### 3M: Sample Care Plan

**Background:** Developing a care plan specific to the needs of each individual patient is critical. This tool is a sample care plan that gives specific examples of actions that should be performed to address a patient’s needs.

**Reference:** Adapted from National Health Service document Slips, trips, and falls in the hospital, available at [www.nrls.npsa.nhs.uk/resources/?EntryId45=59821](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59821). This report is based on Healey F, Monro A, Cockram A, et al. [Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial.](http://www.ncbi.nlm.nih.gov/pubmed/15151914) Age Ageing 2004;33(4):390-5.

**How to use this tool:** This tool includes examples of interventions that may be considered for specific fall risk factors. These should be tailored to meet the needs of your patient. The original care plan was completed for patients with any of the following:

* Fall since admission.
* Attempt to walk alone unsteady/unsafe.
* Patient or relatives anxious about falls.

Your hospital unit may use these factors alone or in combination with additional factors to trigger use of the care plan. This tool should be used collaboratively by staff nurses with input from other disciplines (e.g., physician, pharmacist, physical or occupational therapists). If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

Individualize the care plan to address the needs of at-risk patients.

##### Care Plan

| GOAL: To reduce likelihood of falls while maintaining dignity and independence | State action taken below (sample provided): |
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| **Call.** Ensure call bell explained and in reach. Consider alternatives for patients unable to recall use of call bell, e.g., use brass bell, move bed in sight of nurses’ station. | Call bell in reach but may forget, will probably call her daughter’s name instead; moved within earshot of nurses’ station. |
| **Eyesight.** Ensure eyesight is checked and patient is wearing glasses if needed. Can the patient identify pen/key from bed length away? If eyesight is too poor to identify objects, ask the treating medical provider to review. Ensure glasses/hearing aid are worn or within reach. | Glasses broken in fall at home; family has ordered replacement and hopes to provide it tomorrow. Has fair distance vision without them. Have suggested that the family order a spare pair too. |
| **Bed and bedrails.** Assess the need for bedrails (refer to policy). If patient is likely to fall from bed, ensure bed is at the lowest possible height unless this would reduce mobility or independence. Consider use of special low bed. | Bedrails not appropriate as this patient can mobilize on her own, even though unsteady, and might be confused enough to climb over. Bed set at right height for safe move from sitting to standing. |
| **Medication.** Check for medication associated with fall risk, such as antidepressants, sleeping tablets, sedatives, and antipsychotics. Ask the pharmacist to review and make recommendations to treating medical provider (do not stop abruptly). | On temazepam 15 mg qhs for some years; will discuss with pharmacist. |
| **Mobility.** Determine the patient’s level of mobility and whether actions should be taken to improve or maintain mobility. | Participating in supervised mobility protocol with nursing assistant. Currently able to ambulate 50 feet with front wheeled walker daily. |
| **Interdisciplinary team.** Ensure medical staff, physical therapist, occupational therapist, social worker, and others on the team are aware of the patient’s risk, frequency, nature, and seriousness of falls (local protocol or pathway would cover expected actions by team members, e.g., cognitive evaluation, osteoporosis check, mobility aid review). | Treating physician aware of patient’s fall risk. Physical and occupational therapy referral sent on 11/14/11. Fall risk noted on discharge plan. |
| **Footwear.** Check footwear for secure fit, nonslip sole, no trailing laces. Ask relatives to supply safer replacement or supply new slippers from ward stock. Consider slipper socks in bed for patients at risk of falling at night. | Patient does not have footwear. Provided with new slippers from ward stock. |
| **Place.** Place patient in most appropriate place on the ward for his or her needs, e.g., close to nurses’ station, close to toilet, in quietest area (considering other patients’ needs as well). | Located nearest toilet and within earshot of nurses’ station. |
| **Lighting.** Consider lighting best for patient, e.g., bedside lamp left on overnight, night light in bathroom. | Will have overhead lamp on low overnight. |
| **Toilet.** Does the risk of falls appear to be associated with patient’s need to use toilet? If so, a routine of frequent toilet visits may help prevent falls. | Currently the patient has frequency/urgency; being treated for urinary tract infection. Will offer toilet every hour while patient is awake. |
| **Inform.** Provide falls education brochure to patient/family, engage them in care plan, find out contact wishes in event of fall. | Patient and daughter have falls education brochure, and care plan has been explained. Contact wishes entered into chart. |

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