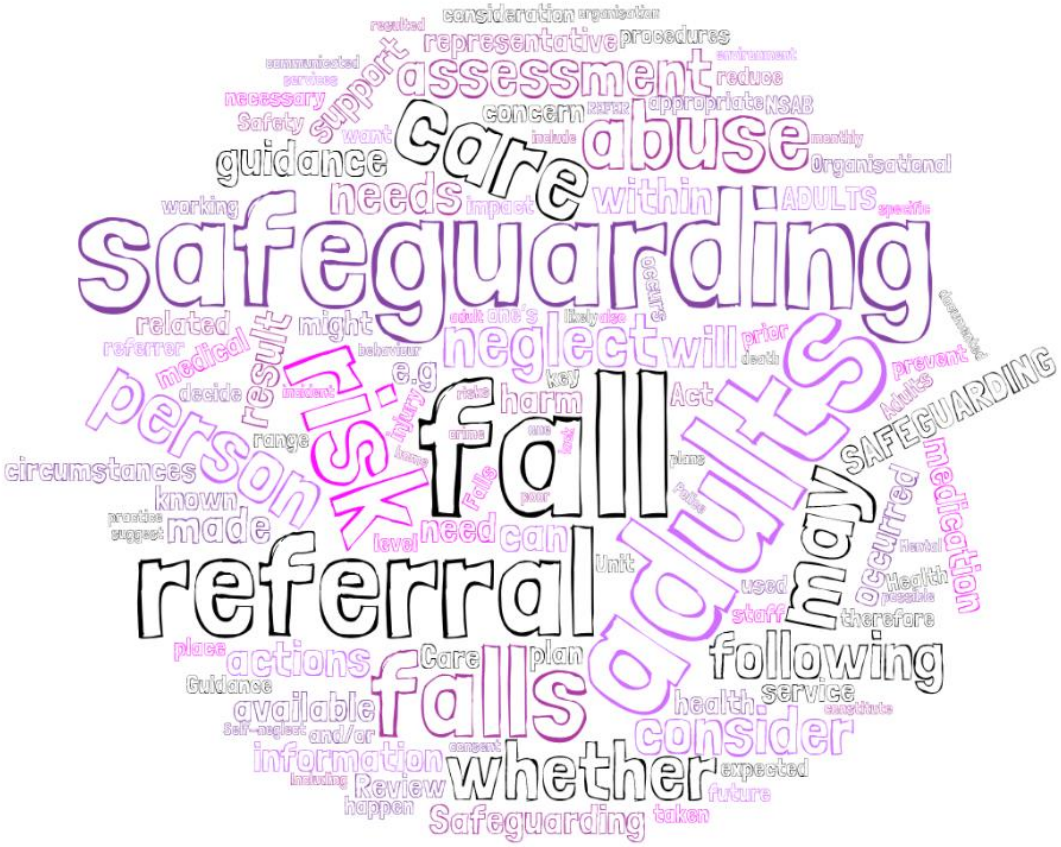
Safeguarding Adults and Falls Protocol:

When is a slip, trip or fall a safeguarding adults issue?



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newcastle safeguarding adults board

CONTENTS

This guidance was developed by a multi-agency Task and Finish Group in Newcastle, representing a wide range of sectors and professions:

- Akari Care
- Homecare Plus
- Momentum Care
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust
- St Cuthbert's Care
- Care Quality Commission
- Manor Care
- Newcastle City Council
- NHS Newcastle Gateshead Clinical Commissioning Group
- Prestwick Care
- Your Homes Newcastle

The NSAB is grateful to all those who contributed to this guidance. Please do not reproduce this guidance without prior agreement of the NSAB.

HOW TO USE THE GUIDANCE

The flow-chart on page 3 provides an overview of the guidance. If you are accessing the document electronically, the flow-chart is interactive; by clicking on the magnifying glasses, readers can find out more information located elsewhere in the document. Readers can then navigate back to the flowchart using the arrows at the bottom of each page.

This guidance has been produced in line with the NSAB multi-agency safeguarding adults policy and procedures. These can be accessed here.

Is the adult who has fallen, an “adult at risk”?

Yes

Does the referrer consider the fall to be as a result of abuse/neglect OR is there suspected abuse/neglect linked to the fall?

Yes

Referrers use NSAB Risk Threshold Tool to determine whether the abuse is at a significant/critical level.

Significant/critical

Make Safeguarding Adults referral using normal reporting routes.

Low

Repeated low level harm related to same adult/worker/establishment

No

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/Belsay Day Unit

Click on in the flowchart to find out more information.

1. DEFINITIONS

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. (National Institute for Clinical excellence, 2014).

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. (Care and Support Statutory Guidance 2018)

ADULT AT RISK

Safeguarding adults duties apply to "adults at risk". These are adults who:

- have needs for care and support (whether or not the local authority is meeting any of those needs)
- are experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect (Care Act, 2014)

ABUSE AND NEGLECT

The Care and Support Statutory Guidance (2018) states that abuse and neglect can take many forms. In relation to falls this may be:

Neglect and acts of omission – ignoring medical, emotional or physical care needs. Failure to provide access to appropriate health, care and support or educational services. The withholding of the necessities of life, such as medication, adequate nutrition and heating.

Organisational abuse - Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes, practices or staffing within an organisation.

Physical abuse – Including assault, hitting, slapping, pushing, misuse of medication, restraint and inappropriate physical sanctions.

Self-neglect - covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Click here to return to flowchart

2. DECIDING WHETHER TO REFER TO ADULT SAFEGUARDING

- ✓ 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.

WHAT TO CONSIDER

A fall can be a safeguarding adults issue when there are concerns 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.

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. See Organisational Abuse Enquiries guidance for more information.
- **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.

The following questions might be helpful in determining whether the fall should be referred as a safeguarding adults 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 referral to GP/Falls Service and develop/update risk assessments/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 falls. A safeguarding adults referral should be

Click here to return to flowchart

made/considered if the person was a known falls risk and this risk was not appropriately documented/communicated.

- **Were all the 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 adults referral should be made/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/aids which was not available. This includes if they were available but not working or available but staff not trained to use it. If the equipment/aids were available but not used, this might suggest negligence on the part of the staff and therefore appropriate to consider a safeguarding adults referral.

- **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, a safeguarding adults referral should be made, in addition to the report to the Police and/or the Health and Safety Executive.

- **Are there others at risk now or in the future?**
  Referrers should consider if there are unsafe practices/procedures within an establishment that could lead to the harm of adults with care and support needs. In these circumstances a safeguarding adults referral should be made.

- **What is the impact of the fall on the person? E.g. has the fall resulted in injury, what is the extent of the injury?**
  On it's own the impact of the fall does not necessarily determine whether a safeguarding adults referral should be made or not e.g. no harm may have occurred on this occasion but there is a concern that the person/others may be at risk in the future and therefore consideration should be given to making a safeguarding adults referral. However, generally the more serious the impact the more likely it is that a safeguarding adults referral 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 adults referral, even if it is unclear whether the fall directly caused the death (appreciating that this may be very difficult to confirm, especially within a reasonable timescale).

- **What are the views of the person or their representative about what they want to happen?**
  A key consideration with any safeguarding adults referral is whether the person or their representative consents to the referral being made and what they want to happen as a result of any safeguarding adults enquiry. If the person or their representative does not consent to the safeguarding adults referral or does not want anything to happen then the referrer would need to consider whether there is a legal basis for overriding consent e.g. because others may be at risk or it is in the public interest.

Click here to return to flowchart

- **What happened following the fall?**
  It will be necessary for the referrer to consider whether the actions taken following the fall would constitute a safeguarding adults referral. It may be that the fall itself did not meet safeguarding adults criteria but the subsequent actions or lack of actions amount to abuse/neglect. The referrer should consider how the immediate needs of the person were met, were they appropriately/inappropriately moved, was necessary medical attention sought?

- **Was the fall witnessed?**
  An unwitnessed fall may be more likely to result in a safeguarding adults referral due to the unknown nature of the circumstances leading up to it.

You will also need to consider the Newcastle Safeguarding Adults Board Risk Threshold Tool to decide whether a referral should be made. 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 representative.

RESPONSIBILITIES OF REFERRER

Use your normal reporting routes to make a safeguarding adults referral. This might be directly to Adult Social Care or via your organisation's safeguarding adults team/lead.

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

- Injuries sustained as a result of the fall (attach body maps to the referral).
- Information related to previous falls/falls risk/falls risk assessment.
- Action taken following the fall (e.g. medical intervention, contact with the person/family).
- Any plans put in place to address increased risk of falling.

DECIDING NOT TO REFER

If the fall does not require a safeguarding adults 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 commencing service
- Complete falls risk assessment
- Document falls history
- Ensure all falls recorded on incident form/log for analysis

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 if fall occurs prior to review date
- Provide falls prevention information
- Refer to GP or Belsay Unit (Falls Clinics or Day Hospital as appropriate)

Click here to return to flowchart

Act to reduce falls

- Check environment for trip/slip hazards (condition of carpets/uneven floors)
- 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 changes to medication, health or fall occurs
- Review care plan if changes to medication, health or fall occurs
- Analyse falls in incident/accident logs for triggers/patterns. Multiple falls related to same person and/or service might suggest the need for a safeguarding adults referral.

3. SAFEGUARDING ADULTS ENQUIRIES RELATED TO FALLS

On receipt of the safeguarding adults referral, the Local Authority will decide whether there is a duty to conduct a Safeguarding Adults (Section 42) Enquiry to investigate the concern(s).

WHO TO INVOLVE IN THE SAFEGUARDING ADULTS ENQUIRY?

The following list is not exhaustive and it will depend on the circumstances of the concern.

- The person/representative
- Safeguarding Adults Unit (the SAU should be contacted in all safeguarding adults cases which relate to a paid worker/volunteer/service provider).
- GP
- Falls specialists (e.g. Belsay Unit, Falls Clinic/Day Hospital)
- Service provider (Health/Social Care/Housing)
- CQC
- Commissioner
- Community Response and Rehabilitation Team
- Community Nurse
- Social Worker
- Police
- Coroner
- Health and Safety Executive

Click here to return to flowchart

SAFEGUARDING ADULTS PLAN

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

- Multi-factorial falls risk assessment
- Multi-factorial intervention
- Referral for strength and balance training
- Care and support assessment/reassessment
- Home hazard 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

Click here to return to flowchart

4. CASE EXAMPLES

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 rami.

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. 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.

His mobility care plan advised staff to ensure that Mr Jack always wore his pendant alarm or was sitting within reach of a nurse call alarm cord and to follow advice given by the physiotherapist.

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 is 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.

Click here to return to flowchart

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 mobilizes 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 risks;
- ✓ There are concerns about Miss Jolly's ability to protect herself from harm;
- ✓ Risk of significant/critical harm;
- ✓ Safeguarding adults enquiry will need to consider Miss Jolly's capacity to understand the risks.

Click here to return to flowchart

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 have identified that Mrs Smith had a urinary tract infection due to dehydration.

Safeguarding adults 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.

Click here to return to flowchart

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 ok 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 A calling through the wall. An ambulance was called.

Safeguarding adults 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 adults enquiry will need to consider a full re-assessment of Mr Ali's care and support needs.

Click here to return to flowchart

5. TRAINING AND RESOURCES

People working with adults with care and support needs should be able to access falls training or guidance via their employer or professional group/body (e.g. Royal College of Nursing, Royal College of Occupational Therapists).

SAFEGUARDING ADULTS TRAINING

Professionals who come into contact with adults with care and support needs should complete safeguarding adults training at least every three years. Free multi agency training is offered by the Newcastle Safeguarding Adults Board to all organisations providing a service within Newcastle. There are a range of different courses - from basic awareness through to specialist, thematic courses. You can find out more about them here.

RESOURCES

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

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

Click here to return to flowchart

APPENDICES

KEY CONTACTS

Community Health and Social Care Direct - To make safeguarding adults referrals - to access social care support and community health services - to refer to the Belsay Unit	0191 278 8377
Safeguarding Adults Unit Professionals Advice Line, Mon-Fri, 9am-5pm	0191 278 8156
Belsay Unit	0191 282 3100

Use your normal reporting routes to make a safeguarding adults referral. This might be directly to Adult Social Care or via your organisation's safeguarding adults team/lead.

Safeguarding Adults Initial Enquiry Form (referral form)

Click here to return to flowchart