Actions to take following a fall

If a patient experiences a fall **in any in patient** setting then the following interventions should be followed.

1. Carry out clinical assessment to check for injury and illness immediately.

2. Undertake clinical observations. In in-patient areas this must include BP, temperature, SATS. Commence neurological observations when a head injury is known or suspected.

3. Refer to medical practitioner for further assessment and treatment as appropriate unless the service user has a suspected fracture of a major limb or other serious injury e.g. spinal/head then the following interventions should be followed.

4. If the patient has a **suspected fracture** of a major limb (e.g. hip) or other serious injury e.g. spinal/head nursing/care staff will **immediately contact ambulance control** and request an serious but non-life threatening category of Blue Light ambulance **(9-999).** Nursing staff must inform ambulance control that the patient has a suspected fracture or other serious but non-life threatening injury, and must also ensure that all appropriate clinical information is handed over as part of the call, indicating that we as a healthcare provider cannot safely treat the patient, the caller must indicate a requirement for a serious but non-life threatening category of ambulance.

   A risk assessment must be carried out at the time and must inform of the actions in circumstances where, following a fall or other significant injury and against advice and guidance being offered by the clinical team, a patient actively attempts to move; and also in extreme circumstances (e.g. Fire) or a known delay in ambulance attendance where safety and wellbeing are further compromised. **The Risk Assessment must be clearly recorded in the patient's notes**.

   Consideration should be made to contact next of kin and inform of current situation as agreed at the point of admission.

   Symptoms of a hip fracture can include any of the following:

   - Severe pain in the hip or groin
   - A turned out leg that may appear shorter than the opposite leg
   - Swelling, tenderness and bruising around the hip
   - Inability to stand up (from either weakness or pain)
   - Deformed appearance to the hip
   - Hip too weak to lift the leg

5. If the patient has suffered a head injury then Medical staff **should** define the level of neurological observations required, then nursing staff **should** commence neurological the Medical staff **should** assess the patient and discuss with medical staff at the local acute hospital and determine if they meet the criteria for a CT scan which includes:

   Adults:

   For adults with any of the following risk factors who have experienced some loss of consciousness or amnesia since the injury, perform a CT head scan within 8 hours of the head injury:

   - Age 65 years or older.
   - Any history of bleeding or clotting disorders.
   - Dangerous mechanism of injury (a pedestrian or cyclist struck by a motor vehicle, an occupant ejected from a motor vehicle or a fall from a height of greater than 1 metre or 5 stairs).
   - More than 30 minutes' retrograde amnesia of events immediately before the head injury.

   Children:

   For children who have sustained a head injury they **should** be assessed by a medical practitioner and the assessing medical practitioner should seek advice from the local acute trust to determine appropriate treatment plan.

   In both Adults and Children a provisional written radiology report **should** be made available within 1 hour of the scan being performed.

6. Clinical staff will complete appropriate transfer of care documentation and ensure document and copy of the patient's current prescription accompanies the patient/patient escort to Accident and Emergency Department.

7. Inform patient's relatives of fall as soon as practical

8. Report slips, trips or falls incidents, including near misses using the Trusts web based Incident reporting system. If the fall results in a fracture femur or other serious injury then this **must** be reported as a serious incident by ticking the SI box on the web form and the serious incident process will be implemented.

9. If the patient sustains a fracture of a major limb other than a fractured femur as a result of a fall the Ward manager/Clinical Team leader will co ordinate a multi disciplinary review using the Trusts

After Action Review documentation. The findings of which should be shared through the local operational groups.

10. The Safety Team once notified of any incident of major injury (e.g. fracture) where a patient is harmed, arising out of or in connection with the work being conducted by the organisation will complete the RIDDOR report form. Injuries resulting form ill health, dementia and other health related conditions are not reportable under RIDDOR.

11. Health care record documentation will demonstrate the chronology of events, the factors observed and the response to care.

12. Health care records documentation will also detail circumstances surrounding the fall, e.g. where and when did the fall occur, what the patient was doing will be documented.

13. Reassess the patient using the falls assessment tool. Commence or reassess falls care plan in nursing/clinical records.

14. The Qualified Nurse/Clinical Team Leader will co-ordinate a multi-disciplinary critical analysis to inform future management.

If a patient experiences a fall in any **community setting** then the following interventions should be followed.

Carry out clinical assessment to check for injury and illness immediately and consider appropriate medical intervention such as GP/or emergency services.

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Falls Management Process

Northumberland, Tyne and Wear NHS Foundation Trust