Procedure for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

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1. Falls in Hospital

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo.

[Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

Falls are a common problem in hospitals and are associated with significant morbidity and mortality. Hospital inpatients, particularly older people are at increased risk of falls, largely because of their co morbidities rather than by virtue of advanced age alone.

Consequences of hospital falls include injury, depression, and loss of confidence, loss of functional ability and increased length of stay. The most significant injuries are fractures, especially fractured neck of femur, which can be devastating for the individual. A small number of patients die each year in hospital as a direct result of a fall.

Falls which occur in hospital cause distress to patients and can result in anxiety amongst relatives. Falls are a source of complaints that can relate to the injuries sustained, the distress caused, or to communication issues surrounding the circumstances. Staff may feel guilty and demoralised. It is vital therefore that a standardised approach to the management of falls is in place, so that staff are supported in managing falls risk, and patients, relatives and carers can be informed of the steps taken to prevent falls and ensure patient safety.

Risk factors for falling include unsteadiness, muscle weakness, a previous history of falls, poor vision, cognitive impairment, urinary incontinence, poly-pharmacy, postural hypotension, delirium and environmental hazards. It is recognised that acute illness in older people can lead to worsening of gait problems, increased confusion and unsteadiness. On occasion, a fall may be the only presenting feature of such an acute illness. A fall in hospital may be the first sign that a patient has acutely deteriorated. Those who have a history of substance misuse have an increased risk of falling. The interaction between risk factors is complex and a multidisciplinary review to address prevention is required.

Published evidence no longer recommends using falls risk prediction tools (NICE 2013), however Care Bundles based on multi-factorial falls assessment followed by multidisciplinary intervention, tailored to the individual should be initiated (Falls Safe Quality Improvement Project RCP 2013).Components of the multidisciplinary intervention are nursing, medical, physiotherapy, occupational therapy and pharmacist .Other useful interventions include optometry, podiatry and bone health services.

2. Evidence Base:

Published evidence supports multidisciplinary assessment of risk factors and targeted interventions to reduce or reverse these risks. There is a small body of evidence from randomised controlled trials in older people in a variety of hospital settings which supports this. The best evidence for falls prevention comes from community studies with generally healthier, fitter individuals. In hospital settings the studies are difficult to compare as they are heterogeneous however some studies mainly in Medicine of the Elderly wards have reported up to a 30% risk reduction of falling using this approach. These studies looked at wards with no prior falls risk strategies in place. More recently the patient safety literature supports a methodology using high impact actions to prevent falls in a hospital setting which may be effective in reducing harm rather than overall falls rates. There are no long term studies of these interventions as yet to support them in terms of sustainability. (Appendix 1)

3. Identification and Assessment of those at Risk

All adult patients should have the falls bundle (see page 4) for inpatients commenced as soon as possible on admission and at least within 24 hours of admission to the ward or department. This includes the following:

- Assess whether falls risk is considered likely at this admission. If deemed not relevant at this time a rationale **must** be provided, otherwise continue to complete 5 questions
- Complete and document the screen for more vulnerable patients (5Qs) see below

The 5Qs (if answers "yes" to any of the five questions, the patient is identified as "more vulnerable" to falling):

1. Has the patient had a fall in the last 6 months – including during this admission?
2. Does the patient have an AMT less than 8 (or 4AT greater than 0) or acute confusion (delirium)?
3. Does the patient attempt to walk alone although unsteady or unsafe?
4. Does the patient or their relative/s have fear or anxiety re falling?
5. Based on your clinical judgement, is this patient at high risk of falling?

Follow the flowchart below
Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/FallsBundle.aspx

NHS Lothian

Complete 5Qs Falls Assessment Screening Tool for ALL Patients

Falls Bundle for ALL Patients (where to find the information)

1. Mobility Assessment (Risk Assessment)
2. Walking aid within reach (Care Rounding)
3. Call bell in reach and working (Care Rounding)
4. Appropriate footwear (Care Rounding)
5. Glasses and Hearing aid available and used if required (Care Rounding)

If the patient is **more vulnerable to falls** (including all patients in care of the elderly wards)

Safety Bundle for patients more vulnerable to falls

MDT Assessment & Intervention Bundle

Falls Safety Bundle
For patients more vulnerable to falls

1. Communicate mobility and transfer status (Safety Brief, Falls Display Sign)
2. Chair and bed height consistently at best height (Care Rounding)
3. Identify patients with cognitive impairment and/ or poor mobility and known not to ask for assistance
4. Clearly document intensity of observation required e.g. positioning of bed; cohorting of 'at risk' patients; 1:1 observations; care rounding
5. Complete Bed Rail Assessment

MDT Assessment & Intervention Bundle

For patients more vulnerable to falls

1. Complete cognitive impairment assessment
2. Complete bladder and bowel assessment
3. Lying and Standing blood pressure
4. Medication review
5. Multidisciplinary review

† In addition to bundle components 1-4 this includes a falls history , (including causes and consequences such as injury and fear of falling), health problems that may increase their risk of falling, postural instability, mobility problems and/or balance problems, syncope syndrome, visual impairment and assessment of fracture/osteoporosis risk.

If assessment identifies risk a care plan must be completed, with regular review, indicating if any of the above cannot be completed and reason why.

4. Falls Risk Assessment

It is recognised that acute illness in older people can lead to worsening of gait problems, increased confusion and unsteadiness. On occasion, a fall may be the only presenting feature of such an acute illness. A fall in hospital may be the first sign that a patient has acutely deteriorated. The interaction between risk factors is complex and a multidisciplinary review to address prevention is required.

Published evidence recommends risk assessment followed by multidisciplinary intervention tailored to the individual. Components of the multidisciplinary intervention are nursing, medical; physiotherapy, occupational therapy and pharmacist .Other useful interventions include optometry, podiatry and bone health services.

It is important to identify any concern with the patient's balance, mobility, nutritional status, continence issues or confusion through individual assessment as these factors contribute to falls risk. Acute and chronic conditions can also impact on a person's falls risk and should also be considered when making a clinical judgement about a person's risk of falls when in hospital.

Risk factors identified for patients who fall are listed below. These include multiple co morbidities. The more risk factors an individual has, the greater the risk of a fall with associated harm. A serious injury e.g. hip fracture may occur if the individual also has osteoporosis.

Acute illness
History of previous falls e.g. previous admissions with fall or fracture
Cognitive impairment: delirium (acute confusion) or dementia
Bladder and bowel dysfunction
Postural hypotension
Unsteadiness or gait problem from any cause
Polypharmacy (4 or more drugs) especially psychotropics/sedatives
Inappropriate foot wear or foot problems
Lower limb weakness or joint disease
Cardiac disease e.g. arrhythmia or aortic stenosis if syncope is suspected
Neurological disease e.g. Stroke, Parkinson's/peripheral neuropathy
Visual impairment e.g. cataracts, macular degeneration, poor glasses
Age>75

5. Management of patients at risk of falls

Patients who are identified as at risk of falling require to be identified at the ward safety brief and may be escalated at the site safety huddle. A safety bundle should be initiated and a person centred plan of care completed with input from the patient, and if appropriate, their relatives. Falls prevention information should be provided on admission and relatives / carers encouraged to actively participate in minimising the risk of falls (See Appendix 2 & 3)

Staff should identify communication needs and provide appropriate support to enable this risk assessment to take place. For translation assistance please click on link below: http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/translationinterpretationandcommunicationsupport/Pages/default.aspx

Actions taken will vary from individual to individual depending on their risk factors. Some risk factors may not be modifiable but should be identified and acknowledged. Patients and families should take an active role in care planning to ensure that it is person centred. (Appendix 4)

Patients identified at risk of falling should have a multidisciplinary assessment and intervention bundle completed and documented management plan completed.

1 Patients identified at risk of falls should be identified at the ward safety brief/ huddle, patient at-a-glance board or, if agreed, by a sign by the bed-side

2 For patients admitted due to a fall or collapse, or who have a history of falls, first line management requires a medical review in order to establish whether there is an acute illness. This will include a history, full physical examination and medication review.

3 A medication review is also vital if the patient is found to have significant postural hypotension (defined as a drop of 20mmHg or more in systolic BP +/ minus a drop of 10mmHg in diastolic). BP measurements should be repeated if patients experience light-headedness on standing, as blood pressure varies throughout the day. Culprit medications should be reviewed and it may be appropriate to withhold them until the patient improves or discontinue altogether. There should be a documented plan of care for any multidisciplinary assessment and intervention within the patient's record.

4 Anticoagulation with heparin or warfarin may not be safe in an individual with recurrent falls, particularly if they sustain a head injury. Ward teams should seek pharmacist’s advice.

