

# Post Falls Management Guide

Notify medical officer using ISBAR and follow local Clinical Emergency Response Systems (CERS) protocol for escalation of care.

## Immediate Response

### BASIC LIFE SUPPORT

Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABCD).

### RAPID ASSESSMENT

Perform a systematic A-G assessment including a full set of vital signs, neurological observations and identify signs of injury.

**Do not move the patient until assessed:** examine cervical spine and immobilise if there is an indication of injury. Follow the CEC Post fall assessment for injury guide.

Keep the patient Nil By Mouth pending medical review.

## Ongoing observations and monitoring

### ONGOING OBSERVATIONS

Conduct a full set of vital signs and neurological observations for at least hourly for the first 4 hours. Then fourth hourly for the next 24 hours (as a minimum) or more frequently as clinically indicated, then **REVIEW - ongoing observations as required.**

Check for	Consider	Action
Sepsis	Signs of infection with organ dysfunction	Follow Sepsis Pathway
Delirium	Fluctuating cognition, new confusion or behaviour changes	Complete 4AT
Acute Coronary Syndrome	Chest pain/pressure, radiating pain arm/back/jaw, SOB, sweating, dizziness or nausea	Follow pathway for Acute Coronary Syndrome Assessment
Syncope	Causes of syncope	Assess patient for postural hypotension and follow syncope diagnosis and management pathway
Stroke	Facial droop, weakness, speech or vision changes?	Follow local stroke pathway Complete B.E.F.A.S.T test
Head/C-Spine Injury	Trauma or tenderness	CT Scan recommended

### Strong indicators for CT scan:

- Patient on anticoagulants, antiplatelets, or with known coagulopathy (check INR/aPTT)
- Abnormal or fluctuating Glasgow coma scale (GCS), changes in cognition or behaviour, or new/increasing confusion
- Large facial/scalp bruising, nausea, vomiting, or persistent severe headache
- Age >65 years (use clinical judgement) – **older patients on anticoagulants may sustain an intracranial bleed without direct impact**
- **If anyone including the patient, family and/or carer is worried the patient is getting worse - escalate as per local CERS.**

## Communicate

- Notify the person responsible. Inform identified family/carer/friend
- Discuss treatment options with the patient or person responsible in line with any Advance Care Plan
- Notify the incident in the incident management system and document in the health care record
- Conduct a multidisciplinary post fall huddle
- Communicate revised strategies/care plan at safety huddles & clinical handover
- Incorporate strategies during intentional rounding.