Name of Care Home:

Post Fall Analysis

NHS Greenwich Clinical Commissioning Group

To be completed following a fall
Date of fall:
Name of person completing form: Position:

Personal information	
Name …………………………………………	DOB ……………..… Date of admission to CH ……………..…

Medical history (including falls) (A,B,F)	**Medication (I)**	
Pacemaker y/n If yes, date reviewed…………	…………………………	…………………………
………………………………………………………	…………………………	…………………………
………………………………………………………	…………………………	New medication started in past 2 weeks? y/n
………………………………………………………	…………………………	
………………………………………………………	…………………………	…………………………

Was Ambulance called? y/n **Taken to hospital y/n** If yes, state length of stay:	**Was anyone called before the ambulance? y/n** If yes, state who:

Description of fall

Time 24hr clock (A)	**Location of fall (e.g next to chair in bedroom) (A)**	**Description of fall in resident's own words (include how they fell and what they were doing as they fell) (A)**	**If fall witnessed: Name of person:** **Description of fall by witness (include how they fell and what they were doing as they fell) (A)**

Time on floor (please circle time)			**Did resident attempt to summon help? (F) y/n** **If no please comment**
5 mins or less	1 hour or less	More than 1 hour	

How did resident get up from the floor? (C,D,G)

Without any assistance ☐ with verbal prompting ☐ with minimal assistance ☐ hoist ☐

Observations (B)

Response Level: Conscious y/n If no, how long unconscious?.............. If yes, any change from their mental state eg more confused than normal Please comment:	**B/P:** **Pulse:** **Blood glucose:**	**Temp:** **NEWS:**	**Slurred speech y/n** **Obvious weakness y/n**
	Breathing problems y/n If yes, state what problems:		If yes, state where weakness is:
	Cold/clammy y/n **Chest pain y/n** **Vomiting y/n**		**If normally continent any:** **Loss of bladder control y/n** **Loss of bowel control y/n**

Urinalysis Result: Any nitrites/leucocytes present? y/n

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Environment/Equipment

Footwear (L)

Type of footwear: ………………………………

Well-fitting/appropriate? y/n

If no, state problem with footwear:

Walking Aids (D)

Does resident use a walking aid? y/n

If yes, was it used at time of fall y/n

Was aid in easy reach y/n

Glasses (E)

Does resident wear glasses? y/n

If yes, were they wearing them at time of fall? y/n

If not wearing them, please comment why not:

Hearing (E)

Does resident wear hearing aid? y/n

If yes, were they wearing it at time of fall y/n

If not wearing it, please comment why not:

Was lighting adequate? (H) y/n

Any spillages? y/n

Could resident reach alarm button y/n

Does the resident have any other assistive technology? y/n

If yes, what:

Please state if any other hazards were observed:

Injuries sustained at time of fall

Lacerations **y/n**

If yes, state where:

Bleeding **y/n**

If yes, state where from:

New pain **y/n**

If yes, state where:

Have photograph been taken **y/n**

If no, state why:

Bruising **y/n**

If yes, state where:

Swelling **y/n**

If yes, state where:

Treatment details:

Events prior to fall

Any complaints of dizziness? (B) y/n

Any complaints of nausea? (B) y/n

Any other complaints of feeling unwell prior to fall? y/n (B) If yes, please comment:

General Health

Memory problems (F)	**y/n**	**Does client drink enough (J)**	**y/n**
Sleep problems	**y/n**	**Incontinence Urine (H)**	**y/n**
Does client eat well (J)	**y/n**	**Bowel problems (H)**	**y/n**

Action

Refer to Falls Check List for suggested actions and referral options.

Check resident's notes for history of previous falls.

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Action Plan – What will be done?
   Record in resident's notes actions taken and update their falls prevention care plan
Referrals made – state expectations

Use this form as Referral Form to refer to the CAR Team. To refer please send or fax to:

Information and Contact Officers, 1st Floor,
The Woolwich Centre, 35 Wellington Street, Woolwich, London SE18 6HQ

Tel: 020 8921 2304 Fax: 020 8921 3392