

Commence primary survey/care: ABCDE assessment, NEWS score, emergency care
If NEWS score has deteriorated to ≥ 9 or peri arrest call resuscitation team: 2222
 Reassure patient and give explanations whilst assessing and delivering care at all times
Care must take into account the patient's ability to understand and communicate

Avoid unnecessary patient movement and instruct the patient to keep still – Do Not Move but remember that clinical judgement must be made regarding patient movement in life threatening situations.

Ask all patients who have fallen the following questions:

- Do you have any new or increased pain or tenderness in midline back, neck, buttocks or lower back (lumbar region)?
- Are you **unable** to move fingers and toes?
- Do you feel any new pins and needles or tingling in any part of your body?
- Do you have any new loss of sensation?
- Do you have any electric shock type sensation or burning sensation in trunk or limbs?

If yes to any of these:

Did fall or incident history involve:

- Fall where a head injury cannot be excluded
- Altered or loss of consciousness?
- Obvious injuries to head/face/neck including minor abrasions?
- Fall over bedrails?
- An un-witnessed fall?
- A fall from a trolley?
- Fall/ jump from a height?
- Fall down stairs?
- Disclosure of head injury

Anti-coagulated patients are at increased risk

Has patient any:

- Obvious deformity to indicate bone injury: shortening and/or external rotation of affected leg or obvious abnormal movement, swelling or deformity of long bones or joints?
- Visible bone protrusion or significant haematoma?
- New or increased pain in any lower limb joints?

Neurological observations guidance
 Repeat neurological observations every 30 minutes for 2 hours
 then
 If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or vomiting: follow with neurological observations for every 1 hour for a further 4 hours
 then
 If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or vomiting: follow with neurological observations every 2 hours thereafter/ seek medical review

Any deterioration in GCS, new focal neurological deficit, suspicion of skull fracture, new amnesia, vomiting leakage of cerebro spinal fluid from ear or nose needs urgent medical review; revert to 30 minute observations

Medical assessment must consider need/ no need for CT scan
Remain aware of a potential delay in onset of symptoms

For minor or no obvious injury:
 If appropriate treat minor injuries.

Record observations, including: temperature, pulse, respiration rate, blood pressure, oxygen saturation. If the patient has diabetes, record blood sugar levels.

Use clinical judgment to discuss with doctor at appropriate time.

Retrieve patient from floor using standard manual handling methods as appropriate.

For minor or no obvious injury

Keep limb immobilised. Escalate for medical assessment. Move patient using safe techniques

Commence neurological observations: Assess and record GCS and a full set of vital signs.
 Any deterioration in GCS, new focal neurological deficit, suspicion of skull fracture, new amnesia or vomiting or leakage of cerebro spinal fluid from ear or nose needs urgent medical review
Escalate as below

Avoid unnecessary patient movement & Escalate as below

Escalation Procedure (informed by NEWS and SBAR)

- Fast bleed ward doctor (day hours) to assess patient or H@N (out of hours)
- In community hospitals/mental health services as above if available or dial 999 out of hours.
 - UHW /UHL out of hours call site practitioner to assist with triple immobilising and flat-lifting
 - UHW/UHL in hours Mon-Fri: call nurse practitioners or critical care outreach team to assist with triple immobilising and flat-lifting

FLAT LIFTING
 At UHW / UHL flat lifting equipment (Hoverjack & scoop) is available via porters for the safe retrieval of patient onto bed/trolley with spinal injury or for patients with fractured neck of femur (Hoverjack only).

If flat-lifting equipment is unavailable for safe retrieval of fractured neck of femur, continue to use hoist

When a spinal injury is suspected and trained (ATLS/ or equivalent) staff are **not** available, dial 999 for safe immobilisation and retrieval of patient.

- Make safe any environmental hazards
- Complete incident form and document in notes
- Complete post falls assessment action log
- Reassess falls assessment tools and **modify risks**
- Inform relatives and carers
- Communicate information about falls to any receiving care settings & GP