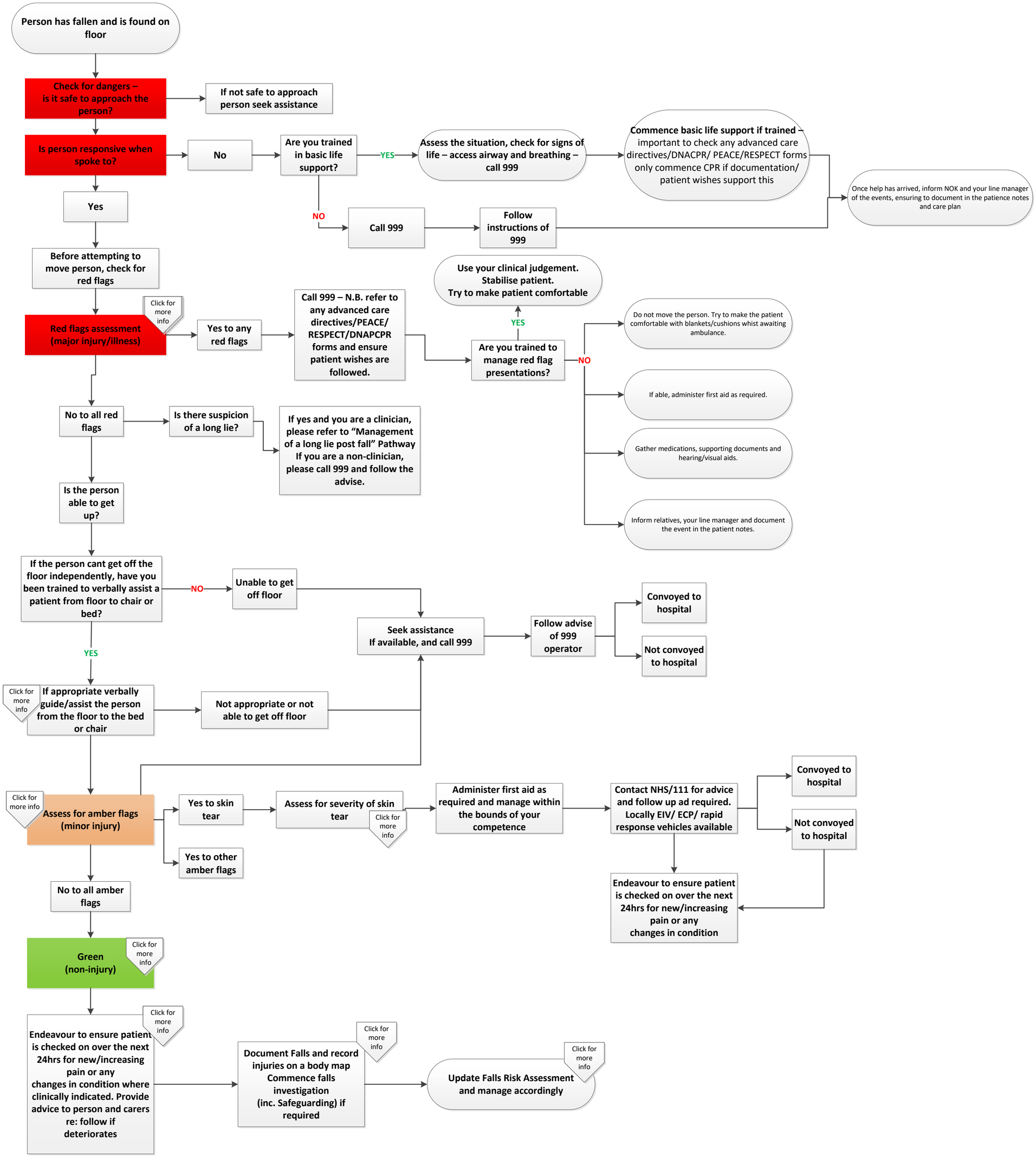
Hertfordshire and West Essex Integrated Care System

Management by a Clinician/Non Clinician of Person who has Fallen in the Community



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Red Flags

Use your clinical judgement, these are indicators of when to call 999

NB: use clinical judgement as to whether safe to move patient*, and perform first aid if 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 'Definition of a skin tear' box in 'Acute, Same-Day Management of Skin Tears by Clinician in the Community
    (for adults)':
  - 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

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

**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.*

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If appropriate verbally guide/assist the person from the floor to the bed or chair

Use your 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 increased the risk of:

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

When you attempt to move the person, if they are in pain or have difficulty in mobilising (Compared to usual) – depending on your clinical competency, escalate as appropriate. If indicated, call 999

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Assess for amber flags (minor injury)

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

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

Manage within your competence and escalate if concerned 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

*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 or fears)

Use your judgement and knowledge of the service user when discovering and unwitnessed fall. For example, if a fall is discovered on the first visit of the day, there is a clear risk that the service user has been on the floor all night. Even if the service user appears uninjured, use your clinical judgement and escalate appropriately. Depending on clinical competency, NHS 111 advice should be sought. It is important to explain that the fall was unwitnessed and the estimated approximate time that the patient has been on the floor.

