FALLS AND SAFEGUARDING ADULTS –

GUIDANCE FOR CARE PROVIDERS

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1.0 Definitions

1.1 Definition of a fall – National Institute for Clinical Excellence (2014)

- A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

1.2 Safeguarding Adults – Care and Support Statutory Guidance (2018)

Safeguarding adults is protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop abuse and neglect happening

1.3 Definition of an adult at risk – The Care Act, Section 42 (1) (a) & (b)

- An adult at risk is someone over 18 years of age who has care and support needs (whether or not the local authority is meeting any of those needs)
- And are experiencing or at risk of abuse or neglect
- as a result of those care and support needs are unable to protect themselves from abuse or neglect because of their care and support needs (Care Act 2014).

2.0 Deciding whether to refer to adult safeguarding

- Not all falls will require a safeguarding referral.
- The referrer will need to consider whether there was abuse or neglect linked to the fall including self-neglect or that care and treatment following a fall was abusive or neglectful for example an individual sustains a physical injury or harm and there is a concern that a risk assessment was not in place, not followed or not updated to reduce risk. The key factor is that the individual has experienced avoidable harm, which is neglect, either by the staff member or the organisation.
- General concerns about an individual's safety are **not** a safeguarding concern. Safeguarding process **will** only be escalated if there has been significant harm or there are concerning patterns.

2.1 Where there is doubt as to whether to raise a safeguarding concern, staff should always speak to their safeguarding lead or equivalent in their organisation or the local authority.

2.2 The following questions may be helpful in determining whether the fall should be referred as a safeguarding adults concern. In line with the key principles of safeguarding adults, any actions taken must be proportionate to the level of presenting risk or harm and be driven by the desired outcomes of the adult or their representatives.

Question	Circumstances	Possible actions
Was the person a known falls risk and therefore was the fall predictable/preventable? Has the person fallen under similar circumstances more than once?	If the fall was not predictable (i.e. was the first known fall), it is unlikely that the fall would be considered under safeguarding adults procedures.	Professionals should consider referrals to GP/Falls Service and develop or update risk assessments and care plans
Does the person have a falls risk assessment in place and was this appropriately documented, communicated and followed?	If the person was a known falls risk, there would be an expectation that this would be documented and communicated with all relevant professionals. It would also be expected that there was a risk assessment in place to try and prevent the falls and/or reduce the harm caused because of the falls.	A safeguarding adult's referral should only be considered if the person was a known falls risk and this was not appropriately documented or communicated.
Were all the necessary aids and equipment (e.g. call bell, sensor mat, walking aids available and working? Were these used as would be expected?	If the service had not used specific equipment or aids which was not available or not working or staff not trained to use it.	A safeguarding adult's referral should be considered if the fall could have been prevented or the level of harm reduced. Or if the equipment or aids were available but not used, this might suggest negligence on the part of the staff.
Is it possible that a crime occurred?	Crimes that may be applicable include ill-treatment/wilful neglect under the MCA 2005, breach of Health and Safety at Work Act, Common Assault.	A safeguarding adult's referral should be made, in addition to reporting to the Police and/or Health and Safety Executive.
Are there others at risk now or in the future?	Were there unsafe practices/procedures within an establishment that could lead to the harm of adults with care and support needs.	A safeguarding adult's referral should be made.
What is the impact of the fall on the person?	Did the fall result in a significant/serious injury	A safeguarding adult's referral should be made

	or has a head injury/lost consciousness?	particularly if they may be at risk in the future. In the event of a death related to a fall this should always result in a safeguarding referral even if it is unclear whether the fall directly caused the death.
What are the views of the adult or their representative?	If the adult or their representative does not agree to a safeguarding referral or does not want anything to happen.	The referrer would need to consider whether there is a legal basis for overriding consent for example because others may be at risk or it is in the public interest.
What happened following the fall?	It may be that the fall itself did not meet the safeguarding criteria, but the subsequent actions or lack of actions amount to abuse or neglect.	The referrer should consider how the immediate needs of the person were met i.e., were they appropriately/inappropriately moved, was necessary medical attention sought.
Was the fall unwitnessed	It would be dependent on whether significant injuries occurred or there was neglectful practice. It may be more helpful to use the term 'unexplained injury' rather than an 'unwitnessed fall'.	Safeguarding referral should be considered if a significant or suspicious injury has occurred which is unexplained or where the adult has repeated unexplained injuries.

3.0 Responsibilities of Referrer

3.1 Prevention and accountability are key principles in safeguarding adults. Care providers are expected to reduce the risk of falls and harm from falls for every person they support.

3.2 There is evidence that residents and service users are particularly at risk from falls and fractures in the first few months after admission to a residential home or new setting. This may be due to the environment changes and/or a period of ill health prior to admission. It is therefore essential that all individuals are assessed for their risk of falling and a care plan put into practice to manage risk, prior to, or as soon as possible after moving into residential care or a supported living environment.

3.3 All falls should be reported in line with other regulatory bodies, contractual requirements and their own policies and procedures. Any internal/

organisational reporting process must not delay safeguarding reporting where it is required. Both can be done at the same time. Where organisations triage concerns, through managers for example, a care provider would need to ensure staff are clear when and how to escalate for immediate or quick decisions for example out of hours.

3.4 Use the safeguarding adult's referral form to make a safeguarding adult's referral. This will provide you with evidence of submission.

3.5 Specific information to include within a referral related to a fall:

- Injuries sustained as a result of the fall, attach body maps if relevant.
- Information related to previous falls/falls risk assessments
- Action taken following the fall for example medical intervention, contact with the adult/family
- Any plans put in place to address increased risk of falling.

3.6 Deciding not to refer

If the fall does not require a safeguarding adult's referral, there will still be actions you need to consider to reduce risks and to try and prevent falls happening in the future.

- Recognition of risk – assessment prior to placement; complete falls risk assessment; document falls history; ensure all falls recorded on incident form; analyse falls.
- Address risk – update care plans, review monthly or before if fall occurs prior to review date, provide falls prevention information, refer to health professionals i.e., GP, falls clinic.
- Act to reduce falls – check environment for trip/slip hazards, check lighting is sufficient, have eye tests been carried out recently, is the medication record up to date, consider alcohol/drug use.
- Review and monitor – review falls risk assessments monthly or if changes to medication, health or fall occurs. Review care plans and analyse falls for triggers or patterns.
- Report fall to keyworker/care manager for information.

4.0 **On receipt of safeguarding referral**

4.1 The safeguarding referral will be sent to the allocated worker if an open case or safeguarding triage if the adult is unknown or closed to Adult Social Care.

4.2 Information will be collated from relevant professionals and the views of the adult or their representative clarified. A decision will be made within 24 hours on receipt of referral.

4.3 The decision may indicate a low-level concern in which an Adult Concern Notification will be recorded, and a safety plan established.

4.4 If the decision indicates further enquiries are needed as there is reasonable cause to suspect abuse or neglect has occurred. The MASH (Multi-agency

Safeguarding Hub) process will commence, and a Section 42 Enquiry initiated. An interim safety plan will be developed, which will involve the adult or their representative. The referrer will be notified of the decision and be invited to a Safeguarding Strategy Meeting if appropriate.

4.5 At the Safeguarding Strategy Meeting actions will be agreed. The following list provides some examples of actions that may feature in a safeguarding adults plan where the concerns relate to falls, however this list is not exhaustive:

- Multi-factorial falls risk assessment
- Multi-factorial intervention
- Referral for strength and balance training
- Care and support assessment/re-assessment
- Home hazard assessment and safety interventions
- Provision of equipment or aids
- Training for staff
- Revision of policies and procedures
- Disciplinary action (including possible referral to DBS/professional bodies)
- Criminal action

5.0 Case Examples

5.1 Mr JACK

Mr Jack has poor mobility, cognitive, hearing and sight impairment and is prescribed strong pain medication with a history of ongoing hip pain. Mr Jack had previously sustained a fractured pubic ramus. On admission to the unit, Mr Jack was given instruction on how to use the nurse call alarm system attached to his bedroom wall and was also given a pendant call alarm to wear around his neck and advised to summon staff when wishing to transfer or mobilise. This was recorded in his care plan.

