Proforma for medical examination after an inpatient fall

Patient name:		**MRN/ NHS number:**	
Date of fall:		**Time of fall:**	
Medical examination conducted by:		**Date and time of examination:**	
Brief description of incident:			
Patient transfer method:	☐ **Spinal board** ☐ **Flat lifting equipment** ☐ **Standard hoist (without flat lifting capability)** ☐ **Assisted to get up with help by staff** ☐ **Got up independently** ☐ **Method not documented** ☐ **Still on the floor**		
Patient location at assessment:	☐ **Floor** ☐ **Bed** ☐ **Chair** ☐ **Other: _____**		
Fall witnessed?	☐ **Yes** ☐ **No**		

Observations:

Heart rate		**Oxygen saturations**	
Respiratory rate		**Blood pressure**	
Temperature		**Blood glucose**	
NEWS2 score			
GCS Baseline GCS___ **Current GCS ____**	**Eyes:** ☐ Spontaneous (4) ☐ To speech (3) ☐ To pain (2) ☐ None (1)	**Verbal:** ☐ Oriented (5) ☐ Confused (4) ☐ Inappropriate words (3) ☐ Incomprehensible sounds (2) ☐ None (1)	**Motor:** ☐ Obeys commands (6) ☐ Localises pain (5) ☐ Withdraws from pain (4) ☐ Flexion to pain (3) ☐ Extension to pain (2) ☐ None (1)

Primary Survey

Airway ☐ **Patent** ☐ **Obstructed**

C-spine concerns? ☐ **Yes** ☐ **No**

Breathing compromise? ☐ **Yes** ☐ **No**

Cardiovascular compromise ☐ **Yes** ☐ **No**

Disability: _____

Exposure: _____

Other findings/ concerns:

IMMEDIATE ACTION:

Escalation? ☐ **Yes** ☐ **No**

Escalated to

_____

Secondary Survey

Medical examination conducted by:		**Date and time of examination:**	
Head	**Reported head injury** ☐ **Yes** ☐ **No** **Visible signs of head injury** ☐ **Yes** ☐ **No** Additional findings:		**CT head indicated?** ☐ **Yes** ☐ **No** **Neuro obs indicated** ☐ **Yes** ☐ **No**
C-spine	**Suspected C-spine injury** ☐ **Yes** ☐ **No** If yes, immobilised? ☐ Yes ☐ No Additional findings:		**CT C-spine indicated?** ☐ **Yes** ☐ **No**
Thoracic/lumbar spine:	**Suspected thoracic/lumbar fracture** ☐ **Yes** ☐ **No** **Abnormal neurology** ☐ **Yes** ☐ **No** If yes, immobilised? ☐ Yes ☐ No Additional findings:		**Imaging indicated?** ☐ **No** ☐ **X-ray** ☐ **CT**
Chest:	**Suspected fracture:** ☐ **No chest injury suspected** ☐ **Rib fracture |** ☐ **Clavicle fracture |** ☐ **Sternum fracture** ☐ **Scapula fracture** Additional findings:		**CT indicated?** ☐ **Yes** ☐ **No**
Abdomen	**Internal organ injury suspected?** ☐ **Yes** ☐ **No** **Signs present (bruising, tenderness, urinary retention, abnormal bowel sounds)?** ☐ **Yes** ☐ **No** Additional findings:		
Hip/pelvis	**Suspected hip/pelvic fracture?** ☐ **Yes** ☐ **No** Findings:		**Imaging indicated?** ☐ **No** ☐ **X-ray hip** ☐ **X-ray pelvis** ☐ **CT hip** ☐ **CT pelvis** ☐ **Trauma CT**
Extremities – bones/joints/skin all 4 limbs	**Right upper limb injury?** ☐ **Yes** ☐ **No** **Left upper limb injury?** ☐ **Yes** ☐ **No** **Right lower limb injury?** ☐ **Yes** ☐ **No** **Left lower limb injury?** ☐ **Yes** ☐ **No**		**Xray indicated?** ☐ **Yes** ☐ **No** **If yes specify** _____

Pain score reviewed	☐ **Yes** ☐ **No**
Analgesia reviewed	☐ **Yes** ☐ **No** **Time of administration of analgesia:** _____
Anticoagulation/antiplatelets reviewed	☐ **Yes** ☐ **No** **Outcome:** _____
Delirium screen completed. (e.g. 4AT)	☐ **Yes** ☐ **No** Is delirium suspected ☐ Yes ☐ No Triggers identified: _____

Summary

Cause of fall:	
Injuries sustained:	
Any handover arrangements/outstanding assessments:	
Incident reported as per local policies?	☐ **Yes** ☐ ***No** *If not reported, ask appropriate personnel to report event
Is duty of candour required?	☐ ***Yes** ☐ **No** *If yes, indicate responsible person: _____