



Queensland Government

In-patient Falls Assessment and Management Plan

Facility: QV Retirement Village

(Affix identification label here)

URN: 246802

Family name: Thorne

Given name(s): Alex

Address:

Date of birth: 01 JAN 1924

Adult

Sex: M F I

- 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 (page2)

Falls Risk Assessment

Identify risk factors Tick (✓) Yes or No (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	Time		Actions	Date	Time
Initial						
Screen: The patient has had a fall in the last 6 months	<u>24/1/17</u>	<u>1100</u>		• Refer patient to physiotherapist for gait and balance assessment		
The patient is observed to be unsteady				• Conduct pre-activity screening prior to off bed transfer		
The patient requires supervision or assistance with transfer				• Ensure glasses / visual aid is within reach • Consider referral (e.g. ophthalmologist, optometrist)		
The patient is visually impaired				• Initiate ward urinalysis • Notify MO and facilitate tests as ordered (e.g. MSU)		
The patient has new onset incontinence				• Initiate toileting routine • Consider use of continence aids • Refer for continence assessment (as appropriate)		
The patient has existing incontinence, frequency or requires assisted toileting				• Measure lying and standing BP		
The patient reports postural symptoms				• Notify MO and facilitate tests as ordered (e.g. ECG, CT, ECHO, EEG, holter monitor)		
The patient has a recent history of syncope				• Refer to MO / Pharmacist for medication review / simplification		
The patient is on one of the following medications: (antihypertensive, antidepressant, sedative, antipsychotic, benzodiazepine)				• Facilitate tests ordered by MO (e.g. TFT, calcium, vitamin D assay, PTH, sEPP) • Refer to Dietitian (as appropriate)		
The patient is on more than 4 medications				• 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 has a minimal trauma fracture and / or history of osteoporosis				• Conduct or refer for cognitive assessment (if appropriate)		
The patient has new onset or increased confusion / delirium						
The patient is usually confused						

Following assessment, proceed to management plan (page 2)


DO NOT WRITE IN THIS BINDING MARGIN

v4.00 - 03/2017



SW134

IN-PATIENT FALLS ASSESSMENT AND MANAGEMENT PLAN

 <p>Queensland Government</p> <p style="text-align: center;">In-patient Falls Assessment and Management Plan</p>	<p style="text-align: right;">(Affix identification label here)</p> <p>URN: 246802</p> <p>Family name: Thorne</p> <p>Given name(s): Alex</p> <p>Address:</p> <p>Date of birth: 01 JAN 1924 Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p> <div style="text-align: right; font-size: 2em; font-weight: bold; opacity: 0.5;">Adult</div>
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- 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 falls prevention information (e.g. <i>Stay On Your Feet® BE SAFE brochure</i>)			
	■	Communicate patients 'at risk' status at bedside handover			
	Ⓟ	Instruct patient to call for assistance when getting out of bed / mobilising (if required)			
		Falls risk patients on anti-coagulant / antiplatelet medication, request MO / Pharmacy medication review			
Environment / Equipment	▲	Orientate patient to surroundings, routine and location of bathroom and toilet			
		Ensure clutter free and safe environment (e.g. night time lighting)			
		Ensure the bed height and position are suitable for the patient's needs			
		Apply bed brakes correctly			
		Ensure bed rails are at appropriate height for patient's needs			
		Keep buzzer in reach; educate patient on buzzer usage			
		Keep patient's routine belongings within reach			
Observations	▲	Ensure frequent rounding and surveillance			
		Consider supervision during toileting / showering / mobilisation			
		Ensure suitable toileting protocols are in place			
Other Care (specify)	▲			
	♦			
	■			
	Ⓟ			
Discharge Planning / Education	▲	Provide information on falls risk factors and prevention strategies (e.g. <i>Stay On Your Feet® Checklist</i>)			
	♦	Refer to OT for ADL and home assessment			
		Complete nursing discharge summary and facilitate referrals			

DO NOT WRITE IN THIS BINDING MARGIN

Signature Log

Initial	Print name	Designation	Signature		Initial	Print name	Designation	Signature
ML	Monica Linnane	MO	MLL					