Post-falls guidelines for care homes

Department of Health
www.health-ni.gov.uk

Northern Ireland Frailty Network
support • confidence • strength

HSC Public Health Agency

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Introduction

This guidance can be used by care home staff in the event of a resident experiencing a fall.

It provides instructions on steps to take for residents who fall, regardless of the severity of that fall (from no injury to a significant harm injury).

When applying this guidance, you must ensure that the capacity of the resident to make their own decisions about their care takes precedence.

For example: in the event that the guidance suggests a resident should not be moved and the resident has capacity to make the decision to change position and is aided to do so, the resident's decision should be clearly documented in the comments section.

It is important to note that this guidance is building on work done previously by Northern Health and Social Care (HSC) Trust, in particular by their Falls Coordinator and team. A big thank you to residents, their carers and family and the managers and staff in the pilot partner homes and other HSC Trust Falls coordinators and wider MDT members who are supporting the delivery of this work.

This work was developed by the Northern Ireland Frailty Network as part of the Enhancing Clinical Care Framework (ECCF). It is a key component of the Regional Falls in Care Homes Pathway and Bundle **www.health-ni.gov.uk/publications/regional-falls-care-homes-pathway-and-bundle**

If you would like to join the frailty network, please email **frailtynetwork@hscni.net**

Definitions

Consent and capacity: Consent must be provided by the resident for every proposed action. No other person can provide consent on behalf of another adult (unless mandated by a Court). Detailed information must be provided to the resident to facilitate a resident to provide informed consent. Where you reasonably believe that a resident is unable to independently provide consent, that is, lacks the capacity to make the decision at that time, best interests' decision-making process should be followed. Capacity to make decisions should be reviewed throughout the management of the fall.

Intense pain: (consider residents with cognitive and communication difficulties)
New pain since fall: Includes headache, chest pain and abdominal pain;
Consider pain from injury caused by fall or medical causes.

Suspected collapse: Ask resident what caused them to fall - if they tripped or collapsed.
Any dizziness, palpitations or sudden nausea before fall?
Includes near fainting episode.

Trauma to neck/back/head: New pain in neck/back/head following fall;
New lump, dent or laceration in neck/back/head with/without bleeding;
Any new numbness/paralysis in any limbs?

Unusual behaviour: New confusion;
Acting differently to usual self: agitated, drowsy, quiet;
New difficulty speaking, for example slurred speech, words mixed up, marked stuttering. Think stroke – act FAST (F- Facial drooping, A- Arm weakness, S- Speech difficulties, T- Time).

Marked difficulty in breathing/chest pain: Severe shortness of breath, not improved when anxiety is reduced;
Unable to complete sentences;
Blue/pale lips, fingertips, becoming lethargic or confused, palpitations.

Bleeding freely: Free flowing, pumping or squirting blood from wound;
Apply constant direct pressure to injury with clean dressing (elevate if possible);
Try to estimate blood loss (in mls/cupfuls).

Loss of consciousness - Use ACVPU (Alert, Confusion, Verbal, Pain, Unresponsive): Knocked out;
Altered level of alertness;
Limited memory of events before, during or after fall;
Unable to retain or recall information/repeating themselves, which is unusual for them.

Evidence of fracture: New obvious deformity, for example shortened/rotated, bone visible, severe swelling;
Reduced range of movement in affected area;
Unusual movement around affected area.

Definitions of antiplatelet and anti-coagulant

Title	Definition	Example
Anti-coagulant	Anti-coagulants are medicines that help prevent blood clots. They're given to people at high risk of getting clots, to reduce their chances of developing serious conditions such as strokes and heart attacks. Anticoagulants work by interrupting the process involved in the formation of blood clots.	Warfarin Apixaban Edoxaban Rivaroxaban Dabigatran Enoxaparin
Single antiplatelet therapy	Antiplatelet drugs decrease platelet aggregation and prevent clot formation in the arterial circulation. They may be used as single or dual therapy. Residents on one antiplatelet drug are in receipt of single therapy	Asprin Clopidogrel Ticagrelor Prasugrel Dipyridamole Cilostazol
Dual antiplatelet therapy (DAPT)	The combined use of Aspirin plus another antiplatelet drug	Clopidogrel Ticagrelor Prasugrel
Triple therapy	The combined use of anti-coagulant with dual antiplatelet therapy (DAPT)	Warfarin with Aspirin Clopidogrel

