Title	Essential Care after an Adult Inpatient Fall in Lindean and Borders Specialist Dementia Unit
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Healthcare Inequality Impact Assessed (statutory for policies)	N/R

When an Adult inpatient falls in Lindean or Borders Specialist Dementia unit

Immediate response: (Ensure safety of responder)

- Assess environment and **CALL FOR HELP** (Emergency buzzer if required)
- **Initial ABCDE Assessment:** **A=** Airway; **B=** **B**reathing; **C** = **C**irculation; **D=** **D**isability (**A**lert, response to **V**oice, response to **Pain, U**nresponsive);**E** = **E**xposure and respond accordingly, **NEWS 2, GCS**

No signs of life

DNACPR in place? If **NO** then **CALL CARDIAC ARREST TEAM (2222)**

Perform **CPR** according to current guidelines (including COVID 19 recommendations)

Signs of life

Initial checks before attempting to move patient

- **Position** – consider how the patient is lying/why they may have fallen and whether they have tried to move
- **Head, Neck and/or Spine Injury** – e.g. new or worsening pain in their neck; a change in their level of consciousness; bruising or a wound on their scalp; new pain or obvious injury to their spine; or new weakness in their limbs
- **Signs of Serious Injury** – do they have an obvious injury? (Is there swelling, deformity, bleeding or extensive bruising, acute confusion, airway or breathing problems, pain in limbs or chest, unable to move limbs on command?

Major/Illness Injury sustained

DO NOT MOVE THE PERSON – CALL (unless in immediate danger of further injury danger of further injury, to protect airway or to treat profuse bleeding)

- Seek urgent medical review within 30 minutes
- If specialist assistance/equipment is required e.g. spinal immobilisation for suspected spinal injury, splints for suspected fractures, then contact the ED for advice
- Continue observations using NEWs 2 Chart (escalate as indicated)
- Provide reassurance, assess for pain and administer pain relief as prescribed and continue to reassess.
- Attend to superficial wounds

Head injury

For patient **where head injury cannot be excluded** (i.e. un-witnessed fall)

Assessment and classification – The management of a patient with a head injury should be guided by clinical assessments and protocols based on the Glasgow Coma Scale (GCS) and Score:

- GCS recordings should be taken using NEWs 2 Chart - half hourly for 2 hours then, hourly for 4 hours then, 2 hourly for 6 hours or until medical review
- Adult patients with any of the following signs and symptoms should be referred for further investigation of potential brain injury:
  - **GCS<15 at initial assessment** (if this is thought to be alcohol- related, observe for 2 hours, and refer if GCS score remains <15 after this time)
  - **Post-traumatic seizure** (generalised or focal)
  - **Focal neurological signs**
  - **Signs of a skull fracture** (including CSF from nose or wars, haemotympanum, boggy haematoma, post-auricular or periorbital bruising)
  - **Loss of consciousness**
  - **Severe and persistent headache**
  - **Repeated vomiting** (two or more occasions)
  - **Post-traumatic amnesia >5 minutes**
  - **Retrograde amnesia > 30 minutes**
  - **High risk mechanism of injury** (road traffic accident, significant fall)
  - **Coagulopathy, whether drug-induced or otherwise** (Consider CT Head especially if on anticoagulants)
- Deterioration in GCS at any time should result in urgent medical review

Signpost - SIGN 110 Early Management of patient with a head injury

No apparent injury/Minor injury sustained

Minor injury: Signs of bruising, minor wounds to skin or slight discomfort

No apparent injury: Conscious and responding as usual, no bruising/wounds/bleeding, no apparent head injury, no pain/discomfort verbal/ nonverbal, mobility unaffected- able to move limbs on command spontaneously, no signs of limb deformity/shortening/rotation

- Administer first aid as required
- Continue observations using NEWs 2 Chart
- Ascertain if the patient can rise independently
- Use of moving and handling equipment if unable to rise independently
- Inform medical staff for review within 4 hours (or sooner if concerns/deterioration)

ANY CHANGE IN CONDITION CAUSING CONCERN – CALL MEDICAL TEAM IMMEDIATELY

- Falls risk assessment within the person centred falls bundle should be undertaken or reviewed and person centred nursing care plan updated accordingly, implementing any falls prevention interventions required
- Record fall on DATIX and document in clinical notes (please complete Duty of Candour within Datix)

Ensure that relative/main carer is notified of the fall and any injury at the earliest opportunity.

If there is a major injury or head injury a Fall Review Tool will be required. For all other falls it is good practice to complete a fall review tool but not mandatory.