An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

Service User Falls A Practical Guide for Review

Revision 2, October 2022

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

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Reader Information

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Use of the Term "Service User" in this document

*Note: The term *Service User* is used in this document to include any persons who use health and social care service within HSE or HSE funded services and who have suffered a fall.

The term *Service User* also includes their appropriate Relevant Person who has been legally assigned, or who has been nominated in writing to the health services provider, as a person to whom clinical information in relation to the patient may be disclosed.

Relevant Persons is defined in the Civil Liability (Amendment) Act 2017 as:
"Relevant person", in relation to a patient, means a person— (a) who is— (i) a parent, guardian, son or daughter, (ii) a spouse, or (iii) a civil partner of the patient, (b) who is cohabiting with the patient or (c) whom the patient has nominated in writing to the health services provider as a person to whom clinical information in relation to the patient may be disclosed[1].

[1] Note : This definition must not be conflated with the definition of "relevant person" in the Assisted Decision-Making (Capacity) Act 2015

Introduction

The HSE Patient Safety Strategy[2] has highlighted patient/service user falls as one of the Common Causes of Harm and a priority area for patient safety improvement. Falls are the most commonly reported incident within the HSE and HSE-funded services with 34,114 falls being reported in 2021 including 18,023 in acute hospitals and 15,958 in community services. Falls have an impact on the service user, on the health and social care professional, and on the service provider. In 2021, falls caused harm in 19% of cases in acute services and 16% in community services[3].

A fall is defined by the World Health Organisation (WHO) as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (1). Falls and falls related injuries are the second leading cause of accidental or unintentional injury deaths worldwide with an estimated 684,000 people dying each year as a result of a fall and adults older than 60 years suffering the greatest number of fatal falls (1). Globally on an annual basis 37.3 million falls require medical attention with many resulting in lasting disabilities. The WHO estimated the cost of falls to be in excess of €400 billion each year.

Serious injury, such as hip fracture, traumatic brain injury and death, occurs in nearly 6% of all acute services falls (2, 3, 4). There are similar rates for serious injury in residential services for older persons (5). 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 (6).

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 (7) and 40% of all service users who suffer an in-hospital hip fracture will die within three months (8).

People with intellectual disabilities have a similar risk of falls throughout their lives as older people in the general population. Around one-third of falls by people with intellectual disabilities result in injury and the rate of fractures is higher than in the rest of the population. This may be due to increased risk of osteoporosis (9). The prevalence of falls involving people with intellectual disabilities (ID) is high in comparison with the general population. In a recent study, seven risk factors were identified: decreasing physical ability, epilepsy, paretic conditions, impulsiveness, previous falls, incontinence and non-use of assistive equipment (10).

A number of studies have highlighted the risk of falls in mental health care settings due to a variety of reasons: patient mobility varies greatly; and a variety of mental health disorders, including substance use and abuse disorders, result in a range of patient fall prevention and safety needs and pose a challenge to traditional fall prevention methods. Patients in mental health care settings are at high risk

[2] https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf

[3] Data sourced directly from NIMS database, June 2022. The National Incident Management System (NIMS) is a dynamic system and is the key platform for HSE and HSE-funded healthcare providers to report incidents on. Additionally, the NIMS system is the source of data in terms of incident management as a quality indicator and is also used to inform the National Service Plan KPIs. More information is available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html or NIMS helpdesk at nims@hse.ie.

for falls as they may be on psychotropic medications, may experience agitation, and may have a limited ability to follow instructions and realise limitations when in acute phases of illness (11, 12).

In Ireland data from the National Office of Clinical Audit shows that low-trauma falls are the main mechanism of injury leading to serious injuries including hip fracture and major trauma. The Irish Hip Fracture Database 2020 Report shows that the majority (95%) of hip fractures occurred following a low trauma fall and the location was where the person was residing, 85% in the home and 10% in a long-term care facility (13). Similar findings from the Major Trauma Audit 2019-2020 Report show that 62% of major traumas (which are accidents resulting in life-changing or life-threatening injuries) occurred due to a low-fall and 56% of major traumas occurred in the home. Both audits have demonstrated an increase in the incidence of low-falls year on year (14).

Every fall, regardless of harm, is an opportunity to prevent another fall (15). A proportionate and responsive review post-fall can identify 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[4].

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

[4] HSE Incident Management Framework and Guidance, 2020: For the most current version of the Incident Management Framework please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/

Aim

The aim of this document is to provide staff within HSE and HSE funded services with a practical guide to reviewing falls which aligns to the six steps described in the HSE Incident Management Framework (see Figure 1).

Scope

The scope of this document relates to all service users within HSE and HSE-funded services. This document should be read in conjunction with the most up to date HSE Incident Management Framework and Guidance document available on the QPSD Incident Management Team website at: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/ and the National Incident Management System (NIMS) at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html .

Abbreviations

A full list of abbreviations and definitions is available in the Incident Management Framework which should be read in conjunction with this Concise Review Tool. The following are abbreviations used in this document.

CHO	Community Health Organisation
HCA	Health Care Assistant
HG	Hospital Group
HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professional
HSE	Health Service Executive
LAO	Local Accountable Officer
MHC	Mental Health Commission
MRN	Medical Record Number
NAS	National Ambulance Service
NIRF	National Incident Report Form
NIMS	National Incident Management System
NOCA	National Office of Clinical Audit
NQPSD	National Quality and Patient Safety Directorate
QI	Quality Improvement
QPS	Quality & Patient Safety
QPSD	Quality and Patient Safety Directorate
SAO	Senior Accountable Officer
SIMT	Serious Incident Management Team
SRE	Serious Reportable Event
WHO	World Health Organisation

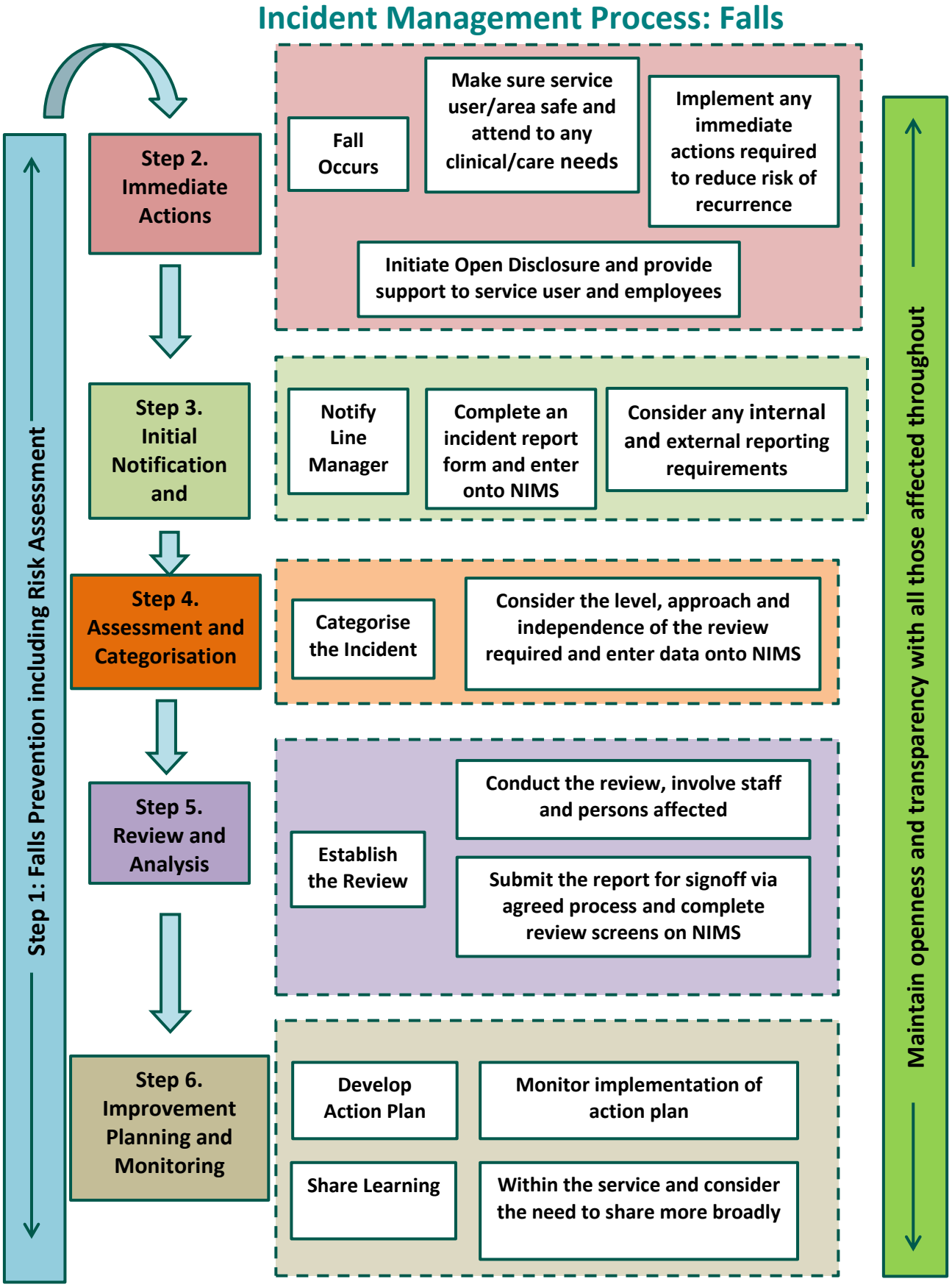


Figure 1: Adapted from HSE Incident Management Framework

Step 1: Falls Prevention – including Falls Risk Assessment

Falls and fall-related injuries are the most common reportable incident in the HSE and HSE funded services. All inpatient, residential and community care services (where should have a Falls Prevention and Management Policy in place to reduce the risk of falls and harm from falls (16, 17). Prevention strategies should emphasize education, training, creating safer environments, prioritizing fall-related research and establishing effective policies to reduce risk (1). The policy must describe procedures relating to falls and fracture risk management, such as falls risk assessment (including bone health assessment and a frailty assessment where indicated), management of the service user post-fall, details of the organisational infrastructure, roles and responsibilities, education and training and measures and monitors relating to falls prevention and management.

