** Safeguarding Adults**

**Guidance on Raising Concerns about Abuse and Neglect**

**Appendix 1: Supplementary guidance on when to consider raising a safeguarding concern regarding falls**

This supplementary guidance should be read in conjunction with:

* [Guidance on Raising Concerns about Abuse and Neglect](https://www.eastsussexsab.org.uk/documents/guidance-on-raising-concerns-about-abuse-and-neglect/)
* [Sussex Safeguarding Adults Policy and Procedures](http://sussexsafeguardingadults.procedures.org.uk/).
* [Falls and Safeguarding Toolkit](https://www.eastsussexsab.org.uk/documents/falls-toolkit/)
* [NICE Guidance Falls in Older People](https://www.nice.org.uk/guidance/qs86)

**Definition of a fall**

The National Institute for Clinical Excellence (NICE, 2014) defines a fall as “an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level”.

Falls may, or may not result in an adult sustaining harm. A fall may happen as a one-off incident, or on more than one occasion, to one individual or other adults who they reside with.

**Falls and safeguarding**

***Agencies must use their own internal incident policy and processes and ensure that all falls are reported using the appropriate procedures. However not all falls will require a safeguarding concern to be raised. What is important is that each incident needs to be considered according to the individual circumstances of the situation and a professional judgement reached.***

There is evidence that adults moving into residential care or other form of supported accommodation are particularly at risk from falls and fractures in the first few months following their move. This may be due to the environmental changes and / or a period of ill health prior to admission. It is therefore essential that all adults are assessed for their risk of falling and a care plan implemented to manage risk from the moment the person moves into residential care or supported accommodation.

**Responsibilities of care providers**

There are a number of general measures that can be taken to reduce the risk of falling and harm from falls:

* Pre-admission assessments should inform the risk of, and the management of falls before a placement starts.
* The registered manager must ensure that a Moving and Handling Policy is in place and all staff are trained in moving and handling.
* Comprehensive risk assessments and personalised care plans to manage those identified risks are key to effective falls prevention and management. (Also see section below on good practice in the management of falls).
* All falls should be reported in line with agencies own internal incident management processes and contractual requirements, whether a safeguarding concern is raised or not.

**Good practice in the management of falls**

* Assessments and care plans should be reviewed and updated on a monthly basis, and falls risk assessments should be reviewed every six months as a minimum.
* There should be a complete review of the falls risk assessment and care plan:
  + Following a fall;
  + When there is a significant change in the adult’s condition, for example during or following an illness;
  + On transfer from another care setting, for example discharge from hospital.
* Falls diaries can be a useful tool for those known to fall. A senior staff member should examine and analyse the information so that in the event of a fall all relevant documentation is completed, such as an incident form or RIDDOR notification if required.
* All members of the care / support team should be aware of and involved in the assessment, care planning and evaluation of risk of falls.
* Appropriate health professionals e.g. GP, district nurses, community matrons, falls prevention teams, physiotherapy, occupational therapy should be involved as and when required and their advice followed and outlined in care plan documentation.

***The Care Quality Commission (CQC), as part of their inspection process, will require written evidence to confirm that internal reviews, including subsequent actions, have taken place following a fall.***

**Situations in which unwitnessed falls / unexplained injuries do not require reporting as a safeguarding concern:**

It should not be necessary to raise a safeguarding concern if:

* An unwitnessed fall takes place, but the person has provided a reasonable explanation as to what happened, and abuse or neglect has not been a contributory factor from this explanation; AND
* Appropriate risk assessments are in place and up-to-date, AND
* Post fall protocols have been followed.

In circumstances in which a person has sustained an unexplained injury a senior member of staff should use their professional judgement based on the available evidence to determine what may have happened.

**Raising a safeguarding concern following a fall**

Under the Care Act 2014 agencies have a legal responsibility to raise a safeguarding concern with the local authority where there is a suspicion that abuse of an adult with care and support needs has taken place as a result of neglect or omission of care.

It is important to note that a safeguarding concern should be raised where there is a concern about potential abuse or neglect, as a result of a fall, by another person and not because there is a general concern about a person’s safety.

**Situations in which a safeguarding concern should be raised:**

* Where an adult in a service sustains a physical injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed. The key factor is that the person has experienced avoidable harm.
* Where an adult in a service has sustained an injury (other than a very minor injury) which is unexplained or in which appropriate medical attention was not sought.
* Where an adult has repeated falls or there are patterns of high falls for adults living within a service.
* Where an adult has repeated unexplained injuries.

**Examples of falls which may be taken into a safeguarding enquiry:**

* Medication not being given on time resulting in a fall and injury.
* A fall causing harm as a result of safety equipment not being in working order or not in place following an assessment of need.
* Environmental hazards, such as poor lighting or clutter, resulting in a fall and injury.
* Repeated falls despite preventative advice being given and a series of minor injuries.
* Members of staff not receiving training in falls management and / or not adhering to the falls policy and protocols following a fall.
* Supervision levels not being sufficient to ensure safety resulting in falls.
* A fall resulting in 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.

***If there is any doubt as to whether to raise a safeguarding concern you should contact Health and Social Care Connect for further consultation on 0345 60 80 191.***