Humber Teaching
NHS Foundation Trust

Exploration of Fall (Version 1.01)
All Falls (witnessed and unwitnessed)

Patient Name ………………………………….. **NHS number** …………………………………….

Completed by ………………………………….. **Date** ……………………………………………….

Time	Location
Was the fall witnessed by staff?	**Yes [ ] No [ ]**
Did anyone other than staff witness the fall? If so, who and what did they see?	**Yes [ ] No [ ]**
Reason/cause of the fall Due to blackouts **Yes** [ ] **No** [ ] Palpitations **Yes** [ ] **No** [ ] Due to a seizure **Yes [ ] No [ ]**	
Activity at time of fall Was the fall result of a Slip **Yes** [ ] **No** [ ] Trip **Yes** [ ] **No** [ ] Dizziness **Yes** [ ] **No** [ ]	
Description of the fall – how did the patient fall Backwards **Yes** [ ] **No** [ ] Forwards **Yes** [ ] **No** [ ] Knees crumble or give way **Yes** [ ] **No** [ ]	
Did the fall result in injury? **Yes [ ] No [ ]** **Please complete the body chart**	
Was the person able to get up from the floor unaided? **Yes [ ] No [ ]** What assistance did they require?	
Baseline mobility Was the patient able to walk before the fall **Yes [ ] No [ ]**	
Were they able to walk following the fall? **Yes** [ ] **No** [ ]	Do they remember falling (syncope)? **Yes** [ ] **No** [ ]
Was the patient able to summon help? **Yes** [ ] **No** [ ]	Is the patient afraid of falling again? **Yes** [ ] **No** [ ]

Has the patient a history of falling? Before admission? **Yes** [ ] **No** [ ] Since admission? **Yes** [ ] **No** [ ] (in addition to this fall)
Is there a pattern to the falls **Yes** [ ] **No** [ ] **Unpredictable** [ ] **N/A [ ]** When does the patient fall? Morning [ ] Afternoon [ ] Early evening [ ] Night time [ ]

Other contributing factors:

Mobility Issues
Any restriction **Yes [ ] No [ ]** or transfer issues **Yes [ ] No [ ]** (explain)
Walking Aids **Yes [ ] No [ ]**

Did the patient receive any medication/s prior to the fall that are associated with an increased risk of falling? **(see appendix 1 of the Falls Protocol) Yes [ ] No [ ]**

Any medication issues **Yes [ ] explain** **No [ ]**			
Bedside vision check Was patient wearing prescribed eyewear at time of fall **Yes** [ ] **No** [ ] **Not required [ ]**			
Any agitated or altered mental state **Yes** [ ] **No** [ ]	Any confusion **Yes** [ ] **No** [ ]	Inability to call for help **Yes** [ ] **No** [ ]	Unwillingness to call for help **Yes** [ ] **No** [ ]
Environmental Issues Yes [ ] No [ ]			

Examination:			
Blood Pressure (20 MmHg systolic drop with or without symptoms or 10 MmHg diastolic)	Lying BP (*5 minutes*)		
	Sitting BP *(2 minutes)*		
	Standing BP (*2 minutes*)		
Any dizziness on standing? **YES** [ ] **NO [ ]**			
Pulse (BPM)		**Oxygen saturations (SPO2%)**	
ECG (if required)			
Ears – examined for any abnormalities (wax)	Right		
	Left		
Routine Urinalysis			
Constipation?	Yes [ ] No [ ]		
Blood Glucose	**Result**	**mmols**	**Time am/pm**
Bloods (optional depending when last checked)			

IMMEDIATE REPORTING

Medic contacted to review		**Family Informed**		**Passed to ward MDT for information**	

ACTION TAKEN/REQUIRED TO REDUCE LIKELIHOOD OF FUTURE HARM – please tick if actioned

Physical examination		Referral to Physiotherapist		Provision of aids	
Medication review		Fluid intake monitoring		Changes in observation level	
Provision of suitable footwear/clothing		Provision of a bed/chair sensor		Other (hip protectors/helmet etc.)	
Print name		Designation		Band	
Signature		Date		Time	
Name of patient		NHS number		Date and time of fall	

Body Chart

	Description	Date
Describe injury, marks or bruising on patient and date observed.		
Patient's description of any pain or non-verbal signs of patient's pain.		

Mark on the chart below injury, marks and/or bruising.