NSQHS Standard 5 Comprehensive Care Definitions sheet – Edition 2

Comprehensive Care Audit Tools Definitions

The following definitions and examples apply to the Comprehensive Care Audit Tools:

Comprehensive care planning and delivery

Comprehensive care at the end of life

Preventing and managing pressure injuries

1. Pressure Injury Support Surfaces Information
2. Pressure Injury Risk Assessment
3. Pressure Injury Prevention and Management Plan
4. Comprehensive Skin Inspection Information
5. Non-Surgical Wound Information
6. Pressure Injury Staging Guide

Note: The information in this document is taken from the Queensland Bedside Audit (QBA) information sheets.

Preventing falls and harm from falls

1. Bed Rails
2. Falls Risk Screen and Assessment
3. Falls Prevention Plan (FPP)

Note: The information in this document is taken from the Queensland Bedside Audit (QBA) information sheets.

Nutrition and hydration

Preventing delirium and managing cognitive impairment

Comprehensive care at the end of life

https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life

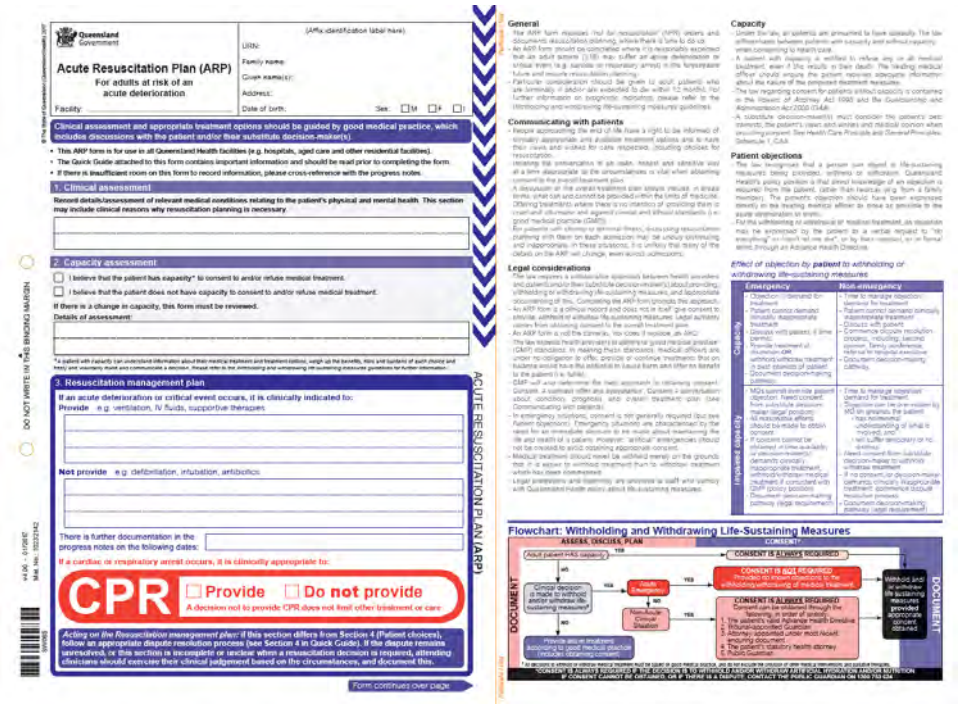
https://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/

National Consensus Statement: essential elements for safe and high-quality end-of-life care 2015, https://www.safetyandquality.gov.au/wp-content/uploads/2015/05/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf

ACSQHS end of life care patient audit tool and clinician survey
https://www.safetyandquality.gov.au/audit-toolkit-home/tools#end-of-life-care-audit-tool

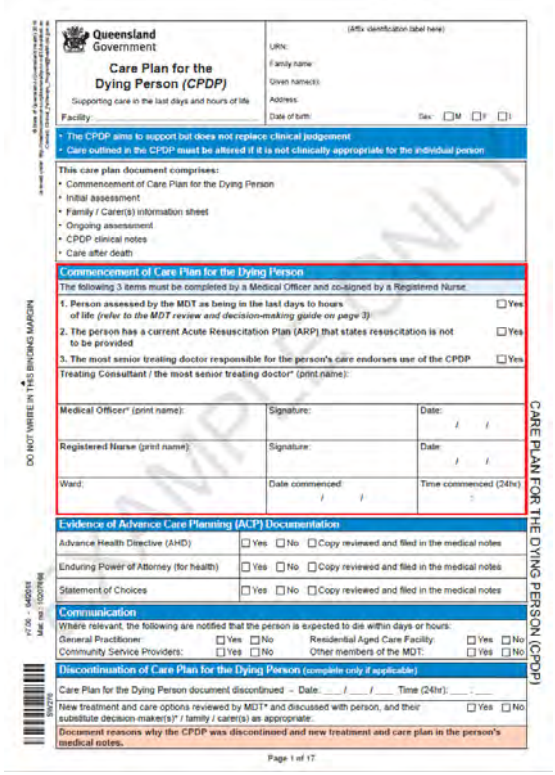
Acute Resuscitation Plan

https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688267/sw065-acute-resus-form.pdf



Care Plan for the Dying Person

https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/care-plan-dying-person.pdf



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Care Plan for the Dying Person (CPDP)

Supporting care in the last days and hours of life

Facility:

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐M ☐F ☐I

- The CPDP aims to support but does not replace clinical judgement
- Care outlined in the CPDP must be altered if it is not clinically appropriate for the individual person

This care plan document comprises:

- Commencement of Care Plan for the Dying Person
- Initial assessment
- Family / Carer(s) information sheet
- Ongoing assessment
- CPDP clinical notes
- Care after death

Commencement of Care Plan for the Dying Person

The following 3 items must be completed by a Medical Officer and co-signed by a Registered Nurse

1. Person assessed by the MDT as being in the last days to hours of life *(refer to the MDT review and decision-making guide on page 3)* ☐Yes
2. The person has a current Acute Resuscitation Plan (ARP) that states resuscitation is not to be provided ☐Yes
3. The most senior treating doctor responsible for the person's care endorses use of the CPDP ☐Yes

Treating Consultant / the most senior treating doctor* (print name):

Medical Officer* (print name):	Signature:	Date: / /
Registered Nurse (print name):	Signature:	Date: / /
Ward:	Date commenced: / /	Time commenced (24hr): :

Evidence of Advance Care Planning (ACP) Documentation

Advance Health Directive (AHD)	☐Yes ☐No	☐Copy reviewed and filed in the medical notes
Enduring Power of Attorney (for health)	☐Yes ☐No	☐Copy reviewed and filed in the medical notes
Statement of Choices	☐Yes ☐No	☐Copy reviewed and filed in the medical notes

Communication

Where relevant, the following are notified that the person is expected to die within days or hours:

General Practitioner ☐Yes ☐No Residential Aged Care Facility ☐Yes ☐No
Community Service Providers: ☐Yes ☐No Other members of the MDT: ☐Yes ☐No

Discontinuation of Care Plan for the Dying Person (complete only if applicable)

Care Plan for the Dying Person document discontinued – Date: ___ / ___ / ___ Time (24hr): ___ : ___

New treatment and care options reviewed by MDT* and discussed with person, and their substitute decision-maker(s)* / family / carer(s) as appropriate. ☐Yes ☐No

Document reasons why the CPDP was discontinued and new treatment and care plan in the person's medical notes.

DO NOT WRITE IN THIS BINDING MARGIN

CARE PLAN FOR THE DYING PERSON (CPDP)

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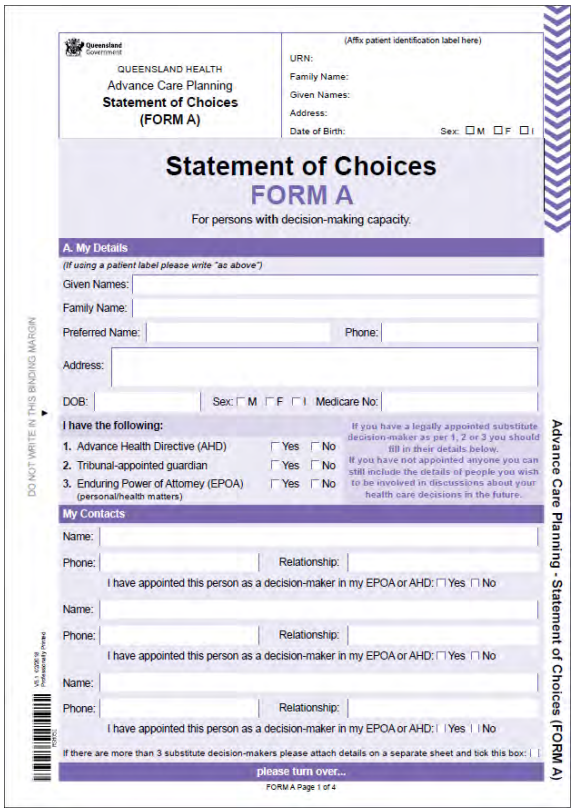
Statement of Choices

https://metrosouth.health.qld.gov.au/acp/statement-of-choices-form



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QUEENSLAND HEALTH
Advance Care Planning
Statement of Choices (FORM A)

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐I

Statement of Choices
FORM A

For persons with decision-making capacity.

