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Ballarat Health Services
Putting your health first

Ref: CMO Corresp: COR 2019 004763 MH/CA

24 April 2021

Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Re: Ballarat Health Services Response to COR 2019 004763

There has been much work done internationally on management of minor head injury in anticoagulated patients, and whilst the general management consensus has moved towards obligate CT, there remains some debate within the field (1, 2). The recommendation for a mandatory CT scan in patients with a minor head injury who are anticoagulated is part of the Victorian Trauma Guidelines (3), and as such, the policies at BHS aim to adhere to this.

We have reviewed the BHS policies in this field as per recommendation (i).

The BHS policy document "Head Injury (closed) – Adult," CPP0057, follows the current Victorian Trauma Guidelines, namely that all patients with a head injury and who are anticoagulated should have an immediate CT scan. We attach the printed copy of the relevant protocol, valid as of 20/04/2021.

The BHS policy document "Post Fall Management," CPP0489, is a document outlining management of a falls patient across all body areas and systems. As part of the immediate management post-fall it requires reference to CP0057 as above. We attach the printed copy of the relevant protocol valid as of 20/04/2021. This policy in attempting to address all possible injuries post-fall is extremely complicated and would benefit from revision. This process is now underway and will result in far clearer guidance for staff of all levels dealing with a patient who has fallen.

It may be that the policy documents provided to the CPU were not these specific documents, as the "Review of care" section mentions "relevant policies" but does not detail them further. These are, however, the policies which would have applied. Having examined the head injury policy, which reflects the current Victorian Guidelines and current best practice, we cannot agree with finding 30 that head injury guidelines do not reflect current standard practice.

The review has, however, highlighted that in an increasingly complex field an all-encompassing protocol may actually confuse the issue. The risk of overlooking the instruction of the need for head injuries to be managed according to CPP0057 should be highlighted further within the post fall management document. We have now undertaken the necessary steps to ensure that this occurs and as a result of the coroner's recommendation, the guidance for our staff will be far clearer.

Furthermore, to ensure that current and correct policy documentation is always available to the Coroner's Office and the CPU, we will clarify with them the contact route for obtaining such from Ballarat Health Services.

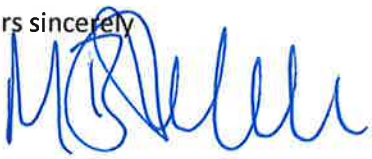
1. Kuczawski M, Stevenson M, Goodacre S, Teare MD, Ramlakhan S, Morris F, Mason S. Should all anticoagulated patients with head injury receive a CT scan? Decision-analysis modelling of an observational cohort. BMJ open. 2016 Dec 1;6(12).

2. Campiglio L, Bianchi F, Cattalini C, Belvedere D, Rosci CE, Casellato CL, Secchi M, Saetti MC, Baratelli E, Innocenti A, Cova I. Mild brain injury and anticoagulants: Less is enough. Neurology: Clinical Practice. 2017 Aug 1;7(4):296-305.

3. Trauma Victoria. https://trauma.reach.vic.gov.au/guidelines/anticoagulation-in-trauma/head-injury-and-oral-anticoagulants. Accessed 21/04/2021

Should you require any further information regarding the above responses, please do not hesitate to contact me on 5320 4278 or email matthew.hadfield@bhs.org.au.

Yours sincerely



Mr Matthew Hadfield FRCS (Gen Surg), FRACS (Vasc)
Chief Medical Officer
Ballarat Health Services

Atts

Copy: Dr Linda Danvers, BHS Medico Legal Officer

Ballarat Health Services

CLINICAL PRACTICE PROTOCOL

Head Injury (closed) - Adult
SCOPE (Area): Emergency
SCOPE (Staff): Medical, Nursing

Printed versions of this document SHOULD NOT be considered up to date / current

Rationale

Closed head injury is a common problem presenting to the Emergency Department with the majority fitting in the "mild head injury" category. CT scanning guidelines have been developed (Canadian CT head rule and New Orleans Criteria) to help guide when to scan this group of patients. This is a high risk clinical scenario (up to 5% of mild head injury patients require neurosurgical intervention) and there have been several coronial recommendations regarding the management of these patients.