5 Vision corrected: If reversible visual problems are suspected such as poor glass prescriptions, or cataracts then an ophthalmology review may be indicated.

6 Active treatment and investigation of any cardiac problems such as arrhythmia is important if syncope is suspected as the cause for the fall.

7 Treatment of specific neurological or joint disease (where possible).

8 Ensure patients have appropriate footwear and access to podiatry

9 Physiotherapists assess gait, posture and mobility aids, and provide strength and balance training. Exercise programmes have been found to be the most effective interventions in randomised controlled trials and ones targeting these specific areas e.g. OTAGO strength and retraining programme should be prescribed. Staff should ensure that the patient is as mobile as possible according to management plan

10 Occupational therapists assess risk of falls and environmental hazards when engaging in everyday functional tasks with patients e.g. transfers and personal care. If problems are identified appropriate modifications and equipment can be provided.

11 If osteoporosis is suspected (e.g. previous history of fracture or obvious spinal vertebral deformity such as kyphosis) DEXA scanning and bone protection therapy should be considered.

12 Information should be provided about the process of risk assessment and management to relatives and carers. A leaflet is available for this purpose for inpatients and written information should be displayed on the wards

6. Patients with Delirium (Acute Confusion) or Dementia

Patients who are confused are one of the largest groups of individuals at risk of falls within the hospital setting because of their reduced safety awareness. Confusion, whether acute (secondary to an acute illness i.e. delirium) or chronic, (secondary to dementia) should be screened for using the 4AT, or if a fuller screening is required, a Mini-Mental State Examination (MMSE). It is essential to establish a collateral history from carers and relatives to try to determine if the problem is acute or chronic.

If delirium is suspected it is imperative to initiate investigation of triggers and commence treatment of underlying causes

http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGuidance/General/Delirium%20Pathway.pdf

Patients with dementia or delirium can become disorientated when in an unfamiliar environment increasing their risk of wandering. This combined with poor safety awareness makes these individuals particularly vulnerable. It is important to ask whether the patient has a diagnosis of dementia, whether these episodes have occurred before and under what circumstances.

These individuals require careful management with regular orientation and nursing in a well-lit environment. Medical problems such as urinary retention, constipation, pain or sepsis should be considered, particularly in patients who are unable to communicate the source of their distress.

In order to reduce the risk of injury, the bed can be lowered nearer the floor. Sedatives should be avoided if possible as they often worsen unsteadiness and can cause paradoxical agitation. Risk assessment and nursing / multifactorial interventions should be employed to help reduce the risk of falling

If the patient is identified as at risk of falls but also requires supervision to ensure safety it is appropriate to consider the patients individual needs and increase the frequency of care rounding to accommodate this. It may be necessary to provide supervision whilst the patient is in the toilet and/ or bathroom and this must be carried out whilst preserving their dignity and privacy as much as possible.

Use of the “Getting to know me” document will help to provide useful personal information for staff to provide person centred care.

An assessment of patient’s capacity should be made in order to determine whether treatment should be carried out under the guidance of Adults with Incapacity Act and if uncertain, psychiatry advice should be sought. This is particularly important if considering the use of falls sensors, bed rails or wander guard. Staff can also refer to the Safe and Effective use of Bed Rails policy.

7. Patients requiring Increased Supervision

An increased risk of falls may require the person to be placed in an observable area e.g. near the nurses’ station.

A consideration may be to co-hort the person into a multi-bedded room and ensure that a member of staff is always present to assist.

If the person is showing signs of stress or distress then a systematic approach to identify the cause is recommended to help identify possible trigger. Challenging behaviour – a systematic approach to assessment

All other alternatives should be considered before requesting 1:1 observation. Please see (Appendix 5)

If 1:1 care is provided then an hourly summary of the person's presentation must be recorded.

1:1 care should be assessed every 24 hours by the multi-disciplinary team (if possible) and stepped down as soon as the person's safety has improved.

8. Management of a fall within a Hospital Setting

All staff must ensure that the Incident Management Policy is followed and the incident recorded on DATIX, ensuring that the rating of severity of harm follows the definitions as defined in the policy.

