Teeswide Safeguarding Adults Board

TSAB Falls and Safeguarding Protocol

Version 1.2

Our safeguarding arrangements will effectively prevent and respond to adult abuse

Contents

Revision Number	Date Approved by the Board	Change Record	Review Date:
1	26 April 2022	New guidance	April 2024
1.2	N/A (Minor Amendment – June 2023)		June 2024

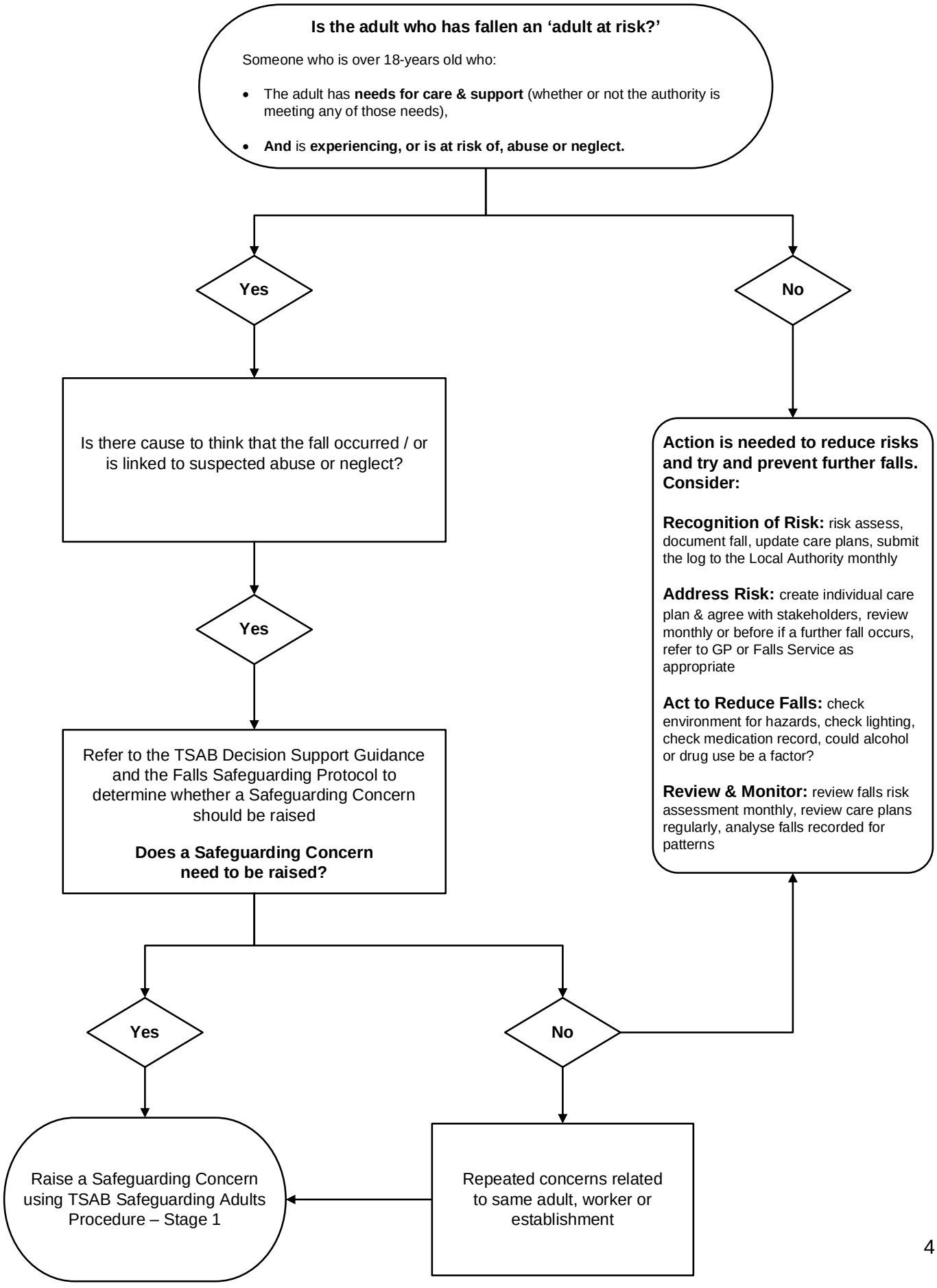
1. Introduction

This TSAB Falls and Safeguarding Guidance has been developed to support staff in making decisions about when to raise a safeguarding concern in relation to falls.

The toolkit has been developed by a multi-agency task and finish group and in consultation with relevant service providers.

We gratefully acknowledge the agreement of both North Tyneside Safeguarding Adults Board and Newcastle Safeguarding Adults Board in using some of their materials.

TSAB Falls & Safeguarding Flowchart



2. Safeguarding Adults

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].

Safeguarding duties apply to adults over 18 years old and:

- have care and support needs (whether or not the Local Authority is meeting any of those needs)
- is experiencing, or at risk of, abuse and neglect

An **adult at risk** may therefore be a person who, for example:

- is an older person who is frail due to ill health, physical disability, or cognitive impairment
- has a learning disability
- has a physical disability and/or sensory impairment
- has mental health needs including dementia
- has a long-term illness/condition
- misuses substances or alcohol
- is an unpaid carer, such as a family member/ friend who provides personal assistance

The Care and Support Guidance (2022) states that abuse and neglect can take place in many forms. In relation to falls this may be:

- Neglect and acts of omission
- Organisational abuse
- Physical abuse
- Self-Neglect

3. Definition of Falls

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.[2]

4. Falls Prevention

Falls can significantly damage self-confidence, increase social isolation, reduce independence, and hasten a move into a residential care setting. The fear of falling may lead to deterioration in a person's well-being and quality of life, even if the fall itself does not result in a serious consequence.

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 place to manage risk, prior to, or as soon as possible after moving into residential care or a supported living environment.

Falls prevention strategies and interventions need to consider the fact that falls can have a number of causes, such as frailty, infection, confusion, and the effects of some prescribed drugs that require many different interventions.

Providers of health and care services will have a Falls Policy and Procedure; these should follow national guidance and good practice.

[1] Care and Support Statutory Guidance, 2022
[2] National Institute for Clinical Excellence, 2015

Please refer to Section 11 for further information and useful resources.

5. Unwitnessed falls and unexplained injuries

It is important to note the difference between an 'unwitnessed fall' and an 'unexplained injury'.
An **Unwitnessed fall** is when a fall has occurred, and the person has explained what happened. If there is no suggestion that the fall occurred due to possible abuse, neglect or omission of care, a safeguarding concern is not required. All falls should continue to be reported in line with the service provider's management of incidents policies, and contractual/registration requirements, with risk assessments being reviewed and post fall protocols being adhered to, whether a safeguarding concern is raised or not.

Any fall that is deemed as unwitnessed, unexplained and results in injury should be referred to as an **unexplained injury**, rather than an unwitnessed fall. In these circumstances the senior staff member on duty should use judgement based on the evidence available to determine what may have happened. If the person has an injury which cannot be explained, then this should be referred as a safeguarding concern.

In any event, it is important that immediate medical attention is sought when a person presents with any head injury whether or not the cause is known. If there are no injuries evident at the time of the incident, ongoing monitoring must be undertaken, and advice sought if there is any change to clinical presentation.

6. Decision making: when is a fall a safeguarding concern?

Remember:

- Not all falls will require a safeguarding concern to be raised.
- The person raising the safeguarding concern will need to consider whether the person is an adult at risk and whether there was abuse or neglect linked to the fall.
- A safeguarding concern is not the route to access further support/ services in relation to falls.

What to consider:

A fall can be a safeguarding concern if there is abuse or neglect linked to it. There could be 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.

The person raising the safeguarding concern will need to decide whether one of the following categories of abuse apply:

- Neglect – the person/s responsible for the care and support needs (whether paid or 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 e.g. failure to carry out risk assessments, poor staffing levels, lack of communication regarding care plan
- Physical abuse – someone pushed or tripped the adult resulting in the fall
- Self-neglect – the fall happening because of a lack of self-care, care of the environment or a refusal of services. Mental capacity will be a key consideration in these cases.

The following questions might be helpful in determining whether the fall should be referred as a safeguarding concern.

