Calderdale Safeguarding Multi-Agency Falls Protocol

Ratified:

Joint CSAB/CSCP Learning and Improvement subgroup

Version control:

Date agreed by SAB – July 2018
Date Review April 2022
Next Date of Review February 2025

Contents

Introduction

This multi-agency falls protocol has been approved by the Safeguarding Adults Board and should be used by all agencies to respond to falls in conjunction with the Joint Multi-Agency Safeguarding Adults Police and Procedures (2021) and their own specific falls protocol if available.

This protocol is for use by those who work with or support people living in different settings, some of whom may be receiving formal or informal care, or those who live independently therefore, not all this guidance will be applicable to every situation. It does apply to all agencies who have contact with people regardless of their living arrangements or the setting in which a fall occurs and is designed to assist consideration of when a fall should result in a safeguarding concern.

1.Definitions

1.1 Definition: Adult at Risk

An **Adult at Risk** is a person over 18 years who:

has care and support needs

AND

may be experiencing or at risk of abuse or neglect

AND

is unable to protect themselves from abuse and neglect because of their care and support needs

An adult at risk may therefore be a person who,for example:

- is an older person who is frail due to ill health, physical disability or cognitive impairment
- has a learning and/or physical disability and/or a sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long-term illness/condition
- misuses substances or alcohol
- is an unpaid carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse

1.2 Definition: Fall

The 2015 NICE Quality Standards defines a fall as an unexpected loss of balance resulting in a person unintentionally coming to rest on the ground or floor, or other lower-level surface regardless of whether an injury was sustained. This also includes falling on the stairs and onto a piece of furniture with or without loss of consciousness.

A fall is distinct from a collapse which is because of an acute medical condition such as arrhythmia, transient ischaemic attack (TIA) or vertigo.

Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Most falls do not result in serious injury, however, once a person has experienced a fall, they are more likely to have recurring falls. Some falls may cause serious injury, even death. In addition to any physical injury, a fall can impact on a person's self-confidence, increase social isolation, and reduce independence. It is therefore important to provide relevant

support and advice where possible to prevent falls occurring by taking into consideration each person's individual risk (for example, by undertaking a falls risk assessment including environmental risk assessment and where appropriate, to ensure falls risk reduction measures are in place (see section 4 for further information).
Fall prevention strategies and interventions need to consider the fact that falls can have several causes, such as frailty, infection, confusion, and the effect of certain prescribed drugs that require many different interventions. Fall prevention is the key to safeguard people from harm.

2.What to do when someone you care for has a fall.

Where the person has or may have sustained an injury requiring medical assessment/treatment or any head injury a medical assessment should ALWAYS be arranged as a matter of urgency.

2.1 Immediate action to take

If the person is still on the floor, follow these assessment steps:

1.Is the person who has fallen clear of dangers? Are they responsive? Are their airways open? Is their breathing adequate? Do they have a pulse?

- If the answer to any of the above is **NO**, keep the person calm, still and comfortable and ring 999, waiting with the person until the responder arrives.
- If the answer to all of the above is **YES**, move onto step 2.

2. Does the person who has fallen have new neck of back pain?

- If the answer to this question is **YES**, keep the person calm, still and comfortable and ring 999, waiting with the person until the responder arrives.
- If the answer is **NO,** move onto step 3.

3. Does the person who has fallen have **pain** (headache, chest pain, abdominal pain)?

Suspected collapse (did they trip, collapse, feel dizzy or nauseous)?

Trauma to the neck, back or head (new pain in head/neck/back; new lump with or without bleeding; Any new numbness/paralysis in the limbs; taking blood thinners/anticoagulants)?

Unusual behaviour (new confusion; acting differently to normal self; difficulty speaking)?

Marked difficulty in breathing/chest pain (severe shortness of breath; unable to complete sentences; blue lips or fingertips)?

