Re-assess risk assessments for falls and bed rails and ACT UPON RESULTS Y/N

Datix Y/N

Inform next of kin Y/N

Falls leaflet Y/N

SIG…………………………………………..DESIGNATION………………………………………..

**Request to Dr Review within 12 hours**

NEWS2 stable

Witnessed fall

No obvious injury.

**Request Dr to Review within 30 minutes**

Head injury with normal GCS or on anticoagulation/antiplatelet therapy. Pain AND suspected injury including fracture. Injury requiring medical treatment.

**Request Immediate Dr Review**

Unconscious or reduced GCS, neurological deficit since head injury, fitting, suspected open/depressed skull fracture neck pain/suspected spinal injury.





**Nursing Post Fall Checklist**

Date/time of fall............................ Ward.............................. Time Dr Called..........................

Witnessed? Y / N Previous inpatient falls? Y / N Known confusion? Y/N

Where was patient found…………………………………………………………………………………

Any obvious injury? N/ Y- Where and what?.................................................................................

.......................................................................................................................................................

Pain? Y/N

Tick which pathway is necessary.

For **RED** and **AMBER** escalation pathways please commence neurological observations every 30 minutes until medical plan documented.

Assessed for injury prior to moving? Y/N

Manual handling technique used………………………………………………………………………………………………………………………………………

Observations done? Neurological Observations Y/N/NA

**When patient is safe-**

Comments

(Reviewed May 22. Next review Nov 2024)

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