Diogelu Gwent
Gwent Safeguarding

FALLS AND ADULT SAFEGUARDING GUIDANCE FOR PROVIDERS

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1. Introduction

This protocol is intended to provide guidance on to how to respond to falls and to support the use of professional judgement when determining whether an Adult Safeguarding Duty to Report is required. falls and fractures in older people are often preventable. Reducing falls and fractures is important for maintaining the health, wellbeing and independence of older people. It should be read in conjunction with the Gwent Safeguarding Board regional adult Safeguarding guidance which can be found here To report or not to report - Adult Safeguarding guidance (gwentSafeguarding.org.uk), and with your own organisational policies and procedures.

This document is intended to be a guidance tool to promote safe and best practice in understanding when a fall may need reporting as a Safeguarding concern. It should be used in conjunction with professional judgement. It is not a substitute for the policies and procedures required of providers to ensure safe care. Where there is any doubt whether to raise a Safeguarding concern, staff should always speak with the Safeguarding lead or equivalent in their organisation.

2. Definitions

Fall

There are several definitions of a fall. In this guidance the following definition will be used: -

'***an event which causes a person to unintentionally, come to rest on the ground or lower level and is not a result of a major intrinsic event, (such as a stroke) or overwhelming hazard'*** (National Institute for Health and Care Excellence (NICE) 2020)

Safeguarding Adults

'Safeguarding aims to protect individuals' rights to live in safety, free from abuse and neglect while promoting their wellbeing and considering their views and wishes'. (Wales Safeguarding Procedures 2020). It is also about people and organisations working together to prevent and stop abuse and neglect happening.

Prevention is a key principle in Safeguarding adults. Providers are expected to put in place interventions 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 due to osteoporosis) followed by personalised care planning to manage those risks.

Adult at Risk

Section 126(1) of the Social Services and Well-being (Wales) Act 2014 defines and adult at risk as an adult who:

1. Is experiencing or is at risk of abuse or neglect,
2. Has needs for care and support (whether or not the authority is meeting any of those needs), and

3. As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

Neglect

The Wales Safeguarding Procedures state that neglect: -

- describes a failure to meet a person's basic needs physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health).
- It can take place in a range of settings, such as a private dwelling, residential or day care provision.

Abuse

The Wales Safeguarding procedures state that abuse: -

- can be physical, sexual, psychological, emotional, or financial (includes theft, fraud, pressure about money, misuse of money)
- take place in any setting, whether in a private dwelling, an institution, or any other place

3. When to refer or not

Not all falls will require the submission of a Duty to Report. There will also be additional processes and duties within organisations, such as local and national reporting arrangements, and the application of the Duty of Candour within the Health & Social Care (Quality & Engagement Act) (Wales) 2020.

A Duty to Report will be required if the individual is an adult at risk and there is suspected or known abuse or neglect linked to the fall.

A Duty to Report is not the way to access further support/services in relation to falls.

A fall can be a Safeguarding issue when there are concerns there is abuse or neglect (including self-neglect) linked to it. There could be concerns that the fall occurred because of a failure to adhere to risk assessments or falls protocol.

You will need to decide whether one of the following categories of abuse apply:

- **Neglect** - Person(s) responsible for the care and support needs 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 Adult Complex Abuse Protocol- June 2023 (gwentSafeguarding.org.uk) 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 Children & Adult At Risk Neglect Guidance & Toolkits (gwentSafeguarding.org.uk) for more information.

The following questions may support your decision making as to whether a Duty to Report is required:

1) Was the person a known falls risk and therefore was the fall predictable or preventable? Has the person fallen under similar circumstances more than once?
If the fall was not predictable, it is unlikely that the fall would be considered under the Wales Safeguarding Procedures. Therefore, Practitioners should consider referral to appropriate services. Residential, Nursing and Support settings should develop/update relevant risk assessments and care plans.
2) 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 comprehensively and communicated with all relevant practitioners. It would also be expected that there was a risk assessment and care plan in place to try and prevent the falls and/or reduce the harm caused because of falls. A Safeguarding Duty to Report should be made/considered if the person was a known falls risk, and this risk was not appropriately documented/communicated.
3) **Was all necessary equipment, (e.g. call bell, falls mat/sensor, walking aids) available and in good working order/fit for purpose? Were these used as would be expected?**
A Safeguarding Duty to Report 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 or could have used specific equipment, (which the person has been individually assessed as needing) which was not available. This includes if equipment was available but not working, or available but staff were not trained in using it. If equipment was available but not used, this might suggest negligence on the part of staff and therefore it is appropriate to consider a Safeguarding Duty to Report. This also includes if equipment has not been serviced within timescale or Lifting Operations Lifting Equipment Regulations, (LOLER) had not been adhered to. Organisations/Employers will need to consider their responsibilities for reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
4) 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 etc. If this is the case, a Safeguarding Duty to Report should be submitted, in addition a report must be made to the Police and/or the Health and Safety Executive. Organisations/Employers will need to consider their responsibilities for reporting

under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

5) Are there others at risk now or in the future?

