification of the number of staff from all Directorates attending training/ awareness and for which courses. Using OLM.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Analysis of Safeguarding referrals by Directorates for type of abuse, age group and client group.</td>
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<tr>
<td></td>
<td>• Review the robustness and timeliness of all safeguarding adults referrals.</td>
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<tr>
<td></td>
<td>• Whether staff members/</td>
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</table>
15. **We are here for you**

The Trust is committed to providing the highest quality of care to our patients, so we can pledge to them that ‘we are here for you’. This Trust supports a patient centred culture of continuous improvement delivered by our staff. The Trust established the Values and Behaviours programme to enable Nottingham University Hospitals to continue to improve patient safety, outcomes and experiences. The set of twelve agreed values and behaviours explicitly describe to employes the required way of working and behaving, both to patients and each other, which would enable patients to have clear expectations as to their experience of our services.
### Section One: Equality and Environmental Impact Assessment

<table>
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<tr>
<th>What is being assessed?</th>
<th>Is the policy/function/service/project</th>
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<tbody>
<tr>
<td>Policy ☒ Guideline ☐ Procedure ☐ Plan ☐</td>
<td>Existing ☒ Proposed ☐</td>
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<tr>
<td>Service ☐</td>
<td>Changing/Reviewed ☒</td>
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<table>
<thead>
<tr>
<th>Name of Policy or Service</th>
<th>Name of Responsible Manager</th>
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</thead>
<tbody>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>Medical Director</td>
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</table>

<table>
<thead>
<tr>
<th>Give a brief description, aims and objectives of the Policy/Guideline/Procedure/Plan/Service</th>
<th>Will there be a requirement to consult on the proposed Policy, Guideline, Procedure, Plan or Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This policy defines the way in which Nottingham University Hospitals NHS Trust will ensure that its working practices and procedures will discharge statutory responsibilities and will comply with best-practice framework based on the guidance contained in No Secrets (2000 Department of Health, Home Office) and Safeguarding Adults (2005 Association of Directors of Social Services) and as published by the</td>
<td>Yes ☒ No ☐</td>
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<table>
<thead>
<tr>
<th>If Yes who will be consulted?</th>
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<tr>
<td>Staff ☒ Patients ☒ Stakeholders ☒</td>
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| Environment ☐ | Staff ☒ Patients ☒ Stakeholders ☒ |
established responsible local multi-agency groups, notably the Nottinghamshire Committee for the Protection of Vulnerable Adults.
### Section Two: Screening Checklist

Does your Policy, Guideline, Procedure, Plan or Service contain any statements or actions which may potentially impact upon any of the following Areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>If “Yes” please complete the Full Impact Assessment in section 4</td>
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<tr>
<td>If “No” please give reasons on the summary sheet in section 3</td>
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#### EQUALITY

<table>
<thead>
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</tr>
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<tbody>
<tr>
<td>Age</td>
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<td>Sexual Orientation</td>
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<td>Religion or Belief</td>
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<td>Disability</td>
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<td>Dignity &amp; Human Rights</td>
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#### ENVIRONMENTAL

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<tr>
<td>Water</td>
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</table>
### Section Three: Summary of Screening

**Please state your reasons below giving as much information as possible including any relevant data to support your findings**

| **Equality** | The policy is designed to ensure that all vulnerable patients who are in the care of Nottingham University Hospitals NHS Trust receive safe and effective medical and social assessment and care regardless of their actual or perceived race, religion, sexual orientation, Age, gender, disability, social status and will not infringe upon their basic human rights. The policy supports to protect the social and physical wellbeing of vulnerable adults and to promote their empowerment and welfare, through working practices in NUH, practices in its partnership working and its assurance framework |
| **Environment** | The policy is not applicable to environmental issues. |

<table>
<thead>
<tr>
<th><strong>Date EIA Completed</strong></th>
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</thead>
<tbody>
<tr>
<td>17 May 2010</td>
<td><strong>Please state the monitoring and review arrangements</strong></td>
<td><strong>State the names of those involved in the EEIA assessment:</strong></td>
</tr>
<tr>
<td><strong>Reviewed 10 March 2011</strong></td>
<td>Once ratified, this policy should be reviewed inline with NUH guidelines</td>
<td><strong>Name</strong></td>
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<td>EIA Officer</td>
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<td><strong>Reviewed 10 March 2011</strong></td>
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<td>Safeguarding adults</td>
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</table>

**COMPLETE THIS SECTION IF YOU HAVE ANSWERED “NO” IN THE SCREENING SECTION**
We Are Here For You Policy and Trust-wide Procedure Compliance Toolkit

The We Are Here For You service standards have been developed together with more than 1,000 staff and patients. They can help us to be more consistent in what we do and say to help people to feel cared for, safe and confident in their treatment. The standards apply to how we behave not only with patients and visitors, but with all of our colleagues too.

They apply to all of us, every day, in everything that we do. Therefore, their inclusion in Policies and Trust-wide Procedures is essential to embed them in our organization.

This toolkit has been designed for Policy Owners to assess the compliance of their Policy or Trust-wide Procedure in light of the We Are Here For You values. It is now mandatory for all Policies and Trust-wide Procedures to incorporate the We Are Here For You Values and undergo this compliance assessment.

Please complete the grid below to assess your Policy or Trust-wide Procedure. The toolkit will then advise Policy-owners on the steps they need to take to become We Are Here For You compliant.

To what extent is your Policy or Trust-wide Procedure affected by the following We Are Here For You values?

Please rate each value from 1 – 3 (1 being not at all, 2 being affected and 3 being very affected)

<table>
<thead>
<tr>
<th>1. Polite and Respectful</th>
<th>3</th>
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<tbody>
<tr>
<td>Whatever our role we are polite, welcoming and positive in the face of adversity, and are always respectful of people’s individuality, privacy and dignity.</td>
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</table>

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<th>2. Communicate and Listen</th>
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<tr>
<td>We take the time to listen, asking open questions, to hear what people say; and keep people informed of what’s happening; providing smooth handovers.</td>
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</table>
### 3. Helpful and Kind

All of us keep our ‘eyes open’ for (and don’t ‘avoid’) people who need help; we take ownership of delivering the help and can be relied on.

### 4. Vigilant (patients are safe)

Every one of us is vigilant across all aspects of safety, practices hand hygiene and demonstrates attention to detail for a clean and tidy environment everywhere.

### 5. On Stage (patients feel safe)

We imagine anywhere that patients could see or hear us as a ‘stage’. Whenever we are ‘on stage’ we look and behave professionally, acting as an ambassador for the Trust, so patients, families and carers feel safe, and are never unduly worried.

### 6. Speak Up (patients stay safe)

We are confident to speak up if colleagues don’t meet these standards, we are appreciative when they do, and are open to ‘positive challenge’ by colleagues.

### 7. Informative

We involve people as partners in their own care, helping them to be clear about their condition, choices, care plan and how they might feel. We answer their questions without jargon. We do the same when delivering services to colleagues.
8. Timely
We appreciate that other people’s time is valuable, and offer a responsive service, to keep waiting to a minimum, with convenient appointments, helping patients get better quicker and spend only appropriate time in hospital. 2

9. Compassionate
We understand the important role that patients' and family’s feelings play in helping them feel better. We are considerate of patients’ pain, and compassionate, gentle and reassuring with patients and colleagues. 3

10. Accountable
Take responsibility for our own actions and results 3

11. Best Use of Time and Resources
Simplify processes and eliminate waste, while improving quality 2

12. Improve
Our best gets better. Working in teams to innovate and to solve patient frustrations 3

TOTAL 34
Nottingham and Nottinghamshire Safeguarding Adults Procedures

Defining vulnerable adults and abuse

Vulnerable Adult

A ‘Vulnerable Adult’ as defined by No Secrets (DH 2000) is:

‘A person aged 18 years or over who is or maybe in need of community care services by reason of mental or other disability, age or illness;

AND

Who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.’

Significant harm refers to: ‘ill treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development.’ ("Who decides?" Law Commission 1997).

The term adult abuse is subject to wide interpretation. ‘No Secrets’ provides the following definition as a starting point:

Abuse is a violation of an individual’s human and civil rights by any other person or persons.

For the purposes of this document community care services are taken to include all care services provided in any setting or context. The term describes care in its widest sense.

Those in need of community care services may include:

- People with a Learning Disability
- People with a Physical Disability
- People with Mental Ill Health
- People who are Profoundly Deaf
- People who are Visually Impaired
- People who are Deaf/Blind
- People over 65
- People with HIV/AIDS
Carers of people in need of community care services may also be vulnerable adults and subject to abuse from the people they care for. (Note: the term ‘carer’ does not include those paid to provide care or acting as volunteers).

Of course not all individuals from these groups would see themselves, or be seen by others, as ‘vulnerable adults’. An individual may be both a vulnerable adult and a carer. Assessment of the environment and context should be taken into account when determining if an individual is vulnerable, as well as the person’s capacity.

Types of Abuse

There are many different kinds of abuse and, whilst short comprehensive definitions are difficult, the important features are outlined here, taken from No Secrets and recommended in the interests of achieving a "common language" when discussing abuse:

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

Sexual abuse including; rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or is incapable of giving informed consent or was pressured into consenting; this may involve contact or non-contact abuse (e.g. touch, masturbation, being photographed, teasing, inappropriate touching).

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 or inheritance or financial transactions, or the 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, culture and discrimination and other forms of harassment, slurs or similar treatment. Abusive activity may be of an organised kind – the work of a number of people victimising others.

Institutional abuse where neglect and poor professional practice in care settings also need to be taken into account. It may take the form of isolated incidents of poor practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. It can occur when the routines, systems, communications and norms of an institution compel individuals to sacrifice their preferred life style and cultural diversity to the needs of that institution. Repeated instances of poor care may be an indication of more serious problems.

In reality, abusive situations are rarely as tidily or straightforwardly described as these categories suggest, so remember to listen carefully when being told something and where there is any doubt about defining a situation of adult abuse, discuss it with your Line Manager.

Self Harm and Neglect - The remit of the Nottinghamshire Safeguarding Adults Policy does not include self-harm. However, it is acknowledged that this is a serious challenge to all care providers and should be addressed by organisations’ own internal procedures.

The National Institute for Clinical Excellence’s (NICE) clinical Guideline on Self Harm (2004) states that;

"People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, professionals should take full account of the likely distress associated with self-harm”.

Self-harm, as defined in the NICE guideline, is:

"An expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same.

People who harm themselves may feel that they are alone, but self-harm is more common than many people realise. The methods of self-harm can be divided into two broad groups: self-injury and self-poisoning. The most
common method of self-injury is by cutting oneself. Less common methods include swallowing objects, putting objects inside the body, burning, hanging, stabbing, shooting and jumping from heights or in front of vehicles. Self-poisoning involves overdosing with a medicine or medicines, or swallowing a poisonous substance. The majority of people who attend emergency departments after self-poisoning have taken over-the-counter medication. Other people take medicines that have been prescribed by their doctor. A small number of people take a large amount of an illegal drug or poison themselves with another substance. Alcohol may also play a part. Self-injury is more common than self-poisoning as an act of self-harm, although people who self-poison are more likely to seek professional help. During acts of self-harm, it is common for people to feel separate or disconnected from their feelings and their pain”.

Self-neglect is any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short period of time, serious physical, mental or emotional harm or substantial damage to or loss of assets.

Self-neglect can happen as a result of an individual's choice of lifestyle, or the person may:

- be depressed;
- have poor health;
- have cognitive (memory or decision making) problems, or;
- be physically unable to care for self.

Self-neglect includes:

- Living in unsanitary conditions;
- Suffering from an untreated illness, disease or injury;
- Suffering from malnutrition to such an extent that, without an intervention, the adult's physical or mental health is likely to be severely impaired;
- Creating a hazardous situation that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of assets, and;
- Suffering from an illness, disease or injury that results in the adult dealing with his or her assets in a manner that is likely to cause substantial damage to or loss of the assets.
POTENTIAL INDICATORS OF ABUSE

The aim of this guidance is to minimise the risk by early intervention once abuse has occurred, by providing staff with a list of possible indicators and signs of abuse.

