East Sussex County Council

Adult Social Care

Safeguarding Adults

Falls and safeguarding toolkit

Version control	v5.0
Date	December 2019
Review date	December 2020

1. What is the purpose of this toolkit?

The aim of the toolkit

This toolkit is designed to assist Adult Social Care & Health (ASC&H) staff and providers to prevent and reduce the risk of adults experiencing harm or neglect from a fall.

The toolkit aims to promote prevention of falls.

The toolkit may be particularly useful where an adult has had a fall in a residential care home, nursing home or hospital ward. It can also be useful within other services which could include homecare and respite care services.

The scale of the issue

It is projected that the number of people who fall will rise by over 40% in the next 17 years to more than 16 million (Office for National Statistics, 2015). 30% of people aged 65 and over fall at least once a year. For those aged 80 and over, it is 50% (National Institute for Clinical Excellence, 2013). Some of these falls may cause serious injury or even death.

People aged 65 and older are at the highest risk of falling. However, it is important to recognise that it is not only older people who are at risk of falls.

In 2015, the number of injuries due to falls amongst over 65s in East Sussex was 7,100 adults (NHS England, 2015).

Even a minor fall can have serious consequences for an older person's physical and mental health.

A fall can damage an adult's self-confidence, increase social isolation, reduce independence, and hasten a move into residential care.

The fear of falling again may lead to a deterioration in an adult's well-being and quality of life, even if the fall itself does not result in serious consequences.

Definition of a fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level (National Institute for Clinical Excellence, 2014).

The physical consequences of a fall or long lie can include immobility, incontinence, cuts, bruises, soft tissue injuries, burns, fractures, pneumonia, chest infections, head injuries, dislocation, pressure ulcers, dehydration, hypothermia and death.

2. Falls and safeguarding

Care Act 2014

Since April 2015, safeguarding duties under the Care Act mean each local authority must make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. There are ten categories of abuse, one of which is neglect. This is the category that a fall is most likely to come under.

Section 42 of the Care Act places a duty on local authorities to undertake an enquiry, or cause an enquiry to be made, where the 'Three Key Tests' are met.

These are:

- an adult who has needs for care and support (whether or not the local authority is meeting any of those needs),
- may be experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Note Carers are also included where they meet these three key tests.

Falls

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.

All incidents relating to falls require falls prevention assessments to be in place, reviewed and actions undertaken to reduce the risk of falls.

The reason why there could be a safeguarding concern around falls includes:

- Multiple ambulance callouts.

- Not using a fall pendant alarm or the alarm is out of reach.
- No falls risk assessment or care plan is in place, or has not been updated, following the identification of a risk of falls or a fall having taken place
- Following a fall no appropriate medical intervention sought or given.
- No evidence of necessary alterations to the environment, and / or risks from and to others through interaction with others using the service.
- Falls from bedrails and / or hoist.

When to raise a safeguarding concern

In the context of an adult having fallen, service providers should raise a safeguarding concern when abuse and / or neglect is suspected.

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.

See guidance on raising concerns on abuse and neglect – appendix 1: falls guidance.

The purpose of an enquiry in relation to falls is to:

- identify the factors that led to the person falling,
- address the cause through actions in the safeguarding plan, and
- determine actions that need to be taken.

Safeguarding enquiries should follow the Sussex Safeguarding Adults Policy and Procedures, using a person-centred, outcomes focused approach which involves the adult at every stage of decision-making.

3. How can you identify that a fall is due to neglect?

It should be remembered that according to Age UK: **"Falls are not inevitable."**

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 adult falling. Whilst not an exhaustive list, the following should be considered:

Assessment and recording

- Has an adequately detailed falls risk assessment, including a falls screening tool, 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 adult's ability to understand the risk of falling?
- Are any falls-related restrictions or restraint measures in place for an adult who lacks capacity, evidenced in best interest records and in their support plan?
- Does the recording of incidents or accidents meet the required CQC standards for the home or ward?
- 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.

Nutrition and hydration

- Is there evidence of good nutritional care eg. is the adult well-nourished and hydrated?

Independence

- Does the adult's support plan reflect the support needed to remain safely active and mobile?
- Are there opportunities for the adult to exercise safely, and is support given to enable them to remain as mobile as possible?

The workforce

- Are there enough staff to support the needs of the client group?
- Are staff trained to ensure they are competent in moving and handling of adults in relation to falls prevention?

Referrals to specialist professionals

- Is there evidence that referrals have been made to appropriate health care professionals once a risk has been identified (eg. GP, CMHN, eye specialist, Falls Clinic and Falls Management Team)?

Safe systems

- Is there clear guidance for staff to follow once an adult has fallen, including:
  - Immediate action including examination, signs to look for, whether to move the client if injury is suspected.
  - Who to contact (eg. GP, emergency services etc) and when.
  - Follow-up action – reporting, recording, supervision and monitoring, and reviewing of an adult.

- Evidence of both specific and generic incident recording, actions taken and reviewed by provider and / or manager.

Appropriate equipment

- Is the appropriate equipment being used correctly, and are staff trained in its correct and safe use? Eg. hoists.
- Is there appropriate equipment and training to assist staff to safely lift an adult from the floor following a fall?
- Have appropriate equipment and aids to help prevent falls been provided once a risk has been identified?
- Is equipment in good repair?
- Are bedside rails being used appropriately? (see Appendix 1 – Safe use of bedside rails).
- Are call bells or alerting systems in place, being used and monitored?

Environment / footwear

- Are there hazards around the premises that could lead to falls? Eg. 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.
- Is the adult wearing poorly fitting or inappropriate footwear?

4. Planning an enquiry

A safeguarding enquiry can range from a conversation with the adult to a much more formal multi-agency arrangement. A professional who already knows the adult may be the person best placed to carry out the enquiry.

The enquiry must centre on the desired outcomes of the adult through ascertaining the views of the adult, or their representative, including an independent advocate if required.

A safeguarding enquiry will need:

- To determine whether neglect has occurred by establishing the facts. This will include:
  - Assessing whether those providing care carried out appropriate risk assessments considering intrinsic, extrinsic and behavioural risk factors.
  - Assessing whether patterns of falls for both the individual and the service have been identified, and risk factors acted upon in a timely manner.
  - Assessing if risk control measures were included in the support plan and acted upon.
  - Assessing the impact of the fall or 'long lie'.

  For further information see: Recognising the risk from falls.

- A well planned meeting or discussion which involves and utilises the skills of multi-disciplinary partners at the earliest opportunity.

  For further information see: Who can help with what?

- To assess the need for protection and prevention in accordance with the adult's, or representative's, wishes. This should include consideration of the physical and psychological impact of the fall.

  For further information see: How does a fall affect an adult? and Prevention.

- To consider the legal context.

  For further information see: Legal context.

Enquiries into ‘neglect by falls’ follow the Sussex Safeguarding Adults Policy and Procedures.

5. Recognising the risk from falls

There are three separate sets of factors that may lead to falls:

- The characteristics of the adult at risk of falling (intrinsic risk factors).
- Factors associated with the environment in which the fall occurs (extrinsic risk factors).
- The behaviour of the adult which can increase the risk of falls (behavioural risk factors).

Intrinsic risk factors

Intrinsic risk factors can include:

- Medical conditions and changes associated with ageing.
- Balance, gait or mobility problems.
- Dizziness or blackouts.
- Vision or hearing.
- Confusion or cognitive impairment.
- Bone health.
- Medication.
- Continence.
- Footwear.
- Nutrition.
- History of falls.

Extrinsic risk factors

Extrinsic risk factors in the home or ward environment can include:

- Lighting including poor lighting (particularly on stairs) and glare as some people find too much lighting a problem.
- Poor contrast eg. objects that blend into the background are more likely to cause trips and falls.
- Steep stairs.
- Inaccessible lights or windows.
- Lack of safety equipment, such as grab rails.
- Loose carpets or rugs.
- Slippery floors.
- Badly fitting footwear or clothing.
- Low staffing levels.
- Changes in level and types of floor covering.

Behavioural risk factors

Behavioural risk factors can include:

- Limited physical activity or exercise.
- Poor nutrition or fluid intake.
- Alcohol intake.
- Carrying, reaching, bending, risk-taking behaviour (eg. climbing on chairs or ladders).
- Footwear.
- Clothing.
- Inappropriate use of or refusal to use assistive devices.

It is often a combination of factors that leads to a fall, and all of these need to be addressed to reduce someone's risk of falling.

6. Who can help with what?

A key element of any enquiry is identifying what information needs to be gathered and planning who to involve.

This section aims to give you an overview of the resources available when undertaking an enquiry.

The GP

The adult's GP will be able to provide information about their current medical condition and history.

Market Support Team

The Market Support Team in Adult Social Care & Health may be able to assist with an organisational safeguarding plan when systemic issues have been identified as the cause of falls within any of the following settings:

- a care home,
- a domiciliary setting,
- supported living, and
- day care.

Sussex Police

Sussex Police will be involved in an enquiry where there is a suspected crime (ie. an allegation of wilful neglect). If the adult does not have capacity this could be dealt with under Section 44 of the Mental Capacity Act 2005 or, if the adult does have capacity, other relevant criminal legislation could be considered by the police.

Where a practitioner is undertaking an enquiry into neglect by falls and suspects that wilful neglect may have occurred, Sussex Police should be notified.

The Care Quality Commission (CQC)

CQC should be made aware of any safeguarding concerns within a regulated service, and may need to attend safeguarding meetings if the registered service is directly implicated.

Occupational Therapy Teams and Sensory Impairment Team

The Occupational Therapy Teams and Sensory Impairment Team can support an enquiry through safeguarding planning and agreed tasks. In particular, the teams can:

- Provide specialist advice in relation to:
  - mobility, transfer techniques etc
  - contrast, orientation etc.
- Develop adaptive techniques specific to the adult and their home or care environment.
- Prescribe specialist equipment to reduce the risk of falls.
- Prescribe telecare equipment to ensure a swift response in the event of a fall.

Joint Community Rehabilitation (JCR) Service

The JCR Service is an integrated domiciliary service delivered jointly by Adult Social Care & Health (ASC&H) and East Sussex Healthcare NHS Trust (ESHT). It provides rehabilitation and reablement to adults within their own home or other community settings, including equipment, exercise and mobility.

If there is a rehabilitation goal within the safeguarding plan, particularly following injury, illness or a fracture, the JCR Service can provide support in relation to the adult's assessment, action plan and review.

For a referral to be made to the service, the adult must:

- Be 18 or over.
- Be registered with an East Sussex GP, or is a resident within East Sussex.
- Consent to the referral.
- Be medically stable.
- Benefit from assessment and therapeutic or rehabilitation / reablement intervention.
- Be at the optimum stage to benefit from rehabilitation or reablement.
- Have identifiable goals.

Falls clinic

There are consultant-led clinics at Eastbourne District General Hospital and Conquest District General Hospital in St. Leonard's on Sea.

The clinics will investigate whether there is a medical reason for the adult's falls, and treat any underlying problems. They will review medication, consider bone health and make referrals to the JCR Service, as necessary.

Following a Multifactorial Falls Assessment, referrals to the clinics may be made by the individual's GP, doctors from the Eastbourne District General Hospital and Conquest Hospital, the JCR Service / Falls Therapists.

7. How does a fall affect an adult?

The impact of a fall should not be underestimated. The adverse physical consequences for someone who suffers harm or significant harm as a result of a fall can be devastating. However, the psychological and social impact may be more prevalent and have far reaching consequences.

Fear of falling and loss of confidence Fear of falling has been linked to increased levels of depression, anxiety and dependency. In addition, the fear of falling can increase the risk of falls occurring because the individual tends to freeze, becomes agitated and panics.

Physical health Falls can lead to serious injury and a variety of physical disabilities.

Falls are the main cause of disability and the leading cause of death from injury among people aged over 75 in the UK (Age UK).

Psychological health Falls or the fear of falling can lead to social isolation and depression. People with a fear of falling tend to reduce their activity levels, possibly to avoid putting themselves in a situation which may result in anxiety over falling or in an actual fall.

Loss of independence Reduced activity and associated increased levels of dependency can result in greater demands being placed on carers.

8. Prevention

Falls prevention is a key aspect in safeguarding people from harm.

This section is intended to support providers to identify risks so that measures can be put in place that will reduce the incidence or recurrence of falls.

The section is also designed to be cross-referenced by ASC&H staff when creating and agreeing a safeguarding plan. The purpose of the plan is to highlight risks and how these can be effectively managed.

Mobility / balance

Is the adult unsteady or have mobility problems?

Does the adult have a fear of falling?

Consider:

- Moving and handling assessment.
- Mobility assessment.
- Activity of Daily Living Skills assessment including transfers.
- Support plan.
- Encouraging safe activity with use of appropriate and monitored walking aids.
- Referral to Joint Community Rehabilitation Service / Falls Clinic.
- Monitoring alcohol or drugs intake.

Confusion / cognitive impairment

Is the adult cognitively impaired?

Is the adult currently presenting as more confused?

Consider:

- Current health eg. pain, dehydration, nutrition, constipation.
- Ruling out infection / delirium / other mental health conditions.
- Seeking advice from GP / CMHN.
- Optimising environmental safety.

Confusion / cognitive impairment (cont.)

- Telecare.
- Promoting safe exercise and activity.

Falls history

Have there been previous falls?

If so, how many; what were the causes and consequences?

Consider:

- Pre-admission information / strategies.
- Supervision plan, using walking aids where required.
- Encouraging safe activity.
- Referral for further assessment eg. physiotherapy, GP or falls service, if high risk, or unexplained falls or several recent falls.

Medication

Is the adult taking benzodiazepine / psychotropics, four or more medicines, or any other high risk drugs?

Consider:

- Asking about and observing for dizziness / drowsiness.
- Checking blood pressure (lying / standing).
- Medication review by GP.
- CMHN review.

Dizziness / blackouts

Does the adult appear to be dizzy or have fainting attacks?

Consider:

- GP review, including medication review.
- Checking lying / standing blood pressure.
- Referral to Falls Clinic.

Continence

Are there any continence issues?

Consider:

- Checking for infection.
- Toileting regime / suitable toilet facilities.
- Positioning near toilet / location / distance.
- Referral to DN or continence service.
- Appropriate clothing.
- A commode or urinal.
- Using night lights.

Bone health

Does the adult have osteoporosis or osteoporosis risk factors?

Consider:

- Osteoporosis medication and / or calcium and vitamin D.
- Discussing bone health with GP.
- Lifestyle advice eg. a calcium rich diet, safe sunlight exposure, sensible alcohol intake, smoking cessation, weight-bearing activity.

Poor nutrition / hydration

Is the adult underweight or have poor food / liquid intake?

Consider:

- Referral to GP or dietician.
- Starting a food record chart (as advised by GP or dietician).
- Encouraging good fluid intake.

Foot health / footwear

Is footwear suitable?

Are there foot health problems?

Foot health / footwear (cont.)

Consider:

- Discussing suitable footwear with adult and family.
- Introducing a foot care regime.
- Referral to podiatry.

Vision / hearing

Does the adult have impaired hearing or sight?

Consider:

- Ensuring that the adult wears their glasses or hearing aids daily.
- Ensuring glasses and hearing aids are in a good state of repair eg. by checking hearing aid batteries regularly.
- Ensuring glasses have the right prescription as there is a higher risk of falls in older people who wear bifocal / varifocal spectacles.
- Ensuring regular eye and hearing checks, and screening for Diabetic Retinopathy.
- Ensuring lighting is good.
- Checking for ear wax.
- Ensuring staff have an understanding of eye conditions including Age Related Macular Degeneration (AMD), glaucoma, cataracts, Retinitis Pigmentosa (which causes night blindness) and Diabetic Retinopathy.
- Ensuring staff have an understanding of sensory needs including visual acuity, loss of colour, loss of central or peripheral vision, loss of depth perception and problems with glare.
- Referral to optician and / or audiologist.

Environment

Is the environment safe and suitable for the adult?

Consider:

- Orientating the adult to the environment (both indoors and outdoors).
- Using the ‘Environment Assessment Tool’.
- Aids, appliances and / or signage.

Environment and orientation check

This tool can be used as a prompt to consider environmental risks relating to the adult and their own surroundings.

Footwear / clothing

Is footwear correct and non-slip?

Are clothes non-slip and correct length?

