Post Falls Assessment Tool

(Part of the Management of Person who has Fallen in Care Home Pathway)

Scan and send to resident's GP when complete and keep in care records

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

		Tick and sign
Level of conciousness (compared to baseline)	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	

Restore2 assessment score: (follow RESTORE2 escalation pathway) East and North Herts Restore2 Herts Valley Restore2	
Has there been a pattern of falls or a fall in the past 12 months? (if yes refer to multifactoral risk assessment and GP for falls assessment)	

Cause of fall (if known)

Internal factors: (e.g. medication, poor balance, vision, hearing other health related issues)

External factors: (e.g. footwear, mobility aid, obstacles, lighting etc.)

Outcome of Fall

Outcomes	Comments	Tick and sign
Relatives/carers informed		
Post falls assessment completed and sent to GP		
Incident form completed		
Falls investigation (inc. safeguarding) commenced if required		
Falls risk assessment updated		
Reported under Regulation 18 to CQC and HCC if required		
Suspected head injury - 24 hour observations commenced		
Amber Flag - First aid treatment given		
Amber Flag - 111 or HAARC contacted		
Red Flag - First aid and/or CPR given and 999 called		

Severity of Fall Grading Scale

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Please note: The level of harm is indicated by the Classification Code
The addition of a 'U' after the Classification Code means that the fall was Unwitnessed

Classification of Fall	Witnessed (tick)	Unwitnessed (tick)
A. NO HARM – A safety incident that had the potential to cause harm but was prevented, resulting in no harm to the individual OR A safety incident that occurred but where no harm was caused. This includes individuals whose neurological observations were monitored and recorded, but who sustained no injury	A	AU
B. LOW HARM – A safety incident that required extra observation or minor treatment and caused minimal harm (minor treatment includes first aid, additional therapy or additional medication)	B	BU
C. MODERATE HARM – A safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm (for example a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another area such as intensive care because of the incident). Moderate harm also means prolonged pain or prolonged psychological harm which the service user is likely to experience for a continuous period of at least 28 days	C	CU
D. SEVERE HARM – A safety incident that appears to have resulted in permanent harm to one or more individuals receiving care, where the permanent harm directly relates to the incident and not the natural course of the individual's illness or underlying condition. Permanent harm refers to a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions. This includes falls resulting in fractured neck of femur (hip) fracture	D	DU
E. DEATH – Any safety incident that directly results in the death of one or more people receiving care. The death must relate to the incident rather than to the natural course of the individual's illness or underlying condition	E	EU

Body Map - Assessment of Injury

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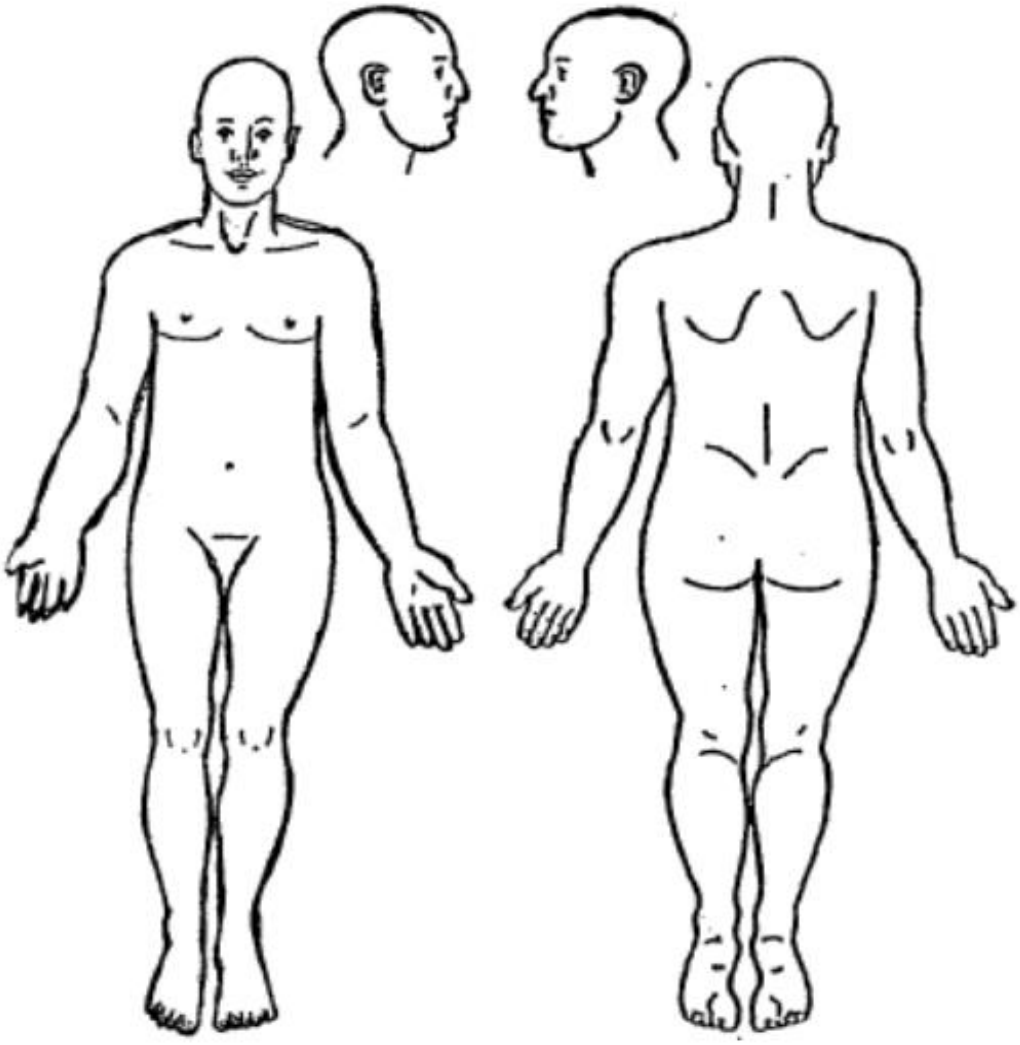
Name and signature of person assessing		Time and date of assessment	



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 Hour Post Fall Observation Log

Keep in care records

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Name of resident	
Place of residence	
Precise Location of fall	
Date and time of fall	

▪ Always monitor the resident for 24 hours following a fall for signs and symptoms of deterioration in their condition.

▪ Follow advice from clincian (111 or HAARC) if they have been consulted.

▪ For suspected head injuries report to a clinician immediately and complete the 24 hour post fall observation log.

First Observation should be as soon as possible after 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 resident up to do the checks as per advice from clincian.

Date	Time	Reported Pain/Signs	Wounds/Bruises	BP Pulse + Neuro Obs As Appropriate	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					