**Post Falls Decision Tool – Decision Recording**

This document should be completed when using the Post Falls Decision Tool to decide on the right course of action with an individual following a fall. A copy should be kept with the individuals’ records.

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| --- | --- | --- | --- | --- |
| Date: |  | | | |
| Name of Resident: |  | | | |
| Name of Decisionmaker: |  | | | |
| **Please circle the decision taken, recording any treatment given or actions taken.** | | | | |
| Is the person breathing and conscious? | | Yes | No | Notes: |
| Does the person have severe or uncontrollable bleeding? | | Yes | No | Notes: |
| Does the person have any of these symptoms:  New central neck or back pain  Blood or clear fluid coming from inside an ear  Swelling or bruising around an eye or behind an ear  Repeated vomiting since the fall  Has fallen from a height of 1 metre or 5 steps | | Yes | No | If yes, which symptom(s)?  Notes: |
| Is the person showing signs of having a heart attack? | | Yes | No | Notes: |
| Is the person showing any signs of having a stroke? | | Yes | No | Notes: |
| Does the person have any of these symptoms:  Leg which appears swollen, out of shape or shorter than the other leg  Foot on injured leg is facing outwards | | Yes | No | If yes, which symptom(s)?  Notes: |
| Is the person showing signs of having had a fit (seizure)? | | Yes | No | Notes: |
| Does the person have any of these symptoms:  Injury to an arm, new bruises, cuts or grazes, mild pain or discomfort, new dizziness, an episode of vomiting since the fall, new memory loss | | Yes | No | If yes, which symptom(s)?  Notes: |
| Is the person taking any anticoagulants (blood thinners)? | | Yes | No | Notes: |
| Is the resident deemed safe to lift? | | Yes | No | Notes: |