

## Inpatient Falls dataset for post fall incident review (Falls resulting in moderate, major and catastrophic harm)

This is the Inpatient Falls Data Set for HSC Trust Post Falls Review as agreed by the Regional Inpatient Falls Prevention Group and PHA.

A post falls review should be carried out within 10 working days exclusive of bank holidays. (PILOT)

<b>Patient Name</b>		<b>Date Of Birth</b>	
<b>Admission type</b>	(Elective/Emergency/Transfer/Other)	<b>Age</b>	
<b>Date &amp; Time of ED attendance</b>		<b>Admitted from:</b>	(home/care home/other hospital/other)
<b>Date &amp; Time of admission to ward</b>		<b>Gender</b>	
<b>Reason For Admission</b>		<b>H&amp;C Number</b>	
		<b>Consultant</b>	
<b>Diagnosis on admission</b>		<b>Admission Ward</b>	
<b>Was pt transferred to / from another ward / Hospital during inpt stay prior to fall</b>	Yes/ No (please include date/time)		
<b>Has the patient had a previous fall during this admission?</b>	Yes/ No	<b>If yes:</b>	<b>Datix Number</b>

<b>Incident Reference Number</b>		<b>Date/time of Fall</b>	
<b>Severity Grading</b>		<b>Date/time Datix Submitted</b>	
<b>Ward / Department</b>		<b>Exact location of fall</b>	

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<b>Was patient an inlier/outlier at time of fall?</b>	<b>Yes/ No</b>	<b>Was patient an additional patient?</b>	<b>Yes/ No</b>	<b>If yes location on ward</b>	
<b>Injury Sustained as a result of fall</b>					
<b>Results of Investigations (include date/time)</b>					
<b>What activity was the patient doing at the time of the fall? Patient account of the incident?</b>					
<b>What is the staff account of the incident?</b>					
<b>Medical History</b>					
<b>At time of fall was patient medically fit for discharge?</b>					
<b>Current condition of the patient at the time of post fall review? (alive / deceased – include date of death and death cert)</b>					
<b>Ward Manager</b>		<b>Assistant Director</b>			
<b>Clinical Service Lead / Lead Nurse</b>		<b>Action Plan Lead</b>			
<b>Copy forwarded to:</b>	If other services have learning e.g. pharmacy, radiology, medics their names need to be included in the list above and not just cc'd into the investigation report - this will be specific to each review and decision to be made with action plan lead / lead nurse				

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Post Fall Proforma

<b>Notes Reviewed</b>	Review admission documentation together with documentation pre and post fall to inform learning (Scope of notes reviewed- all admission docs AHP / Meds / Nursing)
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<b>On admission</b>		
<b>Element</b>	<b>Response</b>	<b>Comments</b>
<b>Was the patient asked if they had a history of falls in the last 12 months?</b> (within 6 hours of admission - specify date and time in comments section, provide details)	<b>Yes / No</b>	Date: Time:
<b>Was the patient asked if they had fear of falling?</b> (within 6 hours of admission - specify date and time in comments section, provide details)	<b>Yes / No</b>	Date: Time:
<b>Does the patient have known postural hypotension?</b>	<b>Yes / No</b>	
<b>For all patients over 65 or who have a medical condition that would increase risk of falls Was a lying and standing B/P performed?</b> (if No or N/A state why. Record date and results of lying and standing BP measurement) 1st reading after 5 minutes supine, 2nd reading within 1 minute standing, 3rd after 3 minutes standing	<b>Yes / No / N/A</b>	
<b>If a positive result was identified, were appropriate actions taken?</b> Please Comment on follow up actions.	<b>Yes / No / N/A</b>	
<b>Did the patient have a cognitive assessment completed?</b> (AMT4) (applicable for all patients over 65 or a medical condition that would increase risk of falls)	<b>Yes / No / N/A</b>	