A. My Details

(If using a patient label please write "as above")

Given Names:
Family Name:
Preferred Name: Phone:
Address:
DOB: Sex: ☐M ☐F ☐I Medicare No:

I have the following:

1. Advance Health Directive (AHD) ☐Yes ☐No
2. Tribunal-appointed guardian ☐Yes ☐No
3. Enduring Power of Attorney (EPOA) (personal/health matters) ☐Yes ☐No

If you have a legally appointed substitute decision-maker as per 1, 2 or 3 you should fill in their details below.
If you have not appointed anyone you can still include the details of people you wish to be involved in discussions about your health care decisions in the future.

My Contacts

Name:
Phone: Relationship:
I have appointed this person as a decision-maker in my EPOA or AHD: ☐Yes ☐No

Name:
Phone: Relationship:
I have appointed this person as a decision-maker in my EPOA or AHD: ☐Yes ☐No

Name:
Phone: Relationship:
I have appointed this person as a decision-maker in my EPOA or AHD: ☐Yes ☐No

If there are more than 3 substitute decision-makers please attach details on a separate sheet and tick this box: ☐

please turn over...

FORM A Page 1 of 4

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Advance Care Planning - Statement of Choices (FORM A)

Advance Health Directive

https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/advance-health-directive

Power of Attorney

https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/power-of-attorney

1. Pressure Injury Support Surfaces Information

Definitions*[1]*:

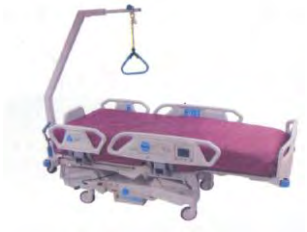
Support Surfaces *are "specialised devices for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions, i.e. any mattress, integrated bed system, mattress replacement, overlay or seat cushion overlay".*[1]

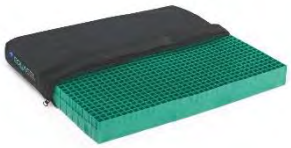
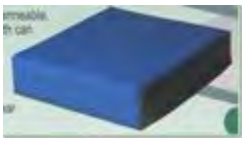
Active Support Surface *is a powered support surface that produces alternating pressure through mechanical means and has the ability to change its load distribution properties with or without an applied load.*

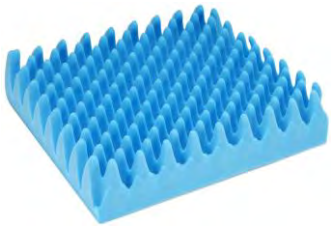
Reactive Support Surface *is a powered or non-powered support surface with the ability to change its load distribution properties only in response to an applied load.*

[1] Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines 2014

Bedding	Description
Standard pressure reducing foam mattress (now called Reactive (unpowered) foam mattress) 	Pressure redistribution mattresses are used for therapeutic pressure reduction and patient comfort. They should be placed directly on top of the bed frame. For Queensland Health facilities, the **minimum requirement** is that a pressure reactive unpowered foam mattress should be available on all beds. A variety of standard foam mattresses are available and vary in size, density, thickness, and weight capacities (e.g. Cirrus1A, Maxifloat, Pentaflex, SoftForm, Soft Touch, SXS198 Simuflex, NP200).
Pressure reducing overlay - unpowered **(now called Reactive (unpowered) overlay)** 	Unpowered overlay devices that may be composed of gel, air, foam or a combination of these products.
Alternating mattress - replacement **(now called Active (powered) alternating mattress replacement)** 	Alternating air mattresses replace reactive (unpowered) foam mattresses (e.g. Active– Alpha Response 4, Auto logic 200, Bi-wave Carer, Cairwave, ClinActiv, Nimbus, Nodec 3, Proficare, Talley Quattro). They should be placed directly on top of the bed frame.
Alternating mattress - overlay **(now called Active (powered) alternating mattress overlay)** 	Alternating mattress overlays are used in conjunction with reactive (unpowered) foam mattresses and are placed on top of these mattresses and not directly on the bed frame (e.g. Autologic 110, AlphaXcell, Alpha Response 3).

Special/self-adjusting mattress **(now called Reactive (powered/unpowered) self-adjusting mattress)**  	High specification mattresses for pressure redistribution and are at constant low pressure (not alternating or low air loss). They can be specialty foam with air cells (e.g. Accumax, AtmosAir). They should be placed directly on top of the bed frame. In some instances a pump may be attached to the mattress.
Specialty bed system **(now called Powered specialty bed system)** 	An integrated bed and mattress system which incorporates a bed frame and a powered mattress or surface which is alternating, low air loss, constant low pressure, or air-fluidised for the purpose of redistribution. They may offer kinetic movement, bariatric capabilities, various positioning options, and imaging compatible surfaces. Bed and mattress cannot be used exclusively of each other (e.g. Total Care Bed, Therapulse, Versa Care, Total lift, In Touch, Progressa, Compella).
Vinyl mattress 	Vinyl covered, single layered foam mattress. This is not considered a static device as the vinyl does not conform to the pressure load applied. **Vinyl mattresses should not be in use.** **Vinyl mattresses are no longer recommended in Queensland Health.**
Chairs	
Pressure reducing chair **(now called Reactive chair)** 	Pressure redistribution chairs at the bedside are more than the standard bedside chair. They do not require a foam cushion to be put on top of the seat surface because an integrated cushion with specialty foam is built into the chair, as well as a specialty cover. Note: There is a two-way stretch vapour permeable fabric over high density foam.
Cushion – air/gel, foam, other **(now called Reactive/Active cushion)**	Unpowered devices that may be composed of gel, air, foam or a combination of these products. The cushion is used in place of or in addition to a basic chair/wheelchair base/cushion. These products are <u>not</u> alternating or low air loss (**reactive**) (e.g. Jay, Roho, Equagel, MacMed). Foam cushions should be high density foam with similar construction to the reactive (unpowered) foam mattress.

   	Cushions that are used in place of or in addition to a basic chair/ wheelchair base/ cushion and are powered, alternating or low air loss (**active**) (e.g. Aura).
Positioning devices	
Gel pads  	Gel pad used for positioning or to reduce shear and to provide pressure redistribution.
Heel elevator   	Heel elevator or boot wedge used for positioning or to reduce shear and to provide pressure redistribution. Device may present in various ways- foam, fibre, air filled.
Bed cradle 	Bed cradle used for offloading of bed linen.
Extra pillow	Extra pillow can be used for pressure relieving if no other devices are available.

Other    	**Prophylactic silicone dressing** Applied to "at risk" areas to reduce the potential for pressure area development. **Eggshell or convoluted foam** Any other equipment item used to facilitate comfort, positioning or to reduce shear and friction not listed above e.g. eggshell or convoluted foam devices, slide sheets, limb elevation devices. Note: Eggshell or fibre-filled overlays may provide some comfort or protection from friction, however are **not** recommended for use on top of support surfaces as they may limit the device's pressure redistribution properties. **Sheepskin** Sheepskins provide comfort only and are **not** pressure redistribution devices.

2. Pressure Injury Risk Assessment

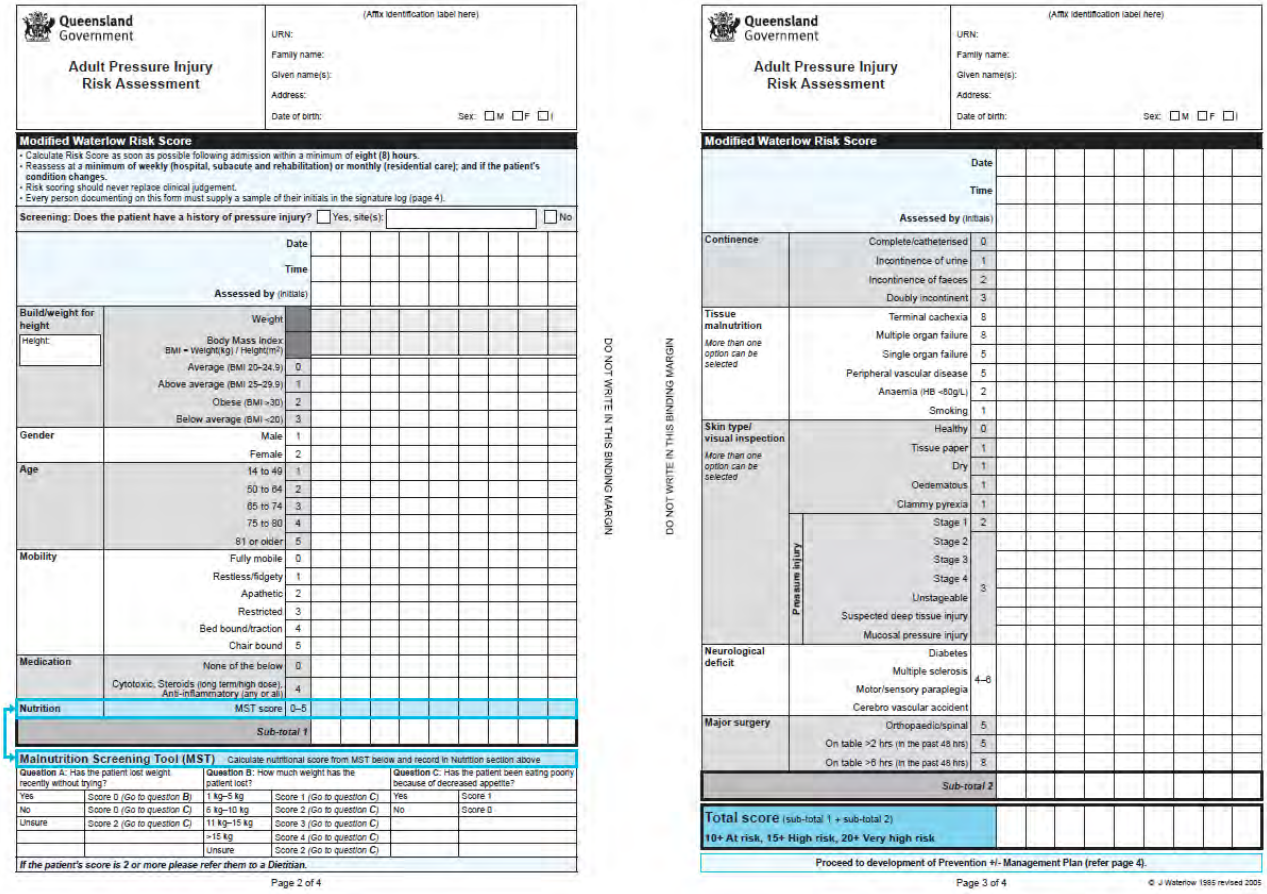
The health service organisation providing the service to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines.[1,5] A pressure injury risk assessment is a formal scale, or score used to determine the degree of pressure injury risk.

