

Safeguarding adults

NHS
London

Your responsibilities

Categories of abuse

Your role as alerter

Information sharing

Capacity and consent

Key - flowchart symbols

The Mental Capacity Act (MCA) 2005

- Decision-making flowchart
- Best-interest decision-making flowchart

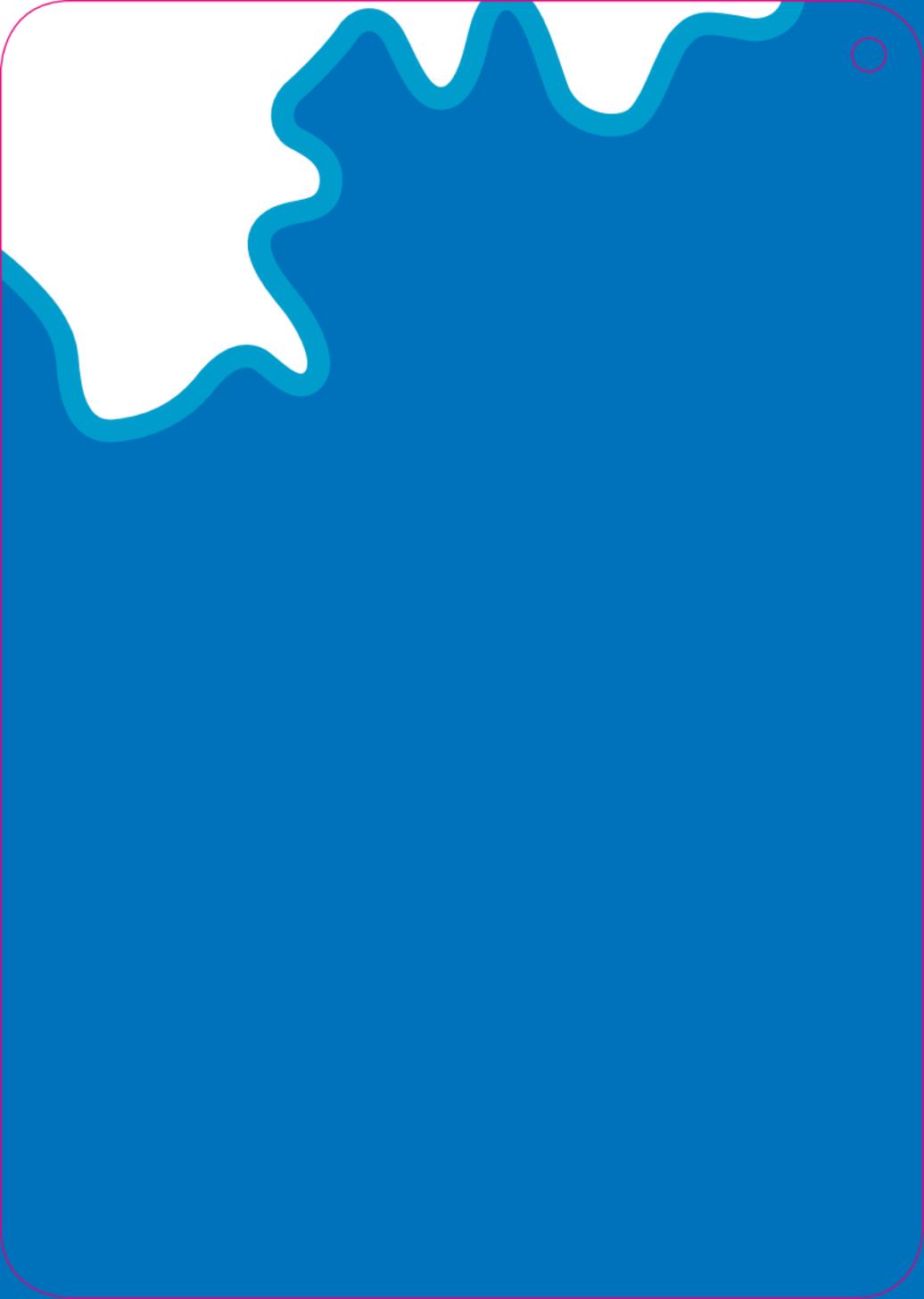
Deprivation of Liberty Safeguards (DoLS)

- Decision-making flowchart

Prevent

- Channel

Resources



Your responsibilities

Safeguarding adults

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and wellbeing.

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost-effective care.

These cards should be used by you as a guide, should you have a safeguarding concern, and should always be used alongside your organisation's safeguarding and the pan-London policy and procedures.

Definition of a adult at risk

Aged 18 years or over; Who may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation

NB: Throughout this publication we have used the term 'patient' to refer to patients and clients.

Your responsibilities when you have safeguarding concerns:

- Assess the situation
i.e. are emergency services required?
- Ensure the safety and wellbeing of the individual
- Establish what the individual's views and wishes are about the safeguarding issue and procedure
- Maintain any evidence and follow internal procedures for reporting incidents/risks
- Remain calm and try not to show any shock or disbelief
- Listen carefully and demonstrate understanding by acknowledging regret and concern that this has happened
- Inform the person that you are required to share the information, explaining what information will be shared and why
- Make a written record of what the person has told you, using their words or what you have seen as well as your actions

Your responsibilities

Whistle blowing

Always act whenever abuse is suspected including when your legitimate concern is not acted upon. Whistle blowers are given protection under the Public Interest Disclosure Act 1998.

Duty of care

You have a duty of care to your patients/service users, your colleagues, your employer, yourself and the public interest. Everyone has a duty of care it is not something that you can opt out of.

The Health Professions Council standards state:

'a person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, particularly if you think there is a significant or immediate risk to life.'

Duty of care can be said to have reasonably been met where an objective group of professionals considers:

- All reasonable steps have been taken
- Reliable assessment methods have been used

- Information has been collated and thoroughly evaluated
- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed
- Practitioners and managers have sought to ascertain the facts and are proactive.

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions.

Ensure that significant others, i.e family member, friend or advocate, are involved to support the individual where appropriate.

However, it is important to recognise that though an individual with capacity has the right to refuse care for themselves, the duty of care extends to considering where others may be at risk and action is needed to protect them.

Your responsibilities

You have a responsibility to follow the six safeguarding principles:

Principle one

Empowerment - Presumption of person-led decisions and consent; Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Principle two

Protection – Support and representation for those in greatest need.

There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle three

Prevention - Prevention of harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves

reducing risks of neglect and abuse occurring within health services.

Principle four

Proportionality and least intrusive response appropriate to the risk presented; Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive to the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle five

Partnerships – Local solutions through services working with their communities. Safeguarding adults will be most effective where citizens, services and communities work collaboratively to identify, respond and prevent harm and abuse.

Principle six

Accountability – Accountability and transparency in delivering safeguarding.

Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

(Ref: The role of Health Service Practitioners, DH 2011)

Categories of abuse

1. The categories of abuse

Physical, psychological/
emotional, sexual and sexual
exploitation, financial, neglect,
discrimination, institutional

Physical: assault, rough handling,
unreasonable physical restraint.

Psychological/emotional: bullying,
intimidation, verbal attack or
other behaviour that affects the
wellbeing of an individual.

Sexual and sexual exploitation:
any non-consenting sexual
act or behaviour.

Financial: theft, fraud,
misappropriating funds i.e.
when using a person's money
for self-gain or gratification.

Neglect: a person's wellbeing is
impaired and care needs not met

Discrimination: psychological abuse
that is racist, sexist or linked to a
person's sexuality, disability or age.

Institutional: Observed lack of
dignity and respect in the care
setting, rigid routine, processes/
tasks organised to meet staff needs,
disrespectful language and attitudes.

Domestic violence and self
harm need to be considered
as possible indicators of abuse
and/or contributory factors

2. Significant harm

"Harm should be taken to include
not only ill treatment, but also
the impairment of, or avoidable
deterioration in, physical or mental
health; and the impairment of
physical, intellectual, emotional,
social, or behavioural development"
Law Commission, 1995.

3. Radicalisation

The processes by which people come
to support violent extremism and,
in some cases, join terrorist groups.

**If in doubt contact your nominated
lead for adult safeguarding.**

Your role as alerter

Your role as 'alerter' in the safeguarding process

The 'alerter' raises a safeguarding concern within their own agency following own policy and procedures.

This concern may result from something that you have seen, been told, or heard.

Make a referral to Safeguarding Children where this is necessary.

