Western Health and Social Care Trust

Policy for the Prevention of Slips, Trips and Falls for Inpatients Within Western Health and Social Care Trust Facilities

February 2016

Western Health and Social Care Trust

Title:	Policy for the Prevention of Slips, Trips and Falls for Inpatient within Western Health and Social Care Trust Facilities			
Reference Number:	Primcare10/01			
Author(s)	Wendy Cross – Lead Nurse Governance and Performance			
Ownership:	Assistant Director of Nursing for Governance, Quality & Performance			
Original Implementation Date	October 2010		**Revised Date**	February 2016
Review Date	January 2018			
Version Number:	2.0	Supersedes:	Policy for the Prevention of Slips, Trips and Falls for Inpatient within Western Health and Social Care Trust Facilities October 2010	
Links to other policies, procedures, guidelines or protocols.	WHSCT – Risk Management Policy WHSCT – Incident Reporting Policy and Procedures WHSCT – Manual Handling Policy WHSCT – Health and Safety Policy WHSCT – Using Bedrails Safely and Effectively`			

CONTENT PAGE

Page Number

1.0 INTRODUCTION

Patient falls have significant human and financial costs. For individual patients, even falls without injury may lead to distress and loss of confidence. Falls with injury can lead to pain and suffering, loss of independence and in some cases, death. Furthermore, following a fall, patients' relatives and nursing staff can feel anxiety and guilt, which can adversely affect caring relationships.

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. Each year, approximately 282,000 falls were reported to the NPSA from hospital and mental health units. A significant number of these result in death, severe or moderate injury including around 840 fractured hips and other types of fractures and 30 intracranial injuries (NPSA, 2011). These figures are for England and Wales only.

The NPSA in its report, "Slips, Trips and Falls in Hospital" states that:

"a range of both clinical and environmental interventions need to be applied in order to have the greatest impact in reducing falls." (NPSA, 2007, p7).

2.0 AIM OF POLICY

The aim of this policy is to reduce the risk of patients falling, in primary and secondary care services that have in-patient facilities. Staff must identify the ***risk factors*** and undertake ***appropriate interventions*** that will reduce the likelihood of patients slipping, tripping or falling. The intention is to protect patients from risk of harm while maintaining their right to make decisions, increase their activity, enhance their confidence, and maximise their independence.

3.0 SCOPE OF POLICY

This policy is for all staff caring for adults who are patients within the Western Trust's inpatient facilities.

Policy Objectives:

- To promote safe, high quality care and wellbeing for patients at risk of falling;
- To enable staff to identify the combination of clinical and environmental risk factors for each individual patient;
- To enable staff to identify the most effective interventions that will urgently minimise the risk of falling;
- To ensure staff clarify with the patients/carers the level of protection that will be required to minimise harm while maintaining the patient's personal freedom, dignity and independence;

- To assist in the reduction of slips, trips and falls evidence of which will be determined by reviews of the number of clinical incident reports.

4.0 ROLES AND RESPONSIBILITES

It is the responsibility of all Trust employees to adhere to this policy. This policy must be read in conjunction with WHSCT Using Bedrails Effectively Policy, WHSCT Risk Management Policy, WHSCT Manual Handling Policy, WHSCT Incident Reporting Policy and Procedures and WHSCT Health and Safety Policy.

Directors:

Directors have the responsibility to coordinate and facilitate circulation and implementation of this policy within their individual directorates for monitoring compliance and reviewing incident reports. Directors are responsible for ensuring that training is undertaken in line with the requirement of this policy in the prevention and management of falls.

Lead Nurses:

Lead Nurses have the responsibility to coordinate and facilitate implementation of this policy and monitoring of compliance within their individual directorates. They are required to ensure that their staff understand the policy and related operational procedures.