Report makers 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 Duty to Report should be made.

6) 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 its own, the impact of the fall does not necessarily determine whether a Safeguarding Duty to Report should be made or not e.g. no harm may have occurred on this occasion, (see points 2 and 3 above also) but there is a concern that the person/others may be at risk in the future. However, the more serious the impact of the fall, the more likely it is that a Safeguarding Duty to Report should be made. It may be apparent that the person has suffered a significant/serious injury requiring medical/clinical assessment by a doctor or paramedic e.g. head injury, bone break etc. In the event of a death related to a fall this should always result in a discussion with the Local Authority Adult Safeguarding Team to consider whether a Duty to Report is needed.

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

A key consideration with any Safeguarding Duty to Report is whether the person or their representative **consents** to the Duty to Report being made and what they want to happen as an outcome of any Safeguarding report. If the person or their representative does not consent to the Safeguarding Duty to Report or does not want anything to happen, then the report maker 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. If you are in doubt, please contact your Local Authority Adult Safeguarding Team.

8) What happened following the fall?

It will be necessary for the report maker to consider whether the actions taken following the fall would constitute a Safeguarding Duty to Report. It may be that the fall itself may not present a Safeguarding concern, but the subsequent actions or lack of actions may amount to abuse/neglect. The report maker should consider how the immediate needs of the person were assessed and met. If it was appropriate, was the person able to be moved safely; was timely and necessary medical attention sought?

9) Was the fall witnessed?

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 because of abuse or neglect and therefore do not need to be reported as a Safeguarding concern. Recording the detail available, causes considered and what action has been taken, will be even more important where the direct cause cannot be determined. Where there remains a high level of uncertainty or a head injury cannot be ruled out, or other serious/significant injury has occurred, the fall would constitute a Safeguarding Duty to Report.

A person may be able to say they fell and explain why, even if it was not witnessed. It is not always necessary to raise a Safeguarding concern if: -

- they have no cognitive impairment which would cause doubt about their story.
- there is a risk assessment and care plan in place.
- a post-fall protocol, including observations, seeking medical advice/assessment has been followed and comprehensively documented.

4. Responsibilities of Providers

Use your normal reporting routes to make a Safeguarding Duty to Report.

This might be directly to your Local Authority Adult Safeguarding Team.

The process for submitting a Safeguarding Duty to Report in Gwent can be found here: Report an adult at risk - Gwent Safeguarding.

Specific information to include within a Safeguarding Duty to Report related to a fall:

- Context to the fall - specify time and location – where was the person, what were they doing, who, (if anyone was present)
- Injuries sustained because of the fall - attach body maps to the referral. Photographs are helpful with the necessary consents being obtained.
- Information related to previous falls/falls risk/falls risk assessment including a falls history.
- Action taken following the fall, (e.g. details of post-falls protocols followed, medical intervention sought and the outcome, contact with the person/family etc.).
- Any interventions and plans put in place to reduce risks of falling.

If the fall does not require a Safeguarding Duty to Report, there will still be actions you need to consider to reduce risks and to try and prevent falls happening in the future – you should refer to your organisational falls prevention and management policies.

Recognition of Risk	Address Risk
• Assessment of the individual person's needs including history of falls or falls risks prior to commencing services.	• Individual care plan in place to identify and mitigate as many falls risks agreed with the person, their representatives and/or any other stakeholders.

• Review and update on commencement of services/admission. • Complete falls risk assessment and care plan and communicate with staff. Post Fall: - • Follow the 'I Stumble' protocol/app along with the Falls Policy for your organisation. This must reflect current guidance. *This does not replace clinical assessment* • Record all falls on an incident log/register for analysis so that patterns and trends can be identified to inform individual and any other actions to be taken.	• Falls Risk Assessment is updated/reviewed monthly or before if a fall occurs or if there is a change in the individual's health prior to the review date. • Provide falls prevention information to staff and service users. • Arrange for staff to attend falls prevention and post-falls management training. • Refer to GP or local falls service for intervention and/or advice. • Communicate actions/issues/concerns about falls through staff handover or other internal communication processes. • Consider updating falls diary where available.
Act to Reduce Falls	**Review and Monitor**
• Check environment for falls risks, e.g. lighting, condition of carpets/uneven floors etc. • Check other risk factors, e.g. – - Has the person's vision deteriorated? When did they last have an eye test? - Is the medication record up to date to include a falls specific medication review? - Could alcohol/drug use be a factor? - Ensure equipment is serviced within timescale and Lifting Operations Lifting Equipment Regulations (LOLER) are adhered to. • Consider, identify & implement actions to remove or minimise any falls risks identified. • Are there any referrals required for assessments/interventions by others? i.e. District Nurse, Occupational Therapist, Physiotherapist, Falls Service, Fracture Liaison Service etc.	• Review falls risk assessment monthly or if changes to medication, health or when a fall occurs. • Review care plan regularly if there are changes to medication, health or a fall/s occurs. • Analyse falls incident/accident logs for triggers/patterns and take action to remove or minimise future risks. • Recurrent falls related to same person and/or service might suggest the need for a Safeguarding Duty to Report. • Review falls risk assessment and care plan upon discharge from hospital/or transfer from another setting.

• Ensure all staff have access to relevant up-to-date education and training related to falls.	

The Health and Social Care (Quality and Engagement Act) (Wales) 2020 also stipulates the duties of Health boards in relation to the Duty of Candour. If provider investigation determines that moderate harm or above has occurred (which may be the case if a fall has met the Duty to Report threshold) the provider is required to notify the Health board that their Duty of Candour has been triggered. This will necessitate a Duty of Candour response from Health to the patient and/or relative, and consideration of the harm caused in respect of NHS Wales Putting Things Right Regulations. Please see links below for further information.

The Duty of Candour - Public Health Wales (NHS. Wales)

Health and Social Care (Quality and Engagement) (Wales) Act: summary | GOV.WALES

Putting Things Right Leaflet (Gov.Wales)

5.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 joint pain. Mr Jack had previously sustained a fracture. 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 get up. 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. 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 however, on one occasion Mr Jack did not use his nurse call pendant or nurse call alarm cord to summon staff and got up by himself. Mr Jack was heard shouting and when staff went to investigate, he was found 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 was completed, and his mobility, and 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. Outcome: - Safeguarding Duty to Report **IS 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 Mr Jack.
✓ One-off incident causing no harm.
✓ Incident forms completed.
✓ Mobility care plan reviewed and updated following fall.
✓ Changes communicated to staff.

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 has not experienced previous falls. She was taken to hospital; the injury was cleaned, 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 identified that Mrs Smith had an infection brought on by dehydration and appeared underweight.

Outcome: - Safeguarding Duty to Report **IS** required.

Rationale: -
✓ Mrs Smith has care and support needs.
✓There is a suggestion that there were preventable underlying health issues 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 Mrs Smith lives in a care setting and others could be at risk.

Mr. Ali

Mr Ali has 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 care calls 4 times per day, 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 fall on the way to the toilet at 7pm 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 as he fell. On this occasion he was able to get himself up using the bath and the basin and staggered to the toilet using the toilet 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 related to Mr Ali having falls previously. A second fall occurred two days later, again unwitnessed. This time he hit his head on the edge of the toilet door and lay on the floor all night. He was incontinent of urine and faeces. The arrived next morning, called an ambulance and assisted with her personal care. He was taken to the Emergency Department after awaiting an ambulance for around 5 hours. His observations and

investigations appeared normal, and he was discharged that evening with no follow-up required. Care calls were re-started with a later call that night. At midnight a neighbour heard Mr Ali calling through the wall. An ambulance was called.

Outcome: - Safeguarding Duty to Report **IS** required.

Rationale: -
✓ Mr Ali has care and support needs
✓ There is a recent, but known falls risk
✓ There is 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 Enquiry will need to consider a full re-assessment of Mr Ali's care and support needs.

Local Authority Safeguarding Teams

Blaenau Gwent
Tel: 01495 315700
Email: DutyTeamAdults@blaenau-gwent.gov.uk

Caerphilly
Tel: 0808 100 2500
Email: povateam@caerphilly.gov.uk or IAAAdults@caerphilly.gov.uk

Torfaen
Tel: 01495 762200
Email: socialcarecalltorfaen@torfaen.gov.uk

Newport
Tel: 01633 656656
Email: firstcontact.adults@newport.gov.uk or pova.team@newport.gov.uk

Monmouthshire
Tel: 01873 735492
Email: MCCadultSafeguarding@monmouthshire.gov.uk

Out of Hours Emergency Duty Team
Tel: 800 328 443

APPENDIX 1 – Decision Maker Quick Guide