Expected Objectives / Outcome

- Apply a consistent approach to the reception, investigation and management of patients who fit into the "mild head injury" category with a clinical guideline (and flowchart) as to when scanning should be performed in this group of patients.
- Rapid investigation and management of those patients in the moderate and severe head injury groups with the treatment goals of expeditious transfer (when required) and prevention of secondary injury.

Definitions

stabbed, wound deeper than it is wide, puncture wound to scalp.

- Closed Head Injury – a traumatic injury to the brain which does not involve either penetration of the cranial vault or open fracture of the cranial vault. Scalp lacerations can occur in the setting of both closed and open head injuries.
- Mild head injury – GCS 14 -15; may be subdivided into low, medium and high risk groups on the basis of history and clinical examination; this group is best suited for a clinical decision rule. Risk stratification involves the following: history of blunt trauma; witnessed or reported loss of consciousness; definite amnesia (of event or anterograde) or witnessed disorientation; injury within 24 hours; post traumatic seizure; focal neurology; and the presence of coagulopathy (history not laboratory).
- Moderate Head Injury – GCS 9 - 13, accounts for approximately 10% patients, mortality less than 20% but disability rates as high as 50%.
- Severe Head Injury – GCS < 9, mortality approaches 40 percent and less than 25 percent make good recovery.
- Anterograde amnesia – short term memory deficit of events after the time of injury (may manifest by asking the same question recurrently).
- Retrograde amnesia – loss of memory of events prior to the injury – may be very difficult to determine without significant collateral history.
- Intoxication – a state of impaired central nervous system function secondary to the presence of a psychoactive substance. **This is a clinical diagnosis not a laboratory one**. Disturbances include perception, judgment, attention, thinking, wakefulness, emotional control and psycho-motor function.
- Raccoon eyes – bilateral black eyes with characteristic appearance in medial lower eyelids.
- Battle's sign – post auricular bruising.
- ABI clinic – Acquired Brain Injury Clinic run from Queen Elizabeth Centre (ext 93612).

Indications

- This guideline applies to all adult patients (age 16 and over) with closed head injury or suspected closed head injury.
- The head CT guidelines apply only to those in the mild head injury group. **A CT scan is considered mandatory in the group with a GCS of 13 or less on presentation to hospital. Penetrating trauma to the head also mandates a CT scan.**

Contraindications

Age under 16

Penetrating trauma is not managed under this pathway, however in the absence of another guideline, the instructions to order a CT if suspected penetrating head wound are applied here.

Issues To Consider

- **Advice from the Adult Trauma Advice & Referral Line (Phone 1300368661) should be sought early regarding all severe head injuries and moderate and minor head injuries with abnormal CT scans (or other reasons requiring transfer).**
- Expeditious transfer may be required and consultant input should be sought early for these patients – in particular to stabilise the patient and make the necessary arrangements for transfer. All transfers should involve consultation with ARV (Phone: 1300 368 661).
- While all people presenting with a GCS 13 or less require a scan it does not necessarily have to be immediately.
- Intoxicated patients remain a very difficult group and should not be allowed to leave (in the setting of a closed head injury) unless they are GCS 15 and they are considered competent (not impaired in judgment) to make a decision to leave. **Whilst intoxication is a clinical diagnosis breath or blood alcohol analysis should be performed in all patients with closed head injury and a suspicion of alcohol intake.**

Detailed Steps, Procedures and Actions

1. Severe Head Injury Group (GCS<9)

- Triage to resuscitation area, Category 1.
- Receive in conjunction with the Trauma Team.
- Urgent CT

  scan of head and cervical spine.
- Treatment aim is to prevent secondary brain injury:
  - Intubation and maintain oxygenation (plus cervical spine protection).
  - Prevent hypotension (treat hypovolaemia and shock).
  - Reverse anticoagulation (if present).
  - Decrease ICP (where indicated) – mannitol (1g/kg), tilt head of bed to 30 degrees, urgent transfer to deal with bleeds.
  - Consider anticonvulsant (phenytoin 15-20mg/kg, no more than 50mg/min).
  - Hyperventilation is not recommended (target CO_2 = 35).
- Arrange transfer to a major trauma service. **Phone ARV 1300 368661.**

