IMMEDIATE MANAGEMENT OF A PATIENT WHEN FALLEN

In caring for a patient who has fallen, we have a responsibility not only to detect and treat the consequences of a fall, but its causes. In older hospital in-patients, falls can be an indication of serious underlying illness.

Nursing staff will usually be first responders to patient falls. Involvement of the appropriate doctor (usually SHO) should be on the basis of need, as outlined below. If the doctor is contacted, the nurse should be clear on the area of concern (use of SBAR)—NOT “Mr X has had a fall” but “Mr X has fallen and his arm is very painful”.

Immediate Safety

1. Address any urgent problems (e.g. control bleeding, protect airway)
2. Reassure the patient; ask them if they feel any pain and check for visible injuries.
3. If there is any suggestion of a spinal injury do not move the patient. Contact the doctor via.
4. If you suspect a fracture (e.g. severe pain or limb in unnatural position) make the patient comfortable on the floor and contact the doctor for advice and pain relief before moving the patient.
5. If there is no sign of spinal injury or obvious fracture, assist the patient back to bed or chair as appropriate, following usual manual handling practices. For all but the most agile patients, hoists are likely to be required following a fall to the floor.
6. If the patient can communicate clearly, the nurse need only examine any areas where they report pain (e.g. “my elbow hurts”).
7. If the patient is unable to communicate clearly, the nurse should examine the patient, checking limbs for unusual positions, legs for equal length/no rotation, observing for grazes, cuts, bruises and non-verbal indications of pain.
8. If the patient is expressing moderate or severe pain, the nurse should contact the doctor.
9. If the patient’s level of consciousness is not normal for that patient (e.g. confused when not usually confused, drowsy when normally alert, any loss of consciousness however brief) the nurse should contact the doctor.

Was it a fall or a collapse?

Unless there is a clear history from the patient of tripping, or they were observed to trip or slip, pulse and BP and O2 sats + BM (use of SBAR) should be checked following a fall, and the doctor informed of any abnormalities.

Could there have been a head injury?

Unless the patient can give a clear history and is sure he/she did not hit his/her head, and/or the fall was observed and he/she did not hit his head, neuro obs should be carried out hourly for six hours following the fall. The doctor should be informed of any abnormalities. If the neuro obs remain normal for six hours they can be discontinued.
Treating minor injuries

We accept experienced nurses usually have greater knowledge of wound care than junior medical staff. Nursing staff should use clinical judgement, but should not hesitate to inform the doctor if they require their input.

1. Bruising should be treated with a cold pack if the patient wishes; there is no need to insist if the patient finds this uncomfortable.
2. Grazes should be treated with a non-adherent or film dressing.
3. Lacerations less than 2cm should usually be steri-stripped.
4. Lacerations greater than 2cm may need gluing or suturing – contact doctor who may decide to suture (packs from A&E) or send the patient to A&E for suturing. It is reasonable to postpone suturing for up to 12 hours if patient is shaken by fall, or wants to go back to bed, etc.
5. If there is a skin tear (i.e. skin displaced in a V shape without extending through underlying tissue) it is important to place the skin back in position as soon and as gently as possible, as this will be impossible once clotting begins. Use steri-strips to maintain it in place and apply a non-adherent dressing. Skin tears where the point of the V faces towards arterial blood flow may not successfully re-establish circulation, and should be observed at least daily.

Review by medical staff

1. All patients who have fallen must be seen by the doctor.

Informing Relatives

1. When the patient is competent, it should be their decision whether, and when, we inform their relatives of any fall.

2. When the patient is too unwell to make that decision, we must act in their best interests.

   a) When a patient falls and suffers significant injury (e.g. fracture) we would inform their next of kin as soon as possible, day or night (if the next of kin have given consent to be contacted overnight).
   b) For a fall with minor injury, we would inform their next of kin during normal waking hours (e.g. for a fall at night, would telephone after 8.30 in the morning).
   c) For a fall with no apparent injury, we would inform when they next visited or telephoned the ward.
   d) Where there is no close relative, staff should use their judgement, considering the closeness of the relationship between the patient and their most significant relative/friend. (e.g. if next of kin is a neighbour who frequently visits patient, inform them of fall, but if next of kin is a second cousin in USA, it may not be appropriate).
3. If the patient is a frequent faller, relative’s preferences about phone calls subsequent to a fall (e.g. no night calls) should be discussed in advance and recorded next to their telephone number in the nursing notes.

**Aftercare**

1. Document fall and actions taken in nursing notes.
2. Instigate Falls Care Plan (or review if already in place).
4. Input information onto DATIX.
5. Inform physio/OT colleagues of fall at next routine handover.
FALLS PROCEDURE ACTION PLAN

FALL OCCURS

No obvious injury sustained:
- Check for any pain, swelling or abnormality
- Check understanding and comprehension
- If in any doubt follow procedure for obvious injury.

Once established as far as reasonably practicable that there has been no obvious injury sustained, correct moving and handling practice should be followed to assist the patient from the floor.

Independent patient:
Verbally talk through rising from the floor.

Dependent patient:
Appropriate hoist and sling must be used to lift from floor.

Obvious injury sustained:
- Do not move the person.
- Call for assistance.
- One staff member to remain with fallen person to reassure and support.
- Other staff member to contact doctor.
- Do not give any food, fluids or medication.
- Keep patient warm and continue to observe and note any changes.

Recording & Reporting:
- Record on DATIX
- Record in patients notes.
- Inform family/next of kin.
- In the event of serious incident/injury notify lead nurse.

Further Action:
- Continue to observe patient for any delayed injury symptoms, bruising, etc.
- Contact doctor if any change in mobility, pain, confusion.
- Continue to keep family informed and document in nursing notes.