Assessment

Your assessment should be holistic and thorough considering the patient's emotional, social, psychological and physical presentation as well as the identified clinical need. You need to be alert to:

- Inconsistencies in the history or explanation
- Skin integrity, hydration or personal presentation, e.g. is the person unkempt?
- Delays or evidence of barriers in seeking or receiving treatment
- Is the patient vulnerable or at risk as defined under 'No Secrets' or the pan-London policy and procedures?
- Is immediate protection required?

- Evidence of frequent attendances to health services or repeated failure to attend (DNA)
- Environmental factors, eg. signs of neglect, the reactions and responses of other people with the patient
- Does the patient have capacity for the decision required? Are they able to give informed consent or is action needed in their best interests?
- Is any action that is being considered proportionate to the risk identified?
- Respect cultural differences and the patient's views/wishes?
- Are there others at risk, e.g. children or other adults?
- Has a crime been committed and should the police be informed? Do you need to preserve any evidence?
- Are there valid reasons to act even without the patient's consent; where others are at risk or you need to address a service failure that may affect others?

Golden rule: A holistic assessment should be carried out, at the initial contact or on admission and discharge, in a community or an acute setting.

Your role as alerter

Communication

- Consider use of communication aids/language line if required to involve the patient
- Take account of individual differences
- Listen carefully, remain calm and try not to show shock or disbelief and acknowledge what is being said
- Do not ask probing or leading questions that may affect credibility of evidence
- Be open and honest and do not promise to keep a secret
- Seek consent to share information if the patient has capacity and if this does not place you or them at increased risk
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm (follow your own organisation's policy and procedures)

Reporting

- Report concern following your safeguarding adult policy and procedures
- Make clear and concise referral, without delay, so that person reading the form understands the key issues
- Concern about a colleague should be raised through your organisation's Managing allegations against staff or whistleblowing policy

Remember that you are accountable for what you do or choose not to do.

Recording

- You are accountable for your actions or omissions
- Make a legible, factual, timely and accurate record of what you did and why, to demonstrate transparent, defensible decision making, e.g. capacity assessment made, best interest decision, any restraint that was required must be proportionate to the situation

Information sharing

Where there are safeguarding concerns staff have a duty to share information.

It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong.

Information should be shared, with consent, wherever possible. A person's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or in best interests, e.g. in the interests of public safety, police investigation, implications for regulated service.

- 1. Remember that the Data Protection Act is not a barrier to sharing information**, but provides a framework to ensure that personal information about living persons is shared appropriately.
- 2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- 3. Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

5. Consider safety and wellbeing and base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Information sharing

Any information disclosed should be:

- clear regarding the nature of the problem and purpose of sharing information
- based on fact, not assumption
- restricted to those with a legitimate need to know
- relevant to specific incident
- strictly limited to the needs of the situation at that time
- recorded in writing, with reasons stated

Sharing data when someone lacks mental capacity

Can the patient give consent to disclosure of information?

You have a responsibility to explore approaches to help them understand.

In some instances the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case, any disclosure of information needs to be considered against the conditions set out in the Data Protection Act 1998 and the Mental Capacity Act (2005).

Capacity and consent

Capacity and consent

- It is okay to ask questions or ask for further guidance/reassurance if:
- It is not clear who has made/ is making the assessment of capacity or best interests
- There is a relevant assessment of capacity and this is documented
- The assessment is specific to the relevant decision and time, Eg - "John lacks capacity" [for what, when?] might raise concern
- All reasonable and appropriate steps have been taken to empower/maximise capacity
- Regular review has been provided for
- An appropriate range of disciplines have been involved
- Family and carers have been involved appropriately
- Family/carers or others may be seeking to override the views of others
- If you disagree with the decision or have concern that the MCA and/ or policy is not being followed

It is not okay to do nothing.

It is your responsibility to make sure you know how to contact your local safeguarding adults lead

Flowchart key

Symbol	Name (alias)	Description
Process/operation symbols		
	Process	Show a process or action step. This is the most common symbol in both process flowcharts and business process maps.
	Predefined process (subroutine)	A predefined process symbol is a marker for another process step or series of process flow steps that are formally defined elsewhere.
	Alternate process	As the shape name suggests, this flowchart symbol is used when the process flow step is an alternate to the normal process step. Flow lines into an alternate process flow step are typically dashed.
Branching and control of flow symbols		
	Flow lines (arrow, connector)	Flow line connectors show the direction that the process flows.
	Terminator (terminal point, oval)	Terminators show the start and stop points in a process. When used as a start symbol, terminators depict a trigger action that sets the process flow into motion.
	Decision	This symbol indicates a question or branch in the process flow. Typically, used when there are two options (yes/no, no/no-go, etc.)
	Off-page connector	Off-page connector shows continuation of a process flowchart on to another page.

