



Queensland Government

In-patient Falls Assessment and Management Plan

Facility: COV Retirement Village

(Affix identification label here)

URN: 246802

Family name: Thorne

Given name(s): Alex

Address: 2A Unity Drive, Pleasantville

Date of birth: 01 JAN 1924 Sex: M F I

Adult

- Complete assessment within eight (8) hours of admission
- Reassess at a minimum of weekly, when there is a change in condition, medication, after a fall and on discharge
- Care plans never replace clinical judgement. Care outlined must be altered if it is not clinically appropriate for the individual patient
- Every person documenting on the form must supply a sample of their initials in the signature log (page2)

Falls Risk Assessment

Identify risk factors Tick (✓) Yes or No (if Yes to any, patient is 'at risk' of a fall)			If YES to any →	Initiate actions Tick when actioned (if indicated)			
Risk Factors	Date	Time	Initial	Actions	Date	Time	Initial
Screen: The patient has had a fall in the last 6 months	<u>24/1/17</u>	<u>1100</u>	<u>ML</u>	• Refer patient to physiotherapist for gait and balance assessment			
The patient is observed to be unsteady	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
The patient requires supervision or assistance with transfer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Conduct pre-activity screening prior to off bed transfer			
The patient is visually impaired	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Ensure glasses / visual aid is within reach • Consider referral (e.g. ophthalmologist, optometrist)			
The patient has new onset incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Initiate ward urinalysis • Notify MO and facilitate tests as ordered (e.g. MSU)			
The patient has existing incontinence, frequency or requires assisted toileting	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Initiate toileting routine • Consider use of continence aids • Refer for continence assessment (as appropriate)			
The patient reports postural symptoms	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Measure lying and standing BP			
The patient has a recent history of syncope	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Notify MO and facilitate tests as ordered (e.g. ECG, CT, ECHO, EEG, holter monitor)			
The patient is on one of the following medications: (antihypertensive, antidepressant, sedative, antipsychotic, benzodiazepine)	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Refer to MO / Pharmacist for medication review / simplification			
The patient is on more than 4 medications	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
The patient has a minimal trauma fracture and / or history of osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Facilitate tests ordered by MO (e.g. TFT, calcium, vitamin D assay, PTH, sEPP) • Refer to Dietitian (as appropriate)			
The patient has new onset or increased confusion / delirium	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Notify MO and facilitate tests as ordered (e.g. MSU, folate, CT, E/LFT, FBE, TFT) • Conduct / refer for cognitive assessment (if appropriate)			
The patient is usually confused	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	• Conduct or refer for cognitive assessment (if appropriate)			

Following assessment, proceed to management plan (page 2)

DO NOT WRITE IN THIS BINDING MARGIN

v4.00 - 03/2017



SW134

IN-PATIENT FALLS ASSESSMENT AND MANAGEMENT PLAN



**Queensland
Government**

In-patient Falls Assessment and Management Plan

(Affix identification label here)

URN: 246802

Family name: Thorne

Given name(s): Alex

Address: 2A Unity Drive, Pleasantville

Date of birth: 01 JAN 1924

Sex: M F I

Adult

- Complete within eight (8) hours of admission
- Review management plan at a minimum daily and document as per local policy
- Initial when strategies are implemented
- V indicates a variance from clinical care and must be documented in the clinical notes

Falls Prevention Management Plan

All care givers who initial are to sign signature log

Key: Key Allied Health Medical Nursing Pharmacy

Category	Key	Description	Date			Time		
			Day	Month	Year	Hour	Min	Sec
Communication	▲	In partnership with patient and / or carer discuss falls risk factors and develop falls prevention plan						
	◆	Provide written falls prevention information (e.g. <i>Stay On Your Feet® BE SAFE brochure</i>)						
	■	Communicate patients 'at risk' status at bedside handover						
	Ⓢ	Instruct patient to call for assistance when getting out of bed / mobilising (if required)						
		Falls risk patients on anti-coagulant / antiplatelet medication, request MO / Pharmacy medication review						
Environment / Equipment	▲	Orientate patient to surroundings, routine and location of bathroom and toilet						
		Ensure clutter free and safe environment (e.g. night time lighting)						
		Ensure the bed height and position are suitable for the patient's needs						
		Apply bed brakes correctly						
		Ensure bed rails are at appropriate height for patient's needs						
		Keep buzzer in reach; educate patient on buzzer usage						
		Keep patient's routine belongings within reach						
Observations	▲	Ensure frequent rounding and surveillance						
		Consider supervision during toileting / showering / mobilisation						
		Ensure suitable toileting protocols are in place						
Other Care (specify)	▲							
	◆							
	■							
	Ⓢ							
Discharge Planning / Education	▲	Provide information on falls risk factors and prevention strategies (e.g. <i>Stay On Your Feet® Checklist</i>)						
	◆	Refer to OT for ADL and home assessment						
		Complete nursing discharge summary and facilitate referrals						

DO NOT WRITE IN THIS BINDING MARGIN

Signature Log

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature
ML	Monica Linnane	MO	<i>MLL</i>				