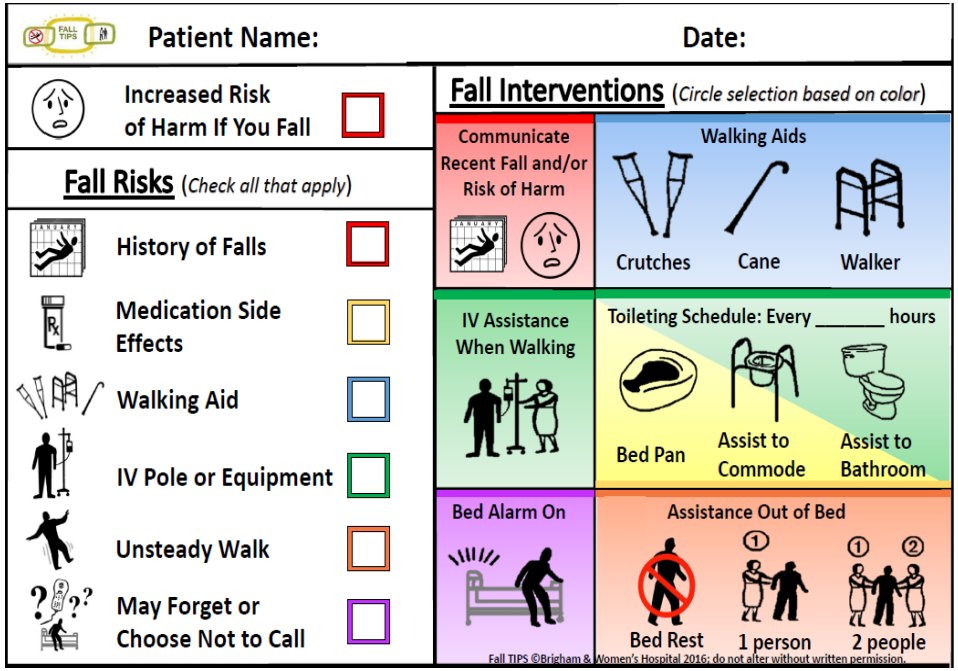
Fall TIPS Common Misconceptions: Assessment/Planning

- ✓ Select the *Walking Aid* that the patient should be using (even if they currently use furniture).
- ✓ *History of Falls* is the factor indicating the patient will likely fall again and under similar circumstances. *Communicate* the details of recent falls via the care plan and change of shift report. Update risk(s) and fall intervention(s) needed to prevent a similar fall.
- ✓ When *Med Side Effects* and/or *IV* risks are selected, then consider *Toileting Schedule* and any *Assistance* that might be needed to prevent a fall related to med side effects and/or increased fluids.



- ✓ If the patient has a hep lock but is not getting any meds or fluids, select the *IV Pole or Equipment* risk factor. There is no intervention necessary, but the patient's status may change quickly so it is a risk factor.
- ✓ *Bed Alarm On* is **only** appropriate for patients who have demonstrated, or nursing judgement indicates, that they will not reliably call for help. Patients who have fallen before or are high risk for falls do not automatically warrant a bed alarm.
- ✓ Update *Name* and *Date* every day so that all team members can trust that the assessment and plan are for the current patient and are up-to-date. This also applies to independent patients without any fall risk factors.