|  |  |  |  |
| --- | --- | --- | --- |
| **Facility:**  Click here to enter facility | **Ward:**  Click here to enter ward | | **IIMS Number:**  Click here to enter IIMS number |
| **Date of incident:**  Select date | **Time of incident:**  Click here to enter time | | **Location of fall e.g. bathroom**  Click here to enter location |
| **TRIM Number:** Click here | **Patient MRN:** Click here | | **Gender: M**  **F** |
| **Patient age:** Click here | **CALD**  **Aboriginal**  **Torres Strait Islander** | | |
| **How long after admission (to unit) did the fall occur?**  Click here to enter length of time | | **Patient’s Admission Diagnosis:**  Click here to enter diagnosis | |
| **Patient’s Co-morbidities:**  Click here to enter co-morbidities | | **What injury(ies) did the patient sustain?**  Click here to enter injury(ies) | |

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| **Synopsis of the incident: a concise description of incident** |
| Click here to enter description |

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| **Core questions**  **These should be considered using the information provided in the Appendices** |
| 1. **a) Were all expected falls risk screens undertaken at all relevant points in his/her care? Was the falls risk screen accurate? (i.e. on admission, whenever a change in the patient’s condition, change in location occurred or when otherwise indicated)** (See[: Appendix 1: Ontario Modified Stratify (Sydney Scoring) Falls Risk Screen](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/ontario-modi-stratify-sydney-scoring-falls-risk-screen.pdf), and/or clinical record)   Click here to enter answer |
| **b) What factors contributed to this not being done as and/or when expected?**  (See [Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf))  Click here to enter answer |
| 1. **a) Was a risk assessment and management plan completed with individual risk factors and strategies identified for implementation e.g. Toileting issue (incontinence) - provide patient with individualised toileting plan** (See [Appendix 4 - Hospital Falls Prevention Strategies](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/hosp-falls-prevent-strategies-june-2013.pdf) and [Appendix 2 - Falls Risk Assessment and Management Plan (FRAMP)](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/framp-final-falls-program-nh606657.pdf), care plan and/or clinical record)   Click here to enter answer |
| **b) What factors contributed to this not being done as expected?**  (See [Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf)).  Click here to enter answer |
| 1. **a) Were identified risk and management strategies for this patient implemented, maintained and monitored?** (See [Appendix 4: Hospital Falls Prevention Strategies](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/hosp-falls-prevent-strategies-june-2013.pdf), care plan and clinical record)   Click here to enter answer |
| **b) What factors contributed to this not being done as and/or when expected?**  (See care plan, clinical record and [Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf))  Click here to enter answer |
| 1. **What was happening in the clinical unit at the time of the patient’s fall? Did any of these factors impact on the care and/or capacity to respond to the patient? Or directly to the patient’s fall?** ([See Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf))   Click here to enter answer |
| 1. **Did failures in any policies/other safety mechanism/expected practice contribute to the incident (e.g. poor handover/communication, policy compliance, skill mix)? (**See [Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf))   Yes  No  **If yes, what factors contributed to this not being done as and/or when expected?**  Click here to enter answer |
| 1. **Were all appropriate actions and patient care implemented after the patient’s fall?**   (See [Appendix 5: CEC Post Fall guide](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/cec-post-fall-guide-june-2013.pdf)).  Yes  No  **What factors contributed to this not being done as and/or when expected? (**See [Appendix 3: System and patient factors](http://www.cec.health.nsw.gov.au/__documents/programs/falls-prevention/2013/append-for-falls-incident-invest-review-form-16-aug-2013.pdf))  Click here to enter answer |

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| --- | --- | --- |
| **Summary of contributing factors leading to this fall incident.** | | |
| **Issue identified** | | **Underlying factor** |
|  | e.g. mobility assessment not completed | Workforce – availability of physiotherapy service |
| 1 | Click here to enter issue | Click here to enter factor |
| 2 | Click here to enter issue | Click here to enter factor |
| 3 | Click here to enter issue | Click here to enter factor |
| 4 | Click here to enter issue | Click here to enter factor |
| 5 | Click here to enter issue | Click here to enter factor |
| 6 | Click here to enter issue | Click here to enter factor |
| 7 | Click here to enter issue | Click here to enter factor |
| 8 | Click here to enter issue | Click here to enter factor |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Issue**  **Number/s**  **(as above)\*** | **Recommended Actions** | **Outcome Measure** | **Target Date** | **Staff designation responsible for implementation** |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
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| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |
| # | Click here to enter action | Click here to enter measure | Select date | Click here to enter name |

\*Note: The Recommended Actions may be relevant to more than one issue identified (*Summary of contributing factors leading to this fall incident* table). Include all relevant issue numbers in the column marked with the asterisk\*

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| Records Management | | | |
| **Recommended actions entered into IIMS: Y**  **N**  **N/A** | | | |
| **Investigating Team Sign-off (to be included if compatible with local record keeping processes)** | | | |
|  | **Team member** | **Team member** | **Team member** |
| **Name** | Click here to enter name | Click here to enter name | Click here to enter name |
| **Designation** | Click here to enter designation | Click here to enter designation | Click here to enter designation |
| **Name** | Click here to enter name | Click here to enter name | Click here to enter name |
| **Designation** | Click here to enter designation | Click here to enter designation | Click here to enter designation |
| **Endorsed by LHD/Facility Patient Safety Team/ Director Clinical Governance** | | | |
| Name: Click here to enter name  Signature:  Date: | | | |
| **This report is to be tabled at the appropriate Falls Prevention Advisory Group/Executive Quality Committee**  **Date forwarded:** Select date | | | |
| **Recommendations/issues added to the Risk Register (e.g. where significant resource is required)**  **Yes**  **No**  **Please list**  Click here to enter recommendations | | | |
| **Date provided to Unit Manager for feedback to staff:** Select date | | | |
| **Date provided to relevant manager for feedback to family:** Select date | | | |