**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

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