Queensland Government

In-patient 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 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 (page 2)

Falls Risk Assessment

Identify risk factors
Tick (✓) **Y**es or **N**o *(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				Actions	Date		
	Time					Time		
	Initial					Initial		
Screen: The patient has had a fall in the last 6 months	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Refer patient to physiotherapist for gait and balance assessment if a mechanical fall (not syncopal)			
The patient is observed to be unsteady	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→				
The patient requires supervision or assistance with transfer	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Conduct pre-activity screening prior to off bed transfer			
The patient is visually impaired	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Ensure glasses / visual aid is within reach • Consider referral (e.g. ophthalmologist, optometrist)			
The patient has new onset incontinence	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Initiate ward urinalysis • Notify MO and facilitate tests as ordered (e.g. MSU)			
The patient has existing incontinence, frequency or requires assisted toileting	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Initiate toileting routine • Consider use of continence aids • Refer for continence assessment (as appropriate)			
The patient reports postural symptoms	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Measure lying and standing BP			
The patient has a recent history of syncope	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Notify MO and facilitate ordering tests if required (e.g. ECG, CT, ECHO, EEG, holter monitor)			
The patient is on one of the following medications: (antihypertensive, antidepressant, sedative, antipsychotic, benzodiazepine)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Refer to MO / Pharmacist for medication review / simplification			
The patient is on more than 4 medications	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→				
The patient has a minimal trauma fracture and / or history of osteoporosis	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Conduct or refer for cognitive assessment (if appropriate)			
The patient is at risk of malnutrition (not eating well and reports unintentional weight loss or appears underweight)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	→	• Complete the Malnutrition Screening Tool (MST) and refer to Dietitian if score ≥2 • Encourage high protein, high energy meals and / or prescribed nutrition supplements • If appropriate, provide meal assistance, monitor oral intake via food charts			

Following assessment, proceed to management plan for ALL patients (page 2)

DO NOT WRITE IN THIS BINDING MARGIN

IN-PATIENT FALLS ASSESSMENT AND MANAGEMENT PLAN

v8.00 - 11/2023
SW134

Queensland Government

In-patient Falls Assessment and Management Plan

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URN:

Family name:

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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 ◆ 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 and verbal falls prevention information (e.g. *Stay On Your Feet® BE SAFE brochure*) using the Australian Commission on Safety and Quality in Health Care (ACSQHC) teach back method				
		Communicate patients 'at risk' status at bedside handover				
		Instruct patient to call for assistance when getting out of bed / mobilising (if required)				
		Communicate with patients on anti-coagulant / antiplatelet medication the increased risk of bleeding if patient falls, request MO / Pharmacy medication review				
		Encourage adequate dietary intake				
Environment / Equipment *(used according to local policy and procedures)*	▲	Orientate patient to surroundings, routine and location of bathroom and toilet				
		Ensure clutter free and safe environment (e.g. night time lighting)				
		Ensure the chair and bed height / position are suitable for the patient's needs (i.e. the patient's feet need to be on the ground with the knees slightly below the hip)				
		Apply brakes to bed, wheelchair and commode correctly				
		Ensure use of bed rails are appropriate for patient's needs and if used, height is appropriate				
		Keep buzzer in reach; educate patient on buzzer usage				
		Keep patient's routine belongings within reach				
		Keep patient's current mobility aid assessed as safe to use within reach (where applicable), remove all other mobility aids from patient's sight and reach				
		Review patient footwear and / or foot problems				
Other Care *(specify)*	▲ ◆ ■ Ⓟ					
Observations	▲	Ensure frequent rounding and surveillance				
		Consider supervision during toileting / showering / mobilisation				
		Ensure suitable toileting protocols are in place				
Specific Patient Centred Goal *(e.g. prefers to wear closed in shoes when transferring / mobilising)*	▲ ◆ Ⓟ ■					
Discharge Planning / Education	▲ ◆	Provide information on falls risk factors and prevention strategies (e.g. *Stay On Your Feet® Checklist*)				
		Refer to OT for ADL and home assessment				
		Complete nursing discharge summary and facilitate referrals				

Signature Log (Every person documenting on the form [page 1 and 2] must supply a sample of their initials)

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature

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