RODWELL FARM NURSING HOME - FALLS PROTOCOL

The Nurse-in-Charge must make an assessment of injury using the Post Fall Assessment Checklist (Appendix 1) prior to moving the resident

Slight/Minor

- No apparent injury
- No head injury
- No complaints of pain/discomfort (verbal/nonverbal)
- Mobility unaffected able to move limbs on command or spontaneously
- No signs of bruising/ wounds
- No signs of limb deformity/shortening rotation

Minor/Injury

- Some bruising
- Slight skin wounds
- Slight discomfort
- No mobility problems able to move limbs on command and spontaneously (within pre-fall range of movement)
- No head injury
- No signs of limb deformity/ shortening/ rotation

Major/Injury

- Loss of consciousness
- Reduced consciousness
- Signs of head injury
- Airway/breathing problems
- Haemorrhage / bleeding
- Chest pain
- Limb deformity
- Pain/discomfort
- Swelling
- Extensive bruising
- Unable to move limbs, joints on command
- Dizziness or vomiting
- Any fall from height above 2 meters
- Any other concerns by assessor.

Any change in condition causing concern, call GP or Emergency Care Practitioner on 999

- Assist resident to a comfortable place (using hoist/handling aid as required)
- Write up Post Falls Assessment in Residata using Checklist in Appendix 2
- Observe resident for 24 hours for pain/and write it up in Residata
- Complete a body map (Appendix 2) and document in Residata.

- Administer first aid and assist resident to a comfortable place (using hoist/handling aid as required)
- Write up Post Falls Assessment in Residata using the Checklist in Appendix 2
- Observe resident for 24 hours for pain/and write it up in Residata
- Complete a body map (Appendix 3) and document the details in Residata.
- Inform relatives and document discussion in Residata
- Inform GP (FAX print out of Post Falls Assessment to Practice) and ask to see resident within next 5 days (unless deterioration)
- Inform Care Manager

- **Do not move resident**
- **Call 999 for ambulance**
- **Inform relatives and document discussion in Residata**

Complete incident form/record in accident book

APPENDIX 1

POST FALL - ASSESSMENT CHECK LIST
The following areas must be written up in Residata "Care Notes" immediately after all falls

Date/Time of Fall	
Level of Consciousness (Check for head injury)	Select one option from: • Responsive (verbal/other) • Less responsive than usual • Unresponsive/unconscious (call 999)
Pain/ Discomfort	Select one option from: • No evidence of pain/discomfort • Showing signs of pain (non verbal) • Complaining of pain (verbal) Site of Pain (if any)
Injury/wounds (check for open wounds, haemorrhage)	Select one option from: • No evidence of bleeding • Swelling/deformity • Bruising/bleeding Site of Injury (if any)
Movement (check for shortening or rotation of limb)	Select one option from: • Able to move limbs on command (within pre-fall range of movement) • Able to move but with pain • Unable to move limbs on command or spontaneously
Observations (Before moving if injury suspected)	Record the following: • Pulse • Blood Sugar • Blood Pressure
Mobility	Select one option from: • Able to get up and weight bear • Able to assist but showing signs of discomfort • Unable to assist themselves up and requires hoist or other handling equipment. • Major change in mobility and condition from pre-fall status?

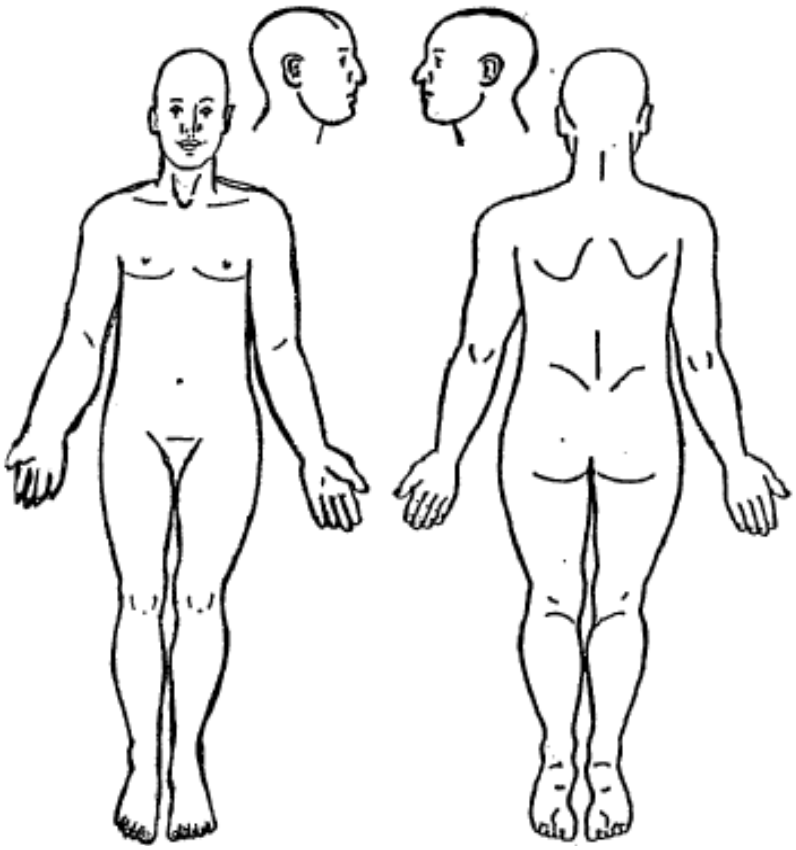
Conclusion, Clinical assessment and judgment	Select one option from:
	• Slight/Minor. If so,
	  o Document in Residata Care Notes
	• Minor/Injury. If so,
	  o Commence 24 hour observation
	  o Inform relatives and document in Residata Care Notes
	  o Inform GP and ask to see within
	  o 5 days (FAX this form to surgery)
	  o Inform Care Manager
	• Major/Injury. If so,
	  o Suspected/confirmed injury, call 999
	  o Inform relatives and document in Residata Care Notes
	  o First aid/resuscitate as appropriate
	  o Close observation until help arrives
	  o Provide ambulance staff with a copy of this form
	  o FAX form to GP surgery
	  o Inform Care Manager

APPENDIX 2

Body Map – Assessment of Injury

Residents Name: _____

Assessed by: _____
(print name)



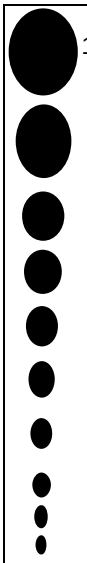
Marks or bruising on residents body (describe and mark on map above)

Date/Time _____

Signature _____

RODWELL HOUSE
NEUROLOGICAL OBSERVATIONS CHART

Date:
Residents' Name:
Suite No:

				Time:																				
 Pupil Scale (mm)	COMA SCALE	EYES OPEN	4 Spontaneously																					
			3 To speech																					
			2 To pain																					
			1 None																					
		BEST VERBAL RESPONSE	5 Orientated																					
			4 Confused																					
			3 Inappropriate words																					
			2 Incomprehensible sounds																					
			1 None																					
		BEST MOTOR RESPONSE	6 Obey commands																					
			5 Localise to pain																					
			4 Withdraws to pain																					
			3 Flexion to pain																					
			2 Extension to pain																					
			1 None																					
			Coma Scale Score																					
If limb power differs, indicate R = Right L = Left	LIMB MOVEMENTS	ARMS	Normal power																					
			Mild weakness																					
			Severe weakness																					
			Flexion																					
			Extension																					
			None																					
		LEGS	Normal power																					
			Mild weakness																					
			Severe weakness																					
			Flexion																					
			Extension																					
			None																					
	PUPILS	R	C = Closed	Size																				
				Reaction																				
		L	C = Closed	Size																				
				Reaction																				
			Pain / Sedation Pain as X Sedation as O	3																				
				2																				
				1																				
				0																				
			Nausea Y = Yes / N = No																					
			Mean Arterial Pressure (MAP)																					
			Central Venous Pressure (CVP)																					
			Intracranial Pressure (ICP)																					
			Nurse Initial																					

		Time																							
Respiratory Rate Accept <……>……		> 25																							
		21-24																							
		12-20																							
		9-11																							
		< 8																							
O2 Saturations Accept <……>……		> 96%																							
		94-95																							
		92-91																							
		< 91																							
Inspired Oxygen																									
Temperature		> 39.1																							
		38.1-39																							
		36.1-38																							
		35.1-36																							
		< 35																							
Blood Pressure Note record both systolic and diastolic pressures but use systolic only to score. Accept systolic BP of …….. as normal for this resident.		> 220																							
		210-219																							
		200-209																							
		190-199																							
		180-189																							
		170-179																							
		160-169																							
		150-159																							
		140-149																							
		130-139																							
		120-129																							
		111-119																							
		101-110																							
		91-100																							
		80-90																							
		70-79																							
		60-69																							
		50-59																							
		40-49																							
Heart Rate Accept heart rate of …….. bpm as normal for this resident.		> 131																							
		121-130																							
		111-120																							
		101-110																							
		91-100																							
		81-90																							
		71-80																							
		61-70																							
		51-60																							
		41-50																							
		< 40																							
Neuro		Alert																							
		Voice																							
		Pain																							
		Unresponsive																							
		Nurse Initial																							