NHS
Dudley
Clinical Commissioning Group

# POST FALLS GUIDANCE

**RESIDENT HAS A FALL**

Before moving the resident check for injury and complete FAST assessment.
Does the person have a complex health condition meaning there is specific guidance to follow after a fall?
If so follow that guidance.
If resident's fall was un-witnessed, they have sustained injury or you are concerned, a full assessment must be completed & action taken as below:

| | | |
|---|---|---|
| **F** | Face | Ask the person to smile. Does one side of the face droop? |
| **A** | Arm | Ask the person to raise both arms. Does one arm drift downward? |
| **S** | Speech | Ask the person to repeat a simple phrase. Is their speech slurred or strange? |
| **T** | Time | If you observe any of these signs, call 999 immediately. |

No apparent injury sustained:
* No bruising
* No apparent head injury
* No pain above normal
* Mobility unaffected
* No wounds or bleeding

*Assist resident to a comfortable place (using hoist /handling aid as appropriate)
*Complete 'Post Falls Assessment Tool'
*Observe resident for 24 hrs (inc. vital signs in nursing home environment) using' **24 Hour Post Fall Observation Log**
*Inform relatives and GP, document all actions

Minor Injury sustained:
* Signs of bruising
* Minor wounds to skin including face
* Slight discomfort

*Administer first aid and assist resident to a comfortable place (using hoist/handling aid as appropriate)
*Complete 'Post Falls Assessment Tool' and observe resident for 24 hours (inc. vital signs in nursing home environment) using **24 Hour Post Fall Observation Log**
*Complete 'body map' and document on care plan
*inform relatives and GP, document discussion and all actions

Major / Serious injury sustained:
*Airway or breathing problems
*Loss of consciousness or unresponsive
*Acute confusion (if not normal for the person)
*Suspected head injury to resident taking anticoagulant. (Eg Warfarin; Apixaban; Rivaroxaban; Dabigatran.)
*Head injury or trauma (other than shallow injuries on the surface of the face - NICE 2014*)
*Pain in limbs or chest
*Bleeding or extensive bruising
*Unable to move limbs on command (if not normal for the person)

DO NOT MOVE THE RESIDENT (except for resuscitation)
Call 999 for ambulance
Follow instructions from Ambulance Control (meet paramedics at door and escort to resident)
Inform relatives and GP and record discussion

**ANY** Change in condition causing concern, review using this flow chart – call Dudley Clinical Hub, 111 or 999

**Complete incident form**

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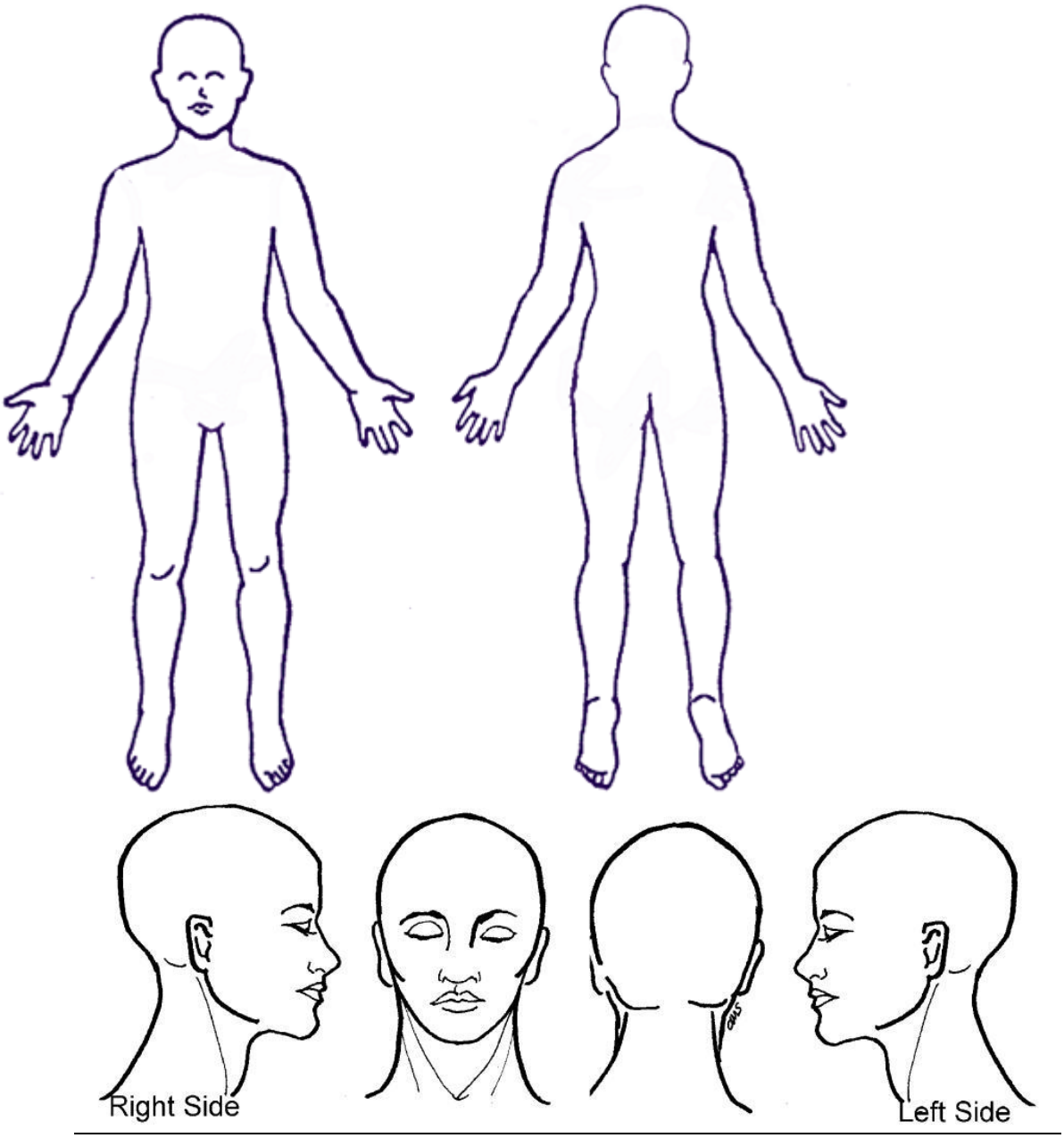
**THIS POST FALLS ASSESSMENT RECORD SHOULD BE KEPT IN THE PERSON'S RECORDS**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name of resident | | | | | | | | |
| Date & Time of Fall | | | | | | | | |
| Name & signature of the person assessing | | | Time & Date of Assessment | | | | | |
| BASIC OSERVATIONS | | | | | | Tick & Sign | | |
| Level of Consciousness | Responsive as normal | | | | | | | |
| | Less responsive than usual | | | | | | | |
| | Unresponsive or unconscious | | | | | | | |
| Level of confusion | No evidence of confusion or disorientation | | | | | | | |
| | No change in the level of confusion or disorientation | | | | | | | |
| | Change in the level of confusion and/or disorientation | | | | | | | |
| Pain or discomfort (Abbey Pain Scale may be useful) | No evidence of pain or discomfort | | | | | | | |
| | Showing signs of new pain or complaining of new 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 | | | | | | | | |
| Pulse | | Blood pressure | | Blood Sugars | | Neuro obs chart | Y | N |
| Conclusion of Assessment | | | | | | Tick & Sign | | |
| No apparent injury or minor injury | Give first aid treatment | | | | | | | |
| | Commence observations (use post falls assessment chart and complete body map) | | | | | | | |
| | Inform relatives & GP (if appropriate) | | | | | | | |
| | 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 & GP | | | | | | | |

## BODY MAP – ASSESSMENT OF INJURY (KEEP IN RESIDENT'S CARE PLAN)

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

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




## RESIDENT'S DESCRIPTION OF ANY PAIN/S OR NON-VERBAL SIGNS OF RESIDENT'S PAIN WITH DATE

| Number of days since the fall | Action taken & Date | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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## 24 Hour Post Fall Observation Log

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

Basic 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

| Basic Observations | | | Time & sign 15mins | Time & sign 15mins | Time & sign 15mins | Time & sign 15mins | Time & sign 30mins |
|---|---|---|---|---|---|---|---|
| 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? | | Any changes? | | | | | |
| 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? | | Any changes? | | | | | |
| 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 | | | | | | |

| Basic Observations | | | Time & sign 1hr | Time & sign 2hrs | Time & sign 4hrs | Time & sign 4hrs | Time & sign 4hrs | Time & sign 4hrs |
|---|---|---|---|---|---|---|---|---|
| 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? | | Any changes? | | | | | | |
| 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? | | Any changes? | | | | | | |
| 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 | | | | | | | |

*NICE GUIDANCE - HEAD INJURY: ASSESSMENT AND EARLY MANAGEMENT CLINICAL GUIDELINE [CG176] PUBLISHED DATE: JANUARY 2014 LAST UPDATED: JUNE 2017