Guidance for Adult Support and Protection

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1. Purpose

1.1 The purpose of this guidance is to provide NHSGGC with a structured framework through which Adult Support and Protection (ASP) is recognised and acted on by all staff who come in to contact with adults who are at risk of harm and/or in need of care and protection. This guidance is for all employees of NHSGGC including independent contractors. Further advice and guidance can be obtained from Public Protection Service 9am – 5pm Monday to Friday on 0141 451 6605.

2. Introduction

2.1 Most adults, who might be considered to be at risk of harm, manage to live their lives without experiencing harm. Often this is with the assistance of caring relatives, friends, paid carers, professional agencies or volunteers. However, some people will experience harm such as physical harm, psychological harm, self-harm, neglect, sexual harm or exploitation of their finances or property. The Adult Support and Protection (Scotland) Act (2007)[1] was introduced to maximise the protection of adults at risk of harm. All staff in NHSGGC are responsible to ensure that adults who may be at risk of harm are safe, respected and included in all decision making.

3. Aims and Objectives

3.1 This guidance document aims to provide all staff with the ability to be able to recognise, respond, record and refer adult support and protection concerns.

NHSGGC ASP guidance is underpinned by the following objectives:

- To ensure safe, person centred, effective and consistent practice in relation to working with vulnerable adults and preventing harm.
- To provide an understanding of legislation underpinning ASP.
- To provide the principles and definition of ASP under the Adult Support and Protection (Scotland) Act (2007)[1]
- To provide guidance on how to identify harm and harmful situations.
- To ensure practitioners understand their roles and responsibilities, including the duty to cooperate and share information with statutory agencies.
- To ensure the referral process is clearly defined.
- To provide an overview of the local authorities adult protection procedures.
- Ensure staff know how and where to seek advice from.

[1] Adult Support and Protection (Scotland) Act (2007) Adult Support and Protection (Scotland) Act 2007 (legislation.gov.uk)

4. Definition of Adult Support and Protection

4.1 The Act defines an 'adult at risk' as individuals aged 16 years or over who:

- are unable to safeguard their own well-being, property, rights or other interests;
- are at risk of harm, and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected

This is often referred to as the **3 point test**. Not all adults who have a physical or mental infirmity constitutes an adult at risk of harm.

4.2 **Health professionals do not need to have to evidence that the three criteria are met in order to make an ASP referral.** The information submitted may form part of a larger picture and that the professional 'knows or believes' the adult to be at risk of harm.

4.3 Even though the Act defines an adult as aged 16, there are various definitions of the boundaries of adulthood and childhood. National updated Guidance for Child Protection in Scotland[2] incorporates the United Nation Convention on the Rights of the Child[3] which includes young people up to the age of 18.

5. The Adult Support and Protection (Scotland) Act[1]

5.1 The Adult Support and Protection (Scotland) Act[1] provides ways to offer support and protection to adults who may be at risk of harm or neglect.

The Act:-

- Provides greater protection to those thought or known to be at risk of harm through powers to investigate and intervene in situations where concern exists.
- Places a duty on councils to make inquiries and investigations to establish whether or not further action is required to stop or prevent harm.
- Places a clear duty on specified organisation, including the NHS to report and co-operate in investigations

5.2 The Basic Principles of the Act Include:

- the past and present wishes and feelings of the adult where they are relevant
- the views of other significant individuals, such as the adult's nearest relative, their primary carer, guardian or attorney.

[2] **National Guidance for Child Protection in Scotland 2021** National Guidance for Child Protection in Scotland 2021 - updated 2023 - gov.scot (www.gov.scot)

[3] **The United Nations Convention on the Rights of the Child 1989** unicef-convention-rights-child-uncrc.pdf

5.3 Other relevant pieces of legislation designed to support and protect adults at risk of harm such as the:

- Adults with Incapacity (Scotland) Act 2000[4]
- Mental Health (Care and Treatment) (Scotland) Act 2015[5]

5.4 ASP sits alongside these pieces of legislation, one of which does not preclude the other. For adults who are subject to mental health legislation The Act should still be considered to ensure the adults rights are upheld.

6.0 What is meant by Harm?

6.1 An adult is at risk of harm if

- another person's conduct is causing (or is likely to cause) the adult to be harmed or
- the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

6.2 Harm includes all harmful conduct and in particular includes those outlined below. This this list is not exhaustive. ***Appendix 1*** presents examples of recent ASP referrals within NHS GGC from HSCPs and the acute setting and are presented under the various types of harm with some demonstrating a range of harms. The case vignettes include the following examples:

- Physical harm
- Psychological harm
- Emotional harm
- Financial harm
- Sexual harm
- Neglect
- Self-harm/neglect
- Domestic abuse
- Sextortion

6.3 Possible signs of harm include the following. The examples provided are not exhaustive and are provided as a guide.

- Unexplained or unusual injuries.
- A delay in seeking treatment for injuries or illness.
- Sudden increase in confusion.
- Unexplained deterioration of health or appearance.

[4] **Adults with Incapacity (Scotland) Act 2000** Adults with Incapacity (Scotland) Act 2000 (legislation.gov.uk)
[5] **Mental Health (Care and Treatment) (Scotland) Act 2015** Mental Health (Care and Treatment) (Scotland) Act 2003 (legislation.gov.uk)

- People being anxious or afraid.
- Misuse of medication, for example, not giving medicines properly.
- Unexplained changes of behaviour, for example, becoming anxious and withdrawn, fear of another person.
- Pressure by family or professional(s) to have someone moved into or taken out of care.
- Hostile or unkind behaviour by a person.
- Unexplained debt, not paying bills for services.
- Not having their basic needs met, such as adequate food or heating.
- Not being provided with adequate information about their rights or entitlements, or being misinformed.
- Prejudicial actions or remarks to the adult about age, gender, disability, race, colour, sexual orientation or religious beliefs.
- Another person using the adult's possessions, bank account or property without his or her informed consent.
- The adult at risk not receiving appropriate care, which would protect them from harm.

