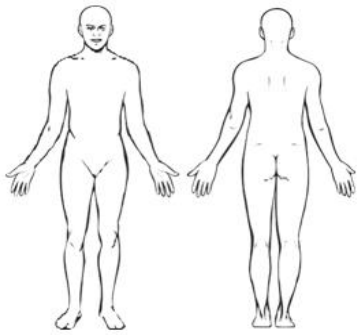
Medical Post Fall Review (file in patient notes)

NHS Greater Glasgow and Clyde

Immediately post fall, consideration must be given as to how the patient can be moved safely from their fallen position into their chair or bed using appropriate moving and handling methods.

A medical review must be completed immediately if there is a head injury, fracture, other serious injury, or the patient is distressed. If no obvious injury is sustained a medical review must be undertaken within 24hours of the fall event.

Patient details

WHAT HAPPENED? when (date & time), what, where, examination findings?	**Indicate site of any Injury**
	

ANY SIGN OF INJURY?	**NO**	**YES**		**ACTIONS:**	**YES**
1. Head Injury?				4 AT (see over page)	
- New onset confusion?				Neuro. Obs. (instruct nurses)	
- Neurological examination normal?			→	CT head	
- GCS = Eyes		/ 4		Discuss with Neurosurgeons	
= Verbal		/ 5		Other (describe)	
= Motor		/ 6			
2. Possible Fracture? (consider the following):				Xray (state site):	
- Painful limb / joint?				- Urgently (discuss if in doubt)	
- Tenderness / deformity any area?			→	- Non-urgently / next day	
- Shortening / external rotation of a leg?				Other (describe)	
- Change in mobility / function?					
3. Soft Tissue Injury?				Wound dressing	
- Cut / abrasion?				Wound suture	
- Bruising / sprain?			→	Immobilisation of limb / joint	
- Other? (describe)				Other (describe)	

WHY DID THE PATIENT FALL?	**YES**	**ACTIONS TO REDUCE FALLS RISK:**
- **Impaired balance?** (eg. CVD, MSk disorder, neuropathy, movement disorder)		
- **Syncope?** (eg. postural hypotension, arrhythmia, aortic stenosis)		
- **Cognitive impairment?** (eg. delirium, dementia)		
- **Medication?** (eg. sedatives, antihypertensives, antipsychotics)		
- **Environment?** (eg. hazard, poor footwear, spectacles not worn)		
- **Other?** (describe)		

MEDICAL REVIEW COMPLETED BY:	
Signature:	**Designation:**
Print name:	**Date:**

Reminders: *How to calculate the **4AT** and the **Glasgow Coma Scale (GCS)***

The 4 'A' Test (4AT): Screening instrument for DELIRIUM AND COGNITIVE IMPAIRMENT.

(1) ALERTNESS This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask the patient to state their name and address to assist rating.**	**Circle**
Normal (fully alert, but not agitate, throughout the assessment.)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal.	**4**
(2) AMT 4 Ask the patient their **Age, Date of Birth, Place** (name of hospital) **Current Year**	
No mistakes	**0**
1 mistake	**1**
2 or more mistakes	**2**
(3) ATTENTION Ask the patient " **Please tell me the months of the year in backward order**, starting at **December**". To assist one prompt of **"What is the month before December**" is permitted.	
Achieves 7 months or more correctly	**0**
Starts buts scores < 7 months or refuses to start	**1**
Untestable (cannot participate because too drowsy or inattentive)	**2**
(4) ACUTE CHANGE or FLUCTUATING COURSE Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.	
No	**0**
Yes	**4**
4AT TOTAL SCORE	

Score >4 This is possible DELIRIUM +/- COGNITIVE IMPAIRMENT	**Score 1-3** This is possible COGNITIVE IMPAIRMENT	**Score 0** Delirium or Cognitive impairment unlikely. However reassess throughout admission.

Glasgow Coma Scale & Score: A method to describe patient responsiveness

Feature	Scale Responses	Score Notation
Eye opening	Spontaneous	4
	To speech	3
	To pain	2
	None	1
Verbal response	Orientated	5
	Confused conversation	4
	Words (inappropriate)	3
	Sounds (incomprehensible)	2
	None	1
Best motor response	Obey commands	6
	Localise pain	5
	Flexion - normal	4
	- abnormal	3
	Extend	2
	None	1
TOTAL COMA 'SCORE'		**3/15 – 15/15**

SIGN Guideline 110 – Early Management of Patients with a Head Injury

Frequency of Neurological Observations:
- half hourly for two hours,
- hourly for four hours,
- two hourly for six hours,
- four hourly thereafter until agreed no longer necessary