Service User Falls A Practical Guide for Review

This guidance document offers service providers a practical guide to reviewing service user falls. It should be read in conjunction with the HSE Incident Management Framework (2018).

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

TABLE OF CONTENTS

INTRODUCTION

Falls are the most commonly reported incident within the HSE and HSE-funded services with 28,714 falls being reported in 2016, including 11,876 in acute hospitals and 15,890 in residential units (NIMS). Falls have an impact on the service user, on the health and social care professional, and on the service provider. Falls cause harm in 24% of cases in acute services and 26% in residential units (NIMS). Serious injury, such as hip fracture, traumatic brain injury and death, occurs in nearly 6% of all acute services falls. There are similar rates for serious injury in older residential services. Service users can also suffer non-physical harm such as fear of falling. Fear of falling can cause the service user to restrict their activities, which drives reduced strength and balance and increases their falls risk. For older persons with multiple comorbidities and frailty, even a 'minor' injury can have a significant effect in terms of impaired or delayed rehabilitation, loss of confidence, longer stay in acute services and ultimately, a poorer quality of life[1]. Of all the harms resulting from falls, hip fracture deserves particular focus as the morbidity and mortality associated with them is significant. Nearly 90% of all service users with a hip fracture will need assistance with at least one activity of daily living one-year post-fracture[2] and 40% of all service users who suffer an in-hospital hip fracture will die within three months[3].

Every fall, regardless of harm, is an opportunity to prevent another fall[4]. A proportionate and responsive review post-fall can identify key causal factors that contributed to the fall in order to implement improvement initiatives to prevent another fall. It also gives assurance that appropriate governance structures and processes are in place, as required by the HSE Incident Management Framework (2018)[5]. The Incident Management Framework describes the following six steps in the management of incidents:

- Prevention through supporting a culture where safety is a priority
- Identification and immediate actions required (for persons directly affected and to minimise risk of further harm to others)
- Initial reporting and notification
- Assessment and categorisation
- Review and analysis
- Improvement planning and monitoring

AIM

The aim of this document is to provide acute hospitals and residential services for older people with a practical guide in reviewing falls which aligns to the six steps described in the HSE Incident Management Framework 2018 (see Figure 1)

SCOPE

The scope of this document relates to service users within HSE and HSE-funded acute hospital and residential services for older people. This document should be read in conjunction with the HSE Incident Management Framework (2018)

ABBREVIATIONS

HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professional
HSE	Health Service Executive
LAO	Local Accountable Officer
NIRF	National Incident Report Form
NIMS	National Incident Management System
QPS	Quality & Patient Safety
SAO	Senior Accountable Officer
SIMT	Serious Incident Management Team
SRE	Serious Reportable Event