The Mental Capacity Act (MCA) 2005

Five principles that underpin the Mental Capacity Act 2005:

In order to protect those who lack capacity and to enable them to take part, as much as possible in decisions that affect them, the following statutory principles apply:

1. You must always assume a person has capacity unless it is proved otherwise
2. You must take all practicable steps to enable people to make their own decisions
3. You must not assume incapacity simply because someone makes an unwise decision
4. Always act, or decide, for a person without capacity in their best interests
5. Carefully consider actions to ensure the least restrictive option is taken

Assessment of capacity:

Follow the two- stage test for capacity:

- **Stage one:** Does the person have an impairment of the mind or brain (temporary or permanent)?

If Yes:

- **Stage two:** Is the person able to:
 - understand the decision they need to make and why they need to make it?
 - understand, retain, use and weigh information relevant to the decision?
 - understand the consequences of making, or not making, this decision?
 - communicate their decision by any means (i.e. speech, sign language)?
 - failure on one point will determine lack of capacity.

How to act in someone's best interests:

Do not make assumptions about capacity based on age, appearance or medical condition.

Encourage the person to participate as fully as possible.

Consider whether the person will in the future have capacity in relation to the matter in question.

Consider the person's past and present beliefs, values, wishes and feelings.

Continued over...

The Mental Capacity Act (MCA) 2005

Take into account the views of others – i.e. carers, relatives, friends, advocates.

Consider the least restrictive options.

A best interests checklist will be available as part of local policy and procedure.

What else do you need to consider?

MCA code of practice:

Professionals and carers must have regard to the code and record reasons for assessing capacity or best interests. If anyone decides to depart from the code they must record their reasons for doing so.

LPAs and ADs:

Is there a valid/current lasting power of attorney or an advance decision in place?

IMCAs:

The Mental Capacity Act sets up the Independent Mental Capacity Advocacy (IMCA) service to help vulnerable people who lack capacity and are facing important decisions, including serious healthcare treatment decisions, with no family or friends apart from paid carers to be consulted as part of making a 'best interests' decision.

Where to find guidance

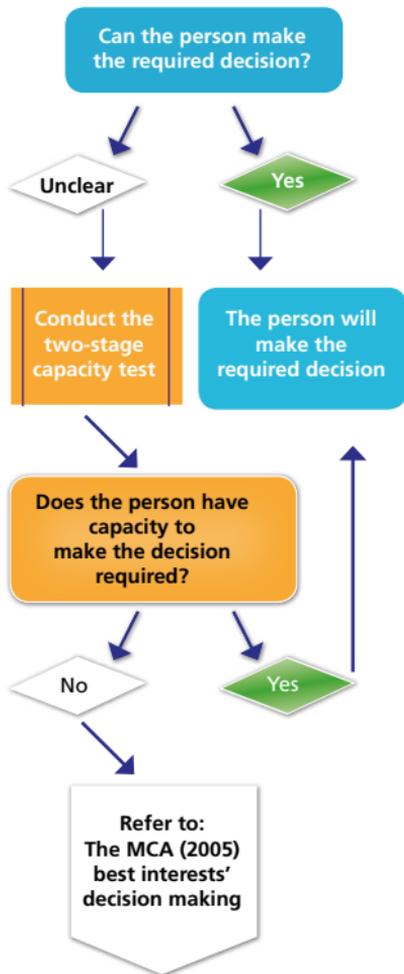
The full text of the Act and the code of practice is available at:

www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf

NB. there may not always be time in emergency situations for full investigation and consultation, and there should be no liability for acting in the reasonable belief that someone lacks capacity, and what you do is reasonably believed to be in their best interests (MCA s5). This can include restraint if need be, if it is proportionate and necessary to prevent harm (MCA s6), and even "a deprivation of liberty", if this is necessary for "life sustaining treatment or a vital act", while a Court Order is sought if need be (MCA s4B).

MCA (2005) decision-making flowchart

All adults should be presumed to have capacity unless the opposite has been demonstrated. Consent must be obtained by the person undertaking the procedure and is specific to the decision to be made.



Refer to the five principles of the MCA:

- A presumption of capacity
- Individuals being supported to make their own decisions
- Unwise decisions
- Best interests
- Least restrictive option

The two-stage capacity test:

Stage one. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,

Stage two. Is the impairment or disturbance sufficient that the person lacks the capacity to make the particular decision?

Can the person:

- Understand the information relevant to the decision,
- Retain that information,
- Weigh that information as a part of the process of making a decision and
- Communicate their decision (whether by talking, using sign language or any other means)?

(Person must demonstrate all four functions above to be deemed as having capacity for the required decision-making.)

The best-interest checklist:

When making a decision in someone's best interests one must:

- Involve the person as much as possible
- Find out the person's wishes and feelings
- Consult people who know the person well
- Consider all relevant information
- Avoid making the decision if it is likely that the person might regain capacity
- Think about what would be the least restrictive option

and must not:

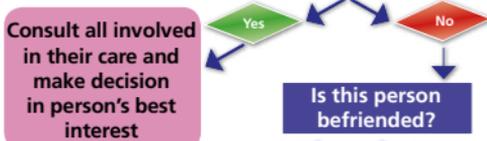
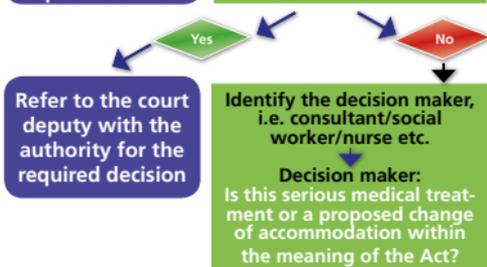
- Make assumptions based on the person's age, appearance, condition or behaviour
- Make a decision involving life-sustaining treatment that is motivated by a desire to end the person's life.

MCA (2005) best-interest decision-making flowchart

The person is assessed as not having the capacity to make a required decision

Have arrangements been made for incapacity?

Has the person made an advanced decision relevant to the required decision?



- ### The decision maker:
- Must ensure that the proposed action/treatment is in the best interests of the person.
 - The decision maker needs to check if there is an Advance Decision (AD), Lasting Power of Attorney [LPA] or Deputy or if there is a friend/carer of person nominated by the person to consult.
 - Advance Decision must be relevant to this decision.

- ### Best-interest-checklist
- The decision maker must:
- Consult with all relevant others, i.e. the person, medic/GP, carers, Allied Health Professionals, social care staff, Advocate/IMCA, or people who know the person well, i.e. LPA or Deputy or Enduring Power of Attorneys
 - Identify the views of all relevant people in the person's life
 - Not make assumptions about a person's best interests based upon the persons age, or appearance, condition or any aspect of their behaviour
 - Consider all the relevant circumstances relating to the decision in question
 - Involve the person as fully as possible
 - Ensure that if the decision concerns the decisions relating to life-sustaining treatment, the decision maker must not be motivated by a desire to bring about death
 - Be able to justify and evidence their decision making
 - Ensure that other least restrictive options are always explored (complete best interests decision record).

A formal best interests meeting is not always needed. It is important that consultation has taken place and the decision maker follows the guidance above with all relevant others and this is documented on the agreed paperwork.

Record keeping: it is important that you accurately record and evidence any decisions made with regards to best interests.

Deprivation of Liberty Safeguards (DoLS)

What are they?

The Deprivation of Liberty Safeguards 2009 (DoLS) are an amendment to the Mental Capacity Act 2005. They provide a legal framework to protect those (over 18 years) who lack the capacity to consent to the arrangements for their treatment or care, for example by reason of dementia, learning disability or brain injury and where levels of restriction or restraint used in delivering that care for the purpose of protection from risk/harm are so extensive as to potentially be depriving the person of their liberty. Deprivation of Liberty Safeguards go beyond the actions permitted under section five of the Mental Capacity Act (MCA) 2005.

Who do they apply to?

The safeguards only apply to people who lack capacity to consent to care/treatment they receive, and are over 18 years of age and receive care in a hospital or a care home setting and the care they receive deprives them of their liberty and they are not detained under the Mental Health Act.

If a person is being deprived of their liberty and they are not in a care home or hospital, their care can only be authorised through the Court of Protection.

Deprivation of Liberty Safeguards (DoLS)

What you need to know

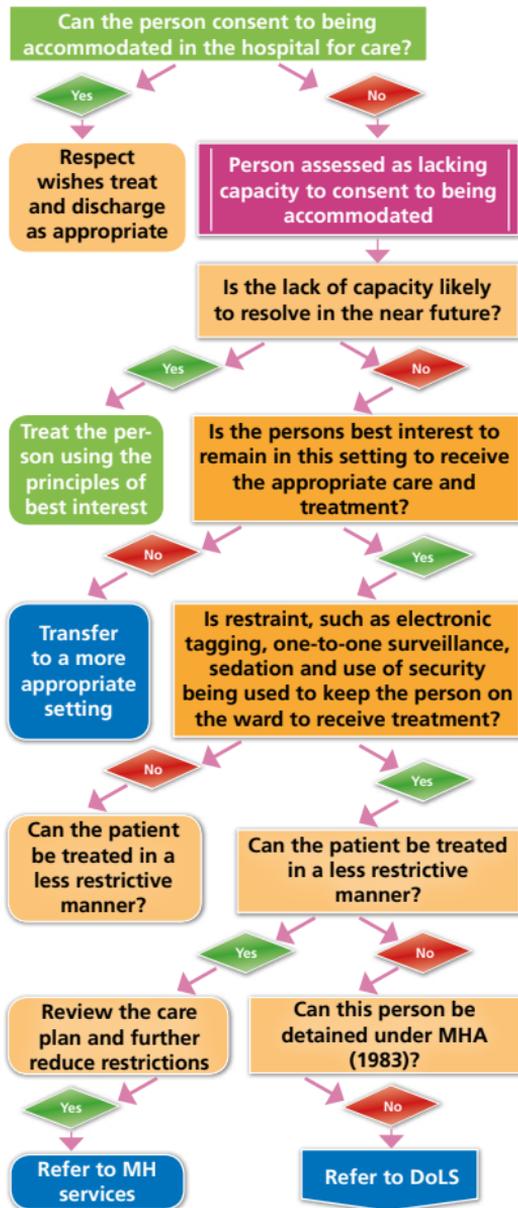
- Sometimes Deprivation of Liberty (DoL) is required to provide care/ treatment and protect people from harm, but every effort should be made to prevent DoL by making provision to avoid placing restrictions. If DoL cannot be avoided, it should be for no longer than is necessary.
- Where the Safeguards apply, there is a legal duty on the hospital or care home to request that the PCT or local authority authorise the depriving of someone's liberty for a limited period of time.
- A major part of preventing DoL is minimizing any restraint. Restraint must be appropriate, proportionate and in the patient's best interests.

What to do

- If you are worried about a patient in your care who you think might be being deprived of their liberty, consider ways in which you can minimise restrictions. Please refer to your local DoLS procedures.
- Discuss the case with your adult safeguarding lead.
- In a community setting you can contact your local authority DoLS team or supervisory body office, who will be able to assist.
- It is important to act quickly to comply with legislation.

Deprivation of Liberty Safeguards (DoLS)

decision-making flowchart



The decision maker:

- Must ensure that the proposed action/treatment is in the best interests of the person.
- The decision maker needs to check if there is no Advance Decision (AD), Lasting Power of Attorney [LPA] or Deputy, or if there is a friend/carer of person nominated by the person to consult.
- The AD must be relevant to this decision

Record keeping:

- It is important that you accurately record and evidence any decisions made with regards to best interest.

The person can be treated safely under the wider provisions of the MCA 2005. Person will be supported to make decisions as the delirium resolves;

Restraint:

- Any one form of restraint should be sufficient for DoLS to be considered as the hospital system of providing assessment and care often deprives the person of autonomy and choice with regards to their care plan.
- It is a given that the care plan will be agreed and reviewed by the ward team at their discretion.
- The person's movement within the ward setting is quite restrictive and the person is not free to wander or leave if so decided by the ward team.

Prevent

Prevent is part of the Government's counter-terrorist strategy known as CONTEST. Prevent aims to reduce the risk we face from terrorism by stopping people becoming terrorists or supporting terrorism.

Healthcare professionals have a key role in Prevent. The strategy focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity. With such vast interaction on a daily basis, there will continue to be occasions where healthcare workers meet and treat individuals who may be open to exploitation by radicalisers.