Post fall bundle

- The person should not be moved until they have been checked for signs and symptoms of fracture or potential spinal injury. The top to toe assessment should be completed and documented
- Safe manual handling methods must be used if there are any signs and symptoms of fracture or potential for spinal injury
- Where head injury has occurred or cannot be excluded (e.g. un-witnessed fall) neurological observations must be recorded and the frequency and duration documented, based on medical guidance
- Medical examination should take place within agreed timescales following a fall especially those with a high vulnerability to injury, or who have been immobilised due to injury
- Conduct a post fall review / rapid root cause analysis to learn how further falls can be prevented for the person and for wider learning

Please refer to the Post-falls flowchart (Appendix 6),

What to do if a patient falls:

1 The staff member who witnesses the patient fall or finds the patient on the floor should assess responsiveness. If unresponsive, open airway and look for signs of life. If no signs of life call cardiac arrest team and perform CPR according to current guidelines. If responsive ask about pain, assess for injury, consider first aid and how best to assist the individual off the floor. The patient should be reviewed according to the NHS Lothian **ABCDE** assessment which assesses airway, responsiveness, breathing, circulation signs of injury and exposure due to injury. This is particularly important prior to moving the patient and if a spinal injury is suspected a spinal board or advice re this must be sought. It is also important to assess the environment of the fall to ensure it is safe.

2. A 'Top to Toe' assessment should be performed by staff to confirm signs of injury. This assessment can be performed by nursing staff if confident and trained or by medical staff. The top to toe examination should be documented in full in the case notes and analgesia should be given as required.

3. If a head injury occurs, or is suspected in an un-witnessed fall, neurological observations should be commenced immediately. The Glasgow Coma scale marked out of 15 should be used as standard. The doctor should be informed immediately.

4. All falls should be reported to the medical staff and they should review the patient as soon as possible, especially if there are obvious signs of injury or if nursing staff are concerned. If no injury is present and the top to toe has been performed the doctor (or HAN team if out of hours) should be informed at the time. An immediate review may not be available in which case the medical and nursing staff must arrange assessment within 12 hours if deemed safe and appropriate to do so.

5. The individual's next of kin should also be contacted about the incident as soon as possible and the situation explained. The nursing staff should complete the DATIX form and note the incident number for investigation by the charge nurse. The outcome of any assessment should be recorded fully in patient's case notes. If a patient sustains a serious injury their treating consultant should also be notified.

6. DATIX recording should include details of the circumstances of the fall and actions taken. All falls which involve harm are subject to incident investigation and if a fracture or death occurs they are reviewed by senior management teams. This is important to ensure safety and enable reflective practice so that lessons may be learned.

7. If not previously noted to be a falls risk, then place falls risk notice above the bed, institute nursing care plan and multidisciplinary falls risk assessment and interventions should be initiated and documented. Information and advice on reducing falls risk should be given to patient and relatives.

9. Discharge from Hospital

Upon discharge from hospital, information will be provided by relevant members of the multi-disciplinary team to inform the person and/ or other healthcare providers, how to help prevent further falls and phone numbers provided for services in the community setting.

Appendix 1: References

Many guidelines exist about falls prevention, and some of the best evidence for prevention of falls in the hospital setting is cited below:

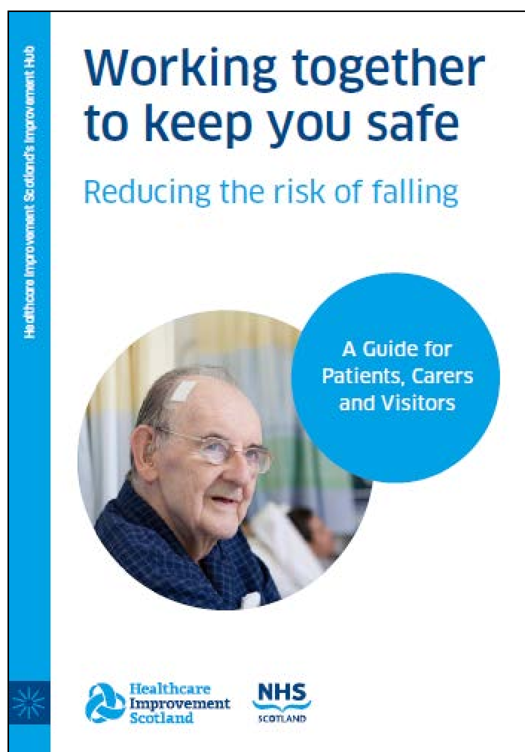
1. National Patient Safety Agency *Slips, trips and falls in hospital*, London, 2007 NPSA www.npsa.nhs.uk
2. National Institute for Health and Clinical Excellence. *Falls: assessment and prevention of falls in older people. Clinical guideline 161 (2013)* Available at: www.nice.org.uk/guidance/CG21/Guidance/pdf/English
3. Department of Health. *The National Service Framework for Older People. (2001)*
4. Haines TP, Bennell KL, Osborne RH, Hill KD. Effectiveness of targeted falls prevention programme in sub acute hospital setting: randomised controlled trial. *BMJ 2004;328*:
5. Healy F, Monro A, Cockram A, Adams V, Heseltine D. Using targeted risk factor reduction to prevent falls in older hospital inpatients: A randomised controlled trial. *Age and Ageing 2004; 33:390-5*
6. Oliver D et al. Risk factors and risk assessment tools for falls in hospital inpatients; a systematic review. *Age and Ageing. 2004;*33:122-130
7. Fonda D, Cook J, Sandler V, Bailey M. Reducing serious falls-related injures in hospital. *Med J Australia 2006;184:379-382*
8. Cameron, I.D. et al., 2010. Interventions for preventing falls in older people in nursing care facilities and hospitals (Review). Cochrane Database of Systematic Reviews
9. NHS Quality Improvement Scotland (2010) Up and About pathways for the prevention and management of falls and fragility fractures, Edinburgh: NHS QIS
10. Scottish Executive. Coordinated, integrated and fit for purpose. A delivery framework for adult rehabilitation in Scotland. 2007
11. American Geriatrics Society, British Geriatrics Society, American Association of Orthopaedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society. 2011*
12. Management of Hip Fracture in Older people Sign Guideline 111 (2009)
13. Vassallo M, Poynter L, Sharma J et al. Falls risk assessment tools compared with clinical judgement: an evaluation in a rehabilitation ward. *Age and Ageing 2008;37:277-81*
14. Royal College of Physicians (2012) Implementing fallsafe: Care bundles to reduce inpatient falls London https://www.rcplondon.ac.uk/projects/falls-prevention-hospital

Appendix 2: Patient and carer leaflet and signage

Falls Prevention in Hospital Leaflet

A Patient information leaflet was developed to support the Falls Prevention work and is available via the link below:

http://www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/falls_prevention_leaflet.aspx



Falls Risk Sign

Please display the falls risk sign below in a place where it can be seen by staff and visitors e.g. behind the bed. These signs should be used for patients determined as at risk using the falls risk assessment tool. The signs should be reproduced in a format that is easy to wipe clean. They are available on the intranet at the link above.

Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Fallsrisksignsandinformationposter.aspx

Appendix 3: Falls risk information poster

Falls Risk Information Poster

Information for Patients, Carers and Visitors

This information is written to help reduce the risk of falling whilst in hospital

Why people are at risk of falls

We know that some people fall whilst in hospital. This may be as a result of the illness or injury that brought them into hospital, the medicines they take, being confused, or as a result of losing their confidence. Even people who have never had a fall before can be at risk because of these problems

What we will do

All patients have a falls assessment completed on admission to the ward to identify their falls risks. If they are identified as being at risk of falls a care plan will be commenced to help reduce the risk of falling whilst in our care

Patients are advised to

- Listen to the advice about moving around given by the ward staff.
- Ask for help by using your call bell
- Take your time when moving and get up slowly
- Keep everything within reach and don't stretch
- Use walking sticks or frames in the way the physiotherapists tell you
- Make sure your shoes or slippers are non-slip, well fitting and in good repair

Carers are advised to

- Tell staff anything you think is important – relating to falls risk
- Tell staff if you have any concerns about your relative
- Tell staff about spills, trailing cables or anything untidy
- Make sure the patient area is clear and put chairs back before leaving
- Make sure your relative knows you are leaving
- Take any unnecessary things home to stop clutter
- Make sure your relative can reach the call bell

Remember

The advice is reviewed regularly and updated as you (or your relative) improve. If you are unsure of what to do, please ask a member of staff

Unfortunately it is NOT possible to prevent all falls in hospital. We will stick to the patient's wishes, or act in their best interests if they are unable to communicate their wishes

By clearly identifying people who are at risk, everyone involved in their care, including you, can help. If you see anyone on the ward who looks unsafe and might fall please alert a member of staff as quickly as possible

An information leaflet is available, please as a member of staff.