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. it was the first known fall), it is unlikely that the fall would be considered under safeguarding adults procedures. Professionals should consider a referral to GP/Falls service and develop/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 and those providing care and support. It would also be expected that there was a risk assessment in place to try and prevent the falls and/ or reduce the level of harm caused because of the falls. A safeguarding concern should be made or considered if the person was a known falls risk, and the risk was not appropriately documented or communicated.

Were all necessary aids and equipment (e.g. call bell, fall mat/ sensor, walking aids) available and working? Were these used as would be expected?

A safeguarding concern should be made or considered if the fall could have been prevented or the level of harm reduced, if it was reasonable to expect that the service should have used specific equipment or aids which were not available. This includes if they were available but not working, or available but staff not trained to use them. If the equipment or aids were available but not used, this might suggest negligence on the part of the staff and therefore it would be appropriate to raise a safeguarding concern.

Is it possible that a crime has occurred?

It may be that the incident relating to the fall would constitute a crime. Crimes that may be applicable include ill-treatment/ wilful neglect under the Mental Capacity Act 2005, breach of Health and Safety at Work Act, common assault. If this is the case then a safeguarding concern must be raised, in addition to a report to the police and/or the Health and Safety Executive.

Are there others at risk now or in the future?

Consideration should be given to unsafe practices and or procedures within the care or health setting that could lead to the harm of adults with care and support needs. In these circumstances a safeguarding concern should be raised.

What is the impact of the fall on the person, e.g. has the fall resulted in injury and what is the extent of the injury?

On its own the impact of the fall does not necessarily determine whether a safeguarding concern should be raised, e.g. no harm may have occurred on this occasion but there is a concern that the person or others may be at risk in the future and therefore consideration should be given to raising a safeguarding concern. However, generally the more serious the impact of the fall the more likely it is that a safeguarding concern should be made. Following medical assessment, it may be apparent that the person has suffered a significant/ serious injury. In the event of a death related to a fall, this should always result in a safeguarding concern being raised, even if it is unclear whether the fall directly caused the death.

What are the views of the person or their representative about what they want to happen?

A key consideration with any safeguarding concern is whether the person or their representative consents to the concern being raised and what they want to happen as a result of the safeguarding enquiry. If the person or their representative does not consent to the safeguarding concern being raised or does not want anything to happen then the person raising the concern 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 will be necessary for the person raising the concern to consider whether the actions taken or not taken following the fall constitute abuse. It may be that the fall itself did not meet the criteria for safeguarding but the subsequent actions or lack of actions amount to abuse or neglect. The person raising the concern should consider how the immediate needs of the person were met, were they appropriately or inappropriately moved, was the necessary medical attention sought?

Was the fall witnessed?

An unwitnessed fall may be more likely to result in a safeguarding concern being raised due to the unknown nature or circumstances leading up to it.

It will be helpful to refer to the TSAB Decision Support Guidance to assist with decision making. In accordance with the key principles of safeguarding adults, any actions taken must be proportionate to the presenting risk or harm and be driven by the desired outcomes of the adult or their representative.

7. Responsibilities of the person raising the concern

Once a decision has been made to raise a safeguarding concern, it is important that the normal referral routes are used. This may be directly into the Local Authority or via the organisation's safeguarding adults team or lead. Please see TSAB Inter-agency Safeguarding Adults Procedures. If wilful neglect or any other criminal act is suspected, then the police must be contacted.

Specific information which should be included in the Safeguarding Concern form includes:

- Any injuries sustained as a result of the fall (attach body map to the concern)
- Information relating to previous falls/ falls risk/ falls risk assessment
- Action taken following the fall (e.g. medical intervention, contact with the person and their family)
- Any plans put in place to address an increased risk in falls

There is an expectation that safeguarding concerns are discussed with the individual and/or their representative wherever possible, and that they are involved in discussing the concern and agreeing on an appropriate course of action. This is called Making Safeguarding Personal (MSP). In cases where there is a pattern of falls involving one or more people receiving care from the same provider, a safeguarding concern will need to be raised even if the person is not in agreement in order to safeguard others who use the service.

8. Deciding not to refer

If the fall does not require a safeguarding adults concern to be raised, there will be actions that need to be considered to reduce risks and to try and prevent falls happening again in the future. It is also good practice to record the rationale for not raising a safeguarding concern.

