**Post-fall debrief additional information.**

The following help notes are designed to support completion of the post-fall debrief.

**Questions 1**

These should be free text giving a summary from the patient’s perspective and from any witnesses.

**Question 2**

The fall was witnessed if another person was present when the patient fell and is able to give a reliable account of what they observed immediately before, at the point of the fall and immediately afterwards.

**Question 3**

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.

**Question 4**

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”.

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.

Answer ‘N/A’ if the fall was not related to the bed.

A bed rail prescription should include a documented assessment to ascertain whether bed rails should be raised.

Answer N/A if the fall was not related to the bed.

**Question 5**

**Call bell given:**

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).

Choose 'Not applicable' if the multi-factorial fall risk assessment mobility assessment indicated no need for supervision when transferring or walking.

**Instructed to ask for help:**

Choose 'Not appropriate' where an assessment has deemed that the patient would be unable to remember, understand, physically comply, or perceive the importance of asking for help.

**Alternative strategy to call bell:**

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).

**Walking aid**

Only answer 'Not applicable' if a walking aid was not required or not appropriate (as stated in mobility assessment and plan).

**Question 6**

If the mobility plan was not followed, select this answer regardless of the reason for this. There are many possible reasons for mobility plans not being followed. Therefore, it is important to acknowledge this and understand the reasons.

**Question 7**

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 and/or 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 the type of walking/mobility aid that has been recommended.

**Question 8**

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.

**Question 9**

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 that the patient has developed a new confusion before the fall, but this was not identified on formal delirium assessment, answer ‘not documented’.

**Question 10**

Lying / standing blood pressure is measured after the patient is supine for 5 minutes and then 1 and 3 minutes after standing up.

**Question 11**

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.

**Question 13**

Record as 'Staff assisted to get up' if the patient was moved without equipment being used.

**Question 15**

Answer according to the level of harm that will be entered into reporting and learning system.

The post-fall debrief form can be printed and completed by hand, completed as an electronic document or the questions migrated into an electronic health records-based form.