**Falls Healthcare Plan**

| **Name:** | FirstName LastName | | | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- | --- | --- |
| **These are my diagnoses that increase my risk of falls:** | | | List all diagnoses that increase risk of falls, or indicate if there are none. | | |
| **I am allergic to these things:** | | | List all known allergies and sensitivities, or note if there are none | | |
| **The goal of this Healthcare Plan is:** | | | I will remain free of falls for ## days/months.  Describe any other goal related to helping me remain free of injuries from falls. | | |
| **Progress in the past year:** | | | How many times have I fallen in the past year and how does this compare with the year before? | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY if:**  **🡪 I lose consciousness (become unresponsive).**  **🡪 I have an injury that cannot be treated with basic First Aid (including suspected fracture).**  **🡪 I have hit my head.**  **🡪 I indicate that I am in pain and you cannot tell what is causing it.**  **🡪 I have fallen during a seizure.**  **🡪 Describe any additional instructions here.** | | | | | |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL**  **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | | | |
| **ALWAYS HELP ME SEEK MEDICAL ATTENTION AFTER ANY FALL, EVEN IF MY FALL HAS NOT RESULTED IN A MEDICAL EMERGENCY. FOLLOW UP WITH MY PCP OR URGENT CARE TO MAKE SURE I DO NOT HAVE AN INJURY THAT SUPPORTERS CANNOT SEE.** | | | | | |
| **Supporters should be aware these things about me that make it more likely that I will fall:** | | | I am not able to walk.  I have weakness in my legs.  I have peripheral neuropathy (weakness, numbness, and/or pain in my feet and hands).  I have diabetes, Parkinson’s disease, arthritis, dementia, or other diagnosis that affects my gait and balance.  One side of my body is weaker than the other.  I have a seizure disorder.  I have a visual impairment.  I take medications that make me tired, dizzy, or weak.  I take psychotropic medications and/or seizure medications.  I have postural hypotension (My blood pressure drops when I get up too quickly).  I have chronic pain.  I have insomnia.  I have urinary urgency (strong and sudden need to urinate).  I have had a stroke.  I move suddenly and impulsively and will not ask for help in standing or walking.  I sometimes display combative or self-injurious behavior.  Other Describe any other things about me that make it more likely I will fall, or indicate if there are none. | | |
| **Supporters should be aware that these things about my environment and activities increase my risk of falling:** | | | Changes in the surface floor surfaces, such as from tile to carpet  Uneven ground in outside areas  Poor lighting  Transitions from one position to another, including getting in and out of vehicles  Transitions from one type of equipment to another, including wheelchairs and other positioning equipment  Cluttered environments  Stairs, especially those without handrails  Wet surfaces, particularly in the bathroom  Lack of grab bars in the bathroom  I use a cane or walker.  Noisy, chaotic, or otherwise distracting environments  Other Describe any other things about the environment or activities that make it more likely that I will fall, or indicate if there are none. | | |
| **This is how to support me to lower the risk of injury from falls:** | | | Make sure that I am wearing proper footwear (flat, well-fitting, rubber soled shoes) before any walking or transfers.  Follow procedures established for safe ambulation and transfers, including use of equipment such as lift and gait belt.  Keep floors dry and free of clutter.  Make sure any areas where I am walking or transferring are well-lit.  Encourage me to use grab bars in the bathroom.  When I am changing positions, encourage me to take my time so that I do not get dizzy and lose my balance.  Make sure my pressure alarm (bed or chair) is working if I am alone in my room, so that supporters can be alerted when I start to transfer.  Make sure that any devices I have for cushioning during falls are available. Describe cushioning and shielding devices uses, e.g., hip pads, floor mats, or indicate if there are none.  Other Describe any other supports I need to reduce the likelihood of falling, or indicate if there are none. | | |
| **When I have fallen, these are the things supporters should do to help me:** | | | If I have fallen due to a seizure, follow my seizure healthcare plan.  Make sure that I am as comfortable as possible.  Notify the nurse.  If I can safely move, help me to sit or lie down comfortably.  If I have a minor cut or scrape, provide First Aid.  Other Describe any other things that need to be done when I have fallen, or indicate if there are none. | | |
| **Documentation:** | | Describe the things that supporters should write down and where they should write them down. | | | |
| **Nursing Intervention:** | | Describe those things that must be done by the nurse relative to falls prevention or response, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. | | | |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

RN Typed Name and Agency

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