When a Fall Occurs

Four steps to take in response to a fall.

Step one: assessment. When a patient falls, don't assume that no injury has occurred—this can be a devastating mistake. Before moving the patient, ask him what he thinks caused the fall and assess any associated symptoms. Then conduct a comprehensive assessment, including the following:

- Check the vital signs and the apical and radial pulses.
- Check the cranial nerve.
- Check the skin for pallor, trauma, circulation, abrasion, bruising, and sensation.
- Check the central nervous system for sensation and movement in the lower extremities.
- Assess the current level of consciousness and determine whether the patient has had a loss of consciousness.
- Look for subtle cognitive changes.
- Check the pupils and orientation.
- Observe the leg rotation, and look for hip pain, shortening of the extremity, and pelvic or spinal pain.
- Note any pain and points of tenderness.

Be aware of the following warning signs: numbness or tingling in the extremities, back pain, rib pain, or an externally rotated or shortened leg. These symptoms suggest spinal cord injury, leg or pelvic fracture, or head injury.

Step two: notification and communication. Notify the physician and a family member, if required by your facility's policy. Also, most facilities require the risk manager or patient safety officer to be notified. Be certain to inform all staff in the patient's area or unit. Such communication is essential to preventing a second fall.

Step three: monitoring and reassessment. After the patient returns to bed, perform frequent neurologic and vital sign checks, including orthostatic vital signs. Fall victims who appear fine have been found dead in their beds a few hours after a fall.

Step four: documentation. Follow your facility's policies and procedures for documenting a fall. Thorough documentation helps ensure that appropriate nursing care and medical attention are given. Whether it's written on the patient's chart or entered in the hospital's electronic medical record, documentation for a fall should include

- all observations.
- patient statements.
- assessments.
- notifications.
- interventions.
- evaluation.

Be sure to note the patient's thoughts about the cause of the fall and associated symptoms, and whether the patient lost consciousness.

Classification. To measure the outcome of a fall, many facilities classify falls using a standardized system. Follow your facility's policy.

Reporting. Most facilities also require that an incident report be completed for quality improvement, risk management, and peer review. This report should include

- patient history.
- how the fall occurred.
- assessment.
- diagnoses.
- intervention.
- outcome.

Analysis. Identify the underlying causes and risk factors of the fall. What was done to prevent it? Is the fall considered accidental (extrinsic), anticipated physiologic (intrinsic), or unanticipated physiologic (unpredictable)? Immediate follow-up will help identify the cause and enable staff to initiate preventative measures.—*Ann Hendrich, MSN, RN, FAAN*

ajn@wolterskluwer.com