The issue of abuse is under scrutiny once more as the government has launched a consultation on the review of its No Secrets guidance (2000) on protecting vulnerable adults (NT News, 21 October, p4). This follows an inquiry by Harrow PCT, which found evidence of ‘the inappropriate use of restraint’ on five vulnerable older patients at Northwick Park Hospital in north London (Harrow PCT, 2008; Mooney, 2008).

The new consultation, launched jointly by the Department of Health, Home Office and Ministry of Justice, asks how the original guidance needs to be changed. It aims to empower both the public and professionals to prevent abuse of vulnerable adults. It focuses on enabling them to identify and manage risk, and to say no to abusive situations and criminal behaviour. It invites a wide range of stakeholders – including NHS staff – to consider the role they can play.

Help the Aged said the consultation was an acknowledgement that the current guidance-based system does not prevent abuse of older people or encourage prosecution of abusers. Nurses can contribute by emailing comments to the No Secrets review team, by 31 January 2009 (see www.dh.gov.uk).

BACKGROUND
The DH and Home Office (2000) acknowledged that the term ‘abuse’ can be subject to wide interpretation. The guidance outlined the starting point for a definition with the following statement: ‘Abuse is a violation of an individual’s human and civil rights by any other person or persons.’ It said a consensus had emerged identifying the following main forms of 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, could not consent or was pressured into consenting;
- Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation and blaming;
- Financial or material abuse – including theft, fraud, exploitation and pressure in connection with wills, property or inheritance;
- Neglect and acts of omission – including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, or the withholding of the necessities of life, such as medication, adequate nutrition and heating;
- Discriminatory abuse – including racism, sexism, abuse based on disability, and other forms of harassment, slurs or similar treatment (DH and Home Office, 2000).

The No Secrets guidance explained that vulnerable adults may be abused by a wide range of people, including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers. It also stressed that abuse may take place in any context: when a vulnerable adult lives alone or with a relative; in nursing, residential or day care settings; in hospitals and custodial settings; within support services provided in people’s own homes; and other places previously assumed safe.

The guidance outlined how to set up an inter-agency framework, developing inter-agency policy and procedures for responding in individual cases of alleged abuse.
Extent of the problem

In its inquiry report on elder abuse, the House of Commons Health Committee (2004) argued that abuse of older people is ‘a hidden, and often ignored, problem in society’. It reported that 500,000 older people in England are being abused at any one time but many people are unaware of the problem and ‘few measures’ have been taken to address it. It added that abuse occurs in institutional settings but more often in the home.

The committee highlighted over-prescription of medication as a problem, sometimes used in the care environment as a tool for managing residents. For care staff it could be a means to ease the burden of care of older people, especially of those with dementia. A particular concern to the committee was the frequency of medication reviews and the administration of drugs by unqualified staff. It recommended that measures be taken to ensure compliance with the NSF target that all people over 75 should normally have medicines reviewed at least annually, and those taking four or more should have a review every six months.

In its response to the committee’s recommendations, the DH (2004) agreed the incorrect prescribing of medicines was a ‘serious problem’. It said the government had taken steps to address it, including incentives in the quality and outcomes framework for medicines management.

SAFEGUARDING IN HEALTH SERVICES

The consultation document outlines several reasons and policy drivers for the increase in NHS engagement with safeguarding. It says the No Secrets guidance envisaged that each NHS organisation would work actively within an inter-agency framework to carry out joint investigations and promote the empowerment and well-being of vulnerable adults.

However, the consultation says listening events have suggested that full engagement has been slow to develop. In many areas, safeguarding was added to the remit of busy nurse managers. Mental health services appeared to be the hardest to engage, with a common perception that the issue did not apply to them.

At the listening events, the consultation team commonly heard that ‘the NHS is in denial’. A common perception seemed to be that ‘abuse is something that happens in care homes and is investigated by social services. It is not an NHS issue.’ However, the document acknowledges that safeguarding has begun to be taken seriously in some parts of the NHS. It also reports an expansion of safeguarding posts in the NHS (although few in London). The most common harm they appear to be focusing on is pressure ulcers. The Commission for Social Care Inspection has been asking the NHS to identify those care homes admitting people to hospital with serious pressure ulcers, and care homes to identify those hospitals discharging people with these, so that both can be investigated.

Other issues include risk of malnutrition on wards, where people are given trays of food but not helped to eat. Other forms of neglect that are an issue include where staff do not know how to make ‘best-interests decisions’ and may leave patients untreated and in pain because they are ‘uncooperative’.

The new No Secrets consultation invites views on the issues discussed and outlines a set of questions for consideration.

CONCLUSION

Nurses are vital in preventing, detecting and alerting other staff and organisations to signs of possible abuse. Some signs to look for are specific to different types of abuse (for example, welt marks, cigarette burns and bruises are signs of possible physical abuse), but there are also some general indicators that abuse may be taking place (see box below). It is essential that nurses remain vigilant for any possible signs and act on these appropriately.

GENERAL BEHAVIOURS LINKED TO ABUSE

Staff should be aware of these general signs that may indicate abuse, remembering that many could also suggest something else, such as an existing or undiagnosed medical condition:
- Seeking shelter or protection;
- Unexplained reactions towards particular individuals;
- Unexplained reactions towards particular settings;
- Frequent or regular visits to the GP or A&E, or hospital admissions;
- Frequent or irrational refusal to accept investigations or treatments for routine difficulties;
- Unexplained change in material circumstances;
- Inconsistency of explanation or no explanation.

The following ‘trigger’ behaviours may be additional indicators of abuse:
- Destruction of the physical environment;
- Turning night into day/sleep disturbance;
- Chronic incontinence;
- Extreme physical and/or emotional dependence;
- Verbal abuse and aggression towards the carer;
- Changes in personality not caused by illness and/or medication;
- Non-compliance with carers’ wishes;
- Obsessive behaviour;
- Wandering/absconding;
- Self-harm.