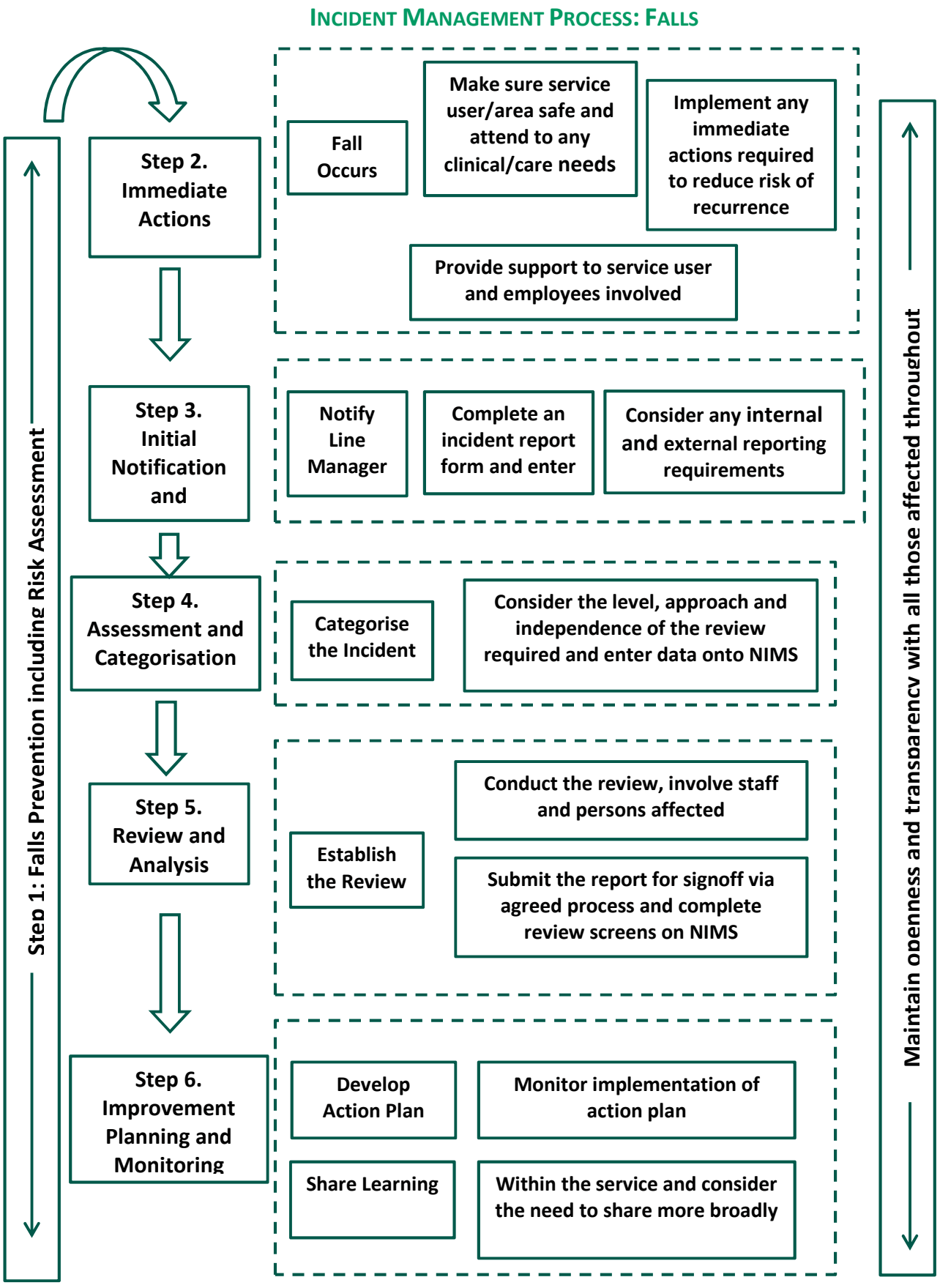

Figure 1: Adapted from HSE Incident Management Framework (2018)

STEP 1: FALLS PREVENTION – INCLUDING FALLS RISK ASSESSMENT

Falls and fall-related injuries are the most common reportable incident in the HSE. All inpatient and residential care services should have a Falls Prevention and Management Policy in place to reduce the risk of falls and harm from falls[6,7]. The policy must describe procedures relating to falls & fracture risk management, such as falls risk assessment; management of the service user post-fall; detail of the organisational infrastructure, roles and responsibilities; education & training; and measures and monitors relating to falls prevention and management.

All admitted service users aged 50 years and older should be considered for falls risk screening[8], as per local policy. If the service user is deemed at risk of falling, then a multifactorial assessment which identifies the service user's individual risk factors for falling should be completed[8]. Interventions should address each of the service users risk factors for falling[8]. Interventions implemented may vary depending on setting i.e. acute care, residential care.

STEP 2: IDENTIFICATION AND ACTIONS REQUIRED

(FOR PERSONS DIRECTLY AFFECTED AND TO MINIMISE RISK OF FURTHER HARM TO OTHERS)

There are a number of actions that should be completed in the immediate post-fall period.

1. Service users must have a medical review[9] to identify, and manage, any harm that may have occurred.
2. Service users must have their risk factors for falling reassessed[8]. Interventions should address each of the service user's risk factors for falling[8].
3. Identify and rectify any hazards or risks associated with the fall that may affect other services users' e.g. environmental issues.
4. Factually document all falls and actions taken to ameliorate harm in the service users healthcare record.
5. Open Disclosure should be undertaken by staff both to the service user and/or their next of kin
    a. This is essential as it significantly contributes to the maintenance of confidence in, and trust between, the service user, their family and the service providers.
    b. A record of the salient points of the Open Disclosure discussion and details of the apology and/or expression of regret provided to the service user and/or family should be made in the service user's healthcare record.
6. Identify and address any staff support needs in the aftermath of the incident
    a. Staff can feel responsible and guilty after a service user fall particularly if the fall resulted in significant harm. Falls occur due to a combination of many factors, both intrinsic and extrinsic, rather than acts or omissions of an individual staff member.

STEP 3: INITIAL REPORTING AND NOTIFICATION

The staff member who identified the fall is responsible for

- Notifying the manager on-duty within the area where the fall occurred.
- Completing an incident report form as soon as is practicable after the fall occurs but within 24 hours.
    - All information must be provided in full, as required on the National Incident Reporting Form (Person), and must be factual and objective. This is important as it assists in supporting a just and fair culture.

Local services must clearly identify, and communicate to staff, the route for submission of the form for input onto the National Incident Management System (NIMS). The minimum data set for service user falls has been included on the National Incident Reporting Form (Person). This minimum data set will provide the basis for generating an aggregate review report of falls at a service level.

Local services must also identify the route and process for notification of falls classified as **Category 1** incidents to the Senior Accountable Officer (SAO) within 24 hours of identification. This should distinguish both the arrangements for notifying these events within, and outside, normal working hours. In the context of the management of incidents, the senior accountable officer is the person who has ultimate accountability and responsibility for the services within the area where the incident occurred.

Older Persons Residential Services also have an obligation to notify falls that result in death or serious injury to HIQA. Deaths related to falls in any service are reportable to the Coroner.

STEP 4: ASSESSMENT AND CATEGORISATION

The purpose of assessing and categorising an incident is to determine the level and approach of review that is required. The assessment of harm is made using the impact table on the HSE Risk Assessment Tool. Categorisation is based on the level of harm sustained as a consequence of the fall.

The level and approach of review must be proportionate to the harm sustained as a result of a fall.

Based on the outcome of this assessment falls are categorised as follows:

Category 1 Major/Extreme

- Serious falls resulting in death or major permanent incapacity
- Includes but is not limited to serious falls resulting in death; hip fractures; pelvic fractures; and traumatic brain injuries leading to transient or permanent functional or cognitive decline/deterioration.
- Falls in this category are classified as Serious Reportable Events (SREs)

Category 2 Moderate

- Significant harm requiring medical treatment e.g. wrist fractures

Category 3 Minor/Negligible

- Falls resulting in no harm or low harm

Decision making in relation to the review of Falls incidents.

Based on the categorisation, a graduated and proportional level of review (i.e. Comprehensive, Concise and Aggregate) should be considered in line with the HSE Incident Management Framework (2018). Please refer to the table below for further information.

Decision Making for Category 1 Falls Incidents

Category 1 incidents, when identified must be notified to the SAO within 24 hours. The arrangement for notification must be clearly defined within each organisation. The SAO is required to convene a meeting of the Serious Incident Management Team (SIMT) within 5 working days to make a decision in relation to review.

Preparing for Decision Making by the SIMT

In order to assist decision making at the SIMT, the service is required to complete and return to the QPS Advisor, Part A of the Preliminary Assessment to Assist Review Decision Making form (Appendix 1). The data required to complete this form should be accessed from relevant sources e.g.

- The line manager in whose area of responsibility the fall occurred
- Clinically relevant persons e.g. Falls Lead*, HSCP etc
- National Incident Report Form
- Service user healthcare record
- Engagement with
    - staff who either witnessed the fall or were either on duty at the time of the fall
    - the service user/next of kin

Decision Making by the SIMT

Using the data collected in Part A, the SIMT should determine if there was evidence of *failure to identify and/or intervene on one or a combination of risk factors which were present at the time of the fall* and make a decision in relation to the conduct of a review. A Concise approach to review is generally accepted as appropriate for **Category 1** incidents. However, a Comprehensive approach to review should always be considered.

Where a decision **to review** using a Concise (or Comprehensive) approach is taken, this is noted in Part B of the form along with other required information and the SAO moves to establish the review. The decision to review along with detail of the approach being undertaken must be recorded on the NIMS review screens.

Where a decision **not to review** using a Concise (or Comprehensive) approach is taken, the completed Preliminary Assessment to Assist Review Decision Making form (Part A and Part B) must be submitted to the relevant Quality and Safety Committee for review and ratification of the decision. The decision not to review, when ratified by the QPS Committee, must be recorded the NIMS review screens.

* This may be a local clinical manager such as CNM2, ADON, Person-in-Charge or a person with specialist knowledge in falls

Decision Making for Category 2 Falls Incidents

Following categorisation of an incident as a **Category 2** incident the Local Accountable Officer[†] should be notified of the categorisation and the need to consider a review.

Preparing for Decision Making for Review

In order to assist decision making by the Local Accountable Officer (LAO), the service is required to complete Part A of the Preliminary Assessment to Assist Review Decision Making form (Appendix 1). The data required to complete this form should be accessed from relevant sources e.g.

- The line manager in whose area of responsibility the fall occurred.
- Clinically relevant persons e.g. Falls Lead[‡], HSCP etc
- National Incident Report Form,
- Service user healthcare record,
- Engagement with
    - staff who either witnessed the fall or were either on duty at the time of the fall
    - the service user/family

Decision Making for Review

The Preliminary Assessment Form when complete should be returned to the LAO. Having reviewed the data in Part A the LAO, in consultation with the QPS Advisor will decide whether there is evidence of the following:

- Failure to identify and/or intervene on one or a combination of risk factors which were present at the time of the fall.

Where it is agreed that there was evidence of the above, the conduct of a review must be considered. A concise approach to review is generally considered appropriate for **Category 2** Falls incidents.

Where a decision **to review** using a concise approach is taken, this is noted in Part B of the form along with other required information and the LAO proceeds to commission and establish the review. If, in exceptional circumstances, it is considered that a comprehensive approach is indicated this must be referred to the SAO who is responsible for commissioning comprehensive reviews. The decision to review along with detail of the process to be undertaken must be recorded on the NIMS review screens.

Where a decision is taken **not to review** using either a Comprehensive or Concise approach, the completed Preliminary Assessment to Assist Review Decision Making form (Part A and Part B) must be retained by the LAO for audit purposes. The decision not to review and the rationale for this must be recorded on the NIMS review screens.

[†] For a hospital this may be the ADON and/or Clinical Lead. For a residential setting, this may be the person-in-Charge or designate

[‡] This may be a local clinical manager such as CNM2, ADON, Person-in-Charge or a person with specialist knowledge in falls

Decision Making for Category 3 Falls Incidents

Whilst there is not a requirement to review these incidents individually, if it is considered that an individual **Category 3** incident presents an opportunity for learning a concise review should be considered.

In the main **Category 3** falls incidents should be reviewed on an aggregate basis. See Point 1 in Step 5 Review and Analysis, below for detail of this. Further information on aggregate reviews is available in Step 5: Review and Analysis. It should be noted that although Part A of the Preliminary Assessment to Assist Review Decision Making Form (Appendix 1) has been designed to support decision making with respect to review for **Category 1** and **Category 2** falls incidents, it can also be used for learning at a local level from **Category 3** falls.

STEP 5: REVIEW AND ANALYSIS

The purpose of a review is to find out what happened, why it happened and what learning can be gained in order to minimise the risk of or prevent a similar fall occurring in the future. The review and analysis of falls should be considered a key tool in quality improvement. There is a need not just to understand **what happened** in relation to the fall but also to understand **why it happened** i.e. the cause and the factors that contributed to the fall.

Review of Individual Falls Incidents

There are two levels of review that relate to the conduct of review of individual cases. These are as follows

- ***Comprehensive Review***
    - Reviews at this level can be carried out by use of a Review Team or a Review Panel Approach. Guidance on the methodology for these approaches can be found in the HSE Approaches to Incident Review Guidance[10].

- ***Concise Review***
    - Reviews at this level must be carried out using the Falls Concise Review Tool. This tool is specific to falls incidents and was co-designed by Falls Prevention Specialists and QPS Advisors experienced in the conduct of systems based review. The tool commences with the conduct of a Preliminary Assessment of the fall to enable decision making in relation to the requirement for a review (Appendix 1). Where a decision is taken to conduct a review, guidance on the conduct of the concise review and the Review Report template is also provided (Appendices 2&3).

To assist with aggregate analysis of Falls Reviews the Review Screens on NIMS must be completed in full for all Comprehensive and Concise Reviews carried out. A password protected copy of the report must also be uploaded onto NIMS.

Aggregate Review

There are two types of aggregate reviews that can be carried out.

- ***An 'All Fall' Aggregate Review***
    - The National Incident Report Form - Person (NIRF – Person) contains data relating to falls. Services should seek to pull an 'all falls' report from NIMS on a periodic basis for review at their appropriate MDT meeting/QPS Committee.

- ***Concise Reports Aggregate Review***
    - Due to the structured nature of the concise review process, consideration should also be given to the conduct of aggregate analysis of concise reviews completed within a service/service area. The outcome of such an analysis can contribute to a greater

understanding of the issues underlying falls within the service user population. This can be done at hospital level, hospital group level, and/or national level. For this reason, it is important that all completed Concise Reports are password protected, uploaded to NIMS, and the Review Screens on NIMS are completed in full. Guidance on the methodology for aggregate analysis can be found in the HSE Approaches to Incident Review Guidance. Key learning points from any Comprehensive Review conducted can also be incorporated into this aggregate analysis.

Recommendations made as a consequence of any review undertaken should be used by services to develop action plans to improve safety and reduce the risk of reoccurrence. Recommendations must therefore be linked to the factors that contributed to the fall and must be:

- Framed in a manner that conform with SMART principles
- Capable of supporting any changes in practice required
- Where possible aimed at changing systems in a manner that supports people to behave in a safe and consistent manner rather than relying on people to behave in a specific manner.
- Discussed with the commissioner to ensure that they are both implementable and consistent with the policy framework within which the service operates.

When the draft report is available it will be provided to relevant staff and/or service users/families, to confirm factual accuracy and provide comment within a specified timeframe. This should be carried out in a supportive manner. It is one of the final tasks prior to completion of the incident management cycle and it is important that appropriate consideration is given to how this is done.

Following acceptance of the report by the commissioner the service user/family liaison person should contact them to inform them that the report is finalised and offer them a meeting to discuss this. They should be offered an opportunity to receive a copy of the report in advance of the meeting and so have had a chance to review it.

Staff should also be advised of the outcome of the review in a manner that is supportive.

Following the finalisation of the report, an action plan is developed to ensure that recommendations made in the report are implemented. A copy of the report is also submitted to the relevant QPS Advisor or equivalent for inclusion in Aggregate Analysis to inform learning and to enable the completion of the review screens on NIMS. The final report and action plan is also submitted to the relevant QPS Committee for their information.

STEP 6: IMPROVEMENT PLANNING AND MONITORING

It is the responsibility of the person commissioning the review to ensure that an action plan to implement the recommendations is developed.

Rather than monitor action plans for individual reviews, it is recommended that action plans developed are interfaced with relevant service improvement plans and implementation be monitored through this. To facilitate monitoring, actions developed must be assigned to named individuals with a due date for completion. Where there is evidence that actions are behind schedule appropriate corrective action must be taken to address this. Improvement plans must therefore be owned by the service, and reviewed and updated regularly. If an action is identified which is outside the control of the service, a formal system of escalation should be applied so that the action can be appropriately located for implementation.

REFERENCES

1. Oliver, D., Healey, F., Haines, T.P. (2010) Preventing Falls and Fall-Related Injuries in Hospitals. *Clin Geriatr Med* 26:645–692
2. Kanis JA, Johnell O. (1999) The burden of osteoporosis. *J Endocrinol Invest* 22:583–588.
3. Johal, K.S., et al. (2009) Hip fractures after falls in hospital: a retrospective observational study *Injury* 40: 201-204
4. Voluntary Healthcare Agencies Risk Management Forum. Prevention & Management of Falls & Harmful Falls, including Bone Health: Matters for Consideration. 2017
5. HSE Incident Management Framework (2018)
6. Department of Health and Children, Health Service Executive, National Council on Aging and Older People (2008) Strategy to Prevent Falls and Fractures in Irelands Ageing Population
7. Health Information and Quality Authority (2012) National Standards for Safer Better HealthCare
8. NICE (2013) Falls: assessment and prevention of falls in older people (CG161)
9. NICE (2015) Falls in Older People Quality Standards (QS86)
10. HSE Approaches to Incident Review Guidance (2018)

Appendix 1. Preliminary Assessment to Assist Review Decision Making

Part A – Case Report – To be completed in advance of the SIMT/Review Decision Making Meeting

To be completed in event of a Category 1 or Category 2 Fall Harm as a Result of a Fall

Details of Service User and Fall	
Name:	NIMS Reference No:
MRN: (if available)	Date of Admission:
Date of Birth:	Ward/Unit:
Background of Service User and Reason for Admission. Click here to enter text	
Date of Fall: Click here to select drop down for the date	Ward: Click here to enter text.
Time of Fall: __ __ : __ __ (24 hour clock)	Exact Location: Click here to enter text.
Description of Fall: Click here to enter text	
Actions Taken by the Service in the Period Following the Fall in Respect of the Service User's Care and Prior to this Review**:** Click here to enter text.	
Injury Sustained: Click here to enter text.	
Involvement of the Service User/Family: Click here to enter text	Open Disclosure ❑ Click here to select date Service Contact Person Select Click here to enter name and role.

