Final Draft

Interagency Adult Safeguarding Protocol on Falls

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1. Introduction

1.1 The Care Act 2014, defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults. 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?"

1.2 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 CQC regulated providers have well documented policies and protocols which highlight best practice in their organisation. Safeguarding is not a substitute for good local procedures.

1.3 The National Institute for Health and Care Excellence (NICE) have published a quality standard in March 2015, which covers assessment after a fall and prevention of further falls (secondary prevention) in older people living in the community and during a hospital stay. The guidance can be found at http://nice.org.uk/guidance/qs86

1.4 This protocol will enable health and social care staff to identify when a fall could have been caused as a result of neglect and whether an enquiry under the safeguarding procedures should take place.

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 an appropriate policy 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.

3. Falls and safeguarding

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 but annually approximately 5% of older people living in the community who fall experience fractures or need hospitalisation. The Royal College of Physicians 2011 report (Falling Standards Broken Promises) highlight 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 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.

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 the hospital/care/nursing home/ intermediate care/home care
- admission to the 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. It is recommended that this should be recorded as a specific incident which captures the following:

- Whether the risk assessment was up to date and the plan followed
- Documents any harm and action taken to help the person at the time of the fall
- The actions taken to prevent further falls

4. Managing Falls in 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 concern about possible abuse or neglect. The following situations would trigger a safeguarding referral:

- Where a person sustains an injury due to a fall, and there is a concern that a risk assessment and care plan were not in place or were not followed. The key factor is that the person has experienced *avoidable* harm.
- Where a person has fallen and appropriate medical attention has *not* been sought in a reasonable time frame and in accordance with the organisations policy, 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 circumstances and nature of the fall or explanation given are not consistent with the injury sustained.
- Where the organisations own post falls protocol is not in place or has not been followed.

4.3 A safeguarding concerns does not need to be raised when:

- A person is found on the floor, there is no evidence of injury and all care has been delivered in accordance with the falls policy
- A fall is witnessed and appropriate risk assessment is in place and has been followed
- The falls is attributable to an acute medical condition or episode which has occurred recently i.e. in the past hours or days.
- The person made a capacitated decision about their own risks which is clearly documented.
- There was no risk assessment in place as this was not a foreseeable risk i.e. this is the first fall

4.4 It must be acknowledged that there may be incidents where decision-making is not straightforward and professional judgement is required which must take account of the MCA and people's rights to take risks and to make unwise decisions. In all cases ensure that the reasons for the decision are recorded.

4.5 Where there is doubt as to whether the incident meets the threshold for adult safeguarding referral a referral should always be made.

5. Delegated enquires

5.1 The Care Act 2014, provides local authorities with the opportunity to "cause others to undertake enquiries", which is referred to as "delegating responsibility" for leading safeguarding enquires. In the case of falls, in many instances health care professionals within the organisation responsible for that individual's treatment will be best placed to lead these enquiries and so delegation should always be considered in the management of falls.

5.2 Where the fall meets the threshold in Paragraph 4.2, a safeguarding referral must be made to the local authority. The professional making the referral should have a discussion with the designated local authority decision maker as to whether there should be a multi-agency safeguarding enquiry or is if the enquiry should be delegated to the provider organisation. A summary of the discussion will be recorded by the local authority and shared with the agencies involved in the discussion.

5.3 The principles of Making Safeguarding Personal should be adhered to and therefore there should be a discussion with the patient (and/or their representative or advocate) in terms of what they want to happen in terms of undertaking an enquiry. It should be clearly agreed who will have this discussion. In determining with whom it is most appropriate to hold the discussion, the principles of the Mental Capacity Act should be considered.

5.4 If the enquiry is delegated the partner should gather information and make a recommendation as to whether the fall constituted abuse or neglect. This should be completed by an appropriately skilled and trained person within the organisation.

5.5 The outcome of the falls enquiry should be sent to the local authority. This will include information on:

- Whether the risk was removed, reduced, or remains.
- Whether the persons desired outcomes were met
- The impact of the enquiry on the persons sense of safety and well being
- The actions to be undertaken to embed learning

5.6 The local authority officer will record the information from the delegated enquiry for reporting to the Safeguarding Adults Partnership board.

5.7 If a full enquiry is to be undertaken the local authority will lead on the enquiry following local procedures.

6. Review

6.1 This protocol will be reviewed annually.