*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 | | YesNo  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 minutesAssessment 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:** | |