

SCREEN

Falls Screen on admission

Identify at risk patients

Falls Assessment to identify risk factors

ASSESS & IDENTIFY RISKS

Patient specific

- **Cognition**
- **Mobility & transfer skills**
- Incontinence
- Medical conditions
- Medication review
- Vision/hearing
- Footwear & clothing

Environmental

- Lighting
- Bed height
- Room free of clutter
- Mobility aids
- Call bell

Is patient able to engage in joint planning of preventative strategies?

PREVENTION

NO

(includes those with *cognitive impairment or dementia*)

YES

Strategies

- Increase observation
- Move patient close to the nurse's station
- Sitters program
- Supervise mobilisation and toileting

Strategies

- Medication review avoid sedatives, hypnotics or anti-psychotics
- **Regular toileting plan**
- Orientation to ward
- Call bell within easy reach
- Lo/lo beds / bed at lowest height and brakes on
- Night lights
- Mobility aids checked
- Glasses and hearing aids within easy reach
- Use of non-slip footwear and mats/flooring
- Area clear of hazards
- Use of alarm devices
- Use of Hip protectors
- Referral to Allied health
- Involve family – education and care about the seriousness of Falls
- Provide patient with information about Falls

REASSESS

Reassess, document and communicate to staff if patients condition changes eg delirium, change of ward etc

POST FALL

Reassess, implement, document and communicate to staff post fall assessment and management plan