**Prompt questions for SWARM huddle**

**General principles**

* It 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.
* If a post-fall debrief was undertaken, have this available at the meeting and any concerns raised by the patient or their family.
* Follow guidance for SWARM huddles as set out in the [patient safety learning response toolkit.](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Swarm-huddle-v1-FINAL.pdf)

**Prompt questions**

**Step 1:** Introduce everyone by name.

**Step 2:** Create a safe space to ensure everyone’s voice is heard.

* Emphasise that everyone’s voice is important and that there would be different perspectives and recollections amongst team members.

**Step 3:** Replay the event that prompted the SWARM.

Seek to gain a summary of what happened leading up to and after the fall from the perspective of those who observed it. It may be helpful to go to the location where the fall occurred and ‘walk through’ what happened (see also [A brief guide to walkthrough analysis](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Walkthrough-analysis-v1.1-.pdf)).

Allow each participant to share their recollection in turn. Go in the order staff are standing, not in order of seniority.

**Step 4:** Explore what happened and why through the lens of the SEIPS framework.

**Tools and technology**

Consider tools such as the bedrail, call bell, walking aids, flat lifting equipment, MFRA, post fall checklist:

* Were the relevant tools/equipment available?
* Are there signs of poor design (e.g., sticky notes to guide use)?
* Is equipment reliable and maintained?
* Are manuals, procedures and supports accessible?

**Tasks**

* Talk through task demands, workload and time pressures.

**Person**

* Was there anything specific to the patient’s condition leading up to the fall (think about diagnosis, past medical history, social history, medications including culprit medications, falls history)?
* Had the patient’s cognition or behaviour changed that day?

**Organisation**

* Was there anything relating to the functioning of the ward / unit in the time leading up to the fall (increased acuity, deteriorating patient, staffing concerns, multiple admission/discharges, many patients with high support needs)?

What were the ward staff doing at the time of the fall (where were they? Was this normal ward routine?)?

* Describe how falls training is organised to support safe care.

**Internal environment**

* Was there anything unusual regarding the environment (i.e. heat / cold / lighting / change of layout)?

**Step 5:** Identify where else in the organisation the learning from the SWARM may be relevant:

* Do any of the themes represent ‘system issues’ that might be relevant to other patients in the ward/unit, or in other wards/units in the organisation?

**Step 6:** Identify safety actions, assign leads and deadlines (where feasible).

* Are there any rapid actions that need to be taken including actions specific to the patient?
* Are there any parallels with learning themes arising from previous SWARMs, structured reviews or after-action reviews in your ward/unit?
* Are there any parallels with learning themes arising on other units/wards?
* Use trust/health board falls steering group to discuss shared learning themes and consider actions.
* Consider using improvement methods to address system issues identified as a result of this and other reviews.