Profuse bleeding? Loss of consciousness (knocked out; drifting in and out of consciousness; limited memory of events before, during or after fall; unable to retain or recall information)?

Evidence of fracture (obvious deformity; reduced range of movement in affected area)?

- If the answer to this question is **YES**, keep the person calm, still and comfortable and ring 999, waiting with the person until the responder arrives.
- If the answer is **NO,** move onto step 4

4. Is the person who has fallen FAST test normal?

- If the answer to this question is **NO**, keep the person calm, still and comfortable and ring 999, waiting with the person until the responder arrives.
- If the answer is **YES,** move onto step 5.

5. Can you assist the person up from the floor using safe manual handling techniques and equipment (Mangar Elk cushion, Raizer)?

- If the answer to this question is **NO**, press the person's care-line (if available) or call 999 for assistance, keeping the person calm and comfortable, waiting with the person until the responder arrives.
- If the answer is **YES**, assist the individual from the floor.

6. Inform the persons next of kin of the incident. This will depend on the setting and the circumstances. For example, in a supported housing setting where the person is living in their own apartment and thus their own home, then contact with NoK will be based on the person's wishes and subject to their consent to do so (this would be discussed in advance as part of the person's care and/or support plan re contacts in the event of an emergency) .

7. Complete a set of observations if you have observations kit available and clinical competence to do so, including:

- •Respiration rate
- •Temperature
- •Blood pressure
- •Pulse rate
- •Oxygen Saturation

If unable to complete a set of observations, escalate to another appropriate professional.

Should a person (or their carer) report to you that they have fallen earlier that day due consideration should be given to the above action points to ensure person safety is considered and appropriate actions are taken.

The post-fall assessment should be clearly documented.

(This information is taken from the ISTUMBLE app which can be downloaded free by carers)

2.2 In a 24-hour care setting

Your agency must have a falls risk assessment and/or care plan which should advise you to:

- Consider implementing a 24-48 hour observation chart, particularly if the person has had an injury or unwitnessed fall
- Review existing falls risk assessment (if in place) to ensure there are no amendments needed
- Consider if there is not a falls risk assessment/care plan in place whether there should be one
- Consider seeking a medical review
- When to consider making a referral onto other falls services who may be able to assist or signpost you to other falls preventative mechanisms e.g., assistive technology

- Ensure you document in the person record and ensure other colleagues are aware

2.3 In the persons home/property

Your agency must have a falls risk assessment which should advise you to:

- Consider if the person is safe to be left
    - Consider mental capacity around the decision making of the person
    - Consider if medical attention is required
- Notify and seek guidance from senior colleagues to determine:
    - Whether to remain with the person until medical attention is sought and/or family/friend attend (where applicable – see point 6 above)
    - The potential impact this may have on further calls that day
    - Consider the implementation of an observational chart and suitability of temporarily increasing call/visits (where applicable liaising the local authority)
- Document in the persons record (especially mental capacity decision making) and ensure this is handed over to those visiting next

If you are a carer and not part of an organisation, please speak with a member of the SAT/G2C for further advice and signposting to an agency who can support (see section 4)

2.4 Ongoing monitoring of falls risks

A person's falls risk assessment must be re-evaluated if the person's condition changes, and the relevant sections of the risk assessment updated.
Changes which would indicate re-assessment are:

- A further fall
- An acute infection (e.g. chest infection, urinary infection, cellulitis)
- Change to mobility
- Medication changes involving high-risk falls medication (eg an increase to a dose of sedatives, opiates or blood-pressure medication)
- Changes to conscious level or confusion

3. When to raise a safeguarding concern?

Under the Care Act 2014, agencies have a legal responsibility to make safeguarding adult referrals where there is a suspicion that abuse of an adult has occurred which may be because of neglect or omission of care.

3.1 Unavoidable fall:

A fall that has occurred where the provider of care **did:**

- assess and evaluate the person's falls risk
- plan and implement interventions that are consistent with the person's needs and goals, or clearly document that falls risk remain despite optimal intervention
- monitor and evaluate the impact of the interventions
- revise the interventions as appropriate
- document clear concordance issues and those appropriate interventions were attempted to improve concordance

Example; If the risk could not have been anticipated or there is a risk assessment in place, the person is able to explain the fall which does not indicate abuse or neglect; and post fall observations are followed, it is not necessary to make a safeguarding referral. The person has explained what happened and abuse or neglect is not likely or suspected to have occurred.

3.2 Avoidable fall:

A fall that has occurred where the provider of care **did not**:

- evaluate the person's falls risk
- plan and implement interventions that are consistent with the person's needs and goals
- monitor and evaluate the impact of the interventions
- revise the interventions as appropriate

Example; If the person has experienced avoidable harm, they sustained a physical injury and there is a concern that a risk assessment was not in place and should have been or following an agency intervention which identified a falls risk or the risk assessment was not followed, this must also be raised as a safeguarding concern. Making a safeguarding referral therefore relates to whether or not a falls risk assessment has been completed; and whether or not all falls risk reduction measures have been correctly adhered to, regardless of whether or not the fall was witnessed or harm occurred.

These are avoidable falls which should require a safeguarding referral:

Organisational Neglect

- Where medication has not been given on time resulting in a fall and injury.
- 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 there was a delay in responding to a known fall or seeking appropriate medical attention in a timely manner.
- The person has sustained harm where there is no risk assessment in place or where the risk assessment has not been reviewed or updated to mitigate the falls risk.
- Where the person has fallen under similar circumstances more than once (not necessarily sustaining any injuries) indicating a lack of risk assessment and/or preventive measures.
- The person has repeated unexplained injuries because of multiple falls.

Physical abuse

- The person has fallen because of a push or shove from a staff member or peer.
- Where a person has fallen because of safety equipment not in working order or not in place following an assessment of need, causing the person harm.
- Where environmental hazards, such as poor lighting or clutter, result in a fall and injury.

Self-Neglect

- The person falls due to working outside of falls prevention care plans and has the mental capacity to make these decisions.
- The person has experienced repeated falls despite preventative advice being given and this has resulted in a series of injuries.

This list is not exhaustive.
If a safeguarding referral is made then this should be explained to the person, particularly in instances where the person has previously chosen not to follow preventative advice, given the need to balance the need to respect the person's right to make "unwise" decisions where capacity is not in question with serious concerns about harm

3.3 Deciding not to refer

If the fall does not require a referral to Safeguarding, there will be actions you will need to consider to reduce risks and to try prevent future falls:
Recognising and addressing risk:

- Complete falls risk assessment
- Document falls history
- Ensure all falls recorded on incident form/log for analysis
- Write individual care plan to cover risks to service user
- Agree care plan with relevant others including service user where possible
- Review monthly or before if a fall occurs prior to review date
- Provide falls prevention information including consideration of a referral to the GP

3.4 Considerations when reporting a Concern

The principles of **Making Safeguarding Personal must also apply,** i.e. has the referrer spoken to the person about the concern, what is the person's capacity in relation to the safeguarding concern being made, what is the person's wishes, is the proposed course of action person centred?

The member of staff who has identified the concern should seek advice from their manager if the person does not wish a referral to be made, where it is considered the person has the capacity in order to make the decision if the risk of harm justifies over-riding the person's wishes. A clear record should be made about the rationale relating to making a referral or not. In making this decision, the following should be considered:

Respond To The Concern and Gather Information
This includes working to understand the adult's desired outcomes and agreeing with the person how their concerns will be acted upon. It could also involve speaking with the individual's relatives and anyone involved in their care such as GP's, nurses, hospital staff, looking at care plans, daily records, and medical records.
Risk Management Response
This could involve further requests for information, for example requesting updated risk assessments, further discussions with the individuals/family/those involved in their care.
No Further Action
This outcome is often when a referrer or provider has taken appropriate, proportionate and timely action, for example, seeking medical treatment, updating risk assessments, referring for further investigation and/or support (Community Rehabilitation Team, Quest Matron etc)

3.5 What to expect when reporting a concern

Any person may **Report a Concern** to the local authority (via Gateway to Care) where they are concerned that an adult with care and support needs is experiencing or is at risk of abuse and neglect (including self-neglect). Falls may be an indicator of

abuse or neglect. You will be asked about any immediate response, risk management plans, and any further actions you/ the provider will take.

If a referral is made without the person's consent, then the Duty Officer will look at the information and make a decision on the next steps.

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. Not all cases will be looked into by the Safeguarding Adults Team for the council. In the case of falls, in many instances professionals within the organisation who are 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.

The local authority will check whether the concerns have been addressed and meet the **Outcomes** of the Adult at Risk. This may involve an Outcomes Meeting to determine whether the risk of harm is reduced or removed, and if so a final outcome will be made and the safeguarding procedures will be exited at this stage.

4. Falls Prevention services

The Community Rehabilitation Team

Tel: Please refer via Gateway to care on 01422 264640

The Community Rehabilitation Team offer multifactorial falls risk assessments for individuals within their own homes (including care homes). Individuals may see a Physiotherapist, an Occupational Therapist or a Falls Prevention Worker, or be offered written and telephone advice at the point of referral, dependent on their needs. Individualised falls-prevention interventions may include advice, aids and adaptations, strength and balance exercises in the home or within a class environment, supported rehabilitation, anxiety management, or referrals to other professionals.

The Quest Matrons for Quality in Care Homes Service

Tel: 07917 086450

The care homes in Calderdale use the 'Quest Matron' service. As part of the service, care home residents have access to telecare equipment such as falls detectors, bed occupancy sensors and chair occupancy sensors, which help to prevent falls and also enable staff to respond quicker when residents have fallen. This provides reassurance to residents and their families and supports care home staff.

The 'Quest' care homes also have access to an out of hours telemonitoring service, where care homes can phone Local Care Direct and have a Skype video triage with a Senior Clinician which can support/advise when residents have fallen.

Community Matron

Tel: Please refer via Gateway to care on 01422 264640

The community matrons support the co-ordination of care for individuals with long term conditions to reduce hospital admissions and maximise treatment and support for individuals in their own homes. They are also able to conduct multifactorial falls assessments to support individuals in the community.

Falls Clinic

Tel: Please refer via Gateway to care on 01422 264640

Falls Clinic is offered in Calderdale for individuals who have fallen and there is an unexplained reason for their fall that may require further medical intervention. The referral is triaged by a physiotherapist and a community matron initially and signposted for assessment in the community where this is appropriate. It is overseen by a geriatric consultant and a clinic appointment can be arranged with the consultant if further investigation is required. Referrals into falls clinic are made by a healthcare professional.

Telecare Services

Tel: Please refer via Gateway to care on 01422 264640

Gateway to Care provides simple pieces of equipment that enable people to stay safe and continue to live independently in their own home. Telecare can make a real difference to someone's quality of life and provides support and reassurance for family and carers. Telecare equipment includes the Careline alarm service which is worn by people who are at risk of falls, so that if they do fall, they can call for help. Other pieces of equipment can also be connected to the Careline alarm including a variety of detectors, sensors and alarms available, such as: falls detectors; bed and chair occupancy sensors; portable telecare alarms and pagers for carers etc.

Primary Care

From July 2017 the GP contract required practices to use an appropriate tool (usually the electronic frailty index) to identify patients aged 65 and over who are living with moderate or severe frailty. For those people identified with severe frailty, practices are required to review them annually and as part of this review, to ask if the patient has fallen in the last 12 months and provide any relevant interventions, for example referral to the Community Rehabilitation Team.