Recognition of Risk

- Assessment of risk prior to commencing service
- Complete falls risk assessment
- Document falls history
- Ensure all falls are recorded on the incident form or log for further analysis
- Update Care Plans
- Submit the log to the Local Authority each month

Address risk

- Write individual care plan to cover risks to service user/ patient
- Agree care plan and sign off by all stakeholders
- Review monthly or before this if a further fall occurs
- Provide falls prevention information
- Refer to GP or Falls Service, as appropriate

Act to reduce falls

- Check environment for trip/slip hazards, including the condition of carpets and uneven floor surfaces
- Check lighting is sufficient/ have eye tests been carried out recently
- Is the medication record up to date
- Could alcohol/ drug use be a factor?

Review and monitor

- Review falls risk assessment monthly or if there are changes to medication, physical or mental health or if a fall occurs
- Review care plan if there are changes to medication, health or falls
- Analyse falls recorded on the incident /accident logs for triggers or patterns. Multiple falls related to the same person and/ or service might suggest the need for a safeguarding concern to be raised.

9. Safeguarding adults enquiries related to falls

On receipt of the safeguarding adults concern, the Local Authority will decide whether there is a duty to conduct a Safeguarding Adults Enquiry (Section 42) to investigate the concern. The Local Authority may carry out the enquiry themselves or may determine that they are able to 'cause' the enquiry to be undertaken by someone else, for example, the provider. Please see Causing Section 42 Enquiries Guidance v1.

Whoever is undertaking the enquiry should consider who should be involved; the list below is not exhaustive and it will depend on the circumstances of the concern.

- The person/ representative
- The Local Authority Safeguarding Team (should be involved in all cases where the concern relates to a paid worker, volunteer or service provider)
- Falls specialists
- Service Provider (health, social care, housing)
- CQC
- Commissioner
- Community team and rehabilitation team

- Community nurse
- Social worker
- Police
- Coroner (in the event of death)
- Health and Safety Executive

10. Safeguarding adult plans

The following list provides some examples of actions that may feature in a safeguarding adults plan where the concern relates to falls.

- Holistic falls risk assessment
- Multiple Interventions for example: physical health, mental health and emotional needs
- Referral to Falls Clinic
- Medical/ care needs assessment
- Home hazard's assessment and safety interventions
- Provision of equipment or aids
- Training for staff
- Revision of policy and procedures
- Disciplinary action (including possible referral to DBS/ professional bodies)
- Criminal action

11. Case examples

MR FRANK

Mr Frank had been living in a residential care home for people over the age of 65 for over two years, he was experiencing a deterioration in his cognitive ability, which was also impacting on his mobility, however since moving into the care home he had not sustained a fall.

Staff had completed a falls risk assessment for Mr Frank which had been reviewed monthly, he had previously been assessed as a low risk of falls however on the last review the risk had increased to a medium risk of falls. Mr Frank's mobility care plan had been updated to reflect the increase in risk and a request for a GP review had been made due to a general deterioration in his presentation.

Following the GP review a referral to the physiotherapist team had been made who had attended the home and advised Mr Frank would benefit from a walking frame. Mr Frank's care plan had been updated to reflect the advice given by the physiotherapist which included Mr Frank utilising the nurse call system to summon assistance when getting out of bed.

On one occasion Mr Frank did not use the nurse call system and got out of bed without assistance, he was heard shouting and when staff attended, he was found lying on the floor near his bed. Mr Frank had not sustained any injuries. Following the fall staff had completed an accident form, informed his family and care manager, updated his falls risk assessment and reviewed his mobility care plan.

The review considered the reliance of Mr Frank himself to use call aids to summon help and given his cognitive impairment, sensor mats were also considered.

Referral to safeguarding adults not required. Rationale:

- ✓ Falls risk assessment in place which had been reviewed monthly and following the fall

- ✓ Mobility care plan in place which reflected the falls risk assessment, reviewed following the fall and appropriate actions identified within the care plan to reduce the risk of falls
- ✓ Specialist professional involved in assessing mobility and falls risk
- ✓ Mobility aids and call aids in place however the call aid not utilised by Mr Frank
- ✓ One-off incident causing no harm
- ✓ Correct action taken following the fall

MRS SMITH

Mrs Smith is an 80-year-old female who resided in a care home where she had 24-hour nursing care. Mrs Smith's mobility would fluctuate and her mobility began to decline.