Signs and symptoms of the most common post-falls injuries

If concerned about moving the resident, or that appropriate equipment is not available, maintain the resident's safety, comfort and dignity on the floor until assessed by medical staff or emergency services (paramedic). Please follow the guidelines for when a resident is lying on the floor for more than an hour ('long lie' poster). Please remember if the patient has capacity, you must respect their wishes regarding positioning.

This is not an exhaustive list, for example other fractures may include rib and wrist.

Head injuries

Common signs of a minor head injury:	Signs of a severe head injury include those of a minor head injury and also:
• headache • light headedness • spinning sensation • new mild confusion • nausea • temporary ringing in the ears • bruising and contusions.	• loss of consciousness • seizures • vomiting • balance or coordination problems • serious disorientation • an inability to focus the eyes • leaking of blood-stained clear fluid from the ear or the nose • abnormal eye movements • loss of muscle control • a persistent or worsening headache • new memory loss • changes in behaviour or mood.

Spinal injuries

Common signs of a spinal injury:	Areas of the spine where a spinal injury commonly occurs:
• pain in the neck, back at the site of injury or in the middle of the back over the spine • tenderness and/or bruising in the skin over the spine • movement of limbs may be weak or absent • loss of sensation, or abnormal sensations, such as burning or tingling • loss of bladder and/or bowel control • new breathing difficulties.	**Cervical (C1-C8, neck)** Damage to the spinal cord in the cervical spine is considered the most severe because it can be life-threatening. Symptoms of cervical spinal cord damage may affect the arms, legs, mid-body, and even the ability to breathe independently. The higher up in the cervical spine the damage occurs, the worse the injury. **Thoracic (T1-T12, upper to mid-back)** Damage to the spinal cord in the thoracic spine typically affects the legs. Thoracic spinal cord damage high up in the area may affect blood pressure. **Lumbar (L1-L5, lower back)** Damage to the spinal cord in the lumbar spine typically affects one or both legs. Patients with lumbar spinal cord damage may also have trouble controlling their bladder and/or bowel function. Symptoms may be felt on one or both sides of the body.

Fractures of the hip and pelvis

Common signs of hip fracture:	Common signs of pelvic fracture:
• pain in hip • pain in groin • unable to stand or bear weight • inability to move the limb • mismatched leg lengths (shortening of affected leg) • affected leg toes turned outwards (rotating) • bruising, stiffness or swelling in upper thigh and hip area.	• pain and tenderness in the groin, hip, lower back, buttock or pelvis • bruising and swelling over the pelvic bones • numbness or tingling in the genital area or in the upper thighs • pain which may also be present on sitting and when having a bowel movement • vaginal bleeding in women and bruising to the scrotum in men • blood in the urine or coming from the back passage.

If concerned about moving the patient, or appropriate equipment is not available, maintain patient's safety, comfort and dignity on the floor until assessed by medical staff or emergency services (paramedic). Please remember that if the patient has capacity, you must respect their wishes regarding positioning.

Appendices

Post-falls guideline

Ensure the environment is free from hazard. Ask the resident what happened.

Proceed to assess the resident and follow actions in the appropriate colour pathway below.

Consent and capacity or the resident's wishes must be factored into decision-making.

Also refer to **Treatment Escalation Plan/Advance Care Plan** where available.

Registered Health Care Professionals (HCPs) should continue to use their clinical judgement and decision-making skills as appropriate when using these guidelines.

