Enfield Safeguarding Adults Board.

Falls and Safeguarding Adults Protocol.

This guidance is produced with thanks to the Richmond and Norfolk Safeguarding Adults Boards whose own protocols form the basis of this work.

Introduction

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 Integrated Care Board (ICB), Care Quality Commission (CQC), Enfield Local Authority or through other routes (e.g., RIDDOR). All providers of care services should be able to demonstrate that they have processes in place to assess and respond to risk.

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. It should be used in conjunction with professional judgement. It will also identify what is expected in relation to documentation and consideration regarding falls from providers. It is not a substitute for the individual policies, procedures and risk assessments required of care providers to ensure safe care.

The Care Act (2014) defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Safeguarding Adults is about preventing and responding to concerns of abuse, harm or neglect of adults whilst still prioritising the person's views and wishes. In the case of falls, it is imperative to balance risk and the ability of people to live the lives they want to live. In the words of Justice Munby "What good is it making someone safe if it merely makes them miserable?"

Falls and injuries in hospital, community and residential settings are common due to physical frailty of adults at risk, the presence of a long-term condition, such as Parkinson's disease, dementia, or arthritis, or being unfamiliar with the environment. There are general measures which can reduce the risk of falls such as undertaking a risk assessment and developing a personalised care plan to manage the risks. It is vital that all care providers (including both residential and domiciliary providers and including those who are not registered with the Care Quality Commission) have well documented policies and protocols which highlight best practice in their organisation. Again, safeguarding is not a substitute for good local procedures etc.

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: Enfield Multi-Agency Safeguarding Hub via telephone: 020 8379 3196 or email: TheMASHTeam@enfield.gov.uk.

u There is guidance available on Making Good Safeguarding Adults Referrals in Enfield here also which may be helpful to services (also available as 1 page guidance).

At the end of this document, there are a number of links to guidance around falls, prevention and recording which should complement this guidance and may support in the development or review of provider procedures.

2. Purpose of the Protocol

2.1 This multi-agency protocol has been developed to assist in decision making as to whether to report a fall as a safeguarding concern. It provides good practice guidance to support all agencies in making a referral decision. It is not a substitute for organisations' requirements to provide safe and effective care and to have appropriate policies and procedures to guide staff.

2.2 Every organisation is responsible for ensuring that the protocol is used appropriately and monitor and review its use. This would include reviewing decisions to raise or not raise concerns within internal governance processes and managing risk of falls within the organisations policy.

2.3 This Protocol was produced following discussion at the Enfield Safeguarding Adults Board and consultation with provider and health partners.

3. Processes around Falls.

3.1 The 2015 NICE Quality Standards defines a fall as an unexpected loss of balance resulting in coming to rest on the floor, the ground or on an object below the knee. A fall is distinct from a collapse which is as a result of an acute medical condition such as arrhythmia, transient ischaemic attack (TIA) or vertigo .

3.2 Falls and fall related injuries are a common and serious problem for older people, particularly those with underlying conditions and pathologies. Falls are a major cause of disability and the leading cause of mortality for those aged 75 and above. Most falls do not result in injury; however, each year approximately 5% of older people living in the community who fall experience fractures or need hospitalisation. The Royal College of Physician's 2011 report (Falling Standards, Broken Promises) highlights that falls and fractures in people over 65 account for 4 million hospital bed days each year in England alone.

3.3 People with care and support needs have an increased risk of falling compared to the general population due to their physical frailty, underlying medical conditions, muscle weakness, poor balance, medication, or unfamiliarity with a new environment.

3.4 The human cost of falling includes distress, pain injury, loss of confidence, loss of independence and mortality. Falling also has an impact on the family members and carers of people who fall. The consequences are exacerbated if people do not receive quick and appropriate assistance at the time of the fall.

3.5 Not all falls can be prevented but best practice requires that a multifactorial falls risk assessment should be in place as part of the overall care plan.

This assessment and the care plan should be discussed and agreed with the person and their representative in line with the principles of Making Safeguarding Personal. If the person lacks the mental capacity to understand the risk assessment and proposed care plan then an advocate or representative should be consulted and agree the risk assessment and proposed plan using the principles of the Mental Capacity Act.

If the measures required to mitigate the risk of falls would amount to restriction or continuous supervision then a Deprivation of Liberty Safeguard may need to be considered.

3.6 In terms of a falls risk assessment, care planning and risk management, these should be undertaken at a number of key points in a person's journey of care for example:

- Pre-admission to hospital / care / nursing home / intermediate care / home care
- Admission to hospital / care/ nursing home / intermediate care / home care
- At any point when the resident / service user's needs change
- After a fall

3.7 All organisations offering care and support in a hospital, community, own home, or care home setting should have a clear policy in place as to how falls are documented. In the case of any fall –

whether this is reported as a Safeguarding Concern or not – the following documents should be in place:

- An incident form which shows the circumstances of the fall, the post-fall actions taken as well as analysis of the causes and any mitigations that could have stopped the fall.
- A body map to show any injury (or to evidence that the individual was checked for injury, and nothing was found).
- The updated Falls Risk Assessment – showing that the learning from the Incident form has been incorporated into the previous assessment (or simply noting the more recent fall has been considered if there is no concrete learning to apply).
- Internal provider falls monitoring documentation which ensures you are aware at a glance of how many falls an individual has had over time.
- Notes around any necessary medical intervention.

