

Immediate actions following adult in-patient fall:

Prevention and management of falls in vulnerable adults procedures

<http://www.cardiffandvaleuhb.wales.nhs.uk/document/173048>

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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:

Avoid unnecessary patient movement & Escalate as below

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

Anticoagulation = increases risk

Alert doctor if patient is anticoagulated or at risk of bleeding

Commence neurological observations, vital signs and GCS recordings:

Any deterioration in GCS, new focal neurological deficit, suspicion of skull fracture, new amnesia or vomiting or leakage of CSF from ear or nose needs urgent medical review.

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?

***Many #NoFs do not show signs of shortening/rotation**

For patients with cognitive impairment, resistance to movement is a red flag

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

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 CSF from ear or nose needs urgent medical review; revert to 30 minute observations

Medical assessment must consider need/ no need for CT scan

“For patients who have sustained a head injury with no other indications for a CT head scan and who are having warfarin treatment, perform a CT head scan within 8 hours of the injury” NICE CG 176

Be alert to the potential for a delay in symptom onset

For minor or no obvious injury

For minor or no obvious injury:

If appropriate treat minor injuries. Record observations, including: temperature, pulse, respiration rate, blood pressure, oxygen saturation and blood glucose levels.

Use clinical judgment to discuss with doctor at appropriate time.

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

FLAT LIFTING

At Ysbyty Calon y Draig- Dragon's Heart Hospital flat lifting equipment (scoop) is available for the safe retrieval of patient onto bed/trolley with spinal injury.

Sling hoist may be used for patients with suspected fractured neck of femur in the absence of a hoverjack.

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

Escalation Procedure (informed by NEWS and SBAR)

- **Fast bleep ward doctor (day hours) to assess patient or H@N (out of hours)**

Make safe any environmental hazards

Complete eDatix and document in notes

Complete post falls assessment action log and

Reassess falls assessment and **modify risks**

Inform relatives and carers

Communicate information about falls to any receiving care settings & GP