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<b>Has the patient a diagnosed cognitive impairment?</b> If yes please specify.	<b>Yes / No</b>	
<b>Is the patient at risk of delirium?</b> (ie is over 65 years, has a cognitive decline, has an acute illness, has a fractured neck of femur)	<b>Yes / No</b>	
<b>SQID Positive/negative</b> (if +ve - was there a diagnosis of delirium and symptoms pre fall)	<b>+ve/-ve</b>	
<b>Was the delirium care pathway commenced and completed appropriately?</b>	<b>Yes / No / N/A</b>	
<b>Does the patient use a mobility aid?</b> If yes, what type?	<b>Yes / No / N/A</b>	
<b>Does the patient have appropriate footwear?</b> (if no, or N/A state why and action taken)	<b>Yes / No / N/A</b>	
<b>Was the patient commenced on a moving and handling care pathway/care plan if applicable?</b>	<b>Yes / No / N/A</b>	
<b>Did the patient have any communication difficulties?</b> ie hearing aids; language; speech; If YES please specify and if available	<b>Yes / No / N/A</b>	
<b>Does the patient have a diagnosed visual impairment?</b> (please specify)	<b>Yes / No / N/A</b>	
<b>Does the patient wear glasses or other aids?</b>	<b>Yes / No / N/A</b>	
<b>Was patient asked date of last eye test?</b>	<b>Yes / No</b>	
<b>Was patient's ability to use the call bell assessed on admission?</b>	<b>Yes / No</b>	
<b>Was the patient able to use the call bell?</b> If the patient was unable to use the call bell, what other measures were put in place?	<b>Yes / No</b>	

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<b>Was the patient assessed for urinary continence / frequency / urgency?</b> (Provide details)	<b>Yes / No</b>	
<b>If continence problems identified was a plan of care commenced?</b>	<b>Yes / No / N/A</b>	<b>check with NMQAN</b>
<b>Was a medication review/reconciliation carried out on admission?</b> Provide date:time	<b>Yes / No</b>	
<b>Clinical Frailty Score on admission completed?</b> (Rockwood)	<b>Yes / No / N/A</b>	Please specify score and if appropriate
<b>Was the Regional Inpatient Falls Leaflet provided and discussed with the patient on admission?</b>	<b>Yes / No</b>	<i>(was this available on ward)</i>

<b>During Inpatient Stay</b>		
<b>Element</b>	<b>Response</b>	<b>Comments</b>
<b>Was a urinalysis obtained during this inpatient stay?</b> (provide date and results in comments)	<b>Yes / No / N/A</b>	
<b>Were there symptoms of possible urine infection?</b> (if yes please document actions and treatment provided)	<b>Yes / No / N/A</b>	
<b>If applicable, were blood sugars recorded pre fall?</b> (Provide results in comments)	<b>Yes / No / N/A</b>	
<b>Was the blood sugar recording a contributory factor to the fall?</b>	<b>Yes / No / N/A</b>	
<b>Was patient administered any medications which may increase their risk of falls?</b> (specify drug/time/rationale) Please refer to MOOP	<b>Yes / No</b>	

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<b>Was new prescription of night sedation avoided?</b> (If NO provide rationale for prescription)	<b>Yes / No</b>	
<b>Was patient identified as being at risk of falls?</b>	<b>Yes / No</b>	
<b>If falls risk identified what actions were taken to reduce risks?</b>	<b>Yes / No / N/A</b>	
<b>Was a falls care plan implemented?</b>	<b>Yes / No / N/A</b>	
<b>Was patient highlighted at safety brief/bedside/electronic board as a falls risk?</b>	<b>Yes / No / N/A</b>	
<b>Was risk taking behaviour evident from admission to date of fall?</b> (e.g. climbing out of bed, not compliance with advice, impulsive behaviour)	<b>Yes / No / N/A</b>	
<b>If risk taking behaviour was evident were actions implemented to reduce same?</b> (If yes, specify)	<b>Yes / No / N/A</b>	
<b>Was enhanced care in place / EPCO?</b> Specify:	<b>Yes / No / N/A</b>	
<b>Did the patient have a DOLS in place?</b>	<b>Yes / No / N/A</b>	
<b>If required to be nursed in a specific location on ward was this done?</b> (if yes specify)	<b>Yes / No / N/A</b>	
<b>If assistive technology was required was this in place?</b> (if yes, please specify)	<b>Yes / No / N/A</b>	
<b>If an ultra-low entry bed was required was this in place?</b> If NO give reason.	<b>Yes / No / N/A</b>	
<b>Was the Patient assessed / reviewed by AHP's?</b>	<b>Yes / No / N/A</b>	