Service User - Falls Risk Factor					
Did the patient have any of the following falls risk factors present **at the time of the fall**? (select all that apply). Identify interventions that **were in place** to address each fall risk factor.					
Risk Factor		**Intervention(s) In Place**	**Risk Factor**		**Intervention(s) In Place**
Age 65+	❑	Click here to enter text.	Impaired Transfers	❑	Click here to enter text.

Use of Walking Aid	❑	Click here to enter text.	Impaired ADLs	❑	Click here to enter text.
Hearing Impairment	❑	Click here to enter text.	Postural Instability, Mobility Problems, and / or Balance Problems	❑	Click here to enter text.
Incontinence	❑	Click here to enter text.			
Inappropriate Footwear	❑	Click here to enter text.			
Pain	❑	Click here to enter text.			
Impaired Vision	❑	Click here to enter text.	Medication e.g. Polypharmacy, Drugs with Sedative Effect	❑	Click here to enter text.
Depression / Low Mood	❑	Click here to enter text.			
Fear of Falling	❑	Click here to enter text.			
Cog. Impairment	❑	Click here to enter text.	Fracture Risk, such as *Previous Fragility Fractures* *Alcohol Use (≥21u/week)* *Rheumatoid Arthritis* *Smoker* *Recent Steroid Use* *Low BMI (≤19)*	❑	Click here to enter text.
Dizzy / Lightheaded	❑	Click here to enter text.			
Loss of Consciousness	❑	Click here to enter text.			
Syncope Syndrome	☑	Click here to enter text.			
Delirium	❑	Click here to enter text.			
Dementia	❑	Click here to enter text.			
Health Condition that Increases Falls Risk e.g. neurological or musculoskeletal Click here to list relevant health conditions.				❑	Click here to enter text.

List any service user related risk factors that, at the time of fall, were i) identified but did NOT have an appropriate intervention or ii) present but were NOT identified and therefore did NOT have an appropriate intervention.

Click here to enter text.

ENVIRONMENT & EQUIPMENT – FALLS RISK FACTORS

Were there any environmental or equipment related risk factors at the time of the fall? (tick all that apply).
Identify any control(s) in place prior to the fall to reduce this risk.

Risk Factor		Describe role in the Fall?	Control(s) In Place
Lighting	❑	Click here to enter text.	Click here to enter text.
Floors	❑	Click here to enter text.	Click here to enter text.
Furniture	❑	Click here to enter text.	Click here to enter text.
Fittings	❑	Click here to enter text.	Click here to enter text.
Wheelchairs	❑	Click here to enter text.	Click here to enter text.
Walking Aids	❑	Click here to enter text.	Click here to enter text.

Bed / Bedrails	❑	Click here to enter text.	Click here to enter text.
Call Bells	❑	Click here to enter text.	Click here to enter text.

List any environmental or equipment related risk factors that, at the time of fall, were i) present but NO control(s) in place or ii) absent and should have been in place.

Click here to enter text.

STAFFING – FALLS RISK FACTORS

What was the staffing and skill mix on the shift that the service user fell?	Nurse: Enter No.	HCA: Enter No.	Student: Enter No.
Were all rostered staff on the ward at the time of service user fall? (e.g. not off ward/on break/in handover)			Select
Have all staff on the shift that the service user fell been trained in the falls prevention policies of the service?			Select

List any staffing related issues at the time of fall as they relate to the above questions

Click here to enter text.

TASK & TEAM – FALLS RISK FACTORS

Was a falls risk assessment completed prior to the fall as per the falls prevention policy of the hospital?	Select
Was the service user's falls risk communicated to the patient, their families and all relevant staff?	Select
Was the service user's falls risk communicated at handover / shift reports?	Select

List any task and team related factors at the time of the fall to the above questions

Click here to enter text.

ADDITIONAL INFORMATION

If you are unable to answer any question above, or wish to expand on any answer, please click here and write:

PART B – RECORD OF DECISION (TO BE COMPLETED AT THE SIMT/REVIEW DECISION MAKING MEETING.

Decision to commission a CONCISE REVIEW or a COMPREHENSIVE REVIEW should be considered in the event of **CATEGORY 1** or **CATEGORY 2** harm falls incidents. Part A of this form seeks to identify whether or not the key elements required for falls prevention were in place. Part A should therefore be considered in making the decision to conduct a review or to decide if a review is not required.

Consideration therefore should be given to whether the information provided in Part A that there is evidence of the following

- *A failure to identify and/or intervene on one or a combination of risk factors which were present at the time of the fall*

In cases where all risk factors were identified, the appropriate interventions were in place and the fall occurred despite this, it may indicate the fall was not preventable and that a review is not required.

RECORD OF DECISION TO CONDUCT A REVIEW

Incident Details	
NIMS Ref No:	**Date entered on NIMS:**
Date of Incident:	**Date Notified to SAO/LAO:**
Date of SIMT /Relevant Meeting:	**Case Officer/ QPS Manager:**

Decision to Conduct a Review under the Incident Management Framework					
Please indicate the decision in relation to the level of review to be conducted:					
Comprehensive Review		Concise Review		No Review *	

Comprehensive Review	
If the decision is to commission a Comprehensive Review, indicate whether this will be by way of:	
Review Team Approach	
Review Panel Approach	
The Final Report of the Comprehensive Review must be accepted by the SAO within 125 days of identification of the incident.	

Concise Review
If the decision is to commission a Concise Review, please complete the Review Report found in Appendix 3.
The Final Report of the Concise Review must be accepted by the SAO/Local Accountable Officer (as appropriate to incident categorisation) within 125 days of identification of the incident.

