Hot debrief – to be performed **immediately after** every fall in the ward

This should be performed by staff on the ward at the time of the fall and be completed before the end of that shift. It should be recorded by someone who witnessed the fall or was responsible for the patient’s care around the time of the fall. When this is complete, file in the notes and send a copy to the pilot project lead.

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| --- | --- |
| **DATE OF FALL:**  | **TIME OF FALL:**  |
| **QUESTIONS ABOUT THE FALL** |
| 1. **What did the patient say happened (where appropriate or possible to ascertain)?**
 |
| Use free text (this information is not needed for the audit, but can be used in your after-action review):  |
| 1. **What did staff say happened?**
 |
| Use free text (this information is not needed for the audit, but can be used in your after-action review):   |
| 1. **Was the fall witnessed?**
 |
| 🗆 Yes🗆 No |  |
| 1. **Was the patient on their own at the time of the fall?**
 |
| 🗆 The patient was on their own🗆 The patient was with a member of staff🗆 The patient was with a family member or friend | *If the patient was in a location with another patient or visitor but no staff or family/friends were present – answer that the patient was on their own. If a member of staff or family member was in the same room or bay but did not have the patient in their sight line (i.e. the patient was behind a curtain or door), consider the patient to be on their own.* |
| 1. **What was the patient doing at the time of the fall?**
 |
| 🗆 Lying/sitting in the bed🗆 Sitting in a chair🗆 Using a commode🗆 Transferring between the bed/chair/commode🗆 Walking on the ward🗆 Using the toilet/bathroom🗆 Not on the ward at the time of the fall🗆 Not known as the fall was unwitnessed | *If the patient was in the process of getting up or sitting down from the bed / chair / commode, choose “transferring between the bed / chair / commode”* |
| * 1. **If the fall was from the bed:**

Was the bed height appropriately configured for safe transfers at the **time of the fall**? |
| 🗆 Yes🗆 No🗆 N/A | *The bed should have been positioned at an appropriate height based on an individualised assessment of the patient, with a judgement weighing up the risk of the patient falling from the bed against the difficulty of standing from a bed that is too low.*Answer No if there was no documentation of bed height.N/A the fall was not related to the bed. |
| * 1. **If the fall was from the bed:**

Was an appropriate bed rail prescription in place at **the time of the fall**? |
| 🗆 Bed rails not recommended🗆 Bed rails recommended🗆 No assessment🗆 N/A | *A bed rail prescription should include a documented assessment to ascertain whether bed rails should be raised.* N/A: The fall was not related to the bed. |
| * + 1. *Was the bed rail prescription plan in place at* ***the time of the fall****?*
 |
| 🗆 Prescription being followed🗆 Prescription not being followed🗆 N/A | N/A: The fall was not related to the bed. |
| 1. **Were any of the following actions in place at the time of the fall?**
 |
| * 1. *The patient was given the call bell and instructed on how to use it:*
 |
| 🗆 Yes🗆 No🗆 Not appropriate🗆 Not known | *Choose 'Not appropriate' where an assessment has deemed that the patient would be unable to use a call bell effectively (i.e. due to cognitive impairment or physical difficulties).* |
| * 1. *The patient was requested to ask for help before moving:*
 |
| 🗆 Yes🗆 No🗆 Not appropriate🗆 Not known | *Answer 'Not applicable' if the Multi-factorial fall risk assessment mobility assessment indicated no need for supervision when transferring or walking.**Choose 'Not appropriate' where an assessment has deemed that the patient would be unable to remember, understand, physically comply, or grasp the importance in order to ask for help.* |
| * 1. *An alternative strategy was put into place as the patient was deemed unable to ask for help or use the call bell:*
 |
| 🗆 Yes🗆 No🗆 Not appropriate🗆 Not known | *Only answer Yes if:-Use of a call bell or prompting to ask for help was deemed unlikely to be effective due to physical limitations, poor cognition, delirium etc and,- An alternative strategy was in place (or possible) for the patient to seek assistance.Answer 'Not appropriate' if an alternative strategy was not indicated (i.e. assessment for dementia and delirium identified no evidence of cognitive impairment or confusion and no communication issues were observed).* |
| * 1. *A walking aid was situated within the patients reach (if aid was indicated in the mobility plan)?*
 |
| 🗆 Yes🗆 No🗆 Not applicable🗆 Not known | *Only answer 'Not applicable' if a walking aid was not required or not appropriate (as stated in mobility assessment and plan).* |
| 1. **Was the patient’s mobility plan being followed with regards to walking aid use and supervision provided at the time of the fall?**
 |
| 🗆 Yes🗆 Mobility plan was NOT FOLLOWED in full🗆 No mobility plan or plan unclear | *Please answer that the mobility plan was not followed regardless of the reason for this. There are many possible reasons for mobility plans not being followed. Ascertaining the underlying cause will form part of the post fall debrief.*  |
| 1. **Was the patient using a walking or mobility aid at the time of the fall?**
 |
| 🗆 Not indicated for this patient🗆 Aid in mobility plan was being used🗆 Recommended aid was NOT being used🗆 Not known | *A walking aid is a device used by the patient, designed with the purpose of supporting walking or transfers, usually by incorporating the arms to re-distribute some of the load of weight-bearing or to increase stability. Commonly encountered walking aids include sticks, crutches, frames or/and three and four-wheel walkers. A mobility aid is a device that is used to enhance mobility more generally. This could include a wheelchair or braces/splints worn when mobilising. Review mobility plan to determine what walking/mobility aid has been recommended.* |
| 1. **Did the patient have a continence care plan and was it being followed at the time of the fall?**
 |
| 🗆 No continence problems identified🗆 Continence care plan was being followed🗆 Continence care plan not followed🗆 Not known | *An individualised continence care plan consists of a documented assessment of urinary and faecal continence, flagging any problems identified and a plan to address these problems.* |
| 1. **Did the patient have a delirium care plan and was it being followed at the time of the fall?**
 |
| 🗆 Not delirious on formal assessment🗆 Delirium identified - but no care plan documented🗆 Delirium identified - care plan documented🗆 No assessment for delirium🗆 Not known | *A delirium care plan includes a standardised assessment for the presence of delirium. If delirium is present, there should be a management plan in place which may consist of generic measures known to reduce delirium intensity and/or specific interventions tailored to assessment findings. This can be in the form of a specific care plan or detailed in the clinical notes.**If a patient develops a new onset confusion, assessment for delirium and initiation of a care plan should begin without delay. Therefore, if there is evidence the patient has developed a new confusion before the fall that caused the fracture, but this was not identified on formal delirium assessment, answer not documented.*  |
| 1. **When was the most recent lying / standing blood pressure recorded?**
 |
| 🗆 Date lying / standing BP last measured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗆 Lying / standing BP NOT recorded 🗆 Lying / standing BP not appropriate (only in patients unable to stand) |
| * 1. If there was a lying / standing blood pressure recorded, did the patient have orthostatic hypotension? (a drop in systolic BP of >20mmHg, diastolic of >10% or systolic drops to below 100mmHg on standing).
 |
| 🗆 The patient had orthostatic hypotension on the most recent measurement🗆 The patient did not have orthostatic hypotension 🗆 N/A (no lying / standing BP recorded) |
| * + 1. If the patient had orthostatic hypotension, was any action taken to address this?
 |
| 🗆 Yes – describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗆 No 🗆 N/A (no orthostatic hypotension) |
| 1. **Has the patient had a medication review since admission?**
 |
| 🗆 Yes – date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗆 No 🗆 N/A (not on any medication) | *Was the patient assessed to identify any drugs that might contribute to falls. This could be by a doctor, pharmacist or any other appropriate member of staff. It is also asking whether any changes were made in light of this, or if a decision was recorded that no changes were required/possible. This question is asking whether the patient’s medications were assessed to identify any drugs that might contribute to falls. This could be by a doctor, pharmacist or any other appropriate member of staff. It is also asking whether any changes were made in light of this, or if a decision was recorded that no changes were required/possible.*  |
| **QUESTIONS ABOUT AFTER THE FALL** |  |
| 1. **Was the patient checked for signs or symptoms of potential for spinal injury and fracture before they were moved?**
 |
|  Yes - injury suspected Yes - no injury suspected No |  |
| 1. **What manual handling method was used to move the patient following the fall?**
 |
|  Flat lifting equipment/scoop hoist Standard hoist / other lifting equipment Ambulance service equipment Assisted to get up with help by staff Got up independently Not known | *Record as 'Staff assisted to get up' if the patient was moved without equipment being used.* |
| 1. **Did the patient have a medical assessment after the fall?**
 |
|  Assessment by medically qualified professional within 30 minutes Assessment by other healthcare professional within 30 minutes Assessment requested but not yet completed  Assessment not requested |  |
| 1. **What level of harm will/have you attribute(d) to the fall?**
 |
|  Death Severe harm Moderate harm Low harm No harm | *Answer as to the level of harm to be entered into reporting and learning system.* |
| 1. **Have the patient’s next of kin been contacted?**
 |
|  NOK were contacted The patient had requested not to contact NOK No NOK OR NOK were uncontactable |  |
| **DATA COLLECTED BY: SIGNED: DATE:**  |