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.

NSW FALLS PREVENTION PROGRAM

CLINICAL EXCELLENCE COMMISSION

IMMEDIATE RESPONSE

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, SpO_2, Blood Glucose and Pain Score, Neuro Observations

Your Local Clinical Emergency Response System and Protocols

Notify Medical Officer of Fall (using ISBAR)

Between the Flags — Keeping patients safe

CLINICAL REVIEW

RAPID RESPONSE

ONGOING OBSERVATIONS and MONITORING

BP, P, R, T, SpO_2, 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?

YES → Follow Sepsis Pathway

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

YES → Complete CAM

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, antiplatelets, 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 -

COMMUNICATE

- 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.