FALLS RISK ASSESSMENT TOOL AND GUIDELINES

Tasmania
Department of Health and Human Services

FALLS RISK ASSESSMENT TOOL AND GUIDELINES

FACILITY: _____
WARD

LAUNCESTON GENERAL HOSPITAL

M.R.N.										

SURNAME ..... D.O.B. .....
OTHER NAMES ..... SEX
ADDRESS ..... MARITAL STATUS
..... REL.

LABEL

NOTE: All categories are to have a risk score documented. Where a category characteristic is not indicated at assessment document 'O' in the score column.

Identified risk and strategies implemented to be documented in patient medical record			1. Pre admission Clinic	2. On admission to Ward	3. Specify .....
Category	**Characteristics**	**Risk Score**	**Date** ...../...../.....	**Date** ...../...../.....	**Date** ...../...../.....
Age	> 60 years	1			
Mental Status	Confusion / agitation at all times	1			
	Intermittent confusion / agitation	1			
History of falls	Fall(s) within last 2 weeks	1			
	Fall(s) within last 12 months	1			
Elimination	Catheter and / or Ostomy	1			
	Assistance required	1			
	Independent and incontinent	1			
Medications	3 or more medications	1			
Functional Status	Requires an appliance / gait aid	1			
	General weakness / debility	1			
	Hemiplegia	1			
	Amputee	1			
	Unsteady	1			
	Dizziness	1			
Physiological 1 pt each	Hypotension	1			
	Ethanol use	1			
Sensory deficit 1 pt each	Impaired vision	1			
	Impaired hearing	1			
	Comprehension problems	1			
Score range indicates the patients risk of fall. TOTAL					
Score Range: *L*ow risk: 0 - 3	*H*igh risk: 4 or more		*L / H*	*L / H*	*L / H*

Health Professional Name, Initial and Title

1. ..... Date:...../...../.....
2. ..... Date:...../...../.....
3. ..... Date:...../...../.....

FALLS PREVENTION STRATEGIES:

Low Risk: (0 - 3)

- Monitor / visual observation of patient routinely.

High Risk: (4 or more) Document falls risk on patient alert sheet.

- Falls risk bed card.
- Monitor / visual observation of patient ½ - 1 hourly.
- Supervise / assist with all transfers.
- Supervise / assist with hygiene and ADL.
- Request willing family / carer to sit with patient.
- Room close to reception area.
- Where appropriate reinforce with the patient the need to ask for assistance.
- In view of multi disciplinary assessment, *and*, if not detrimental to the patient's clinical condition:
  (a) Position mattress on the floor (*NB:* safe lifting policy). (b) Use of cot sides / restraints.

1. Falls assessment should be completed:
(a) within 24 hours of patient admission
(b) if significant change in patient condition including a fall
(c) on the day of discharge for those patients identified at risk of fall(s)
2. Score each category to best reflect the patient's characteristics and "total"
3. Implement the "Falls Prevention Strategies" that correspond to the patient's "score range". Strategies recommended are to be used in association with clinical assessment/judgement (see Strategies below)
4. RN/RM referral to physiotherapy for individuals identified at High Risk where a score includes:
   a) history of falls
   b) impaired functional status
   c) age > 60 years

STRATEGIES TO BE IMPLEMENTED FOR ALL PATIENTS

Environment:
- Orientate patient to the ward / unit.
- Items required by the patient are within reach.
- Call bell is working and within patient reach.
- Gait aids are within patient reach, as appropriate.
- Bed is in lowest position when patient is unattended.
- Immediate patient area is clutter free.
- Discuss patient safety needs with family / carer / visitors.
- Brakes are in locked position on bed, chair and locker.

Patient Education:
- Discuss strategies to avoid a fall(s) with patient.
  - rising slowly from a lying or sitting position.
  - correct fitting footwear.
  - correct fitting clothes (ie: not too long / too large).
  - ensure cords / ties are tied. (ie: dressing gown.)
- Discuss with patient how to obtain staff assistance.
  - reinforce use of call bell.

ADMISSION RISK SCREEN & ASSESSMENT TOOL

Tasmania
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ADMISSION RISK SCREEN & ASSESSMENT TOOL

To be commenced on admission to the hospital & completed within 24hours

LAUNCESTON GENERAL HOSPITAL

M.R.N.										

SURNAME ..... D.O.B. .....
OTHER NAMES ..... SEX
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..... REL.

