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Adult Social Care

Falls and Safeguarding Guidance

Reshaping our practice

Name of document

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Contents

[Introduction 4](#_Toc110853789)

[What is a fall? 4](#_Toc110853790)

[Deciding whether to raise a safeguarding alert 4](#_Toc110853791)

[Responsibilities for regulated providers 5](#_Toc110853792)

[Best practice for managing falls 6](#_Toc110853793)

[Statutory requirements for reporting 7](#_Toc110853794)

[Raising a safeguarding concern following a fall 7](#_Toc110853795)

[When to raise a safeguarding following a fall 8](#_Toc110853796)

[Deciding not to refer 9](#_Toc110853797)

[Systemic failings 9](#_Toc110853798)

[Commissioning responsibilities 9](#_Toc110853799)

# Introduction

This guidance has been produced to support health and social care providers in Buckinghamshire to understand when a fall is a safeguarding concern.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

Although most falls do not result in serious injury, the consequences for an individual of falling or of not being able to get up after a fall can include:

* psychological problems, for example, a fear of falling and loss of confidence in

being able to move about safely, loss of mobility, leading to social isolation and

depression

* increase in dependency and disability
* hypothermia
* pressure-related injury
* infection

The guidance is not intended to replace existing falls policies; however, it should be used as a reference document to ensure that existing policies are in line with best practice.

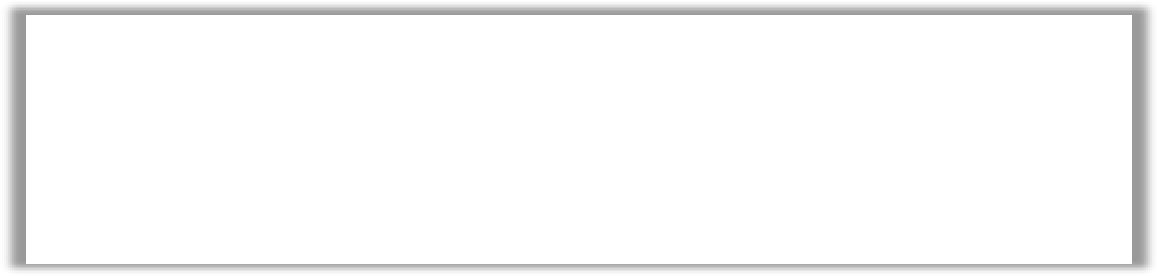
### What is a fall?

*“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….*

*“An unexpected event when a person ‘falls’ to the ground from any level, this also includes falling on the stairs and onto a piece of furniture with or without loss of consciousness”.*

National Institute for Clinical Excellence (NICE, 2004) <https://www.nice.org.uk/>

### Deciding whether to raise a safeguarding alert



* Not all falls will require a safeguarding adults referral
* The referrer will need to consider whether the person is an adult at risk and whether there was abuse/neglect linked to the fall.
* A safeguarding adults referral is not the route to access further support/services in relation to falls.

All falls must be recorded and reported using the appropriate procedures but not all falls will be safeguarding issues.

A fall can be a safeguarding adults’ issue when there are concerns that the fall occurred because of abuse or neglect (including self-neglect) or that care and treatment following a fall was abusive or neglectful.

You will need to decide whether one of the following categories of abuse apply:

* Neglect - Person(s) responsible for the care and support needs (whether paid/unpaid) did not carry out their responsibilities as expected before or after the fall.
* Organisational abuse - The fall occurred because of wider systemic failures within an organisation.
* Physical abuse - Someone pushed/tripped the adult which resulted in the fall.
* Self-neglect - The fall occurred because of a lack of self-care, care of one’s environment or a refusal of services. Mental capacity will be a key consideration in these cases. See Self-Neglect Guidance for more information.

### Responsibilities for regulated providers

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.

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 new setting. This may be due to the environmental 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 being admitted into hospital, moving into residential/nursing care or a supported living environment.

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.

There are general health and safety measures that can be taken to reduce the risk of falling and harm from falls for all individuals by taking into consideration individual needs and risk:

* Pre-admission Falls Risk assessments should be undertaken prior to a placement commencing.
* To protect service users against the risks associated with falls, by having a Moving and Handling Policy and ensuring that all staff are trained in moving and handling.
* Assessing a resident/service user's risk of falls/fractures followed by personalised care plan to manage risk is key to fall/fracture prevention and management in community settings of care.
* All falls should be reported in line with the care providers, management of incidents policies and procedures, and contractual requirements, whether a safeguarding concern is raised or not.

### Best practice for managing falls

* The assessment and care plan should be reviewed and updated as a minimum every month, and the falls risk assessment (including environmental risk assessment) and care plan should be reviewed every six months as a minimum.
* There should be a complete review of both the assessment and care plan:

(a) Following a fall

(b) When there is a significant change in a person’s condition i.e., during/ following illness, bereavement, new equipment or change in medication.

(c) On transfer from another care setting i.e., discharge from hospital

* Falls diaries are essential in falls management and should be completed for those known to fall. A senior staff member should examine and analyse the information so that in the event of a fall all relevant documentation is completed such as an accident form and RIDDOR notification if required.
* All members of the care/support team should be aware of and involved in the assessment, care planning and evaluation of risk of falls.
* Appropriate health professional e.g. GP, district nurses, community matrons, falls clinic, physiotherapy, occupational therapists and dietician should be involved as and when required and their advice followed.
* Consideration should be given to assistive technology e.g., sensor mats, call bells etc., to minimise and prevent the risk of falls.
* Identification of falls history
* Assessment of gait, balance and mobility, and muscle weakness
* Assessment of osteoporosis risk
* Assessment of the older person's perceived functional ability and fear relating to falling
* Assessment of visual impairment
* Assessment of cognitive impairment and neurological examination
* Assessment of urinary incontinence
* Assessment of home hazards
* Cardiovascular examination and medication review.

**The CQC, as part of the inspection process for registered services, will require written evidence to confirm that internal reviews, including subsequent actions, have taken place following a fall.**

### Statutory requirements for reporting

Regulation 13 HSCA - The intention of this regulation is to *“safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment”.* It requires care providers to notify CQC of every allegation of abuse/risk of abuse, which means they must notify CQC of any safeguarding referral related to a fall.

* Your organisations “Registered Person” must protect individuals against the risks associated with falls, by ensuring appropriate moving and handling, risk assessments, any equipment required are in place and used for the purposes of providing safe care.
* There is no requirement to notify the Care Quality Commission regarding falls unless the cause or effect of the fall met the following criteria*:*
  + A death
  + An injury
  + Abuse, or an allegation of abuse
  + An incident reported to or investigated by the police.
* Where relevant, you should make it clear that a fall was a known or possible cause or effect of these incidents or events being notified.
* A fall should be reported to CQC in line with the regulated care providers and management of incidents policy as soon as possible after the incident.

### Raising a safeguarding concern following a fall

Under the Care Act 2014, organisations have a common law duty of care/contractual duty and responsibility to raise safeguarding concerns where there is a suspicion that abuse of a vulnerable adult has occurred.

*'Safeguarding means 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 both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action'.*

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.

The questions in **Appendix 1** 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.

### When to raise a safeguarding following a fall

It is important to remember that a safeguarding concern must be raised following a fall where there is concern about:

* Possible abuse, neglect, or omission of care, and not because there is a general concern about an individual’s safety.
* Where an individual sustains a physical injury due to a fall, **and** there is a concern that a risk assessment was not in place or was not followed.
* There have been multiple unwitnessed falls for the same person.

Or

* Where an individual has sustained an injury requiring medical advice or attention, and this has not been sought.
* There is a delay is seeking medical advice or attention.

***The key factor is that the individual has experienced possible avoidable harm.***

Unwitnessed’ falls / unexplained injury not requiring a safeguarding concern:

* It is not a requirement that a safeguarding concern should be raised in respect of all ‘unwitnessed falls’. If a fall is unwitnessed, it cannot be determined how the individual fell therefore, it is possible that they were pushed or knocked over by someone else. The important issue is that each individual incident needs to be considered according to the unique factors of the case and a professional judgement made.
* Falls that were unwitnessed where the individual has explained how they fell. If there is a risk assessment in place, and the post fall protocol requirement, including observations, have been followed, it is not necessary to raise a safeguarding concern. The individual has explained what happened and abuse or neglect is not likely to have occurred.
* It is more helpful to use the term ‘unexplained injury’ rather than ‘unwitnessed fall’. In circumstances where an individual has sustained an unexplained injury, a senior staff member should use judgement based on the evidence available to determine what may have happened and whether a safeguarding concern should be raised.

Unwitnessed’ falls / unexplained injury requiring a safeguarding concern:

* Where an individual has a significant or suspicious (consider nature and location of injury) injury following a fall, this must be raised as a safeguarding concern.
* Where an individual has one or repeated unexplained injuries, a safeguarding concern should be raised.

**Examples of falls which may also be considered appropriate for raising a safeguarding concern:-**

* A fall as a result of safety equipment not being in working order, not being used or not being in place following an assessment of need, causing harm.
* A fall resulting in harm where there is no risk assessment in place or where the risk assessment has not been reviewed within the required timescale or updated to mitigate the falls risk.
* Repeated falls despite preventative advice being given and a series of minor injuries.
* Fall and injury as a result of possible medication mismanagement.
* Members of staff not receiving training in falls management and/or not adhering to the falls policy and protocols following a fall.
* Supervision levels appearing to be insufficient to ensure safety resulting in falls.
* Environmental hazards, such as poor lighting or clutter, which may have contributing to the fall and injury.

### 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.

### Systemic failings

Where there are systemic failings in a care providers falls management process which leads to repeated falls, a safeguarding concern should be raised under organisational abuse.

Where the falls are due to external factors or services e.g. change in medication, unsafe hospital discharge, poor equipment etc. there is an obligation on all services to identify the failing and ensure the issue is addressed.

This can be done through contacting the appropriate services to support a resolution. This could include local medicine management team, GPs, Occupational Therapists, Social Workers or Care Co-ordinators, family members, or discussing with commissioners of local services.

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### Commissioning responsibilities

Falls are reviewed as part of the contract monitoring process. Commissioners will seek assurance that: -

* The commissioned services have policy and processes in place on how to deal with falls in line with CQC and NICE guidance.
* All the staff within the commissioned service have had up-to-date training on falls management.

All Safeguarding referrals are recorded as Organisational Safeguarding concerns on BC’s client information recording system (LAS) which will support monitoring of themes and patterns for specific providers/settings.

This information could trigger an earlier or additional contract and monitoring review/visit.

As part of Quality monitoring this information is used to triangulate a joint response to identify and manage wider concerns.

This document is intended as a guidance tool and should be used in conjunction with professional judgement. When there is any doubt as to whether to raise a safeguarding concern, staff should always speak to the safeguarding lead in their organisation, and if further advice is required to contact Buckinghamshire Council Early Resolution and Safeguarding team on 0800 137 915 or [safeguardingadults@buckinghamshire.gov.uk](mailto:safeguardingadults@buckinghamshire.gov.uk).

**APPENDIX 1**

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| 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 or has a head injury/lost consciousness? | A safeguarding adult’s referral should be made 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. |