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Assess for severity of skin tear

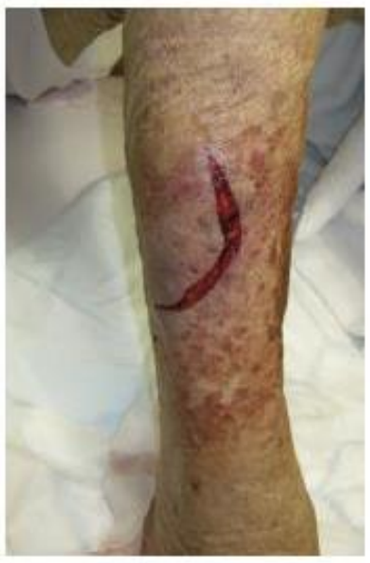
If skin tear is present refer to '*Acute, Same- Day Management of Skin Tear by Clinician in the Community (for adults)'* or '*Acute, Same- Day Management of Skin Tear by Non-clinician in the Community* (for Adults)' depending on your clinical competency

If not competent for managing skin tears, contact a healthcare professional to continue the management of the patient (urgent/same day). Call 111 before urgent care/minor injuries/ extended access GP)

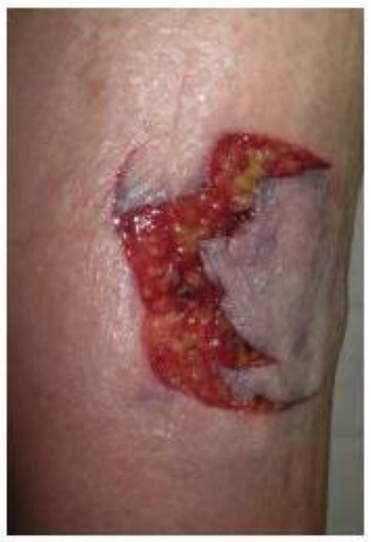
Definition of skin tears

"A wound caused by shear, friction and/or blunt force resulting in separation of skin layers. A skin tear can be partial thickness (separation of the epidermis from the dermis) or full thickness (separation of both the epidermis and dermis from underlying structures)" (LeBlanc and Baranoski, 2011).Example pictures demonstrating different severities of skin tears are shown below.

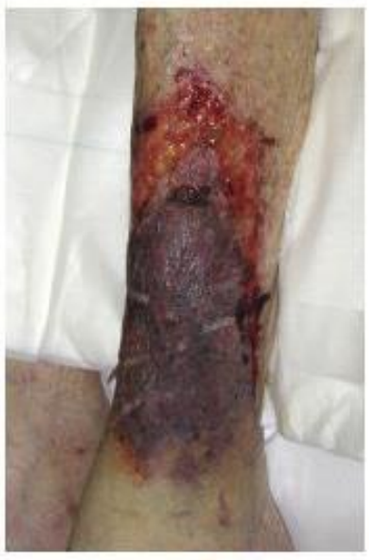
Classifications of skin tears of the lower limb



Type 1: linea laceration, no skin Loss **Green Flag**

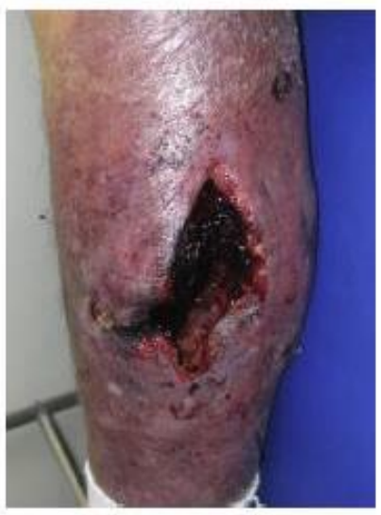


Type 2a: flap laceration, non or minimal skin loss, flap looks viable/ proximal or lateral base
Green Flag



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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Endeavour to ensure patient is checked on over the next 24hrs for new/increasing pain or any changes in condition

24 Hour Observation:

If a clinician cannot provide this themselves, they are advised to utilise any other support available.
Discuss with the person and/or their carer and agree together a plan for checking on them over the next 24hrs (agree this with your senior manager as appropriate).
This could include, but is not limited to:

- Identify if any other care visits or visits from other services are expected
- Use of visits later in the day
- Identifying friends, family or neighbours who could visit the service user or may choose to contact them via telephone to check on wellbeing.
- Use of tele-healthcare, if installed
- Remind the service user to use assistive technology e.g. pendant alarm as required
- Consider use of other services including the VCSE (Voluntary Community Social Enterprise) sector

Provide advice and give leaflet to the person who has fallen about signs and symptoms to be aware of and advise them to call NHS 111 if concerned or 999 in an emergency

- **If there are any changes in the service users condition causing concern, follow local escalation processes and manage within your competency. Consider calling NHS 111 or Contact 999 in an emergency**

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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

Ensure the following are completed. Some of these actions may be completed by your line manager:

- Inform your line management
- Inform NOK or care agency
- Contact the patient's GP and update
- Update organisation records
- Make any onward referrals to falls clinic/intermediate care / postural stability / admission avoidance team as
- per falls management pathway Consider safeguarding

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Update Falls Risk Assessment and manage accordingly

- Consider, can the person do what they did before or do they require more support (i.e.. Social care, meals on wheels)
- Full set of clinical observations, review falls risk and assessment, review mobility
- Consider Advance Care planning decisions (if in place)
- Consider patient choice and inform next of kin if appropriate
- Inform GP
- Document in patient records/ Datix
- See Proactive Management of Person at Risk of Falls in the Community – May need referral to falls clinic/immediate care team/ postural stability

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