Post-fall SWARM

The post-fall SWARM should include representation from the multidisciplinary team and take place as soon as possible after the event (ideally within five working days) to ensure the event is fresh in the minds of the team.

The template should be used with the Post-Fall SWARM help notes.

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| **Patient Name:** | **NHS Number:** | **Age:** |
| **Time & date of fall:** | **Injury Sustained:** | **Level of harm reported:** |
| **Length of Stay in trust prior to this fall**  **Time in days:**  **Time in hours:** | **Ward & Division/care group:** | **Incident report no:** |
| **Date & time of review:** | **MDT members present:** | |

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

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

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| **Step 3: Replay the event that prompted the SWARM** |
| **If RCP post-fall debrief was conducted, consider the answers to questions 1-5 (about the fall)** |
| **If RCP post-fall debrief was conducted, consider the answers to questions 6-11 (fall prevention activity prior to fall)** |
| **If RCP post-fall debrief was conducted, consider the answers to questions 12-16 (immediate post-fall management)** |

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| **Step 4. Explore what happened and why through the lens of the SEIPS framework** |
| **Tools & Technology**  **Organisation**  **Internal environment**  **Person**  **Tasks**  **External environment** |

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| **Step 5. Identify where else in the organisation the learning from the SWARM may be relevant:**  Use this section to discuss the issues identified in this review that might be relevant to other similar situations in this ward / unit and in other wards/units in the organisation. |
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| **Step 6: Identify safety actions, assign leads and deadlines (where feasible)**  Use this section to describe any actions as a result of the review. Include actions specific to the patient discussed as well as any ‘systems level’ issues identified. |
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| **Duty of candour** | |
| Duty of candour completed:  Date completed:  Completed by: | Yes / No |
| Discuss any concerns raised by the patient or their family. | |

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| **Sign off** | | | | | |
| **Review led by:** |  | **Signed:** |  | **Date:** |  |