Examples of validated scales for assessing pressure injury risk in adults include the Waterlow Score, Braden Scale and Norton Scale.[2] Examples of validated scales for paediatric patients include the Glamorgan Risk Assessment Scale and Braden Q. Risk assessment may also occur using an integrated risk assessment tool, or assessment of risk factors in conjunction with a comprehensive skin inspection. The statewide "Adult Pressure Injury Risk Assessment" form combines a skin inspection, risk assessment and management plan.

Each patient should be assessed for pressure injury risk as soon as possible following admission (within eight hours) and the assessment repeated regularly throughout the patient's admission.[2] The results should be documented in the appropriate admission form/nursing care plan or patient record.

In facilities not using an integrated risk form, or the "Adult Pressure Injury Risk Assessment" form, ongoing risk assessment may be documented in the "Patient Daily Care Record" or other generic care plan, and a "Pressure Injury Prevention Plan" may then be commenced for at risk patients.

Adult Pressure Injury Risk Assessment form example



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Adult Pressure Injury Risk Assessment

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐M ☐F ☐I

Modified Waterlow Risk Score

- Calculate Risk Score as soon as possible following admission within a minimum of **eight (8) hours.**
- Reassess at a **minimum of weekly (hospital, subacute and rehabilitation) or monthly (residential care); and if the patient's condition changes.**
- Risk scoring should never replace clinical judgement.
- Every person documenting on this form must supply a sample of their initials in the signature log (page 4).

Screening: Does the patient have a history of pressure injury? ☐ Yes, site(s): ☐ No

			Date	Time	Assessed by (initials)
Build/weight for height	Weight				
Height:	Body Mass index BMI = Weight(kg) / Height(m²)				
	Average (BMI 20–24.9)	0			
	Above average (BMI 25–29.9)	1			
	Obese (BMI >30)	2			
	Below average (BMI <20)	3			
Gender	Male	1			
	Female	2			
Age	14 to 49	1			
	50 to 64	2			
	65 to 74	3			
	75 to 80	4			
	81 or older	5			
Mobility	Fully mobile	0			
	Restless/fidgety	1			
	Apathetic	2			
	Restricted	3			
	Bed bound/traction	4			
	Chair bound	5			
Medication	None of the below	0			
	Cytotoxic, Steroids (long term/high dose), Anti-inflammatory (any or all)	4			
Nutrition	MST score	0–5			
	Sub-total 1				

Malnutrition Screening Tool (MST) Calculate nutritional score from MST below and record in Nutrition section above

Question A: Has the patient lost weight recently without trying?		**Question B:** How much weight has the patient lost?		**Question C:** Has the patient been eating poorly because of decreased appetite?	
Yes	Score 0 *(Go to question B)*	1 kg–5 kg	Score 1 *(Go to question C)*	Yes	Score 1
No	Score 0 *(Go to question C)*	6 kg–10 kg	Score 2 *(Go to question C)*	No	Score 0
Unsure	Score 2 *(Go to question C)*	11 kg–15 kg	Score 3 *(Go to question C)*		
		>15 kg	Score 4 *(Go to question C)*		
		Unsure	Score 2 *(Go to question C)*		

If the patient's score is 2 or more please refer them to a Dietitian.

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Queensland Government

Adult Pressure Injury Risk Assessment

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐M ☐F ☐I

Modified Waterlow Risk Score

			Date	Time	Assessed by (initials)
Continence	Complete/catheterised	0			
	Incontinence of urine	1			
	Incontinence of faeces	2			
	Doubly incontinent	3			
Tissue malnutrition *More than one option can be selected*	Terminal cachexia	8			
	Multiple organ failure	8			
	Single organ failure	5			
	Peripheral vascular disease	5			
	Anaemia (Hb <80g/L)	2			
	Smoking	1			
Skin type/ visual inspection *More than one option can be selected*	Healthy	0			
	Tissue paper	1			
	Dry	1			
	Oedematous	1			
	Clammy pyrexia	1			
	Pressure injury: Stage 1	2			
	Pressure injury: Stage 2	3			
	Pressure injury: Stage 3	3			
	Pressure injury: Stage 4	3			
	Pressure injury: Unstageable	3			
	Pressure injury: Suspected deep tissue injury	3			
	Pressure injury: Mucosal pressure injury	3			
Neurological deficit	Diabetes	4–6			
	Multiple sclerosis	4–6			
	Motor/sensory paraplegia	4–6			
	Cerebro vascular accident	4–6			
Major surgery	Orthopaedic/spinal	5			
	On table >2 hrs (in the past 48 hrs)	5			
	On table >6 hrs (in the past 48 hrs)	8			
	Sub-total 2				

Total score (sub-total 1 + sub-total 2)

10+ At risk, 15+ High risk, 20+ Very high risk

Proceed to development of Prevention +/- Management Plan (refer page 4).

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Validated scale for assessing pressure injury risk in paediatric patients – examples

Braden Q - includes a four-point Likert scale for assessment of seven clinical risk factors for PIs: sensory perception, moisture, activity, mobility, nutrition, tissue perfusion, friction and shear. A cumulative score is used to qualify the patient's PI risk as low, moderate or high.[3]

BRADEN Q SCALE: A risk assessment to be completed on admission and each 24 hours for patients with decreased level of mobility in relation to developmental age. Evidence of pressure ulcers will be defined using the classification system stage I to 4

Intensity and Duration of Pressure					Score
Mobility – Ability to change & control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to completely turn self independently	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	
Activity – The degree of physical activity	1. Bedfast Confined to bed	2. Chair Fast Ability to walk severely limited or non-existent. Cannot bear own weight &/or must be assisted into chair	3. Walks Occasionally Walks occasionally during day but for very short distances with or without assistance. Spends majority of each shift in bed or chair	4. All patients too young to ambulate OR walks frequently Walks outside the room at least twice daily and inside room at least once every 2 hours during waking hours	
Sensory Perception – The ability to respond in a developmentally appropriate way to pressure related discomfort	1. Completely Limited Unresponsive to painful stimuli due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has sensory impairment which limits the ability to feel pain or discomfort over half of body	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned OR has sensory impairment which limits the ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit, which limits ability to feel or communicate pain or discomfort	
Tolerance of the Skin and Supporting Structure					
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least every 8 hours.	3. Occasionally Moist Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely Moist Skin is usually dry, routine nappy changes, linen only requires changing every 24 hours.	
Friction – Shear Friction – occurs when skin moves against support surfaces Shear – occurs when skin and adjacent bony surface slide across one another	1. Significant Problem Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction	2. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No Apparent Problem Able to completely lift patient during a position change. Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	
Nutrition	1. Very Poor NBM &/or maintained on clear fluids, or IV's for more than 5 days OR albumin < 25mg/l	2. Inadequate Is on liquid diet or tube feedings/TPN which provide inadequate calories and minerals for age OR albumin < 30mg/l	3. Adequate Is on tube feedings or TPN which provide adequate calories and minerals for age OR albumin > 30mg/l	4. Excellent Is on a normal diet providing adequate calories for age. Does not require supplementation	
Tissue Perfusion and Oxygenation	1. Extremely Compromised Hypotensive (MAP < 50mmHg, < 40mmHg newborn) OR the patient does not physiologically tolerate position changes	2. Compromised Normotensive, Oxygen saturation may be < 95% OR haemoglobin may be < 100mg/l OR capillary refill may be > 2 seconds, Serum pH is < 7.40	3. Adequate Normotensive, Oxygen saturation may be < 95% OR haemoglobin may be < 100mg/l OR capillary refill may be > 2 seconds. Serum pH is normal	4. Excellent Normotensive, Oxygen saturation >95%, normal haemoglobin & capillary refill < 2 seconds	

