

Norfolk Safeguarding Adults Board

Falls and safeguarding – guidance for providers

FINAL

21 January 2021

Issue Number	02 – FINAL (minor revisions for clarity made to page one - 18 Feb 2021)
Document Owner	Norfolk Safeguarding Adults Board
Date Approved	21 January 2021
Date Published on NSAB website	January 2021
Review Date	January 2023, or sooner if required

When a fall should be reported as a safeguarding concern

All falls must be recorded and reported using appropriate procedures but not all falls will need to be raised as a safeguarding concern.

Falls all need to be documented and checked for your own risk assessments and quality audits; you may also be asked to report on falls to the Clinical Commissioning Group (CCG), Care Quality Commission (CQC), Norfolk County Council Quality team or through other routes (e.g. RIDDOR).

The document is intended to be a guidance tool to promote **best practice** in understanding when a fall may need reporting as a Safeguarding Adults concern and should be used in conjunction with professional judgement. It is not a substitute for the policies and procedures required of care providers to ensure safe care.

Where there is any doubt whether to raise a safeguarding concern, staff should always speak with the safeguarding lead or equivalent in their organisation. If further advice is needed, consult with the local authority: Norfolk County Council, adult social care 0344 800 8020 – this is the same number to call to report a safeguarding concern.

Responsibilities of care providers

Prevention is a key principle in safeguarding adults. Care providers are expected to put in place a number of things to reduce the risk of falls, and harm from falls, for every person they support.

Key to prevention and management is first identifying the person's specific risk of falls or risk of harm from falls (e.g. high likelihood of fractures if has osteoporosis) followed by personalised care planning to manage those risks.

Pre-admission assessment should consider the risk of falls, and how to manage that before a change takes place. This should include relevant history as well as looking at potential risks in the new environment.

The registered person has a duty of care to protect service users and staff from risks relating to physical assistance. Moving and handling policies must be up to date and

all staff must have relevant training to minimise risk associated. Equipment must be checked regularly and kept in safe working order.

Accountability is another key principle of safeguarding adults – so all falls should be reported in line with:

- Internal/organisational policies and procedures supporting care providers around management of incidents
- Any contractual requirements (e.g. CQC, NCC, CHC, CCG)
- legal and regulatory (requirements (including RIDDOR, health and safety)
- Safeguarding adults policy, where indicated

Please note that any internal/company reporting processes must not delay safeguarding reporting where it is required; both can be done at the same time.

Ensure that where organisations triage concerns, through managers for example, staff are clear when and how to escalate for immediate or quick decisions, e.g. at weekends.

Best Practice for the management of falls

- Individual assessments and care plans should be reviewed and updated as a minimum every month, and the falls risk assessment (including environmental risk assessment) and any associated management (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 e.g. during/following illness or infection, change in medication, diagnosis of postural hypotension
 - c. On transfer from another care setting e.g. discharge from hospital
 - d. If the 'falls team' or other professionals have assessed or reviewed
- Falls records are essential in falls management and should be completed for every fall that happens. A designated staff member should review and analyse the information so that possible causes can be identified, preventative

measures put in place, or further referrals made. This should include checking for any safeguarding issues

- All members of the care/support team should be aware of, and involved in, the assessment, care planning and evaluation of risk of falls
- Other appropriate professionals e.g. GP, community nurses, falls team, physiotherapy, occupational therapists and dietician, should be involved as and when required, and their advice recorded and followed

Post-fall Protocol

- A clear post-fall protocol should be in place to support staff in taking the right action when a fall has occurred - see link below to *IStumble*, which has an example of this, as well as comprehensive information and guidance around falls, and a training package
- Staff should receive guidance and training to ensure that further harm is not caused as a result of their post-fall intervention
- It is essential that individuals are checked for injury before any attempt is made to move them
- Medical treatment should always be sought promptly where necessary via GP, NHS 111 or 999 in an emergency
- Information regarding falls services, including lifting services, should be easily available to staff, especially outside of standard daytime working hours

(continues)

Raising a safeguarding concern following a fall

All agencies have a duty to raise safeguarding concerns where there is a cause to believe that abuse of an adult with care and support needs has occurred.

This is in addition to other requirements on care providers around the management of falls.

There could be concerns that a fall occurred because of abuse or neglect (including self-neglect), or that care and treatment following a fall was abusive or neglectful.

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

- **Physical abuse** - Someone pushed/hit /tripped/barged the adult which resulted in the fall
- **Neglect & acts of omission** – care plans not followed, checks not completed, failure to assess/recognise and respond to need e.g. where there has been a significant history of falls with no action taken
- **Organisational abuse** – systems have failed to support safe care – e.g. lack of staff, untrained staff, care plan reviews 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

When to raise a safeguarding concern following a fall

- Where there is concern about actual or possible abuse (as above) – **not** because there is a general concern about an individual's safety
- Where an individual sustains a physical injury or harm due to a fall 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

- Where an individual has sustained an injury from a fall which requires medical advice or attention, in a timely fashion, and this **has not** been sought.