This guidance is by no means exhaustive and you should not wait until one of these indicators becomes apparent. If you are ever in doubt whether a vulnerable adult has been abused, you should alert the person responsible for Referring and your manager (if different) immediately in line with the Safeguarding Adults Procedure.

Possible Indicators of Abuse

Discriminatory abuse including; racist, sexist, that based on a person’s disability, culture and discrimination and other forms of harassment, slurs or similar treatment may be indicated by:

- lack of respect shown to an individual;
- signs of a sub-standard service offered to an individual;
- repeated exclusion from rights afforded to citizens such as health, education, employment, criminal justice and civic status.

Physical abuse including; hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions may be indicated by:

- any injury not fully explained by the history given;
- injuries inconsistent with the lifestyle of the vulnerable adult;
- bruises and/or welts on face, lips, mouth, torso, arms, back, buttocks, thighs;
- clusters of injuries forming regular patterns;
- burns;
- friction burns, rope or electric appliance burns;
- multiple fractures;
- lacerations or abrasions to mouth, lips, gums, eyes, external genitalia;
- marks on body, including slap marks, finger marks;
- injuries at different stages of healing;
- medication misuse.
Sexual abuse including; rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or is incapable of giving informed consent or was pressured into consenting. This may involve contact or non-contact abuse (e.g. touch, masturbation, being photographed, teasing, inappropriate touching) may be indicated by:

- significant change in sexual behaviour or attitude;
- pregnancy;
- wetting or soiling;
- poor concentration;
- vulnerable adult appearing withdrawn, depressed, stressed;
- unusual difficulty in walking or sitting;
- torn, stained or bloody underclothing;
- bruises, bleeding, pain or itching in genital area;
- sexually transmitted diseases, urinary tract or vaginal infection, love bites;
- bruising to thighs or upper arms.

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 may be indicated by:

- change in appetite;
- low self esteem, deference, passivity and resignation;
- unexplained fear, defensiveness, ambivalence;
- emotional withdrawal;
- sleep disturbance.

Financial or material abuse: including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits may be indicated by:

- unexplained sudden inability to pay bills or maintain lifestyle;
- unusual or inappropriate bank account activity;
- withholding money;
- recent change of deeds or title of property;
- unusual interest shown by family or other in the person’s assets;
- person managing financial affairs is evasive or uncooperative;
- misappropriation of benefits and/or use of the person’s money by other members of the household;
• fraud or intimidation in connection with wills, property or other assets.

**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 may be indicated by:

• physical condition of person is poor e.g. bed sores, unwashed, ulcers;
• clothing in poor condition e.g. unclean, wet, ragged;
• inadequate physical environment;
• inadequate diet;
• untreated injuries or medical problems;
• inconsistent or reluctant contact with health or social care agencies;
• failure to engage in social interaction;
• malnutrition when not living alone;
• inadequate heating;
• failure to give prescribed medication;
• poor personal hygiene;
• failure to provide access to key services such as health care, dentistry, prostheses.

**Institutional abuse**; Neglect and poor professional practice in care settings, also need to be taken into account. It may take the form of isolated incidents of poor practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. It can occur when the routines, systems, communications and norms of an institution compel individuals to sacrifice their preferred lifestyle and cultural diversity to the needs of that institution. Repeated instances of poor care may be an indication of more serious problems. Institutional Abuse may be indicated by:

• inappropriate or poor care;
• misuse of medication;
• restraint;
• sensory deprivation e.g. denial of use of spectacles, hearing aid etc;
• lack of respect shown to personal dignity;
• lack of flexibility and choice: e.g. mealtimes and bedtimes, choice of food;
• lack of personal clothing or possessions;
• lack of privacy;
• lack of adequate procedures e.g. for medication, financial management;
• controlling relationships between staff and service users;
• poor professional practice.
**Fundamental care and the quality of the environment. This includes signs that:**

- The service is unable to keep people safe, meet their care needs and treat them with dignity;
- Individuals have little to do;
- The environment is in a poor state or cold / unclean.

