Queensland Government

Community Falls Assessment and Management Plan

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐ M ☐ F ☐ I

Adult

- **Complete this form on initial assessment, when there is a change in client's health status, function or medication, following a recent hospital admission or fall; reassess annually or per local policy**
- **Care plans never replace clinical judgement. Care outlined must be altered if it is not clinically appropriate for the individual client**
- Every person documenting on the form must supply a sample of their initials in the signature log (page 2)

Falls Risk Assessment

Identify risk factors
Tick (✓) **Y**es or **N**o
(if Yes to any, client 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 client has had a fall in the last 6 months	☐ Y ☐ N	• Refer client to physiotherapist for gait and balance assessment Client offered: ☐ Yes ☐ No ☐ Physio services unavailable	
The client is observed to be unsteady	☐ Y ☐ N	• Review client footwear and / or foot problems	
The client is using a non-prescribed mobility aid	☐ Y ☐ N		
The client has a pre-existing neurological disorder that affects balance, or uses a mobility aid ***and*** has not been reviewed in the last 12 months	☐ Y ☐ N		
The client is visually impaired	☐ Y ☐ N	• Conduct or refer for visual assessment • Refer / consent to OT referral for environmental assessment	
The client requires supervision or assistance with transfers or ADL	☐ Y ☐ N	• Complete ADL assessment (as indicated) • Discussed plan and safety options with client / family • Refer / consent to OT for environmental assessment	
The client has new onset or increased confusion / delirium	☐ Y ☐ N	• Notify GP • Discussed with senior nurse and liaise with GP • Conduct or refer for cognitive assessment (as indicated)	
The client is usually confused	☐ Y ☐ N	• Complete home hazard / safety assessment • Liaise with GP (as indicated)	
The client has new onset or existing incontinence	☐ Y ☐ N	• Refer to GP for investigation *(new onset)* • Initiate / review toileting routine / program • Consider / review continence aids • Refer for continence assessment (if appropriate)	
The client is on one of the following medications: antihypertensive, antidepressant, sedative, benzodiazepine, antipsychotic	☐ Y ☐ N	• Refer to GP for medication review / simplification where appropriate (encourage three monthly review)	
The client is on more than 4 medications	☐ Y ☐ N		
The client reports postural symptoms (e.g. regular dizziness, light headedness, recent history of syncope)	☐ Y ☐ N	• Refer to GP for investigation (postural symptoms, review adequate hydration) • Measure lying and standing BP	
The client has a minimal trauma fracture and / or history of osteoporosis	☐ Y ☐ N	• Refer to GP to assess causes of osteoporosis and treatment options (where appropriate)	

DO NOT WRITE IN THIS BINDING MARGIN

COMMUNITY FALLS ASSESSMENT AND MANAGEMENT PLAN

v4.00 - 04/2021
SW133

Queensland Government

Community Falls Assessment and Management Plan

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Adult

Falls Prevention and Management Plan Actions

The client's current Falls Prevention and Management Plan includes: *(tick if yes and complete)*

- ☐ Physiotherapy for: .....
- ☐ Exercise physiologist for: .....
- ☐ Podiatrist for: .....
- ☐ NDIS support for: .....
- ☐ MyAged Care (MAC) referral for: .....
- ☐ Discussed with client / family falls risk assessment, prevention plan and strategies
- ☐ Educated client / family about falls prevention strategies using the Queensland Health *Stay On Your Feet®* and the Australian Commission on Safety and Quality in Health Care (ACSQHC) teach back method
- ☐ Nursing interventions
- ☐ Shoes safety assessment and documented footwear
- ☐ Personal alarm options discussed and/or organised (if appropriate): .....

Notes / Comments

Signature Log

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature