Multi-disciplinary after-action review (AAR)– to be performed no more than 5 days following a fall

The after-action review should take place on the ward where the fall occurred and must include representation from the multi-disciplinary team (MDT). It should take place within 5 working days of the fall so that the event is fresh in the minds of the team. This meeting is not designed to generate paperwork or reports. Its aim is to generate discussion, reflection and identify actions required for this particular patient or themes which can be considered for future action to improve safety. The questions provided below are prompts for discussion and other questions may be added depending on where the discussion leads. Use the information from the hot debrief to contribute to this review. The meeting should be led by a clinician or member of the falls/safety team who has expertise in facilitating discussion-based exploration of incidents. File this form in the patient’s health records as it will assist in data collection for the national audit of inpatient falls (NAIF).

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| **SECTION 1: QUESTIONS FOR AFTER ACTION REVIEW OF FALL PREVENTION ACTIVITY (to be discussed with the MDT based on the ward where the fall happened)** |
| 1. **Time and date of fall:**   DATE: DD/MM/YYYY:  TIME: HH:MM: |
| Was there anything particular about the time of day that might have contributed to this fall?  What were the available staff on the ward doing at the time of the fall / where were they?  This is not aimed to attribute blame, but to explain circumstances that might have impacted on supervision. |
| 1. **Length of stay in the trust / health board before this fall:**   Time in days:  Time in hours: |
| Was there anything specific to the point in the admission that contributed to this fall?  Examples might include: the patient was feeling better so had started to walk more, the patient had been in hospital for a week and had not had a repeat multi-factorial fall risk assessment despite their condition changing significantly (more confused, started different medications etc.). |
| 1. **Multi-factorial fall risk assessment**  * **Did the patient have a multi-factorial fall risk assessment (MFRA)?[[1]](#footnote-1) Y / N** * **How many days was the MFRA done prior to the fall?** * **Had the patient already fallen during the same admission?** * **Had the MFRA been reviewed following any previous falls?** * **Is there anything to suggest that the MFRA intervention plan was NOT being followed at the time of the fall?** |
| Suggestions for questions:  If there was no MFRA, is there an explanation for this?  If there was a MFRA – was it up to date (i.e. had anything changed since the previous MFRA that should have been included)?  Was anything important missed in the MFRA?  Why was the MFRA not updated (if an update was indicated)?  Why was the MFRA not implemented as planned (if not implemented)? |
| 1. **Components of MFRA present (if more than one, use the one most recent to the fall):**  * Vision assessment (yes / no). Visual impairment identified: (yes / no) * Lying-standing blood pressure measurement (yes / no). Orthostatic hypotension identified (yes / no) * Medication review (yes / no) * Continence care plan (yes / no), care plan being followed (yes / no / NA) * Delirium assessment (yes / no), evidence of delirium (yes/ no), delirium care plan (yes / no / NA) * Mobility care plan being followed (yes / no / no care plan) |
| Were the above assessments conducted (and if not why)?  Were interventions put into place to address all the assessment findings (if not why)?  Were MFRA assessment and interventions updated as necessary (if not why not)?  An update is indicated if there is a change in the patient’s condition (such as a change in mobility, delirium during the admission) or after a fall. |
| 1. **Was there a prescribed enhanced supervision plan being followed at the time of the IFF?** |
| Considering the patient’s condition at the time of the fall, was the level of enhanced supervision prescribed adequate?  If an enhanced supervision plan was not being followed, why? |
| CONCLUSION ON FALL PREVENTION ACTIVITIES |
| Review the discussion, list and analyse the themes from the discussion. |
| What has the team identified as key issues related to fall prevention in this case? |
| SMART patient-related actions needed (include correspondence[[2]](#footnote-2) with the patient and their family)[[3]](#footnote-3)? |

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| **SECTION 2: QUESTIONS FOR AFTER ACTION REVIEW OF POST FALL MANAGEMENT (to be discussed by the MDT on the ward where the fall happened)** |
| 1. **Was the patient checked for signs or symptoms of potential for spinal injury OR fracture before they were moved?**   Yes, injury suspected / yes, and no injury suspected / no: |
| If answered no: Why was the patient not checked for injury?  Does the organisational fall training include these skills? Were all staff on duty at the time of the fall up to date with this training? |
| 1. **What manual handling method was used to move the patient following the fall?**   Type of handling method |
| If flat lifting equipment was not used, what was the reason?  Does the organisation provide staff with adequate access to appropriate flat lifting equipment? Does the organisational falls training include management/ handling/ use of equipment for the fallen patient with suspected injury? Were all staff on duty at the time of the fall up to date with this training? |
| 1. **Did the patient have a timely medical assessment?** |
| What were the reasons for the delay in assessment?  Delay in assessment for injury, access to lifting equipment, administering analgesia, medical assessment, investigations.  What were the consequences of this wait for the patient?  Was the patient seen by doctor or other health care professional and did this have any impact on ongoing care (explain the impact and whether this was positive or negative)? |
| 1. **Was appropriate action was taken to inform next of kin (NOK)?**   Yes / No NOK / patient requested not to contact / not documented |
| Why was the NOK not contacted? |
| CONCLUSION |
| Review the discussion, list and analyse the themes from the discussion of post fall management. |
| What has the team identified as key issues related to post fall management in this case? |
| SMART patient-related actions needed for post fall management (include correspondence with the patient and their family)[[4]](#footnote-4)? |
| **ARR LED BY: SIGNED: DATE:** |

1. See <https://www.rcplondon.ac.uk/projects/outputs/falls-prevention-hospital> for a description of MFRA [↑](#footnote-ref-1)
2. Ensure correspondence is in line with local policy. [↑](#footnote-ref-2)
3. Specify if actions are local or need to be raised at the fall coordination group. State who will be responsible for each action. Aim for plans to be SMART (Specific, measurable, achievable, realistic and time bound). [↑](#footnote-ref-3)
4. Specify if actions are local or need to be raised at the fall coordination group. State who will be responsible for each action. Aim for plans to be SMART (Specific, measurable, achievable, realistic and time-bound). [↑](#footnote-ref-4)