##### Post-fall Clinical Assessment

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| --- | --- | --- |
| **Patient does not hit head**   * Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your center’s protocol. * Call for assistance. Activate appropriate emergency response team if required. * Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider. * Identify all visible injuries and initiate first aid; for example, cover wounds. * Assess surgical site if post-operative * Assist patient to move using safe handling practices.   **Proceed to:**   * Check vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, and hydration). * Clean and dress any wounds. * Inform treating medical provider. * Provide analgesia if required and not contraindicated. * Arrange further tests as indicated, such as blood sugar levels and x rays. |  | **Patient hits head or has unwitnessed fall**   * Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your center’s protocol. * Call for assistance. Activate appropriate emergency response team if required. * Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider. * Assess Glasgow Coma Scale (next page). * Identify all visible injuries and initiate first aid; for example, cover wounds. * Assess surgical site if post-operative * Assist patient to move using safe handling practices.   **Proceed to:**   * Record neurologic observations, including Glasgow Coma Scale. Observe for signs indicating stroke, change in consciousness, headache, amnesia, or vomiting. * Get baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, and hydration). * Clean and dress any wounds. * Arrange medical review. * Provide analgesia if required and not contraindicated. * Arrange further tests as indicated, such as blood sugar levels, x rays, ECG, and CT scan. |

##### Important Communications

* In the medical record, document the incident, outcome, and initial and ongoing observations, and care plan.
* Notify the treating medical provider at the time of the incident.
* At any handovers, inform all clinical team members about the incident, and any changes to the care plan.
* Notify family in accordance with your center’s policy.

##### Glasgow Coma Scale

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

**Activity Score**

|  |  |
| --- | --- |
| **Eye opening** | |
| None | 1 = Even to supraorbital pressure |
| To pain | 2 = Pain from sternum/limb/supraorbital pressure |
| To speech | 3 = Nonspecific response, not necessarily to command |
| Spontaneous | 4 = Eyes open, not necessarily aware |
| **Motor response** | |
| None | 1 = To any pain; limbs remain flaccid |
| Extension | 2 = Shoulder adducted and shoulder and forearm rotated internally |
| Flexor response | 3 = Withdrawal response or assumption of hemiplegic posture |
| Withdrawal | 4 = Arm withdraws to pain, shoulder abducts |
| Localizes pain | 5 = Arm attempts to remove supraorbital/chest pressure |
| Obeys commands | 6 = Follows simple commands |
| **Verbal response** | |
| None | 1 = No verbalization of any type |
| Incomprehensible | 2 = Moans/groans, no speech |
| Inappropriate | 3 = Intelligible, no sustained sentences |
| Confused | 4 = Converses but confused, disoriented |
| Oriented | 5 = Converses and oriented |

**TOTAL (3–15): \_\_\_\_\_\_\_**