4LSAB Multi-Agency Protocol for Falls and Adult Safeguarding

July 2025

Protocol for falls and adult safeguarding

'A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard.' (PHE, 2018). Around a third of people aged 65 and over, and around a half of people aged 80 and over, fall at least once a year, and falls are a significant cause of morbidity and mortality. (NICE, NG249)

Falls must not be seen as an inevitable part of ageing. A fall should be seen as an event that needs questioning and investigating to prevent future occurrence. Many falls and injuries as a consequence of a fall are preventable, but not all, particularly within the care home setting where some of the most frail and dependent of our population reside. However, we should take a preventative approach to the delivery of high-quality care. Best practice is underpinned by appropriate risk assessment, individualised care planning, good team communication and following appropriate post-fall procedures including reporting.

The Chief Medical Officer's guidance states that 'there is strong evidence that physical activity contributes to increased physical function, reduced impairment, independent living, and improved quality of life in both healthy and frail older adults'. Conversely, 'prolonged sedentary behaviour is associated with many poor health and functional outcomes in older adults'. (DHSC, 2019) Therefore when undertaking risk assessments, the risk of falls should be considered alongside potential harm from deconditioning where people are not moving or moving less.

1. Falls risk assessment

It is essential that on admission to a service, or commencement of care, a Multifactorial Falls Risk Assessment is undertaken to identify the person's individual falls risk factors. This assessment will help identify the appropriate actions required to reduce the risk of falling. Such actions should take into consideration the service user's wishes and clarify the responsibilities of the service. The plan for the person must reflect the outcome of the falls assessment and should be shared with them and their relatives, if appropriate.

Where there are concerns about an adult's capacity to understand the risk and implications of falling, capacity must be assessed under the Mental Capacity Act 2005 (MCA) and, if needed, a best interest decision made to maintain the safety of the adult. The outcome of this assessment must be recorded in the person's records and added to their care plan.

Documentation should provide evidence of:

- An appropriate multifactorial falls risk assessment demonstrating why a person is at risk of falling.
- Actions/strategies that have been put in place to reduce the risk, including involving other professionals when necessary.
- Equipment required to support mobility (e.g. walking aids, stand aids, hoists etc) and minimise falls risk (telecare, falls sensor, high/low bed)
- If bed rails are needed, then a bed rails assessment should be completed by the prescriber and added to the assessment. If the person lacks capacity to consent to the use of bed rails, then the MCA should be followed and a best interest decision recorded, with consideration given if this needs to be part of the Deprivation of Liberty Safeguards plan.
- Actions/strategies that are yet to be carried out.
- The risk assessment should be reviewed if a fall occurs or if the person's clinical condition or status changes.
- Discussion with the person and/or family regarding the assessment process and necessary actions required to prevent falls.
- Accurate falls reporting with evidence of care plan updates should a fall occur.

2. Seeking medical advice following a fall

It is important that the appropriate level of response is sought following a fall, this may include the need for an urgent medical response. This will be dependent upon whether

the fall has resulted in an injury or there is suspicion of an injury requiring specialist assessment. Any fall where there is suspicion of a collapse, long lie, a head or neck injury or a fracture (pain, swelling, deformity) will always require urgent medical attention. Please ensure that the patient's medication is reviewed to see if the person is or has recently been taking anticoagulant or antiplatelet (blood thinning) medication, in which case specialist advice should be sought. The decision will be made by the manager or senior clinician/carer on duty based on the individual circumstances and current clinical presentation of the case.

It is good practice to notify the individual's responsible medical clinician (i.e. General Practitioner, hospital clinician), should a fall occur as a medical review may be required to contribute to the investigation of the cause of the fall.

3. Fall with head injury

A head injury is a blow to the head from a force outside the body, like an accident, fall or attack. When the brain is damaged by such an event, this is called a traumatic brain injury.

The symptoms and effects of head injury can vary widely, depending on the level of injury and which part of the brain, if any, is injured. They can range from a bump or bruise on the head to loss of consciousness. Where the person has sustained a head injury a medical assessment or 999/111 triage should always be arranged as a matter of urgency, especially if the person is on any anticoagulant or antiplatelet (blood thinning) medication. Staff should always follow the local protocol for managing patients with a head injury.

4. Post fall procedures

In the event of a fall occurring, the fall must be recorded within the daily care record and the care plan and risk assessment reviewed and updated as required. Documentation should include the circumstances of the fall, assessment of any injury and how the person was assisted off the floor again. Many falls are "unobserved" or "unwitnessed" but the person may still be able to explain what happened. This information can be used as part of the post-fall analysis.

