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CEC DRAFT Post Fall Assessment & Management Guide

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November 2011

Post Fall Assessment and Management for ALL adult patients

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level: (ACSQHC 2009 Falls Best Practice Guidelines).

Please note: if a patient is found on the floor or lower level, it should be assumed that a fall has occurred unless there is reasonable evidence of a sudden onset of paralysis, epileptic seizure, loss of consciousness or overwhelming external force (being applied).

- For implementation in all NSW Health facilities including small rural and Multi Purpose Services (MPS). Will apply to the clinical management of aged care residents in MPS.
- Links with the Clinical Emergency Response System (CERS) procedures developed in consultation with Between the Flags Program.
- Please note that it may not be possible for the patient to be reviewed by a Medical Officer in some Rural Sites. Staff are to follow local protocols in regards to Clinical Emergency Response Systems for Clinical Review and Rapid Response.
- Applies to **all adult patients** who have had a fall: Falls and Hits Head; Falls and Does Not Hit Head; Unwitnessed Fall. Replaces the CEC Post Falls & Management Guide (Revised Sept 2009).

Purpose:

The purpose of document is to guide immediate care following a fall. A fall event can be serious and cause injury and even death. In hospital a patient fall may be a flag that the patient's underlying medical condition may have deteriorated. The causes of falls are complex, and immediate post fall assessment and management with clinical review will help to reduce the degree of harm to the patient. In the event that a patient has an Advance Care Plan or Directive in place, symptom management will remain a priority in the plan of care.

1. Post Fall Assessment and Management for all adult falls: Algorithm

Each box steps through the patient journey following a fall and actions for staff to take in caring for the patient that falls.

- Immediate Response
- Observations & Ongoing Monitoring
- Communication and Documentation

2. Guidance for Post Fall Assessment and Management of all adult patient falls.

- Assessment of Risk of Bleeding
- Assessment for Delirium
- Assessment of Injury: with particular regards to injury to the head and all limbs
- Assessment of Ward Environment, Equipment and level of Supervision
- Indications for CT Scan

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Post Fall Assessment and Management – all adult patient falls



IMMEDIATE RESPONSE - Initiate clinical care and call for assistance

- Basic Life Support: Danger, Responsive, Send for help, Airway, Breathing, CPR? Defib (DRSABCD)
- Rapid assessment – pain: bleeding: injury (do not move until assessed: Examine cervical spine, and immobilise if there is an indication of injury).
- Base-line Observations: Full set: BP,P, R,T, SpO₂, Blood Glucose and Pain score, Neuro obs
- Notify Medical Officer of fall

If patients' observations are in **YELLOW** or **RED** zone you must ACTION your Local Clinical Emergency Response System

Observations & Ongoing Monitoring for ALL Patient Falls

- ❖ Standard Adult General Observation Chart include pain, and
- ❖ Adult Neurological Observation Chart

- At least hourly for a minimum of 4 hours: REVIEW
- 4 hourly for the next 24 hours or as required, then
- REVIEW –ongoing observations as required (Seek clinical advice)

If patients' observations move into **YELLOW** or **RED** zone you must ACTION your Local Clinical Emergency Response System

Clinical Review Action required for any following presenting signs

- ❖ Patients on anticoagulant/or antiplatelet therapy and patients with known coagulopathy are **HIGH RISK** for bleeding
- ❖ Fluctuating Behaviours and/or increasing confusion: increased agitation, restlessness, or changes in level of alertness –lethargy, flattened : complete assessment for Delirium
- ❖ Injury- facial bruising, hit head when fell , fracture
- ❖ Vomiting, headache

CT Scan
Recommended

Ongoing Monitoring is important.

Note: there may be manifestations of head injury after 24hrs

- Change in level of consciousness – headache, vomiting
- Increasing confusion and fluctuating behaviours: increased agitation, restlessness, lethargy

Communication and Documentation

- Reassure the patient and explain all treatment and investigations
- All patient falls are to be reported to medical officer for review.
- Is there a Substitute Decision Maker if the person is not able to communicate effectively?
- Notify the Person Responsible(family/carer/friend) with permission and inform them about the fall and plan of care
- Is there an Advance Care Plan or Directive in place? Determine appropriate treatment options with person responsible.
- Write treatment, palliation/escalation process and outcome in the clinical record
- Review falls status to: high risk and record in clinical record and modify care plan.
- Discuss at clinical bedside handover including noting ongoing observations and monitoring and change in falls risk status to high risk
- Complete IIMS report
- Complete a review of fall event with clinical leadership team.

Version 2 : 21 Oct 2011

CLINICAL REVIEW

RAPID RESPONSE

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Guidance for Post Fall Assessment and Management of all adult patient falls

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Response Emergency Systems and if at any time a staff member is concerned about a patient (or unsure whether to call) you may call for a Clinical Review if worried.

Elder people who fall in hospital (falls and hits head, falls and does not hit head, and unwitnessed falls) are all at risk of intracranial injury due to ageing and physiological changes in the brain. Early signs of deterioration are fluctuating behaviours or increasing confusion following a fall (increased agitation, restlessness or changes in alertness – lethargy, flattened). These changes may occur sometime (days) after a patient falls.

A patient with known ~~coagulopathy~~ or on anticoagulant therapy is at increased risk of intracranial injury and bleeding if they fall. Decisions in regards to treatment options should be discussed with the patient &/or person responsible. In the event that a patient has an Advance Care Plan or Directive in place, symptom management will remain a priority in the plan of care.

Assessment for Risk of Bleeding

- Patient is receiving anti-coagulant therapy (Warfarin, Heparin, Enoxaparin (Clexane), Dabigatran (Praxin), Rivaroxaban)
- Patient is receiving anti-platelet therapy (Aspirin, ~~Clopidogrel~~, Aspirin/~~Clopidogrel/Ticagrelor~~)
- Known ~~coagulopathy~~
- Haematological disease
- Renal failure – end stage and haemodialysis patients

~~Patients at High Risk of Intracranial Haemorrhages if they fall.~~

Clinical Review and CT Scan Recommended

Monitor Cognition & Assess for Delirium: Confusion Assessment Method (CAM) tool.

Delirium is a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. It involves altered consciousness and fluctuating behaviours and /or increasing confusion (increased agitation, restlessness, and changes in alertness – lethargy, flattened).

Increase observation – close to nurses' station, hourly rounding, go and on and care.

Fluctuating changes in cognition following a fall?

Clinical Review and CT Scan Recommended

Assessment of Injury: looking for signs of

Bruising, Lacerations, Swelling, Redness, Abrasions, Shortening of limbs, Restricted limb Movement, External Rotation of lower limbs, inability to weight bear, Pain on applying pressure, Signs of Deformity.

~~CT Scan Recommended~~

~~Suspicious~~

Clinical review and Investigations

Assessment of Ward Environment, Equipment for mobilising, Supervision

Modify any environmental risk factors, equipment factors or supervision level that has contributed to the patient's falls incident.

Complete a review of the fall event and with clinical leadership team and revise patient care plan. Communicate changes to care plan at ward handover and revise falls risk to HIGH.

Indications for CT Scan.

Patients aged >65 with a mild head injury should have a CT scan due to the increased risk of intracranial injury.

If CT scan is not available and the patient has no other identified risk factors then the absolute risk is probably small and clinical judgement can be used to justify prolonged observation rather than transfer for CT scan. Prolonged observation in hospital or at home should be considered even if an initial CT scan is normal due to the increased risk of delayed complications.

- GCS 15: Immediate CT; GCS 9-15 Urgent CT
- Patients at 'highest risk' of intracranial injury including those with known ~~coagulopathy~~ or anticoagulant/~~antiplatelet~~ therapy (particularly if age >65 or INR >4), any unconscious or seizure post injury. High risk should be discussed with neurological team or the regional neurosurgical service regarding urgent transfer for CT scan.
- Patient age >65 years is a strong indication for CT scanning
- Persistent abnormal mental status manifested by abnormal alertness, abnormal behaviour or cognitive impairment is a strong indication for CT scanning. Observe for change in level of consciousness, headache, emesis or vomiting.
- 'High risk' mild head injury patients should be closely observed and be considered for transfer to a hospital with neurosurgical and CT scan facilities when CT scan is unavailable.
- A clear decision about the need for transfer for CT scanning for 'high risk' patients should be made at the time of initial assessment or after a brief period of observation.
- A local senior clinician should be consulted and the patient discussed with the neurological team or regional neurosurgical service.

Reference: The Initial Management of Closed Head Injury in Adults (2nd Edition), 2011, NSW Institute of Trauma and Injury Management.

Post fall assessment & management



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1. Immediate Response

- initiate clinical care & call for assistance
- Rapid assessment- pain: bleeding: injury (do not move until assessed - check cervical spine & immobilise if signs of injury)
- Base-line observations
- Notify Medical officer

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2. Observation & Monitoring for ALL Patients

- At least hourly for a minimum of 4 hours:

REVIEW

- 4 hourly for the next 24 hours or as required, then
- REVIEW -ongoing observations as required
(Seek clinical advice)

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- Patients on anticoagulants/antiplatelet therapy are at **HIGH RISK** for bleeding if they fall
- **Call for medical review**
- **CT MAY BE INDICATED**

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- Fluctuating Behaviours and /or increasing confusion, agitation, restlessness or changes in level of alertness - lethargy, flattened
- Assessment for Delirium - CAM
- Call for medical review
- CT MAY BE INDICATED
- Ongoing Monitoring is important

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Assessment of Injury

- Injury - facial bruising, hit head when fell, fracture
- Vomiting, headache

Assessment of Ward Environment, Equipment for mobilising, Supervision

- Modify any environmental risk factors, equipment factors or need for increased supervision

Ongoing Monitoring is important

Post fall assessment & management



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3. Communication & Documentation

- All patient falls are to be reported to medical officer
- Notify person responsible/family/carer
- Determine appropriate treatment options with patient/ family & medical officer
- Document in notes
- **Communicate - AT HANDOVER**