Patient 'At Risk' / Mild Risk	'Moderate Risk'	'High Risk'	'Very High Risk'
16 - 23	13 – 15	10 - 12	9 or below

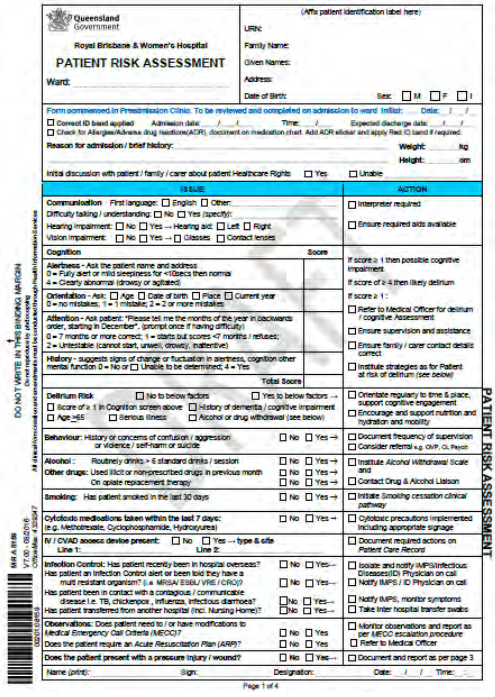
Glamorgan Risk Assessment Scale - clinical tool designed to help you assess risk of a child developing a pressure injury.

Risk Factor	Score
Child cannot be moved without great difficulty or deterioration in condition / prolonged surgery	20
Unable to change his/her position without assistance /cannot control body movement	15
Some mobility, but reduced for age	10
Normal mobility for age	0
Equipment / objects / hard surface pressing or rubbing on skin	15
Significant anaemia (Hb <90g/L)	1
Persistent pyrexia (temperature > 38ºC for more than 4 hours)	1
Poor peripheral perfusion (cold extremities/ capillary refill > 2 seconds / cool mottled skin)	1
Inadequate nutrition (any of the following) • Recently decreased/poor for ≥ 2 days • NG aspirates >10ml/kg or >200mls on ≥ 3 consecutive occasions NB. Any of the above requires dietitian referral.	1
Low serum albumin (< 35g/L)	1
Weight less than 10th centile (requires dietitian referral)	1
Incontinence (inappropriate for age)	1
Total score	

Risk score	Category	Suggested action
10+	At risk	Inspect skin at least twice a day. Relieve pressure by helping child to move at least every 2 hours. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.
15+	High risk	Inspect skin with each positioning. Reposition child / equipment/ devices at least every 2 hours. Relieve pressure before any skin redness develops. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.
20+	Very high risk	Inspect skin at least hourly. Move or turn if possible, before skin becomes red. Ensure equipment / objects are not pressing on the skin. Consider using specialised pressure relieving equipment.

Integrated risk assessment tool example

Integrated risk assessment tools can be a hybrid tool, with a screening and assessment component that may contain variable risk factor questions that prompt a pressure injury prevention action for each identified risk factor.


Queensland Government
Royal Brisbane & Women's Hospital
PATIENT RISK ASSESSMENT
Ward:
(Affix patient identification label here)
URN:
Family Name:
Given Names:
Address:
Date of Birth:
Sex:
ISSUE
ACTION
Cognition
Score
Total Score
Delirium Risk
Behaviour: History or concerns of confusion / aggression or violence / self-harm or suicide
Alcohol:
Other drugs:
Smoking:
Infection Control:
Observations:
Does the patient present with a pressure injury / wound?
Name (print):
Sign:
Designation:
Date:
Time:
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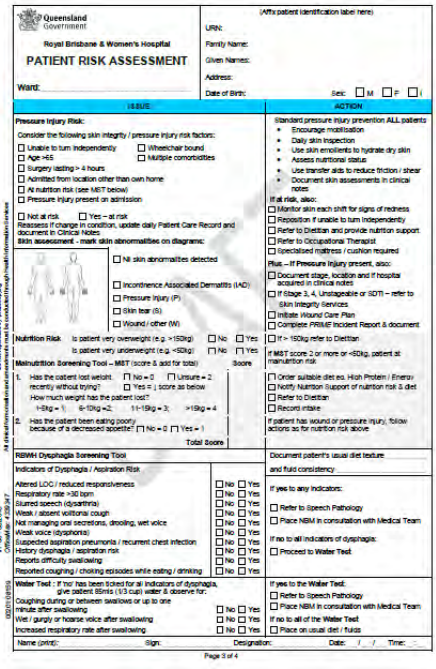
PATIENT RISK ASSESSMENT


Queensland Government
Royal Brisbane & Women's Hospital
PATIENT RISK ASSESSMENT
Ward:
(Affix patient identification label here)
URN:
Family Name:
Given Names:
Address:
Date of Birth:
Sex:
ISSUE
ACTION
Pressure Injury Risk:
Nutrition Risk
Malnutrition Screening Tool – MST (score & add for total)
Score
Total Score
RBWH Dysphagia Screening Tool
Indicators of Dysphagia / Aspiration Risk
Name (print):
Sign:
Designation:
Date:
Time:
Page 3 of 4

1. Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries (October 2012). Sydney http://www.internationalguideline.com/guideline.
2. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline- EPUAP, NPUAP, Pan Pacific Pressure Injury Alliance, Cambridge Media 2014.
3. Noonan, C., Quiley, S., & Curley, M. A.(2011) Using the Braden Q Scale to Predict Pressure Ulcer Risk in pediatric patients. *Journal of pediatric nursing 26 (6): 566-575* DOI: 10.1016/j.pedn.2010.07.006
4. Glamorgan Pressure Ulcer Risk Assessment Scale - For more information - CHQ Nursing standard 00260: Pressure Injury Screening, Management & Prevention: http://qheps.health.qld.gov.au/childrenshealth/resources/nursestand/docs/ns_00260.pdf
5. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Comprehensive Care. 2nd Ed. Sydney: ACSQHC; 2017.

3. Pressure Injury Prevention and Management Plan

Pressure Injury Prevention and Management Plan (PIPP) is defined as a single use or combination of interventions applied to a patient based upon a standardised risk assessment in order to reduce risk factors associated with Pressure Injury development. A PIPP, to be complete, should include interventions that minimise or eliminate friction and shear, minimise pressure with off-loading, manage moisture, and maintain adequate nutrition and hydration. Actions in the PIPP should address each of the identified risk factors. A PIPP must be documented at the bedside and 'not applicable' is written in the chart if the patient is not at risk. The PIPP should be current and as such should be for review in the daily care plan.

4. Comprehensive Skin Inspection Information

Skin status is the most significant early indicator of the skin's response to pressure exposure and the ongoing risk of pressure injury. Every patient should have a comprehensive skin inspection as soon as possible following admission (within eight hours)[2]. Reassessment should occur at a minimum of daily if 'at risk', on transfer, when there is a change in the patient's condition and on discharge. A comprehensive skin inspection must be systematic so that pressure injuries and wounds can be correctly identified and documented with an appropriate plan of care established.[3]

A **skin inspection** involves a comprehensive head-to-toe (anterior and posterior) assessment and **DIFFERS** from a **risk assessment** (e.g. Waterlow) that provides a formal scale/score to help determine the degree of risk for developing a pressure injury.

This inspection should include assessment for any signs of:

- erythema
- blanching response
- localised heat, oedema
- induration
- skin breakdown.

The inspection should specifically focus upon:

- skin overlying bony prominences including the sacral region, heels, ischial tuberosities and greater trochanters
- areas of skin that may be damaged due to medical related devices (e.g. braces, splints, harnesses, cervical collars, hip protectors, compression garments)
- areas identified by the patient where pressure is causing pain or discomfort.

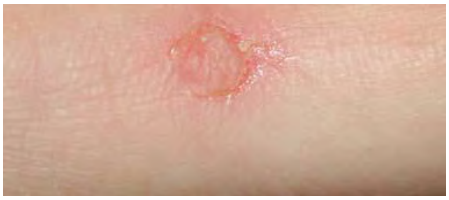
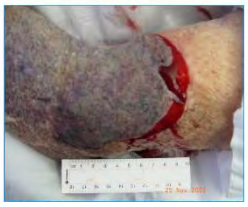
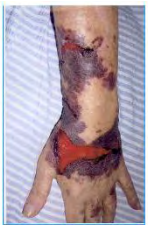
[2] National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (ed.) Cambridge Media: Osbourne Park, Western Australia: 2014

[3] Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries (October 2012) Sydney

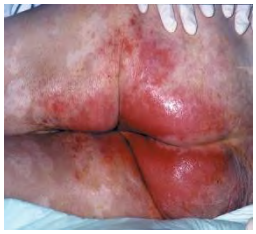
5. Non-Surgical Wound Information

Non-surgical wounds disrupt the integrity of the skin, increasing the risk of infection and can be the source of physical and emotional discomfort. A non-surgical wound such as a Skin Tear, Incontinence Associated Dermatitis (IAD) or a Chronic Vascular Ulcer can affect patients in our care, and are sometimes confused with a pressure injury. It is important to define and distinguish these wounds from pressure injuries for reporting purposes and to ensure appropriate management strategies are implemented.

