POST-FALL EVENT ALGORITHM

Is Patient Conscious?

YES

Does the patient have neck/head pain or new neurological defects?

NO

Obtain Vital Signs and Complete Assessments

Gather pertinent info: History, medications, lab results, injury risk factors.

Notify physician to report fall, symptoms, & pertinent info. Ask if testing or medication hold is indicated.

Document date/time of event, assessment, intervention, physician notification & outcomes in medical record. (See Follow-up Section)

1. Do not move patient, get assistance. Use C-spine immobilization if necessary (Contact ED charge RN to complete)

2. Gather pertinent info via assessment boxes below and contact physician. Prepare for appropriate testing.


NO

Check ABC’s: Begin CPR if necessary

Code 99/Rapid response

CARDIAC:
Assess & document: Orthostatic VS, pulses, heart sounds, O2 sat, telemetry (if applicable).

If NO head trauma:
VS every 8 hours X 48 hours

If MINOR head trauma:
VS every 4 hours X 48 hours (and neuro assessment as below)

INTEGUMENT:
Assess & document: Bruising, lacerations, hematomas, abrasions, or obvious bleeding.

NEURO:
Assess & document: Blood sugar, pupils, speech, numbness or tingling, changes in mental status/LOC.

If MINOR head trauma:
Neuro assessment every 2 hours X 12 hours, then every 3 hours X 24 hours, then every 4 hours X 24 hours.

MUSCULOSKELETAL:
Assess & document: Pain or deformities

FOLLOW-UP:
1. Increase patients fall risk to high per Fall Prevention Policy and Procedure

2. Add and document on the “POST EVENT” intervention (assure the event date & time are added as intervention “text” on the process intervention screen by using the “edit text” function)

3. Complete an incident report through the Quantros system

4. 24 hours post fall event, evaluate & document for injury (if any) in the post event screen.