In line with WHO guidance (1), for service users aged 60 years and over, age is automatically considered as a risk factor for a fall. For those with a physical or intellectual disability, those aged 45 and over should be considered at risk for falling. In addition, all service users aged 50 years and older admitted to acute hospital services, should be considered for falls risk screening (16), as per local policy.

Other risk factors include history of previous fall within previous 12 months, underlying medical conditions, side effects of medication, anxiety, poor mobility, cognition and vision and unsafe environments (1,18).

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. Interventions should address each of the service user's risk factors for falling (18, 19). Interventions implemented may vary depending on setting i.e. acute care, residential care.

The Patient Safety Strategy, 2019-2024 identifies the reduction of the risk of harm from falls as a key patient safety improvement area. The Patient Safety Programme within the National Quality and Patient Safety Directorate[5], in partnership with key stakeholders, are leading out of a series of Quality Improvement (QI) collaboratives with a focus to reduce avoidable falls using a suite of evidence based interventions. A number of resources for the prevention of falls are available on the Patient Safety Programme website at https://www.hse.ie/eng/about/who/nqpsd/patient-safety-programme/falls-2020.html.

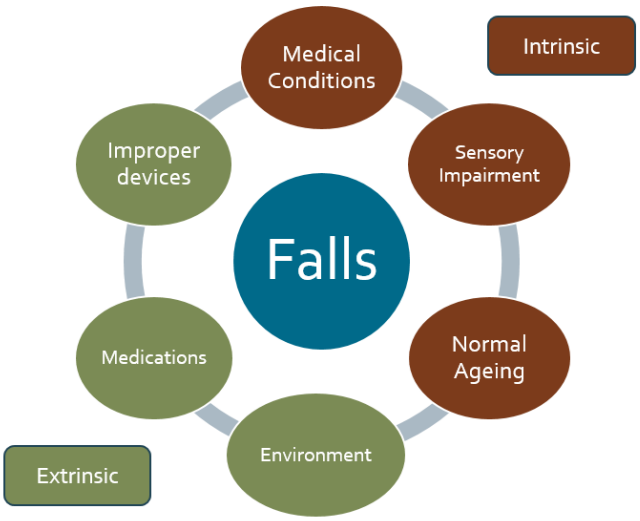
[5] https://www.hse.ie/eng/about/who/nqpsd/

Step 2: Identification of Fall and Actions Required

There are a number of actions that should be completed in the immediate post-fall period both for persons directly affected and to minimise risk of further harm to others (please refer to the Incident Management Framework for additional information) including:

1. Service users must have a medical review (19) to identify any causative factors e.g. delirium, polypharmacy etc., and manage, any harm that may have occurred. A comprehensive assessment may be appropriate for some service users who are frailer as the causes of falls may be more complex or warrant a more holistic approach (20).
2. Service users must have their risk factors for falling reassessed and interventions should address each of the service user's risk factors for falling (19).
3. Identify and rectify any hazards or risks associated with the fall that may affect other service users e.g. environmental issues.
4. Clearly and factually document the fall, any relevant details pertinent to the fall and any immediate actions taken and interventions required in the service user's healthcare record (and individual care plan where appropriate).
5. Open Disclosure[6] should be undertaken by staff to the service user
    a. This is essential as it significantly contributes to the maintenance of confidence in, and trust between the service user 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 should be made in the service user's healthcare record.
6. Identify and address any staff support needs in the aftermath of the incident.

Staff can feel responsible and guilty after a service user fall, particularly if the fall resulted in significant harm (21). Falls occur due to a combination of many factors, both intrinsic and extrinsic (see diagram below), rather than acts or omissions of an individual staff member (1, 13, 14, 21).



[6] The most up to date HSE Open Disclosure Policy and related information may be accessed at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/national-open-disclosure-policy-and-guidelines.html

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 (NIRF) or directly on to the National Incident Management System (NIMS) (where electronic point of entry is available) 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 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[7] 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.

Residential Services for Older Persons or for Persons with Disabilities also have an obligation to notify falls that result in death or serious injury to the Health Information and Quality Authority (HIQA).

Within the mental health care setting, Category 1 falls that meet the criteria of a serious reportable event (5d) must be reported to the Mental Health Commission[8]. In addition, all deaths of any resident of an approved centre, including a resident transferred to a general hospital for care and treatment, are notified to the Mental Health Commission as soon as is practicable and, in any event, no later than within 48 hours of the death occurring[9].

Deaths related to falls in any service are reportable to the Coroner[10].

[7] Category 1 Incident: Clinical and non-clinical incidents rated as Major or Extreme as per the HSE's Risk Impact Table.
Category 2 Incident: Clinical and non-clinical incidents rated as Moderate as per the HSE's Risk Impact Table.
Category 3 Incident: Clinical and non-clinical incidents rated as Minor or Negligible as per the HSE's Risk Impact Table.
Ref: HSE Incident Management Framework and Guidance: For the most current version of the Incident Management Framework please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/

[8] https://www.mhcirl.ie/sites/default/files/2021-08/MHC-QSN-Guidance-November-2020.pdf

[9] MHC Judgement Support Framework Special Edition 2022

[10] Refer to the Incident Management Framework Guidance document (Section 6) for external reporting requirements. Mental Health Commission (2020) requires any serious reportable event involving a resident to be reported within 48 hours, guidance available at https://www.mhcirl.ie/sites/default/files/2021-08/MHC-QSN-Guidance-November-2020.pdf
HIQA, Monitoring Notifications handbook available at https://www.hiqa.ie/sites/default/files/2018-02/Monitoring-Notification-Handbook-DCOP_Guidance.pdf

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[11]. 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. This includes 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

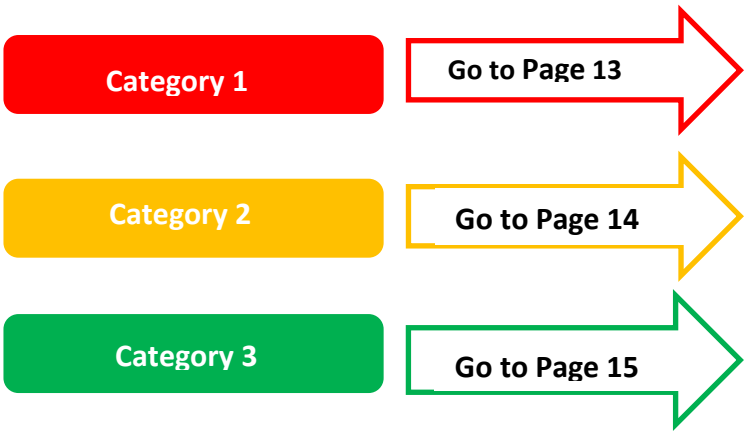
- Significant harm requiring medical treatment e.g. wrist fractures

Category 3 Minor/Negligible

- Falls resulting in no harm or low harm

Decision making in relation to the review of incidents of falls.

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[12]. Please refer to the table below for further information.



[11] https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/risk-management-support-tools.html

[12] HSE Incident Management Framework and Guidance. For the most current version of the Incident Management Framework please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/

Decision Making for Category 1 Falls Incidents

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. In line with the Incident Management Framework, 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[13].

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 Quality and Patient Safety (QPS) Advisor (or equivalent), 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[14], HSCP etc.
- National Incident Report Form /NIMS
- Service user healthcare record
- Engagement with
    - staff who either witnessed the fall or were on duty at the time of the fall
    - the service user[15]

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. As per the Incident Management Framework, a Comprehensive approach to review is generally accepted as appropriate for **Category 1** incidents. The process for a Comprehensive review using a review team approach is detailed in the Incident Management Framework. However, a Concise approach to review may be considered by the SIMT for some Category 1 incidents if deemed appropriate by the SIMT.

Where a decision **to review** using a Comprehensive (or Concise) 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** 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 (or equivalent) for review and ratification of the decision. The decision not to review, when ratified by the Quality and Safety Committee (or equivalent), must be recorded on the NIMS review screens.

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[13] In line with the IMF, the SIMT meets on a scheduled basis to monitor and gain assurance in relation to the ongoing management of all Category 1 incidents within the service. The SIMT must also convene on an unscheduled basis within 5 working days of a Category 1 incident.

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

[15] In all interactions with the service user, inclusion of the

Decision Making for Category 2 Falls Incidents

Category 2 Falls Incidents

Following categorisation of an incident as a **Category 2** incident the Local Accountable Officer[16] 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[17], HSCP etc.
- National Incident Report Form/ NIMS
- 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

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 (or equivalent) will decide whether there is evidence of the following:

- *Failure to identify and/or intervene in one or a combination of risk factors which were present at the time of the fall, which increased the likelihood that the service user would 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 (as per the Incident Management Framework). 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**, 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.

[16] 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

[17] 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

Category 3 Falls Incidents

While 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.

The review of Category 3 incidents should occur both at the time of occurrence/ identification to identify any immediate actions required and further discussed as part of the business of the service's multidisciplinary team meeting

In the main **Category 3** falls incidents should be reviewed on an aggregate basis. 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 incident occurring in the future. The review and analysis of falls should be considered a key tool in quality improvement. There is a need to understand **what happened** in relation to the fall and also to understand **why it happened** i.e. 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 are carried out by use of a Review Team Approach using Systems Analysis Review Methodology. Guidance on this methodology can be found in the HSE Incident Management Framework.

- ***Concise Review***
    - Reviews at this level must be carried out using the Falls Concise Review Tool, detailed in Appendix 2 of this document. This tool is specific to falls incidents and was co-designed by Falls Prevention Specialists and QPS Advisors/ Managers who are experienced in the conduct of systems based reviews. 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 and 3).

To assist with aggregate analysis of Falls Reviews, the Reporting Screens on NIMS must be completed in full for all Comprehensive and Concise Reviews carried out. A copy of the review 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/ Quality and Safety Committee (or equivalent).

- ***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 service level, regional level, care group level and/or national level. ***For this reason, it is important that completed Concise Reports are uploaded to NIMS, and the Reporting Screens on NIMS are completed in full.*** Guidance on the methodology for aggregate analysis

can be found in the HSE Incident Management Framework. Key learning points from any Comprehensive Review conducted can also be incorporated into this aggregate analysis.

Whatever approach to review is taken a report will be developed which will set out details of the case, identify the Statement of Findings and the Factors which contributed to the Fall and set out recommendations for areas where improvement has been identified as being required (Appendix 3).[18]

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 CLEAR[19] 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.
- 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 the Service User to confirm factual accuracy and provide comment within a specified timeframe in line with the Incident Management Framework. 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.

In line with the Incident Management Framework, following acceptance of the report by the Commissioner, the Service User Designated Support Person should contact the service user to inform them that the report is finalised and offer them a meeting to discuss this. The service user 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 and can be provided with a copy of the report.

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 Quality and Safety Committee (or equivalent) for their information and consideration as part of the service's overall quality improvement plans.

Refer to the HSE Incident Management Framework for details on the governance and approval process for review reports.

[18] See Appendix 3 for report template and also link to template available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/incident-management.html

[19] CLEAR is an acronym used to describe the key elements/features that a recommendation should have to support successful implementation i.e. Case for Change, Learning Orientated, Evidence, Assign, Review.

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 action 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 referred to the appropriate level/service for implementation.

To guide and support the improvement process, application of the HSE's Framework for Improving Quality[20] can assist in influencing and guiding the planning and delivery of care in services to help improve service user experience and outcomes. The framework describes six drivers of quality that need to be considered in every improvement effort to ensure successful, continuous and sustainable improvements in the quality of care even in the busiest environments.

[20] HSE Framework for Improving Quality, available at https://www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/ and Quality Improvement Toolkit available at https://www.hse.ie/eng/about/who/nqpsd/qps-education/quality-improvement-toolkit.html

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Additional References:

- HSE Incident Management Framework and Guidance, 2020: For the most current version of the Incident Management Framework please access: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/
- National HSE Open Disclosure Guidelines, available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/national-open-disclosure-policy-and-guidelines.html
- HSE Patient Safety Strategy (2019-2024) available at https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf
- HSE Framework for Improving Quality, available at https://www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/ and Quality Improvement Toolkit available at https://www.hse.ie/eng/about/who/nqpsd/qps-education/quality-improvement-toolkit.html

Appendix 1. Preliminary Assessment to Assist Review Decision Making

Service User Falls: 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 LEVEL OF HARM AS A RESULT OF A FALL

Section 1: Details of Service User and Fall *(affix service user label to a copy of this form for retention in healthcare record)*			
NIMS Reference No:		**Date entered on NIMS:**	
Date notified to SAO/LAO:		**Date of SIMT/ QPS meeting:**	
Service within which fall occurred			
Location of service			
Date of Admission (if applicable):		**MRN: (if applicable)**	
Ward/Unit/Care/Service Setting			
Reason for admission (if applicable):			
Background of Service User:			
Date of Fall:		**Time of Fall:**	
Exact location of Service User at time of fall			
State if fall was witnessed or unwitnessed			
Description of Fall:			
Injury Sustained:			
Actions Taken by the Service in the Period Following the Fall (and Prior to this Review) in Respect of the Service User's Care:			

Detail engagement with the Service User since the Fall and prior to the review:	**Process**	**Tick if Yes**
	Open Disclosure?	
	Date:	
	Designated Support Person identified for Service User?	
	Name:	

Name(s) of person(s) completing Preliminary Assessment Form	
Date completed:	

Section 2: Service User - Falls Risk Factor					
Did the service user have any of the following falls risk factors present **at the time of the fall**? (Select all that apply or add additional risk factors as appropriate). 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[21]60+			**Impaired Transfers**		
Age 45+ with intellectual disability					
Age 45+ with physical disability					
Age 50+ and admitted to acute hospital			**Impaired Activities of daily Living (ADL)**		
Use of Walking Aid					
Hearing Impairment					
Incontinence			**Postural Instability, Mobility Problems, and / or Balance Problems**		
Inappropriate Footwear					
Pain					
Impaired Vision					
Depression / Low Mood			**Medication** **e.g. Polypharmacy, Drugs with Sedative Effect such as sedatives, anti-depressants, anti-psychotic, anticholinergics, dopaminergics, etc.**		
Fear of Falling					
Cog. Impairment					
Dizzy / Lightheaded					
Loss of Consciousness					
Syncope Syndrome			**Fracture Risk, such as *Previous Fragility Fractures; Alcohol Use (≥21u/week) Rheumatoid Arthritis Smoker; Recent Steroid Use; Low BMI (≤19)***		
Delirium					
Dementia					
Previous fall within last 12 months					
Intellectual Disability		Please describe:			
Physical Disability		Please describe			
Other Health Condition that Increases Falls Risk e.g. neurological or musculoskeletal, osteoporosis, malnutrition etc					
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.					

[21] Age 60+ is an automatic risk factor for falls for those without a physical or intellectual disability. The age risk is lower for those with a physical or intellectual disability and should be considered a risk factor for those aged 45+.

Section 3: 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			
Floors			
Furniture			
Fittings			
Wheelchairs			
Walking Aids			
Bed / Bedrails			
Call Bells			
Tethers (e.g. drip/monitor)			
Other:			
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.			
Based on the above assessment, identify any areas where improvement is required:			

Section 4: Staffing – Falls Risk Factors			
What was the staffing and skill mix on the shift that the service user fell? (enter quantity for each)	**Nurse:**	**HCA:**	**Student:**
Were all rostered staff on the ward at the time of service user fall? (e.g. not off ward/on break/in handover)			
Have all staff on the shift that the service user fell been trained in the falls prevention policies of the service?			
List any staffing related issues at the time of fall as they relate to the above questions:			
Based on the above assessment, identify any areas where improvement is required:			

Section 5: Task & Team – Falls Risk Factors	
Was a falls risk assessment completed prior to the fall as per the falls prevention policy?	
If required, was there a falls care plan in place supported by a timely review process?	
Was the service user's falls risk communicated to the service user and all relevant staff?	
Was the service user's falls risk appropriately documented and communicated at handover / shift reports?	
List any task and team related factors at the time of the fall as they relate to the above questions:	
Based on the above assessment, identify any areas where improvement is required:	

Section 6: 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 COMPREHENSIVE REVIEW or a CONCISE 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:

Failure to identify and/or intervene in one or a combination of risk factors which were present at the time of the fall, which increased the likelihood that the service user would 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 of Incident:
Date of SIMT /Relevant Meeting:
Date entered on NIMS:
Date Notified to SAO/LAO:
Case Officer/ QPS Manager:

Section A. Decision to Conduct a Review under the Incident Management Framework		
Please indicate the decision in relation to the level of review to be conducted[22]:		
Comprehensive Review		**If a Comprehensive Review is selected please proceed to Section C of this form**
Concise Review		**If a Concise Review is selected please proceed to Section C of this form**
No Review *		**If No Review is selected please proceed to Section B of this form**

[22] Document on NIMS the decision to review the incident and as the incident review progresses, update all fields on the NIMS Review Screen to capture and track the management of the incident.

Section B. 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 and staff.* • *Submitted for review and ratification by the Quality & Safety Committee, along with Part A* • *Complete NIMS Review Screens and this should include the reason and rationale for no further review.* *These incidents should be included in an Aggregate Review process.*
Sign Off: (as applicable to the level of review chosen) **Name of SAO/LAO:** **Signature of SAO/LAO:** **Date:**
Ratification by QPS Committee (or equivalent) Having reviewed the Preliminary Assessment and discussed the incident the QPS Committee agrees/disagrees (circle as appropriate) with the recommendation that No Review is required. **Name of Chair:** **Signature of Chair:** **Date:** ***Note: In cases where the QPS Committee feels that a review is required the case is referred back to the SAO (Category 1 incidents) or LAO (Category 2 incidents) for commissioning.***

Section C.
Comprehensive Review
If the decision is to commission a Comprehensive Review, this will be by way of a **Review Team Approach** and the Systems Analysis review Report Template as detailed in the HSE Incident Management Framework is utilised.
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 Falls Review Report Template
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/ Regional Health Area[23]	
4. Team external to the CHO/HG/NAS Directorate/ Regional Health Area	

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	
Name	
Title	
Email	
Telephone	
Service User Designated Support Person	
Name	
Title	
Email	
Telephone	
Staff Liaison	
Name	
Title	
Email	
Telephone	

[23] Once these are established. See https://healthservice.hse.ie/staff/news/latest-updates-on-regional-health-areas-in-the-hse/

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** – Commissioned by Senior Accountable Officer
- **Category 2 Incident** – Commissioned by 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. (Refer to the Incident Management Framework for guidance on developing the Terms of Reference).

The review should ensure that the principles of Just Culture, Natural Justice and Fair Procedure are adhered to at all times. These principles enhance psychological safety and strengthen a culture of learning from incidents. These principles are described in greater detail in the HSE Incident Management Framework.

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 and the service user.

The service user 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, where there systems issues that contributed to the fall 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
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 service user should be included here.
1. Details of Service User and Fall	Concise details of the service user's background 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.
2. 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.
3. 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.
4. Staffing – Falls Risk Factors	All staffing related risk factors should be identified. List any staffing related issues.
5. Task and Team – Falls Risk Factors	All task and team related risk factors should be identified. List any task and team related issues.
6. Additional Information	Use this section to provide any additional information relevant to the incident
7. Statements of Finding and Contributory Factors	Statement of Findings are statements which describe the relationship between the contributing factors and the incident and/or outcome. 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 Statement of Finding is best described as: **Failure to identify and/or intervene in one or a combination of risk factors which were present at the time of the fall, which increased the likelihood that the service user would fall.** This Statement of Finding 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 service users do not get an intervention directed at each of these

	risk factors. Similarly, a service user 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 Statement of Findings. 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 service user at the outset of the review that are not dealt with in the above report. This is important as 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 Causal Factors identified. **Indirect system of care/service issues** - No 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 CLEAR 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 Quality and Safety Committee (or equivalent) and have it included in an aggregate review of harmful falls.
14. Sign off	Prior to completion of this section the draft report should be considered in the context of the Governance Approval Process for Final Draft Reports (please refer to the HSE Incident Management Framework). It is the responsibility of the Commissioner of the report to ensure that the above consideration is carried out. The draft report is then submitted to the Commissioner. Based on a satisfactory review of the report and its acceptance by the Commissioner, the report is then considered final. Completed reports must be uploaded onto NIMS. Review screens on NIMS must be completed at this stage as the availability of this summary information is important to assist with aggregate analysis.

Appendix 3 – Concise Review Report Template

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

REVIEW OF A FALL

(add title and detail as required)

CONCISE REPORT

CONFIDENTIAL

Date of Incident	Click here to select drop down for date
NIMS Reference Number	Click here to enter number.
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
Date report uploaded on to NIMS	Click here to select drop down for the date

Note: Part 1, Sections 2-6 are identical to the Preliminary Assessment Form and therefore, these sections from the PAF may be inserted in to this template and updated if further information has come to light since the SIMT meeting.

To complete the Concise Review of the Fall, Part 2 must be completed to identify Findings, Contributory Factors, Recommendations and Shared Learning

Review Report Part 1

INTRODUCTION

Section 1: Details of Service User and Fall			
Background of Service User:			
Date of Fall:		**Time of Fall:**	
Exact location of Service User at time of fall			
Description of Fall:			
Actions Taken by the Service in the Period Following the Fall in Respect of the Service User's Care and Prior to this Review:			
Injury Sustained:			
Detail engagement with the Service User since the Fall and prior to the review:	**Process**	**Tick if Yes**	
	Open Disclosure		
	Date:		
	Staff member identified to act as Designated Support for Service User		
	Name and Role:		
Any other relevant information:			

Section 2: Service User - Falls Risk Factor					
Did the service user have any of the following falls risk factors present **at the time of the fall**? (Select all that apply or add additional risk factors as appropriate). 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[24]60+			**Impaired Transfers**		
Age 45+ with intellectual disability					
Age 45+ with physical disability					
Age 50+ and admitted to acute hospital			**Impaired Activities of daily Living (ADL)**		
Use of Walking Aid					
Hearing Impairment					
Incontinence			**Postural Instability, Mobility Problems, and / or Balance Problems**		
Inappropriate Footwear					
Pain					
Impaired Vision					
Depression / Low Mood			**Medication** **e.g. Polypharmacy, Drugs with Sedative Effect such as sedatives, anti-depressants, anti-psychotic, anticholinergics, dopaminergics, etc.**		
Fear of Falling					
Cog. Impairment					
Dizzy / Lightheaded					
Loss of Consciousness					
Syncope Syndrome			**Fracture Risk, such as *Previous Fragility Fractures; Alcohol Use (≥21u/week) Rheumatoid Arthritis Smoker; Recent Steroid Use; Low BMI (≤19)***		
Delirium					
Dementia					
Previous fall within last 12 months					
Intellectual Disability		Please describe:			
Physical Disability		Please describe			
Other Health Condition that Increases Falls Risk e.g. neurological or musculoskeletal, osteoporosis, malnutrition etc					
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.					

[24] Age 60+ is an automatic risk factor for falls for those without a physical or intellectual disability. The age risk is lower for those with a physical or intellectual disability and should be considered a risk factor for those aged 45+.

