Please complete this template for all injurious falls classified as moderate, major or severe harm. All Inpatient fractured femur and neck of femur should be classified as at least major harm.

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| Patient’s Name | Click here to enter text. |
| Hospital Number / NHS Number | Click here to enter text. |
| Date of Birth | Click here to enter a date. |
| Date of Death (if applicable) | Click here to enter a date. |
| Hospital and Ward / Area of Fall | Click here to enter text. |
| Date and time of fall | Click here to enter text. |
| Date and Time admitted to ward | Click here to enter text. |
| Specific location of fall | Click here to enter text. |
| Datix Incident ID | Click here to enter text. |
|  |  |
| Reason for Admission to Ward | Click here to enter text. |
| Where was patient admitted from | Choose an item.  Click here to enter text. |
| Relevant Past Medical History | Click here to enter text. |
| Did the previous care setting communicate all risk factors on handover? | Choose an item. |
| What injury was sustained? | Choose an item. |
| Treatment required post fall | Click here to enter text. |
| Outcome post fall | Click here to enter text. |
| Was fall from:   * Bed? * Chair? * Whilst mobilising? * Other? Describe | Click here to enter text. |
| Describe how the fall occurred. If from bed:   * What model of bed? * Did patient have raised bedrails? Which sides? * State rail length * Did patient fall over the bedrails? * Did patient fall from bottom of bed?   If unsure, what does the injury / position of the patient lead you to believe? | Click here to enter text. |

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| **Multifactorial Assessment (MFA) Multifactorial Interventions (MFI)** | | | | |  | | | | | | |
| Standard Guidance: | | | | |  | | | | | | |
| * Was the call bell working and in reach? | | | | | Choose an item. | | | | | | |
| * Advise on safe transfer / mobility and promote consistent messages | | | | | Choose an item.Click here to enter text. | | | | | | |
| * Was the patient advised on safe footwear? | | | | | Choose an item. | | | | | | |
| * What was the patient wearing on their feet at time of fall? | | | | | Describe: Click here to enter text. | | | | | | |
| * Had the patient been provided with “Reducing Harm from Falls” leaflet? | | | | | Choose an item. | | | | | | |
| * If patient on anticoagulants, was this included on safety briefing / handover? | | | | | Choose an item. | | | | | | |
| Environment / Equipment: | | | | |  | | | | | | |
| * Was patient oriented to ward? | | | | | Choose an item. | | | | | | |
| * Was the patient advised on risks from drips / tubing / aids? | | | | | Choose an item. | | | | | | |
| * Were any slip / trip risks mitigated? | | | | | Choose an item. | | | | | | |
| Post Anaesthetic Procedure: | | | | |  | | | | | | |
| * Was patient advised about transfer / mobilising following anaesthetic procedure? | | | | | Choose an item. | | | | | | |
| Was bedrail assessment completed? | | | | | Yes / No | | | | | | |
| Bedrail assessment completed as per guidance.   * On admission? * On transfer to different clinical area? * On transfer to a different model of bed? * Review and re-assessment weekly / monthly: * Review and reassess on change in clinical condition | | | | | Please describe:  Click here to enter text. | | | | | | |
| Were the bedrails raised / lowered as specified in bedrails assessment? | | | | | Please describe: | | | | | | |
| To be reviewed at least weekly, and:   * Following every fall * Change in patient’s condition   + Increasing level of frailty / acuity or improvement * Following transfer to a different clinical area * Prior to discharge to consider interventions that may reduce the risk of a fall. | | | | | | Date MFA last completed:Click here to enter a date.  Was completion in accordance with Policy?Click here to enter text. | | | | | | |
| **Update and record Fall and Fracture History**  Details of past history of falls / fractures prior to admission to ward. History of low trauma fractures; osteoporosis / lives in care home | | | | | | Describe as fully as possible. Include dates and settings of falls:Click here to enter text. | | | | | | |
| **Underlying Medical Causes**   * On medications that lower blood pressure or cause dizziness? * Medically unwell, e.g. scoring on NEWS, fallen or at risk of seizures? | | | | | | Describe as fully as possible.Click here to enter text.  Orthostatic hypotension assessment is mandatory on all inpatients who can stand over the age of 65 or those over 50 with risk factors. Date of last standing / lying BP assessment:Click here to enter a date. | | | | | | |
| **Cognitive / Mental State:**   * Agitated; restless; impulsive; disorientated or confused? * Diagnosis of dementia? * THINK DELIRIUM and its cause | | | | | | Has the delirium assessment (such as 4AT) been completed? Are behaviours new or chronic? Was the patient able to follow advice and instruction?Click here to enter text. | | | | | | |
| **Prescribed Medication:**   * Prescribed sedatives, hypnotics, antipsychotics or diuretics? | | | | | | When was the last documented medication review undertaken?Click here to enter text. | | | | | | |
| **Mobility:**   * Needs help to stand and / or walk? * Tries to walk unaided but unsafe, e.g. to toilet? * Uses walking aids? * Foot problems? | | | | | | Date of last Mobility Assessment:Click here to enter a date.  Describe as fully as possible.Click here to enter text. | | | | | | |
| **Sensory Deficits:**   * Sight and/or hearing impairment? * Glasses or hearing aid unavailable? * Numbness, weakness or spatial perception problems? | | | | | | Describe as fully as possible.Click here to enter text. | | | | | | |
| **Essential Care and Assessment Issues:**   * For example; continence; nutrition; hydration or communication needs? | | | | | | Describe as fully as possible.Click here to enter text. | | | | | | |
