



**Queensland
Government**

Day Oncology Pressure Injury and Falls Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Facility:

- The following assessments should be completed **weekly** (at minimum), following any change in condition (e.g. following hospitalisation, or commencement of new medication) or as per local policy
- Oncology patients are at risk of pressure injury as a result of their treatment side effects, age and comorbidities
- **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 sign the signature log (page 1)

BASELINE Strategies for all patients

- Educate patient and / or carer to check patients skin and advise staff of any area of increased temperature, swelling, pain or discolouration
- Provide pressure injury information and partner with patient / carer in care planning
- Encourage position changes while receiving treatment
- Ensure appropriate positioning
- Ensure use of appropriate support surface
- Educate patient / carer / family on the importance of frequent small shifts to reduce pressure

ADDITIONAL STRATEGIES for at risk patients, i.e.:

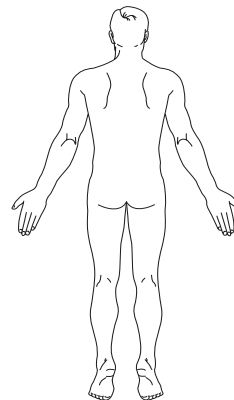
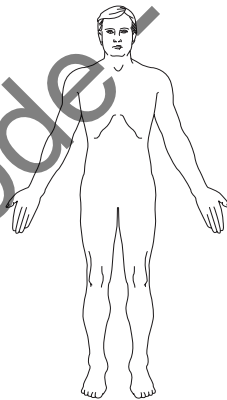
- Scores >10 on Waterlow
- Has had a previous pressure injury
- Is unable to reposition independently
- Has impaired sensation
- Is diabetic

- Ensure patient is repositioned every 2 hours throughout treatment and record when pressure area care is provided on the observation chart
- Encourage patient to reposition by making frequent small shifts as able
- Provide pressure relieving devices to affected areas
- Refer to occupational therapy for pressure relieving devices - date referred: / /
- Refer to podiatrist for diabetic foot care - date referred: / /

Skin Assessment To be performed weekly at minimum, and each session if patient is high risk or has existing pressure injury

Date	Time												
	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	
Ask patient: Completed by (initial)													
Have you or your carer checked your skin this week?	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N
Are there any areas of your skin that you are concerned about? (e.g. painful, discoloured) <i>If yes, record findings on diagram, using legend to indicate nature of injury</i>	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N
Do you consent to a comprehensive skin inspection? <i>If yes, record findings on diagram, using legend to indicate nature of injury</i>	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N	<input type="checkbox"/> N
Interventions (document on page 2) (e.g. 'A')													

Record and date skin related issues on diagram below



- Legend:**
P Pressure injury
W Wound
S Skin tear

If skin injury is found

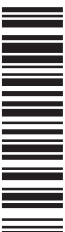
- Date injury found - 1: / / 2: / / 3: / /
- Record findings in the medical notes and consult with wound nurse as needed
- Record injury in PRIME / RiskMan (date recorded) - 1: / / 2: / /

Signature Log Every person documenting on the form must supply a sample of their initials below

Initial	Print name	Role	Signature	Initial	Print name	Role	Signature

DO NOT WRITE IN THIS BINDING MARGIN

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 Mat. No.: 10353640



SW806

DAY ONCOLOGY PRESSURE INJURY AND FALLS ASSESSMENT



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Date Time Completed by (initial)												
	Screen: Has the patient had a fall (in any location) in the last week?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the patient prescribed opioids or benzodiazepines?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Has the patient had a recent change in anti-hypertensive 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the patient unsteady on their feet and / or uses a mobility aid?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the patient an amputee or wheelchair bound?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the patient confused or impulsive?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Does the patient experience severe postural hypotension?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Does the patient have a history of minimal trauma fracture?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Interventions (e.g. 'A')												

Falls Prevention Strategies

- If yes to any of the above questions, discuss the risk of falls with the patient or carer and implement falls prevention strategies
- Instruct patient to not mobilise independently, to buzz and wait for assistance
- Provide frequent observation, supervision and assistance, especially during weighing, toileting and mobilising
- Physiotherapy referral where able (consider community referral) - date referred: / /
- If possible, locate the patient treatment chair in a highly visible location
- Consider use of additional staff for constant supervision and assistance with mobility

Date / Time	Interventions and Clinical Comments (record here and note letter in Intervention row)	Initials
	A	
	B	
	C	
	D	
	E	
	F	
	G	
	H	
	I	
	J	
	K	
	L	
	M	
	N	

DO NOT WRITE IN THIS BINDING MARGIN