Falls

Evaluation/Management

- Assess patients at bedside. Look for any injury; any locality on exam must be worked up in the appropriate manner (e.g. head CT, plain films, immobilization, etc). In particular, look for: ecchymosis, abrasions, fractures, pain, asymmetry, deformity, decreased range of motion, look at head, hands, shoulders, hips, knees, feet.
- Do a complete neuro exam including gait, strength, and cerebellar tests. Mental status testing may be necessary if a patient is confused or altered.
- Check orthostatics.
- Try to find out the circumstances of the fall. Witnessed? By whom?
- Loss of consciousness (does the patient remember hitting the ground)? Mechanism (getting out of bed, going to bathroom, standing up, turning around, etc.)? Associated symptoms (premonitory aura, incontinence, dizziness, headache, visual symptoms, palpitations, chest pain, dyspnea)? Preceding actions (coughing, urinating, straining, standing suddenly)? Past medical history, prior falls)?

Differential diagnosis.

- Differentiate mechanical fall vs. transient loss of consciousness.
- Don’t forget the following:
  - Neuro: seizure, CVA/TIA, gait disorder, Parkinson’s, vertigo, dementia, normal pressure hydrocephalus, poor proprioception
  - Cardiac: arrhythmia, MI, vasovagal, hypovolemia, orthostasis
  - Meds: new medication or new dose, especially sedative/hypnotics, antidepressants, antihypertensive, vasodilators, opioids, alcohol, diuretics (requiring frequent trips to the bathroom). Don’t forget alcohol and illicit drugs.
  - Musculoskeletal: arthritis, pain, deconditioning, weakness
  - Other: anemia, poor eyesight, dim lighting, room change, bed rails left down, wet floor. 4. Document the fall by writing a progress note.

Revision #3
Created 25 February 2022 06:15:02 by Katarina Soewono
Updated 10 June 2022 04:39:55 by Katarina Soewono