Inpatient Post Fall Assessment

Royal Devon and Exeter NHS
NHS Foundation Trust

Patient name: ....
NHS no: ....
Hospital no: ....Please affix patient ID label within this box
DOB: ....

Fall Date & Time:	

Description of fall *including environmental factors, witnessed? By whom?*

Observations										Time Dr called:	
BP		HR		Sp02		RR		GCS		Time Dr arrived:	

NURSING ASSESSMENT

Assessed the patient for injury:	Yes ☐ No ☐	Documented everything in the patient's notes:	Yes ☐ No ☐
Requested an immediate medical review:	Yes ☐ No ☐	Informed the relatives	Yes ☐ No ☐
If there is any suspicion of a head injury, commence neurological observations *(until medical review plan)*:	Yes ☐ No ☐	Updated the Falls Care Plan:	Yes ☐ No ☐
		Ensured other staff on duty are made aware of the fall:	Yes ☐ No ☐
Is the patient on anti-coagulants *(inform doctor)*:	Yes ☐ No ☐	Completed an incident report form on Datix	Yes ☐ No ☐
Considered other measures to prevent another fall:	Yes ☐ No ☐		

Nurse Signature:		**Date:**	
Print name:		**Time:**	

MEDICAL ASSESSMENT

Observations:	**BP**		**HR**		**SpO2**		**RR**		**GCS**	**/15 (E V M)**

Top-toe examination:		**Checked:** *(sign)*	**Comments:**
Skull	Scalp wound/haematoma/ depression/ ridge in skull?		
Eyes	Pupils – equal/reactive?		
Ears	Discharge/bleeding?		
Nose	Discharge/bleeding?		
Skin	Colour/lacerations/ grazes/ bruising?		
Mouth	Tongue bitten/teeth dislodge?		
Neck	Tenderness? Tingling/weakness?		
Spine			
Chest	Difficulty in breathing? Tenderness - Collar bones/ ribs?		
Abdomen	Tenderness?		
Pelvis	Tenderness? Haematuria?		
Arms	Deformity? Range of movement?		
Legs			

IMPRESSION			
Drug chart changes:		**Anticoagulation review:**	

Handover Plan

Doctor Signature:		**Date:**	
Print name:		**Time:**	

Health Records:
Where Filed
UID:

PLEASE DO NOT WRITE IN THIS BOX