Over a two-week period, Mrs Smith had 3 falls where she was supported by staff to get up off the floor. On the fourth occasion Mrs Smith was found in her bathroom on the floor with marks to her head, arm and leg. The care home manager called the Safeguarding Team to ask if a Concern needed to be sent as a result of the fall. During this discussion there was no disclosure of the first three incidents.

During the decision-making stage it was identified that there were previous falls and Mrs Smith sustained injuries from the fall. At the time Mrs Smith felt staff should have been supporting her whilst she was on the toilet. Staff had gone off to see another resident and Mrs Smith was unable to hold her own body weight causing her to fall.

The concern was progressed for further enquiries which identified failings by staff. It was identified that no urgent medical attention was sought by the staff despite Mrs Smith having a mark on her head. The care home acknowledged this failing and agreed that their policy is to call for urgent medical attention with any unwitnessed or witnessed head injury.

The staff involved were subject to disciplinary matters for failing to support Mrs Smith in the way her care plan stipulated. All staff were supported with a team session to discuss what had happened and ways to avoid this in the future.

Referral to safeguarding adults was required. Rationale:

- ✓ Mrs Smith has Care & Support needs
- ✓ Known falls risk
- ✓ Attempts to address risk do not appear to have reduced risks
- ✓ There are concerns about Mrs Smith's ability to protect herself from harm
- ✓ TSAB decision support guidance considered
- ✓ Risk of significant / critical harm

MRS FELLOWES

Mrs Fellowes is a 94-year-old lady who has a diagnosis of Alzheimer's Dementia with unclear speech that is difficult to comprehend. Mrs Fellowes is fully reliant on care staff for the management of her personal safety and care which include meal provision, hygiene support and medication. Mrs Fellowes is currently a resident within a regulated care setting.

Mrs Fellowes is non-compliant with intervention including medication, she relentlessly walks throughout the unit corridors and can be invasive to peers thereby putting herself at risk.

Throughout a 6-month period 4 safeguarding concerns had been made to the Local authority in relation to physical abuse due to what was believed to be unwitnessed falls.

Over the six-month period a total of 32 possible falls were identified some of which resulted in fractures, cuts and bruising.

Following assessment, it was established Mrs Fellowes had a DoLS in place with a number of conditions. Due to her cognitive impairment, it was difficult to establish the wishes of Mrs Fellowes, so the Relevant Person's Representative (RPR) / Family were approached and included as part of a Best Interest meeting. The details of each incident were investigated with Mrs Fellowes family being aware and engaged in the safeguarding process.

The safeguarding process identified that of the 32 presumed falls:

- 12 referrals were received by the falls team during this time.
- 19 additional health interventions recorded following a fall including Nurses, GPs, community team interventions, attendance at Accident & Emergency, Emergency Assessment Unit, hospital inpatient settings and treatment by ambulance crews on the scene.

Referral to safeguarding adults was required. Rationale:

- ✓ Mrs Fellowes has Care and Support needs
- ✓ TSAB decision support guidance considered
- ✓ All but three presumed falls were escalated and reported
- ✓ 4 previous Safeguarding Concerns raised in relation to physical abuse due to unwitnessed falls
- ✓ Further information gathering required around possible neglect and organisational abuse due to multiple falls resulting in fractures, cuts and bruising
- ✓ Safeguarding adults enquiry will need to consider a full re-assessment of Mrs Fellowes care and support needs

12. Useful resources and references;

Care Act 2014
https://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Department of Health & Social Care (2014) Care and Support Statutory Guidance
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

National Institute for Excellence (2013) Falls in older people
https://www.nice.org.uk/guidance/cg161/resources/falls-in-older-people-assessing-risk-and-prevention-pdf-35109686728645

National Institute for Excellence (2015) Preventing falls in care homes
https://www.nice.org.uk/guidance/qs86/resources/falls-in-older-people-pdf-2098911933637

National Institute for Health and care Excellence (2013) Preventing falls in care homes.
https://www.nice.org.uk/guidance/cg161/evidence/falls-full-guidance-190033741