6.4 Trauma Informed Practice

Trauma particularly in early childhood can continue to influence how adults interact with others including professionals. It is therefore essential that staff understand trauma and that they have the requisite knowledge and skills to ensure their practice is trauma informed to ensure patients feel physically and emotionally safe. Health professionals may also observe behaviours in an adult that are harmful but may be related to adaptions taken by the patient to help them cope with past experiences.

6.5 Who Can Cause Harm?

Anyone can cause actual or potential harm. It could be a close family member, other relatives, friend, neighbour, acquaintance or a stranger. It could be someone who works with you. Harm can also be self-inflicted. Adults can experience harm in a number of various settings. This can include in their own home, in the community, a care, residential or hospital setting. They may also be at risk due to inappropriate care arrangements in a range of health or social care settings. We recognise that when harm is caused by a member of staff this can be very challenging for all. It is important that in these situations due diligence is taken in applying ASP procedures with strict adherence to GDPR and the Data Protection Act.[6] Staff must also report these cases to their line manager and professional lead as appropriate and/ or seek guidance from the Public Protection Service. Consideration should be given to contacting relevant professional body.

7. Capacity

7.1 Individuals can be supported and protected under the Act whether they have mental capacity or not, however it is often beneficial to assess the adult's safeguarding capacity to inform risk assessment and aid decision making.

7.2 When assessing **over-arching capacity** the relevant legislation is the Adults with Incapacity (Scotland) Act 2000. The Adults with Incapacity Scotland Act 2000[2] defines incapacity as a

[6] **Data Protection Act 2018** Data Protection Act 2018 (legislation.gov.uk)

person who is unable to make decision for him/herself due to mental disorder or inability to communicate due to physical disability. They are incapable of:

- Acting; or
- Making decisions; or
- Communication decisions; or
- Understanding decisions; or
- Retaining the memory of decisions

This affects the individual's ability to keep themselves safe and may contribute to their ability to protect themselves from harm.

7.3 However, **capacity is not all or nothing** as outlined in the revised ASP Act 2007: guidance for General practice[7] which reflects developments in policy, practice and legislation both in the overall context of adult support and protection and in day to day activity. The guidance provides information and detail to support practical application of the 2007 Act for General Practitioners (GP) and staff in general practice.

7.4 The *Adult Support and Protection (Scotland) Act 2007* recognises that **a person may be capable of some decisions and actions and not capable of others**. A person lacks capacity to take a particular decision or action when there is evidence that he/she is unable to do so. Adult support and protection applies to those **with and without mental capacity.**

7.5 An inability to safeguard oneself is **not the same** as an adult lacking mental capacity. Physical limitations that restrict their ability to implement actions to safeguard themselves. For example, a person may have relevant mental capacity, but also have physical limitations that restrict their ability to implement actions to safeguard themselves. Additionally, due to many situational factors in an individual's life, capacity to make an authentic decision is subject to changes. Staff should consider even where a person can make a free and authentic decision, that they can action that decision to safeguard themselves.

7.6 Specifically with regard to the Act, General Practices are not assessing overall capacity (as per the (Adults with Incapacity (Scotland) Act 2000) but instead an assessment of capacity in terms of being able to safeguard oneself within a particular context.

7.7 The General Practitioner Guidance[7]provides triage questions to assist practitioners in reflecting whether fuller consideration of a person's capacity which may include the following:-

- Does the person understand the situation they are facing?
- Does the person understand the options?
- Does the person understand the possible ramifications of choosing various options?
- Do they fluctuate in their understanding of choices?
- Are they able to act on stated safeguarding decisions?

7Adult Support and Protection (Scotland) Act 2007: guidance for General Practice Adult Support and Protection (Scotland) Act 2007: guidance for General Practice - gov.scot (www.gov.scot)

7.8 For further information on assessing capacity, please refer to the Guide to Assessing Capacity[8]

7.9 The **principles** of the Adults with Incapacity (Scotland) Act 2000 must be followed to ensure that all decisions that are made are for the benefit of the adult. The underpinning principles for decision making that have to be followed in any decision taken for an incapable adult when deciding which measure will be the most suitable for meeting the needs of the individual.

7.10 In terms of the Act in summary some of the key factors to consider when assessing capacity and an individual's ability to safeguard are outlined below. However it is important to note that this list in not exhaustive.

7.11 A person may not have the ability to make a particular decision at a certain time, but this does not mean that they will never have the ability to make that decision:

- That you consider your patient's ability to safeguard with regard to each decision/task as to their ability to; act, or make a decision, or communicate decisions, or understand decisions, or retain the memory of decisions.
- Ensure that the assessment is context, decision and task specific.
- Listen to the adult and take their views into consideration.
- If feasible, and appropriate, consult and take into consideration views of family members or friends.
- All practicable steps must be taken to assist the adult and help them understand and communicate.