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**Time of fall / Post Fall Care**

<b>Element</b>	<b>Response</b>	<b>Comments</b>
<b>Prior to the falls was the patient complaining of any symptoms that may have contributed to their fall?</b> (if yes, specify)	<b>Yes / No</b>	
<b>Was the fall witnessed?</b> If witnessed, by whom?	<b>Yes / No</b>	
<b>Was loss of consciousness associated with the fall?</b>	<b>Yes / No</b>	
<b>Were there any slips/trips/hazards that contributed to fall?</b>	<b>Yes / No</b>	
<b>Call bell in sight and in reach at time of incident</b>	<b>Yes / No</b>	
<b>Were personal items within reach of the patient at the time of the fall?</b>	<b>Yes / No</b>	
<b>Was the patient wearing glasses at the time of the fall?</b> (if No / NA specify why)	<b>Yes / No</b>	
<b>Was the patient wearing appropriate footwear at the time of the fall?</b> Provide details.	<b>Yes / No</b>	
<b>Was patient using mobility aid at time of fall</b> (if applicable)	<b>Yes / No / N/A</b>	
<b>Was the patient mobilising with the recommended level of support for safe mobility at the time of the fall?</b> Specify level of assistance & aid required.	<b>Yes / No</b>	
<b>At time of fall was the patient provided with correct level of enhanced care/supervision</b> (if correct level not provided please add additional detail)	<b>Yes / No / N/A</b>	

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<b>Was a body check completed to assess for injury / harm prior to moving the patient post fall? What was the outcome?</b>	<b>Yes / No</b>	
<b>Was a post fall flow sheet completed on encompass?</b>	<b>Yes / No</b>	
<b>Were appropriate care plans updated</b>	<b>Yes / No</b>	Please specify
<b>At the time of the fall were bed rails in use (is this in keeping with latest bed rail risk assessment)</b>	<b>Yes / No</b>	
<b>What additional falls prevention interventions have been implemented following this fall?</b>		
<b>Is a need for increased supervision now identified? If yes has this been implemented (ie EPCO updated)</b>	<b>Yes / No / N/A</b>	
<b>Post fall has the patient's location on the ward / ward changed?</b>	<b>Yes / No / N/A</b>	
<b>Is the use of assistive technology now in place?</b>	<b>Yes / No / N/A</b>	
<b>Is a low entry bed required to manage risks post fall?</b>	<b>Yes / No / N/A</b>	
<b>Were appropriate observations recorded? If potential head injury - CNS observations should be commenced</b>	<b>Yes / No</b>	
<b>If CNS observations required were they completed as per NICE guidelines?</b> if CNS obs were to be discontinued - was this documented by senior medic	<b>Yes / No / N/A</b>	
<b>If applicable, was a blood sugar level recorded post fall?</b>	<b>Yes / No / N/A</b>	
<b>Was patient offered with analgesia - specify Date /time/type</b>	<b>Yes / No / N/A</b>	