Consider:

- Liaising with next of kin and discussing with the adult the importance of suitable footwear and clothing.
- Checking footwear monthly.
- Provision of equipment eg. long handled shoehorn, helping hand if required.

Mobility aid / wheelchair

Do they require an appropriate mobility aid?

Do they require an assessment for mobility?

Is their own walking aid / wheelchair clean and in a good state of repair?

Consider:

- Referral to the Occupational Therapy Team (equipment) or Joint Community Rehabilitation Service / Falls Clinic (rehabilitation), a physiotherapist, or the Wheelchair Service.
- Checking condition of mobility aid, replace ferrules if required.
- Checking condition of wheelchair, arrange wheelchair repair if required.
- Check if lap belts are being used appropriately.

Flooring

Is the flooring in good condition and non-slip?

Are all thresholds flush?

Are there changes in flooring?

Flooring (cont.)

Are there changes in the level of flooring?

Is there adequate space, free from clutter?

Consider:

- Reporting and recording any problems.
- Re-arranging furniture if required.
- Encouraging good housekeeping.

Bathroom / Toileting

Does the bathroom meet the adult's and staff needs?

Can the adult access and use the bathroom?

Consider:

- Position and height of buzzer / call bell / alarm.
- Position and height of soap / hand towels / toilet rolls.
- Using a raised toilet seat / toilet frame.
- Is there space for walking aid / moving and handling equipment?
- Signage.
- Grab rails.
- Lightweight door.
- Adequate circulation space.
- Contrasting colours.

Furniture

Is there adequate space including circulation space for mobility aid / moving and handling equipment?

Consider:

- Rearranging furniture.
- Removing unnecessary furniture.
- Are footstools able to be moved and stored safely?

Furniture (cont.)

- Accessibility to:
  - buzzer / call bells / alarm.
  - electrical equipment.
  - wardrobes and drawers.

Bed

Is the bed suitable for the adult's assessed needs?

Consider:

- Height.
- Mattress suitability.
- Position in room.
- Circulation around bed.
- Accessibility and ability to use buzzer.
- Grab rails.
- Need for bedside rails (see Appendix 1).

Chair

Is their chair suitable for the adult's assessed needs?

Consider:

- Height.
- Arm rests.
- Support for transfer.
- Depth and width.
- Accessibility to buzzer / call bells / alarms.

Surrounding area

Are the hallways well-lit and well signposted for the adult?

Is there level and well-lit access?

Surrounding area (cont.)

Consider:

- Additional lighting.
- Additional signage.
- Marking edges (eg. steps or stairs, or a change in surfaces) with a bright contrast edging so they are visible.
- Floors different colour from walls (eg. door frames different colour from door and door handle different colour from door) – for colour contrast.
- Adequate and well-designed handrails which are at the correct height.
- Clutter free.
- Reporting and recording any issues.

Lighting

Is the lighting suitable for the adult's needs within their room?

Consider:

- Night light.
- Bedside light.
- Accessibility to adult.
- Adjustable lighting that is sufficient to see but not so bright that it causes glare.
- Additional lighting if required.
- Timer lighting if required.
- Appropriate monitoring technology including telecare.

Systems

Is there an alerting system in place for when an adult falls?

Consider:

- Accessibility.
- Usability.
- Maintenance and being switched on.
- Adequate training on how to use the system.

9. Self-help

Suggestions for how everyone can help themselves to reduce their risk of falling.

Exercise Focus on regular activities to improve balance and strengthen legs eg. gardening, dancing or tai chi.

Medicines Contact your GP or pharmacist if medicines are affecting your balance or making you feel faint.

Eyesight and hearing Eyesight and hearing may affect balance and co-ordination. So it is important to have regular sight and hearing tests, and to discuss any ear pain or difficulties with your GP.

For more information see: www.lookafteryoureyes.org/eye-care/vision-and-ageing and Vision, hearing and falls.

Feet Pain can affect balance. You should wear well-fitting shoes and slippers, and discuss any foot problems with your GP or chiropodist.

Calcium and vitamin D A diet rich in calcium and vitamin D helps to keep bones strong. Good sources of calcium are milk, cheese, yoghurt, fortified soya products and canned fish. Good sources of vitamin D are sunshine, oily fish and eggs.