Organisations and professionals should be open, honest and transparent (duty of candour) with the person, or where appropriate their representative, post fall.

Registered providers are required to report to CQC any serious injuries (as defined by Regulation 18) to people who use their service.

5. When to report a fall as a safeguarding concern

Report a safeguarding concern about a person with care and support needs in the following circumstances:

- When there is a concern about possible abuse or neglect by another person, including other service users or staff, or the organisation.

- When a person is identified as being at risk of falls and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed i.e. there is evidence of neglect.

- When a person sustains a fall, which does or does not result in harm, and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed, or that the care plan is not updated after the fall i.e. there is evidence of neglect.

- Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures.

- When a person has an injury, other than a very minor, which is unwitnessed and unexplained. In circumstances where a person has sustained an injury the manager on duty should use judgement based on the evidence available to determine what may have happened. If the person has an injury which cannot be explained, then this should be referred as a Safeguarding Concern.

- When appropriate medical attention has not been sought following a fall. If no injury is apparent, there is no observed change in function and actions and observations have been recorded, then a GP or Hospital review may not be necessary. This decision will be made by the manager or clinician on duty based on the individual circumstances of the case to determine what may have happened.

- When appropriate measures have not been taken to maximise the safety of the person from an environmental perspective, including avoiding harm from other clients / service users.

- Where there is an open Section 42 enquiry regarding the person.

- Where there has been more than one incident during a 6-month period requiring attendance at hospital.

- Multiple incidents where it is not clear that professional advice or support has been sought at the appropriate time.

- Where there have been other similar incidents or areas of concern.

- Where there is an open Large-Scale Safeguarding Enquiry (LSSE) regarding the service.

If in doubt, discuss your concerns with the local authority in your area.

When considering whether a fall is the result of neglect, it is necessary to establish that everything practicable was done to reduce the risk of the person falling.

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

- Has an appropriate and adequately detailed falls risk assessment been undertaken?

- Has there been a reassessment of the adult's risk factors after each fall, with control measures and care plans updated accordingly?

- 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 person's ability to understand the risk of falling?

- Are any falls-related restrictions or restraint measures taken for an adult who lacks capacity evidenced in best interest records and within their care plan, and form part of their Deprivation of Liberty Safeguards assessment?

- Is there evidence that referrals have been made to appropriate health care professionals once a risk has been identified (e.g. GP, specialist clinician, Falls Clinic, Falls Management Team etc)?

- Does the recording of incidents / accidents meet the required CQC standards for the home / ward?

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

- Are there opportunities for the adult to exercise safely, and is support given to enable them to remain as mobile as possible?

- Does the adult have appropriate footwear and clothing good footcare

- Are staff trained to ensure they are competent in moving and handling of adults in relation to falls prevention?

- Is the appropriate equipment being used correctly, and are staff trained in its correct and safe use? e.g. hoists, stand aid etc.

- Is equipment in good repair?

- Are call bells or alerting systems in place, being used and monitored?

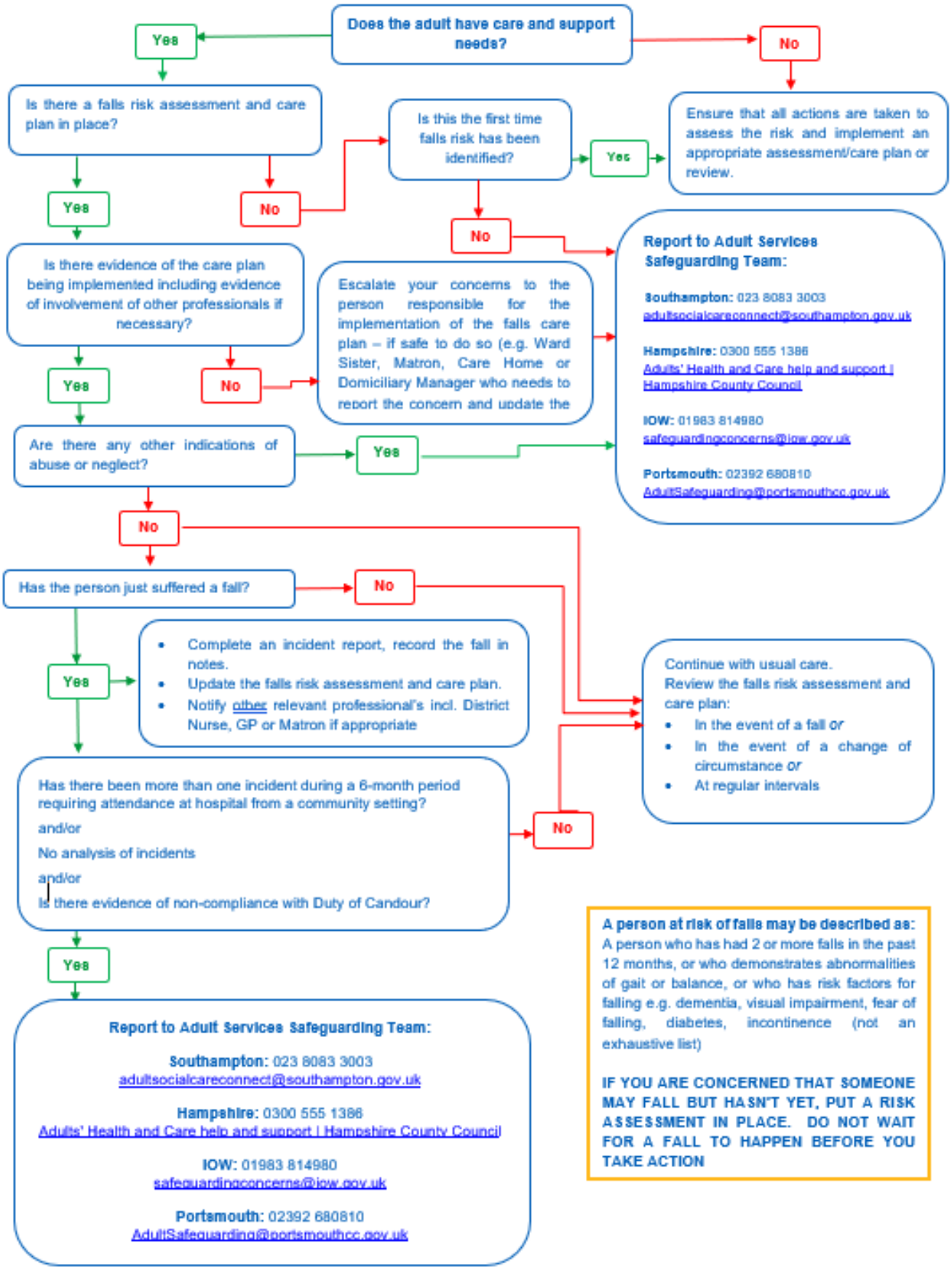
- Are there hazards around the premises that could lead to falls? e.g. uneven or worn flooring or ground, changes in levels, types of floor covering, lack of appropriate safety measures around stairs, poorly lit areas, trailing wires?

- Is there evidence that falls data (within residential / nursing homes or hospitals) is captured and analysed to identify patterns, and has been evaluated and acted upon? For example, time of falls, mealtimes, environmental factors

6. Guidance This tool is to aid decision making about falls and safeguarding concerns. These are just a few examples, and this does not replace professional judgement or aim to set a rigid criteria for intervention. It helps you consider the type of abuse and the circumstances in which a safeguarding concern would be raised to the local authority.

Type of abuse	Non-reportable	Requires consultation	Reportable
FALLS **Some people who are frail or have mobility problems may have a greater risk of falling.** **Following a fall, the individual may require more intensive services for longer, and in some cases may never return to previous levels of mobility.** **A fall does not automatically indicate neglect, and each individual case should be examined to understand the context of the fall.**	Lower-level concern where it would be unlikely to meet the definition of a safeguarding concern. Internal policies and procedures should be followed and an internal written record of what happened and what action was taken should be kept. **Where there are several low-level concerns, consideration should be given as to whether the criteria may be met for a safeguarding concern due to increased risk and therefore should be reported as the local authority have the statutory duty to make this decision.**	All appropriate action should be taken to reduce risk and internal policies and procedures followed. Consultation should be undertaken internally, refer to your local 4LSAB Safeguarding Adults Policy and Procedures and consider if consultation is needed with the local authority. Incidents at all levels should be recorded. **Following consultation, consideration should be given as to whether the criteria may be met for a safeguarding concern and therefore a referral into the local authority is required.**	Incidents at this level should be raised as a safeguarding concern with the local authority. **Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.**
	Examples: A fall where no injury has occurred and: • There is a reasonable explanation as to why this occurred. • A care plan and/or risk assessment is in place and being adhered to. • Actions are being taken to minimise further risk. • Other relevant professionals have been notified. • Full discussions with the person or people, next-of-kin, or any other representative. • There are no other indicators of abuse or neglect.	**Examples:** Multiple falls have occurred where: • A care plan and/or risk assessment is not in place or has not been fully implemented. • It is not clear that professional advice or support has been sought at the appropriate time (e.g., Falls Prevention Service, provider services monitoring team) • There have been other similar issues or areas of concern. • There may be other indicators of abuse or neglect.	**Examples:** • When there is a concern about possible abuse or neglect by another person, including other service users or staff, or the organisation. • When a person is identified as being at risk of falls and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed i.e. there is evidence of neglect. • When a person sustains a fall, which does or does not result in harm, and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed, or that the care plan is not updated after the fall i.e. there is evidence of neglect. • Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures. • When a person has an injury, other than a very minor, which is unwitnessed and unexplained. • When appropriate medical attention has not been sought following a fall. • When appropriate measures have not been taken to maximise the safety of the person from an environmental perspective, including avoiding harm from other clients / service users. • Where there is an open Section 42 enquiry regarding the person. • Where there has been more than one incident during a 6-month period requiring attendance at hospital. • Multiple incidents where it is not clear that professional advice or support has been sought at the appropriate time. • Where there have been other similar incidents or areas of concern. • Where there is an open Large-Scale Safeguarding Enquiry (LSSE) regarding the service.
Alternative actions to consider at every stage	• Follow relevant internal policies and procedures. • Review and revise current care plans /risk assessments • Share information with the Falls Prevention Service or Occupational Therapy service. • Consider referral for telecare services • Share information with GP for any medical issues.	• Share information with the ICB Quality Team and/or the CQC. • Referral to the local authority Adult Social Care department for a social care assessment, carers assessment, or review of existing arrangements. • Complaints or disciplinary processes. • Consideration of whether mental capacity is an issue.	**RAISE SAFEGUARDING CONCERN** If there is an indication a criminal act has occurred, the police **MUST** be consulted. Immediate safety plans must be implemented.

7. Flowchart


Does the adult have care and support needs?
Yes
No
Is there a falls risk assessment and care plan in place?
Yes
No
Is this the first time falls risk has been identified?
Yes
Ensure that all actions are taken to assess the risk and implement an appropriate assessment/care plan or review.
No
Report to Adult Services Safeguarding Team:
Southampton: 023 8083 3003
adultsocialcareconnect@southampton.gov.uk
Hampshire: 0300 555 1386
Adults' Health and Care help and support | Hampshire County Council
IOW: 01983 814980
safeguardingconcerns@iow.gov.uk
Portsmouth: 02392 680810
AdultSafeguarding@portsmouthcc.gov.uk
Is there evidence of the care plan being implemented including evidence of involvement of other professionals if necessary?
Yes
No
Escalate your concerns to the person responsible for the implementation of the falls care plan – if safe to do so (e.g. Ward Sister, Matron, Care Home or Domiciliary Manager who needs to report the concern and update the
Are there any other indications of abuse or neglect?
Yes
No
Has the person just suffered a fall?
No
Yes
Complete an incident report, record the fall in notes.
Update the falls risk assessment and care plan.
Notify other relevant professional's incl. District Nurse, GP or Matron if appropriate
Continue with usual care.
Review the falls risk assessment and care plan:
In the event of a fall or
In the event of a change of circumstance or
At regular intervals
Has there been more than one incident during a 6-month period requiring attendance at hospital from a community setting?
and/or
No analysis of incidents
and/or
Is there evidence of non-compliance with Duty of Candour?
No
Yes
Report to Adult Services Safeguarding Team:
Southampton: 023 8083 3003
adultsocialcareconnect@southampton.gov.uk
Hampshire: 0300 555 1386
Adults' Health and Care help and support | Hampshire County Council
IOW: 01983 814980
safeguardingconcerns@iow.gov.uk
Portsmouth: 02392 680810
AdultSafeguarding@portsmouthcc.gov.uk
A person at risk of falls may be described as:
A person who has had 2 or more falls in the past 12 months, or who demonstrates abnormalities of gait or balance, or who has risk factors for falling e.g. dementia, visual impairment, fear of falling, diabetes, incontinence (not an exhaustive list)
IF YOU ARE CONCERNED THAT SOMEONE MAY FALL BUT HASN'T YET, PUT A RISK ASSESSMENT IN PLACE. DO NOT WAIT FOR A FALL TO HAPPEN BEFORE YOU TAKE ACTION

8. Links to relevant information

For more information, please use the links below:

Care Act 2014 Statutory Guidance Chapter 14 - Safeguarding

Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents

NHS | Anticoagulant / Antiplatelet Medicines

NICE | Quality standard QS86 | Falls | April 2025

NICE | Guideline NG249 | Falls: assessment and prevention in older people and in people 50 and over at higher risk | April 2025

NICE | Quality standard QS74 | Head injury | May 2023

NICE | Guideline NG232 | Head injury: assessment and early management | May 2023