



Falls management in a care home

Dear readers,

Welcome to “Clinical Matters” a monthly clinical update. Each month we will cover a different clinical topic. This month’s update is on: Falls management in a care home. And remember *“Falls can be prevented except when falling in love”*

I hope you enjoy this update and find it informative. If you have any questions please feel free to contact myself at clinicalnursingofficer@h1healthcare.com.

Kindest regards

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DEFINITIONS

FALL:

A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

ACCIDENTAL FALL

A slipping, tripping or other mishap generally related to environmental factors

ANTICIPATED PHYSIOLOGICAL FALL

Falls that occur with patients that are identified as at risk of falling.

UNANTICIPATED FALL

Attributed to physiological causes but are created by conditions that cannot be predicted before the first occurrence

INTRINSIC CAUSES

1. Ageing process (risk increases over 65yrs)
2. Poor mobility
3. Cognitive impairment / confusion/ agitation
4. Continence problems
5. History of falls
6. Medical conditions
7. Sensory deficits (vision, hearing, sensation)
8. Poor nutritional status
9. Emotional distress / depression

EX INTRINSIC CAUSES

1. Medication known to affect balance/cognition
2. Polypharmacy
3. Lack of exercise
4. Environmental hazards (steps, stairs, worn carpets, rugs etc)
5. Inappropriate nutrition

AFTER FIRST FALL

- Assess signs of injury Consider moving to a safe place
- Refer to medical staff
- The multidisciplinary team should be alerted
- An Incident/Accident form must be completed
- A falls risk assessment Risk Assessment Tool
- Update mobility moving and handling Risk Assessment
- Relatives to be informed at earliest opportunity

AFTER SECOND FALL

- Assess the patient for injury
- A safe place
- Referred to medical staff
- The multidisciplinary team should be alerted
- An Incident/Accident form must be completed
- Update mobility moving and handling
- Risk Assessment
- Falls Map for a period of seven days
- Relatives to be informed
- Referral to Falls Co-ordinator

