Falls With Head Injury Order Set
Duke MOVES Champions
Tips Sheet

Purpose

The overall goal of this order set is to identify and escalate care for patient who might have sustained an intracranial hemorrhage (ICH) from a fall.

Important to Know

- This order set is to be initiated by providers for unwitnessed falls or the patient hit their head
- RN is to notify provider ASAP for unwitnessed falls and/or patient hit their head
- Provider review pt. meds. and history to determine if a high risk or low risk for bleed
- Follow the orders VS, assessment frequency and interventions
- Notify provider for decline in VS, any slight neuro assessment changes immediately
- Anticipate orders for a stat head CT & neurosurgery consult for decline in neuro status
- Team to discuss higher level of care for declining neuro status

Assessments and when to notify Provider

Assessment tool	Notify Provider
Glasgow Coma Scale	Score below 15 or decline from baseline
Cincinnati Prehospital Stroke Scale	Any facial droop/ slurred speech/ arm drift
Headache (HA)	Increase in headache is indicative of an ICH
Change in Vision	Any change in vision, blurred, double or loss of vision are indicative of head trauma
Nausea or vomiting	Indicative of potential for ICH

Post Fall Huddle

- Perform huddle at bedside ASAP
- Include patient/family if appropriate
- Follow the post fall Huddle form

Include questions:

- Was this an unwitnessed fall?
- Did patient hit their head ?

Additional 'Just in Time" Resources on the CEPD Website under "Falls Prevention / Duke Moves"