Ward Managers / Team Leaders:

Ward Managers / Team Leaders have the responsibility to adhere and implement this policy and to monitor compliance within their teams. They are accountable to the Lead Nurse and must:

- Ensure performance monitoring
- Ensure staff have the appropriate training on the prevention and management of falls
- Ensure staff have the appropriate mandatory training and training in related falls prevention equipment
- Ensure records are maintained locally of staff training
- Monitor ward fall rates and identify local trends that may contribute to falls
- Develop and implement systems to identify at risk patients e.g. safety brief, falls safety cross
- Develop action plans and share learning from reported falls and/or near miss falls
- Participate in route cause analysis reviews or serious adverse incident investigations

Individual Staff Members:

All staff who care for patients are responsible for ensuring they have the appropriate knowledge to do so. It is the responsibility of all healthcare workers to identify any skills or knowledge deficits in relation to the prevention and management of falls.

All staff must:

- Adhere to all policy and guidance in relation to the prevention and management of falls
- Nursing Staff must complete individual patient risk assessments and intervention plans and record the outcomes of cares in the patient notes
- The Multidisciplinary Team must ensure that all information is recorded in the patient's notes, any actions or recommendations regarding assessments or treatment plans and must be communicated to the Nursing Team.

Decisions regarding the interventions to prevent patient falls are the responsibility of the registered nurse responsible for the patient and should be made in agreement with the multi-disciplinary team and the patient and/or family. These decisions and discussions must be clearly documented in the patient's notes.

5.0 DEFINITIONS

All slips, trips and falls even those considered as a 'near miss' event must be reported in accordance with the Trust's Incident Reporting Policy (2014).

Included in the Trust's Incident Reporting policy (2014) is a definition of an Incident.

The DHSSPSNI document "Safety First: A framework for Sustainable Improvement in the HPSS" defines an error or incident as

"Any event or circumstances that could have or did lead to harm loss or damage to people, property, environment or reputation".

This definition includes 'near misses' as it acknowledges that not all errors result in harm to patients and service users.

6.0 RISK FACTORS THAT ALERT INCREASED TENDENCY TO FALL

Preventing patients from falling is a particular challenge in hospital settings because the treatments and interventions that ensure a patient's safety sometimes hinder their independence. Rehabilitation ***always*** involves risks, and a patient who is not ***permitted*** to walk without staff may become a patient who is *unable* to walk without staff. Older people are more vulnerable to falls and those who have fallen once are at a higher risk of falling again**.** Surgery and anaesthetic can cause imbalance while sedation, pain relief and other medications can affect balance and memory. Delirium, brain injury and dementia can cause confusion. Patients with dementia are at a higher risk of falling as they find it difficult to recognize environmental hazards, find it hard to save themselves when they become off-balance, and may be unaware of any limitations to their own mobility. Dementia is also associated with

changes in walking patterns and low blood pressure on standing, making people with dementia at least twice as vulnerable to falls compared to those without memory or cognitive problems.

Most falls are due to a combination of several factors and the interaction between these factors is crucial. The following intrinsic and extrinsic factors will increase the likelihood of a patient falling:

Types of intrinsic and extrinsic risk factors

		Examples
Intrinsic Factors	**Personality and lifestyle**	Activities, attitudes to risk, independence and receptiveness to advice.
	Age related	Changes in mobility, strength, flexibility and eyesight that occur even in healthy old age.
	Illness or injury	Stroke, arthritis, dementia, cardiac disease, acquired brain injury, delirium, Parkinson's disease, dehydration, disordered blood chemistry and hypoglycemic episodes in diabetes.
Extrinsic Factors	**Medication**	Sleeping tablets, sedation, painkillers, medication that causes low blood pressure, medication with Parkinsonian side effects, alcohol and street drugs.
	Environment	Lighting, wet floors, loose carpets, cables, steps, footwear, distances and spaces.

7.0 BALANCING RISK AND PERSONAL FREEDOM

Healthcare staff have a duty of care to prevent or reduce risk of harm to a person or others. They are also expected not to interfere unduly with an individual's personal freedom and autonomy. In the interest of providing a reasonable degree of freedom for individuals, some degree of risk will exist. All harm cannot be eliminated but staff must demonstrate that they have minimised risk as far as reasonably possible. Patients' and their carers' views MUST be included in planning interventions, which will give clarity about providing a balance between maintaining and promoting independence and dignity and minimising risk of harm.