| **Patient and Family Perspective:**   * Other risk highlighted by patient and / or family? | | | | | | Describe as fully as possible. Click here to enter text. | | | | | | |
| **Were referrals made:**  To ward doctor:   * All medical issues * Use of medication to promote bone health   To therapists:   * For mobility * For foot care * For activities of daily living issues   To pharmacists or doctor:   * Medication reviews | | | | | | Describe as fully as possible.Click here to enter text. | | | | | | |
| **Targeted Interventions:**   * Ultra-low beds * Floor safety mats * Intentional rounding (how often) * Closer observation / move to more observable area * Movement sensors * Enhanced Observation (specify Level 1-4) | | | | | | Describe as fully as possible.Click here to enter text. | | | | | | |
| **Immediate Post Falls Actions** | | | | | |  | | | | | | |
| Was an immediate Post Falls Assessment documented? | | | | | | Choose an item. | | | | | | |
| * Was the patient asked to keep still on floor before being moved? | | | | | | Choose an item. | | | | | | |
| * Was the patient screened for a spinal injury? | | | | | | Choose an item. | | | | | | |
| * Was the patient screened for a head injury? | | | | | | Choose an item. | | | | | | |
| * Was the patient screened for a long bone or other fracture? | | | | | | Choose an item. | | | | | | |
| Who was involved in this assessment? | | | | | | Name and role of all present:  Click here to enter text. | | | | | | |
| What manual handling method was used to move the patient following the fall? | | | | | | Choose an item. | | | | | | |
| Is there documented evidence that the patient had a medical assessment following the fall? | | | | | | Choose an item. | | | | | | |
| Was the patient on anti-coagulants or at risk of bleeding? | | | | | | Choose an item. | | | | | | |
| * If yes, what time was the ward doctors informed? | | | | | | Click here to enter a date. | | | | | | |
| * If yes, what actions were required? | | | | | | Click here to enter text. | | | | | | |
| * If yes, what time was the CT Head scan performed? | | | | | | Click here to enter a date. | | | | | | |
| Was a head injury excluded? | | | | | | Choose an item. | | | | | | |
| If yes, where is this recorded? | | | | | | Click here to enter text. | | | | | | |
| If no, give times and scores of neurological observations : | | | | | | | | | | | | |
| Time 24 hr clock |  |  |  |  | | |  |  |  |  |  | |
| GCS score |  |  |  |  | | |  |  |  |  |  | |
| Time 24 hr clock |  |  |  |  | | |  |  |  |  |  | |
| GCS score |  |  |  |  | | |  |  |  |  |  | |
| When were neuro observations discontinued and why? | | | | | | Click here to enter text. | | | | | | |
| Please specify if any of the post falls actions were not completed and why | | | | | | Click here to enter text. | | | | | | |
| Any other factors that should be considered? | | | | | | Describe as fully as possibleClick here to enter text. | | | | | | |
| **Staffing:** | | | | | |  | | | | | | |
| Describe establishment for registered and unregistered staff at time of fall: | | | | | | Click here to enter text. | | | | | | |
| Describe registered and unregistered staff on duty at time of incident (including medical team and AHP): | | | | | | Click here to enter text. | | | | | | |
| Were any staff on a break or off ward at time of fall? If so, please explain circumstances | | | | | | Click here to enter text. | | | | | | |
| Were any staff at handover? | | | | | | Choose an item. | | | | | | |
| Were there any other circumstances that contributed to the ward acuity? Describe as fully as possible | | | | | | Click here to enter text. | | | | | | |
| What escalation score did you report? | | | | | | Click here to enter text. | | | | | | |
| Was enhanced observation required for any other patient on the ward? Please describe, specifying Level of Enhanced Observation 1-4 and if any extra staff had been utilised to facilitate this | | | | | | Click here to enter text. | | | | | | |
| If enhanced observations were required but not possible due to lack of staff, please describe mitigating actions, e.g. cohorting patients, intermittent observations? | | | | | | Click here to enter text. | | | | | | |
| Were there any slip/trip obstructions or defects within the environment? | | | | | | Click here to enter text. | | | | | | |
| Date and time family were informed of fall | | | | | | Click here to enter text. | | | | | | |
| Recorded:   1. As a complaint 2. Reported to HM Coroner 3. Reported to WG as SI (include date and details) | | | | | | Click here to enter text. | | | | | | |
| If reported to WG, has family been informed? | | | | | | Click here to enter text. | | | | | | |
| Is family aware that an SI meeting will be held? | | | | | | Choose an item. | | | | | | |
| Does family wish to meet UHB staff following SI meeting to discuss findings and recommendations? | | | | | | Click here to enter text. | | | | | | |
| Any further information / notes? | | | | | | Click here to enter text. | | | | | | |
| What were the findings of investigation? | | | | | | Click here to enter text. | | | | | | |
| Immediate remedial actions (e.g. broken bed) | | | | | | Click here to enter text. | | | | | | |
| Investigation undertaken by (state name, role and date) | | | | | | Click here to enter text. | | | | | | |
| N.B. The information contained in this template informs the SI meeting and subsequent recommendations | | | | | | | | | | | | |
| **Serious Incident Meeting Update:** | | | | | |  | | | | | | |
| SI Meeting date | | | | | |  | | | | | | |
| What learning / actions have been generated from this incident? | | | | | |  | | | | | | |
| Recommendations: | | | | | |  | | | | | | |
| What is the plan for disseminating the learning: | | | | | | Please describe fully:  Click here to enter text. | | | | | | |