# 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.**

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| **To Be Completed in Event of a Category 1 or Category 2 level of Harm as a Result of a Fall** |

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| **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:**  | Click here to select drop down for the date | **Time of Fall:** | \_\_ \_\_ : \_\_ \_\_ (24 hour clock) |
| **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:**  |  |

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| **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[[1]](#footnote-1)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, anti-hypertensives, hypoglycaemic, 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** | [ ]  |  |
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| **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.** |

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| **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:** |  |  |
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| **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:** |

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| **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:**  |
|  | **Yes** | **No** | **N/A** |
| **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 (i.e. supervision issues at the time of fall):** |
| **Based on the above assessment, identify any areas where improvement is required:** |

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| **Section 5: Task & Team – Falls Risk Factors** |
|  | **Yes** | **No** | **N/A** |
| **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:** |

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| **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**

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| **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:** |

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| **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[[2]](#footnote-2): |
| 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** |

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|  **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: |
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| *\* 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.***  |

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| **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. |

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| **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. |

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| **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[[3]](#footnote-3) |[ ]
| 4. Team external to the CHO/HG/NAS Directorate/ Regional Health Area |[ ]

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| **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*
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| **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* |

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| **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 |  |

1. 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+. [↑](#footnote-ref-1)
2. 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. [↑](#footnote-ref-2)
3. Once these are established. See <https://healthservice.hse.ie/staff/news/latest-updates-on-regional-health-areas-in-the-hse/> [↑](#footnote-ref-3)