GP If you have had a fall or are worried about falling, make an appointment with your GP.

Hazards in the home Ensure your home is well lit and free from hazards eg. loose wires, clutter, loose or frayed carpets.

10. Legal context

Additionally to the Care Act 2014, the legal framework for keeping adult's safe from injury, including injuries caused by falls, is to be found within a wide range of statutes and regulations.

Currently, the primary obligations on care providers and professionals can be found in the following regulations.

However, where practitioners are in any doubt as to compliance with the law they should seek specific legal advice. In the first instance, they should email Legal Services. A duty solicitor will be able to assist and, if necessary, elicit further advice from a barrister specialising in this area of the law.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The following regulations have not been written in full. Further details can be found here, on the CQC website. This also includes safeguarding and Key Lines of Enquiry (KLOEs).

Regulation 9 – Person-centred care

Care providers need to do everything that is reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate and meets their needs. This includes:

- Carrying out an assessment of the needs and preferences for care and treatment of the adult.
- Designing care or treatment with a view to achieving the adult's preferences and ensuring their needs are met.
- Enabling and supporting relevant persons to understand the care or treatment choices available to the adult and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment.

- Enabling and supporting relevant persons to make, or participate in making, decisions relating to the adult's care or treatment to the maximum extent possible.

- Making reasonable adjustments to enable the adult to receive their care or treatment.

- Where meeting an adult's nutritional and hydration needs, having regard to the adult's well-being.

Regulation 12 – Safe care and treatment

Care providers must provide care and treatment in a safe way and do all that is reasonably practicable to mitigate risks. This includes:

- Assessing the risks to the health and safety of adults of receiving the care or treatment.

- Doing all that is reasonably practicable to mitigate any such risk ensuring that persons providing care or treatment to adults have the qualifications, competence, skills and experience to do so safely.

- Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

- Ensuring that the equipment used by the service provider for providing care or treatment to an adult is safe for such use and is used in a safe way.

- Where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of adults and to meet their needs.

- The proper and safe management of medicines, assessing the risk of, and preventing, detecting and controlling the spread of infections.

Regulation 15 – Premises and equipment

Care providers should ensure all premises and equipment where care and treatment are delivered are clean and suitable for the intended purpose. This includes:

- Clean, secure and suitable for the purpose for which they are being used.

- Properly used, properly maintained, and appropriately located for the purpose for which they are being used.

Regulation 17 – Good governance

Care providers must have effective governance, including assurance and auditing systems or processes. This includes:

- Assessing, monitoring and improving the quality and safety of the services.

- Assessing, monitoring and mitigating the risks relating to the health, safety and welfare of adults and others who may be at risk.

- Maintaining securely an accurate, complete and contemporaneous record in respect of each adult.

- Maintaining securely such other records as are necessary to be kept in relation to the management of regulated activity.

Health and Safety in Care Homes 2001

This Health and Safety Executive guidance advises on a wide range of legal, managerial and technical matters relating to effective health and safety management. The guidance is intended for owners and managers of care homes, their staff and safety representatives. It describes the main risks found in care homes and how to safeguard workers and residents. It can be downloaded free of charge at www.hse.gov.uk.

The Health and Safety at Work Act 1974

This act places a duty on employers to protect those not in their employment (eg. care home residents, patients and members of the public) from health and safety risks.

The act also demands that employees conduct themselves appropriately to safeguard their own health and safety and that of others affected by their

actions. They should also co-operate with their employer over the employer's health and safety obligations.

The Workplace (Health, Safety and Welfare) Regulations 1992

These regulations stipulate that every floor and the surface of every thoroughfare should be suitable for the purpose for which it is used. Floors should not pose a risk to a person's health or safety because they slope, or are uneven or slippery.

The Management of Health and Safety at Work Regulations 1999

These regulations require employers to carry out an appropriate assessment of the risks, arising from the business, to the health and safety of those not in their employment.

The Mental Capacity Act 2005

Section 44 of the Mental Capacity Act 2005 introduced offences of wilful neglect and ill-treatment of an adult lacking mental capacity.

Practitioners should also be aware of negligence under common law. If someone suffers injury or harm as a result of another person failing to take reasonable care, where it was foreseeable that their failure could cause injury or harm, then that person could be sued.

Most of the above legislation can be found by searching legislation.gov.uk. However, practitioners are advised that this area of law is continuously being updated and therefore legal advice should be sought to confirm whether statutes or regulations have been repealed or superseded.

Examples of falls-related prosecutions against care homes may be found on the Health and Safety Executive website:

- GA Projects Ltd
- Bupa Care Homes Ltd

11. Case examples

Mr B

Mr B, a man in his seventies, was a resident at a residential home for people with dementia. A safeguarding concern was raised by Sussex Police following a post mortem which was carried out after a fall in the home which resulted in him sustaining a fractured cervical spine which then led to his death.

The allegation was one of neglect. It was reported that Mr B had a number of falls prior to the fall which resulted in his death.

Action taken

A safeguarding enquiry, led by the local authority, took place. This focussed on the residential home's management of the falls, including preventative measures implemented and action taken after each fall.

The Enquiry Officer examined:

- Documentation held by the residential home including risk assessments and hospital discharge assessments.
- Documentation held by Sussex Partnership NHS Foundation Trust.
- The enquiry report completed by the registered manager of the home which gave details of all the falls suffered by Mr B and others.
- The coroner's report.
- The report provided by the GP.
- Witness statements from carers on duty at the residential home.

The Enquiry Officer interviewed and consulted:

- Mr B's nephew.
- A representative of the Community Rehabilitation Team.
- The Compliance Officer, CQC.
- The Market Support Team

The Enquiry Officer also had a meeting with the person thought to be the cause of risk, ie. the registered manager of the residential home, to gain their perspective on the allegation.

The outcome of the enquiry was that the allegation of neglect supported the concern which was based upon:

- The risk of falls had been identified but no action had been taken forward from this.
- There had been no evaluation of the risk and no plans to manage the risk, eg. use of equipment, had been put in place.
- A failure to review the risk after each fall.
- The increase in Mr B's level of confusion had not been taken into account when assessing the risk of falls.
- There were no guidelines to staff of how monitoring and supervision should be done.
- There was no evidence of an assessment being undertaken by the residential home following Mr B's discharge from hospital.

A safeguarding plan was implemented. This:

- Introduced a new falls policy and procedure including:
  - who needs to be contacted,
  - completion of accident / incident form,
  - updating of risk assessments and care plans,
  - increased monitoring of all clients after a fall.
- Stipulated that risk assessments were to be audited by team leaders once a month.
- Introduced a procedure for evaluating falls within the residential home to identify any patterns.
- Ensured that an assessment prior to discharge from hospital was completed by the team leader, manager or deputy manager.

11. Case examples

Mrs A

Mrs A moved into a residential care home for people over the age of 65. She is in her 80s and has the early stages of dementia, which has increased her risk of falling, and her mobility is decreasing.

A safeguarding concern was raised by the manager of the home as a result of Mrs A being found on the floor in her bedroom by staff during the night. She had sustained an injury to her forehead which required stitches.

The allegation was one of neglect due to the harm Mrs A suffered as a result of the fall which required a hospital admission and treatment for a head injury.

Action taken

A safeguarding enquiry took place. This looked at the management of Mrs A's falls, including action taken after a fall and prevention.

The people involved in the enquiry were:

- Mrs A and her son,
- The Community Mental Health Nurse,
- The provider manager,
- The provider area manager,
- The consultant psychiatrist,
- Mrs A's GP.

The Enquiry Officer examined:

- Mrs A's risk assessments, care and support plans.
- The provider report completed by the registered manager of the residential care home.

- Community Mental Health Nurse records.
- A mental capacity assessment for Mrs A, who was assessed as having capacity to understand the safeguarding enquiry.

Outcome

The outcome of the enquiry did not support the concern. Mrs A had wanted to go to the toilet during the night and had not thought it necessary to use the call bell to alert the night staff. She slipped whilst getting out of bed and fell onto the floor. The night staff were alerted by Mrs A's sensor pad and contacted emergency services immediately.

There was evidence of preventative measures being in place to reduce the risk of Mrs A falling. These included:

- A falls risk assessment had been completed and was up-to-date. This identified that Mrs A had not fallen but was at increased risk due to becoming more unsteady.
- The physiotherapist had advised on transfer techniques, use of a rollator and grab rails within the home.
- Mrs A's GP ruled out any concerns about her diet, blood pressure or osteoporosis, but changed her medication following a recommendation by her Community Mental Health Nurse.
- Recent input from a podiatrist had recommended that Mrs A should have appropriate footwear at night.
- Checks for Mrs A's eyesight and hearing were up-to-date, and no concerns had been identified.

A safeguarding plan was implemented with agreed additional preventative measures being actioned prior to Mrs A's discharge:

- Mrs A would be referred to the Falls Clinic at the hospital (due to the high risk of her falling again).
- Continence issues would be checked.
- The night and bedside lighting in Mrs A's room would be checked.
- A falls evaluation system for the home would be implemented.

12. Appendix 1 – Bedside rails

Bedside rails can be used to reduce the risk of falls from a bed. They should only be prescribed where there is a risk of the bed occupant falling out of bed, and when bed safety rails are considered to be the safest way forward. The least restrictive option should be taken with all other options considered including ultra-low beds, telecare and falls mats.

They are not:

- intended to limit the freedom of movement,
- meant to be used to restrain people, or
- to be used as grab handles.

There have been more than 20 deaths from bedside rails in the UK since 2007.

The risks associated with the use of bedside rails are:

- entrapment of the head, neck and limbs,
- hitting head on rails if restless,
- attempts to climb over the rail, head or footboard,
- unlatching the device,
- violently shaking the rails and dislodging them,
- fear of confinement by bedside rails.

The following should be considered when using bedside rails:

- A thorough risk assessment must be carried out by a qualified person before bedside rails are ordered. This should be reviewed regularly with further risk assessments completed after any change in bed equipment or the bed occupant's condition.
- Only use bedside rails when they are the right solution to prevent falls.

- The Mental Capacity Act and deprivation of liberty should be considered.
- The rail must be suitable for the bed and mattress.
- The mattress must fit snugly between the rails.
- The bedside rail must be correctly fitted.
- Gaps that could cause entrapment of the neck, head, limbs and chest must be eliminated.
- Staff must be fully trained in the safe use of bedside rails.
- The client and their family must be involved in the decision.

For more information see: www.hse.gov.uk.

13. Additional resources

Falls prevention resources

ageuk.org.uk

Falls in older people: assessing risk and prevention, National Institute for Health and Care Excellence (NICE), June 2013

nice.org.uk

Commissioning care homes: common safeguarding challenges, Social Care Institute for Excellence, February 2012

scie.org.uk

Falls in older people, National Institute for Health and Care Excellence (NICE), 2015

nice.org.uk

14. Who to contact

In the event of an emergency, please dial 999.

Reporting a safeguarding concern

- Tel: 0345 60 80 191
- Email: HSCC@eastsussex.gov.uk

Referrals to Sussex Police

Referrals for Eastbourne / Lewes / Weald:

- Tel: 01323 747373
- Email: MASH.Eastbourne@sussex.pnn.police.uk

Referrals for Hastings / Rother:

- Tel: 01424 724144
- Email: MASH.Hastings@sussex.pnn.police.uk

Market Support Team

- Tel: 01323 464060
- Email: market.support@eastsussex.gov.uk

Occupational Therapy Teams and Sensory Impairment Team

Hastings & Rother

- Email: ASCOTRT-.Hastings&Rother@eastsussex.gov.uk

Eastbourne & South Wealden

- Email: ASCOTRT-.Eastbourne&SouthWealden@eastsussex.gov.uk

Lewes & North Wealden

- Email: ASCOTRT-.Lewes&NorthWealden@eastsussex.gov.uk

Sensory Impairment Team

- Email: AS.Sensory.Duty@eastsussex.gov.uk

Joint Community Rehabilitation Service (JCR)

Note Referrals should be made to **Health and Social Care Connect (HSCC)**

- Tel: 0345 60 80 191
- Email: HSCC@eastsussex.gov.uk

POhWER – independent advocacy service in East Sussex

- Tel: 0300 456 2370
- Email: pohwer@pohwer.net

Care Quality Commission

- Tel: 03000 616161
- Fax: 03000 616171
- Email: enquires@cqc.org.uk