8.0 THE FALLSAFE CARE BUNDLE

The FallSafe Care Bundle was developed as part of the FallSafe Project run by the Royal College of Physicians with the Royal College of Nursing and the National Patient Safety Association.

This project was a quality improvement programme that used evidence based care bundles to reduce patient falls.

The care bundle consists of a bundle for all patients, older and more vulnerable patients and a bundle for after a fall (Appendix 1).

The FallSafe Care Bundle has been adopted regionally in Northern Ireland as the tool of choice and has been implemented as one of the Chief Nursing Officer's key performance indicators.

8.1 Falls Prevention Management Plan:

The FallSafe Care Bundle has been included into the Regional Nursing Assessment Booklet and must be used on all patients within 6 hours of admission and any subsequent review (Appendix 2).

If the patient is identified as being at risk of falling the individually targeted falls risk assessment and intervention plan must be completed (Appendix 3).

The intervention plan has a range of potential interventions that are to be considered. The interventions that are appropriate to the patient's individual needs must be described.

8.2 Frequency of Risk Assessment:

All patients must be reassessed using the falls prevention plan following a change in condition; post a fall or near fall: after a period of 28 days in a hospital setting and if there are any other concerns by the patient, family, nursing or medical staff in relation to falls.

8.3 When a Patient Falls:

When a patient falls, staff must ensure least harm, ensure medical assessment and make the patient as comfortable as possible in accordance with moving and handling legislation (NPSA 2011, Essential Care of an Inpatient Fall). All staff must adhere to the Inpatient Nursing Post Fall Protocol (Appendix 4) and Inpatient Post Fall Medical Algorithm (Appendix 5).

8.4 Unwitnessed Falls:

Head injury observations must be carried out on a patient where a head injury has occurred or where it cannot be ruled out. This includes unwitnessed falls.

Staff must record GCS observations with a minimum frequency of observations:

- ½ hourly for 2 hours
- 1 hourly for 4 hours
- 2 hourly thereafter as appropriate to the individual patient's clinical picture (refer to Inpatient Post Fall Medical Algorithm)

GCS observations must be carried out ½ hourly until GCS = 15. If a patient with GCS = 15 deteriorates at any time after the initial 2 hour period, then

observations should revert to ½ hourly and follow ongoing frequency schedule.

8.5 Reporting Falls /Suspected Falls:

Following a fall / near miss, all falls must be reported online on the Trust Datix or the system using an incident reporting book. All fields with the Datix reporting system must be completed with as much information as possible regarding the circumstances surrounding the fall completed.

This information will provide the Trust and wards and departments with detailed information regarding trends in relation to falls which can be then targeted to develop falls prevention strategies.

If a fall is a cause of death or causes significant harm or fracture, then a round table meeting or root cause analysis must be completed. The fall may also be required to be reported as a serious adverse incident and maybe reported to RIDDOR. (Advice can be obtained from the Risk Management Team).

9.0 EDUCATION AND TRAINING

Education on the prevention and management of falls must be included in ward induction programmes.

A range of training is currently available from the HSC Clinical Education Centre

- WHSCT Falls Prevention and Management
- WHSCT Falls Risk Assessment and Implementing Falls Bundle
- WHSCT Slips, Trips and Falls for Healthcare Assistants

This training is also supported by the WHSCT Mandatory Training.

10.0 REFERENCES

Cohen I, Guin P (1991) Implementation of a patient fall prevention program. ***Journal of Neuroscience Nursing****. 23(5): 315- 319.*

National Patient Safety Agency (2007) ***Slips, trips and falls in Hospital. The third report from the patient Safety Observatory****. National Patient Safety Agency. London.*

Royal College of Physicians (2011) ***The FallSafe Care Bundle.*** *RCP London*

National Patient Safety Agency (2011) ***Essential Care after an Inpatient Fall.*** *National Patent Safety Agency, London.*

Royal College of Physicians

The FallSafe care bundle

Bundle for all patients

1 A history of previous falls and of fear of falling is taken at the time of admission.*
   > Admission processes and paperwork need to be changed to include these items.

2 Urinalysis is conducted on admission

3 New prescriptions of night sedation are avoided.

4 A call bell is in reach.
   > The existing call bell system must be able to reach all patient beds and chairs.
   > Systems are needed for rapid repair of faulty call bells.