DRAFT V6 April 2017

Appendix 4:Nursing Care Plan - Example

Person centred Care Plan - Falls Risk Assessment

Field	Entry
Patient's function/ability prior to admission	Demo's daughter states that Demo has "not been on her feet for months". Demo had a fall on 3/7 and reportedly injured her back.
Date identified	20.07.16
Problem / Need	Demo is very unsteady on her feet and has difficulty mobilising. Demo was observed attempting to mobilise by herself. Physiotherapy assessment completed and falls sensor in place to alert staff to Demo attempting to mobile without assistance.
Desired outcome	Promote a safe environment for Demo with ongoing supervision and support. Staff will offer assistance with all mobilising to encourage Demo to mobile safely.
Review timescale	Daily
Nursing / Patient action (Agreed action)	Demo is identified as falls risk, all staff to ensure well fitted footwear. Demo will be offered assistance hourly though Care Rounding. Demo has agreed to supervision and understands the rationale, Demo is not to be left unsupervised while in the toilet/bathroom.
Outcome (How successful was it?)	Demo does not use her call bell to alert staff to need and attempts to walk unaided. Therefore supervision and one hourly Care Rounding is to continue. Falls risk to be reassessed daily to identify learning and try to further reduce Demo's risk of falling.
Date completed	

Consider:
Communication / discussion of mobility status to MDT
What information does the patient and their family require?
Observation and positioning of bed space / surrounding area
- Identify factors impacting on risk of falls or need for bedrails, such as dementia, visual impairment or confusion levels
- Is mobility risk associated with toileting needs
- Review of medication
- Lying / standing BP advised?

