Norfolk Safeguarding Adults Board

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# Falls and safeguarding – guidance for care and health services

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## Context

Falls must not be seen as an inevitable part of ageing. A fall should be seen as an event that needs curious investigation to seek ways to reduce or prevent future occurrence.

People may fall for a wide range of reasons, and it is not always possible to prevent falls from happening. A good understanding of basic falls awareness and effective falls management can decrease the likelihood of unintentional neglectful practices which can create the conditions for falls to occur, sometimes causing harm to the adult which can have a devastating impact.

Norfolk Safeguarding Adults Board (NSAB) recognises that not all falls are preventable and continues to promote the view that adults should be supported to make choices that balance risks with positive choice and control in their lives, including less restrictive options where an individual has been assessed to lack capacity in that decision.

This document provides proportionate guidance around how providers/services can help to prevent and manage the risk of falls, and what constitutes a safeguarding concern where a failure to follow the guidance has been identified.

## When a fall should be reported as a safeguarding concern

**All falls must be recorded and reported using appropriate internal procedures within your specific organisation, but not all falls will need to be raised to the local authority as a potential safeguarding concern**.

Service providers should ensure that falls are recorded and investigated via individual provider processes, risk assessments and quality audits; you may also be asked to report on falls to the Integrated Care Board (ICB), Care Quality Commission (CQC), Norfolk County Council (NCC) Integrated Quality team or through other routes (e.g. RIDDOR – see useful links below).

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. For specific guidance around falls, including identifying triggers for external referral, please use the links at the end of this document.

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 Norfolk County Council, adult social care 0344 800 8020 – this is the same number to call to report a safeguarding concern.

## Responsibilities of health and care providers

Prevention is a key principle in safeguarding adults. In relation to falls, we would expect staff within your service to be attentive and aware of falls risk and prevention. Service providers are expected to put in place a number of things (through policies and processes) 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 or admission assessments should consider the risk of falls, and what interventions or considerations may be needed to support the person in reducing the risk of falls whilst within the providers care. This should include relevant past medical and falls history as well as looking at potential risks in the care environment.

Organisations and service providers have a duty of care to protect people who use their services, and their 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 with falls prevention. 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, Continuing Health Care, ICB)
- 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 or out of hours.

## Best Practice for the management of falls (regardless of safeguarding)

Whether a fall does or does not require raising a safeguarding adults concern, there are still actions you need to consider in order to reduce risks and to try and prevent falls happening in the future.

- Individual assessments and care plans should be reviewed and updated according to your service provider policy standards – for social care providers this should be 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 falls 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 and recording a rationale for why a safeguarding concern **was or was not** raised.
- 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.

There are some useful links to specific falls guidance at the end of this document.

A note on behaviour – some adults may fall to the ground in a more controlled way or place themselves on the floor, often expressing a need of some kind. As with any risk, this should be assessed and a care plan developed. In these scenarios it is more likely that a concern would be raised where agreed protective or preventative measures put in place have not been followed and harm occurs.

## 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 – in acute and community health settings post fall assessments are an integral part of incident reporting systems; for care providers 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 – this should be promoted through your post-fall protocol
- Medical treatment should always be sought promptly where necessary via GP, NHS 111 or 999 only in an emergency or via internal escalation processes within NHS inpatient settings
- Information regarding falls services, including lifting devices, should be easily available to staff, especially outside of standard daytime working hours

## 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 – you must of course consider the mental capacity of the person to make decisions to decline support, as well as positive risk taking, but balancing this against the level of risk or harm involved

### 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.
- Where individual care plans and/or risk assessments were not followed correctly.

### Examples of falls to report as 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)
- 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 room nearby. Found on floor, 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 checked regularly through the night as per care plan, on one check found on the floor of his bathroom. He told staff that he got up to use the toilet and lost balance. 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 acted when this need changed; 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 rpatient from bed to chair in the early morning. Sling strap broke and the patient 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 hospital had not kept up regular checks of all equipment; risk to other patients 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?
- What preventive measures, if any, have been identified and implemented within 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?

Please ensure that referral information is accurate, transparent, and reported to safeguarding in a timely fashion. Further safeguarding enquiries could be raised if information sharing concerns are identified.

**Links to further information:**

- Falls and Fractures (careinspectorate.com)
- Falls Management (knowledgeanglia.nhs.uk) (IStumble)
- Falls: applying All Our Health - GOV.UK (www.gov.uk) (updated 2022)
- Frailty - elearning for healthcare (e-lfh.org.uk)
- Falls in older people: assessing risk and prevention (National Institute for Health and Care Excellence, 2013) (note: being updated)
- Preventing falls in care homes (Social Care Institute for Excellence, 2005)
- Fall prevention for the elderly | Age UK
  RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 - HSE

(Quick reference flowchart on next page)

**Quick Reference Falls and Safeguarding**

**Check:** does the adult have care and support needs (is an adult at risk*) and is abuse / neglect evident or suspected?

**Physical abuse – The adult was pushed /hit /tripped/barged 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**

*__Adult at risk__ (Aged over 18; has needs for care and support** and as a result of those needs, is unable to protect him or herself against the abuse/neglect or the risk of it.)

** "needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors." (Care Act 2014))

**YES** → **Raise a Safeguarding Concern**

**Witnessed fall with no injury, evidence that care plan / risk assessment / equipment in place**

**Multiple falls without injury, where appropriate external referrals for support have been made, relevant equipment and staffing in place, care plans and risk assessment up to date**

**NO** →

**No requirement to raise a Safeguarding Concern, but:**

- **Record** (In notes/incident log)
- **Communicate** (Ensure relevant others are aware of the fall)
- **Risk Assess** (Develop/update falls risk assessment)
- **Care plan** (Update care plan as required)
- **Refer** (To GP/Falls Service)
- **Record** actions taken