**Patterns of abuse/abusing**

Patterns of abuse and abusing vary and reflect very different dynamics. They include:

- serial abusing, in which the perpetrator seeks out and ‘grooms’ vulnerable individuals. Sexual abuse usually falls into this pattern, as do forms of financial abuse;
- long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations;
- opportunistic abuse such as theft occurring because money is easily accessible;
- situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour;
- neglect of a person’s needs because those around him or her are not able to be responsible for their care - for example if the carer has difficulties attributable to issues such as debt, alcohol misuse or mental health problems;
- institutional abuse featuring poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and insufficient knowledge base within the service;
- unacceptable ‘treatments’ or programmes which include sanctions or punishment such as withholding of food or drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication.
**Action for the admitting team when there are concerns about Adult Abuse or Neglect**

**Concerns about an Adult:**
- Ensure the immediate safety and welfare of The Vulnerable Adult
- Ensure Adult has a physical examination by a Dr at F2 level and a ‘Body Map’ is completed

Inform your manager & make a referral to Adult Social Care.

Inform the Adult’s Consultant.
Document all concerns and discussions in the Medical/Nursing Notes.

Phone the “Safeguarding Adults Referral” to Social services within 24hrs of alert being received. Use the referral pro-forma form to help you collect relevant information.

>You do not need to send this to Social Services.
Social Services will follow up the referral within 24hrs and will contact the referer to inform them of the outcome.

Inform the family/Carer that advice is being sought and/or a referral has been made.
(Unless to do so would put the Adult at risk!)

**NB:** The Adult should not be discharged until the MDT team, including the Consultant, has agreed a plan and the Adult is in a place of safety. You must liaise with Social Services and other relevant agencies e.g. Police

**For All Relevant Documents and more information see:**
- The “Nottingham and Nottinghamshire Safeguarding Adults Policy, Procedure and Guidance for Alerters and Referrers” - available in all Clinical Areas.
- **Nottinghamshire Adult Protection website:** -www.nottsadultprotection.org
- NUH Safeguarding Vulnerable Adults Committee 2008 c/o Bella Furse

**Referral forms are available in all clinical areas/via Trust Intranet**

**Body Map is Available in the Policy, Procedures and Guidance Document**

**Social Services Tel numbers**
- City: - 01158838460
- County: - 08449 80 80 80
- Out of Hours City: - 01159159299
- County: - 03004564545

If Further Advice is required contact: -
Dr: - Rob Morris mobile No: - 07970086731
RN: Bella Furse Safeguarding Adults Matron Mobile: 07775226277
**Decision to invoke Safeguarding Adults procedures for reported stage 3 and 4 pressure ulcers.**

A referral to social care and a strategy discussion is required when there is a high risk of serious harm being caused by acts or omissions which could have reasonably been avoided. This applies whether the patient is being treated for a pressure ulcer or not.

After presentation of root cause analysis’s at Pressure Ulcer Strategy meeting. The following questions should be considered:

1) **Are there concerns that all reasonable steps have not been taken to prevent the pressure ulcer?**

2) **Is the adult vulnerable? (DH definition of Vulnerable Adult)**

A vulnerable adult, for the purpose of these procedures is any person aged 18 years or over who is or maybe in need of community care services by reason of mental or other disability, age or illness;

And

Who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

3) **Is there evidence of neglect?**

Not all pressure ulcers in a vulnerable adult are the result of neglect.

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, and that this has resulted in, or is highly likely to result in (when considering other vulnerable adults in the same situation), a preventable pressure ulcer.
Should the illness, behaviour or disability of the vulnerable adult have reasonably required the monitoring of skin condition (where no monitoring has taken place prior to serious pressure ulcers occurring)?

If monitoring was then refused by the vulnerable adult was it reasonable for advice to be sought? The vulnerable adult’s consent to monitoring should always be sought but if the person lacks mental capacity to make a decision regarding this, then a decision will need to be taken in their best interests.