5 Appropriate footwear is available and in use.
   > Supplies need to be made available for patients without relatives or friends.

6 There is immediate assessment for and provision of walking aids.
   > Physiotherapists must train nursing staff to provide appropriate walking aids at the time of admission to the ward, or as soon as they might be required.
   > Walking aids need to be made available for each ward area, and need a suitable storage area.

Bundle for older and more vulnerable patients

7 A cognitive assessment (mini-mental state examination (MMSE) or abbreviated mental test score (AMTS)) is conducted in all admissions aged >70yrs.

8 Those at risk are tested for delirium (confusion assessment method).
   > Trusts must implement delirium screening as per NICE guidelines.

9 An assessment of risk versus benefit for use of a bedrail is conducted.

10 Visual assessment is conducted.
   > The ability to recognise objects from end of the bed can be used as a screen for severe eyesight problems, and fuller assessment should be carried out if required.

11 Lying and standing blood pressure are taken with a manual sphygmomanometer.

12 Medication is reviewed with respect to cardiovascular and central nervous system acting medications (see enclosure).
   > Nurses should request a review of medication to try and reduce the burden of drugs, particularly those associated with falls, and in patients who are unsteady, hypotensive, or have orthostatic hypotension.

13 Based on observation, toileting arrangements are assessed and planned (tailored to needs rather than the standard two-hourly arrangement).

Bundle for after a fall

14 After a fall, appropriate assessments and procedures are followed (see enclosure), including neurological observations in those who have hit their head or had an unwitnessed fall.
   > Trusts have been mandated to include these procedures within their policies by July 2011.

15 A post-fall review (how can further falls be prevented for this patient) is conducted.

16 A complete incident report (all falls) is created.

17 A root cause analysis (lessons to prevent falls for future patients) is carried out for severe harm falls.

* Long stay units may wish to amend to 'at least monthly' rather than 'on admission'

† For rehabilitation units, community hospitals, stroke units, orthogeriatrics units, care of the elderly units, and dementia units this should equate to all patients. In wards and units with a more mixed population, patients with a high vulnerability to falls is likely to be determined by local policy e.g. positive response to any of the NPSA 'four questions', total of Morse score or STRATIFY score, or all patients not fully independent and mobile.

Supported by:

The Health Foundation Improving healthcare through improvement

Royal College of Nursing

avma action against medical accidents

Royal College of Surgeons of Edinburgh

NHS National Patient Safety Agency

NHS South Central

FALLS RISK ASSESSMENT & PREVENTION

This must be completed within 6 hours of admission

DOES THE PATIENT HAVE A HISTORY OF FALLING (within the last 12 months)? **YES / NO** (Circle)

DOES THE PATIENT HAVE A FEAR OF FALLING? **YES / NO** (Circle)

Part A: The following actions must be carried out for all patients at point of admission (record if actions are completed ✓ or NA)

Risk Factor	Actions to be considered & actioned	✓ *Yes or NA (Comments)*
On admission, please ensure:		
Environment	Call bell is working (check) Call bell is in reach of the patient	
	Ensure personal items are in reach and ensure area is free of objects to prevent slips, trips and falls hazards	
Mobility	Consider referral for a walking aid	
	Safe suitable footwear is worn / available	
Communication	Clear Communication of mobility status? (i.e. Visual cues at bedside, room door, whiteboard / safety brief)	
Signature of Assessing Nurse		
Date		

Part B

Part B must be completed on all inpatients over 65 years and also on patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition (patients with a sensory impairment or dementia, and patients admitted to hospital with a fall, stroke, syncope, delirium or gait disturbances)

Risk Factor	Actions	*Record or NA*
Maintaining a safe environment	Measure and record lying and standing Blood Pressure using manual sphygmomanometer if applicable	**Lying** **Standing**
	Bed rails risk assessment completed	
Signature of Assessing Nurse		
Date		