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<b>Has a post fall medical assessment been completed and medical treatment plan implemented?</b> (specify Date:time) if so by who/when/grade & provide detail	<b>Yes / No / N/A</b>	
<b>Was the Trust immediate post fall medical proforma completed?</b>	<b>Yes / No / N/A</b>	
<b>Was patient on any anticoagulants/antiplatelet therapy (if yes – was reversal treatment commenced)</b>	<b>Yes / No</b>	
<b>If indicated was a CT Brain completed within the appropriate time frame?</b> (within 1 hour for urgent and within 8 hours for non urgent)  Include Date & Time recorded in nursing and medical notes	<b>Yes / No / N/A</b>	
<b>Was fall escalated to senior medical team/ senior nursing manager/falls team/ health &amp; safety</b>	<b>Yes / No</b>	
<b>Was Next Of Kin informed</b> (please add date/time)	<b>Yes / No</b>	
<b>Was patient's fall discussed at safety brief?</b>	<b>Yes / No</b>	
<b>Has the MDT been informed that patient has had a fall?</b>	<b>Yes / No</b>	
<b>Has the fall safety cross / walking stick been updated?</b>	<b>Yes / No / N/A</b>	
<b>Are there any issues with the ward / environment?</b> (if yes, specify) Were these escalated?	<b>Yes / No</b>	
Workforce at time of fall incident to include outstanding shifts, substantive staff / bank / agency? (specify)		
<b>Were patient acuity and dependancy levels acceptable?</b>	<b>Yes / No</b>	

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<b>Were there additional patients nursed on the ward in escalation beds?</b> (please specify)	<b>Yes / No</b>				
<b>Was FallSafe audit for the ward up to date?</b> (if no or N/A specify why) last 3 months scores and comment on compliance	<b>Yes / No / N/A</b>	Month			
		% Compliance Fall safe A			
		% Compliance Fall safe B			
		% Total Compliance Fall safe			

<b>Retrieval from floor</b>	
<b>Element</b>	<b>Comments</b>
Patient got up unaided	
Patient assisted (Number of staff involved)	
Patient Hoisted with sling (Type used)	
Supine transfer of patient (Equipment used)	
Flat Lifting Equipment (number of staff involved)	
Other (Specify)	

<b>Risk assessments</b>				
<i>Insert date/time of completion. If not completed, insert X. If non-applicable, insert NA</i>				
	<b>Falls</b>	<b>Moving &amp; Handling</b>	<b>Bed rails</b>	<b>Details incl if outcomes appropriate to pt's condition</b>
1. On admission (within 6 hrs)				
2. Weekly (if appropriate)				

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3. Following change in pts condition				
4. Following a previous fall				
5. Following this fall				
6. On transfer from another ward				

**Contributory Factors to fall and additional information**

<b>Patient's clinical condition</b> <i>(review NEWS 2, NIECR e.g. blood work)</i>	
<b>Relevant past medical history:</b>	
<b>Environment</b> e.g. hazards, transfers, undesignated beds:	
<b>Staffing</b> e.g. agency and bank staff /1:1 not on duty when requested:	
<b>Acuity of patients</b> e.g. confused patients:	
<b>Other:</b> please specify:	

Profroma Completed by:

Date & Time:

Signature:

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**Post Fall Review Meeting**

<b>Date of Meeting</b>		<b>Staff in Attendance</b>	
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**What went well (examples)**

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**Areas for improvement**

<b>PRE FALL</b>
<b>POST FALL</b>

**Comments**

Ward Manager/Lead Nurse to discuss with senior managers if any particular issues or new learning identified which should be investigated through the SAI process

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<b>Completed By</b>	Name	
	Designation	
	Contact Details	
<b>Date &amp; Time</b>		
<b>Signature</b>		

**Lead Nurse and Ward Manager are to complete an action plan relating to the above areas for improvement. The completed action plan MUST then be attached to the relevant incident on DATIXWEB. It is the responsibility of the Lead Nurse to ensure that this occurs.**

**Lead Nurse and Ward Manager to ensure the above learning is shared with all relevant team members / Division.**

<b>Date Falls Team informed if applicable: (by whom)</b>	
<b>Date Health &amp; Safety informed:</b>	
<b>Was incident RIDDOR reportable:</b>	
<b>Date Investigation finalised and uploaded onto datix:</b>	

Datix ref:

Date/time of fall: