Assessment of Falls in Older People Protocol

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Review date 25/9/2021

Nursing staff check patient for any injury

(Check for pain, limb deformity, loss of sensation or head injury)

MAJOR INJURY

Suspected fracture, spinal injury or major head injury – **call ambulance (999)**

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Give appropriate pain relief

Keep warm

Monitor continuously

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Monitor vital signs

NEWs, pain score,

Blood glucose

Neuro obs if head injury or unwitnessed fall

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Contact NOK regardless of time of day

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Send medical and nursing notes, Kardex and obs charts with patient if going to acute hospital

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Complete Datix

Head injury observations

Head injury observations:

NEWS

GCS

Limb response

Pupil size and response

Frequency

30 minutes for 2 hours

1 hourly for 4 hours

2 hourly for 6 hours

Call doctor if:

Drop GCS by 1 point, vomiting

Headache, New agitation

Altered neurology

Be very cautious with patient on anticoagulants such as warfarin, apixaban, edoxaban, tinzaparin

NO MAJOR INJURY

Return to bed using safe manual handling methods

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Monitor vital signs

NEWs, pain score,

Blood glucose

Neuro obs if head injury or unwitnessed fall

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If minor injury (bruising, minor wound, slight discomfort) administer first aid

Record injury in nursing notes

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Complete nursing staff falls sticker and update nursing care plan

Update falls risk assessment

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Add to doctors' diary for review

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Contact NOK as soon as practical or if fall happens between 23:00 and 8:00 contact NOK at 08:00

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Complete Datix

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Any change in condition causing concern call doctor or OOH GPs

For all falls

Try to establish cause of fall	Address any fixable causes
- Falls ABC - Review medication	- Footwear - Walking aid appropriate and available? - Location of nurse call buzzer - If fall detector technology being used did it work