Te Tāhū Hauora
Health Quality & Safety Commission

Event of harm review report: fall with fracture

This report provides an account of the review undertaken into

The report outlines the analysis, findings and opportunities for improvement. The review is undertaken according to the organisation's review of harm principles, reflecting the Healing, Learning and Improving from Harm national policy https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/national-adverse-events-reporting-policy.

REPORTABLE EVENT NUMBER: [*insert organisation's number*]	
Consumer/resident name:	Consumer/resident location:
NHI Number:	Date and time of fall:
Date of birth: / Age: Gender:	Fracture site:
Ethnicity:	Date of admission:

REVIEW TEAM	
Role:	**Designation:**
Role:	**Designation:**
Meet people who were affected by the fall to seek to understand their experience	**Consumer** **Whānau** **Health care workers**
Date review completed:	

REPORT CONFIRMED AND AUTHORISED BY:			
Signature 1:		**Signature 2:**	
Name:		**Name:**	
Role:		**Role:**	
Date:		**Date:**	

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EXECUTIVE SUMMARY

REVIEW

a. Background- describe the event

b. Influencing Factors (tick of relevant for this consumer/resident)

Consumer/resident factors – that increased likelihood they would fall	✓	Comments
History of previous falls	☐	
Predisposing medications / polypharmacy	☐	
Comorbidities / clinical conditions	☐	
Personal needs were unmet (toileting, hygiene, hydration)	☐	
Communication / vision / hearing deficits	☐	
Inappropriate footwear	☐	
Inappropriate bed space location for consumer/resident	☐	
Family not present at the time of the fall	☐	
Cognitive impairment / confusion / delirium	☐	
Unsafe to mobilise independently	☐	
Didn't seek assistance to mobilise (as required in care plan)	☐	
Consumer/resident refused to use preventative tools and aids	☐	
Task factors – were tasks completed?		
Risk assessment had been completed	☐	
Risk assessment current	☐	
Care plan current	☐	

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Care plan addresses risks	☐	
Care plan implemented	☐	
	☐	
Environmental factors		
Hazards present (flooring material, state of floor, clutter, self-closing doors, small physical environment)	☐	
Assistive devices (handrails)	☐	
Deconditioned and dehydrated	☐	
Inappropriate ambulating devices (walker, crutches)	☐	
Absent communicating devices (call bell)	☐	
Inappropriate use of bed rails	☐	
Inappropriate lighting	☐	
Other?	☐	
Staff factors – issues related to staff training/numbers and competency		**Be mindful that 'human error' is not a 'cause' of the fall rather a symptom of a system problem. Seek to understand how decisions made sense at the time for staff.**
Staffing number/skill mix not at planned level	☐	
Training given (e.g. completion of falls prevention training, use of hoist)	☐	
Risk perception	☐	
Ability to adapt to changing work conditions and prioritisation	☐	
Organisation of care factors		
Consumer/resident checking/regular rounding in place	☐	
Consumer/resident received close care/observation	☐	
Care plan implemented	☐	
Consumer/resident alarms in use	☐	

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Communication		
Information regarding falls prevention plan transferred at handover	☐	
Visual cues reinforcing risk used (coloured wrist band, alert band on walking aid)	☐	
Risk of falling was communicated (patient boards, signaling system e.g. trendcare hospital at a glance)	☐	
Teamwork factors		
Cover arrangements during staff breaks provided care for consumer/resident	☐	
Multidisciplinary team referrals made	☐	
Model of care enabled teamwork	☐	
Organisational influences		
Falls policy utilised	☐	
Equipment resourced and education on how to use	☐	
Managers support/lead falls prevention	☐	
If consumer/resident under observation, was the observer required to oversee multiple people	☐	
The Systems Engineering Initiative for Patient Safety Human Factors tool (which informed this template) may provide further support to enable a system review https://www.hqsc.govt.nz/resources/resource-library/systems-engineering-initiative-for-patient-safety-human-factors-tool/		

c. Findings (determine underlying systems or process issues involved in the event of harm)	
1.	
2.	
3.	

d. Additional Findings (identified as a quality issue)	
4.	
5.	
6.	

Opportunities

a. Opportunities to improve

Finding	**Quality improvement action**

b. Organisational learning and sharing

Event of harm Action Plan					
Event reference number:		**Service:**	**Report date:**		
Key finding	**Identified opportunities to improve**	**Actions required and progress**	**Person/role responsible**	**By when**	**Date completed**
1.					
2.					
3.					

Authorising Signature (1): Date:

Authorising Signature (2): Date: