fraserhealth

POST FALL ASSESSMENT & MANAGEMENT RECORD – NURSING
(Acute Care)

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INSTRUCTIONS: Most responsible nurse to initiate record and complete time schedule for all post-fall assessments.

Hold ALL anticoagulant/antiplatelet medication, sedatives, and narcotics until reviewed with MRP.

Document additional information using the progress notes, vital sign neurological, and neurovascular records.

HEAD definition: ALL areas above the neck (e.g. chin, eye, ear, nose, forehead, and scalp).

Date and time of fall discovery: _____ @ _____ hr.→ ☐ Witnessed ☐ Unwitnessed

Initial when completed:

IMMEDIATE RESPONSE (Complete full assessment on the floor):

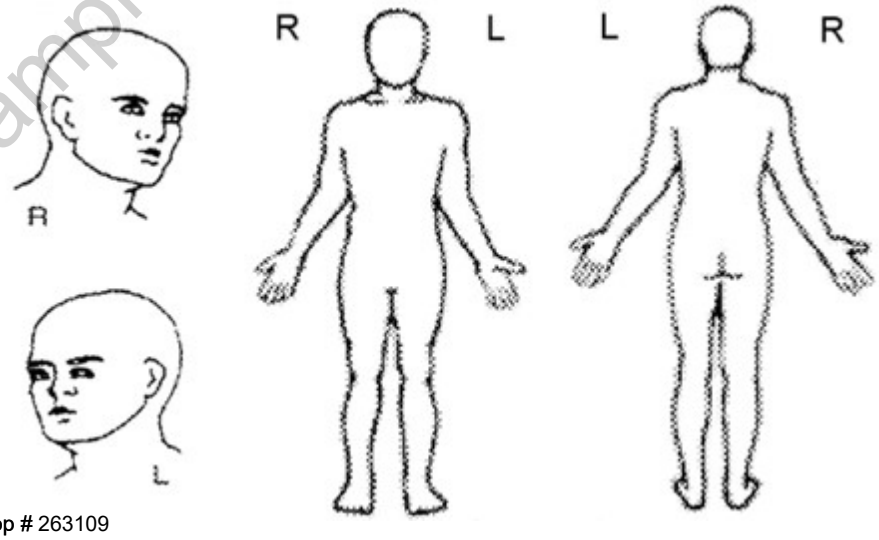
- Assess Airway, Breathing, Circulation, and Level Of Consciousness _____
  - If patient critical and/or unconscious initiate Code Blue or call 911 if off site
  - Review goals of care
- Assess for bleeding, change in level of consciousness head impact, fractures _____
- **Vital signs** (BP, P, R, T, O2 sat) _____
- **Blood glucose** _____
- **NVS** (Glasgow Coma Scale, LOC, pupil reaction grip strength) _____
- **CWMS** (Colour, Warmth, Movement, Sensation) _____
- Mechanism of injury _____
- Status prior to the fall, possible reason for fall (e.g. delirium, dizziness) _____
- **SPINAL INJURY ASSESSMENT** e.g. new neck/back pain, numbness/tingling, decreased movement, breathing impairment, unconscious. If present, **manually immobilize** head and neck in position found, unless airway compromised, until further direction from the MRP (e.g. application of collar) _____
- Notify MRP immediately with any abnormal spinal injury assessment findings _____

TRANSFER METHOD:

☐ Independent/assist ☐ Lift ☐ C spine precautions ☐ Other: _____ _____

INJURY ASSESSMENT ☐ No injuries evident ☐ Yes (complete below) _____

KEY: **A** - abrasion, **C** - contusion, **D** - deformity, **L** - laceration, **P** - pain, **R** - rotation, **S** - skin tear



POST FALL ASSESSMENT & MANAGEMENT RECORD – NURSING Cont'd

HOLD all anticoagulant/antiplatelet medications, sedatives, and narcotics until reviewed with MRP _____

ONGOING ASSESSMENTS:

☐ **Unwitnessed/Head impact** (all areas above the neck)

Date/time VS/NVS due		Initial when completed
Q15 minutes x 1H		
1		
2		
3		
4		
When above stable, proceed to Q1H x 4		
1		
2		
3		
4		
When above stable, proceed to Q4H x 24hr		
1		
2		
3		
4		
5		

☐ **Witnessed without head impact**

Date/time due		Initial when completed
VS/NVS Q1H x 2		
1		
2		
When above stable, proceed to Q4H x 24 hr		
1		
2		
3		
4		
5		

*Patient may require more frequent assessments consider increasing age (brain atrophy), presence of dementia/cognitive impairment, anticoagulant/antiplatelet medications and coagulopathy.

***Alert - MRP & caregiver of changes and/or deterioration, review goals of care.**

Initial or NA:

If suspected neurovascular injury assess Colour, Warmth, Movement and Sensation:

- Q15min x 1 H, if stable than Q1H x 4, if stable Q4H x 24 hours _____
- Clean and dress wounds, provide analgesic as needed _____

MRP notification: notify 24 hours a day, with or without injury and with any deterioration

Time: _____ Date: _____ Name: _____ Plan: _____

- Review risk factors (e.g. medications, bleeding risks, changes in cognition/behaviour) _____
- Review medications on hold and discuss plan (*circle*: anticoagulant, antiplatelet, sedatives, narcotics), and goals of care _____
- Discuss with MRP whether additional investigations are needed (e.g. x-ray, CT scan, bloodwork) _____

Family/caregiver notification: notify 24 hours a day unless otherwise indicated, and with any deterioration.

Time: _____ Date: _____ Name: _____ Plan: _____

- Notify with any deterioration
- Between 2300 - 0600 hr - if no apparent injuries, wait until after 0600. If directed otherwise, call by end of shift.

Complete safety huddle with staff and patient/caregiver _____
Document additional information on applicable records _____
Review/update care plan as needed _____
Report fall as per FH Patient Safety Incident Management Policy _____