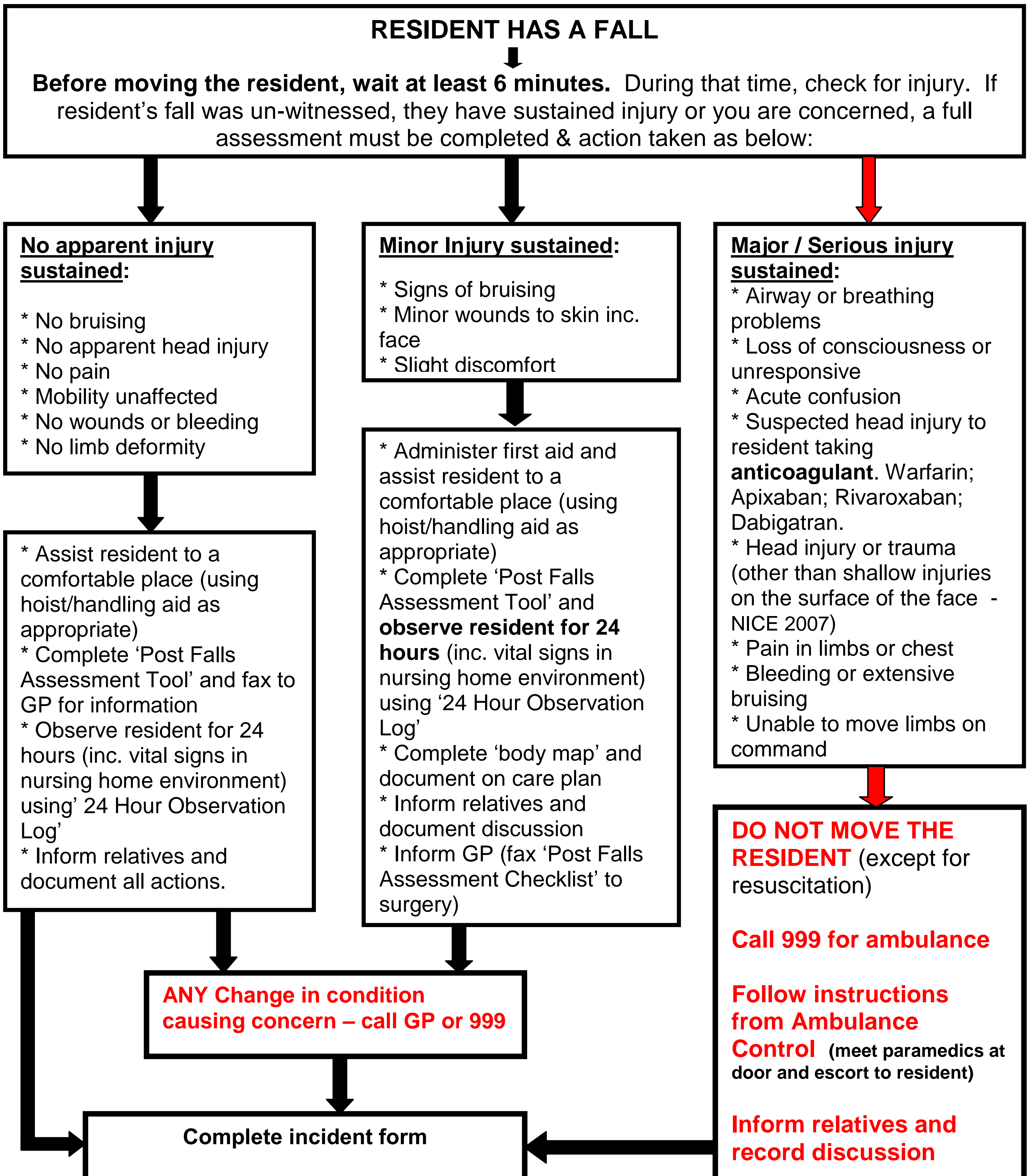
POST FALLS PROTOCOL



Duty Officer / Nurse Action Checklist (response to falls)

DANGER	check for dangers, seek advice	**999**
RESPONSE	unresponsive	**999**
AIRWAY	compromised airway	**999**
BREATHING	absent or difficulty breathing	**999**

- UNCONSCIOUS **999**
- REDUCED LEVEL OF CONCIOUSNESS **999**
- HEAD INJURY AND TAKES ANTICOAGULANT **999** (Warfarin, Enoxaparin, Dabigatran, Rivaroxaban, Apixaban)
- HEAD INJURY / TRAUMA **999**
- MAJOR HAEMORRHAGE **999**
- CHEST PAIN **999**
- OTHER SEVERE PAIN **999**
- LIMB DEFORMITY (inc shortening and rotation) **999**
- EXCESSIVE SWELLING AND BRUISING **999**
- DIZZINESS / VOMITTING (after fall or head injury) **999**
- FALL GREATER THAN 2 METRES **999**
- CONDITION - causing serious concern for staff **999**

ADMINISTER FIRST AID AND RESUSITATION APPROPRIATE TO NEED
Do not move the resident and follow the emergency treatment and instructions given by Ambulance Control

IF NO REQUIREMENT FOR AN EMERGENCY AMBULANCE RESPONSE

- Administer first aid as appropriate
- Complete the post falls assessment with resident (blood pressure and blood sugar - Nurse only)
- Assist resident to a comfortable place (using a hoist and manual handling aids as required)
- Inform relatives and document the discussion in the care plan
- Fax the completed post falls assessment to the GP Practice
- Observe resident for 24 / 48 hours using the post fall observation log (blood pressure - Nurse only) - keep in care records
- Complete body map - keep in care records
- Complete incident form and follow incident reporting procedure

IF AN AMBULANCE CLINICIAN HAS ATTENDED THE RESIDENT, THERE IS STILL A REQUIREMENT TO FULFILL THE FOLLOWING ACTIONS

- Complete post falls assessment documentation and body map
- Observe resident for 24 / 48 hours if remaining in HCC care
- Inform relatives and document the discussion in the care plan
- Complete incident form and follow incident reporting procedure

IN ALL CASES WHERE THE RESIDENT REMAINS IN THE CARE OF HAMPSHIRE COUNTY COUNCIL, THE POST FALLS ASSESSMENT TOOL SHOULD BE SCANNED TO THE RESIDENT'S GP PRACTICE

POST FALL ASSESSMENT TOOL SCAN & SEND TO RESIDENT'S GP WHEN COMPLETE

Name of resident			
Date and time of fall			
Place of residence			
Name and signature of person assessing		Time and date of assessment	

		√ *Tick and sign*
Level of consciousness	Responsive as normal	
	Less responsive than usual	
	Unresponsive or unconscious (call 999)	
Pain or discomfort	No evidence of pain or discomfort	
	Showing signs of pain or complaining of pain	
Where is the pain?		
Injury or wounds	No evidence of injury, bleeding or wounds	
	Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb	
Where is the injury or wound/s?		
Movement and mobility	Able to move all limbs as normal for the resident	
	Able to move limbs but has pain on movement	
	Unable to move limbs as normal for the resident or there is a major change in mobility	

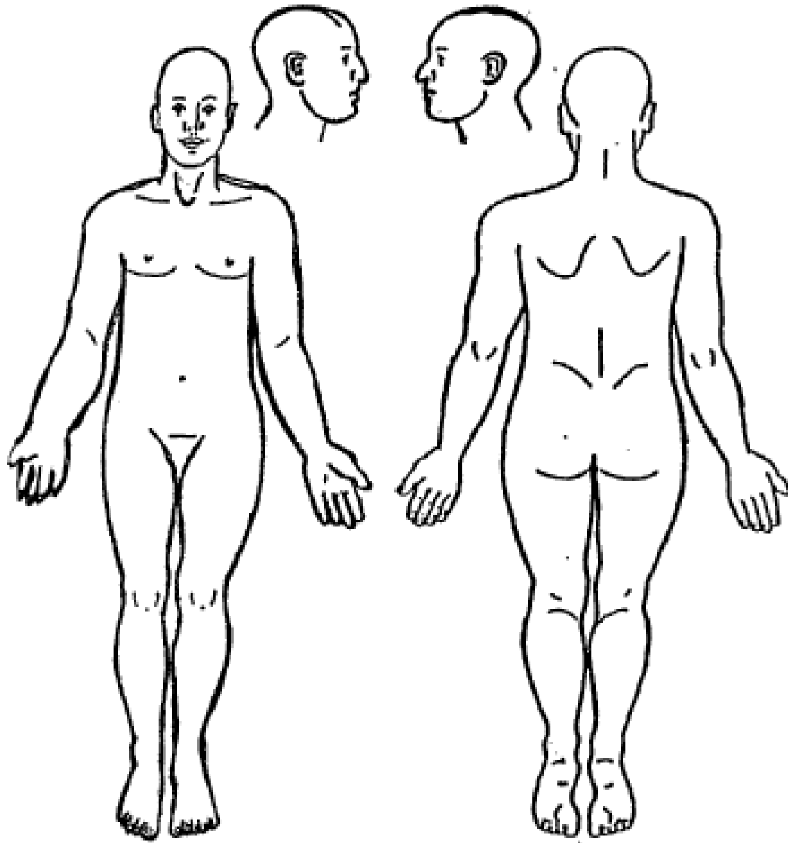
Observations including neurological observations (nursing homes only)

Pulse		**Blood pressure**		**Blood sugar**		**Neuro-Obs chart**	**Tick & sign**

Conclusion of assessment		*Tick and sign*
No apparent injury or minor injury ☐	Give first aid treatment	
	Commence observations (use post falls assessment chart and complete body map)	
	Inform relatives	
	Complete an incident form	
Major injury ☐	Give first aid / resuscitate and **call 999** **DO NOT MOVE THE RESIDENT**	
	Commence observations (use post falls assessment chart and complete body map)	
	Inform relatives	
	Complete an incident form	

Body Map – Assessment of Injury (keep in resident's care plan)

Name of resident		Date of Birth	
Residence		Date and time of fall	



Marks or bruising on resident's body (describe, mark on map above with date observed)

Residents description of any pain/s or non-verbal signs of residents pain with date

Day number following fall, Date & Time	Action taken and Date	Signature

24-48 Hour Post Fall Observation Log

Name of resident		Date of Birth	
Residence		Date and time of fall	

Observations should be done as soon as possible after the fall, then:

- **Every 15 minutes for one hour**
- **Once half an hour later**
- **Once one hour later**
- **Once two hours later**
- **Every four hours until 24 hours post-fall. Wake the resident up to do the checks. *Do not assume the resident is simply asleep.***

Fill in the time observations are due in the 'Time' column on the chart

Date	Time	Reported Pain/ signs	Wounds/ Bruises	BP Pulse + Neuro obs chart	Comments	Signature
	ASAP					
	15 min later					
	15 min later					
	15 min later					
	15 min later					
	30 mins later					
	One hour later					
	2 hours later					
	4 hours later					
	4 hours later					
	4 hours later					
	4 hours later					
	4 hours later					