Appendix 2

Luton Falls Matrix

Readers are advised to refer to Local Authority procedures for determining referrals to social care *Safeguarding Adults Best Practice Matrix.* The matrix below contains examples of concerns with an indication of which safeguarding level they may fit into. The examples outlined are not an exhaustive list and do not provide an absolute definition. There will be cases that do not fit easily into a specific level and advice should be sought from your organisation's Adult Safeguarding Lead if there is any query as to which level a concern should be placed in. If in doubt and no expert safeguarding advice is available, complete a Safeguarding Adults referral.

Useful information:

Luton Adult Safeguarding (MASH) adultsafeguarding@Luton.gov.uk

All care homes in Luton can refer to (without going via GP) for any residents that have fallen or are at risk of falls either by calling on 0333 405 3000 or emailing us CCS-TR.LutonFallsTeam@nhs.net
https://www.cambscommunityservices.nhs.uk/luton/adults/falls-prevention-service

N.B. NHS settings are required by NHS England to report all falls to the ICB – both avoidable and unavoidable although not all will require a section 42 enquiry.

All Falls regardless of causes should be addressed among other things with person centred approaches, reviewing of care plans, falls risk assessments and specialist referrals for support as may be appropriate

Non-Reportable to Adult Safeguarding	Requires Consultation	Reportable to Adult Safeguarding
Incidents at this level do not require reporting to the Adult Safeguarding Hub. However, agencies should keep a written internal record of what happened and what action was taken. Actions/outcomes may include advice, information, risk management, staff training and discussion at Monthly MDT.	*(Contact your Safeguarding Lead for guidance)* Incidents at this level should be discussed with your safeguarding Lead and or the Adults MASH on 01582547730. After the consultation, you may be asked to formally report the concern.	Incidents at this level should be reported using the AP1 (Safeguarding Adults Concern Form. If there is any indication a criminal act has occurred the Police must be consulted
• **Isolated incident were no harm is suffered** • **One off fall were no harm is suffered involving more than one person within the same care setting** • **Isolated incident involving client on client** • **Inexplicable very light marking found on one occasion** • **A fall has occurred where care planning documentation does not identify individual's needs, not resulting in harm.** • **Poor quality care or professional practice that does not result in harm, albeit an adult may be dissatisfied with the service.**	• **Fall where harm occurs whilst in receipt of care** • **A fall occurred in an environment where there are high levels of hoarding present. (Refer to https://panbedfordshiresabs.trixonline.co.uk/chapter/self-neglect-and-hoarding)** • **Recurrent falls where there is no injuries sustained** • **Where an Adult at risk assessed to have mental capacity in relation to falls is going against professional advice.** • **The adult is not eating or drinking adequately, and this is impacting on**	• **All falls causing catastrophic harm to one person possible-hospitalisation / irreparable damage / death where there has been previous concerns identified** • **Where a referral to police is required in relation to serious injury** • **Previous falls concerns identified but not addressed sufficiently by organisation.** • **Numerous falls affecting more than one person from the same care setting or care provider requiring medical treatment** • **Inexplicable fractures/injuries to a an adult at risk with reduced mobility**

Non-Reportable to Adult Safeguarding	Requires Consultation	Reportable to Adult Safeguarding
• There are concerns about levels of hygiene and clutter within the adult's environment which may pose a risk to the adult's health and safety, but they are willing to engage in support to address this. • A fall related to known a medical reason • Rolling out of bed and or sliding out of chair, No harm suffered. • Staff error causing no/little harm, e.g. superficial skin friction mark • Minor events that still meet criteria for 'incident reporting'	their health or there is high risk of impact. • Inexplicable marking or lesions, burns, cuts or grip marks on a number of occasions • Accumulation of falls on one person or within one working area e.g. ward, care home • Falls related to medication mis/management • Falls related to transfers • One person experiencing recurring falls whilst in a care setting or receiving care services and no harm has occurred • Fall which results in injury where there is known falls risk, but existing care plans and risk assessments have been followed appropriately and referrals made to the relevant health professionals.	• Poor, ill-informed or outdated care practice/transfers that could cause harm • Falls due to service design where groups of adults living together are incompatible and harm occurs • Failure to whistle blow on serious issues when it has not been possible to resolve issues internally • The adult is consistently neglecting their health needs, and this is significantly impacting on their wellbeing- self neglect and falls. • Falls professional advise recommendations not followed • Absence of policies or procedures or training/supervision in relation to key aspects of practice but which do not result in harm