Falls

Effective: January 1, 2024
Replaces: New

1. Routine Treatment

1.1. Routine Medical Care – Adult **(700-S04),**
1.2. Complete rapid trauma assessment
1.2.1. If patient meets trauma alert criteria **(Policy 605)** follow the Trauma Care Protocol **(700-A16)** select the appropriate trauma center and transport immediately **(Policy 602).** Exceptions may apply to hospice/advance directive patients.
1.3. Control bleeding as appropriate
1.4. Spinal Motion Restriction **(700-M11)** as appropriate
1.5. Blood Glucose Level (BGL), if less than 60 mg/dL, treat for hypoglycemia **(700-A03)**
1.6. Asses for signs and symptoms of stroke and treat as appropriate **(700-A13)**
1.7. Assess for signs and symptoms of chest pain and treat as appropriate **(700-A08)**
1.8. Assess for signs and symptoms of cardiac dysrhythmia and treat as appropriate **(700-A05; 700-A14)**
1.9. If patient actively seizing, treat as appropriate (**700-A02**)
1.10. Assess for extremity fractures, dislocations, or sprains
1.10.1. Consider pain management (**700-S04**) prior to stabilization and immobilization
1.10.2. Elevate in neutral position
1.10.3. Apply ice/cold packs to minimize swelling (do not apply directly to bare skin)
1.10.4. Assess and reassess neurovascular status when manipulating or splinting fractures
1.10.5. Suspected hip fractures not meeting trauma alert criteria can be transported to closest ED for evaluation

2. ALS Treatment

2.1. **Consider** Vascular Access (IV/IO)
2.1.1. A second **IV** or **Saline lock** may be established as appropriate
2.2. **Consider** cardiac monitoring and obtain **12 Lead ECG**
2.3. **Consider 500mL Fluid bolus,** to maintain SBP greater than 90 mmHg

3. Special Considerations

3.1. Dizziness, loss of balance, and gait ataxia may indicate presence of stroke
3.2. Syncopal episodes in geriatrics can be due to cardiac dysrhythmias
3.3. Patients with bleeding disorders or taking anticoagulants are at an increased risk for cerebral hemorrhage. For patients whose head may have hit ground/object yet have no apparent injuries can be transported to closest ED for evaluation.
3.4. For patients who are not being transported (i.e., lift assist, stable and/or refuse transport) attempt to rectify falls risks such as floor clutter, throw rugs, walking devices in reach etc.
3.4.1. Encourage a caregiver to remain with patient and monitor for changes in neurological status for at least 24 hours
3.4.2. Provide fall education and consider referral to fall prevention program

4. Fall Flowchart