7.12 Complex cases can be discussed with Public Protection Service 9am – 5pm Monday to Friday on 0141 451 6605.

8. Consent to Share Information and Data Protection

8.1 Does the Adult Need to Consent to the Referral?

The adults consent **is not required** for you to make a referral under the Act. If possible staff should inform the adult that their concerns will be reported to their line manager and the police where a potential crime has been committed and that these will be recorded. While the adult's consent should usually be sought before the police are contacted, remember that adults at risk of harm are individuals in their own right and must be allowed to exercise their right to choose the way they live their life, unless as outlined in the West of Scotland ASP Guidance[9]

- The adult is at immediate risk of significant harm.
- The adult does not have capacity to understand his/her choice or consequences.
- There is concern the person is being unduly pressured to withhold their consent.
- The situation involves a service provider and other adults may also be at risk of harm.
- There is a public safety concern and it is in the public interest to override consent because of the seriousness of the incident or allegation and/or risk to other people.
- Any member of staff from any agency witnessed a crime being committed.

8 Adults with incapacity: Guide to Assessing Capacity Guide to Assessing Capacity

9 West of Scotland Inter Agency Adult Support and Protection Practice Guidance West-of-Scotland-Inter-Agency-ASP-Guidance.pdf (east-ayrshire.gov.uk)

- Voluntary and private sector agencies are usually required to report actual or suspected harm of an adult at risk under their contractual agreement. When making a referral to the Police or Social Services they should be advised if the adult has consented to the referral or not.

8.2 Professionals should refer to their own professional body's advice regarding information sharing. For example, the GMC[10] offers this information on confidentiality and sharing information, the NMC[11] has the Code for Nurses and Midwives. Legislation underpinning information sharing includes General Data Protection Regulation the Data Protection Act 2018[12], The Human Rights Act 1998 and the European Convention on Human Rights[13] (ECHR). This legislation supports lawful information sharing and as such should not be seen as a barrier. Consideration should also be given to The Common Law Duty of Confidentiality[14] and for health data the Caldicott Principles[15] which provide guidance on how patient data should be used. The following are regarded as the **'seven golden rules'** of information sharing:-

1. Data Protection Law should not be regarded as a barrier to sharing information.
2. A record should be kept of what has been shared, with whom and for what purpose, and of every decision made and the reasoning behind it.
3. It is important to be open and honest with the individual concerned (and their family, where appropriate) from the outset, about why, what, how and with whom information will, or could, be shared, and to seek their agreement, **unless** it is unsafe or inappropriate to do so and may place the adult or others at greater risk of harm.
4. Information may be shared lawfully without consent if it is believed, based on the facts of the case, that lack of consent can be overridden in the public interest or seeking consent would be harmful to an investigation. Consent will not apply where the matter is clearly one of protecting adults at risk of harm. Consent should not be sought if the decision has already been taken to share the information. Base your judgement on the facts of each individual case.
5. If there is reasonable concern that an adult is or is likely to be at risk of harm this will always override a professional or agency`s requirement to keep information confidential. All professionals and service providers have a responsibility to act to make sure that adults who may be at risk are protected from harm.
6. It is important to consider the safety and well-being of the individual concerned, as well as others who may be affected by their actions.
7. Information sharing should always be necessary, proportionate, relevant, accurate, timely and secure.

8. The Board Data Protection Officer should be contacted for advice to address any concerns or questions on data sharing. The information Governance Department can be contacted on 0141 355 2020 or Email: data.protection@ggc.scot.nhs.uk

[10] General Medical Council Confidentiality: good practice in handling patient information - professional standards - GMC (gmc-uk.org)

[11] Nursing and Midwifery Council The Nursing & Midwifery CouncilThe Nursing & Midwifery Council - The Nursing and Midwifery Council (nmc.org.uk)

[12] General Data Protection Regulation (2022) General Data Protection Regulation (GDPR) – Official Legal Text (gdpr-info.eu)

[13] European Convention of Human Rights Convention Convention_ENG.pdf (coe.int)

[14] The Common Law Duty of Confidentiality Duty of confidentiality — UKCGC

[15] The Caldicott Principles The Caldicott Principles The Caldicott Principles - GOV.UK (www.gov.uk)

9. Reporting/Referring Adult Protection Concerns

9.1 How to Report Adult Support and Protection Concerns

9.2 A telephone call should be made to duty social work team in the Health and Social Care Partnership (HSCP) in which the adult resides. This should be followed up immediately with an Adult Protection 1 Form (AP1). The AP1 Form can be found within clinical portal and will therefore be stored there. For GP's the AP1 will be found on sky gateway. Independent contractors will access the AP1 via their local HSCP website and will file within their own records.

It is important that the Adult record is updated with the following detail:-

- the name of duty social worker contacted.
- the date.
- time of referral.

9.3 If the adult is in immediate danger emergency services should be contacted. Please see ***Appendix 2*** which provides further detail contained in a process chart and guidance on completing an AP1 form in clinical portal.

10. When to Complete a Datix Incident Form

10.1 Where appropriate a **Datix** incident form should be completed. The **Datix** incident form can be found within staffnet. The **Datix** number should be recorded in the patient record. Not all ASP referrals are incidents and therefore do not require a Datix incident form. Some examples of when to complete a Datix incident form are given below.

Datix incidents include:-

- Adults experiencing significant harm including neglect and physical abuse who require admission or care and treatment due to this.
- Adult deaths thought to be related to neglect and abuse or concerns about ASP.
- Non-compliance with ASP procedures.
- Staff witnessing significant harmful interactions involving vulnerable adults.

10.2 A Briefing note must be completed for **Severity 4/5 incidents** for consideration of Significant Adverse Event Review (SAER).

