

## POST FALLS ASSESSMENT

### ACTIONS TO BE TAKEN IMMEDIATELY POST FALL

If the resident is in acute pain and/or has lower / upper limb or pelvic/hip injury or spinal injury. **DO NOT MOVE** them but make them comfortable in the position of fall and call 999. Call 999 if the resident has hit their head **AND/OR** has associated vomiting or drowsiness or weakness of body, change in conscious level and if able start neuro observations.

**CALL GP/CHAT** if no serious injuries but the resident complains of pain or has any swelling of lower / upper limb or;  
If their temperature is raised or blood pressure low / high or;  
Their BM is abnormal or; (below 4.0mmol or above 17.0mmol and ketones in urine call 999)  
They have offensive urine smell, a positive urine dipstick or signs/symptoms on chest infection and may require antibiotics.

### TAKE OBSERVATIONS:

If trained to do so check pulse, blood pressure, temperature, SATS, respirations. If safe to move them you can check lying and standing or sitting and standing blood pressure.

**If the resident is stable** and no indication for 999 or GP complete body chart to show injuries / skin tears / red areas etc and record the fall as an incident/accident as per care home policy.

Any concerns with a resident who is frequently falling refer to GP/CHAT to review.

### DOCUMENTATION (see next page for guidance on documentation for an incident form)

How did the resident fall?

How did they land?

What part of the body did they land on?

Did they lose consciousness?

Did they hit their head?

What time of day did they fall?

Exactly where did they fall - 'in their room' is not sufficient.

What were they doing prior to fall?

What was the resident's cognitive state post fall (any change)?

Did they have anything on their feet? (socks, slippers etc. and condition)?

Was the floor wet?

Was the resident using their prescribed mobility aid?

How was the resident got up off the floor?

Have they fallen before - if so how many times in the last 12 months?

Consider the cause of the fall by looking at post falls assessment sheets 1 – 4.

Make a written record in incident book as well as resident notes.

Review risk assessments and care plans for resident post fall and record any new measures put in place.

Between 9-5 pm you can call CHAT team for further advice. Out of hours call CCRT/111