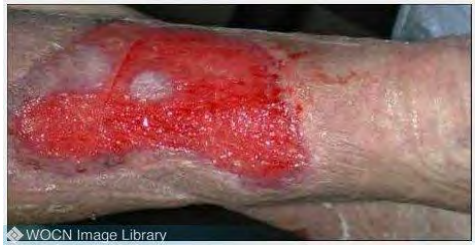
Skin Tear – is a wound caused as a result of shear and/or friction forces which separate the epidermis from the dermis, or separate both epidermis and dermis from underlying tissue. The images below represent some skin tears as per the STAR Classification System.[1]

Incontinence Associated Dermatitis – is skin damage associated with exposure to urine or stool. The affected area usually has poorly defined edges and may be patchy or continuous over large areas.[2]



Chronic Vascular Ulcer – Chronic leg or vascular ulcers typically manifest as arterial, neurotrophic, or venous ulcers. The patient may feel burning, itching and pain. There may also be a rash, redness, brown discoloration or dry, scaly skin.[3]



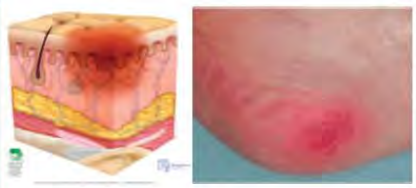
Other – includes all other wound types e.g. burns, neuropathic ulcer.

Pressure Injury – is a localised injury to the skin and/or underlying tissue usually over bony prominences, as a result of pressure, or pressure in combination with shear[4]. See Pressure Injury Staging Guide for more information.

1. Silver Chain Nursing Association 2009. STAR Project: http://www.awma.com.au/publications/2010_wa_star-skin-tear-tool-g-04022010.pdf
2. Beekman, D., et al. (2015) Proceedings of the Global IAD Expert Panel. Incontinence-associated dermatitis: moving prevention forward. *Wounds International*, http://www.woundsinternational.com/
3. Allen Gabriel, MD; Chief Editor: Joseph A Molnar, MD, PhD, FACS .Vascular Ulcers http://emedicine.medscape.com/article/1298345-verview#a0104
4. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline 2nd Edition - EPUAP, NPUAP, Pan Pacific Pressure Injury Alliance, Cambridge Media 2014. https://npuap.org/page/2014Guidelines

6. Pressure Injury Staging Guide

Stage I: non-blanchable erythema

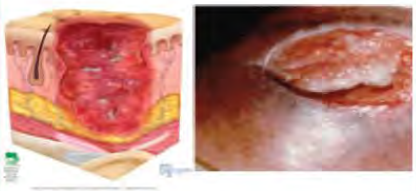


- **Intact** skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a heralding sign of risk).

Stage II: partial thickness skin loss

- Partial thickness loss of dermis presenting as a **shallow**, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow injury without slough or bruising.
- Stage II Pressure Injury (PI) should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage III: full thickness skin loss



- Full thickness tissue loss. **Subcutaneous fat** may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

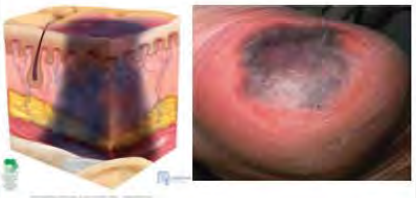
Stage IV: full thickness tissue loss

- Full thickness tissue loss with exposed **bone**, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

Unstageable: depth unknown

- Full thickness tissue loss in which the base of the PI is **covered** by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined.

Suspected Deep Tissue Injury: depth unknown



- **Purple** or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Mucosal Membrane Injury

Definition: Mucosal pressure injuries are pressure injuries found on mucous membranes with a history of a **medical device** in use at the location of the injury.
The staging system for pressure injuries of the skin cannot be used to stage mucosal pressure injury. Non-blanchable erythema cannot be seen in mucous membrane, as shallow open injuries indicating superficial tissue loss of the non-keratinised epithelium are so shallow that they are visually indistinguishable from deeper, full thickness injuries.

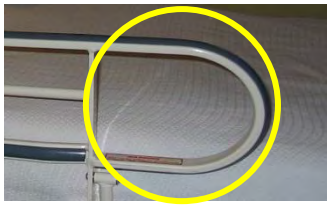
1. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014.

2. The National Pressure Ulcer Advisory Panel (NPUAP) 2016 (Illustrations).

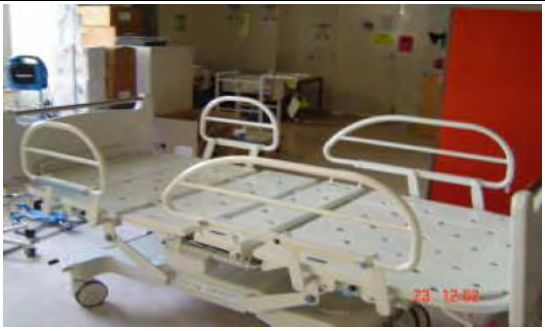
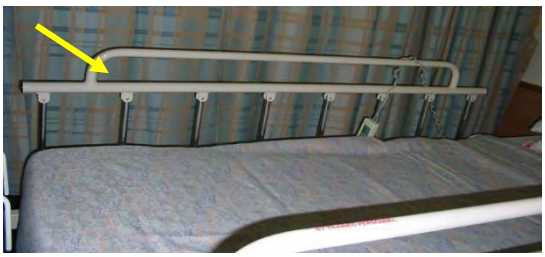
1. Bed Rails

The following bed types are outside the scope of this audit, i.e. are N/A:

- paediatric beds
- cots
- bassinets
- trolleys and stretchers

Rail Type	Description	Examples
No Bed Rail	No bed side rail fitted. May be a bed that does not have side rails, or a bed which has had side rails intentionally removed.	 
Horizontal	Usually three horizontal rails that run the length of the side rail assembly	 
Horizontal, Joyce 900 **IMPORTANT – PATIENT SAFETY ALERT**	A fixed shape horizontal bed rail fitted to the Joyce 900 bed. This bed side rail was subject to a **corrective action** in 2005 in which large, D-shaped gaps in the end of the bed rail had a spring loaded insert fitted to reduce gap size, hence reducing the likelihood of head/neck entrapment occurring. It has been observed that some Joyce 900 beds are missing the insert. Investigation showed that in some cases the insert could be easily removed by hand.	  **Joyce 900 Horizontal bed rail with corrective action in place**  **Joyce 900 Horizontal bed rail without corrective action in place**

Horizontal Mid Position	Some bed rails in Queensland Health facilities have various positions between being fully raised or down. Some can only go fully up or fully down and others have a mid/ middle/ intermediate position between being fully up or down. This bed rail position is often used to accommodate patient meal trays. Some horizontal bed rails may introduce a head/neck entrapment risk in the mid/ middle/intermediate position. Setting the bed rail in the mid position is not recommended due to the increased risk of head/neck entrapment.	 
Split - Solid	Two sections per side, which can be operated independently. Solid in construction, usually a single piece of moulded plastic or similar designed to prevent adult head and neck entrapment. Solid split bed rail designs are generally not safe for most paediatric patients. The gaps within the side rails or between the two side rails or between side rails and head board may introduce a head/ neck entrapment risk for paediatric patients and/or paediatric patients with disabilities. The gap between the two split side rails may also introduce a hanging risk for young paediatric patients or paediatric patients with disabilities when the bed is in a raised position or when their feet cannot touch the ground.	

Split - Open	Two sections per side that can be operated independently – Constructed from metal bars or similar, and has large openings within side rail. Most older open split bed rail designs may introduce a head, neck and upper body entrapment risk between the split side rails or within the side rail.	
Vertical - Rigid	Side rails with a series of vertical bars – Vertical bars are made from rigid metal or similar. Some may feature a horizontal extension above the top horizontal rail (falls risk), as shown in the second picture. Some vertical bed rails no longer comply with current standards. Investigation showed that the gap size within some vertical bed rails introduces a head/neck/upper body entrapment risk.	  **Rail extension fitted to a vertical rigid bed rail**
Vertical - Flexible	Side rails with a single horizontal bar along the top, rigid vertical supports and soft wire rope (potentially with plastic tubular covering) vertical bars in the middle. Some may feature a horizontal extension above the top horizontal rail (falls risk). Some vertical bed rails no longer comply with current standards. Investigation showed that the gap size within some vertical bed rails introduces a head/neck/upper body entrapment risk.	

The Bed Rail Information sheet was compiled in association with Biomedical Technology Services (BTS), Queensland Health.

