### 3N: Postfall Assessment, Clinical Review

**Background:** This protocol explains how to assess and follow injury risk in a patient who has fallen.

**Reference:** Adapted from the South Australia Health Fall Prevention Toolkit. Available at: [www.sahealth.sa.gov.au/wps/wcm/connect/5a7adb80464f6640a604fe2e504170d4/Post+fall+management+protocol-SaQ-20110330.pdf?MOD=AJPERES&CACHEID=5a7adb80464f6640a604fe2e504170d4](http://www.sahealth.sa.gov.au/wps/wcm/connect/5a7adb80464f6640a604fe2e504170d4/Post%2Bfall%2Bmanagement%2Bprotocol-SaQ-20110330.pdf?MOD=AJPERES&CACHEID=5a7adb80464f6640a604fe2e504170d4)

**How to use this tool:** Staff nurses and physicians should follow this protocol, in combination with clinical judgment, with patients who have just fallen. Training on the Glasgow Coma Scale is available at: [www.nursingtimes.net/Binaries/0-4-1/4-1735373.pdf](http://www.nursingtimes.net/Binaries/0-4-1/4-1735373.pdf). (Full citation: Jevon P. Neurological assessment part 4 - Glasgow Coma Scale 2. Nurs Times 2008;104(30):24-5.) This training includes graphics demonstrating various aspects of the scale.

##### Postfall Assessment, Clinical Review

**Note:** There is increased risk of intracranial hemorrhage in patients with advanced age; on anticoagulant and/or antiplatelet therapy; and known coagulopathy, including those with alcoholism.In addition, there may be late manifestations of head injury after 24 hours.

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| **Does not hit head*** Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your hospital’s protocol.
* Call for assistance. Activate appropriate emergency response team if required.
* Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider.
* Identify all visible injuries and initiate first aid; for example, cover wounds.
* Assist patient to move using safe handling practices.

**Proceed to:*** Check vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, and hydration).
* Clean and dress any wounds.
* Inform treating medical provider.
* Provide analgesia if required and not contraindicated.
* Arrange further tests as indicated, such as blood sugar levels and x rays.
* Review current care plan and implement additional fall prevention strategies.
* Provide fall prevention information (Tool 3J).

**Observations:*** Continue observations at least every 4 hours for 24 hours or as required.
 |  | **Hits head or has unwitnessed fall*** Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your hospital’s protocol.
* Call for assistance. Activate appropriate emergency response team if required.
* Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider.
* Assess Glasgow Coma Scale (next page).
* Identify all visible injuries and initiate first aid; for example, cover wounds.
* Assist patient to move using safe handling practices.

**Proceed to:*** Record neurologic observations, including Glasgow Coma Scale. Observe for signs indicating stroke, change in consciousness, headache, amnesia, or vomiting.
* Get baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, and hydration).
* Clean and dress any wounds.
* Arrange medical review.
* Provide analgesia if required and not contraindicated.
* Arrange further tests as indicated, such as blood sugar levels, x rays, ECG, and CT scan.
* Review current care plan and implement additional fall prevention strategies.
* Provide fall prevention information (Tool 3J).

**Observations:*** Record vital signs and neurologic observations at least hourly for 4 hours and then review.
* Continue observations at least every 4 hours for 24 hours, then as required.
* Notify treating medical provider immediately if any change in observations.
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##### Important Communications

* In the medical record, document the incident, outcome, and initial and ongoing observations, and update fall risk assessment and care plan.
* Notify the treating medical provider at the time of the incident, and schedule an interdisciplinary review of the patient’s care.
* At handover, inform all clinical team members about the incident, any changes to the care plan, and possible investigation process.
* Notify family in accordance with your hospital’s policy.

##### Glasgow Coma Scale

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

**Activity Score**

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| **Eye opening** |
| None | 1 = Even to supraorbital pressure  |
| To pain | 2 = Pain from sternum/limb/supraorbital pressure  |
| To speech | 3 = Nonspecific response, not necessarily to command  |
| Spontaneous | 4 = Eyes open, not necessarily aware  |
| **Motor response** |
| None | 1 = To any pain; limbs remain flaccid  |
| Extension | 2 = Shoulder adducted and shoulder and forearm rotated internally  |
| Flexor response | 3 = Withdrawal response or assumption of hemiplegic posture |
| Withdrawal | 4 = Arm withdraws to pain, shoulder abducts  |
| Localizes pain | 5 = Arm attempts to remove supraorbital/chest pressure  |
| Obeys commands | 6 = Follows simple commands  |
| **Verbal response**  |
| None | 1 = No verbalization of any type  |
| Incomprehensible | 2 = Moans/groans, no speech  |
| Inappropriate | 3 = Intelligible, no sustained sentences  |
| Confused | 4 = Converses but confused, disoriented  |
| Oriented | 5 = Converses and oriented  |

**TOTAL (3–15): \_\_\_\_\_\_\_**

**Reference**

Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. Lancet 1974;2(7872):81-4.