2. Moderate Head Injury Group (GCS 9-13)

- Triage to resuscitation area for assessment, Category 1-2.
- Receive in conjunction with the Trauma Team.
- Co-operative patients should have an urgent CT scan of head and cervical spine.
- Un-cooperative patients require control prior to CT and often intubation is the best option in this group. Sedation with haloperidol (+/- midazolam) may be used in the presence of medical staff qualified to secure the airway rapidly. **No sedated patient should go to CT without an experienced medical escort and advanced airway equipment.**
- Once the CT has been performed then decision regarding transfer or admission to BHS needs to be made. This may involve consultation with either the Surgical Unit and/or the Intensive Care Unit in the patient with a normal or near normal CT scan. If in doubt, consult via ARV.
- Treatment aims are as for the severe head injury group. Patients with abnormal CT scans should be transferred to a major trauma service. **Phone ARV 1300 368 661.**

3. Minor Head Injury Group (GCS 14-15)

- Patients in this group should have a history of blunt trauma (within 24 hours) and **at least one** of the following:
  - witnessed or reported loss of consciousness (NOT MANDATORY).
  - definite amnesia (of event, retrograde or anterograde).
  - witnessed disorientation.
  - external evidence of injury above the clavicles (open wounds or significant bruising).
  - any vomiting.
  - severe headache.
  - focal neurology.
- Any patient that fits within the above criteria and has **any** of the following should have an immediate CT scan (refer to flowchart):
  - seizure after the trauma.
  - any history of anticoagulation or bleeding disorder.
  - focal neurology.
  - any fall in GCS.
- The Canadian Head CT rule should be applied to the remainder of this group (refer to flow chart).
  - a CT scan is required for patients with any of the following

High risk (for neurosurgical intervention)

- GCS < 15 two hours after injury (not presentation)
- Suspected open or depressed skull fracture
- Any sign of base of skull fracture (haemotympanum, "racoon" eyes, CSF otorrhoea or rhinorrhoea, Battle's sign)
- Any vomiting
- Age over 60.

Medium Risk (for brain injury on CT)

- Amnesia before impact > 30 minutes
- Dangerous mechanism (pedestrian struck by motor vehicle, passenger ejected from motor vehicle, fall from height > one metre or five stairs).
- The remaining patients should be observed for four hours (or longer) and discharged when safe to go home. **Any patient with a fall in their GCS during the period of observation requires an immediate CT scan.**

- After a normal CT scan further observation or discharge should be considered for each case on its merits. **No patient should be discharged prior to attaining a GCS of 15 and being able to safely ambulate.**

4. Discharge Post Closed Head Injury

- All patients should be provided with a head injury instruction booklet and all patients who required a CT should be referred to the Acute Brain Injury (ABI) clinic. Other patients should be considered for ABI clinic referral (on the appropriate referral form - see attachment).
- Safe discharge is imperative and patients post CHI (or intoxicated with CHI) must be assessed as "competent" to discharge themselves against medical advice. **If in doubt seek advice and/or restrain the patient (physically or chemically) until a decision is made. Adequate documentation in such cases is mandatory.**
- All suspected penetrating skull injuries to have CT prior to discharge (immediate or next morning depending on clinical situation).
- All patients should be discharged in the care of a responsible adult.

NOTES / PRECAUTIONS

Intubation is the preferred method of control in the acutely disturbed head injured patient. **Chemical restraint should only be considered when experienced medical staff (able to gain control of the airway rapidly) are available. These patients require a medical escort when leaving the ED for scans.**

Intoxicated patients are at much higher risk of adverse outcome and as such a lower threshold for scanning is appropriate in this group.

Scalp wounds should be satisfactorily explored where there is any question of underlying skull fracture or penetrating injury.

Related Documents

- CPG0001 - Cervical Spine Injury Assessment And Clearance Flow Chart
- CPG0090 - Trauma Team Activation
- CPP0555 - Discharge At Own Risk - Against Medical Advice.
- SOP0001 - Principles Of Clinical Care

References

- Department of Health and Human Services, Victoria. (2020). The Victorian State Trauma System (VSTS). Retrieved from
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- The Royal ChildrenÃ¢â‚¬â„¢s Hospital Melbourne. (2018). Head injury - clinical practice guideline. Retrieved from
- Tintinalli, J. E., Stapczynski, J. S., Ma, O. J., Yealu, D. M., Cline, D. M. & Meckler, G. D. (eds). (2016). Tintinalli's emergency medicine: a comprehensive study guide (8th ed.). New York: McGraw Hill.

Appendix

- Appendix 1 Minor Head Injury Flow Chart GCS>13

Reg Authority: Clinical Online Ratification Group	**Date Effective:** 27/10/2020
Review Responsibility: Emergency Physician - Emergency Department	**Date for Review:** 27/10/2023

Ballarat Health Services

CLINICAL PRACTICE PROTOCOL

Post Fall Management
SCOPE (Area): Acute, Sub Acute, Mental Health, Allied Health Community Programs
SCOPE (Staff): All Staff

Printed versions of this document SHOULD NOT be considered up to date / current

Rationale

Clinical leaders and senior managers of Ballarat Health Services (BHS) implement systems to prevent patient falls and minimise harm from falls.

Falls-related injury is one of the leading causes of morbidity and mortality in older Australians.[1] Falls are a leading cause of injuries for older hospitalised patients.[2] Falls in hospitals are associated with an increased length of stay, higher rates of discharge to institutional settings and greater use of healthcare resources.[2] The effects of fall-related injuries, such as functional impairment, pain and distress, can be significant for older people in hospital, who may already be frail or at risk of functional decline. For these reasons, the reduction of falls and fall-related injuries are major concerns for patients, their carers and health care staff at BHS.

Expected Objectives / Outcome

This protocol outlines the responsibilities of Ballarat Health Services staff after a patient/client has fallen and aims to:

- Enable a consistent and best-practice approach to post-fall assessment, management and follow-up
- Minimise harm from falls and falls-related injuries

Definitions

Fall - an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.(World Health Organisation, 2012). This means as long as a person falls unintentionally onto a lower lever, whether or not it is on the ground, it is considered a fall. This can include slips, trips, loss of balance and applies to events that are witnessed or unwittnessed.

Abbreviations and Acronyms

- BP - Blood pressure
- DRSABCD - Danger, Response, Send for Help, Airway, Breathing, Cardiopulmonary Resuscitation (CPR), Defibrillation
- GCS - Glascow Coma Scale
- ISBAR - Identification, Situation, Background, Assessment, Response
- ISR - Incident Severity Rating
- MO- Medical Officer
- ORC - Observation and Response Chart
- SMMSE - Standardised Mini Mental State Examination
- VHIMS - Victoria Health Incident Management System
- PMP - Patient Management Plan

Indications

In the event of a fall at RHS in Acute, Subacute, Mental Health or Clinic-based Community Programs (classified as Subacute Ambulatory Care), the person/patient will have management and care implemented in accordance with this Clinical Practice Protocol.

Community Programs
Community Programs which are not classified as Subacute Ambulatory Care Services will follow CPP0588 Post Fall Management - Community Programs

Palliative patients
Care for patients on **option D** "Goal of Care plan - Comfort during dying" who fall will not follow this CPP. Management for this group will focus on:

- Physical assessment to diagnose injuries, however, no further investigations are required
- Fall risk mitigation strategies applied
- Medical review as indicated for pain management and/or other emerging symptoms e.g. confusion
- Incident documented on the Care of the Dying Management Plan MR2760.1
- VHIMS report completed

Issues To Consider

Anticoagulation

Patients who are prescribed antiplatelet or anticoagulant medication have an increased risk of sustaining an intracranial, intrathoracic or intra abdominal haemorrhage after a fall.[3] The intracranial haemorrhage may occur even if they did not hit their head.

- Anticoagulants include but are not limited to warfarin, heparin, enoxaparin, dalteparin, rivaroxaban, dabigatran, apixaban.
- Antiplatelet drugs include, but are not limited to, aspirin, clopidogrel, aspirin plus dipyridamole (asasantin)
- Alcohol dependant persons, people with liver disease or people with bleeding disorders are all considered coagulopathic.
- The RISK versus harm of continuing anticoagulant therapy post fall should be considered by the treating medical team.
- A suitably qualified clinician should be consulted prior to continuing or discontinuing anticoagulant use post-fall

Other considerations

- Special consideration should be given for older patients because of atypical or subtle presentations of fractures and closed head injury.
- There may be late manifestations of head injury up to 72 hours after a fall.
- Fall incidents resulting in surgical intervention or rated ISR 1 or 2 are to be reviewed within 24 hours
- Refer to Safe Transfer and Handling of People (No Lift)- NCG0019 when considering the most appropriate means of moving a patient who has fallen. The use of lifting devices may be indicated.

Detailed Steps, Procedures and Actions

1. **Immediate management post fall** (Post Fall Management Flow chart Appendix 1)

- Do not move initially (Follow DRSABCD - Appendix 2). Activate Medical Emergency Team (MET) or clinical review if patient meets criteria for prompt care.
- Call for assistance
- Immobilise cervical spine if head and neck pain is reported or suspected
- Baseline vital signs - BP, heart rate, respiratory rate, oxygen saturation, temperature, blood glucose levels
    - **If fall is unwitnessed and/or head strike OR the patient is on anticoagulant/antiplatelet medication undertake observations as per section 2**
    - **If fall is witnessed and no head strike occurs, undertake observations as per section 3.**
- Check for other potential injuries being aware that a patient may not want to draw attention to all of their injuries or may not be able to articulate if cognitively impaired.
- Conduct Neurological observations and assessments, including GCS, speech, eye movements and pupil abnormalities (note baseline GCS should be undertaken for all falls whether witnessed or unwittnessed) (Refer Head Injury Observations Adult CPP0376)
- Observe for new or worsening confusion, headache, amnesia, vomiting or change in the level of consciousness

- Clean and dress wounds - consider tetanus prophylaxis if required
- Assess if patient can be moved and made comfortable. Assess most appropriate method of moving patient if injury to limbs suspected. Refer to NCG0019 for Safe Transfer and Handling of People (No Lift)
- Notify medical officer and request a review - or refer to Clinical Escalation CPP0231
- Consider need for pain relief and offer analgaesia as indicated
- Consider need to appropriate investigations - ECG, x-rays, CT scan, blood tests (full blood count, coagulation profiles, septic screening) Refer to CPP0057 Head Injury (Closed).

2. Unwitnessed fall and/or head strike OR the patient is on anticoagulant/antiplatelet medication

- Record vital signs and neurological observations - BP, heart rate, respiratory rate, oxygen saturation, temperature, blood glucose levels
  First 6 hours post fall
  - Baseline
  - 30 minutely for 4 hours then hourly for 2 hours. Then request medical review. Continue observations at least 4 hourly for 24 hours or as required
- Observe for change in the level of consciousness, headache, amnesia or vomiting
- Notify MO immediately in any change in observations.
  6-12 hours post fall
- If 4 hourly neurological and physiological observations are stable continue until 24 hours after the fall
- If 4 hourly neurological and physiological observations are unstable, return to 30 minutely Neurological and Physical observations and request medical review.
  12-24 hours post fall
- If all observations remain stable for 24 hours, return to normal pre fall observations, however remain vigilant as there may be late manifestations of head injury.
- If observations are unstable, return to 30 minutely Neurological and Physiological observations and request medical review.
- If unstable observations are at anytime fall outside acceptable parameters as per the ORC, an appropriate clinical review or MET response will be called

3. Witnessed fall and no head strike

- Monitor vital signs for 24 hours - BP, heart rate, respiratory rate, oxygen saturation, temperature, blood glucose levels
  - a fall is often the first indicator of another underlying condition so close monitoring is warranted.
  - Baseline, then 30 minutely for 1 hour. Then hourly for next 5 hours. Then request medical review after 6 hours
  - If at anytime observations become unstable, return to 30 minutely Neurological and Physiological observations as above. Consider clinical review or MET response should observations fall outside acceptable parameters as per ORC .

Within hours post-fall

- Record vital signs and neurological observations as indicated above
- Promptly action any observations outside of acceptable parameters.
- Notify MO of any visual or focal motor/ sensory changes or speech disturbance.
- Continue investigation and treatment of injuries sustained.
- Notify Next of Kin and provide patient, family and carer falls risk management education.
- If not already identified as high risk of fall injury, ensure falls risk is upgraded to **HIGH** for patient.
- Ensure minimum standards as per Patient Management Plan (PMP), and all other appropriate falls interventions are in place as per assessed risk as per multifactorial risk assessment.
- Complete VHIMS adverse event report and fully document in patient medical record.
- Consider need for transfer if further medical review required (e.g Emergency Department from sub-acute)
  Post-fall review
  - Document fall in medical record. Include mechanisms of fall, location, time, injury and actions taken. Note any fall that results in surgical intervention or is rated ISR 1 or 2 must be reviewed within 24 hours.
  - Reassess falls risk status
  - Document and update PMP to ensure appropriate falls prevention strategies are in place.
  - Conduct/update cognition assessment as required utilising approved screening tool.
  - Refer to relevant staff as per PMP e.g physiotherapist, cognition nurse consultant
  - Communicate incident, outcomes and care plan to all relevant staff and highlight as high falls risk on shift-to-shift handover

Ongoing management

- Reassure patient and their family
- Notify MO of any visual or focal motor/ sensory changes or speech disturbance.

- Ensure care plan and PMP are in place, effective and updated as required
- Review investigation results. Clinical escalation if required
- Modify environment to reduce falls - as per minimum falls prevention strategies.
- Refer to relevant staff
    - Physiotherapist within 48 hours post fall
    - Occupational Therapist within 48 hours post fall
    - Pharmacist review within 48 hours post fall
    - Dietitian review if indicated via Malnutrition Screening Tool
    - Podiatry if indicated
    - Social work or psychology if the patient exhibits any signs of fear of falling
    - Specialist Clinical Nurse Consultant - cognition, continence, wound care, aged care, if indicated
- Continue patient, family and carer education on falls risk management and ensure inclusion of patient and family in development of falls prevention plan
- Optimise secondary prevention of further falls by:
    - Consider Vitamin D testing.
    - Consider bone mineral density scan if patient is at risk of osteoporosis.
    - Consider use of hip protectors
    - Consider type of bed to utilise

Fall without injury in Sub-Acute Ambulatory Care

If a sub-acute ambulatory care patient has a fall in the out patient setting, that patient will be fully assessed as per immediate post management fall. If the patient has not injured themselves and has been reviewed by a suitable allied health professional, they may be discharged to home, with advice to have a review via their GP to have their falls risk and prevention interventions reviewed, and if condition changes prior to GP review to attend the Emergency Department. This will be fully documented in their medical note and a VHIMS will be recorded.

Family will only be advised of patient fall if patient gives consent or if the patient is injured and requires ongoing medical attention.

Manager Post Fall Review and Documentation

Each fall shall be reviewed by the manager with review findings documented in Manager Review section of VHIMS. When reviewing each fall, the manager should assess whether appropriate falls intervention strategies have been implemented, based upon the patient's falls risk assessment. See appendix 3 for Post Fall Review - Appropriate Interventions Check List, for suggestions of minimum preventative strategies that should be shown to be implemented as per VHIMS..

Related Documents

- CPP0433 - Medical Emergency Team (MET) / Respond Blue
- CPP0045 - Preventing Falls And Harm From Falls - Acute Subacute
- CPP0048 - Mobility, Dexterity & Rehabilitation Part A And Falls Management Part B
- CPP0057 - Head Injury (closed) - Adult
- CPP0231 - Escalation Of Patient Safety Concerns
- CPP0376 - Neurological Observations (Adult)
- NCG0019 - Safe Patient Handling (sph)
- POL0208 - Preventing Falls And Harm From Falls
- CPP0468 - Adult Observation And Response Chart - Orc
- CPP0583 - Preventing Falls And Harm From Falls - Mental Health
- CPP0498 - Preventing Falls And Harm From Falls - Community Programs
- CPP0588 - Post Fall Management - Community Programs
- SOP0001 - Principles Of Clinical Care

References

- 1. WHO. (2017). Falls fact sheet.
- 2. Australian Commission on Safety and Quality in Health Care. (2009). Preventing falls and harm from falls in older people: best practice guidelines for Australian hospitals.
- 3. Department of Health, WA. (2015). Post-fall management guidelines in WA healthcare settings.

Appendix

- Appendix 1 Post Fall Management Flow Chart
- Appendix 2. Basic Life Support (DRSABCD)
- Appendix 3 Post Fall Review Assessment of Appropropriate Interventions Check List

Reg Authority: Clinical Online Ratification Group	**Date Effective:** 25/10/2017
Review Responsibility: Clinical Governance Coordinator/Consumer Participation	**Date for Review:** 25/10/2022