Post-Fall

DEFINITION

A patient fall is an unplanned descent to the floor with or without injury.

SIGNS & SYMPTOMS

- Loss of consciousness for a few seconds to a few minutes.
- No loss of consciousness, but a state of being dazed, confused, or disoriented.
- Headache.
- Nausea or vomiting.
- Fatigue or drowsiness.
- Difficulty sleeping.
- Sleeping more than usual.
- Dizziness or loss of balance.

ASSESSMENT:

History-

- History of previous falls.
- Medical history, diseases and their risk for fall, medication plus their side effects.

Physical-Mental

- The first priority in fall assessment is the evaluation of basic life support, i.e., airway, breathing and circulation.
- Evaluation of disability and identification of injuries comes second, followed by evaluation of the underlying cause(s) of the fall.
- A fallen person should not be moved until a complete and thorough examination has been performed to rule out cervical or thoracic spine injury. Once it is clear that the patient is stable: ask about the presence of pain; and ask the patient/witness how they fell; about shortness of breath and about any significant preceding event such as syncope, palpitations or chest pain.
- Slide your hands along the patient or resident's entire body with a firm but gentle pressure using a systematic head-to-toe approach. Feel for deformities and watch the patient's face for expressions of pain.

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- Check the head, ears, eyes, nose and throat for lacerations, bruising or bleeding.
- Inspect the patient's chest and abdomen for asymmetrical chest movement, rapid, shallow breathing, use of accessory muscles and/or tenderness of chest that may indicate a rib fracture or respiratory distress.
- Auscultate lung sounds and if absent, consider airway obstruction, pleural effusion or pulmonary edema.
- A firm, distended or tender abdomen may suggest internal bleeding, peritonitis or bowel obstruction. Assess for a pelvis injury by applying pressure to both iliac crests while moving the hips forward and backward. Any pain or crepitus (a feeling of grating with movement) may mean a pelvic fracture.

NURSING INTERVENTIONS

- Do not move patient initially, reassure patient.
- Call for assistance.
- Immobilize cervical spine if head and neck pain is reported or suspected.
- Check for other potential injuries.
- Vital signs observations (blood pressure, pulse, respiration rates, oxygen saturation, blood sugar, temperature, pain).
- Neurological observations and assessments, including Glasgow Coma Scale7, speech, eye movements and pupil abnormalities.
- Call 911 if patient meets criteria for prompt care.
- Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in the level of consciousness.
- Clean and dress wounds – consider immunization status for tetanus.
- Patient movement should be guided by local policy guidelines.
- Notify physician and request a review or refer to local clinical escalation procedure. Consider need for pain relief and offer analgesia as indicated.
- Obtain order for relevant investigations – consider ECG, x-rays, CT scan and blood tests (full blood count, coagulation profiles, septic screening).

Within 6 hours post-fall

- Record vital signs and neurological observations every 30-60 minutes for 4 hours then review.
- Prompt action if any observations outside of acceptable parameters.
- Notify physician of any visual or focal motor/ sensory changes or speech disturbance.
- Continue investigation and treatment of injuries sustained.
- Notify Next of Kin and provide patient and family falls risk management education.
- If not already identified as high risk of fall injury, flag as per local policy.
- Complete Clinical Incident Form.
- Consider need for transfer to tertiary health service if at secondary health service.

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6 To 48 hours post-fall

- Unwitnessed fall and/or hits head OR is on anticoagulants/ antiplatelet medication: Continue neurological observations based on patient's condition; 30-60 minute as indicated by parameters on the observational chart; 4 hourly if stable.
- Witnessed fall and did not hit head: Continue vital signs observations 4- 6 hourly for 48 hours then review.
- For all patients:
- Notify physician of any visual or focal motor/ sensory changes or speech disturbance.
- Review investigation results.
- Modify environment to reduce falls.
- Refer to relevant staff
- Continue patient and family education on falls risk management.

48 to 72 hours post-fall

- If patient is considered stable at 72 hours, return to pre-fall level of observations.
- All specialist and allied health review must be completed and plan of care/ treatment documented in the patient's notes for falls risk management.

CULTURAL CONSIDERATIONS

Educate patient and family on fall risk and prevention.

COORDINATING CARE WITH NURSING ASSISTANT

- All staff involved in care of the patient to be informed of incident outcome and revise care plan.
- Closely supervise patients at risk for falls during the first few days, especially at night.
- Encourage the patient to use the call light to request assistance and is within easy reach.
- Place bedside tables and over bed tables near the bed or chair so that patients do not overreach and then lose their balance.
- Always keep hospital beds in the low position when not providing care so that patients can move in and out of bed easily.
- Encourage patients to use grab bars mounted in the toilet and bathing areas and railings along facility corridors.

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