Post-Fall Management

Getting patients off the floor safely

Acknowledgments CCLHD: Tara Milligan Acute Aged Care CNE and Cheryl Baldwin Aged Care CNC
Margaret Armstrong NSLHD Falls Prevention Co-Ordinator 2023

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is *everyone's* business

Why is this important?

- We have governing documents that guide and support our practice in post-fall management – PPGs and the CEC Post Fall Flowchart
- But – the CEC Flowchart does not cover the **immediate** post-fall opportunities for intervention
- We know most falls are unwitnessed
- So – how we assess patients **immediately** post fall/incident is very important
- How we get patients off the floor is also important to us, as individuals (WH&S), and to patients (risk of injury or exacerbating an injury – especially if unknown)

What you do next matters to both you and your patient

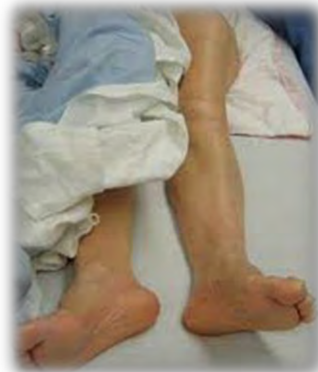
Injuries are not always obvious

We could unintentionally *increase* harm by moving someone before doing a full assessment

- We should never make assumptions that a *simple* or unwitnessed fall won't result in an injury – need to appropriately assess the patient head to toe using a *'high level of enquiry'*
- **Particularly** when a fall is *unwitnessed*

One patient incident #NOF

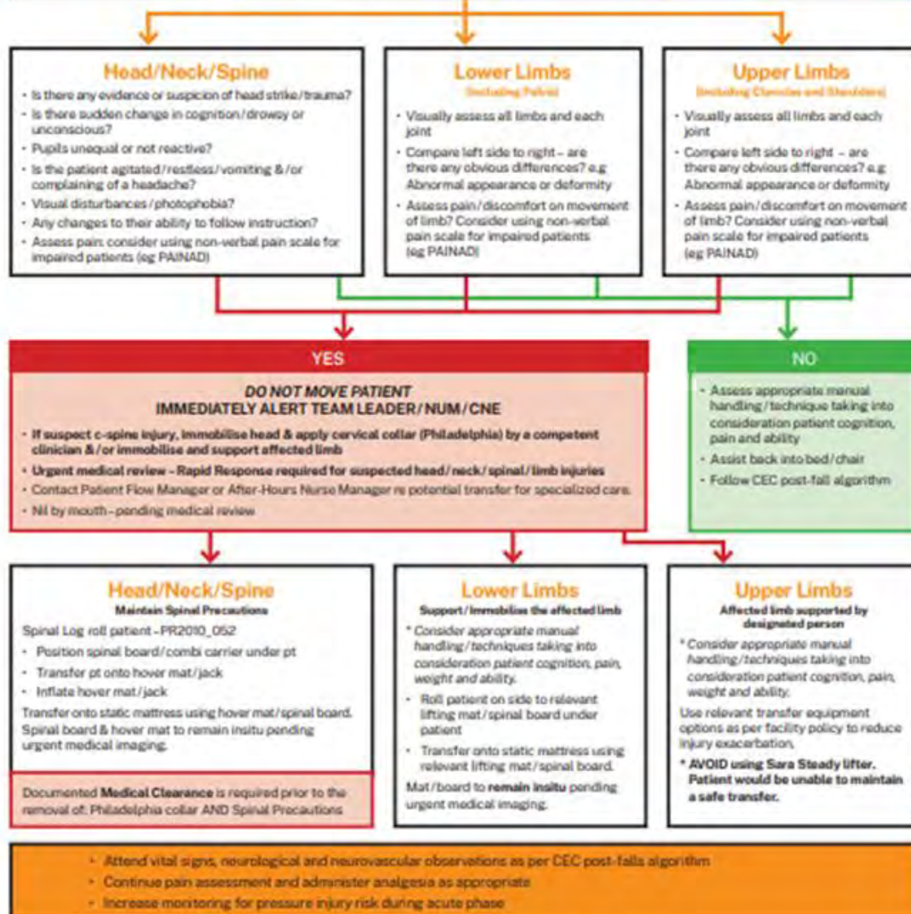
injuries were "obvious" and patient had significant pain



One patient incident #C2 & #L2 head laceration with other injuries not obvious

Northern Sydney Local Health District

Immediate Post-Fall Injury Assessment



Before moving patient:
Immediate Action – ASK, LOOK, FEEL
To be used in conjunction with PD2008_001 Falls Prevention and Management Policy – NSLHD and the Clinical Excellence Commission Post-Fall Assessment Algorithm 2013

Head/Neck/Spine
- Is there any evidence or suspicion of head strike/trauma?
- Is there sudden change in cognition/drowsy or unconscious?
- Pupils unequal or not reactive?
- Is the patient agitated/restless/vomiting &/or complaining of a headache?
- Visual disturbances/photophobia?
- Any changes to their ability to follow instruction?
- Assess pain: consider using non-verbal pain scale for impaired patients (eg PAINAD)

Lower Limbs
- Visually assess all limbs and each joint
- Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity
- Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)

Upper Limbs
- Visually assess all limbs and each joint
- Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity
- Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)

YES

DO NOT MOVE PATIENT
IMMEDIATELY ALERT TEAM LEADER/NUM/CNE
- **If suspect c-spine injury, immobilise head & apply cervical collar (Philadelphia) by a competent clinician &/or immobilise and support affected limb**
- **Urgent medical review – Rapid Response required for suspected head/neck/spinal/limb injuries**
- Contact Patient Flow Manager or After-Hours Nurse Manager re potential transfer for specialized care.
- Nil by mouth – pending medical review

NO
- Assess appropriate manual handling/technique taking into consideration patient cognition, pain and ability
- Assist back into bed/chair
- Follow CEC post-fall algorithm

Head/Neck/Spine
Maintain Spinal Precautions
Spinal Log roll patient – PR2010_052
- Position spinal board/combi carrier under pt
- Transfer pt onto hover mat/jack
- Inflate hover mat/jack

Transfer onto static mattress using hover mat/spinal board. Spinal board & hover mat to remain insitu pending urgent medical imaging.

Documented **Medical Clearance** is required prior to the removal of: Philadelphia collar AND Spinal Precautions

Lower Limbs
Support/Immobilise the affected limb
* *Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.*
- Roll patient on side to relevant lifting mat/spinal board under patient
- Transfer onto static mattress using relevant lifting mat/spinal board.

Mat/board to **remain insitu** pending urgent medical imaging.

Upper Limbs
Affected limb supported by designated person
* *Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.*

Use relevant transfer equipment options as per facility policy to reduce injury exacerbation.

* **AVOID using Sara Steady lifter. Patient would be unable to maintain a safe transfer.**

- Attend vital signs, neurological and neurovascular observations as per CEC post-falls algorithm
- Continue pain assessment and administer analgesia as appropriate
- Increase monitoring for pressure injury risk during acute phase

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Ref: https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-program/falls-prevention/hospitals/post-fall

Acknowledgement – Central Coast Local Health District

JUL23/V1 CATALOGUE NO. NS09667J-A4-E

What can *we* do??

-Immediate Post-Fall Injury Assessment..

Have you seen this poster/flyer?

Step 1

Immediate Post-Fall Injury Assessment

Before moving patient:

Immediate Action – ASK, LOOK, FEEL

To be used in conjunction with PO2008_001 Falls Prevention and Management Policy – NSLHD and the Clinical Excellence Commission Post-Fall Assessment Algorithm 2013

After a fall – **leave** the patient on the floor *if considered safe,* and conduct injury assessment/medical review, ***before*** moving patient back into bed or chair

Step 2

Top to toe assessment

Head/Neck/Spine	Lower Limbs (Including Pelvis)	Upper Limbs (Including Clavicles and Shoulders)
• Is there any evidence or suspicion of head strike/trauma? • Is there sudden change in cognition/drowsy or unconscious? • Pupils unequal or not reactive? • Is the patient agitated/restless/vomiting &/or complaining of a headache? • Visual disturbances/photophobia? • Any changes to their ability to follow instruction? • Assess pain: consider using non-verbal pain scale for impaired patients (eg PAINAD)	• Visually assess all limbs and each joint • Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity • Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)	• Visually assess all limbs and each joint • Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity • Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)

YES

DO NOT MOVE PATIENT

IMMEDIATELY ALERT TEAM LEADER/NUM/CNE

- **If suspect c-spine injury, immobilise head & apply cervical collar (Philadelphia) by a competent clinician &/or immobilise and support affected limb**
- **Urgent medical review – Rapid Response required for suspected head/neck/spinal/limb injuries**
- Contact Patient Flow Manager or After-Hours Nurse Manager re potential transfer for specialized care.
- Nil by mouth – pending medical review

NO

- Assess appropriate manual handling/technique taking into consideration patient cognition, pain and ability
- Assist back into bed/chair
- Follow CEC post-fall algorithm

Step 3

Safely getting off the floor after assessment

Head/Neck/Spine

Maintain Spinal Precautions

Spinal Log roll patient – PR2010_052

- Position spinal board/combi carrier under pt
- Transfer pt onto hover mat/jack
- Inflate hover mat/jack

Transfer onto static mattress using hover mat/spinal board. Spinal board & hover mat to remain insitu pending urgent medical imaging.

Documented **Medical Clearance** is required prior to the removal of: Philadelphia collar AND Spinal Precautions

Lower Limbs

Support/Immobilise the affected limb

* *Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.*

- Roll patient on side to relevant lifting mat/spinal board under patient
- Transfer onto static mattress using relevant lifting mat/spinal board.

Mat/board to **remain insitu** pending urgent medical imaging.

Upper Limbs

Affected limb supported by designated person

* *Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.*

Use relevant transfer equipment options as per facility policy to reduce injury exacerbation.

* **AVOID using Sara Steady lifter. Patient would be unable to maintain a safe transfer.**

- Attend vital signs, neurological and neurovascular observations as per CEC post-falls algorithm
- Continue pain assessment and administer analgesia as appropriate
- Increase monitoring for pressure injury risk during acute phase

Do you have access to the right equipment?

Utilising a **Spinal Board** on the hover jack/mat when moving a patient off the ground provides a firm and stable surface to maintain spinal cord alignment

Step 4 CEC Post Fall Guide

CEC POST FALL GUIDE

NSW FALLS PREVENTION PROGRAM

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.

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, SpO₂, Blood Glucose and Pain Score, Neuro Observations

Your Local Clinical Emergency Response System and Protocols

Notify Medical Officer of Fall (using ISBAR)

ONGOING OBSERVATIONS and MONITORING

BP, P, R, T, Sp02, 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 -

CLINICAL REVIEW

RAPID RESPONSE

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.

NO
- Assess appropriate manual handling/technique taking into consideration patient cognition, pain and ability
- Assist back into bed/chair
- Follow CEC post-fall algorithm

Use this algorithm for all falls as usual *once* initially assessed

Step 5

After a fall, complete the:

- Post Fall Management Form
- *And* the Post-Fall Huddle Form (where used)

08/07/2016 1144 By: Davis, Melissa

Post Fall Management

De-identified

This form is to be completed post fall ***Refer to the CEC Post Fall Guide

Date of fall: Time found: Ward / Dept: IIMS number:

Most recent fall risk score and date completed:

POST FALL OBSERVATIONS initiated (as per CEC post fall guide) and recorded on observation chart? ◯ Yes

NEUORLOGICAL OBSERVATIONS initiated and recorded on observation chart? ◯ Yes

CHECK FOR SEPSIS (as per CEC post fall guide):

Does this patient have sepsis risk factors and / or signs & symptoms of infections?
and
Does this patient have observations in the yellow zone?
◯ Yes - Follow Sepsis Path ◯ No

CHECK FOR DELIRIUM (as per CEC post fall guide):

Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion? ◯ Yes ◯ No

Alert medical officer: ◯ Yes ◯ No

Complete CAM: ◯ Yes ◯ No

Refer to FRAMP for management strategies: ◯ Yes

CHECK FOR HEAD INJURY (as per CEC post falls guide):

Please note that head trauma / intracranial injury can still occur in the absence of hitting head or visible trauma.
Monitor observations and cognition and consider:

Patient on anticoagulants / anti-platelets? ◯ Yes ◯ No CT brain ordered? ◯ Yes ◯ No

Initial injuries: ◯ Yes ◯ No Injury type: X-Ray ordered: ◯ Yes ◯ No

MO notified: ◯ Yes ◯ No Time notified: MO Name:

Person responsible notified: ◯ Yes ◯ No By whom: If not, why:

Fall prevention information provided to patient / carer / family: ◯ Yes ◯ No

Fall Risk Assessment and Management Plan (FRAMP) reviewed: ◯ Yes

Implemented and documented in patients notes: ◯ Yes

High fall risk status documented in notes: ◯ Yes Clinical handover updated: ◯ Yes Medication review requested: ◯ Yes ◯ No

Referrals made:

Notified of fall and injuries:

☐ Nurse Unit Manager ☐ Department Head ☐ Registered Nurse ☐ In Charge ☐ Medical Officer ☐ Admitting Team ☐ Other

Acknowledgement to CCLHD, SESLHD, ISLHD and the CEC Falls Prevention as per paper version NH700042 16.02.2015

Where can I find ?

Order from Design and Print:
CATALOGUE NO: NS09667J-A4-E

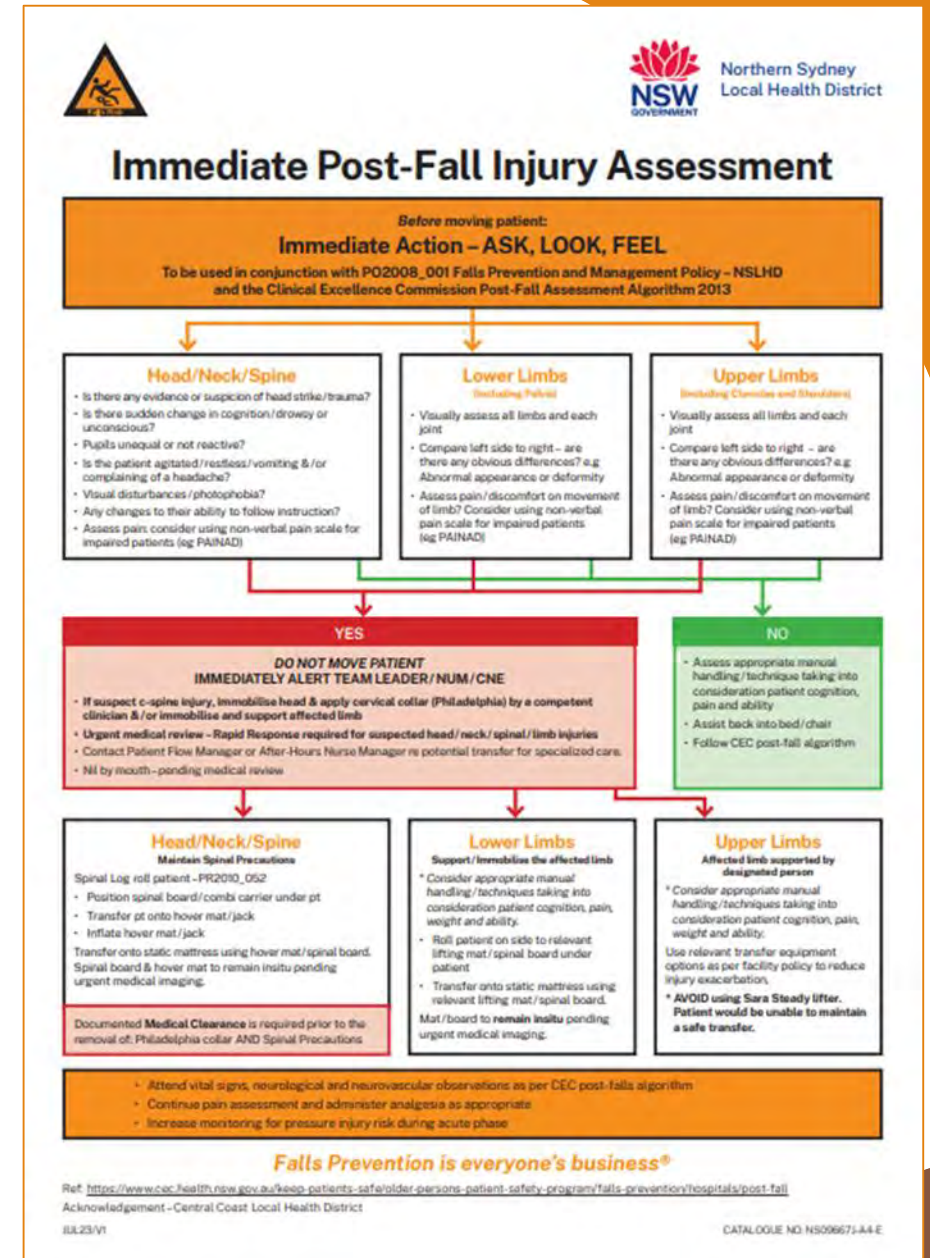
A4 self-print PDF version available on the online Catalogue:

http://intranet.nsccahs.nswhealth.net/corpsupport/CorpCom/design/CatalogueNS/catalogue/NS09667J-A4-E.pdf

A3 self-print PDF version available on the online Catalogue:

http://intranet.nsccahs.nswhealth.net/corpsupport/CorpCom/design/CatalogueNS/catalogue/NS09667J-A3-E.pdf

Please print in colour



Northern Sydney Local Health District

NSW GOVERNMENT

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Any questions?

Thank you

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Presentation designed by Allyson Waird, CNC Aged Care, Delirium and Dementia