10.3 **SAER's** are commissioned where there is a risk of significant harm to patients. NHSGGC have responsibility to ensure significant events have been appropriately reviewed to minimise the risk of recurrence by applying lessons learned. A copy of the policy, toolkit and template are attached and can be accessed by via sharepoint. Significant Adverse Events Policy and Toolkit (sharepoint.com)

10.4 An **ASP Learning Review** is a means for public bodies with responsibility relating to ASP to consider the circumstances where an adult at risk has been significantly harmed or has died. It is commissioned by and carried out by the Adult Support and Protection Committee. It is a means of reflecting and learning from practice and should be viewed in

the context of continuous improvement national-guidance-adult-protection-committees-undertaking - learning-reviews.pdf (www.gov.scot)

10.5 Should staff have queries in relation to decision making around severity of incident they should speak with their line manager. Support in relation to decision making is also available from the Public Protection Service.

11. Possible Outcomes of Reporting an ASP include the following:-

11.1 **Immediate Action to Safeguard:** The information shared may require that agencies take immediate action to mitigate risk. This might include seeking a place of safety and use of legislation.

11.2 **Further ASP action:** This might include progressing to Interagency Referral Discussion (IRD), ASP investigation or Case Conference.

11.3 **No further action required:** Sufficient information is available to decide that no further action is required.

12. Dissent/Escalation

12.1 If there is local disagreement with the outcome of a referral this should be discussed with Social Work duty team leader in the HSCP where the person lives or the hospital social work team leader as appropriate. In the context of health staff dissent advice and support is available from the Public Protection Service. It may be useful in these circumstances for agencies to come together and share information in an Interagency Referral Discussion to aid decision making.

13. Overview of Adult Protection Procedure

13.1 Inquires/Investigations

The Act places a duty on local authorities to make inquiries if it knows or believes that the person is an adult at risk and that they may need to intervene. Council officers have the power to carry out investigation through visits, interviews and examination of records except health records.

13.2 Role of Health Staff in ASP Procedures

Health staff have a duty to recognise and report ASP concerns**. They can also provide essential information in relation to decision making during ASP inquiries.** The local authority may request information from a GP or other health professional to provide a report about the adult relating to the circumstances leading to or relevant to its inquiries. Health professionals have the power to carry out medical examinations as part of investigations and to examine health records. Consent should however be sought from the adult in a way they understand. The adult and health professional need to come to an agreement on the best way forward, based on the adult's values and preferences and the health professional's clinical knowledge. As part of the investigation it may be useful for professionals to come together in a planned way to share information at an Interagency Referral Discussion,

13.3 Interagency Referral Discussion

An Interagency Referral Discussion (IRD) is a professional discussion held with relevant representatives from social work, health, police and any other agency with knowledge of the adult at risk of harm. The sharing of information and planning of approaches can be conducted by phone or in person. IRDs provide a forum for inter-agency discussion and decision-making about the next steps in protecting an individual. As such they will broadly address the same matters as outlined in the initial stage of an inquiry but build in an expectation of inter-agency engagement and discussion to the process. An IRD can be triggered when there are concerns of multiple presentations of adults identified as vulnerable within health services. This can also be applied to adults who have multiple social work referrals or are frequently brought to the attention of the police.

13.4 Second Workers

The lead investigating officer (council officer) is a registered and qualified social worker and will lead the investigation. In certain circumstances, it may be appropriate for a health professional to be involved along with the council officer in the course of an investigation to fulfil second worker role. Health staff may therefore be involved both in supporting the investigation process through the sharing of relevant health information or undertaking a health examination of the adult at risk. Health Staff should have completed second worker training in order to have the necessary skills and knowledge to undertake the role and function of a second worker, as part of the Adult Support and Protection 2007 Act.

13.5 Case Conferences

An ASP case conference can take place if required following an investigation. The purpose of the case conference is for relevant professional to share information/ reports about the adult. Health staff may be required to attend the case conference. The adult is invited along to the conference and are given the opportunity to share their views. The adult should be offered advocacy services to support them prior to, during and after the meeting. The conference, in conjunction with the adult will develop a plan in order to provide support and protection to the adult.

13.6 Large Scale Investigations

A Large Scale Investigation (LSI), may be required where an adult who is resident of a care home, supported accommodation, an NHS hospital or other facility, or receives services in their own home has been referred as at risk of harm and where investigation indicates that the risk of harm could be due to another resident, a member of staff or some failing or deficit in the management regime, or environment of the establishment or service. A Large-Scale Investigation (LSI) is a multi-agency response to such circumstances and should be considered where an adult is at risk of harm and there is concern that other adults may also be experiencing or be at risk of harm from the same source. An LSI can therefore apply to all adults at risk of harm who reside in care homes, are inpatients in hospitals, attend day care

or receive care at home from a care provider. However an LSI can also apply where individual perpetrators who may be systemically targeting the adults. This procedure can also apply where harm, or risk of harm, has the potential to include more than one adult but only one referral has been received.

Health staff will therefore be required to support the LSI process. It is important that staff understand their specific role and contribution to the LSI and that they have the appropriate time to support council officers in their investigation and prepare for LSI meetings where health information is being shared, discussed and analysed by the group.

Whistleblowing is a way someone can formally raise concerns about an issue that is in the public interest, such as patient safety or suspected abuse. More information about whistleblowing can be found at Speak Up (sharepoint.com)

14. Learning and Education

NHSGGC has a Public Protection Learning and Education Framework which sets out our aims to deliver high quality learning opportunities that support staff to become confident and capable to achieve the competencies, knowledge and skills required to meet their responsibilities.

All training provided respects diversity (including culture, race, religion and disability) and encourages the participation of patients, carers, children, families and adults in safeguarding and protection processes. The framework sets out the roles and responsibilities for staff an outlines appropriate training levels for staff.