A physiotherapist assessed Mr Jack's mobility and advised that a member of staff walk with Mr Jack and remind him to lean into his frame as there was a tendency to lean back over. His GP and the unit consultant continued to monitor pain levels and arranged for more x-rays and prescribed an increase in pain medication.

Staff followed instructions given by the physiotherapist however, on one occasion Mr Jack did not use his nurse call pendant to summon staff and got up by himself. Mr Jack was heard shouting and when staff went to investigate, he was found to be on the floor. Mr Jack had not sustained any injuries. Staff supported Mr Jack into a safe position and reminded him to use his pendant to summon assistance. An accident form was completed, and his mobility care plan was reviewed and updated.

The review takes in to account the reliance on Mr Jack himself to use call-aids to summon help. Given his cognitive impairment, sensor mats were to be considered.

Referral to safeguarding adults **not** required.

Rationale:

- Known falls risk with mobility care plan in place.
- Specialist professionals involved in assessing mobility and falls risk.
- Mobility aids and call aids in place – however, not used by Jack.
- One-off incident causing no harm.
- Incident forms completed.
- Mobility care plan reviewed and updated following fall.

5.2 MISS JOLLY

Miss Jolly was admitted to hospital having fallen over a pile of clothes in her property. She lay on the floor for over 12 hours until she was found. Miss Jolly had been incontinent of urine and faeces in this time. On admission to hospital, ambulance crew raised a cause for concern regarding the condition of Miss Jolly's home environment. An assessment notice was sent to the Hospital Social Work team to assess Miss Jolly's care and support needs prior to her discharge. Miss Jolly acknowledged that her home is unkempt and consented to the house being cleaned. Miss Jolly acknowledges that she has historically mistaken her medication, resulting in two full medication packs being found on an environmental visit. She would therefore accept support with medication to encourage her to establish a routine. She also admits to having difficulty reaching her feet and would agree to support with washing and dressing on a morning. Miss Jolly was discharged home with two calls daily with reablement and a pendant alarm. She mobilises with a Zimmer frame and can be erratic with her movements.

Miss Jolly's only living relative was her nephew that lived close by with his family – he wanted his aunt to go into 24-hour care however respected the fact she wanted to stay in her own home if she could. Staff supported Miss Jolly twice a day – often with minimal support as often she was reluctant and were often reminding her to wear her pendant. A month following her hospital admission, staff visited to support Miss Jolly however didn't get a reply; the no reply process was followed with the duty team and her nephew was informed of the no reply – Miss Jolly was found lying on the floor of her bathroom early afternoon by her nephew and taken to hospital. She had tripped over the mat in her bathroom.

Safeguarding adults referral **required**.

Rationale:

- Miss Jolly has care and support needs.
- Known falls risk and concerns of self-neglect.
- Attempts to address risks (assessment and provision of care and support needs), do not appear to have reduced risk.
- There are concerns about Miss Jolly's ability to protect herself from harm
- Risk of significant/critical harm
- Safeguarding adult's enquiry will need to consider Miss Jolly's capacity to understand the risks.

5.3 MRS SMITH

Mrs Smith suffers from dementia and requires hoisting for all transfers. She suffered an unwitnessed fall in the lounge of her care home, resulting in a bump above her left eyebrow and two black eyes. Staff were in the lounge but dealing with another resident who required the toilet.

Mrs Smith had had no previous falls. She was taken to hospital; the injury was cleaned up and a dressing placed on her forehead. Since then, she has been fine and is still able to sit in the lounge. There is now, following this incident, always a member of staff in the lounge but another staff member will be called on to watch Mrs Smith whenever she is in the lounge.

Mrs Smith lacks capacity to give her views, but her son has stated that he is satisfied with the outcome and does not want the matter investigated further.

The hospital has identified that Mrs Smith had a urinary tract infection due to dehydration.

Safeguarding adult's referral **required**.

Rationale:

- Mrs Smith has care and support needs.
- There is a suggestion that there was a preventable underlying health issue, impacting upon her stability – possible neglect.
- Even though Mrs Smith's son does not want anything further to happen, it would be in the public interest to override his wishes given that this is in a care setting and others could be at risk.

5.4 MR ALI

Mr Ali has known Parkinson's Disease, diagnosed 5 years ago. He keeps his appointments at the Movement Disorder Clinic, but it is now some

months since his last review. He has x 4 carers daily, takes 6 medications and is cognitively impaired.

The only relative Mr Ali has, is his older sister and they only ever have contact on the phone, so she is not aware of his physical deterioration. Mr Ali had an unwitnessed stumble on the way to the toilet at 7p.m. in the evening, half an hour after his last carer left. He did not quite fall to the floor but sustained bruising to his right hip as he hit the bath side. On this occasion he was able to right himself using the bath and the basin and stagger to the toilet using the frame in situ.

The carer called the next morning and Mr Ali was vague about the incident occurring. The carer was under pressure and did not notice the bruise on Mr Ali's right hip. There was no documentation of history or risks. A second fall occurred two days later, again unwitnessed. This time he hit his head on the edge of the toilet door and lay there all night. He was incontinent of urine and faeces. The carer cleaned him up and he was taken to A & E after awaiting an ambulance for around 5 hours.

His observations were okay, and he was discharged that evening with no follow-up. Carers were re-started with a later call that night. At midnight a neighbour heard Mr Ali calling through the wall. An ambulance was called.

Safeguarding adult's referral **required.**

Rationale:

- Mr Ali has care and support needs.
- Recent, but known falls risk.
- Further information gathering required around possible neglect and organisational abuse – missed first fall, length of wait for ambulance, actions taken to manage risk following hospital discharge (e.g. not clear appropriate risk assessments in place or if equipment was provided to reduce risks associated with falls).
- Safeguarding adult's enquiry will need to consider a full re-assessment of Mr Ali's care and support needs

6.0 Training and Resources

6.1 Training:

Northumberland County Council Social Care Training Team provide a range of relevant safeguarding adults and associated training. In addition, we can tailor training programmes to suit your service needs.

For further information and details of current courses, including how to apply, please e-mail: socialcaretraining@northumberland.gov.uk

6.2 Resources:

- Falls in older people: assessing risk and prevention (National Institute for Health and Care Excellence, (NICE) 2013)

- Preventing falls in care homes (Social Care Institute for Excellence, (SCIE) 2005)

PROCESS CHART FOR FALLS WHICH REQUIRE A SAFEGUARDING RESPONSE

Is the adult who has fallen, an "adult at risk" as per The Care Act 2014

a) Does the adult have needs for care and support (whether or not the LA is meeting any of those needs) and

b) Is the adult experiencing, or at risk of, abuse of neglect? Section 42 (1) (a) & (b)

Yes

Does the referrer consider the fall to be as a result of abuse or neglect which has resulted in a significant injury OR is there suspected abuse or neglect linked to the fall?

Consider if one or more of the following categories of abuse apply.

- **Physical Abuse** – someone pushed/hit/tripped/barged the adult which resulted in a fall
- **Neglect & Acts of Omission** – care plans and risk assessments not followed, failure to recognise and respond to need
- **Organisational Abuse** – systems have failed to support safe care e.g., lack of staff, untrained staff, care plans and risk assessments not completed, information not communicated effectively
- **Self-Neglect** – fall occurred because the person is not caring for themselves, or their environment, or refusing help – consider the mental capacity of the person to make decisions to decline support

Yes

Refer to Safeguarding Adults via Safeguarding Referral Form

LINK

No

Record – in notes/incident log

Communicate – ensure relevant others are aware of the fall i.e., Adult Social Care Allocated worker, staff within agency

Risk Assess – develop/update falls risk assessment

Care Plan – Update care plan as required

Refer – to relevant health professionals