If monitoring agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Would monitoring have shown changes in the presentation of the skin (eg persistent change in colour, temperature of skin etc) that should have triggered the need for intervention or the seeking of more expert assistance that would have prevented serious harm or its high likelihood?

Was the appropriate expert assistance sought? If so did that result in a care plan/equipment provision appropriate to address the pressure care needs of the vulnerable adult? Did the care plan address the management of risks that should have reasonably been identified? (eg the high risk of non compliance.)

Was the care plan adhered to and revised appropriately?

Was the equipment provided in a timely manner and used appropriately?

4) Are there concerns that all reasonable steps have not been taken to prevent the pressure ulcer?

If the answer to the above 4 questions is yes then Safeguarding Adults procedures should be invoked and a referral to social care made by Safeguarding Adults and Consent Matron. RCA to be shared with allocated social work manager.
## Safeguarding Adults Training Plan

<table>
<thead>
<tr>
<th>Training</th>
<th>Action and Input Required</th>
<th>Responsible Person</th>
<th>Review Date</th>
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</table>
| **Level 1- Basic Awareness Training for all staff working within the health care setting (clinical and non-clinical) Combined session Children & Adults** | - Basic awareness of how to recognise signs of abuse, what to do, information sharing, and policies/procedures. To be combined training both adult and children and young people.  
- 30 minute training session  
- Drop in sessions  
- Available to book via Learning & Organisational Development  
- Updates 3 yearly | Safeguarding Nurse Specialist (children) Training and Education  
Safeguarding Adults and Consent Matron  
Mandatory Training Coordinator, Learning and Organisational Development. | Review April 2011 |
| **Level 2- Targeted for those professional staff predominantly in contact with vulnerable adults.** | - As level 1 plus an understanding of the Mental Capacity Act, Deprivation of Liberty Safeguards and Learning Disability Awareness  
- To understand roles and responsibilities in relation to adult safeguarding to identify those adults at increased risks. An understanding of documentation and to be able to share concerns effectively. To educate qualified staff to be able to make a referral to social care.  
- 1.5 hr Hour course  
- Also forms part of Corporate Induction for Nurses & Midwives | Safeguarding Adults and Consent Matron  
Acute Learning Disabilities Liaison Nurses  
Safeguarding Trust Champions | Review April 2011 |
| Level 3- Training for Safeguarding Adults Champions |  
|-----------------------------------------------|---|
| Full day’s course provided by outside trainer | Safeguarding Adults and Consent Matron |
| Detailed training on making a referral       |                                      |
| Explores whole safeguarding process          |                                      |
| Case studies                                 |                                      |
| Tips for investigating                       |                                      |

- Advertised in intranet, booked Training & Development.
- 3 yearly updates
- Updates to any procedure via intranet/ward managers
- Option of E learning for MCA
CERTIFICATION OF EMPLOYEE AWARENESS

<table>
<thead>
<tr>
<th>Document Title</th>
<th>SAFEGUARDING VULNERABLE ADULTS POLICY</th>
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<tbody>
<tr>
<td>Version (number)</td>
<td>2</td>
</tr>
<tr>
<td>Version (date)</td>
<td>5 May 2011</td>
</tr>
</tbody>
</table>

I hereby certify that I have:

- Identified (by reference to the document control sheet of the above policy/ procedure) the staff groups within my area of responsibility to whom this policy/ procedure applies.
- Made arrangements to ensure that such members of staff have the opportunity to be aware of the existence of this document and have the means to access, read and understand it.

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<th>Signature</th>
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<tr>
<td>Date</td>
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<tr>
<td>Directorate/ Department</td>
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</table>

The manager completing this certification should retain it for audit and/or other purposes for a period of six years (even if subsequent versions of the document are implemented). The suggested level of certification is;

- Clinical directorates - general manager
- Non clinical directorates - deputy director or equivalent.

The manager may, at their discretion, also require that subordinate levels of their directorate/ department utilize this form in a similar way, but this would always be an additional (not replacement) action.