CEC POST FALL GUIDE

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Emergency Response Systems and if at any time a staff member is concerned about a patient they can call for a Clinical Review.

**Basic life support**
Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABCD)

**Rapid assessment**
Pain, bleeding, injury, fracture
Do not move until assessed: examine cervical spine and immobilise if there is an indication of injury

**Observations**
BP, P, R, T, SpO2, Blood Glucose and Pain Score, Neuro Observations

**BP, P, R, T, SpO2, Pain Score, Neuro Observations, BGL (if indicated)**
- At least hourly for a minimum of 4 hours
- 4 hourly for the next 24 hours or as clinically indicated, then
- REVIEW - ongoing observations as required

**CHECK FOR SEPSIS**
- Does this patient have sepsis risk factors or signs & symptoms of infection? and
- Does this patient have observations in the yellow zone?

**CHECK FOR DELIRIUM**
- Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion?

**CHECK FOR HEAD INJURY**
Does this patient have a head injury?

Refer to PD2012_013: Initial Management of Closed Head Injury in Adults. Algorithm: Initial Management of Adult Mild Closed Head Injury

Strong indicators for a CT Scan include (see algorithm for full list of risk factors):
- The patient is on anticoagulants, antplatelets, or with a known coagulopathy, (check INR/APPT).
- Has an abnormal GCS or fluctuating changes in cognition, changes in behaviour, or increasing confusion.
- Has large facial or scalp bruising, nausea, vomiting or persistent severe headache.
- Age ≥ 65 years (clinical judgement required).

Are you concerned about this patient and or family, carer has reported concerns?

**THERE MAY BE MANIFESTATIONS OF HEAD INJURY AFTER 24 HOURS**
- CONTINUE TO MONITOR -

**COMUNICATE**
- Reassure the patient and explain all treatment and investigations.
- All patient falls are to be reported to medical officer for review.
- Notify the person responsible (family/carer/friend) with permission and inform them about the fall.
- If the person is not able to communicate effectively engage with the substitute decision maker.
- Discuss appropriate treatment options and clarify if there is an Advance Care Directive in place - symptom management is important.
- Implement plan of care and inform staff of care plan.
- Communicate at clinical handover - observations, falls risk and interventions in place.

**DOCUMENT**
- Treatment, palliation/escalation process and outcome documented in the clinical record.
- Change falls status to: HIGH RISK and record in clinical record and complete revised care plan.
- Complete IIMS report and note incident and IIMS number in the clinical record.
- Complete a review of fall event with ward clinical leadership team.
- Complete CEC Incident Review for any serious injury/outcome from fall.