Appendix 3: Falls Risk Assessment and Intervention Plan

	If the patient has a fear of falling/ history of falling in the last 12 months/fallen since admission please complete the plan below.				
Assessment of Pt. Risk Factors	**Potential Interventions (list not exhaustive)**	**Date**	**Record patient intervention**	**Date**	**Record patient intervention**
Mental state	Requires orientate patient to time and place Record the level of supervision required ie one to one Review/ request a medical assessment re: delirium/cognitive impairment/disorientation				
Environmental Hazards	Check call bell is in reach (inappropriate for confused, disorientated patients) Keep personal possessions in easy reach Nurse in direct line of view if possible Nurse on lowest bed height/use low bed Ask for chair assessment/ use suitable chair Consider the use of alarm sensors Consider bed rails assessment Keep area clutter free Consider leaving on the bed side light overnight				
Restricted Mobility	Ensure moving and handling assessment is completed Record the assistance required – one/ two staff , Is uses/ requires walking aid – ensure it is correct height				
Footwear	Ensure well fitting footwear, no trailing laces, non-slip sole Offer non slip slippers				
Bladder & Bowel Management	Assess and treat any cause of frequency Assess and treat any possible constipation Record the assistance required to and from the bathroom Consider further Urinalysis/ MSU				
Medications	Ask Doctor to review medications / times associated with a risk of falls Request review of night sedation Do not stop abruptly				
Patient's Vision / Hearing	Ensure patients glasses are worn if/as appropriate Check if eyes require testing and initiate if required Leave personal objects within easy reach Hearing aid working and in use (if used)f				
Medical Conditions	Requires referral to Doctor to detect and treat cardiovascular disease, postural hypotension or osteoporosis Check as appropriate Lying / standing BP recorded				
Communication	Discuss with patient/ carer and gain agreement on the use of interventions which may infringe on their personal freedom and autonomy Information leaflet on falls prevention given				
Referrals	Consider Referral to Physiotherapy Occupational therapy / Rehabilitation Team,				
		Signature: Review Date:		Signature: Review Date:	

Appendix 4: Acute Hospital Inpatient Nursing Post Fall Emergency Response Protocol

Immediate Response (DRSABC)
Danger
Response
Shout Help
Airway
Breathing

- Check for immediate danger;
- Check for the response of the person fallen.
- Call for assistance.
- Assess airway, breathing, circulation and activate crash team response if required.

Check for Injuries.
If serious head injury, spinal injury or possible lower limb fracture suspected:-
DO NOT ATTEMPT TO MOVE THE PATIENT.
Contact medical team immediately for urgent assessment.

- Carry out preliminary assessment including vital signs and level of consciousness. Neuro observations must be completed if a head injury is suspected or it cannot be ruled out (e.g unwitnessed fall) Complete NEWS / Neuro obs chart.
- *Neuro Observations should be carried out half-hourly until GCS equal to 15. The minimum frequency of observations for patients with GCS equal to 15 should be as follows,*
- *half-hourly for 2 hours*
- *then 1-hourly for 4 hours*
- *then 2-hourly thereafter.*
  Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs should revert to half -hourly and follow the original frequency schedule
- Check for any signs of injury including abrasions, contusions, lacerations, fracture and head injury.
- Refer to inpatient post fall Medical algorithm if suspected head injury, cervical / pelvis fragility/ spine injury/fracture

Moving and Handling Assessment

Access Specialist Equipment

Altnagelvin Equipment Library 3rd floor
Hoist, stretcher, Spinal Board (including bariatric board), Head Immobilisers

SWAH
Manual Handling Room 2ndFloor
Spinal Board (Including Bariatric Board), Head Immobilisers
Hoist Stretchers and slings

Emergency Department
ICU
Hoist Stretchers and slings

- Assess whether it is safe to move the person from their position and any special considerations in moving them.
- DO NOT MOVE if patient exhibits any pain, loss of sensation, visible injury or limb deformity until appropriately immobilised. Contact medical team immediately for urgent assessment and following medical assessment agree appropriate moving and handling requirements
- Access appropriate moving and handling equipment, flat lifting equipment, hard collars or spinal boards.
- Follow appropriate moving and handling procedures including using staff who have received appropriate training.
- If NO head injury / spinal injury / lower limb fracture suspected then hoist or assist to stand / sitting position.

Communication

- Reassure fallen person at all times.
- Refer to medical staff even if injuries are not apparent.
- Refer to inpatient falls algorithm regarding medical assessment and treatment.
- At earliest convenience notify next of kin.
- Inform Nurse in Charge / HSM / H@N

Treatment and Care

- Assess for any injuries. Initiate diagnostic care and treatment interventions for any contributing causes.
- Continue to carry out vital signs including neuro observations if applicable as clinical condition requires as per inpatient protocol
- Treat and dress any wounds / lacerations. Refer to surgical / orthopaedic team if required in liaison with Medical staff.
- Provide analgesia if required and not contra-indicated.
- Ensure adequate hydration and all nursing care needs are attended to.
- Ensure on-going monitoring of the person as some injuries may not be apparent at the time of fall.
- On-going communication between patient / relatives/multidisciplinary team
- Review the implementation of any falls prevention strategies for the person and discuss with the multidisciplinary team.
- Implement a targeted individual plan of daily care.
- Ensure medical review regarding possible reason for fall and review of medications which may contribute to fall.
- Consider investigations and treatment for osteoporosis.

Documentation

- Document all details regarding fall into the persons nursing record.
- Complete Trust Incident Form / Datix.
- Refer to Inpatient Post Falls Medical Algorithm for completion by medical staff.
- Undertake or review falls assessment.
- Document discussions in nursing notes with patient/relatives/ multidisciplinary team regarding care and treatment

Communication

- Ensure effective communication of assessment and management recommendations with the multi-disciplinary team.

Learning the Lessons

- Complete safety cross.
- Discuss themes and lessons learned with the multi-disciplinary team.

Appendix 5: Non-Acute Hospital/Facility Inpatient Nursing Emergency Response Post Fall Protocol

Immediate Response (DRSABC)
Danger
Response
Shout Help
Airway
Breathing

- Check for immediate danger;
- Check for the response of the person fallen.
- Call for assistance.
- Assess airway, breathing, circulation and activate crash team response if required.

Check for Injuries.
If serious head injury, spinal injury or possible lower limb fracture suspected:-
DO NOT ATTEMPT TO MOVE THE PATIENT.
Depending on location either Contact Doctor/out of hours or call Ambulance immediately

- Carry out preliminary assessment including vital signs and level of consciousness. Neuro observations must be completed if a head injury is suspected or it cannot be ruled out (e.g unwitnessed fall) Complete NEWS / Neuro obs chart.
- *Neuro Observations should be carried out half-hourly until GCS equal to 15. The minimum frequency of observations for patients with GCS equal to 15 should be as follows,*
- *half-hourly for 2 hours*
- *then 1-hourly for 4 hours*
- *then 2-hourly thereafter.*
  Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs should revert to half -hourly and follow the original frequency schedule
- Check for any signs of injury including abrasions, contusions, lacerations, fracture and head injury.

Moving and Handling Assessment

- Assess whether it is safe to move the person from their position and any special considerations in moving them.
- DO NOT MOVE if patient exhibits any pain, loss of sensation, visible injury or limb deformity until appropriately immobilised. Contact Doctor/Ambulance immediately for urgent assessment and following assessment agree appropriate moving and handling requirements
- Follow appropriate moving and handling procedures including using staff who have received appropriate training.
- If NO head injury / spinal injury / lower limb fracture suspected then hoist or assist to stand / sitting position.

Communication

- Reassure fallen person at all times.
- Refer to medical staff even if injuries are not apparent.
- Refer to inpatient falls algorithm regarding medical assessment and treatment.
- At earliest convenience notify next of kin within shift where the accident happened.
- Inform Nurse in Charge of the shift immediately; Ward Sister/Charge Nurse and Head of Service at earliest opportunity

Treatment and Care

- Assess for any injuries. Initiate diagnostic care and treatment interventions for any contributing causes.
- Continue to carry out vital signs including neuro observations if applicable as clinical condition requires as per inpatient protocol
- Provide analgesia if required and not contra-indicated.
- Ensure adequate hydration and all nursing care needs are attended to.
- Ensure on-going monitoring of the person as some injuries may not be apparent at the time of fall.
- On-going communication between patient / relatives/multidisciplinary team
- Review the implementation of any falls prevention strategies for the person and discuss with the multidisciplinary team.
- Implement a targeted individual plan of daily care.
- Ensure medical review regarding possible reason for fall and review of medications which may contribute to fall.
- Consider with the medical staff the need for investigations and treatment for osteoporosis.