The key challenge for the health sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, healthcare workers can interpret those signs correctly, are aware of the support that is available and are confident in referring the person for further support. If you have concerns you should raise these with your organisational Prevent lead or Safeguarding lead.

The DH has developed Prevent guidance and a toolkit for the NHS, Private and Voluntary health sectors to guide delivery of the strategy at a local level. The documents – 'Building Partnerships, Staying Safe' provide a framework for health organisations

to ensure that they are sufficiently structured to manage concerns about vulnerable individuals who may be exploited and drawn into terrorism. The escalation model reflects current safeguarding principals, together with a drive to support vulnerable individuals through closer partnership working across organisations within the public, private and voluntary sector. Building Partnerships, Staying Safe is available from the Department of Health website.

<http://www.dh.gov.uk/health/2011/12/guidance-vulnerable-adults/>

In conjunction with the Home Office, the DH has also developed a workshop tailored to the healthcare sector, known as HealthWRAP (Working to Raise Awareness of Prevent). This workshop is used to raise awareness of Prevent as well as the importance of having robust escalation procedures in place within an organisation, alongside partnership sector arrangements. Please contact your Prevent or Safeguarding lead for further information about awareness raising training.

Caroline Perez is the NHS London Prevent Coordinator and can be contacted at:
caroline.perez@london.nhs.uk
for further information on Prevent.

Prevent - Channel

What is Channel?

The Channel group provides a mechanism for supporting individuals who may be vulnerable to terrorist-related activity by assessing the nature and the extent of the potential risk, agreeing and providing an appropriate support package tailored to the individual's needs. Channel is part of the PREVENT strand of the Government's Counter Terrorism Strategy CONTEST. Channel is a multi-agency partnership that works with existing safeguarding partnerships and crime reduction panels in order to assess referrals of vulnerable individuals that are at risk of being drawn into terrorism. Channel is administered and coordinated by police, but chaired by the local authority.

What happens with the referral?

- Each referral is screened for suitability. If the referral is not appropriate for Channel an exit strategy will be planned.
- Appropriate referrals will go through a preliminary assessment coordinated by the police Channel coordinator.
- Partners will be asked to check and report back to the

police Channel coordinator if the vulnerable individual is known to their service and a case profile will be created for the Channel meeting.

- The multi-agency panel will convene and be chaired by the local authority, support needs will be identified and action plan will be drafted.
- Each case will be reviewed a minimum of every six weeks.
- There will be a six-monthly and 12-monthly review for each case.

Will the vulnerable person be informed that they have been referred for Channel intervention?

This will depend on individual circumstances. If there is genuine concern that informing individuals of the referral will jeopardise their engagement and increase vulnerability, partners may agree not to inform them, this should be judged on a case by case basis.

How to refer to the Channel programme?

If you have a concern about an individual please refer to your Channel referral protocol which will be held with your organisational Prevent lead or Safeguarding lead.

Resources

For the resources listed below, visit:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

- [Clinical Governance and Adult Safeguarding: An integrated process. February 2010](#)
- [Safeguarding Adults: The Role of Health Service Managers and their Boards DH March 2011](#)
- [Safeguarding Adults: The Role of Health Service Practitioners DH March 2011](#)
- [Safeguarding adults: The Role of NHS Commissioners DH March 2011](#)
- [Safeguarding Adults Self-Assessment and Assurance Framework DH March 2011](#)
- [Safeguarding Adults and the Role of Health Services: Analysis of the Impact on Equality](#)
- [Statement of Government Policy on Adult Safeguarding DH May 2011](#)

More resources:

Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse

<http://www.scie.org.uk/publications/reports/report39.pdf>

Safeguarding adults at risk of harm: A legal guide for practitioners

<http://www.scie.org.uk/publications/reports/report50.pdf>

Self-neglect and adult safeguarding: findings from research

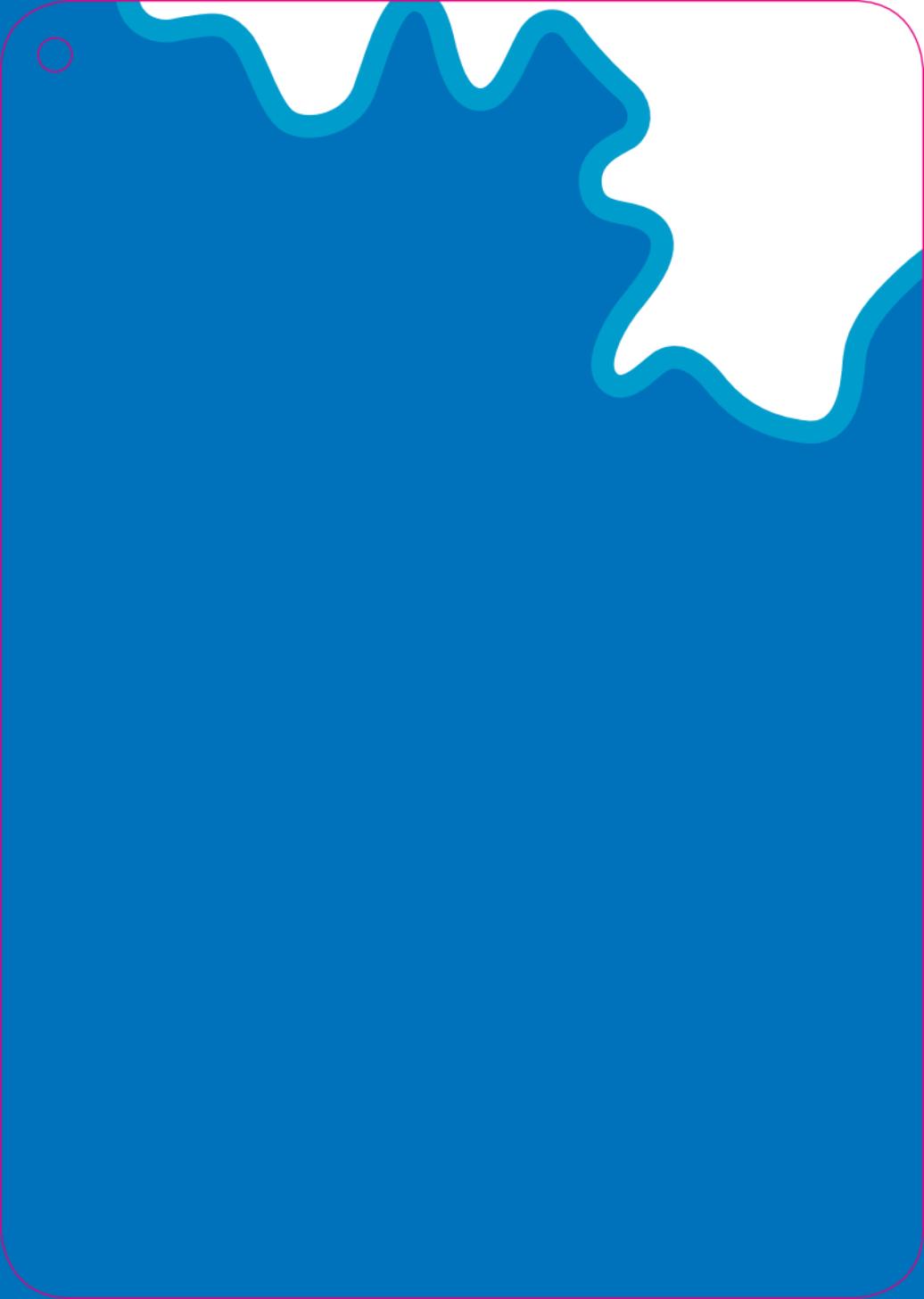
<http://www.scie.org.uk/publications/reports/report46.pdf>

Association of Directors of Adult Social Services – Safeguarding Adults Key Documents www.adass.org.uk

Adult Safeguarding Resources and Reports from Social Care Institute for Excellence: <http://www.scie.org.uk/adults/safeguarding/index.asp>

Adult Safeguarding Community of Practice: <http://www.communities.idea.gov.uk/comm/landing-home.do?id=2962596>

Mental Capacity Act 2005 in primary care E-learning toolkit www.mcahealth.net





This pack was produced by the NHS in London Safeguarding Adults Network and the MCA and DoLS flowcharts working group, (Munyaradzi Hute, Martin Grant, Steve Chamberlain, Mala Karasu and John Emery), with thanks to Judi Thorley and the East Midlands Safeguarding Adults Health Network, for the original idea.

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