## Residential Care and Multipurpose Health Facility Falls Assessment and Management Plan

Facility:	Date of birth:	Sex: M
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URN:

Family name:

Given name(s):

• Complete this form within 24 hours of admission, when there is a change in condition, medication, or after a fall; and reassess as per local policy

Address:

(Affix identification label here)

Adult

• Care plans never replace clinical judgement. Care outlined must be altered if not clinically appropriate for the individual care recipient

Every person documenting on the form mu	ıst supp	oly a s	ample	of thei	ir ini	tials in	the signature lo	g (page 2)			
Identify risk factors Tick (✓) Yes or No (if Yes to any, care recipient is 'at risk' of a fall)			If YES to any Initiate actions Tick when actioned (if indi			ed)					
Date									Date		
Risk Factors	Time						Actions	Time			
	Initial						. (	1	Initial		
Screen: The care recipient has had a fall in the last 6 months	•	□ Y □ N	□ Y □ N	□ Y □ N			118				
The care recipient is observed to be unstead	dy	□ Y □ N	□ Y □ N	□ Y □ N			o physiothera		nd		
The care recipient uses a non-prescribed mobility aid		□ Y □ N	□Y □N	□Y □N		halar	nce assessment				
The care recipient has a neurological disord that affects balance; or uses a mobility aid <b>a</b> has not been reviewed within 12 months		□ Y □ N	□N			0					
The care recipient is visually impaired		1	∠ Y □ N	□Y □N			re glasses/visua r for visual asse				
The care recipient requires supervision or assistance with transfers or ADL	0	□ Y	□Y □N	□ \ □ N		• Com	plete ADL asses	sment (if requ	uired)		
The care recipient has new onset incontine	ce	□Y	☑Y □N	□ Y □ N		• Refe	r to GP for inves	stigation (e.g.	MSU)		
The care recipient has existing incontinence frequency or requires assisted toileting	0	□N	□Y	□Y		<ul><li>Cons</li><li>Refer</li></ul>	te toileting routir ider use of cont rral for continen ppropriate)	inence aids	nt		
The care recipient reports postural symptom (e.g. regular dizziness, light headedness, rechistory of syncope)		□ Y □ N	□ Y □ N	□ Y □ N			sure lying and st r to GP (as appr	•			
The care recipient is on one of the following medications: antihypertensive, antidepressa sedative, benzodiazepine, antipsychotic	nt,	□ Y □ N □ Y	□ Y □ N	□ Y □ N			r to GP/Pharma	cist for medic	ation review		
The care recipient is on more than 4 medications			□ Y □ N	□ Y □ N		(as appropriate)					
The care recipient has a minimal trauma fracand/or history of osteoporosis		□ Y □ N	□ Y □ N	□ Y □ N		• Refe	r to Dietitian (when to GP to assest reatment option	s causes of c	steoporosis		
The care recipient has new onset or increas confusion/delirium	ed	□ Y □ N	□ Y □ N	□ Y □ N		• Notify	y GP for further luct or refer for o	investigations	<b>i</b>		
The care recipient is usually confused		□ Y □ N	□ Y □ N	□ Y □ N		• Cond	luct or refer for o	cognitive asse	essment		
The care recipient is at risk of malnutrition		□Y	□Ү	□Y		and f	ew Malnutrition of follow up with Di urage high prote	etitian if score	e ≥2		
(not eating well and appears underweight)		□N	□N	□N		and/o	or prescribed nu propriate, provid ntake	trition supple	ments		



## Residential Care and Multipurpose Health Facility Falls Assessment and Management Plan

(Affix identification label here)							
URN:							
Family name:	A14						
Given name(s):	Adult						
Address:							
Date of birth:	Sex: M F I						

- · Initial when strategies are implemented
- Care plans never replace clinical judgement. Care outlined must be altered if not clinically appropriate for the individual care recipient
- V indicates a variance from clinical care and must be documented in the clinical notes

	_	om clinical care and must be documented in the clinical notes			
Falls Prevention					
All clinicians who initia	l are	to sign signature log	Nursing	Phar	macy
		D	ate		
Category	8	Ti	me		
Communication	<b>A</b>				
	<b>A</b>	In partnership with care recipient and/or carer discuss falls risk factors, goals of care and develop falls prevention plan to prevent falls			
	(P)	Instruct care recipient to call for assistance when getting out of bed/mobilising (if required/as appropriate)			
		Communicate care recipient's 'at risk' status at handover			
		GP review of antiplatelet/anticoagulant medication for at risk care capitals			
		Encourage adequate dietary intake, provide meal assistance if 'eq vired			
Environment/ Equipment	•	Orientate to surroundings, routine and location of bathroom and toilet			
1.1		Ensure clutter free and safe environment (e.g. night time lighting)			
		Ensure the chair and bed height/position are suitab's for the care recipient's needs (i.e. the patient's feet need to be on the ground with the knees slight'v below the hip)			
		Apply brakes to bed, wheelchair and commode for ectly			
		Ensure use of bed rails are appropriate for `arc recipien 's cods and appropriate height, if prescribed			
		Keep buzzer in reach; educate ca. e . cir ient on l'uzzer usage			
		Keep care recipient's routine by lon lings within react			
		Keep care recipient's mability and well maintained and within reach if applicable			
		Review care recipient for twear and/or foot problems			
Observations	•	Ensure frequent rour dirig and survoillance			
		Consider supervision during to et.or/showering/mobilisation			
		Ensure suitable toileting protocols are in place			
		Implement Allied Hralth recommendations			
		V			
Allied Health/ Medical Review	<b>A</b>				
(e.g. MO, Physio, OT, Podiatry, Dietitian,	®				
Pharmacist)					
Specific Care Recipient Centred	<b>A</b>				
Goal (e.g. prefers to	• •				
wear closed in shoes when transferring/					
mobilising)					
Other Care (specify)	<b>A</b>				

Signature Log											
Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature				