**Inpatient Fall Assessment**

**To be completed by Medical Staff**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** | **Date of Fall:** | **Time of Fall :** | **Ward:** |
| History of Fall:  |

Witnessed Fall □ Unwitnessed Fall □

Witnessed by: ……………………………………………………………………………………………………………………………….

Preceding features: ………………………………………………………………………………………………………………………

Palpitations □ Shortness of Breath □ Chest Pain □ Pre-Syncope □ Syncope □

Subsequent features: ………………………………………………………………………………………….

Headache □ Visual Disturbances □ Drowsiness □ Vomiting □ Pain □

**LOSS OF CONSCIOUSNESS YES** □ **NO** □

History of Recurrent Falls YES □ NO □ Blood Sugar …………………………………………..

**Examination**

Last documented Obs Temp …… BP …… HR …… RR …… Sats …… GCS …… Confused? YES □ NO □

Post Fall Obs Temp …… BP …… HR …… RR …… Sats …… GCS …… Confused? YES □ NO □

GCS on Assessment ………………….. **HEAD INJURY? YES** □ **NO** □

Pupils ……………………………………..

Neurological Assessment ……………………………………………………………………………………………………………………………………..

Musculoskeletal Assessment ……………………………………………………………………………………………………………………………….

**SUSPECTED FRACTURE REQUIRING X-RAY?** ……………………………………………………………………….

**Investigations**

ECG ……………… Lying & Standing BP ……………… tick if Not Applicable □

**Anticoagulation (including NOAC) or antiplatelet (Clopidogrel or Ticagrelor)**□ **INR** ………………………..

**Impression**

**Plan for Nurses** (tick if required)

Neuro-observations as per Trust guidelines □ Lying & Standing BP □

**Contact on-call doctors if deterioration in neuro obs or if GCS drops by 1 parameter**

**Plan for Doctors**

Imaging □ Review Anti-coagulation □ Review recent blood results □ Review drug chart □

**Discuss with Senior if one or more red flag features present, reduced GCS or any concerns**

**Handover**

Regular team to review

**Medication/ Sedation/Need for anticoagulation/falls prevention measures/ Bone Protections**

**PRINT Name ……………………….. Sign ……………………………… GMC No …………………. Date \_\_/\_\_/\_\_ Time: \_\_:\_\_**