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Contact: PSQIS_Comms@health.qld.gov.au

Queensland Government

Residential Care and Multipurpose Health Facility 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 within 24 hours of admission, when there is a change in condition, medication, or after a fall; and reassess as per local policy**
- **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 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, care recipient is 'at risk' of a fall)

If YES to any →

Initiate actions
Tick when actioned (if indicated)

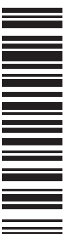
Risk Factors				Actions			
Date				Date			
Time				Time			
Initial				Initial			
Screen: The care recipient has had a fall in the last 6 months	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Refer to physiotherapist for gait and balance assessment			
The care recipient is observed to be unsteady	☐Y ☐N	☐Y ☐N	☐Y ☐N				
The care recipient uses a non-prescribed mobility aid	☐Y ☐N	☐Y ☐N	☐Y ☐N				
The care recipient has a neurological disorder that affects balance; or uses a mobility aid ***and*** has not been reviewed within 12 months	☐Y ☐N	☐Y ☐N	☐Y ☐N				
The care recipient is visually impaired	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Ensure glasses/visual aid is within reach			
				• Refer for visual assessment (where appropriate)			
The care recipient requires supervision or assistance with transfers or ADL	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Complete ADL assessment (if required)			
The care recipient has new onset incontinence	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Refer to GP for investigation (e.g. MSU)			
The care recipient has existing incontinence, frequency or requires assisted toileting	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Initiate toileting routine			
				• Consider use of continence aids			
				• Referral for continence assessment (as appropriate)			
The care recipient reports postural symptoms (e.g. regular dizziness, light headedness, recent history of syncope)	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Measure lying and standing BP			
				• Refer to GP (as appropriate)			
The care recipient is on one of the following medications: antihypertensive, antidepressant, sedative, benzodiazepine, antipsychotic	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Refer to GP/Pharmacist for medication review (as appropriate)			
The care recipient is on more than 4 medications	☐Y ☐N	☐Y ☐N	☐Y ☐N				
The care recipient has a minimal trauma fracture and/or history of osteoporosis	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Refer to Dietitian (where appropriate)			
				• Refer to GP to assess causes of osteoporosis and treatment options (if appropriate)			
The care recipient has new onset or increased confusion/delirium	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Notify GP for further investigations			
				• Conduct or refer for cognitive assessment			
The care recipient is usually confused	☐Y ☐N	☐Y ☐N	☐Y ☐N	• Conduct or refer for cognitive assessment			

Following assessment, inform care recipient/carers of assessment outcome; and proceed to develop management plan (page 2)

Available from WINC
Code - 1NY31414

DO NOT WRITE IN THIS BINDING MARGIN

v6.00 - 09/2021



SW136

Queensland Government

Residential Care and Multipurpose Health Facility Falls Assessment and Management Plan

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URN:

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Date of birth:

Sex: ☐ M ☐ F ☐ I

Adult

- 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

Falls Prevention Management Plan

All clinicians who initial are to sign signature log — Key: ◆ Allied Health ■ Medical ▲ Nursing ℗ Pharmacy

Category	Key		Date/Time		
Communication	▲ ℗ ■	In partnership with care recipient and/or carer discuss falls risk factors and goals of care to prevent falls			
		Instruct care recipient to call for assistance when getting out of bed/mobilising (if required)			
		Communicate care recipient's 'at risk' status at handover			
		GP review of antiplatelet/anticoagulant medication for at risk care recipients			
Environment/ Equipment	▲	Orientate 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 care recipient'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 bed rails are at appropriate height for care recipient's needs, if prescribed			
		Keep buzzer in reach; educate care recipient on buzzer usage			
		Keep care recipient's routine belongings within reach			
		Keep care recipient's mobility aid well maintained and within reach if applicable			
		Review care recipient footwear and/or foot problems			
Observations	▲	Ensure frequent rounding and surveillance			
		Consider supervision during toileting/showering/mobilisation			
		Ensure suitable toileting protocols are in place			
		Implement Allied Health recommendations			
Allied Health/ Medical Review *(e.g. MO, Physio, OT, Podiatry, Dietitian, Pharmacist)*	▲ ◆ ℗ ■				
Specific Care Recipient Centred Goal *(e.g. prefers to wear closed in shoes when transferring/ mobilising)*	▲ ◆ ℗ ■				
Other Care *(specify)*	▲				

Signature Log

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature

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