15. Resources

Adult Support and Protection (Scotland) Act 2007 | Care Information Scotland (careinfoscotland.scot)

Adult Support and Protection Act | Mental Welfare Commission for Scotland (mwcscot.org.uk)

Adult Support and Protection: everyone's business | Iriss

Adult Support and Protection code of Practice & Guidance -

capacity_and_consent-interactive.pdf (scot.nhs.uk)

Resources for Professionals - Adult Support and Protection - Public Protection (dgppp.org.uk)

Social Work ScotlandTell Someone - Scottish Care

Supported Decision Making 2021.pdf (mwcscot.org.uk)

Trauma – national trauma training programme | NHS Education for (scot.nhs.uk)

NHSGGC - Seen something? Say something (youtube.com)

NHSGGC - Sextortion Scams (youtube.com)

Appendix 1

The following Case Vignettes are cases that have led to ASP referrals being made within NHS GGC. Examples have been taken from HSCPs and the acute setting. The examples relate to the range of harms outlined in section 6. The case vignettes are provided to support staff in their understanding of ASP and the application of the ASP guidance. The main type of neglect has been highlighted. However, as is often the case in relation to ASP issues, there can be more than one category of harm are often interrelated.

Case Vignette 1 – Physical Abuse

Description:

Inpatient in high dependency unit due to ingestion of bleach causing chemical burns. Concern partner may have encouraged this. When partner was visiting patient became agitated and wanted to go home. Nursing and medical staff explained that due to admission circumstances he is unable to leave and could be detained due to his mental health. Patient initially accepted this and agreed to stay. Partner was angry stating they were leaving and they were going to Ireland in the morning. It was explained to patient that he would not be able to leave hospital for his own safety. Partner became aggressive and despite staff trying to defuse the situation left the ward with his partner. Staff felt it was unsafe to follow couple.

Immediate Actions:

Medical staff were informed and emergency detention order completed. Police informed. Missing patient policy followed. Patient was returned by police.

Case Vignette 2 – Psychological Harm / Emotional Abuse

Description:

Patient is being cared for under mental health legislation (Community Treatment Order), and under ASP legislation. These have been in place for a period of 8 months. During this time the adult required inpatient treatment for mental health.

Prior to presenting to mental health services the patient was taken by her family to Birmingham. The family reported on their return that the patient had been restrained for hours. The family reported torture/exorcisms due to their cultural/religious beliefs. The patient had significant bruising, bite marks and burn marks on admission (body map was completed on EMIS). The patient was acutely unwell, and unable to safeguard herself.

ASP has been active since admission, and there have been regular case conferences. Police Scotland have attended meetings in support of positive risk taking on

discharge. Prior to discharge, the family (mother, brother and sister), all agreed to allow access for health care, and that they would support the patient every fortnight to receive their depot.

On discharge, the first depot was administered at home within the community setting, with resistance from the patients mother (patient consented). On subsequent visits the patient then refused depot medication.

Several contacts have been made with patient and supporting family members (brother and sister) to discuss the requirement for medication in support of the patient's wellbeing, and safety. Mother is now actively blocking any care for the patient.

There is a risk of untreated psychosis, and risk of harm coming to the patient due to past exorcisms undertaken by the family. Patient is highly vulnerable to her family who police have considered in the past as being a risk to the patient.

Immediate Actions:

The patient was formally recalled to hospital for disengagement due to several failed contacts earlier in the week. Police Scotland contacted for support. Police spoke to the keyworker, registrar doctor, and consultant psychiatrist who provided concerns from health. The mental health officer and ASP allocated social worker also outlined their concerns to police.

Case Vignette 3 - Financial Abuse

Description:

Patient's son arrived to visit patient in the ward. Son was asking patient for money. Son's partner then took the patients bag from her. This was overhead by staff. Staff also overheard the son and his partner trying to convince the patient to discharge herself from hospital. Patient has disclosed that her son has stolen from her in the past. Patient's sister raised concern that the patient's son will try to take the patients keys and show an 'aggressive and bullying' behaviour. Further incident when patient had a phone call from her son who had been verbally abusive over the phone. Patient appeared frightened of her son and requested that her son is not allowed on the ward. Patient requested that her next of kin be changed from her son to her sister.

Immediate Action:

Patient was spoken to by the nursing staff and ward doctors. All valuable locked away in patient's locker. Next of kin changed from patient's son to sister. Social informed via telephone and AP1 completed and submitted

Case Vignette 4 – Sexual Abuse

Description:

Patient divulged information to staff that she was being sexually abused by her boyfriend. This was prior to admission and not during admission. Patient showed phone messages between her and her boyfriend. Nurse documented this conversation and the content of the text messages. Patient has 'Adult with Incapacity' in place.

Immediate Action:

No Power of Attorney or Guardianship in place therefore next of kin not informed at this stage. Senior charge nurse, lead nurse and consultant informed. Incident reported to police. Social work informed via telephone and AP1 completed and submitted.

Case Vignette 5 - Neglect

Description:

District Nurse attended at patients home for a visit. Patient has a learning disability, was bedbound and lives at home with her husband. The patient requires full support with all activities of daily living. Has 4 visits daily from care at home carers for support with personal care.

Patient's husband reported that the patient had not been feeling well over past few days, was off their food and very tired. Patient could not remember the district nurse which was unusual. Patient was in bed and looked dehydrated. Patient's mouth was open and looked dry there was a strong smell of urine in property. The patient`s catheter bag full. Care at home team had visited 45 mins prior to District Nursing Service visit. Urine in catheter bag was very dark, cloudy and strong smelling. There was no evidence of this being recorded in carer records, other than the catheter bag has been emptied and changed from night bag to day bag. Patient appeared unkempt, fingernails were noted to be dirty with faeces.