Level of Independence attaching to the Review	Please Tick
1. Team internal to the ward/department/NAS Operational Region	
2. Team internal to the service/hospital/NAS Operational Area	
3. Team external to the service/hospital but internal to the CHO/HG/NAS Corporate Area	
4. Team involve service users external to the CHO/HG/NAS Directorate	

Terms of Reference
Please include at a minimum detail of the purpose and scope of the review and that it will adhere to the principles of natural justice and fair procedures e.g. • *That the purpose of the review is to identify what happened, why it happened and to identify recommendations to reduce the risk of recurrence.* • *The scope of the review i.e. from X time e.g. admission to Y time e.g. time the fall was identified* • *That the process will adhere to the principles of natural justice and fair procedures*
Composition of the Review Team
Whilst it is not necessary to identify by name members of the Review Team at this stage the composition by title/profession should be listed here

Contacts in relation to the review process.	
Commissioner of the Review	
Title	
Email	
Telephone	

Service User Liaison	
Title	
Email	
Telephone	
Staff Liaison	
Title	
Email	
Telephone	

No Review

If the decision is **NOT** to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based.

_____
_____
_____
_____

** Decisions not to review must be:*

- *Communicated to persons affected i.e. service user, family and staff.*
- *Entered onto NIMS and this should include the reason and rationale for same.*

Note: *Where the decision not to review relates to a Category 1 incident, the Preliminary Assessment to Assist Review Decision Making (Part A and B) must be submitted for review and ratification by the Quality & Safety Committee.*

These incidents should also be included in an Aggregate Review process.

APPENDIX 2 - GUIDANCE FOR CONDUCTING A CONCISE REVIEW

Commissioning

The responsibility for review lies within the line management arrangements in which the fall occurred. The level of commissioning will depend on the categorisation of the incident.

Category 1 Incident – Senior Accountable Officer
Category 2 Incident – Local Accountable Officer i.e. the manager of the service in which the incident occurred.

Terms of Reference

The terms of reference should have been set out in the Preliminary Assessment to Assist Review Decision Making Form – Part B – Record of Decision.

Who Should Be Involved?

The review should seek the involvement of relevant staff i.e. those on duty at the time of the fall, the line manager in the relevant area, the service user/family.

The service user/family should be contacted to advise them of the plan for review and to ask them if there are any specific issues that they would like to see addressed by the review. This engagement also provides an opportunity to clarify the purpose of the review, the likely timeframe for completion and how they will be advised of the outcome.

In relation to staff whilst there is no requirement to conduct formal interviews it is important to engage with staff to understand their involvement and gain their perspective. This can be done on a one to one basis or by way of a multidisciplinary meeting.

If engaging on a multidisciplinary basis it is important to facilitate this in a way which focuses on learning. To ensure that the process is open and participative the following ground rules should be set at the outset: everyone's perspective is valued (regardless of their grade/profession); it is not about blame or finger pointing; and the focus is understanding why the fall occurred and what can be learned in order to prevent the fall recurring.

The Report

The Falls Review Report template (Appendix 3) should be used in **all** circumstances and completed in **full**. This is important so that services can conduct an aggregate analysis of completed concise reports to identify further learning.

Much of the Falls Review Report reflects information gathered in the completion of Part A and Part B forms earlier in the process. The blank review report template is 6 pages long and it is anticipated that a concise report when complete should not exceed 10 pages.

The review report is divided into the following 14 sections. *It is recommended that you print off this table when drafting the report as it will serve as a guide to completion.*

Section	Detail to be included
1. Introduction	This section should include a piece about the services commitment to quality and how the learning from this review will inform safety improvement. It should also contain detail of the approach to review used, the information considered, and the source of this information e.g. healthcare record, discussion with key staff etc. Detail of the disclosure of the fall provided to the family should be included here.
2. Details of Service User and Fall	Concise details of the service users background user i.e. when and why they were admitted and brief detail of their medical and social history. Description of the fall should be included such as the mechanism of fall, and immediate actions after the fall.
3. Service User – Falls Risk Factors	All service related risk factors should be identified and interventions that addressed each risk factor should be described. List any service user related risk factors that, at the time of fall, were i) identified but did NOT have an appropriate intervention or ii) present but were NOT identified and therefore did NOT have an appropriate intervention. Service user risk factors are the main cause of falls and particular emphasis should be given to this section.
4. Environment & Equipment – Falls Risk Factors	All environment and equipment related risk factors should be identified and interventions that addressed each risk factor should be described. List any environmental or equipment related risk factors that, at the time of fall, were i) present but NO control(s) in place or ii) absent and should have been in place.
5. Staffing – Falls Risk Factors	All staffing related risk factors should be identified. List any staffing related issues.
6. Task and Team – Falls Risk Factors	All task and team related risk factors should be identified. List any task and team related issues.
7. Key Causal Factor and Contributory Factors	Key Causal Factors are 'issues that arose in the process of delivering and managing health services which had an effect on the eventual harm'. In the context of falls, the issue that arises is the failure to identify a risk factor for falling and/or a failure to intervene on that risk factor. This means that the key causal factor is best described as **a failure to identify or intervene upon a risk factor or a combination of risk factors at the time of the fall.** This key causal factor has therefore been pre-populated on the Falls Review Report. In relation to contributory factors for falls, we often place too much emphasis on the environmental factors and fail to consider delirium, polypharmacy, fear or falling, or syncope syndrome as possible risk factors for falling. As a result, many patients do not get an intervention directed at each of these risk factors. Similarly, a patient may have impaired ADLs or

