Title	Essential Care after an Fall in A Community Hospital or Mental Health Inpatient Unit – Huntlyburn and East Brig
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When an Adult Inpatient falls in a Community Hospitals or Mental Health Unit (Huntlyburn & East Brig)

Immediate response: (Ensure safety of responder)

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

No signs of life

DNACPR in place? If **NO** then **CALL 999**

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** – eg 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 999 (unless in immediate danger of further injury, to protect airway or to treat profuse bleeding)

Scottish Ambulance Service (SAS) will use the trauma triage tool to decide whether the patient should go directly to the major trauma centre rather than BGH ED

- 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
- Seek medical support from Emergency Department(ED) BGH
- Community Hospitals complete urgent transfer to BGH SBAR

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
- Indications for referral to the ED – Adult patients with any of the following signs and symptoms should be referred to ED 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 ears, 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 from duty doctor or 999 (update GP)
- Community Hospitals complete urgent transfer to BGH SBAR

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

No apparent/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 (escalate as indicated)
- Ascertain if the patient can rise independently
- Use of moving and handling equipment if unable to rise independently
- Inform Duty Doctors/BECs or ANP (For Mental Health contact duty doctor within hours, outwith contact BCT in first instance), for review within 4 hours (or sooner if concerns/deterioration)

ANY CHANGE IN CONDITION CAUSING CONCERN – CALL DUTY DOCTOR/BECS OR 999

- 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