4LSAB Multi-Agency Protocol for Falls and Adult Safeguarding

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Protocol for falls and adult safeguarding

Falls must not be seen as an inevitable part of ageing. A fall should be seen as an event that needs questioning and investigating to prevent future occurrence. Many falls and injuries as a consequence of a fall are preventable, but not all, particularly within the care home setting where some of the most frail and dependent of our population reside. However, we should take a preventative approach to the delivery of high-quality care. Best practice is underpinned by appropriate risk assessment, individualised care planning, good team communication and following appropriate post-fall procedures including reporting.

1. Falls Risk Assessment

It is essential that on admission to a service, a Multifactorial Falls Risk Assessment is undertaken to identify the person's individual falls risk factors. This assessment will help identify the appropriate actions required to reduce the risk of falling. Such actions should take into consideration the service users wishes and clarify the responsibilities of the service. The plan for the adult must reflect the outcome of the falls assessment and should be shared with the person and their relatives, if appropriate.

Where there are concerns about an adults capacity to understand the risk and implications of falling, capacity must be assessed under the Mental Capacity Act and, if needed, a best interest decision made to maintain the safety of the adult. The outcome of this assessment must be recorded in the person's records.

Documentation should provide evidence of:

1. An appropriate multifactorial falls risk assessment demonstrating why a person is at risk of falling.
2. Actions/strategies that have been put in place to reduce the risk, including involving other professionals when necessary.
3. Actions/strategies that are yet to be carried out.
4. Regular reviews e.g. if a fall occurs, if the person's status changes, or as indicated
5. Discussion with the person and/or family regarding the assessment process and necessary actions required to prevent falls.
6. Accurate falls reporting with evidence of care plan updates should a fall occur.

2. Seeking Medical Advice Following a fall

Not every fall will require immediate medical attention. It will be dependent upon whether the fall has resulted in an injury or there is suspicion of an injury requiring specialist assessment. Any fall where there is suspicion of a collapse, a head or neck injury or a fracture will always require urgent medical attention. The decision will be made by the manager or senior clinician/carer on duty based on the individual circumstances of the case.

It is good practice to notify the individuals General Practitioner, should a fall occur as a medical review may be required to contribute to the investigation of the cause of the fall.

3. Fall with head injury

A head injury is a blow to the head from a force outside the body, like an accident, fall or attack When the brain is damaged by such an event, this is called a traumatic brain injury.
The symptoms and effects of head injury can vary widely, depending on the level of injury and which part of the brain, if any, is injured. They can range from a bump or bruise on the head to loss of consciousness.

Where the person has sustained a head injury a medical assessment should always be arranged as a matter of urgency. Staff should always follow the local protocol for managing patients with a head injury.

4. Post fall procedures

In the event of a fall occurring, the fall must be recorded within the care plan. Documentation should include the circumstances of the fall, assessment of any injury and how the person was assisted off the floor again. Many falls are "unobserved" or "unwitnessed" but the person may still be able to explain what happened. This information can be used as part of the post-fall analysis. Duty of Candour must always be followed post-fall.

Registered providers are required to report to CQC any serious injuries to people who use their service (Regulation 18).

5. When to report a fall as a safeguarding concern

Report a safeguarding concern in the following circumstances:

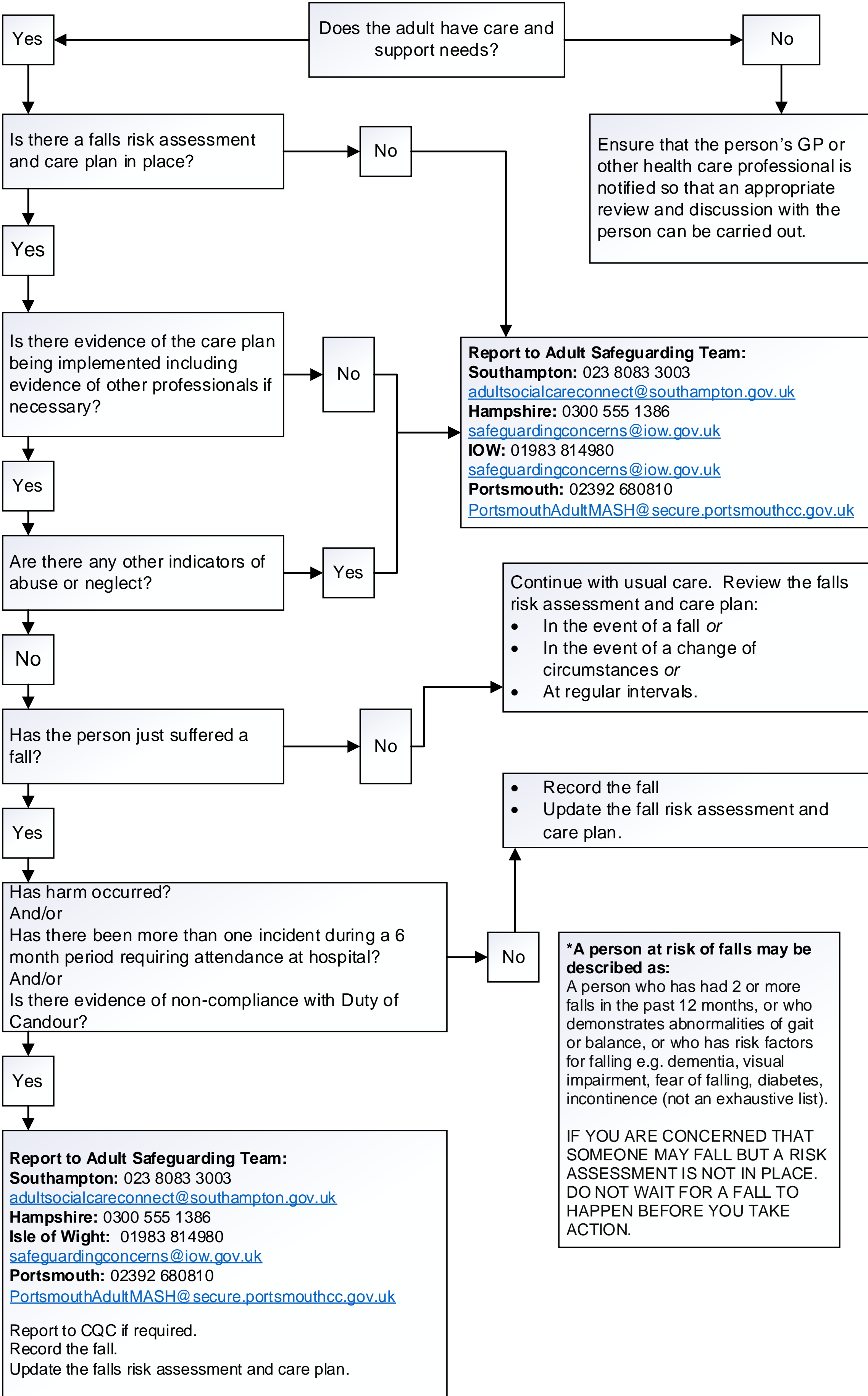
- When there is a concern about possible abuse or neglect by another person
- Where there is a general concern about a persons' safety then please contact the appropriate person i.e. family member, professional etc.
- When a person is identified as being at risk of falls and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed i.e. there is evidence of neglect
- When a person sustains a fall, which **does or does not** result in harm, and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed, or that the care plan is not updated after the fall i.e. there is evidence of neglect
- Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures
- Significant or very significant harm has occurred as a result of the fall
- When a person has an injury, other than a very minor injury, which is unexplained
- When appropriate medical attention has not been sought following a fall
- When appropriate measures have not been taken to maximise the safety of the person from an environmental perspective, including avoiding harm from other clients / service users
- Where there has been more than one incident during a 6-month period requiring attendance at hospital
- Multiple incidents where it is not clear that professional advice or support has been sought at the appropriate time
- Any fall that is deemed as unwitnessed and resulting in injury should be reported through safeguarding procedures. In circumstances where a person has sustained an injury the manager 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. If no injury is apparent, there is no observed change in function and actions and observations have been recorded, then a GP or Hospital review may not be necessary. This decision will be made by the manager or clinician on duty based on the individual circumstances of the case to determine what may have happened.
- Where there have been other similar incidents or areas of concern
- If in doubt, discuss your concerns with the local authority in your area.

When considering whether or not a fall is the result of neglect, it is necessary to establish that everything practicable was done to reduce the risk of the person falling. Whilst not an exhaustive list, the following should be taken into account:

- Has an appropriate and adequately detailed falls risk assessment been undertaken?
- Has there been a reassessment of the adult's risk factors after each fall, and control measures updated?
- Is there evidence that the adult has been supported to make decisions about how they might reduce their risk of falling?
- Has a Mental Capacity Assessment been undertaken where a lack of mental capacity might compromise the person's ability to understand the risk of falling?
- Are any falls-related restrictions or restraint measures taken for an adult who lacks capacity evidenced in best interest records and in their support plan?
- Is there evidence that referrals have been made to appropriate health care professionals once a risk has been identified (e.g. GP, CMHN, eye specialist, Falls Clinic and Falls Management Team)?
- Does the recording of incidents / accidents meet the required CQC standards for the home / ward?
- Is there evidence of good nutritional care e.g. is the adult well-nourished and hydrated?
- Are there opportunities for the adult to exercise safely, and is support given to enable them to remain as mobile as possible?
- Are staff trained to ensure they are competent in moving and handling of adults in relation to falls prevention?
- Is the appropriate equipment being used correctly, and are staff trained in its correct and safe use? e.g. hoists
- Is equipment in good repair?
- Are call bells or alerting systems in place, being used and monitored?
- Are there hazards around the premises that could lead to falls? e.g. uneven or worn flooring or ground, changes in levels, types of floor covering, lack of appropriate safety measures around stairs, poorly lit areas, trailing wires?
- Has falls data (within residential / nursing homes or hospitals) identified patterns, been evaluated and acted upon? For example, time of falls, meal times, environmental factors?

6. Guidance: This tool is to aid decision making about falls and safeguarding concerns. These are just a few examples and this does not replace professional judgement or aim to set a rigid criteria for intervention. It helps you consider the type of abuse and the circumstances in which a safeguarding concern would be raised to the local authority.

Falls				
An isolated or multiple incidence where no significant harm has occurred, there is no evidence of abuse or neglect and where a risk assessment and care plan are in place.	An isolated or multiple incidence where no significant harm has occurred, where no abuse or neglect has been identified and where action is being taken to minimise further risk which is demonstrated by plan.	An isolated incident requiring attendance at hospital and no other form of abuse or neglect is suspected.	The risk could not have been anticipated or there is a risk assessment in place, the person is able to give an explanation for the fall which does not indicate abuse or neglect; and post fall observations are followed.	**PROBABLY NOT A SAFEGUARDING CONCERN**
The adult has experienced avoidable harm.	Any fall where abuse, neglect or omission of care is suspected.	The adult has repeated unexplained injuries as a result of falls.	Where medication has not been given on time resulting in a fall and injury.	**REPORT AS A SAFEGUARDING CONCERN**
Where members of staff are involved, they are not receiving training in falls management and/or not adhering to the falls policy and protocols following a fall or where supervision levels are insufficient to ensure safety.	Where environmental hazards, such as poor lighting or clutter, result in a fall and injury.	Where bedrails are used but where they are not prescribed, where the least restrictive option was not considered.	There is no evidence of the care plan being reviewed and updated following a fall or a change of circumstance.	



Flowchart to Support decision making
Falls and adult safeguarding concerns.
Does the adult have care and support needs?
Yes
No
Ensure that the person's GP or other health care professional is notified so that an appropriate review and discussion with the person can be carried out.
Is there a falls risk assessment and care plan in place?
No
Yes
Is there evidence of the care plan being implemented including evidence of other professionals if necessary?
No
Report to Adult Safeguarding Team:
Southampton: 023 8083 3003
adultsocialcareconnect@southampton.gov.uk
Hampshire: 0300 555 1386
safeguardingconcerns@iow.gov.uk
IOW: 01983 814980
safeguardingconcerns@iow.gov.uk
Portsmouth: 02392 680810
PortsmouthAdultMASH@secure.portsmouthcc.gov.uk
Yes
Are there any other indicators of abuse or neglect?
Yes
No
Continue with usual care. Review the falls risk assessment and care plan:
In the event of a fall or
In the event of a change of circumstances or
At regular intervals.
Has the person just suffered a fall?
No
Record the fall
Update the fall risk assessment and care plan.
Yes
Has harm occurred?
And/or
Has there been more than one incident during a 6 month period requiring attendance at hospital?
And/or
Is there evidence of non-compliance with Duty of Candour?
No
*A person at risk of falls may be described as:
A person who has had 2 or more falls in the past 12 months, or who demonstrates abnormalities of gait or balance, or who has risk factors for falling e.g. dementia, visual impairment, fear of falling, diabetes, incontinence (not an exhaustive list).
IF YOU ARE CONCERNED THAT SOMEONE MAY FALL BUT A RISK ASSESSMENT IS NOT IN PLACE. DO NOT WAIT FOR A FALL TO HAPPEN BEFORE YOU TAKE ACTION.
Yes
Report to Adult Safeguarding Team:
Southampton: 023 8083 3003
adultsocialcareconnect@southampton.gov.uk
Hampshire: 0300 555 1386
Isle of Wight: 01983 814980
safeguardingconcerns@iow.gov.uk
Portsmouth: 02392 680810
PortsmouthAdultMASH@secure.portsmouthcc.gov.uk
Report to CQC if required.
Record the fall.
Update the falls risk assessment and care plan.