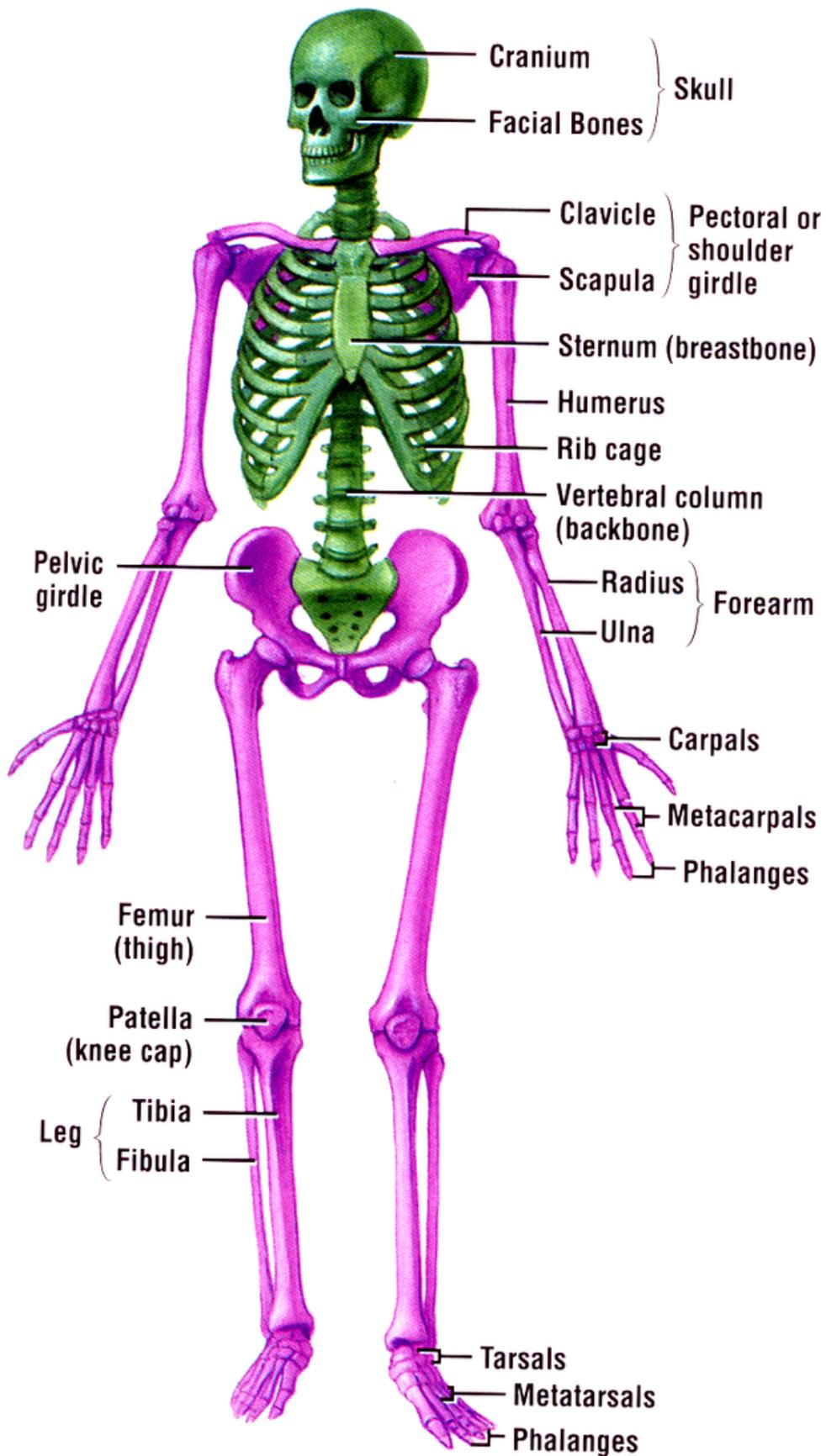
CORE SAFETY PRECAUTIONS FOR ALL PATIENTS

- Ensure buzzer is working and within reach at all times
- Explain the importance of summoning assistance
- Ensure the patient's chair is suitable
- Discuss the patient's walking ability with them
- Ensure that the patient's walking aid (if used) is within reach
- Ensure the bed is always lowered to a level to suit the patient
- Assess that the patient's environment is free of hazards
- Ensure personal effects are within easy reach
- Check footwear/clothing are not ill-fitting

NURSING DOCUMENTATION

- Falls Risk Assessment and Care Plan
- Falls Map - 7 Day Assessment Chart
- Lying and Standing Blood Pressure record
- Mobility Risk Bedside Card
- Occupational Therapy In-patient Falls Referral
- Physiotherapy In-patient Falls Referral
- Care home policy and procedure

HUMAN SKELETON POSSIBLE FRACTURE LOCATIONSE



DEFINITION:

A fracture is a break or crack in a bone.

Considerable force is needed to break a bone, unless it is diseased or old. Bones that are still growing are supple and may:

- split
- bend
- crack
- Greenstick fracture

DIRECT FORCE

- A bone may break at the point where a heavy blow is received
- struck by a car

INDIRECT FORCE

- Twist or a wrench

FRACTURE RECOGNITION

There may be:

- "Sickening", severe pain, and difficulty in
- Moving the area
- Swelling and bruising around the joint
- Shortening, bending, or twisting of the area
- Paralysis
- Fracture the bones involved
- If you are in any doubt, treat the injury as a fracture
- Deformity, swelling, and bruising Pain, and difficulty in moving
- Shortening, bending, or twisting of a limb
- Coarse grating (crepitus) of the bone ends that can be heard or felt
- Signs of shock, especially if the fracture is to the thigh bone or pelvis
- Difficulty in moving a limb normally or at all (for example, inability to walk)
- A wound, possibly with bone ends protruding.

TYPES OF FRACTURES

STABLE INJURY

- Bone is fractured
- The ends of the injury remain in place
- The risk of bleeding or further damage is minimal

UNSTABLE INJURY

- The broken bone ends can easily be displaced by movement or muscle contraction.

CLOSED FRACTURE

- The skin is not broken
- Bone ends may damage nearby tissues and blood vessels
- Internal bleeding is a risk.

OPEN FRACTURE

- Bone is exposed at the surface where it breaks skin
- Bleeding Shock
- Infection

TREATMENT AIMS

To prevent movement at the injury site

To arrange removal to hospital, with comfortable support during transport

Advise the casualty to keep still

Support the injured part with your hands, until it is immobilised

FOR FIRMER SUPPORT

- Bandage the injured part to an unaffected part of the body
- Make sure the bandage is tied on the uninjured side

UPPER LIMB FRACTURES

- immobilise the arm against the trunk

LOWER LIMB FRACTURES

- Bandage the uninjured leg to the injured one if removal to hospital is likely to be delayed.

CLOSED FRACTURE

- Arrange to transport the casualty to hospital as necessary
- Treat for shock if necessary by raising the legs
- Do not raise the injured limb if this causes the casualty more pain
- Check the circulation beyond a bandage s every 10 minutes
- If the circulation is impaired, loosen the bandages
- Do not move the casualty until the injured part is secured and supported, unless she is in danger
- Do not allow the casualty to eat, drink, or smoke as a general anaesthetic may be needed.

OPEN FRACTURE

- Prevent blood loss
- Prevent movement
- Prevent infection at the site of injury
- Arrange removal to hospital, with comfortable support during transport
- Put on gloves
- Make a tent bandage and loosely cover the wound with a large, clean, non-fluffy pad or sterile dressing
- Apply pressure on either side of fracture to control bleeding

- Do not press down directly on a protruding bone end
- Carefully place clean padding over and around the dressing
- Stabilise fracture by immobilising the joint above the fracture and the joint below the fracture
- Monitor level of response, pulse, and breathing
- Check the circulation beyond the bandage every 5 minutes
- Do not move the casualty until the injured part is secured and supported, unless she is in danger
- Do not allow the casualty to eat, drink, or smoke, as a general anaesthetic may be needed.

