Management of Person who has Fallen in Care Home

Click for Care Homes Falls Checklist

A resident has fallen or has been found on the floor

Check for dangers – is it safe to approach the person?

If not safe to approach person seek assistance

Is person responsive when spoken to?

No

Assess the situation (check airway and breathing) – call 999

Commence basic life support/CPR as appropriate (Consider any DNACPR or Advanced Care Plan in place)

Inform your line management/relatives once help has arrived

Yes

Before attempting to move person, check for red flags

Red flags assessment (major injury/illness)

Click for more info

Yes to any red flags

Call 999
Use SBAR tool when giving information

Click for more info

Do not move person. Try to make person comfortable with blankets/cushions whilst awaiting ambulance

Administer first aid (as required)
NB: if skin tear(s) present, refer to 'Acute Management by Non-Clinician in the Community of Skin tears' pathway

Prepare medications, MAR sheets, relevant documents and use 'Red Bag' if available

When able inform your line management/ relatives and document

No to all red flags

The resident may be guided or aided from the floor to a chair or bed. Follow your normal policies and procedures for assisting from the floor

Click for more info

Assess for amber flags (minor injury)

Click for more info

Yes to skin tear

Assess for severity of skin tear

Click for more info

Administer first aid as required

Contact NHS 111 (*6)/ECP (HV) for advice and follow-up as required

Observe person for a minimum of 24hrs for new/increasing pain or any changes in condition

Click for Post Falls Monitoring

Yes to other amber flags

No to all amber flags

Green (non-injury)

Click for more info

Increasing pain or any changes in condition

Click for Post Falls Monitoring

Observe person for a minimum of 24hrs for new/increasing pain or any changes in condition

Inform your line management/person's relatives

Document Falls record and injuries on a body map
Commence falls investigation (inc. Safeguarding) if required

Click for more info

Update Falls Risk Assessment and manage accordingly

Click for more info

See Proactive Management of Person at Risk of Falls in the Community pathway

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Call 999

Use SBAR (Situation, Background, Assessment & Recommendations) tool when giving information – use care home checklist

Follow instructions from 999 call taker

- Wait with resident until ambulance arrives
- Call 999 again if condition changes

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Care Home Falls Checklist

		Yes	No
1	Has the individual fallen more than 1 metre of over 5 stairs?		
2	Is the individual showing any signs of a Stroke – facial droop or limb weakness?		
3	Is there any evidence of intoxication?		
4	Is the individual not acting their normal self?		
5	Has the individual lost consciousness, or not been fully alert throughout the incident?		
6	Is the individual dizzy or sweaty?		
7	Has the individual suffered any amnesia or confusion post or prior to the event – that is not normal for them?		
8	Has the individual vomited since the fall?		
9	Has the individual's colour changed in their face, limbs or centrally?		
10	The individual has loss of circulation or nerve function to limbs		
11	Has the individual got any evidence of swelling, deformity or body tenderness?		
12	Is there any history of blunt or penetrating trauma to the chest or abdomen?		
13	Is there any break in the continuity of the skin – excluding minor abrasions?		
14	Evidence of severe bleeding		

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Red flags assessment (major injury/illness)

Do not move*, call 999 and perform first aid (as indicated):

Life threatening:

- Airway/breathing problems
- Signs of a stroke (FAST positive – Face (droop/cannot smile), Arms (+- legs new weakness), Speech (slurred), Time (to call 999))
- New or unusual chest pain
- Severe or/and uncontrollable bleeding
- The person is very warm, or cold, or clammy to touch
- Major chest or abdominal injury

Head injury/blackout:

- Loss of consciousness (blacked out)
- Reduced levels of consciousness (e.g. not alert or changing; person appears drowsy)
- New dizziness or vomiting
- Head injury and at least one of the following: confusion, memory loss, blurred vision, vomiting, loss of consciousness, dizziness, or person is on anticoagulant/blood thinning medication e.g. warfarin.

Injuries:

- New neck or/and back pain
- Pain on moving limbs
- New limb deformity (including if one leg appears shorter than the other or leg looks rotated)
- New extensive swelling to a limb or joint
- New extensive bruising
- New immobility (cannot move arms or legs normally) or unable to weight bear
- New numbness to a limb/ altered sensation
- Limb appears pale or feels cold
- Significant skin tear/skin flap – type 3b (immediate referral) and type 3a (refer ASAP within 24 hours)
  - If unsure injury is a skin tear, see photo in 'What are skin tears' box in 'Acute Management by Non-Clinician in the Community of Skin tears':
  - Where uncertainty exists regarding type of skin tear, manage as the worst likely type (e.g. if unsure if type 3a or 3b manage as 3b)

- Fall from a height above 1 metre or more than 5 stairs
- Person is acting abnormally compared to their usual behaviour
- Person has signs of being under the influence of drugs or alcohol (this could mask more serious symptoms and injuries)

If trained carry out physical observations (e.g. blood pressure, pulse rate, etc.) and neurological observations (e.g. pupils equal and reacting) – if abnormal escalate as per local protocol

**Moving a person should be avoided due to the risk of worsening of injury. However in some cases, where not moving a person would cause more harm (e.g. in contact with hot pipes/radiator risking burns, vomiting and risk of choking) the person should be moved the minimum amount necessary in the safest and least disruptive way to move them out of danger. Carers should not put themselves at risk of danger.*

Please note: If fall was unwitnessed, use your judgement and assess environment for potential hazards - do rule out fall from height or head injury.