	impaired transfers and may not be referred to physiotherapy for assessment and intervention. These specific gaps in our care should be considered contributory to the main Key Causal Factor. Having said that service user falls will have contributory factors that do relate to equipment, task, or staffing and as such require full consideration. It is also important to note that some risk factors though contributory are non-modifiable such as age and previous falls history.
8. Incidental Findings	These are areas identified in the course of the review, as requiring improvement but did not cause or contribute to the incident.
9. Notable Practice	The inclusion of notable practice is important in providing balance to the report as they highlight positive aspects of the service. Points such as how the service managed the incident at the time of occurrence or if during the review process care and/or practice that had an important positive impact e.g. staff openness, timely and effective management of injury, detail of any immediate actions put in place within the service to prevent a similar event occurring to other service users.
10. Other Issues of Note	These should include detail of the response to any queries raised by the family at the outset of the review that are not dealt with in the above report. This is important as in providing the report to the service user/family, this provides the service with an opportunity to show that they have listened to and responded to all matters of concern to them.
11. Review Outcome	Pick one of the following outcomes and enter it in section 11 of the report. **Appropriate care and/or service** - Well planned and delivered, unavoidable outcome and no Key Causal Factors identified. **Indirect system of care/service issues** - No Key Causal Factors identified but Incidental Findings were identified i.e. improvement lessons can be learned but these were unlikely to have affected the outcome. **Minor system of care/service issues** - A different plan and/or delivery of care may have resulted in a different outcome. For example, systemic factors were identified although there was uncertainty regarding the degree to which these impacted on the outcome. **Major system of care/service issues** - A different plan and/or delivery of care would, on the balance of probability, have been expected to result in a more favourable outcome. For example, systemic factors were considered to have an adverse and causal influence on the outcome.

12. Recommendations	Recommendations must be linked to the factors that contributed to the fall as they aim to reduce the risk of these recurring and harming another service user. This is linked to the purpose set out in the Introduction i.e. improving safety and preventing harm to others. Recommendations should be made in conjunction with the service manager and should be framed in a manner that conforms to SMART principles.
13. Arrangements for Shared Learning	Consider how you will share the learning from this review to; • Staff within the ward/area where the fall occurred • Staff within the hospital/residential unit where the fall occurred • Within the CHO/HG e.g. through the relevant QPS Committee and have it included in an aggregate review of harmful falls.
14. Sign off	Prior to completion of this section and in keeping with the requirements of the HSE's Governance Approval Process for Final Draft Reports, the draft report should then be circulated to all participating staff with a request to them to review for factual accuracy and provide any comments back to the reviewer within a specified timeframe. The service user/family should then be contacted and offered a meeting to discuss the final draft report and its findings. Such a meeting can be used, prior to sign off by the commissioner, to ensure that the review has addressed the issues identified by the family at the outset of the process. Reports when in final draft must be submitted directly to the commissioner for acceptance. As part of the acceptance process the commissioner must ensure at a minimum that; • The report is in keeping with TOR • The process applied was in keeping with due process and natural justice • There are linkages exist between the analysis and the recommendations • That the recommendations are SMART Based on a satisfactory review of the report and its acceptance by the commissioner Section 14 of the report is completed. The report is then considered final. Completed reports must be password protected, uploaded onto NIMS, and review screens must be completed.

Appendix 3 – Concise Review Report Template

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

FALLS REVIEW REPORT

CONFIDENTIAL

Date of Incident	Click here to select drop down for date
NIMS Reference Number	Click here to enter number.
Acute Hospital/Community Service	Click here to enter text.
Review Commissioner	Click here to enter text.
Lead Reviewer	Click here to enter text.
Date Report Completed	Click here to select drop down for the date

INTRODUCTION
Click here to enter text

DETAILS OF PATIENT AND FALL	
Background Click here to enter text	
Date of Fall: Click here to select drop down for the date	Ward: Click here to enter text.
Time of Fall: __ __ : __ __ (24 hour clock)	Exact Location: Click here to enter text.
Description of Fall: Click here to enter text	
Actions Taken by the Service in the Period Following the Fall in Respect of the Service User's Care and Prior to this Review: Click here to enter text.	
Injury Sustained: Click here to enter text.	
Involvement of the Service User/Family: Click here to enter text	Open Disclosure ❑ Click here to select date Service Contact Person Select Click here to enter name and role.

SERVICE USER - FALLS RISK FACTOR

Did the patient have any of the following falls risk factors present **at the time of the fall**? (select all that apply). Identify interventions that were **in place** to address each fall risk factor.

Risk Factor		Intervention(s) In Place	Risk Factor		Intervention(s) In Place
Age 65+	❑	Click here to enter text.	Impaired Transfers	❑	Click here to enter text.
Use of Walking Aid	❑	Click here to enter text.	Impaired ADLs	❑	Click here to enter text.
Hearing Impairment	❑	Click here to enter text.	Postural Instability, Mobility Problems, and / or Balance Problems	❑	Click here to enter text.
Incontinence	❑	Click here to enter text.			
Inappropriate Footwear	❑	Click here to enter text.			
Pain	❑	Click here to enter text.			
Impaired Vision	❑	Click here to enter text.	Medication	❑	Click here to enter text.

