Individual Falls Audit

Residents Name: Date of Birth:

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| 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 sustained  Yes/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 |
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**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