Green Pathway

- No obvious injury or unwitnessed fall with no evidence of loss of consciousness
- No bruising
- No obvious head injury
- No new pain
- Mobility unaffected
- No wounds or bleeding
- No limb deformity

Green Pathway Actions

- Assist resident to a place of safety and comfort if it is safe (using hoist or handling aid if required)
- Complete: **Forms A, B and C** (plus vital signs in nursing home setting)
- Inform family, GP and named worker
- Document all actions

Amber Pathway

Minor injury or minor head injury*:

- Signs of bruising
- Minor wounds to skin including face
- New pain

*If minor head injury, liaise with GP re pausing/stopping anticoagulant/ antiplatelet therapy

Amber Pathway Actions

- Administer first aid and prescribed pain relief as required
- Assist resident to a safe and comfortable place if it is safe to do so (using hoist or handling aid if required)
- Complete: **Forms A, B and C** (plus vital signs in nursing home setting)
- Inform family, GP/Out of hours via phone
- Document all actions

Red Pathway

- Airway or breathing problem
- Loss of consciousness or unresponsive
- Acute loss of mobility or movement in limbs
- Moderate or significant head injury (please refer to signs and symptoms of head injury on page 7)
- Other moderate or significant injury to any part of body
- Actual or suspected collapse
- Acute confusion or altered behaviour which differs from the resident's baseline
- Uncontrolled bleeding or extensive bruising
- New onset of intense pain

Red Pathway Actions

Call 999 for Ambulance

- Registered HCPs should continue to also use clinical decision making
- Inform family
- Complete: **Forms A, B and C** (plus vital signs in nursing home setting)
- If resident is lying on floor for more than 1 hour, see 'Resident experiencing a long lie' poster for further info
- NIAS will have a clinician call back to assess or dispatch a vehicle (meet paramedics at door and escort to resident, have your records and monitoring available)
- NIAS clinicians will then decide whether the resident is to remain in the home or to **transfer the resident to ED** (prepare appropriate documentation for transfer)

If the resident's condition deteriorates at all, call 999

- In all cases, review all relevant falls risk checklists and ensure any learning is communicated, documented and implemented with consent and agreement of resident.

- If resident is admitted for greater than 24 hrs, then complete relevant risk assessments on return to care home
- If resident is assessed and discharged back to care home, continue to complete **Forms A, B and C**

Form A Post-fall assessment and management tool

Name of resident		H&C number	
Date of fall		Time of fall	
Location of fall		Name/designation of person completing form	

Tick/comments

Level of consciousness	Responsive as usual	
	Less responsive than usual	
	Unresponsive or unconscious	
Pain or discomfort	No evidence of new pain or discomfort	
	Showing signs of new pain or complaining of new pain	
	Where is the pain?	
Injury or wounds (See body map)	No evidence of injury, bleeding or wounds	
	Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb	
	Where is the injury or wound/s?	
Movement and mobility	Able to move all limbs as usual for the resident and has no new pain on movement	
	Able to move limbs but has new pain on movement	
	Unable to move limbs as usual for the resident or there is a major change in mobility	
Observations, including neurological observations (in nursing homes only)		

Heart Rate		Blood Pressure (if possible record both) Lying		Blood sugar		Respiratory rate	
Oxygen saturations		Standing		Neuro Obs GCS score		Temperature	

Conclusion of assessment (24hrs post fall)

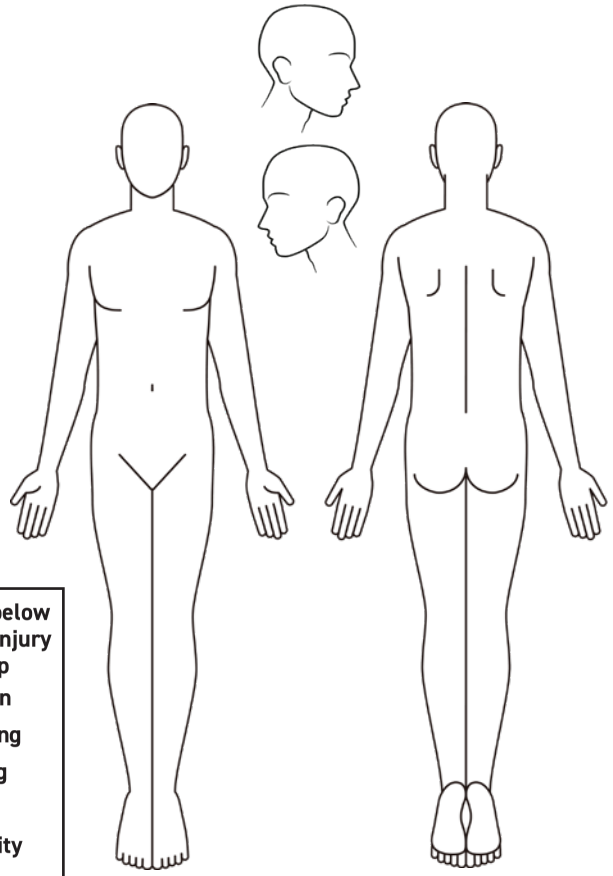
			Tick
No obvious injury sustained		Assisted resident to a comfortable place	
		Completed falls assessment tool, body map and 24 hr observation chart	
		Informed family, named worker, GP and RQIA-if appropriate	
		Completed all relevant paperwork	
Minor Injury sustained		Assisted resident to a comfortable place	
		Administered First Aid	
		Completed falls assessment tool, body map and 24 hr observation chart	
		Informed family, named worker, GP and RQIA-if appropriate	
		Completed all relevant paperwork	
Serious injury sustained		NIAS called – Time: Remained in Home Transferred to ED	
		Completed falls assessment tools, body map and observation chart	
		Informed family, named worker, GP and RQIA	
		Completed all relevant paperwork	

Print Name			**Signature**	
Date and Time			**Designation**	

Form B: Body map

Name of resident		DOB		H&C number	

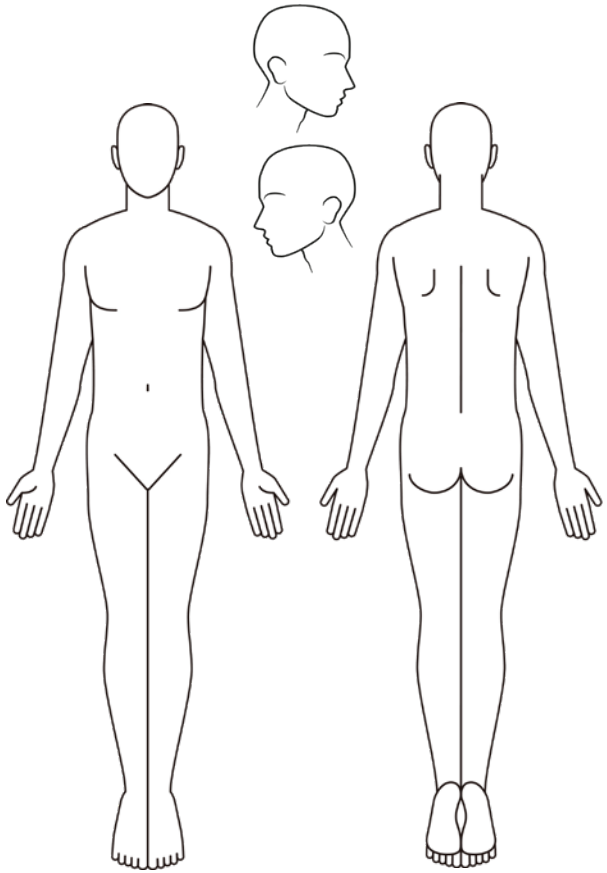
- Complete immediately post-fall then after 1 hour and 24 hours
- If deterioration, please copy this sheet and repeat as necessary
- Completion guidance – insert arrows and relevant codes. If required, draw in diameters of bruising/wounds