These documents should be available upon request by clinicians, the Local Authority or inspecting bodies. Please provide this information at the point of referring any fall into the Local Authority as a Safeguarding Concern. It may be that the Local Authority is able to make decisions about progression to a full Section 42.2 (of the Care Act) Enquiry based on this information alone. It will allow them to quickly identify areas of concern or good practice and ensure a much prompter conclusion for providers and individuals (and/or their loved ones).

3.8 Where an adult is falling repeatedly, for example more than once in a month, then a residential provider should ensure that the adult receives an appropriate clinical review. For example, from the GP or Care Homes Assessment Team. An Occupational Therapy review or physiotherapy assessment may also be appropriate. An individual's GP is good place to start to discuss the Community Health Services which may be available to support them.

A domiciliary care agency should recommend that the individual or their family self refers to the GP or Local Authority. However, if this does not happen then it may be appropriate for the domiciliary care agency to inform the Local Authority.

4. Managing Falls in the context of Adult Safeguarding

4.1 Not all falls should be regarded as needing a safeguarding enquiry.

4.2 The threshold for safeguarding is met when there is a concern about possible abuse or neglect. The following situations must trigger a safeguarding referral by the care provider:

- Where an adult sustains an injury, due to a fall, which requires medical intervention.

- Where an adult has fallen and appropriate medical attention has not been sought in a reasonable time frame, this must be reported as a safeguarding concern. *Note: specific falls guidance states that where the person has sustained a head injury, a medical assessment should always be arranged as a matter of urgency.*

- Where there is concern that the reported circumstances of the fall do not match with the evidence (for example nature of injury).

- Where the organisation's own Post Falls protocol is not in place or has not been followed.

- Where an individual has a care plan stating that they are receiving 1:1 care (at time of fall) but the fall was unobserved.

- Where the adult or their family have alleged to the provider that the fall may have been the result of abuse or neglect.

- Where equipment assessed as required to minimise falls was either absent, poorly maintained or incorrectly used leading to a fall.

- Where is a belief that staffing levels may have been insufficient to monitor the adult safely or staff may have lacked manual handling training leading to a fall.

4.3 A Safeguarding Adults referral does not need to be completed if the above criteria are not met. However, if there is any doubt then a Safeguarding Adults referral should be completed.

4.4 Acute hospital colleges may wish to consider cases where discharge to a more supported environment has been delayed – either internally or externally – which has then led to an increased risk of falls.

4.5 Where the care provider does not believe that the above criteria are met then they may not raise a Safeguarding Adults referral. However, they are still expected to follow the appropriate processes in their own procedures and also as identified in Section 3 of this protocol for prevention purposes. Other professionals and/or private individuals may also refer as safeguarding due to concerns and the provider will be expected to respond fully and to be able to supply the information in Section 3.6 and 3.7.

4.6 A full Safeguarding Adults Enquiry is not necessary in every case where a Safeguarding Adults referral is received by the Local Authority, and not every full Safeguarding Adults Enquiry has to take a long time to conclude. The more information that is provided at the point of the Safeguarding Adults referral then the prompter the conclusion is likely to be.

4.7 As mentioned above, there is guidance available on Making Good Safeguarding Adults Referrals in Enfield here also which may be helpful in identifying what information should be included in your initial referral (also available as 1 page guidance).

5. Review.

5.1 This protocol will be reviewed every three years.

6. Useful Links and information.

The Enfield Local Authority Safeguarding Adults Practice Guidance on Delegated Enquiries here.

NICE Guidance June 2013 Falls in older people: assessing risk and prevention

PHE Guidance Jan 2020 - Falls: applying All Our Health - GOV.UK (www.gov.uk)

Care Quality Commission April 2022 Issue 1: Falls From Improper Use Of Equipment.

The Health and Safety Executive Slips, Trips and Falls in the Health and Social Care.

The National Falls Prevention Co-ordination Group (NFPCG) development of resources to guide individuals, health and care professionals with physical activities following deconditioning effects of the COVID-19 pandemic. To learn more, click here.

As part of an falls risk assessment, it may be good to consider if the person benefit from assistive technology - https://mylife.enfield.gov.uk/safe-and-connected

Enfield Age UK offers a Falls Prevention service – please see here for more information.

Document Title	Falls and Safeguarding Adults Protocol.
Author (Individual & Team name)	Elspeth Smith, Strategic Safeguarding Adults.
Date Written	11th November 2024
Authorised by (Name and Date):	**Pending**
Coproduced / Codesigned (Yes or No)	**No**
Last Review Date	
Next Review Date	**September 2026**