NHS Ayrshire & Arran

Write or attach label

HCR No: .....
CHI No: .....
Surname: .....
Forename: ..... Sex: .....
Address: .....
.....
Date of Birth: .....

Inpatient Post-Fall Assessment Proforma

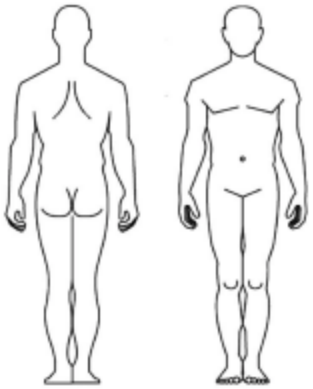
Date and time of fall:				Location (ward and hospital):		
Witnessed ☐ Unwitnessed ☐			*Have a high index of suspicion for head injury following an unwitnessed fall in a patient with confusion/cognitive impairment*			
Description of fall - *Preceding symptoms? Environmental factors? Who witnessed? Loss of consciousness?*						
Initial observations NEWS = ____						
BP	HR	SpO_2	RR	Temp	GCS __/15 E __/4; M __/6; V __/5	BM

Examination findings	
Airway - *(including C-spine)*	
Breathing -	
Circulation -	
Disability - *(including GCS and pupils)*	
Exposure - *(long bone deformity/ tenderness/reduced range of movement?)*	

Neurological examination	RUL	LUL	RLL	LLL
Tone				
Power	___/5	___/5	___/5	___/5
Sensation				
Co-ordination				

Abbreviated Mental Test 4 (AMT4) ____/4	Age ☐	DOB ☐	Place ☐	Year ☐
Baseline	Known cognitive impairment ☐	No cognitive impairment ☐		
Change from baseline AMT/cognition? Yes ☐ No ☐	If yes → low threshold for CT head			

Documentation of injury



Red flags for head injury *(→ immediate CT head - NICE 176 Head Injury Guidelines)*	
GCS <13 on initial assessment or GCS <15 at 2 hours post-injury	Yes ☐ No ☐
Suspected open or depressed skull fracture	Yes ☐ No ☐
Signs of basal skull fracture - haemotympanium, panda eyes, CSF rhinorrhoea/otorrhoea, Battle's sign	Yes ☐ No ☐
Post-traumatic seizure	Yes ☐ No ☐
(New) Focal neurological deficit	Yes ☐ No ☐
2 episodes of vomiting since head injury	Yes ☐ No ☐
Coagulopathy (including platelets <50) or any anticoagulant **and** loss of consciousness ↳ If yes - name and dose _____ ↳ Consider discussion with Haematology on call if platelets <50	Yes ☐ No ☐

Impression - *Cause of fall (mechanical/environmental/postural hypotension/drugs etc.)? Injuries sustained?*

Plan	
Neuro obs? *(signs of head injury/altered neurological examination)**	Yes ☐ No ☐
X-rays requested? If yes, which? _____	Yes ☐ No ☐
CT head requested? *(if signs of head injury → discuss with senior)*	Yes ☐ No ☐
Investigate cause ↳ Change in AMT/suspected delirium → look for cause ↳ Dizziness/palpitations/syncope → ECG, lying and standing BP	
Other -	

Signature		**Date and time**	
Print name		**Page number and grade**	

*Half hourly for 2 hours, hourly for 4 hours, 2 hourly for 6 hours, 4 hourly until no longer required (Medical/ANP decision)