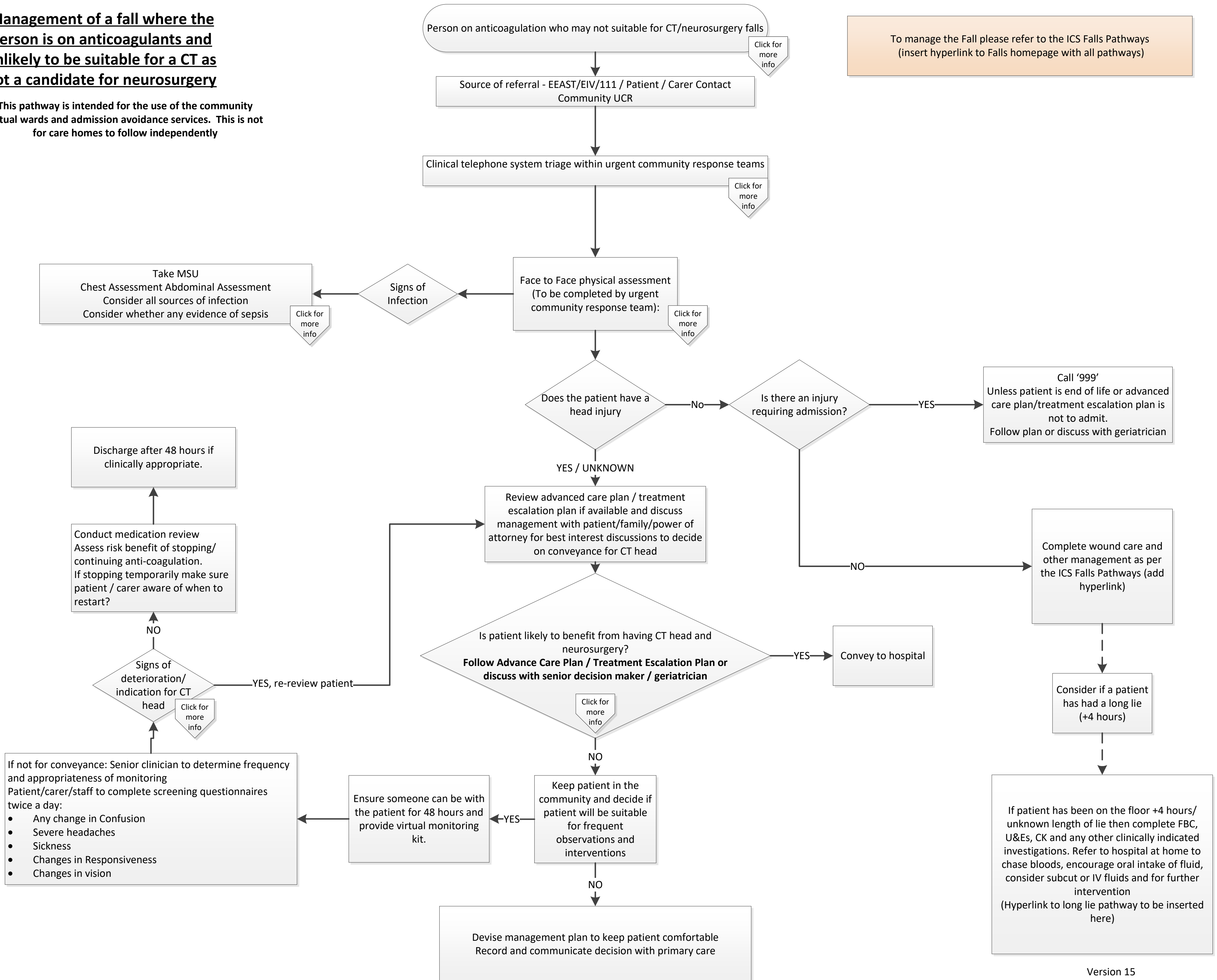

Management of a fall where the person is on anticoagulants and unlikely to be suitable for a CT as not a candidate for neurosurgery
This pathway is intended for the use of the community virtual wards and admission avoidance services. This is not for care homes to follow independently
Person on anticoagulation who may not suitable for CT/neurosurgery falls
Click for more info
To manage the Fall please refer to the ICS Falls Pathways
(insert hyperlink to Falls homepage with all pathways)
Source of referral - EEAST/EIV/111 / Patient / Carer Contact
Community UCR
Clinical telephone system triage within urgent community response teams
Click for more info
Take MSU
Chest Assessment Abdominal Assessment
Consider all sources of infection
Consider whether any evidence of sepsis
Click for more info
Signs of Infection
Face to Face physical assessment
(To be completed by urgent community response team):
Click for more info
Does the patient have a head injury
No
Is there an injury requiring admission?
YES
Call '999'
Unless patient is end of life or advanced care plan/treatment escalation plan is not to admit.
Follow plan or discuss with geriatrician
Discharge after 48 hours if clinically appropriate.
YES / UNKNOWN
Review advanced care plan / treatment escalation plan if available and discuss management with patient/family/power of attorney for best interest discussions to decide on conveyance for CT head
NO
Complete wound care and other management as per the ICS Falls Pathways (add hyperlink)
Conduct medication review
Assess risk benefit of stopping/ continuing anti-coagulation.
If stopping temporarily make sure patient / carer aware of when to restart?
NO
Is patient likely to benefit from having CT head and neurosurgery?
Follow Advance Care Plan / Treatment Escalation Plan or discuss with senior decision maker / geriatrician
Click for more info
YES
Convey to hospital
Consider if a patient has had a long lie (+4 hours)
Signs of deterioration/ indication for CT head
Click for more info
YES, re-review patient
NO
If not for conveyance: Senior clinician to determine frequency and appropriateness of monitoring
Patient/carer/staff to complete screening questionnaires twice a day:
Any change in Confusion
Severe headaches
Sickness
Changes in Responsiveness
Changes in vision
Ensure someone can be with the patient for 48 hours and provide virtual monitoring kit.
YES
Keep patient in the community and decide if patient will be suitable for frequent observations and interventions
NO
Devise management plan to keep patient comfortable
Record and communicate decision with primary care
If patient has been on the floor +4 hours/ unknown length of lie then complete FBC, U&Es, CK and any other clinically indicated investigations. Refer to hospital at home to chase bloods, encourage oral intake of fluid, consider subcut or IV fluids and for further intervention
(Hyperlink to long lie pathway to be inserted here)
Version 15

Back to pathway

Indications of who may not be suitable for neurosurgery

Bedbound
On an end of life pathway
Rockwood greater than 6
Person requiring significant assistance with the activities of daily living
Dementia diagnosis

These are points to consider, however, it is important to take an individual approach this decision. Consider the patients wishes and their past medical history.

This decision is to be made by a senior decision maker within the team

Back to Pathway

Clinical Telephone System – Single Point of Access

- Clinical telephone system triage within SPA to include:
- History of this fall including how long the resident has been on the floor/time of fall/whether they hit their head?

- Assess urinary and bowel symptoms
- History of falls
- History of head injury or bleeds
- Past medical history including recent infection, diagnosis of dementia or cognitive impairment?
- Drug history & allergies
- Is there an advanced care plan (ACP) or treatment escalation plan (TEP) in place and what are the patient's wishes
- Are you able to support the resident off the floor or do you need assistance?

Back to Pathway

Face to Face physical assessment (UCR Team):

Staff member to complete initial assessment against patients baseline as per service policy. However, for this cohort of patients the assessment must include:

- Review subjective history
- Assess for signs of injury
- Assess for signs of infection
- Assess for signs of dehydration
- Assessment of mobility
- Glasgow Coma Scale
- Observations: Heart rate, blood glucose, lying / standing blood pressure (if appropriate), oxygen saturations and temperature.

- Assess for signs of sepsis

- Please note this is not an exhaustive list and clinicians should use their local policy and clinical reasoning to complete any additional assessments.

Back to Pathway

Signs of Deterioration – more information

Any significant change to patients baseline.
Change in GCS
Any change in Confusion
Severe headaches
Sickness
Changes in Responsiveness
Changes in vision

Return to pathway

https://www.nice.org.uk/guidance/ng51/resources/sepsis-recognition-diagnosis-and-early-management-pdf-1837508256709

Sepsis risk stratification tool: people aged 18 years and over out of hospital

High risk criteria

- Behaviour:
  - objective evidence of altered behaviour or mental state
- Respiratory rate:
  - 25 breaths per minute or more **OR**
  - new need for 40% oxygen or more to maintain saturation more than 92% (or more than 88% in known chronic obstructive pulmonary disease)
- Heart rate:
  - more than 130 beats per minute
- Systolic blood pressure:
  - 90 mmHg or less **OR**
  - more than 40 mmHg below normal
- Not passed urine in previous 18 hours, or for catheterised patients passed less than 0.5 ml/kg of urine per hour
- Mottled or ashen appearance
- Cyanosis of skin, lips or tongue
- Non-blanching rash of skin

ANY high risk criteria met

Send patient urgently for emergency care (setting with resuscitation facilities)

Moderate to high risk criteria

- Behaviour:
  - history from patient, friend or relative of new-onset altered behaviour or mental state
  - history of acute deterioration of functional ability
- Impaired immune system
- Trauma, surgery or invasive procedures in the last 6 weeks
- Respiratory rate:
  - 21–24 breaths per minute
- Heart rate:
  - 91–130 beats per minute
  - for pregnant women: 100–130 beats per minute
- New-onset arrythmia
- Systolic blood pressure 91–100 mmHg
- Not passed urine in the past 12–18 hours, or for catheterised patients passed 0.5–1 ml/kg of urine per hour
- Tympanic temperature less than 36°C
- Signs of potential infection:
  - redness
  - swelling or discharge at surgical site
  - breakdown of wound

Can definitive condition be diagnosed and treated in an out of hospital setting?

YES → **Treat definitive condition and/or provide information to safety net**

NO → **Send patient urgently for emergency care (setting with resuscitation facilities)**

Low risk criteria

- Normal behaviour
- No high risk or moderate to high risk criteria met

Provide information about symptoms to monitor and how to access medical care

NICE National Institute for Health and Care Excellence

© NICE 2017. All rights reserved. Subject to Notice of rights.