### 5A: Information To Include in Incident Reports

**Background:** The purpose of this tool is to audit incident reports of falls to see if the reports provide adequate information for root cause analysis. Alternatively, the information below may be used in conjunction with Tool 3O, “Postfall Assessment for Root Cause Analysis” to develop a template to be filled out when reporting a fall.

**Reference:** Adapted from National Health Service publication Slips, Trips, and Falls in the Hospital, available at [www.nrls.npsa.nhs.uk/resources/?EntryId45=59821](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59821).

**How to use this tool:** Review your last 10 incident reports for falls and see whether the information below is captured in the report. This tool should be used by the quality improvement manager. Information systems staff may also use this tool to develop or update electronic templates for submitting incident reports.

Use this tool to identify areas for improvement and develop educational programs where there are gaps.

##### Information To Include in Incident Reports

| **Examples of Information** | **Reason To Collect This Information** |
| --- | --- |
| Reporting factors | Witnessed/not witnessed | Make a clear distinction between what was seen or heard and the patient’s account of what happened. |
| Outcome of investigations recorded | When patients are reported as having x rays or other investigations after a fall, the results of the x ray or other investigation should be included in the report. |
| Type of injury | Be specific, e.g., “fractured tibia,” not “broken leg.” |
| Environmental factors | Buzzer/bell available within reach before fall | Highlight whether there is an issue about accessing call bells. |
| If a fall from bed, whether bedrails were in use | Help assess how bedrail use is affecting falls or injury. |
| Floor wet/dry/talcum powder | Reflect on cleaning regimen and need for nonslip surfaces. |
| Footwear | If problems with missing or unsuitable footwear are highlighted, organizations could develop systems for providing alternatives. |
| Walking aid in use/in reach | It may highlight bedside storage issues or access to walking aids for patients admitted in the evenings or on the weekend. |
| Patient factors | Mental state | Identify those patients most vulnerable to falls because of sedation, dementia, or delirium. |
| First fall this admission or repeat fall | Balance resources between preventing initial falls and secondary prevention. |
| Days since admission | Ensure timescales for assessing and preventing falls are tailored to when falls are most likely to occur. |
| Medication affecting risk of falls | Sedative and psychotropic medication, or medication with drowsiness as a side effect, may contribute to falls. |