JOINT DISLOCATION

- Bones are partially or completely pulled out of position and can affect the shoulder, jaw, or joints in the thumbs or fingers

CAUSED BY A:

- Strong force wrenching the bone into an abnormal position
- Violent muscle contraction

Dislocations may be associated with torn ligaments. If vertebrae in the spine are dislocated, the spinal cord can be damaged.

Dislocation of the shoulder or hip may damage the major nerves.

DO NOT

- Try to reposition a dislocated bone into its socket because this may cause further injury
- Move the casualty until the injured part is secured and supported. Allow the casualty to eat, drink, or smoke, as a general anaesthetic may be needed.

DO

- Follow the facility's policy and procedure
- Follow who clinically assesses the patient before transferring from floor to bed / trolley
- Complete a neurological assessment by using the Glasgow Coma Scale

It may be:

One Nurse, two Nurses or a Doctor.

PATIENT TRANSFER FROM FLOOR TO BED / TROLLEY

- Use a hoist for the transfer
- Place the sling behind the patient
- Come in from the side of the patient
- One leg of the hoist goes under the propped up knees
- One leg of the hoist goes behind the patient's propped up back
- Connect the sling to the hoist and then hoist

HOW TO COMPLETE THE NEUROLOGICAL OBSERVATIONS CHART

Glasgow Coma Scale

The Glasgow Coma Scale uses objective observable characteristics and provides a scale by which to measure level of consciousness and response. The scale is used for assessment of eye opening, best verbal response and best motor response [1-3]

Eye Opening

Assessing eye opening provides an indication of the person's arousal ability. Determine if the person responds to speech (use a loud voice) or to touch. If the person does not respond, apply pressure to the finger beds to determine if there is a response to painful stimuli. If the person cannot open his or her eyes due to swelling, record 'C', or if the person's eyes remain continuously open this should be recorded as a non-eye opening response [2].

Verbal Response

This assessment determines appropriateness of the person's speech. The person's attention should be gained and a conversation attempted, allowing adequate time for the resident to respond. In assessing the person's best verbal response, consider their preferred language, any diagnosed problems that may influence their ability to respond, for example deafness, previous stroke, level of confusion prior to fall and determine if there are any changes to the person's pre-fall condition. Assess the person's response and record:

- Oriented – person can respond appropriately to person/place/time
- Confused – person can talk but is not orientated
- Inappropriate words – speaks only a few words usually in response to physical or painful stimuli
- Incomprehensible sounds – unintelligible sounds such as moans
- None – no response after prolonged stimulation [1,2]

Motor Response

Assess the person using simple commands to determine if the resident has the awareness/ability to respond by movement. If the person resident does not respond to verbal commands such as “squeeze my hands” or “open your eyes, check the person’s best motor response, taking into consideration their usual level of comprehension, usual ability to move their body and any existing medical diagnoses that may contribute to their ability to move for example, previous stroke, dementia. Assess the person’s response and record:

- Obeys command – follows your command
- Localises pain – moves limb away from painful stimuli in a purposeful way or attempts to push painful stimulus away
- Flexion to pain – responds to painful stimuli by bending arms up but does not localise pain
- Extension to pain – responds to painful stimuli by straightening arms but does not localise pain [1,2]

Assessment of Pupils

Assessment of the person’s pupil size and response to light can provide an indication as to the presence and extent of head injury as a result of a fall. The neurological observation chart should provide a pupil scale on which to assess pupil size. An assessment should first be made as to whether the person’s pupils are of equal size and then whether they react equally to exposure to light [1,2]

Assessment of Limb Movement

Assessment of the person's limb movement can give an indication as to the presence and extent of head injury as a result of a fall.

Instruct the person to move their limbs laterally or lift up against gravity or against resistance. If the person does not respond to the request, assess limb movement in response to pain. Observe the type of movement the person can perform and compare the strength of both sides of the body. In assessing the person's limb movements and strength, consider their previous condition and any medical diagnoses that may preclude normal limb movement, for example stroke, musculoskeletal disorders. Consider whether the person has sustained injuries to the limbs, such as fractures, during the fall which may preclude normal movement. Assess and then record:

- Normal power – movements are within the person's normal power strength
- Mild weakness – cannot fully lift limbs against gravity and struggles to move against resistance
- Severe weakness – can move limbs laterally but cannot move against gravity or resistance
- Spastic flexion – arms slowly bend at elbow and are stiff
- Extension – limbs straighten [1,2]

References

- *Scottish Intercollegiate Guidelines Network, Early management of Patients with a Head Injury 1st Ed. 2000, Edinburgh: SIGN*
- *Joanna Briggs Institute, Aged Care Practice Manual 2nd Ed. 2003, Adelaide: JBI*
- *National Collaborating Centre for Acute Care, Clinical Guidelines 4: head injury Triage, assessment, investigation and early management of head injury in infants, children and adults. 1st Ed. London National institute for Clinical Excellence*