Reason excluded

User JP69

Password *******

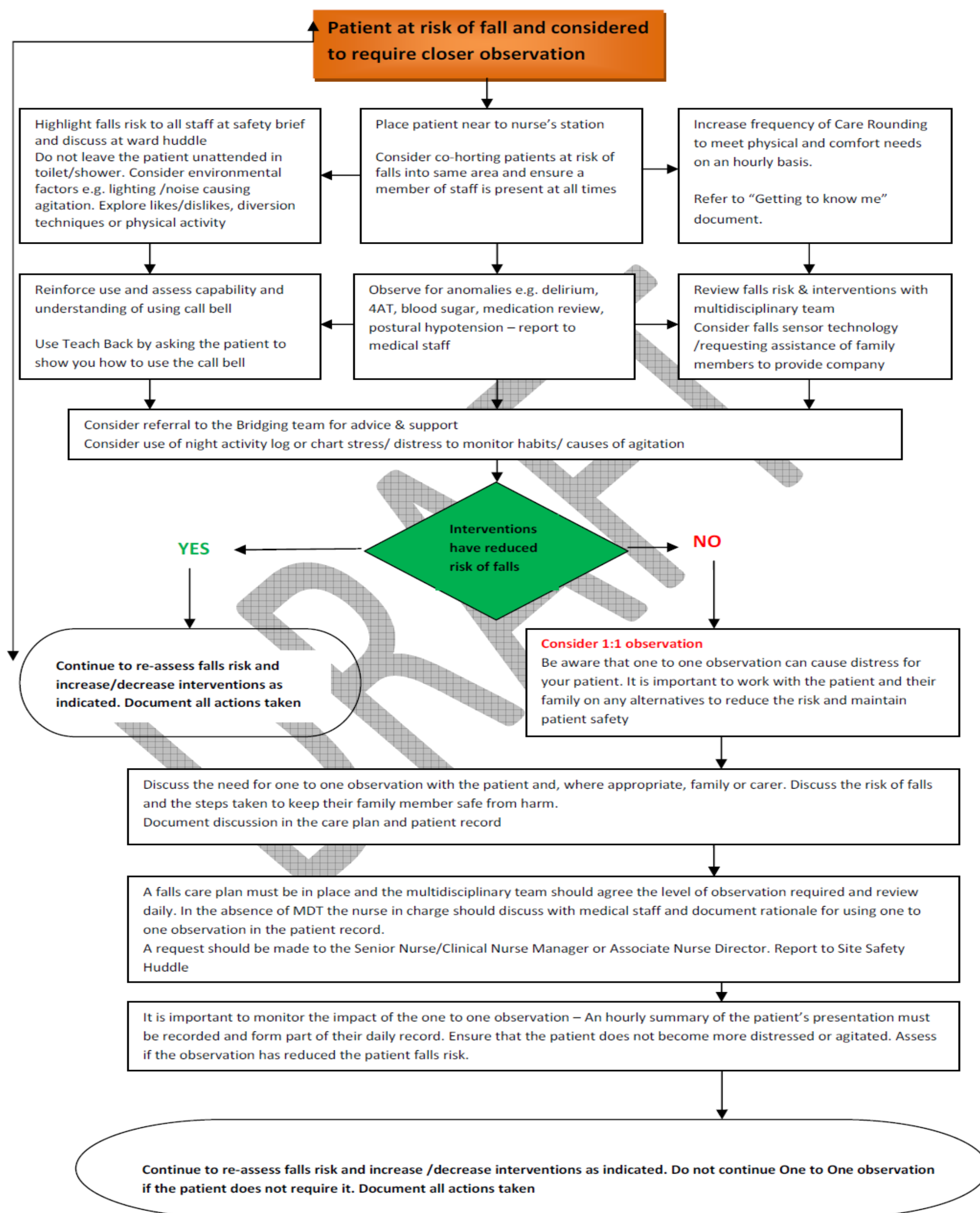
Update

Edit History

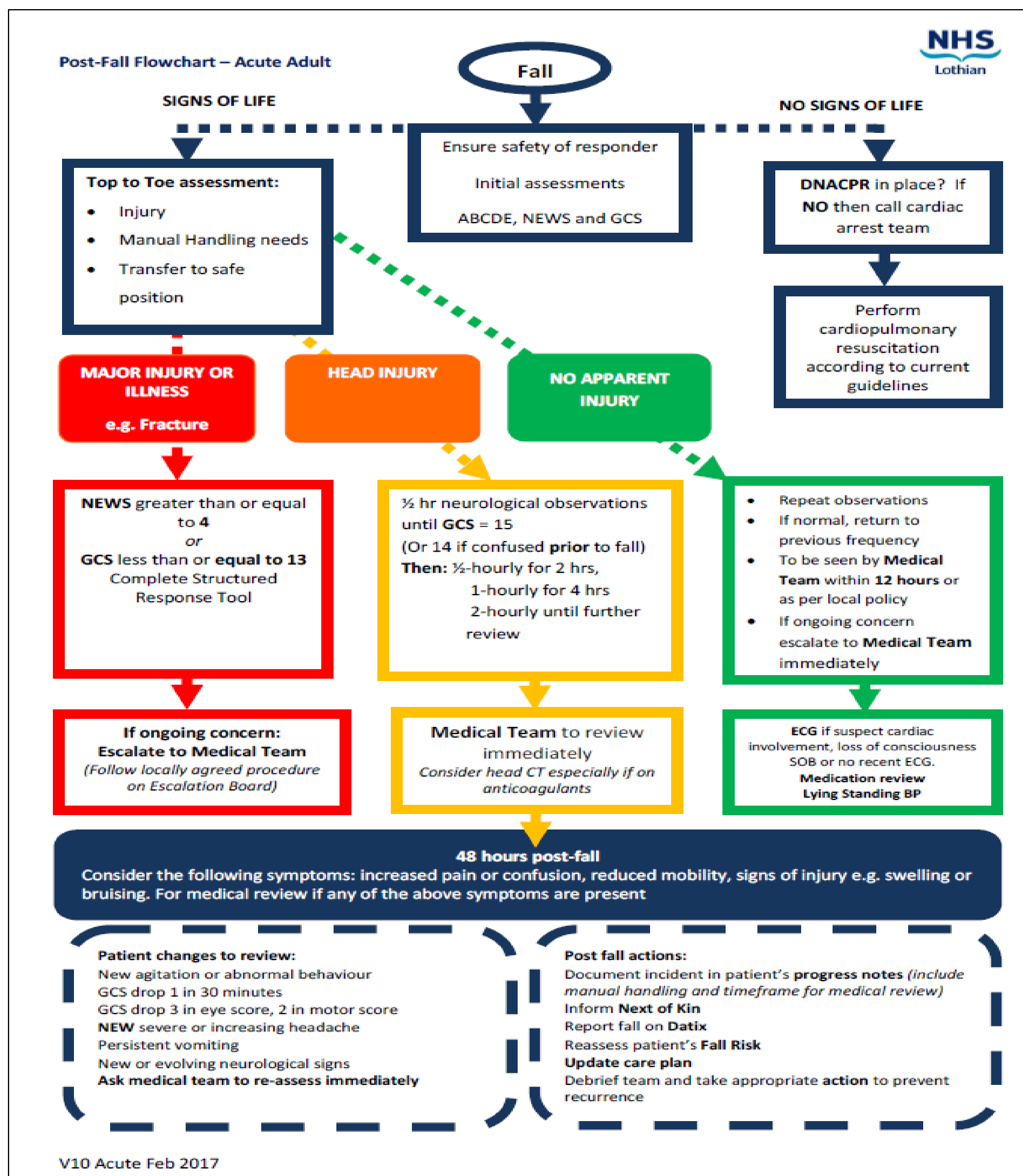
Last Update User
Last Update Date
Last Update Time

Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/Documents/Falls%20Care%20Plan%20-%20MOE.pdf

Appendix 5: Observation Pathway for Falls Prevention



Appendix 6: Post-Fall Flow Chart



Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Postfallcareinhospital.aspx

Appendix 7: NHS LOTHIAN ABDCE Assessment for the Deteriorating Patient

ABCDE Assessment

	ASSESS	POSSIBLE ACTIONS
AIRWAY	**Is the Airway –** ▪ **PATENT** ▪ **AT RISK** ▪ **OBSTRUCTED**	→ Suction if indicated, → Head positioning, → Airway adjuncts, → Administer oxygen, → Call 2222 if at risk.
BREATHING	▪ Respiratory rate ▪ Spo2 ▪ Accessory muscle use ▪ Noises+/- Percussion, Palpation & Auscultation ▪ Position/posture	→Administer high flow O2 (NB: caution with type 2 Respiratory failure), → Summon help → Monitor SpO2/ABGs → Treat underlying cause, → Call 2222 if not breathing.
CIRCULATION	▪ Pulse ▪ Blood pressure ▪ CRT ▪ Core temp/colour ▪ Urine output ▪ Conscious level ▪ Other losses i.e. drains	→ Obtain IV access, → Administer O2, → Summon help, → Prepare fluid challenge, → Initiate Fluid Balance Chart → Call 2222 if no circulation
DISABILITY	▪ AVPU/GCS, ▪ ABG's & treat Hypoxia or Hypovolaemia, ▪ Blood glucose ▪ Drugs.	→ Bedside blood glucose → Check drug chart → Assess pupils → Nurse in lateral position → Summon help
EXPOSURE	▪ Top to Toe examination, ▪ Look for evidence of blood loss / rashes / drains / wounds etc, ▪ Temperature	→ Control bleeding → Treat any underlying conditions identified → Temperature control → Reassess → Maintain patient's dignity

Remember:

To record <u>all</u> observations on NEWS chart & document <u>any</u> deterioration in the notes.

If at any point during your assessment you are concerned about your patient **- Call for help.**

Appendix 8: 'Top to Toe' Survey

<table>
<tr><td>Skull</td><td colspan="2">Scalp wound / haematoma
Depression / ridge in skull</td></tr>
<tr><td>Eyes</td><td colspan="2">Pupils- ? Equal and react to light</td></tr>
<tr><td>Ears</td><td colspan="2">Discharge / bleeding</td></tr>
<tr><td>Nose</td><td colspan="2">Discharge / bleeding</td></tr>
<tr><td>Skin</td><td colspan="2">Colour
Laceration / graze
Bruising
Bleeding</td></tr>
<tr><td>Mouth</td><td colspan="2">Bitten tongue /dislodged teeth or dentures</td></tr>
<tr><td>Neck</td><td rowspan="2">Tenderness
Tingling or weakness in the limbs</td><td rowspan="2">If concerns over neck or spinal injury do not move</td></tr>
<tr><td>Spine</td></tr>
<tr><td>Chest</td><td colspan="2">Difficulties breathing
Collarbones / ribs</td></tr>
<tr><td>Abdomen</td><td colspan="2">Tenderness</td></tr>
<tr><td>Pelvis</td><td colspan="2">Pain on pressing over hip/ groin
Blood in urine / catheter</td></tr>
<tr><td>Arms</td><td colspan="2" rowspan="2">Deformity
Joint movements – range and pain</td></tr>
<tr><td>Legs</td></tr>
</table>

Remember not to mobilise any patient in whom you suspect a spinal injury without the use of a spinal board. Summon help if unsure about manual handling.

Document and record any injuries and if fracture suspected order x-rays immediately once patient is stable. If concerned at any point summon help.

Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Postfallcareinhospital.aspx