**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 painBlood or clear fluid coming from inside an earSwelling or bruising around an eye or behind an earRepeated vomiting since the fallHas 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 legFoot 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: |