



Queensland Government

In-patient Falls Assessment and Management Plan

Facility: QVn Hospital

(Affix identification label here)

URN:

Family name: WEBB

Given name(s): Sam

Address: 200 Smiles St, Pleasantville

Date of birth: 01 JAN 1960

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	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N Date: <u>24/01/17</u> Time: <u>1100</u> Initial: <u>ML</u>	→	• Refer patient to physiotherapist for gait and balance assessment	
The patient is observed to be unsteady	<input type="checkbox"/> Y <input 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 type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N			
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 type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N			
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 type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N			
The patient is on one of the following medications: (antihypertensive, antidepressant, sedative, antipsychotic, benzodiazepine)	<input type="checkbox"/> Y <input 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 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 type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N			
The patient is usually confused	<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 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



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Government**

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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		Date	Time
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</i> ® BE SAFE brochure) ● 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		22/11/17	1100
		ML	
		ML	
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 Keep patient's mobility aid in reach if applicable Review patient footwear and / or foot problems		ML	
		ML	
Observations ▲ Ensure frequent rounding and surveillance Consider supervision during toileting / showering / mobilisation Ensure suitable toileting protocols are in place			
Other Care (specify) ▲ Nil assistance required for mobilisation. ◆ ● ⊕		ML	
Discharge Planning / Education ▲ Provide information on falls risk factors and prevention strategies (e.g. <i>Stay On Your Feet</i> ® Checklist) ◆ Refer to OT for ADL and home assessment Complete nursing discharge summary and facilitate referrals			

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Signature Log

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature
ML	Monica Linnane	MO	MLL				