HSE MID WEST
COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing

PLEASE COMPLETE THIS FORM IN CONJUNCTION WITH FALLS RISK ASSESSMENT & INDIVIDUALISED CARE PLANS TO REDUCE THE RISK OF ANOTHER FALL

Name: _____ MRN: _____

AFFIX PATIENT LABEL HERE

NURSING POST-FALL CHECKLIST

DATE OF FALL:	**TIME OF FALL:**
DESCRIPTION OF FALL:	

1. BEFORE MOVING THE PATIENT

Circle and/or tick as applicable

Ask the patient	
- Hit head	Yes / No / Don't Know
- Hit hip	Yes / No / Don't Know
- LOC / Blackout	Yes / No / Don't Know
- Pain / sore (+ location)	Yes / No / Don't Know
Head to toe assessment (Assess, Look, Feel) - Head, neck, trunk, upper limb, lower limb for pain and loss of movement	Pain / No Pain Full ROM / Loss of ROM
Observe - Confusion - Hip deformity (shortened/rotated) - Wrist deformity (angulated)	❑ ❑ ❑
Suspected Injury	
- Suspected Head Injury	❑
- Suspected Hip Fracture	❑
- Suspected Other Fracture	❑
- Suspected LOC	❑
- Suspected Sprain / Strain	❑
- Laceration / Abrasion / Bruise	❑
- No Injury Suspected	❑

2. RETURN PATIENT TO BED / CHAIR

Circle and/or tick as applicable

How was patient returned to bed / chair?	
- Standard Sling & Hoist	❑
- Spinal Board	❑
- Manual Assist of _____	❑
- Supervision Only	❑
- Other	❑
Perform	
- Skin assessment (Head to Toe)	❑
- Obs (General)	❑
- Obs (Neuro) for unwitnessed fall and/or suspected head injury	❑
Inform	
- Medical Team	❑
- CNMII / CNMIII / ADON	❑
- Family Member (with patient's consent)	❑
Complete	
- Healthcare record	❑
- Incident report form	❑

Multifactorial Falls Risk Assessment completed ❑

Care Plans updated ❑

Place this form in the nursing notes and a copy with the incident report form.

Full Name *(please print)*	Signature	Date