Section 3: 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			
Floors			
Furniture			
Fittings			
Wheelchairs			
Walking Aids			
Bed / Bedrails			
Call Bells			
Tethers (e.g. drip/monitor)			
Other:			
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.			
Based on the above assessment, identify any areas where improvement is required:			

Section 4: Staffing – Falls Risk Factors			
What was the staffing and skill mix on the shift that the service user fell? (enter quantity for each)	**Nurse:**	**HCA:**	**Student:**
Were all rostered staff on the ward at the time of service user fall? (e.g. not off ward/on break/in handover)			
Have all staff on the shift that the service user fell been trained in the falls prevention policies of the service?			
List any staffing related issues at the time of fall as they relate to the above questions:			
Based on the above assessment, identify any areas where improvement is required:			

Section 5: Task & Team – Falls Risk Factors	
Was a falls risk assessment completed prior to the fall as per the falls prevention policy?	
If required, was there a falls care plan in place supported by a timely review process?	
Was the service user's falls risk communicated to the service user and all relevant staff?	
Was the service user's falls risk appropriately documented and communicated at handover / shift reports?	
List any task and team related factors at the time of the fall as they relate to the above questions:	
Based on the above assessment, identify any areas where improvement is required:	

Section 6: Additional Information
If you are unable to answer any question above, or wish to expand on any answer, please click here and write:

Review Report Part 2: Findings and Recommendations

SECTION 7A: STATEMENT OF FINDINGS
This Statement of Finding best explains why this fall occurred.
Failure to identify and/or intervene in one or a combination of risk factors which were present at the time of the fall, which increased the likelihood that the service user would fall.

SECTION 7B: CONTRIBUTORY FACTORS
The Contributory Factors that relate to the Statement of Finding are as follows:
Note: Add additional lines as required to include all relevant Contributory Factors

SECTION 8: INCIDENTAL FINDINGS
These are areas identified as requiring improvement but did not cause or contribute to the incident.
Note: Add additional lines as required to include all relevant Incidental Findings

SECTION 9: 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

SECTION 10: OTHER ISSUES OF NOTE

SECTION 11: REVIEW OUTCOME
Select the outcome that best applies from the following:

- **Appropriate care and/or service**
  Well planned and delivered, unavoidable outcome and no Causal Factors identified.
- **Indirect system of care/service issues**
  No 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.

SECTION 12: RECOMMENDATIONS	
1	
2	
3	
4	
	Add additional lines as required

SECTION 13: ARRANGEMENTS FOR SHARED LEARNING	
Describe how learning has been or will be shared with the service user and staff e.g. team meetings, internal emails, etc.	
1	
2	
3	
4	
	Add additional lines as required

SECTION 14: SIGN OFF	
Was the Service User[25] advised of the plan for review before beginning the review?	
Were the Staff involved in the incident advised of the plan for review before beginning the review?	
Was the Service User provided with on-going communication and support throughout the review?	
Were Staff who participated in the review process provided with the draft report and requested to provide feedback on factual accuracy and their comments?	
Was the Service User given a draft report for review and offered a meeting to discuss?	
Comments:	
Name SAO/LAO:	
Date report accepted:	

[25] Note: The term Service User is used in this document to include any persons who use health and social care service within HSE or HSE funded services and who have suffered a fall. The term Service User also includes their appropriate Relevant Person who has been legally assigned, or who has been nominated in writing to the health services provider, as a person to whom clinical information in relation to the patient may be disclosed. Relevant Persons is defined in the Civil Liability (Amendment) Act 2017 as:
"Relevant person", in relation to a patient, means a person— (a) who is— (i) a parent, guardian, son or daughter, (ii) a spouse, or (iii) a civil partner of the patient, (b) who is cohabiting with the patient or (c) whom the patient has nominated in writing to the health services provider as a person to whom clinical information in relation to the patient may be disclosed.

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 Community, St Mary's Hospital, Phoenix Park, Dublin
- Claire Roe, Quality Assurance Manager, Cork University Hospital

Appendix 5. Membership of the Review Group for the Falls Review Guide (2022)

- Dr. Samantha Hughes, Incident Management Team, QPSD
- Louise Brent, National Irish Hip Fracture Database Coordinator, National Office of Clinical Audit
- Melissa Currid, Falls Prevention Coordinator, Community Health Organisation 1
- Nicole Lam, Guidance Development and Research Lead, National Disability Operations Quality Improvement
- Catriona O' Sullivan, Assistant Risk Manager, Cork University Hospital, South/Southwest Hospital Group
- Daragh Rodger, Advanced Nurse Practitioner, Care of the Older Adult Community, St Mary's Hospital, Phoenix Park, Dublin
- Martina Vaughan, NMPD Officer West Mid-West /Older Person Services
- National QPS, Acute Operations

Thank you also to all those who participated in the consultation process, including the National Quality and Patient Safety Teams in HSE Acute Operations and HSE Community Healthcare. Thank you also to the QPSD Team and the QPSD Incident Management Team members who contributed to reviewing this document.