

Action Following a Fall

Consider risk of bleeding
eg anticoagulants/warfarin

Summon Assistance
Assess for Injury

No Apparent Injury/Minor Injury
eg skin graze

Assess moving and handling and if it is safe to do so assist resident into bed or chair, using appropriate equipment, as per policy

Immediate action to support resident:

Reassess resident
Provide reassurance, Stay with resident
Record observations, BP, pulse, temperature, blood sugar, urinalysis
Consider administering pain relief eg paracetamol if prescribed and if dose has not been given within previous 4 hrs
Ensure call buzzer within reach

Inform GP or Call 111

Request medical assessment and medication review (This may not be until the following day)

Other Major Injury
Suspected neck or spinal injury, suspected limb or hip fracture
New pain or increase in pain
New confusion, agitation or change in behaviour
Onset of new symptoms F.A.S.T (face, arm, speech, time)

While waiting for the ambulance follow ambulance flow chart

DO NOT MOVE RESIDENT
CALL 999

Head Injury or suspected head injury
Unwitnessed Fall
New headache, loss of consciousness
New onset of confusion, agitation or change in behaviour

Neurological Observations (Registered Nurses only)
½ hr until Glasgow Coma Scale = 15 (or 14 if confused BEFORE fall)
Then ½ hourly for 2 hrs
1 hourly for 4 hrs
2 hourly until further review

Symptoms can be delayed and may not become evident until later in the day, **continue to reassess for any changes, if concerned Call 999**

Post Fall Actions:

Inform relatives
Inform manager
Complete falls incident form
Complete post fall assessment protocol according to organisation policy
Reassess resident for risk of falls and adjust care plan as appropriate
Introduce falls prevention assistive technology according to risk assessment
Ensure there is an accurate handover between shift changes with details of the fall and how to continue to monitor the resident

because you matter

