*Affix label here*

Post-fall debrief – to be performed **immediately after** the fall.

This debrief should be undertaken by a staff member who witnessed the fall ***or*** was responsible for the patient’s care around the time of the fall and it should be completed before the end of that shift. The purpose of the hot debrief is to **collect information needed to learn from falls**. The data collected can be used to **identify patterns** associated with inpatient falls and should **inform after-action reviews/structured post-fall reviews**, where one takes place.

The hot debrief can also identify **immediate actions required** to reduce further falls and be a mechanism to **provide support to the staff** involved in a fall incident.

| **Date of fall:** | **Time of fall:**  | **Patient name and NHS number:** |
| --- | --- | --- |
| **Questions about the fall**  |
| 1. **What happened?**

If possible and appropriate, ask the patient what happened and find out from anyone who may have witnessed the fall. Use free text (Please include any information that may provide helpful context to support system learning e.g. : Where members of staff were at the time of the fall, ward acuity, anything different on this shift, any changes in the patient):  |
|  |
| 1. **Was the fall witnessed?**
 | **Who witnessed the fall?** |
| [ ] 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 |
| 1. **What was the patient doing at the time of the fall?**
 | **If the fall was from the bed:** **Was the bed height appropriately configured for safe transfers 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 ( ? patient unable to inform) | [ ] Yes[ ] No[ ] Not documented[ ] N/A (not from the bed) |
| **If the fall was from the bed:****Was an appropriate bed rail prescription in place at the time of the fall?** | **Was the bed rail prescription plan in place at the time of the fall?** |
| [ ] Bed rails recommended[ ] Bed rails not recommended[ ] No assessment[ ] N/A | [ ] Prescription being followed[ ] Prescription not being followed[ ] N/A |
| 1. **Were any of the following actions in place at the time of the fall?**
 |
|  **The patient was given the call bell and instructed on how to use it:** | **The patient was requested to ask for help before moving:** |
| [ ] Yes[ ] No[ ] Not appropriate[ ] Not known | [ ] Yes[ ] No[ ] Not appropriate[ ] Not known |
| **An alternative strategy was put in place as the patient was deemed unable to ask for help or use the call bell:** | **A walking aid was situated within the patients reach (if aid was indicated in the mobility plan)?** |
| [ ] Yes[ ] No[ ] Not appropriate[ ] Not known | [ ] Yes[ ] No[ ] Not applicable[ ] Not known |
| **Multifactorial fall risk assessment and intervention** |
| 1. **Was the patient’s mobility plan being followed at the time of the fall?**
 | 1. **Was the patient using a walking or mobility aid at the time of the fall?**
 |
| [ ] Mobility plan was followed [ ] Mobility plan was NOT FOLLOWED [ ] No mobility plan or mobility plan unclear | [ ] No mobility aid indicated in mobility assessment[ ] Aid in mobility plan was being used[ ] Recommended aid was NOT being used[ ] Mobility aid requirement was not documented |
| 1. **Did the patient have a continence care plan and was it being followed at the time of the fall?**
 | 1. **Did the patient have a delirium care plan and was it being followed at the time of the fall?**
 |
| [ ] No continence problems identified at assessment[ ] Continence care plan was being followed[ ] Continence care plan was NOT FOLLOWED[ ] No continence plan or plan unclear. | [ ] No delirium identified on assessment[ ] Delirium identified – care plan was being followed[ ] Delirium identified - care plan was NOT FOLLOWED [ ] No assessment for delirium |
| 1. **When was the most recent lying / standing blood pressure recorded?**
 | **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).** |
| [ ] Date lying / standing BP last measured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Lying / standing BP NOT recorded [ ] Lying / standing BP not appropriate (only in patients unable to stand) | [ ] The patient had orthostatic hypotension on the most recent measurement[ ] The patient did not have orthostatic hypotension [ ] N/A (no lying / standing BP recorded) |
| **If the patient had orthostatic hypotension, was any action taken to address this?** | 1. **Has the patient had a medication review since admission?**
 |
| [ ] Yes - describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] No [ ] N/A (no orthostatic hypotension) | [ ] Yes – date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] No [ ] N/A (not on any medication) |
| **Questions about after the fall** |
| 1. **Was the patient checked for signs or symptoms of potential spinal injury and fracture before they were moved?**
 | 1. **What moving and handling method was used to move the patient following the fall?**
 |
| [ ] Yes - injury suspected[ ] Yes - no injury suspected[ ] No | [ ] 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 recorded |
| 1. **Did the patient have a medical assessment after the fall?**
 | 1. **What level of harm will/have you attribute(d) to 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 | **Physical harm**[ ] Fatal[ ] Severe physical harm[ ] Moderate physical harm[ ] Low physical harm[ ] No physical harm | **Psychological harm**[ ] Severe psychological harm[ ] Moderate psychological harm[ ] Low psychological harm[ ] No psychological harm |
| 1. **Have the patient’s next of kin (NOK) been contacted?**
 | [ ] NOK were contacted[ ] The patient had requested not to contact NOK[ ] No NOK OR NOK were uncontactable |
| **Immediate actions** |
| 1. **Patients who have had a fall are at increased risk of falling again. What immediate actions have been taken to reduce further falls?**

(Re-assess risk and plans of care, strategies to reduce risk of further falls) |
|  |
| 1. **Were any actions required to support staff following the fall?**
 |
|  |
| **Data collected by:** | **Signed:** | **Date:** |