Examples of falls which may be a safeguarding concern:

- A fall as a result of safety equipment not in working order, not being issued or not in place following an assessment of need causing harm (e.g. bed rails - although bed rails can also be a cause of falls or other harm without proper assessment)
- Repeated falls despite preventative advice being given and a series of minor injuries – may trigger some additional enquiries
- Fall and injury as a result of medication mismanagement (e.g. blood pressure or diabetes medication missed, or not receiving antibiotics to manage infection)
- Falls during assists or using equipment e.g. hoists and slings worn or used incorrectly, falls out of windows that should have opening range limited, sliding out of a chair because of poor positioning
- Members of staff not receiving training in falls management and/or not adhering to the falls policy and protocols following a fall
- Too few staff on duty to meet the needs of the people being supported safely, resulting in falls
- Environmental hazards, such as poor lighting or clutter, equipment left out, wet floors, resulting in a fall and injury

Unwitnessed falls/unexplained injuries

- If a fall is unwitnessed, then it can't be precisely known how the person came to be on the floor. It is possible that they were pushed or knocked over by someone else, or something else has happened
- In these cases, each incident needs to be considered as carefully as possible, using any known history or information, and a judgement made as to the most probable cause. Not all unwitnessed falls will be as a result of abuse or neglect and therefore reported as a safeguarding concern

- Recording the detail available and causes considered and what action has been taken, will be even more important where direct cause cannot be definite. Where there remains a high level of uncertainty, or if significant injury, report as a safeguarding concern
- A person may say that they fell, even if it was not witnessed. It is not always necessary to raise a safeguarding concern if:
 - they have no impairment which would cause doubt about their story, and
 - there is a risk assessment in place, and
 - the post-fall protocol, including observations, has been followed
 then they have explained what has happened, and abuse/neglect is not likely
- It may be more helpful to use the term ‘unexplained injury’ rather than ‘unwitnessed fall’. In circumstances where a person has sustained an unexplained injury, senior staff should make a judgement based on the evidence available to determine what may have happened and whether a safeguarding concern should be raised
- However, where a significant or suspicious injury has occurred which is unexplained, or where the person has repeated unexplained injuries, this should be raised as a concern so that further enquiry can take place

More detailed examples:

- 1) Unwitnessed fall with injury: a resident has dementia, and also sight and hearing loss. Heard to fall by staff in next door room. Found on floor of their room, believed to have tripped over a stand aid which had been left in the corridor while staff were supporting next door.

Safeguarding enquiry – neglect as staff have not considered the risk posed by the equipment for residents with dementia and sensory loss; health and safety issue as a trip hazard; RIDDOR notification.

- 2) Unwitnessed fall with injury: a resident was checked regularly through the night as per care plan, on one check found on the floor of his bathroom. He

tells staff that he got up to use the toilet, and they checked him over before assisting him to get back into bed. He had some pain relief for general discomfort that day but was able to walk around using his frame in his usual manner. A bruise came up on one hand which staff noted and monitored. The next day his hand started to swell, staff supported a GP consultation and an x-ray was arranged, found to have a fractured wrist.

No safeguarding enquiry – resident has capacity and could describe what happened. Evidence that staff supported him correctly, monitored post fall and took action when his need changed; also, evidence from provider that immediately following the fall, a review was done, and preventative measures put in place. No falls history prior to this.

- 3) Unwitnessed fall with injury: staff member supported a resident into bed, became distracted by another resident and left the room without lowering the bed as per falls care plan. The resident fell out of bed, hitting her head and needing hospital admission.

Safeguarding enquiry – neglect the care provider showed evidence of falls diary, care planning, regular review, MDT involvement so no indication of organisation abuse, but it was neglect on the part of the staff member.

- 4) Witnessed fall with injury: two staff used a hoist and sling to support a resident from bed to chair in the early morning. Sling strap broke and the resident fell to the ground, causing a number of skin tears.

Safeguarding enquiry – neglect and organisational abuse the staff did not check the equipment before using it; the provider had not kept up regular checks of all equipment; risk to other residents identified

Questions you are likely to be asked when you raise your concern to NCC

- What happened, where, and when?
- Was the fall witnessed or unwitnessed?
- Does the person have mental capacity?
- Has the person been injured in the fall?
- Has the person been checked by staff for any injuries?
- If there is injury, has the person been seen by a medical professional or medical advice sought? How long after the fall did this happen?
- If the person has been seen by a medical professional, what is their view on the injury/bruising (e.g. unusual/concerning)
- How many falls or similar has the person had in the last 6 months?
- When was their last fall? What management plan was put in place after this (e.g. any specialist equipment, referrals to outside agencies, any regular monitoring - consider night as well as daytime monitoring)
- If a care plan is in place, is there documentation to show the plan was being followed?
- What has been done now to prevent or minimise risk of further falls for the person?
- Has the family or advocate been advised of the fall and action taken by the provider?

Links to further information:

careinspectorate.com/index.php/guidance/9-professional/2737-falls-and-fractures
IStumble:knowledgeanglia.nhs.uk/KMS/SouthNorfolk/Home/ProvidersServices/CareProviders.aspx

PHE Guidance Jan 2020 - [Falls: applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/falls-applying-all-our-health)

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