LABEL

Principle reason for admission: _____

_____

Known Allergies: _____

Language spoken: _____ Interpreter required ☐ Yes ☐ No
Refugee Health ☐ Yes ☐ No

PATIENT'S LIVING ARRANGEMENTS
- ☐ Lives Alone
- ☐ Lives with _____
- ☐ Pt lives in hostel
- ☐ Pt cares for _____
- ☐ Homeless
- ☐ Other _____

Residential Care
- ☐ Low Level
- ☐ High Level
- ☐ Respite
- ☐ Other _____

SUPPORT SERVICES CURRENTLY USED
- ☐ NO SERVICES
- ☐ Community Nursing
- ☐ DVA Nursing
- ☐ Personal Care by: _____
- ☐ Domestic Assistance by: _____
- ☐ Delivered Meals by: _____
- ☐ Palliative Care Service
- ☐ Personal Alarm
- ☐ In home respite by: _____
- ☐ Day Centre: _____
- ☐ Social Support (shopping, bills ..) by: _____

- ☐ Community Aged Care Package (CACP) _____
- ☐ Extended Aged Care in the Home (EACH) _____
- ☐ Transition Care Program (TCP)
- ☐ HACC Post Acute Care Package
- ☐ HACC Home Independence Program
- ☐ Case Manager (contact) _____
- ☐ Other (specify) _____

Support Services notified of admission?
- ☐ Yes
- ☐ Date ____/____/____
- ☐ Contact Name/No. _____

DISCHARGE PLAN
EXPECTED D/C (at time of assessment)
Expected length of stay
- ☐ Overnight ☐ 2 days
- ☐ > 2 days ☐ > 5 days
- ☐ Other _____

Pts admitted through POAU check form I C

CONTACT FOR DISCHARGE PLANNING:
Name _____
Relationship _____
Tel (H) _____
Tel (W) _____
Mobile _____
(See SELF CARE actions / referrals over)

Discharge Planning Comments:

RN Name: _____ **Date:** ____/____/____ **Signature:** _____

SUPPORT SERVICES REQUIRED FOR DISCHARGE (Sign & date when referral made)

	Sign	Date		Sign	Date
☐ **NO SERVICES** required			☐ Social (shopping, bills ...)		
☐ Community Nursing			☐ Day Centre		
☐ DVA Nursing			☐ CACP		
☐ Personal Care			☐ EACH		
☐ Domestic Assistance			☐ TCP		
☐ Delivered Meals			☐ HACC Post Acute Care		
☐ Palliative Care Service			☐ HACC Home Independence		
☐ Personal Alarm			☐ State-wide Continence		
☐ In home respite			☐ Case Manager _____		
			☐ Other (specify) _____		

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FALLS RISK ASSESSMENT TOOL AND GUIDELINES
ADMISSION RISK SCREEN & ASSESSMENT TOOL

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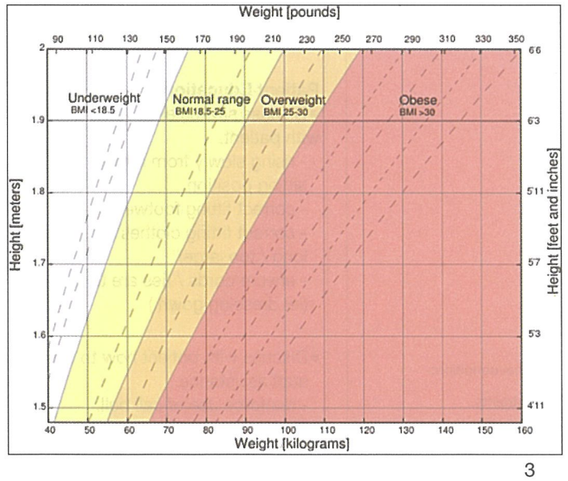
Assessment & risk screen to be attended within 24hours of admission with actions and referrals documented. "Yes" scores indicate a need for further assessment, action or referral.

	Risk Factor	Y	N	Action / Referral	Date/ Sign
Self Care	• Is there evidence of concern about self care? • Does the patient need chronic disease education / support / monitoring? • Does the patient have hearing / visual deficit? • Has the patient had multiple admissions? • Does the patient / carer need assistance to manage community & financial affairs? • Are problems with self care likely to be ongoing? • Has the pt had an ACAT assessment/referral?			☐ Nursing care strategies _____ ☐ OT ☐ SW ☐ Specialiy Nurse/service _____ ☐ Chronic Care programs _____ ☐ Other _____ **ACTION:** D/C Plan	
Skin Integrity	Does the pt have: • A new or existing wound? • Other alteration in skin integrity (e.g. redness, abrasion, bruising)? • Difficulty with bed mobility? • Pressure risk (Refer to Braden Pressure Ulcer Scale) Pressure risk ☐ High ☐ Mod/Mild ☐ None			☐ Nursing care strategies _____ ☐ Wound Care Nurse ☐ OT ☐ Other e.g. Spinal Nurse _____ **ACTION:** Pressure risk minimisation strategies.	
Foot Care	• Are you concerned about foot health? • Does patient have altered foot sensation? • Does patient have altered leg/foot circulation?			☐ Nursing care strategies _____ ☐ Podiatrist /Diabetes Pod. ☐ Other _____	
Oral Care	• Is there evidence or concern about oral hygiene/dentures? • Are there alterations to oral mucosa? • Has pt had Chemo/Radiation/marrow transplant in the last 7 days? • Is assistance with oral care required?			☐ Nursing care strategies _____ ☐ Other _____	
Nutrition	• Has the pt had significant unintentional weight loss (≥3kgs) in the last 3-6 months? • Is there >3day history of nausea / vomiting / diarrhoea / poor appetite? • Does the pt require specialised / diabetic / modified / allergy free diet? • Is there history of constipation? • Does the pt require enteral feeding? • Does pt need physical assistance with eating or drinking?			☐ Nursing care strategies _____ ☐ Dietitian ☐ Speech Pathology ☐ Diabetes educator ☐ Other _____ **ACTION:** Weight _____ Height _____ BMI* _____ Baseline BGL _____ (BMI should be regarded as a guide only)	
Swallow	• Does the pt have difficulty swallowing foods, fluids, medications or saliva? • Is there a history of aspiration / pneumonia? • Does the pt cough or dribble on swallowing?			☐ Nursing care strategies _____ ☐ Speech Pathology ☐ Other _____	
Continence	Is there evidence of: • Urinary Incontinence, stress, urgency & / or frequency? • Change in bowel habits? • Faecal incontinence • Stoma / catheter • Continence aids used?			☐ Nursing care strategies _____ ☐ Continence Nurse ☐ Stomal Therapist ☐ Other _____ **ACTION:** Urinalysis	

	Risk Factor	Y	N	Action / Referral	Date/ Sign
Mobility	• Was the pt admitted with a fall related injury / condition? • Does the pt need assistance to mobilise? • Does the pt need assistance to transfer? • Does the patient score > 1 x dot on the Red Dot Mobility Score? ● ●● ●●● ●●●●			☐ Nursing care strategies _____ ☐ OT ☐ Physio ☐ Other _____ **ACTION:** Red Dot Mobility Score	
Pain	• Is there history of chronic pain? • Does patient have uncontrolled pain? • Are there side effects to pain management that need monitoring?			☐ Nursing care strategies _____ ☐ Medical Team ☐ Other _____	
Pharmacy	• Does the pt / carer require assistance to manage their medications? • Does the pt use an administration pack? • Has the pt had multiple medication changes over the last 12 months?			☐ Nursing care strategies _____ ☐ Medical Team ☐ Other _____ **ACTION:** D/C plan	
Verbal comm.	• Are there any new problems speaking? • New difficulty understanding simple instructions? • Are there other verbal communication issues?			☐ Nursing care strategies _____ ☐ Speech Pathology ☐ Other _____	
Emotion, Cognition Behaviour	• Memory / cognitive impairment? • Loss of consciousness/concussion? • Episodes of delirium/altered behaviour? • Current confusion/wandering? Signs or history of: • Acute stress/anxiety? • Depression or feeling down? • Other mental health issues?			☐ Nursing care strategies _____ ☐ OT / Neurophysiologist ☐ Medical team ☐ Diabetes Psychologist ☐ Psych Liaison Nurse ☐ Outpatients Mental Health ☐ Other _____	
Lifestyle	• Does the pt smoke tobacco? Amount/day _____ • Is there evidence or history of sedative / substance abuse? _____ • Has the Alcohol Audit-C been completed? • Score _____			☐ Nursing care strategies _____ ☐ Smoking Cessation Nurse ☐ Drug & Alcohol Services ☐ Medical Team ☐ Other _____ **ACTION:** ABC , Audit-C strategies, Alcohol Withdrawal Scale.	

Name	Initial	Date	Name	Initial	Date



RED DOT MOBILITY CHECKLIST

●	• Ambulates with or without walking aid • Needs minimal assistance
● ●	• Ambulates with the assistance of one (1) person and/or walking aid • Walk belt and / or pull to stand device PRN • One (1) person for assistance getting in and out of bed • One (1) person for assistance with standing and sitting • One (1) person to assist for bed mobility
● ● ●	• Ambulates with the assistance of two (2) people and/or walking aid • Walk belt and/or pull to stand device and/or hoist PRN • Two (2) people for assistance getting in and out of bed • Two (2) people for assistance with standing and sitting • Slide sheet essential for bed mobility
● ● ● ●	• Non ambulatory patient • Hoist transfer • Two (2) or more people to assist patient as required • Slide sheet essential for bed mobility

Assess patient each shift