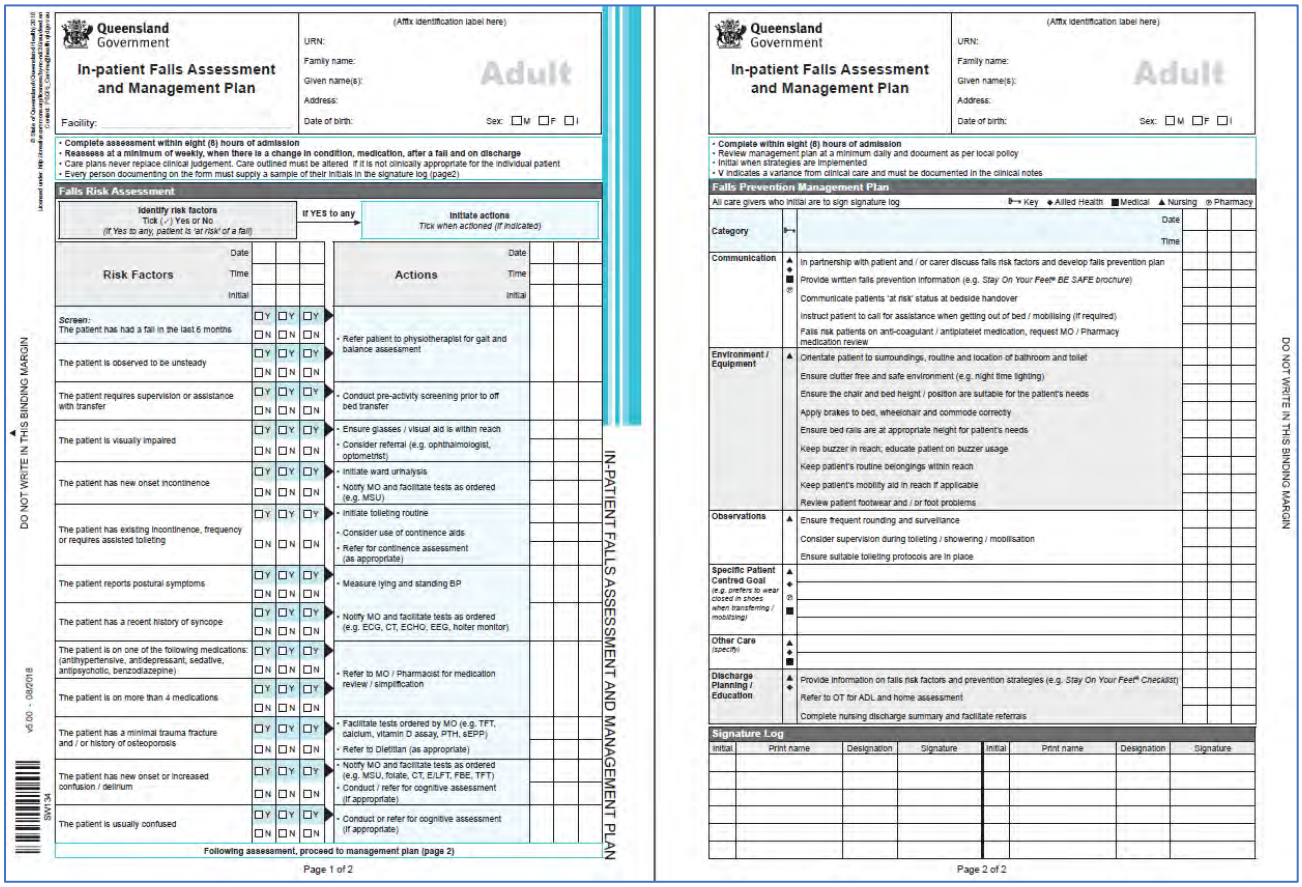
2. Falls Risk Screen and Assessment

A **falls risk screen** determines a person's risk of falling and classifies which people are at increased risk of falling.[1] A minimum falls risk screen would be a single item question: 'Have you had a fall in the last 6-12 months?' A falls risk screen consists of a small number of items (up to five) based on the presence or absence of a risk factor. When the threshold on a falls screen is exceeded it would prompt a more detailed falls risk assessment.[1] It should be noted that falls risk screening identifies a patient's risk of falling but does not provide a framework for planning interventions.

A **falls risk assessment** is a more detailed process than screening and is used to identify modifiable risk factors for falling, appropriate interventions and referral pathways. An assessment systematically and comprehensively identifies factors contributing to a patient's increased risk of falling. Falls risk assessment tools vary in the number of risk factors they include, and how each risk factor is assessed. A falls risk assessment should be done as soon as possible after the patient is admitted and reassessed when the patient's environment is changed, when the patient's health or functional status changes, following a change in medication, after a fall and when the patient is to be discharged.

Interventions should systematically address the risk factors identified. Risk factors identified in the assessment tools inform the strategies recorded in the falls management plan, care plan and/or on the assessment tool.

Department of Health Falls Assessment and Management Plan Tool



Queensland Government

In-patient Falls Assessment and Management Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐M ☐F ☐I

Adult

Facility:

- Complete assessment within eight (8) hours of admission
- Reassess at a minimum of weekly, when there is a change in condition, medication, after a fall and on discharge
- Care plans never replace clinical judgement. Care outlined must be altered if it is not clinically appropriate for the individual patient
- Every person documenting on the form must supply a sample of their initials in the signature log (page2)

Falls Risk Assessment

Identify risk factors — Tick (✓) Yes or No (If Yes to any, patient is 'at risk' of a fall) → If YES to any → Initiate actions — Tick when actioned (if indicated)

Risk Factors	Actions
Screen: The patient has had a fall in the last 6 months	• Refer patient to physiotherapist for gait and balance assessment
The patient is observed to be unsteady	
The patient requires supervision or assistance with transfer	• Conduct pre-activity screening prior to off bed transfer
The patient is visually impaired	• Ensure glasses / visual aid is within reach • Consider referral (e.g. ophthalmologist, optometrist)
The patient has new onset incontinence	• Initiate ward urinalysis • Notify MO and facilitate tests as ordered (e.g. MSU)
The patient has existing incontinence, frequency or requires assisted toileting	• Initiate toileting routine • Consider use of continence aids • Refer for continence assessment (as appropriate)
The patient reports postural symptoms	• Measure lying and standing BP
The patient has a recent history of syncope	• Notify MO and facilitate tests as ordered (e.g. ECG, CT, ECHO, EEG, holter monitor)
The patient is on one of the following medications: (antihypertensive, antidepressant, sedative, antipsychotic, benzodiazepine)	• Refer to MO / Pharmacist for medication review / simplification
The patient is on more than 4 medications	
The patient has a minimal trauma fracture and / or history of osteoporosis	• Facilitate tests ordered by MO (e.g. TFT, calcium, vitamin D assay, PTH, sEPP) • Refer to Dietitian (as appropriate)
The patient has new onset or increased confusion / delirium	• Notify MO and facilitate tests as ordered (e.g. MSU, folate, CT, E/LFT, FBE, TFT) • Conduct / refer for cognitive assessment (if appropriate)
The patient is usually confused	• Conduct or refer for cognitive assessment (if appropriate)

Following assessment, proceed to management plan (page 2)

Page 1 of 2

IN-PATIENT FALLS ASSESSMENT AND MANAGEMENT PLAN

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Queensland Government

In-patient Falls Assessment and Management Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐M ☐F ☐I

Adult

- Complete within eight (8) hours of admission
- Review management plan at a minimum daily and document as per local policy
- Initial when strategies are implemented
- V indicates a variance from clinical care and must be documented in the clinical notes

Falls Prevention Management Plan

All care givers who initial are to sign signature log — Key: ▲ Allied Health ■ Medical ▲ Nursing ⊕ Pharmacy

Category		Date / Time
Communication	▲ ◆ ■ ⊕	In partnership with patient and / or carer discuss falls risk factors and develop falls prevention plan
		Provide written falls prevention information (e.g. *Stay On Your Feet® BE SAFE brochure*)
		Communicate patients 'at risk' status at bedside handover
		Instruct patient to call for assistance when getting out of bed / mobilising (if required)
		Falls risk patients on anti-coagulant / antiplatelet medication, request MO / Pharmacy medication review
Environment / Equipment	▲	Orientate patient to surroundings, routine and location of bathroom and toilet
		Ensure clutter free and safe environment (e.g. night time lighting)
		Ensure the chair and bed height / position are suitable for the patient's needs
		Apply brakes to bed, wheelchair and commode correctly
		Ensure bed rails are at appropriate height for patient's needs
		Keep buzzer in reach; educate patient on buzzer usage
		Keep patient's routine belongings within reach
		Keep patient's mobility aid in reach if applicable
		Review patient footwear and / or foot problems
Observations	▲	Ensure frequent rounding and surveillance
		Consider supervision during toileting / showering / mobilisation
		Ensure suitable toileting protocols are in place
Specific Patient Centred Goal (e.g. prefers to wear closed in shoes when transferring / mobilising)	▲ ◆ ⊕ ■	
Other Care (specify)	▲ ◆ ■	
Discharge Planning / Education	▲ ◆	Provide information on falls risk factors and prevention strategies (e.g. *Stay On Your Feet® Checklist*)
		Refer to OT for ADL and home assessment
		Complete nursing discharge summary and facilitate referrals

