fraserhealth

Post-Fall Assessment and Management Algorithm - Acute Care

<table>
<tr><td colspan="2">IMMEDIATE RESPONSE * DO NOT move patient until assessed and injuries stabilized*</td></tr>
<tr><td>Basic Life Support:
- Assess Airway, Breathing and Circulation, level of consciousness
- Call for HELP

Initial Rapid Assessment:
- Assess for bleeding, change in level of consciousness, head impact, fractures, pain, or new neck pain.
- VS: BP, P, R, T, O2 sat, blood glucose, pain level
- NVS: Glasgow coma scale, LOC, pupil reaction, grip strength
- CWMS (colour, warmth, movement, sensation)
- Status prior to the fall and possible reason for fall (e.g. delirium, sepsis, dizziness)

Possible c-spine injury: e.g. new pain, limb numbness/tingling or decreased movement, breathing impairment, unconscious - manually immobilize head and neck in position found, unless airway compromised, until further direction given by MRP or takes over direction/care (e.g. application of collar)</td><td>If unstable or unconscious initiate Code Blue or call 911 if off site

(review goals of care)</td></tr>
<tr><td colspan="2">TRANSFER: Stabilize all injuries prior to transfer from floor using safe client handling</td></tr>
<tr><td>Stabilize all injuries prior to transfer from the floor using safe client handling (link)
Transfer methods: Independent/assist, lift, other, C-spine precautions
When in doubt, use higher level of assistance</td><td>Clinical Skills</td></tr>
<tr><td colspan="2">ONGOING ASSESSMENTS:</td></tr>
<tr><td>Unwitnessed/head impact: VS/NVS Q15 min x 4, if stable, Q1H x 4, if stable Q4H x 24 h</td><td rowspan="3">Increase/extend monitoring as needed.</td></tr>
<tr><td>Witnessed/no head impact: VS/NVS Q1h x 2, if stable VS Q4H x 24 hrs</td></tr>
<tr><td>If suspected neurovascular injury: CWMS Q15min x 1 hr, if stable, Q1H x 4, if stable Q4H x 24 hours</td></tr>
<tr><td colspan="2">MANAGEMENT:</td></tr>
<tr><td>- Hold ALL anti-coagulant/anti-platelet medications, sedatives, and narcotics until reviewed with MRP</td><td rowspan="2"></td></tr>
<tr><td>- Clean and dress wounds, provide analgesic as needed</td></tr>
<tr><td colspan="2">COMMUNICATION & REPORTING:</td></tr>
<tr><td>MRP: verbal notification 24 hours a day, with or without injury using SBAR format
- Review risk factors (e.g. medications, bleeding risks, changes in behaviour/cognition), goals of care
- Discuss with MRP whether additional investigations are needed (e.g. x-ray, CT scan, blood work, hold medications)</td><td rowspan="3">Notify MRP/caregiver of any deterioration, review goals of care.</td></tr>
<tr><td>Family/caregiver: notify 24 hours a day unless otherwise indicated.
- Note: between 2300 - 0600 hr - if no apparent injuries wait until am (call by end of shift) unless directed otherwise.</td></tr>
<tr><td>Clinical Team:
- Conduct safety huddle with staff and patient to review status, plan of care and ongoing follow-up
- Review and update care plan as needed</td></tr>
<tr><td colspan="2">Report all falls as per FH Patient Safety Incident Management policy</td></tr>
<tr><td colspan="2">DOCUMENTATION: Post-fall Assessment and Management Record, progress notes, VS, NVS, and CSMW record</td></tr>
<tr><td colspan="2">- Head-to-toe assessment
- Details of what was happening prior to the fall and possible reason(s) for the fall
- MRP contact, name, time, report and recommendations
- Caregiver contact, name, time, and response</td></tr>
</table>