



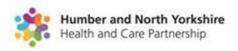
Exploratory tool for understanding why a fall may have occurred, share learning and good practice to prevent future incidents

Step 1 - Complete timeline		Details	
Step 2 - Capture the teams (& residents) perspective re why it happened	Setting:		
Step 3 – Complete the Yorkshire Contributory Factors Framework (YCFF)			Data fall account
Step 4 - Capture the key contributory factors and areas of good practice	Name and position of person completing form	Date completed	Date fall occurred
Step 5 - Share the report			

Step 1 – Timeline of event if appropriate/ Brief description of what happened

Date & Time	Event Overview e.g. relevant information leading up to the incident if appropriate such as medication review/ change in condition, new to the care setting etc and include brief description of what happened	Actions taken





Step 2 – Gaining a holistic view

are setting professional perspective on what happened but may also include others (Residents & other visitors i.e. GPs, DNs where possible	le)

Step 3 - The Yorkshire Contributory Factors Framework- (adapted for Care settings by NHS HNY ICB with permission from YHIA)

Domain 1: Situational Factors			
Team factors		Comments	
Did a reduction or change in teamwork contribute to the fall? For example: Unclear team aims Lack of respect for colleagues Poor adherence to guidance/policy Poor delegation for jobs Absence of feedback	Yes Maybe No		
Individual staff factors	T.		
Were there any reasons this fall was more likely to occur with the particular staff involved? For example: Tiredness Stressed Inexperience Rushed Personal & religious beliefs Staff moving between different homes	Yes Maybe No		
Task characteristics			
Did the care provision make the fall more likely in this setting? For example: Unifamiliar tasks required of care /nursing team Difficult task Monotonous task	Yes Maybe No		

Resident factors		
Were there any reasons the fall was more likely to occur in this group of residents?	Yes	
For example: Language barrier Unusual physiology Dementia Complex medical history Learning disability Mental health Cognitive impairment Nursing Needs	Maybe No	

Domain 2: Local Working Conditions		
Workload and staffing issues		
Was there a reduction in staff hours, workload and staff numbers around the time of the fall? For example: Increased workload Staff absence Reduction in staffing levels due to dependency levels at the home. Inability to access or use agency staff	Yes Maybe No	
Leadership, Supervision and Roles	1	
Was there visible management and leadership at the time of the fall, with a support network for staff? For example: Unclear responsibilities Inappropriate delegation No Registered Manager in place Role modelling from senior team Lack of direction and supervision Was wellbeing support provided?	Yes Maybe No	
Drugs, Equipment and Supplies		
Were there difficulties obtaining the correct drugs and/or working equipment and/or supplies? For example: Medication supplies Moving & Handling equipment not working or access to services Unavailable equipment/ delivery issues Cleaning & storage of equipment e.g. hoists/commodes Inadequate maintenance	Yes Maybe No	

Domain 3: Organisational Factors		
Physical environment		
Did limitations in the home environment play a part in the fall occurring? For example: Poor layout Lack of space Shared rooms Poor visibility of residents Open plan living areas • Excessive noise/ heat/cold • Poor lighting • Poor access to resident	Yes Maybe No	
Support from other professionals		
 Did problems from other agencies play a role in the fall occurring? For example: This includes support from clinical services such as DN, GPs, UCPs/YAS, community pharmacy, community therapies, LA, IPC team, PH, CQC, ICB 	Yes Maybe No	
Bed management & interface with other agencies		
Were there any issues or concerns with admissions or discharges / bed pressures that may have played a role in the fall? For example: Issues with an admission Transfer inappropriate to needs of resident Delay in the provision of care Punding stream issues Trusted Transfer Document not used	Yes Maybe No	

Staff training and Education		
Did issues with staff skill or knowledge play a role in the fall occurring? For example: Inadequate falls prevention training Not enough/ protected time for training and development Practice not up to date with falls prevention guidance Medication awareness No regular updates Training nor standardised Lack of supervision	Yes Maybe No	
Domain 4: External Factors		
Design of Equipment, Supplies and Drugs		
Did any characteristics of the equipment, disposables or drugs play a role in the fall occurring? For example: Confusing equipment design Equipment not fit for purpose i.e. HSE approval Unclear labelling and packaging Equipment not appropriate to task	Yes Maybe No	
National/local policies & guidance		
Did the lack of implementation of relevant policies, procedure or best practice play a part in the fall occurring? For example: Commissioned resources National & Local policy Conflict local vs other guidance Auditing – Quality Assurance requirements. CQC Regulatory Framework Organisational guidance/policy IPC requirements	Yes Maybe No	

Domain 5: Communication and Culture				
Safety culture	Safety culture			
Did the safety culture in your home play a part in the fall occuring? For example: Resident capacity for safety awareness Documenting errors Reporting of incidents Staff ownership/responsibility Attitude to risk management Fear of asking questions Business reputation	Yes Maybe No			
Verbal and Written communication				
Was written and verbal communication effective? For example: Poor communication between staff Effective handover Lack of communication/notes Newsletters & Residents meetings Keeping relatives and friends informed Lack of guidance and posters shared with staff re required practice and behaviours	Yes Maybe No			
Step 4 – Summary of key contributory Factors				
Domain 1 – Situational Factors Domain 2- Local Working Conditions				
Domain 3 – Organisational Factors				
Domain 4-External Factors				
Domain 5- communication				

Areas of good prac	ctice to be shared
Are there key action	ons to be taken following this to support best practice?
Step 5 – Sharing of	the learning
Date	Shared with?