Individual Falls Audit

Residents Name: Date of Birth:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Fall Incident | Time of Fall Incident | Location of Fall Incident | Type of Fall Incident**(Use key below)** | **Details of Fall Incident.****e.g. Slip from chair. Poor transfer from chair/toilet/bed. When mobilising.**  | What caused Incident(**NK** = Not Known) | Was an injury sustainedYes/No **Type of Injury** **Record on Body Map (NEWS2 Score?)** | What happened following the fall?**GP/DN/111/A&E** contact **Referred to other service** **Hospital Admission**  | Date Falls care plan updated | Signature of Falls Lead  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**KEY: S** = Slip  **T** = Trip **F** = Fall **LoB** = Loss of Balance **PM** = Poor mobility **FoF** = Found on Floor

**PC/TT** = Poor chair/toilet transfer **RfLB** = Rolled from lowered bed **SFC** = Slip from chair **SfB** = Slip from bed