COMMUNITY CARE SETTINGS

Procedure Following a Fall

NOTE: Any fall may lead to serious consquences in the older population

CLINICAL REVIEW - GP

Timely review of person by the General Practitioner

CALL AMBULANCE

Rapid Response: Dial Triple 0 (000)

If person requires basic life support

- Remain calm and reassure person and family members
- Immediate Response: Apply DRSABCD (Danger, Responsive, Send for Help, Airway, Breathing. CPR, Defibrilator if available)

Check for signs of injury

OR

Observe for unusual body posture, active bleeding, bruising, new pain, neurological signs

- Leg shortened, rolled outwards could indicate a broken hip
- Deformed wrist/arm could indicate a fracture
- Bruising/bleeding around the head could indicate concussion/head injury
- Confusion: disorientation, agitation, restlessness and changes in usual behaviour - could indicate head injury
- Is the person on anti-coagulants? If yes - be alert for head injury, there is an increased risk of intra-cranial injury/internal bleeding
- If you have concerns based on your clinical judgement, call for a clinical review/rapid response

Person has had a fall and is UNABLE to get to their feet/has an injury/acute confusion and is unable to be treated and stabilised

- **CALL** an **AMBULANCE Triple 0 (000)**
- Take observations (BP, Pulse, Respirations, Neuro obs) - if trained
- Contact a support person and GP
- Make person comfortable and monitor for signs of shock or other change in condition
- **DO NOT** leave client unattended

Person is found on the floor – has no obvious injury and is able to get to their feet OR person reports that they have had a fall

- Where required assist person into a chair – as per procedure page 15 *Staying Active and on your feet* booklet or CEC Flyer *How to get up from a fall*
- Discuss the incident with the person and assess for any change in function (ADL/mobility)
- Contact person responsible or significant support person/carer - and if not available facilitate follow-up call/s to check on condition
- Contact their GP to inform them of the fall and relay any relevant information
- Warn the person/family/carer of delayed signs: dizziness, blurred vision, headaches, confusion (disorientation, agitation, restlessness and changes in behaviour - be alert for head injury), sudden onset of pain or new pain, inability to weight bear
- Advise them to contact their GP and/or ambulance if any of these signs develop
- Gain consent from the person to make referrals to appropriate services for falls risk assessment and management if required
- Do not leave the person until stabilised, or, if possible, when a support person is with them

When you return to the office

- Complete an IIMS report as appropriate
- Document actions - communicate fall information at Clinical Handover
- Make referrals to appropriate disciplines to conduct falls risk assessment and management