Immediate Action:

Writer encouraged fluids and nutrition. Repositioned patient in bed. Cleaned hands and fingernails. Emptied catheter bag and ensured catheter was draining. Contacted single point of access for district nursing to review catheter. Reported concerns to allocated social worker, senior social worker and nurse team lead. Writer encouraged fluids and nutrition. Repositioned. AP1 completed. Antibiotics arranged.

Case Vignette 6– Self Neglect

Description

Patient was admitted to hospital with an infected right foot ulcer, for which he was treated with IV antibiotics. He was also found to be anaemic and commenced on medication for this. The patient had a previous admission due to falls and not coping at home. The patient lives alone.

Patient was discharged with a twice daily POC. Patient is unable to answer his door due to poor mobility. Patient doesn't have a key safe in place and door has been left open. Patient has been sending the carers away and stating he can get himself washed and prepare his own meals. On checking skin yesterday the patient was malodorous and didn't appear to have been washed although patient reported that he had. Patient noted to be wearing the same clothes for days (this was confirmed by daughter). Stains were noted on patient clothes. The patient has a grade 1 pressure ulcer to his buttock. He also has a wound to his right foot which is bandaged. He is unable to attend podiatry clinic or make it to appointments due to poor mobility and impaired cognition. He has missed two vascular appointments recently, risking further deterioration to his right foot. Patient is malodorous and has been wearing the same stained clothes for days. Concern that patient is putting himself at risk of further skin breakdown and bacterial infections. Due to his poor balance and impaired cognition he is not safe in the kitchen. It was noted that there are no smoke alarms in the house which presents a fire safety risk. The patient has had several recent falls. He has a Zimmer to assist mobilisation however he has not been using this. The Zimmer was left in the kitchen when he was being visited. Patient was struggling with his transfers and nearly fell during the visit. Patient required constant verbal prompts when using the Zimmer frame. Patient has also declined to have telecare installed as doesn't have landline and doesn't wish to have landline installed. Patient’s daughter has found patient in a state of undress on a couple of occasions. She is also concerned that he is not taking his medications. A tablet was found on the floor yesterday. The patient reported that he had been looking for the tablet the previous day. Patient became frustrated and agitated during visit. He declined equipment to help him with his toilet transfer. Patient feels he doesn't need carers and reports he is doing fine. He is unable to address how he would care for himself. He has also been passing urine into a bucket downstairs and sleeping in his chair. Patient appears to lack insight into risks and appears to have a cognitive impairment. It was documented he had a fluctuating cognitive impairment during recent admission. Community assessment visit post hospital discharge.

Immediate Actions:

Writer spoke with patient's daughter and son to highlight risks identified and advised he is not safe to be at home. Son visiting patient today. Contacted patient's GP to inform risks identified and concerns that patient is not managing at home. Have referred patient for a home fire safety visit and have sent an adult protection referral.

Case Vignette 7 – Domestic Abuse

Description:

Inpatient in acute service. Patient son came to visit patient in the ward. Son was asking for money and patient was refusing. Son's partner then took his mother's bag. Staff overheard son trying to convince his mother to discharge herself. Patient claims her son has stolen from her in the past. Sister reported to ward staff that patient's son if often aggressive and displays bullying behaviour. Sister is concerned son will take patients keys. Patient received a call on the ward from son who was verbally aggressive to her. Patient has disclosed being frightened of her son. Patient has requested that son cannot visit her on ward and that emergency contact be changed to her sister.

Immediate Actions:

Discussion with patient about referral to social work department for support. Contact number changed. Valuables locked away. Police will be called if son attends ward.

Case Vignette 8 – Sextortion

Description:

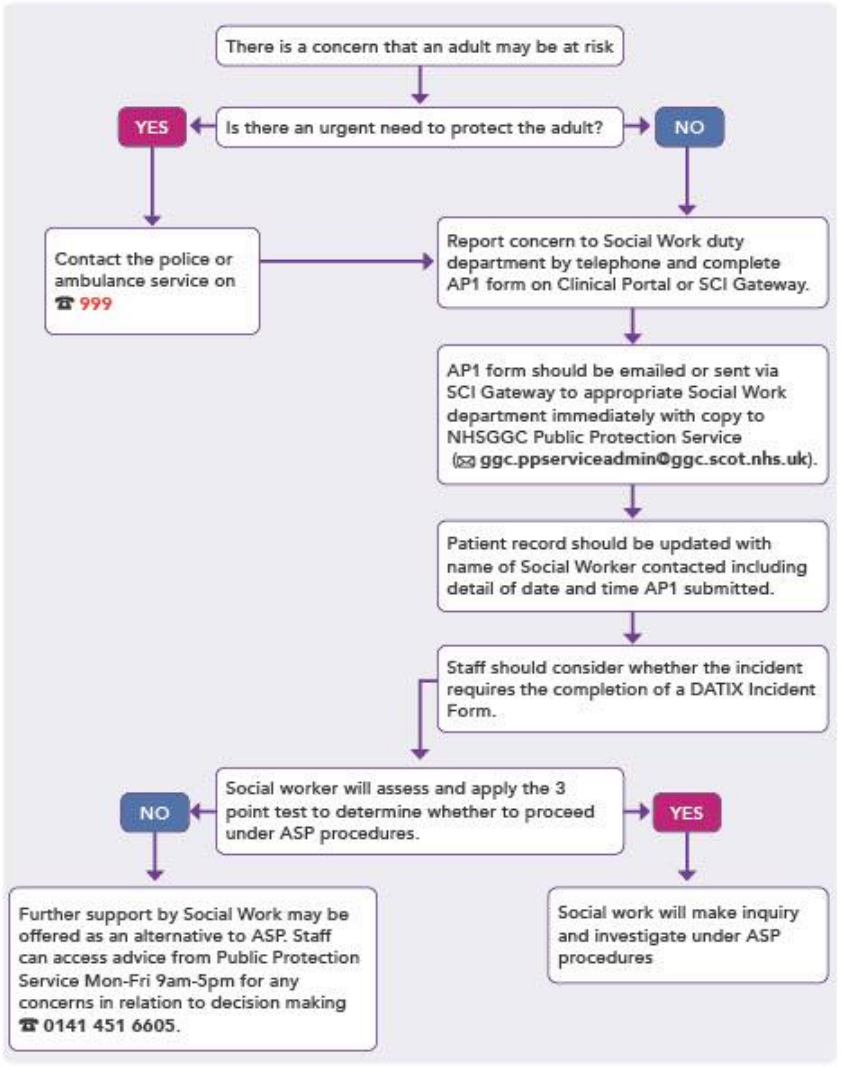
Patient attended treatment room to have stitches removed. His mother was in the waiting room. He disclosed that he sustained the injury whilst drunk. When probed by the treatment room nurse about his alcohol intake he revealed that he doesn't like to drink alcohol but is encouraged by a female friend. He pays for the alcohol and the female friend often takes large sums of money from his account. He was worried as the friend knows the pin number for his account.

