FALLS MANAGEMENT

DEFINITION:

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. A fall (incident) has occurred even when there is no injury, and/or when the resident was 'lowered' to the floor by staff. A Registered Nurse must assess the resident before they are allowed to be moved. A near miss fall should also be reported to a Registered Nurse so that the resident can be assessed, e.g. tripped and almost fell.

1. OFFER BASIC LIFE SUPPORT AND PROVIDE REASSURANCE

- Check for danger.
- Check the resident's airways, breathing and circulation.
- Check whether the resident is responsive:
  - Responds to verbal or physical stimulus
  - Changes in the level of consciousness
  - Headache
  - Amnesia
  - Vomiting (etc)
- **CHECK FOR INJURIES -** abrasions, contusion, laceration, skin tears, fracture, and head injury.
- Reassure and comfort the resident

2. TAKE BASELINE OBSERVATIONS

Conduct a preliminary assessment that includes taking baseline observations of pulse, blood pressure, respiratory rate, oxygen saturation and blood sugar levels. **If the resident has hit their head, or if their fall was unwitnessed, record neurological observations** (e.g., using the Glasgow Coma Scale). Continue to check and document observations and neurological observations as per facility policy.

3. MOVE THE RESIDENT

Assess whether it is safe to move the resident from their position and identify any special considerations in moving them. Staff members should use a lifting device to get the resident up off the ground. **Staff should never lift the person on their own.** Follow the facility's policy or guidelines on lifting.

4. MONITOR THE RESIDENT

- Observe residents who have fallen and who are taking anticoagulants or antiplatelets (blood-thinning medications) carefully, because they have an increased risk of bleeding and intercranial haemorrhage. Residents with a history of alcohol abuse may be more prone to bleeding. Follow the facility's policy.
- Arrange for ongoing monitoring of the resident because some injuries may not be apparent at the time of the fall. Follow the facility's incident report regarding type, frequency and duration of the observations that are required (e.g., pain assessment, neurological observations). Ensure that the appropriate documentation is commenced and maintained (e.g. pain charting, observation charts).
- Once the initial assessment has been completed and the resident is settled on the bed or chair ask them to stand up and take a few steps to assess their function (if they can usually weight bear). Ongoing assessment of weight bearing and function.
- Never cease observations before the timeframe required by the facility as a slow intercranial haemorrhage may only become apparent after three days.

5. REPORT THE FALL

- Report all falls (including near miss falls) to the next of kin of the resident.
- Report all falls to a medical officer, even if injuries are not apparent.
- Report the fall to the appropriate people as directed by the facility's incident report.

6. DOCUMENT

After every fall:

- An incident report must be completed and must include the below detail.
- Document the incident in the resident's progress notes.

Documentation on the incident report and in the progress, note **MUST** include the following:

- Who found the resident?
- Where were they?
- What position were they in?
- How did they get up from the floor (e.g., independently or with a lifting device)
- Did they complain of pain?
- Could they weight bear?
- Were observations taken.
- Was the usual function present in all limbs?
- Was there any swelling/contusions on the head?
- Was there any swelling/contusions elsewhere?
- Was there any shortening or rotation of either leg?
- Was first aid provided.
- Were hip protectors or other falls prevention (sensor mat etc) in use?
- What do you think was the cause of the fall (e.g. inadequate footwear, walking without aid, clutter in room, inadequate lighting, stumbled, tripped etc.)
- What did you do to prevent the fall from happening again (e.g., increased monitoring, put sensor mat in place etc.)?

(*Adapted from Preventing Falls and Harm from Falls in Older People, ACSQHC, 2009)*