Residential Care Facility
Post Fall Clinical Pathway

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Contact: PSU@health.qld.gov.au

• Clinical pathways never replace clinical judgement
• Care outlined in this clinical pathway must be altered if it is not clinically appropriate for the individual resident
• This pathway is to be used for any adult resident who has had a fall
• V indicates a variance from the pathway, document in clinical notes

Immediate actions
» Commence DRSABCD (Danger, Response, Send for help, Airway, Breathing, CPR, Defibrillate - if available) or as per local procedure
» Call for assistance
» Do not move the resident until assessed for injuries and safety
» Observe for symptoms of head and / or muscular skeletal injury e.g. any change in behaviour, change in level of consciousness, headache or vomiting, any deterioration - call 000 where required and / or immediately verbally contact GP for advice

Details of fall and initial actions
Date: / / Time found: : Respiratory rate: O₂ Saturation: % Blood pressure: / Heart rate: GCS score: Temperature: °C BGL:

Was the resident unconscious? □ Yes □ No
Obvious major skeletal deformities / obvious fracture? □ Yes □ No

Major head trauma? □ Yes □ No
Did the resident show signs of increased confusion? □ Yes □ No

All care givers who initial are to sign signature log

Key ➔ Medical ➤ Nursing

Medical assessment
▲ • Verbally contact the GP
Who was notified?

▲ • Verbally notify the GP if any of the following applies to the resident:

known coagulopathy on anticoagulant / antiplatelet therapy
fall from greater than 1 metre in height suspected head injury
other: 

Investigations / observations

Document in observation chart at the following intervals

• Suspected head injury or unwitnessed fall
What: neuro obs, respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When: Day 1
½ hourly for 1 hour, if normal
½ hourly for 2 hours, if normal
¾ hourly for 8 hours, if normal
1st hourly for 6 hours, if normal
2nd hourly for 6 hours, if normal
4th hourly for 8 hours, if normal
8th hourly for 24 hours

or observation as per medical order

• No head injury
What: respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When: Day 2
hourly for 4 hours, if normal
2nd hourly for 6 hours, if normal
4th hourly for 8 hours, if normal

or observations as per medical order

• If there is a reduction in GCS score of 3 or more points or deterioration of observations (any change in behaviour, headache and or vomiting) call 000 immediately and verbally contact GP immediately

Management plan (within 24 hours)
▲ • Notify family of incident as soon as possible (as agreed upon with family)
• Surgical intervention / treatment plan as per GP order
• Document incident and outcomes in resident’s clinical record
• Log incident report
• Communicate incident, outcomes and planned care at handover
• Review Falls Assessment and Management Plan

Signature log (every person documenting in this pathway must also supply a sample of their initials in the signature log below)

Initial Print name Designation Signature
Immediate actions

» Commence DRSABCD (Danger, Response, Send for help, Airway, Breathing, CPR, Defibrillate - if available) or as per local procedure.
» Do not move the resident until assessed for injuries and safety.
» Observe for symptoms of head and/or musculoskeletal injury e.g. any change in behaviour, change in level of consciousness, headache or vomiting, any deterioration - call 000 where required and/or immediately verbally contact GP for advice.

Resident Fall Post Fall Clinical Pathway

Residential Care Facility

Management plan (within 24 hours)
Note that there may be late manifestations of head injury after 24 hours.

» Notify family of incident (as agreed upon with family).
» Surgical intervention as per GP order.
» Document incident and outcomes in resident's clinical record.
» Log incident report.
» Review Falls Assessment and Management Plan.

Investigations / observations

No head injury
What:
» respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When:
» hourly for 4 hours, if normal →
» 2nd hourly for 6 hours, if normal →
» 4th hourly for 8 hours, if normal → or observations as per medical order.

Suspected head injury or unwitnessed fall
What:
» neuro obs, respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When:
» ¼ hourly for 1 hour, if normal →
» ½ hourly for 2 hours, if normal →
» ⅛ hourly for 8 hours, if normal → or observations as per medical order.

Medical assessment

» Document initial observations:
- respiratory rate, O₂ saturation, blood pressure, heart rate, GCS, temperature, blood glucose level (BGL) (as per local policy).
- Document the following:
  » major head trauma
  » major skeletal deformities
  » obvious fracture
  » signs of confusion

Suspected head injury or unwitnessed fall

What:
» respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When:
» hourly for 4 hours, if normal →
» 2nd hourly for 6 hours, if normal →
» 4th hourly for 8 hours, if normal → or observations as per medical order.

Initial assessment

Resident Fall (witnessed or unwitnessed)

Investigations / observations

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» respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When:
» hourly for 4 hours, if normal →
» 2nd hourly for 6 hours, if normal →
» 4th hourly for 8 hours, if normal → or observations as per medical order.

Resident Fall (witnessed or unwitnessed)

What:
» respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
When:
» hourly for 4 hours, if normal →
» 2nd hourly for 6 hours, if normal →
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» respiratory rate, O₂ saturation, blood pressure, heart rate, BGL (as per local policy)
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