Immediate Actions:

Treatment room nurse contacted police and completed an AP1. Police attended the patient's home to obtain more information. Patient then shared with police that when he has been drinking his friend encourages him to have sex with her. Sometimes she brings a friend and he has had sex with the friend too whilst drinking. The female friend has still and video images of their sexual activity. She is threatening to send them to patient's mother if he does not continue to give her money and buy alcohol for them. Police then convened an IRD. The outcome of the IRD was a full police investigation and social work assessment of patient's needs.

Appendix 2

Adult Support and Protection AP1 Referral Process for Health Staff



NHS Greater Glasgow and Clyde

Safeguarding - It Matters to Us

Additional Information

Under the Adult Support and Protection (Scotland) Act 2007[1], an adult is considered at risk if they meet all 3 points of the 3 point test:

- They are unable to safeguard their own wellbeing, property, rights or other interests
- They are at risk of harm; and
- They are affected by a disability, mental disorder, illness, physical or mental infirmity which makes them more vulnerable to harm than adults not affected in this way

Health Professionals do not need to have evidence that the 3 point test has been met in order to make a referral. Staff only require to believe the adult is at risk of significant harm. All information shared will support assessment of risk and decision making.

Staff should consider whether the incident requires the completion of a DATIX Incident Form.

Social Work Duty Teams

Area	Email address	Tel. No.	Out of Hours
Glasgow City	✉ socialcaredirect@glasgow.gov.uk	☎ 0141 287 0555	☎ 0300 343 1505
East Renfrewshire	✉ adultprotectioneastrenfrewshire.gov.uk	☎ 0141 800 7850	☎ 0300 343 1505
Renfrewshire	✉ Adultservicesreferral.sw@renfrewshire.gov.uk	☎ 0300 300 1380	☎ 0300 343 1505
East Dunbartonshire	✉ AdultProtection@eastdunbarton.gov.uk	☎ 0141 355 2200	☎ 0300 343 1505
West Dunbartonshire	✉ WDADULT@west-dunbarton.gov.uk	Dumbarton: ☎ 01389 776499 Clydebank: ☎ 01389 811760	☎ 0300 343 1505
Inverclyde	✉ Ap.referrals@inverclyde.gov.uk	☎ 01475 715010	☎ 0300 343 1505

NHSGG&C Public Protection Service

	Email address	Tel. No.
Further information, support and advice can be obtained from the Public Protection Service	✉ ggc.ppserviceadmin@ggc.scot.nhs.uk	☎ 0141 451 6605 Mon-Fri 9am - 5pm

Reference

1. Adult Support and Protection (Scotland) Act 2007, asp 10. Available: ● https://www.legislation.gov.uk/asp/2007/10/contents

Review date: February 2025

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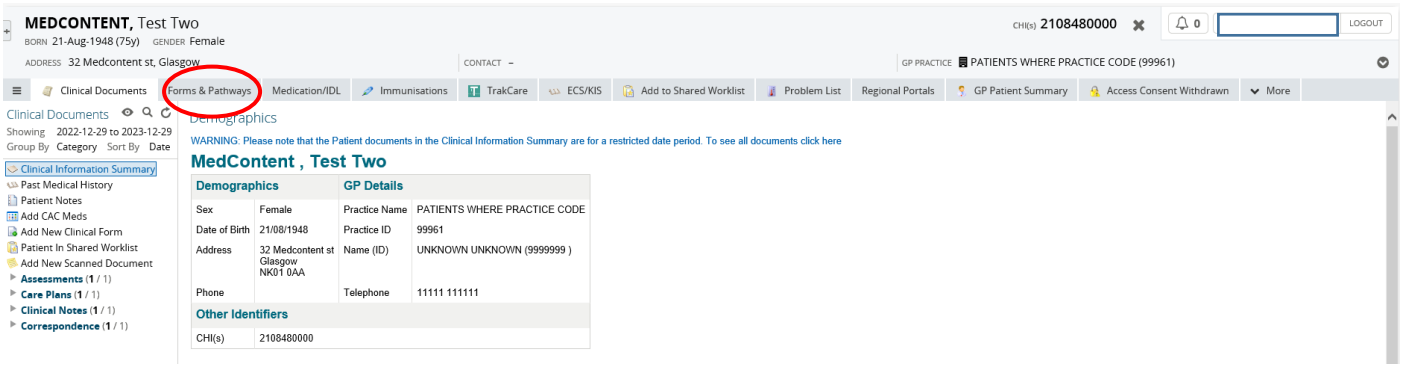
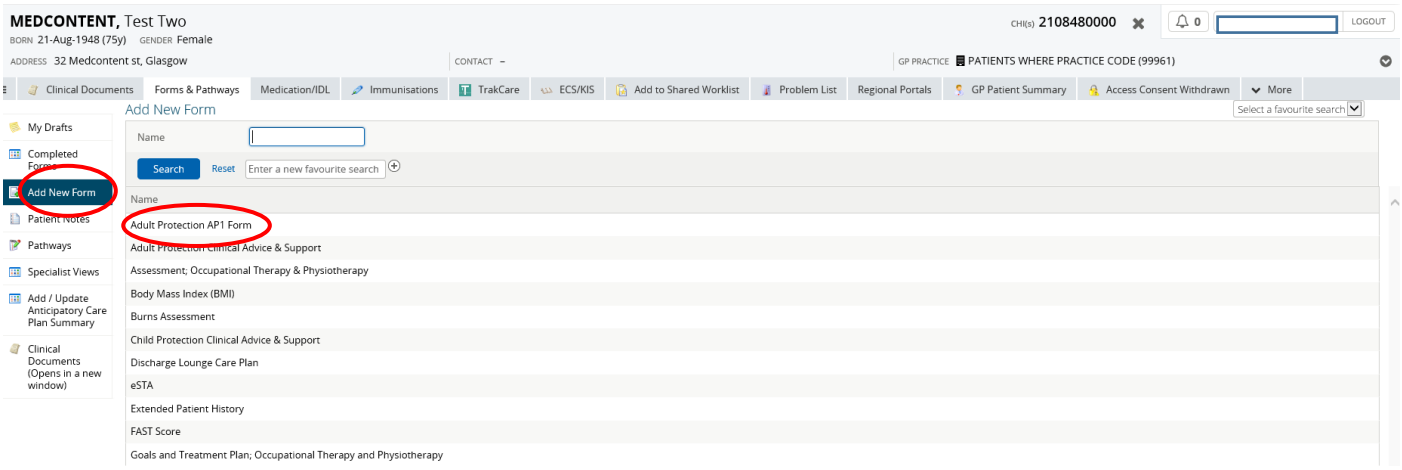
How to access an AP1 form within Clinical Portal

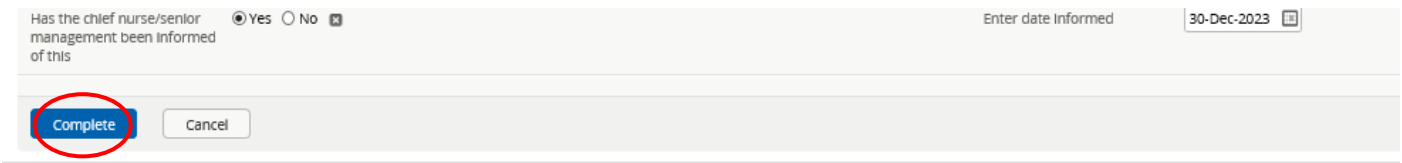
1. `Open patient record in Clinical Portal and access ‘Forms & Pathways’.



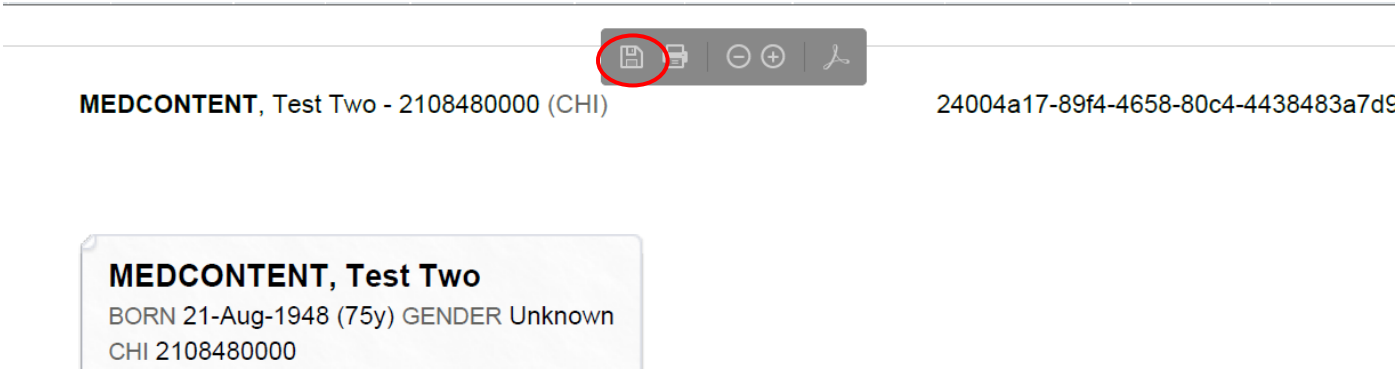
2. Select Add New Form and then select ‘Adult Protection AP1 Form’



3. When all sections of the form have been completed, press ‘complete’.



4. Following this step, a copy of the AP1 form must be saved in your documents in order to email the appropriate social work department and copy your line manager in. In order to do this, press print at the bottom of the completed AP1 form. Once AP1 has been emailed it should then be deleted from your document drive.



5. Once social work have been given a copy of the AP1 form, this should be deleted from your personal drive.