Depression / Low Mood	❑	Click here to enter text.	e.g. Polypharmacy, Drugs with Sedative Effect		
Fear of Falling	❑	Click here to enter text.			
Cog. Impairment	❑	Click here to enter text.	Fracture Risk, such as *Previous Fragility Fractures* *Alcohol Use (≥21u/week)* *Rheumatoid Arthritis* *Smoker* *Recent Steroid Use* *Low BMI (≤19)*	❑	Click here to enter text.
Dizzy / Lightheaded	❑	Click here to enter text.			
Loss of Consciousness	❑	Click here to enter text.			
Syncope Syndrome	❑	Click here to enter text.			
Delirium	❑	Click here to enter text.			
Dementia	❑	Click here to enter text.			
Health Condition that Increases Falls Risk e.g. neurological or musculoskeletal Click here to list relevant health conditions.				❑	Click here to enter text.

List any service user related risk factors that, at the time of fall, were i) identified but did NOT have an appropriate intervention or ii) present but were NOT identified and therefore did NOT have an appropriate intervention.

Click here to enter text.

ENVIRONMENT & EQUIPMENT – FALLS RISK FACTORS

Were there any environmental or equipment related risk factors at the time of the fall? (tick all that apply).
Identify any control(s) in place prior to the fall to reduce this risk.

Risk Factor		Describe role in the Fall?	Control(s) In Place
Lighting	❑	Click here to enter text.	Click here to enter text.
Floors	❑	Click here to enter text.	Click here to enter text.
Furniture	❑	Click here to enter text.	Click here to enter text.
Fittings	❑	Click here to enter text.	Click here to enter text.
Wheelchairs	❑	Click here to enter text.	Click here to enter text.
Walking Aids	❑	Click here to enter text.	Click here to enter text.
Bed / Bedrails	❑	Click here to enter text.	Click here to enter text.

Call Bells	❑	Click here to enter text.	Click here to enter text.

List any environmental or equipment related risk factors that, at the time of fall, were i) present but NO control(s) in place or ii) absent and should have been in place.

Click here to enter text.

STAFFING – FALLS RISK FACTORS

What was the staffing and skill mix on the shift that the service user fell?	Nurse: Enter No.	HCA: Enter No.	Student: Enter No.

Were all rostered staff on the ward at the time of service user fall? (e.g. not off ward/on break/in handover)	Select
Have all staff on the shift that the service user fell been trained in the falls prevention policies of the service?	Select

List any staffing related issues at the time of fall as they relate to the above questions

Click here to enter text.

TASK & TEAM – FALLS RISK FACTORS

Was a falls risk assessment completed prior to the fall as per the falls prevention policy of the hospital?	Select
Was the service user's falls risk communicated to the patient, their families and all relevant staff?	Select
Was the service user's falls risk communicated at handover / shift reports?	Select

List any task and team related factors at the time of the fall as they relate to the above questions

Click here to enter text.

ADDITIONAL INFORMATION

If you are unable to answer any question above, or wish to expand on any answer, please click here and write:

KEY CAUSAL FACTORS

This key causal factor best explains why this fall occurred.

Failure to identify and/or intervene on one or a combination of risk factors which were present at the time of fall

CONTRIBUTORY FACTORS

The contributory factors that relate to the key causal factor identified are as follows:

Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF

INCIDENTAL FINDINGS
These are areas identified as requiring improvement but did not cause or contribute to the incident.
Click here to enter text.
Click here to enter text.
Click here to enter text.
Click here to enter text.

NOTABLE PRACTICE
The following are points in the incident or review process where care and/or practice had an important positive impact and may provide valuable learning opportunities
Click here to enter text.
Click here to enter text.

OTHER ISSUES OF NOTE
Click here to enter text.

REVIEW OUTCOME
Select which of the following outcomes best applies
Select an outcome.

RECOMMENDATIONS	
1	Click here to enter text.
2	Click here to enter text.
3	Click here to enter text.
4	Click here to enter text.

SIGN OFF	
Was the service user and/or family advised of the plan for review before beginning the review?	❑
Was the service user and/or family provided with on-going communication and support throughout the review?	❑
Were staff who participated in the process provided with the draft report and requested to provide feedback on factual accuracy and their comments?	❑
Was the service user and/or family given a draft report for review and offered a meeting to discuss?	❑
Comments: Click here to enter text.	
Name SAO/LAO: Click here to print name	
Date report accepted: Click here to select drop down for the date	

ARRANGEMENTS FOR SHARED LEARNING	
Describe how learning has been or will be shared with the family and staff e.g. team meetings, internal emails, etc.	
1	Click here to enter text.
2	Click here to enter text.
3	Click here to enter text.
4	Click here to enter text.

APPENDIX 4. MEMBERSHIP OF THE SERVICE USER FALLS REVIEW GUIDE GROUP

Cornelia Stuart, Assistant National Director, Quality Risk and Safety, Quality Assurance and Verification Division (Chair)

Louise Brent, National Irish Hip Fracture Database Coordinator, National Office of Clinical Audit

Deirdre Carey, Risk & Incident Officer, Acute Hospitals Division

Gareth Clifford, Quality Standards & Compliance, Quality & Patient Safety, Acute Hospitals Division

Melissa Currid, Falls Prevention Coordinator, Community Health Organisation 1

Deirdre Lang, Director of Nursing, National Clinical Programme for Older People

Margaret McGarry, Risk Manager, Quality Risk and Safety, Quality Assurance and Verification Division

Teresa O Callaghan, Quality Improvement Advisor, National Quality Improvement Division

Daragh Rodger Advanced Nurse Practitioner, Care of the Older Adult, St Mary's Hospital. Phoenix Park, Dublin

Claire Roe, Quality Assurance Manager, Cork University Hospital