Signature Log

Initial	Print name	Designation	Signature	Initial	Print name	Designation	Signature

Page 2 of 2

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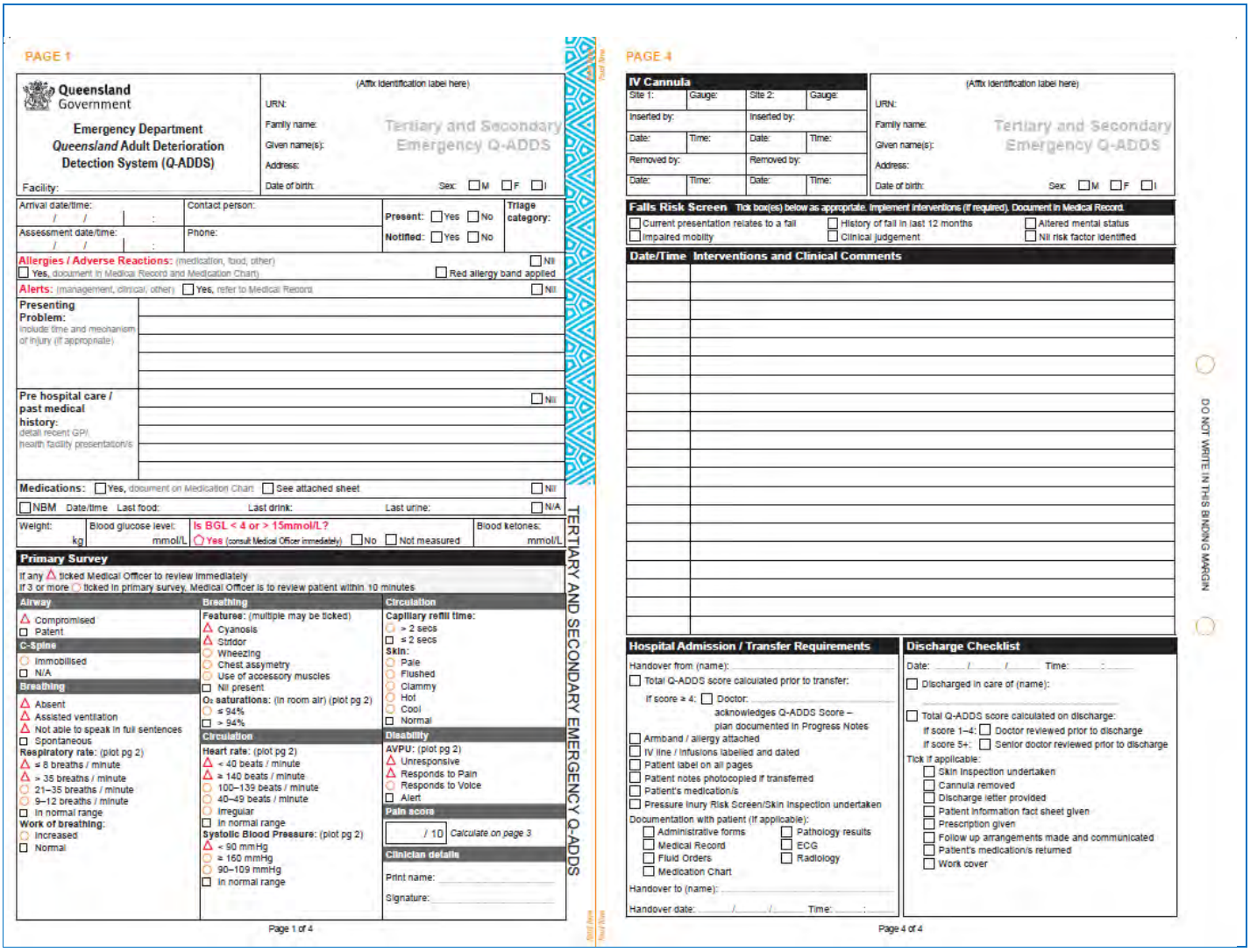
[1] ACSQHC, Preventing Falls and Harm from Falls in Older People – Best Practice Guidelines for Australian Hospitals, 2009.

Department of Health Emergency Department Falls Risk Screening Tool

In 2014, the Emergency Department (ED) Falls Risk Screening Tool was approved for inclusion on the ED Queensland Adult Deterioration Detection System (Q-ADDS) form. This is a quick, evidence-based screen suitable for use in the ED environment. Should the screen identify that the patient is at risk of falling, local falls prevention intervention processes should be initiated. Being identified at risk of falls in ED generates a need for a falls risk assessment to be conducted on admission to hospital or by a health care professional or General Practitioner after discharge.

Emergency Department Falls Risk Screening Tool – incorporated into the Department of Health ED Q-ADDS



PAGE 1

Queensland Government

Emergency Department
Queensland Adult Deterioration Detection System (Q-ADDS)

Facility:

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: M F I

Tertiary and Secondary Emergency Q-ADDS

Arrival date/time: / / :
Assessment date/time: / / :
Contact person:
Phone:
Present: Yes No
Notified: Yes No
Triage category:

Allergies / Adverse Reactions: (medication, food, other) Nil
Yes, document in Medical Record and Medication Chart) Red allergy band applied
Alerts: (management, clinical, other) Yes, refer to Medical Record Nil

Presenting Problem:
Include time and mechanism of injury (if appropriate)

Pre hospital care / past medical history:
detail recent GP/ health facility presentation/s Nil

Medications: Yes, document on Medication Chart See attached sheet Nil
NBM Date/time Last food: Last drink: Last urine: N/A

Weight: kg
Blood glucose level: mmol/L
Is BGL < 4 or > 15mmol/L?
Yes (consult Medical Officer immediately) No Not measured
Blood ketones: mmol/L

Primary Survey

If any △ ticked Medical Officer to review immediately
If 3 or more ○ ticked in primary survey, Medical Officer is to review patient within 10 minutes

Airway
△ Compromised
☐ Patent

C-Spine
○ Immobilised
☐ N/A

Breathing
△ Absent
△ Assisted ventilation
△ Not able to speak in full sentences
☐ Spontaneous
Respiratory rate: (plot pg 2)
△ ≤ 8 breaths / minute
△ > 35 breaths / minute
○ 21–35 breaths / minute
○ 9–12 breaths / minute
☐ In normal range
Work of breathing:
○ Increased
☐ Normal

Breathing
Features: (multiple may be ticked)
△ Cyanosis
△ Stridor
○ Wheezing
○ Chest assymetry
○ Use of accessory muscles
☐ Nil present
O_2 saturations: (in room air) (plot pg 2)
○ ≤ 94%
☐ > 94%

Circulation
Heart rate: (plot pg 2)
△ < 40 beats / minute
△ ≥ 140 beats / minute
○ 100–139 beats / minute
○ 40–49 beats / minute
○ Irregular
☐ In normal range
Systolic Blood Pressure: (plot pg 2)
△ < 90 mmHg
○ ≥ 160 mmHg
○ 90–109 mmHg
☐ In normal range

Circulation
Capillary refill time:
○ > 2 secs
☐ ≤ 2 secs
Skin:
○ Pale
○ Flushed
○ Clammy
○ Hot
○ Cool
☐ Normal

Disability
AVPU: (plot pg 2)
△ Unresponsive
△ Responds to Pain
○ Responds to Voice
☐ Alert

Pain score
/ 10 Calculate on page 3

Clinician details
Print name:
Signature:

Page 1 of 4

TERTIARY AND SECONDARY EMERGENCY Q-ADDS

PAGE 4

IV Cannula

Site 1:	Gauge:	Site 2:	Gauge:
Inserted by:		Inserted by:	
Date:	Time:	Date:	Time:
Removed by:		Removed by:	
Date:	Time:	Date:	Time:

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: M F I

Tertiary and Secondary Emergency Q-ADDS

Falls Risk Screen Tick box(es) below as appropriate. Implement interventions (if required). Document in Medical Record.
☐ Current presentation relates to a fall
☐ History of fall in last 12 months
☐ Altered mental status
☐ Impaired mobility
☐ Clinical judgement
☐ Nil risk factor identified

Date/Time	Interventions and Clinical Comments

Hospital Admission / Transfer Requirements

Handover from (name):
☐ Total Q-ADDS score calculated prior to transfer:
If score ≥ 4: ☐ Doctor: acknowledges Q-ADDS Score – plan documented in Progress Notes
☐ Armband / allergy attached
☐ IV line / infusions labelled and dated
☐ Patient label on all pages
☐ Patient notes photocopied if transferred
☐ Patient's medication/s
☐ Pressure Injury Risk Screen/Skin Inspection undertaken
Documentation with patient (if applicable):
☐ Administrative forms ☐ Pathology results
☐ Medical Record ☐ ECG
☐ Fluid Orders ☐ Radiology
☐ Medication Chart
Handover to (name):
Handover date: / / Time: :

Discharge Checklist

Date: / / Time: :
☐ Discharged in care of (name):
☐ Total Q-ADDS score calculated on discharge:
If score 1–4: ☐ Doctor reviewed prior to discharge
If score 5+: ☐ Senior doctor reviewed prior to discharge
Tick if applicable:
☐ Skin inspection undertaken
☐ Cannula removed
☐ Discharge letter provided
☐ Patient information fact sheet given
☐ Prescription given
☐ Follow up arrangements made and communicated
☐ Patient's medication/s returned
☐ Work cover

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Community context

A falls risk screen determines which people are at greatest risk of falling. A minimum falls risk screen would be a single item question: 'Have you had a fall in the last 6-12 months?' Typically, a falls screen consists of a small number of items (up to five) based on presence or absence of a risk factor e.g. FROP Com-Screen. When the threshold on a falls screen is exceeded it would prompt a more detailed falls risk assessment.1 The state-wide Community Falls Assessment and Management Plan combines a single screening question and a comprehensive risk factor assessment and interventions to form the falls management plan. This tool is designed to use with the ONI (Ongoing Needs Identification).