Documentation

- Document all details regarding fall into the persons nursing record.
- Complete Trust Incident Form / Datix.
- Refer Doctor to Inpatient Post Falls Medical Algorithm for completion by medical staff assessing the patient.
- Undertake or review falls assessment.
- Document discussions in nursing notes with patient/relatives/ multidisciplinary team regarding care and treatment

Communication

- Ensure effective communication of assessment and management recommendations with the multi-disciplinary team.

Learning the Lessons

- Complete safety cross.
- Discuss themes and lessons learned with the multi-disciplinary team.

Western Health and Social Care Trust

Appendix 6: Inpatient Post Fall Medical Algorithm

Please affix addressograph here if available.
Patient's Name: _____
Hospital number / H+C: _____
D.O.B: _____ *Age:* _____
Consultant: _____
Male ☐ *Female* ☐ Ward

- Follow algorithm to assess for suspected Head Injury, Cervical Spine Injury, Hip/Pelvis Fragility and any other injuries following a patient fall.
- Complete, Sign and Print name at the end of the Algorithm indicating outcomes
- Further notes can be made in the patient's medical notes if required regarding treatment or discussions
- This form must be filed in the patient medical notes

DO NOT MOVE PATIENT IF PATIENT EXHIBITS ANY PAIN LOSS OF SENSATION, VISIBLE INJURY, LIMB DEFORMITY UNTIL APPROPRIATELY IMMOBILISED.

COMPLETE FULL MEDICAL ASSESSMENT OF PATIENT FOR HEAD INJURY, SPINAL INJURY, HIP/PELVIS FRAGILITY AND ANY OTHER POTENTIAL INJURIES OR FRACTURES.

HEAD INJURY following initial ABCDE assessment Immediate Action

Is there evidence of head / clinically important brain injury? Including where it cannot be ruled out

If **No**, no action required.
Record EWS/vital signs
Action as per EWS

If **Yes**, are any of the following present?
New GCS <13, suspected open or depressed skull fracture; Sign of fracture of skull base (haemotympanum, "panda eyes", CSF from ears or nose, Battle's sign); Post-traumatic seizure; New focal deficit; >1 episode of vomiting. GCS Obs. carried out half hourly until GCS=15.
GCS minimum frequency of observations: half hourly for 2 hours, hourly for 4 hours and 2-hourly thereafter. Continue to Record EWS
Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs. should revert to half -hourly and follow the original frequency schedule.

If **No**, is there any unexplained amnesia or loss of consciousness since the injury?

If **Yes**, request CT scan immediately

If **Yes**, are any of the following present?
Age ≥65years; Coagulopathy (including on warfarin); Fall from >1m or 5stairs

If **No**, no action required.

After review by supervising doctor IF GCS drop by 1 ≥30min; or ≥2points in motor; ≥3; or severe headache; new neurology then request review.

If **No**, no action required.

If **Yes**, request CT scan within 8hours
GCS minimum frequency of observations: half hourly for 2hours, hourly for 4hours and 2hourly thereafter
Continue to Record EWS
Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs. should revert to half -hourly and follow the original frequency schedule.

NB If GCS ≤8 consideration should be given to involving Anaesthetist. Clinical judgement needs to be applied regarding changes in behaviour/neurology.

CERVICAL SPINE INJURY /suspected Immediate Action

Are any of the following present? (Check both lists.)

1. Patient cannot actively rotate neck to 45° to left and right
2. Not safe to assess range of movement in neck
3. Neck pain or midline tenderness AND ≥65years or fall >1m/5stairs
4. Definitive diagnosis required urgently e.g. to facilitate emergency

If **Yes**, immediate 3 view x-ray **Record EWS**

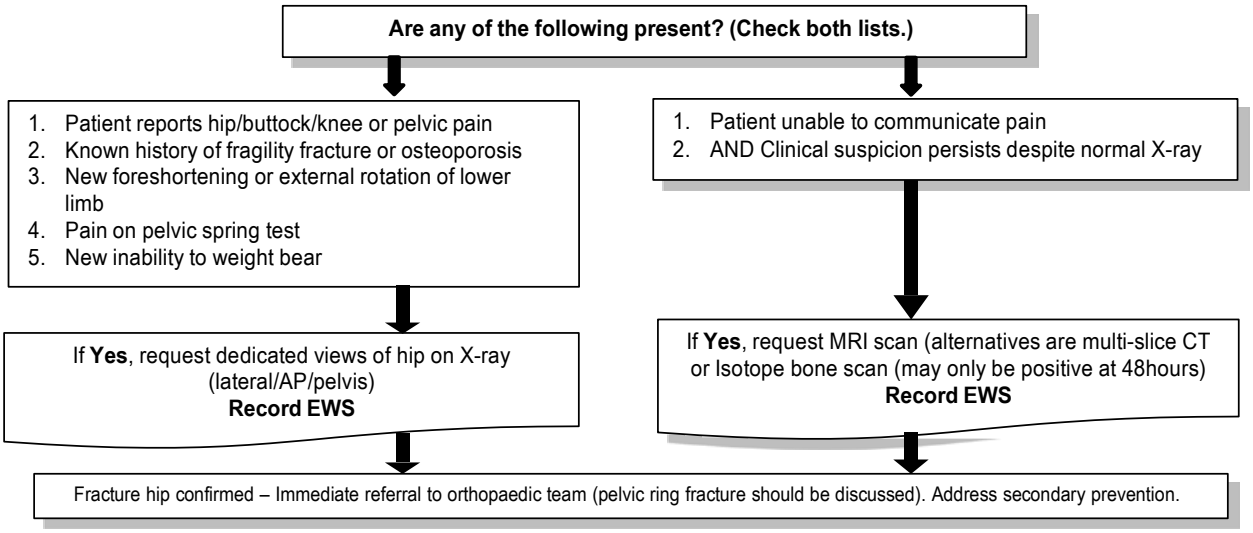
If **No**, no imaging required. **Record EWS**

1. GCS <13 on initial assessment and/or intubated
2. Plain film series technically inadequate, suspicious or definitely abnormal e.g. failure to view trabeculae or cortices of bone due to overlying tissue/objects or simply a poor quality film e.g. angle of beam.
3. Clinical suspicion despite normal X-ray

If **Yes**, immediate CT **Record EWS**

Western Health and Social Care Trust

HIP or PELVIS FRAGILITY/suspected Immediate Action



NB 15% fractures are un-displaced and therefore do not cause foreshortening of external rotation. X-ray interpretation should be by experienced staff.

Algorithm reviewed for: Findings

Head injury □ _____

Cervical spine injury □ _____

Hip/pelvis injury □ _____

Brain imaging Yes □ No □ Bone Imaging Yes □ Site_____ No □

Any Other injuries, factors, issues_____

_____

_____

_____

Further investigations ordered? Yes □ No □ N/A □
Referred / discussed with other medical teams? Yes □ No □ N/A □
If YES who? _____ Date_____ Time _____
Further treatment indicated and timescales agreed? Yes □ No □ N/A □

Degree of harm (See below*)

No harm ☐ Low harm ☐ Moderate harm ☐ Severe harm ☐ Death ☐

Medical assessment to ascertain cause of fall Yes □ No □
Medications reviewed for contributing factors Yes □ No □
Secondary Prevention treatment commenced Yes □ No □
If NO to any of above please indicate who and when these will be completed

_____

Print Name_____Grade_____Bleep_____

Signature_____Date____/_____/____Time_____(24hr)

No harm: *no harm came to the patient.* ***Low harm:*** *harm that required first aid, minor treatment, extra observation or medication.* ***Moderate harm:*** *harm that was likely to require outpatient treatment, admission, surgery or longer stay in hospital.* ***Severe harm:*** *such as brain damage or disability, was likely to result from the fall.* ***Death:*** *death was the direct result of the fall.*