If the person has dementia or another issue which effects their understanding or communication where possible assess for injuries/signs of pain and compare to what is normal for them. When there is uncertainty manage as if the red flag is present.

Use CARE HOME CHECKLIST IF TRAINED

Care Home Falls Checklist (Please see 'Why am I asking these questions' page)
Please note: If fall was unwitnessed, assess environment for potential hazards and do rule out fall from height or head injury

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Assess for amber flags (minor injury)

Once red flags have been ruled out, and the service user is off the floor and made comfortable, assess for minor injury.

- Minor bruising
- Minor cuts - if patient has a skin tear on their lower limb refer to the 'Acute Management by Non-Clinician in the Community of Skin Tears (for Adults)
- Minor discomfort

Call 111 for advice if:

- The person hit their head but have no other associated symptoms (Note: Head injury and associated symptoms is a red flag)
- Person was on floor for a long/unknown time*
- The fall was unwitnessed* and you cannot get a reliable account of the fall (Note if the person lost consciousness this is a red flag)
- Signs of skin breakdown/ pressure points on skin
- Any other concerns from care home staff

***Long lie and unwitnessed falls:**
If a person is on the floor for a long time, it increases the risk of: Skin breakdown and pressure sores; Dehydration; Incontinence; Hypothermia (low body temperature); Psychological issues (including distress and fear).

Use judgement and knowledge of the service user when discovering an unwitnessed fall. For example, if a fall is discovered on the first visit of the day, there is clearly a risk that the service user has been on the floor all night. Even if the service user appears uninjured, in this situation, additional advice from NHS 111 should be sought. It is important to mention that the fall was unwitnessed and estimated time the service user was on the floor (if known) when explaining the purpose of the call.

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Assess for severity of skin tear

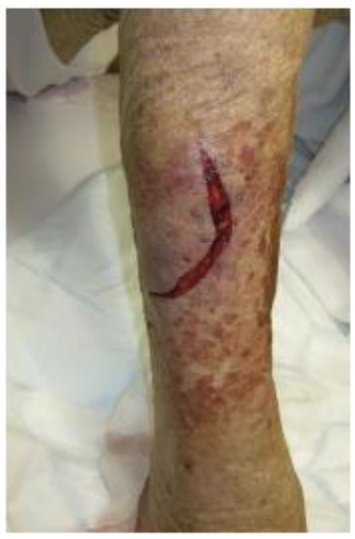
If skin tear is present refer to **'Acute, Same-Day Management of Skin Tears by Non-Clinician in the Community (for adults)'** pathway.

Contact health care professional to continue management of patient (urgent/ same day). Call 111 first before urgent care/minor injuries/ extended access GP

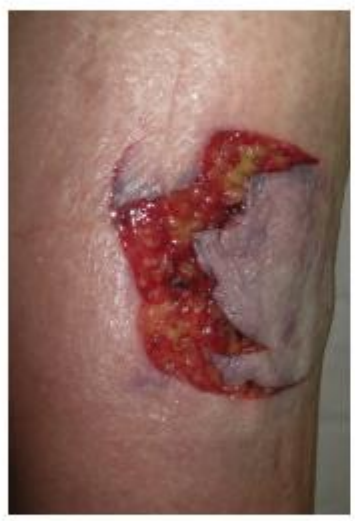
See below for guidance on identifying the skin tear.

Definition of skin tears
A skin tear is a wound caused by shear, friction and/ or blunt force (e.g. after a fall) resulting in separation of skin layers. A skin tear can be full or partial thickness. Example pictures including severity are shown below.

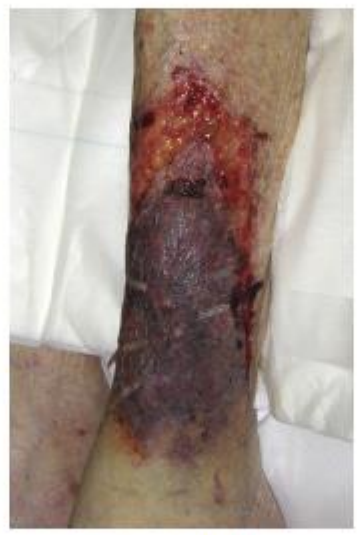
Classifications of skin tears of the lower limb



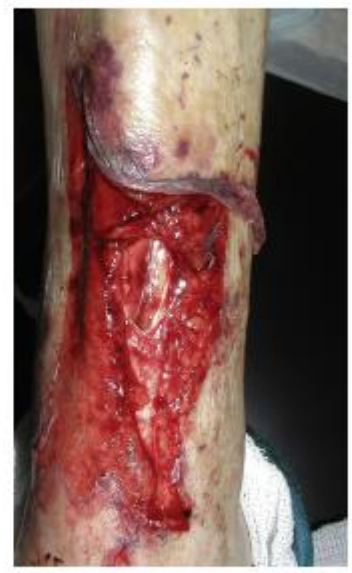
Type 1: linea laceration, no skin loss
Green Flag



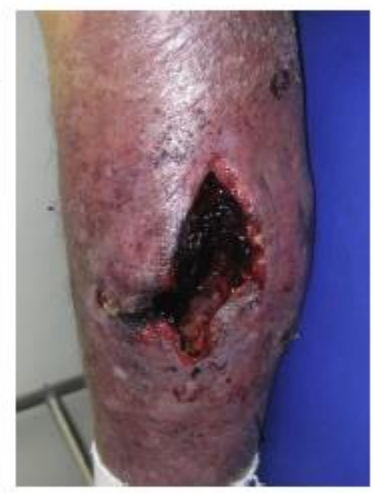
Type 2a: flap laceration, non or minimal skin loss, flap looks viable/ proximal or lateral base
Green Flag



Type 2b: Flap laceration, flap looks non-viable/ distal base
Amber Flag



Type 3a: skin loss
Red Flag



Type 3b: Associated haematoma, associated limb swelling
Red* Flag

Classification and management of skin tear types

Skin Tear Type	Flag Rating	Meaning of Classification	Implication/ Management	Timeframe for referral
Type 3b	Red*	A skin tear with underlying haematoma. The features will be a haematoma (swelling) or an expanding haematoma with tense tissues		3b - ***Refer immediately**
Type 3a	Red	A skin tear where the skin flap is absent, exposing the wound bed. There is no haematoma		3a - Refer ASAP within 24 hours
Type 2b	Amber	A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap is non-viable i.e. colour **is** pale, dusky or darkened	May require surgery if flap non-viable	Refer within 2 days
Type 1 and 2a	Green	2a - A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened	Can treat conservatively with regular dressings - provided it is adequately debrided	May refer to Plastics Dressing Clinic (PDC) for advice during hours (nurse to nurse)
		1 - A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened		

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Green (no injury)

- Conscious and responding as usual
- No apparent injury (apart from type 1 and 2a skin tears)
- No head injury
- No complaints of pain/ discomfort (verbally and non-verbally)
- Mobility unaffected – able to move limbs on command or spontaneously
- No signs of bruising/wounds
- No signs of limb deformity/ shortening/ rotation

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Post Falls Monitoring

Things to monitor post falls:

- Mobility
- Acting normal self
- Any pain
- Acute vomiting
- Acute confusion
- Acute memory loss
- Wellbeing
- Confidence

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The resident may be guided or aided from the floor to a chair or bed

Use your judgement and knowledge of the service user to assess if the person could get up from the floor.

If a person is on the floor for a long time, it increases the risk of:

- Skin breakdown and pressure sores
- Dehydration
- Incontinence
- Hypothermia (low body temperature. Note: if the person feels cold to touch this is a red flag)
- Psychological issues (including distress and fear)

If a person does not have any red flags (see: Red flags assessment), identify if there are any reasons if the person cannot be moved from the floor and where possible, help the person off the floor by either verbally guiding or assisting the person (via usual processes).

When you attempt to move the person, if they are in pain or have difficulty in mobilising (compared to usual) - STOP and call 999.

Once off the floor, ensure the person is comfortable, for example: give the person a blanket, offer them a drink (if they can swallow normally), ensure they are in dry and clean clothes.

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Document Falls record and injures on a body map Commence falls investigation (inc. Safeguarding) if required

Ensure all findings documented

- When and how the person was found
- Any injuries identified
- How long the person was on the floor for
- How they were assisted from the floor e.g. how many people assisted, any equipment used

Follow your organisation's normal safeguarding policy/ procedure

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Update Falls Risk Assessment and manage accordingly

Consult line management
Inform GP
Datix if within scope of your role
Update care home or agency records
Follow organisations post falls protocol or see example protocol for guidance (https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/4-Hampshire%20falls%20protocol.pdf)

See Falls Management pathway – may need referral to falls clinic/ intermediate care team/ postural stability/ Admission avoidance team

Consider the reason for the fall e.g. dehydration or trip hazard, and put a plan in place to mitigate these risks