Immediately post-fall

Signature: _____

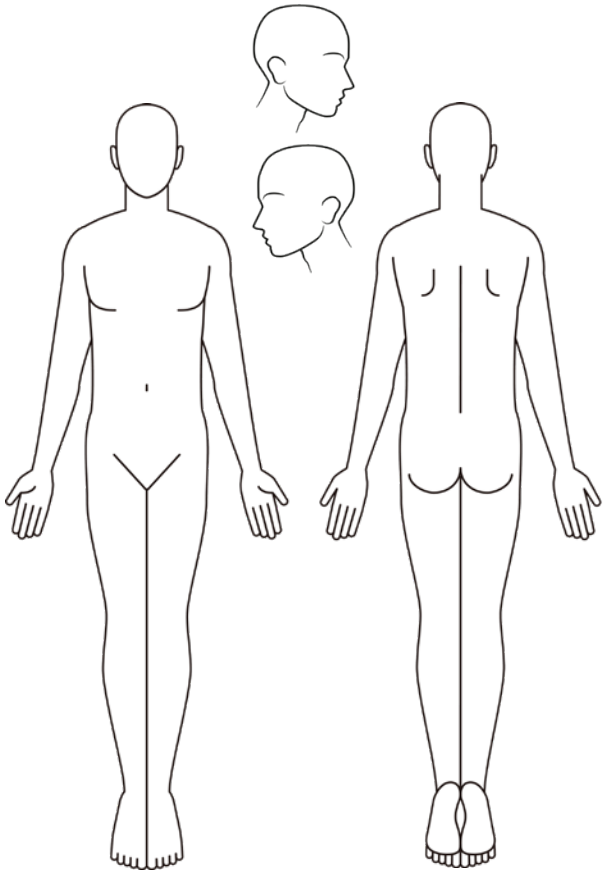
Date/time: _____



1 hour post-fall

Signature: _____

Date/time: _____



24 hours post-fall

Signature: _____

Date/time: _____

Use codes below to indicate injury on body map

A = Abrasion
BL = Bleeding
B = Bruising
BU = Burns
D = Deformity
F = Fracture
L = Laceration
P = Pain
S = Swelling
T = Tenderness

Any additional information should be recorded in the resident's notes

Form C 24-hour post-fall observation chart

Name of resident		DOB		H&C number	

1. Complete checks as per recommended frequency - wake the resident up to do the checks if head injury or suspected head injury
2. Insert tick (√) if completed, (NA) if not applicable, (S) if sleeping or relevant code into each section
3. Areas shaded do not require completion unless clinically indicated
4. Please note that the frequency of observations may increase or decrease depending on the ACVPU/vital signs/GCS score, if resident deteriorates seek further advice

		Unless you have to wake the resident, do not wake for these checks				**Head Injury/Suspected Head injury/ reduced loss of consciousness**			
Date	**Time**	**Pain assessed**	**Offered toilet**	**Items/call bell within reach**	**Wounds/bruising (See body map)**	**Residential** A-Alert C-Confusion V-Responds only to voice P-Responds only to pain U-Unconscious	**Nursing** CNS obs (insert GCS score)	**Comments** including any changes in capacity (see page 5 for info)	**Signature/ Designation**
	ASAP								
	½ hour later								
	½ hour later							This is a 'long lie' see long lies poster	
	½ hour later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								

		Unless you have to wake the resident, do not wake for these checks				**Head Injury/Suspected Head injury/ reduced loss of consciousness**			
Date	**Time**	**Pain assessed**	**Offered toilet**	**Items/call bell within reach**	**Wounds/bruising (See body map)**	**Residential** A-Alert C-Confusion V-Responds only to voice P-Responds only to pain U-Unconscious	**Nursing** CNS obs (insert GCS score)	**Comments** including any changes in capacity (see page 5 for info)	**Signature/ Designation**
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
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	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								

Any change to usual presentation, seek further advice. Record all additional actions in the resident's notes.

HSC Public Health Agency

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