Community Screening Tool

Falls Risk for Older People in the Community (FROP-Com) **Screen**

(Affix Patient ID Label)
UR No
Surname:
Given Name
DOB

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

Date of screen: / /

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	o None (0) o 1 fall (1) o 2 falls (2) o 3 or more (3)	[ ]
FUNCTION: ADL status		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)? • *If no fall in last 12 months, rate current function*	o None (completely independent) (0) o Supervision (1) o Some assistance required (2) o Completely dependent (3)	[ ]
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance? • *Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid. Do not base on self-report.* • *If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3.*	o No unsteadiness observed (0) o Yes, minimally unsteady (1) o Yes, moderately unsteady (needs supervision) (2) o Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	[ ]
	Total Risk Score	[ ]

Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0 - 3 Low risk				4 – 9 High risk					
Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment and / or corresponding management recommendations					

Community Assessment and Management Tool

Queensland Government

Community Falls Assessment and Management Plan

Facility:

(Affix identification label here)
URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐M ☐F ☐I

Adult

- **Complete this form on initial assessment, when there is a change in client's condition, medication, or after a fall; and reassess as per local policy**
- **Care plans never replace clinical judgement. Care outlined must be altered if it is not clinically appropriate for the individual client**
- Every person documenting on the form must supply a sample of their initials in the signature log (page2)

Falls Risk Assessment

Identify risk factors Tick (✓) Yes or No *(if Yes to any, client is 'at risk' of a fall)*	Date / Time / Initial	If YES to any	Initiate actions *Tick when actioned (if indicated)*	Date / Time / Initial
Screen: The client has had a fall in the last 6 months	☐Y ☐N			
The client is observed to be unsteady	☐Y ☐N		• Refer client to physiotherapist for gait and balance assessment	
The client is using a non-prescribed mobility aid	☐Y ☐N			
The client has a pre-existing neurological disorder that affects balance, or uses a mobility aid *and* has not been reviewed in the last 12 months	☐Y ☐N		• Review client footwear and / or foot problems	
The client is visually impaired	☐Y ☐N		• Conduct or refer for visual assessment • Refer to OT for environmental assessment	
The client requires supervision or assistance with transfers or ADL	☐Y ☐N		• Complete ADL assessment (as indicated) • Refer to OT for environmental assessment	
The client has new onset or increased confusion / delirium	☐Y ☐N		• Notify GP • Conduct or refer for cognitive assessment (as indicated)	
The client is usually confused	☐Y ☐N		• Refer for home hazard assessment (as indicated) • Liaise with GP (as indicated)	
The client has new onset or existing incontinence	☐Y ☐N		• Refer to GP for investigation *(new onset)* • Refer for continence assessment (if appropriate)	
The client is on one of the following medications: antihypertensive, antidepressant, sedative, benzodiazepine, antipsychotic	☐Y ☐N		• Refer to GP for medication review / simplification where appropriate (encourage three monthly review)	
The client is on more than 4 medications	☐Y ☐N			
The client reports postural symptoms (e.g. regular dizziness, light headedness, recent history of syncope)	☐Y ☐N		• Refer to GP for investigation • Measure lying and standing BP	
The client has a minimal trauma fracture and / or history of osteoporosis	☐Y ☐N		• Refer to GP to assess causes of osteoporosis and treatment options (where appropriate)	
Partner with client and carer to develop a falls prevention plan				
Ensure verbal and written falls prevention education is provided *(e.g. Stay On Your Feet® booklet)*				

DO NOT WRITE IN THIS BINDING MARGIN

v2.00 - 03/2015

SW133

COMMUNITY FALLS ASSESSMENT AND MANAGEMENT PLAN

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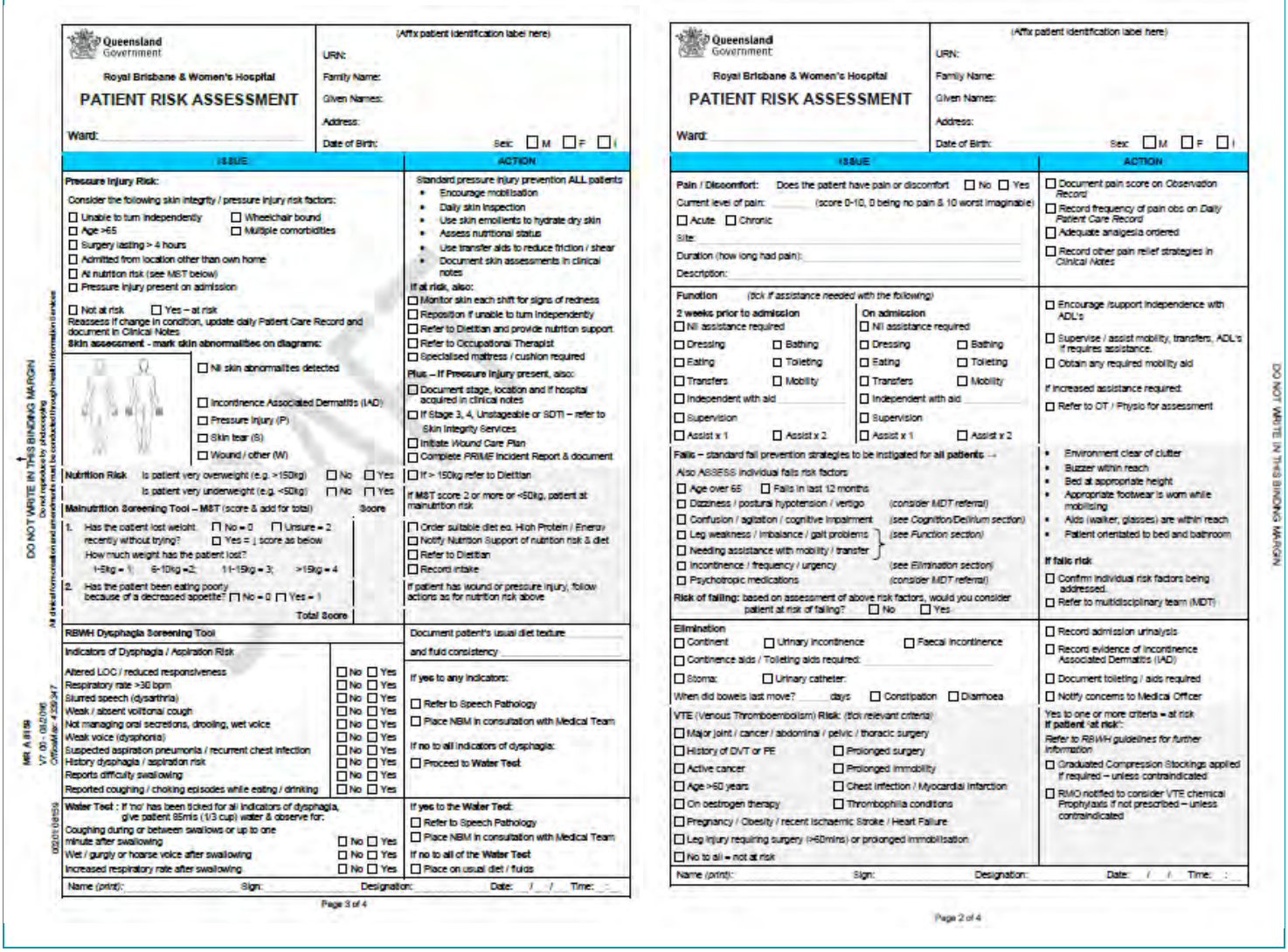
Integrated screening and assessment tools can be a hybrid of both tools, with a screening and scoring component that may contain variable risk factor questions that prompt a falls prevention action for each identified risk factor.

An example of an integrated assessment tool is below. This tool considers the patient's risk of falling in a broader assessment of the patient's risk across multiple domains. Some of these domains are: Pressure Injury, Functional and Nutritional status and Cognition/Delirium Risk.

Integrated Falls Screening and Assessment Tool example



Queensland Government

Royal Brisbane & Women's Hospital

PATIENT RISK ASSESSMENT

Ward: _____

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

ISSUE	ACTION
Pressure Injury Risk: Consider the following skin integrity / pressure injury risk factors: ☐ Unable to turn independently ☐ Wheelchair bound ☐ Age >65 ☐ Multiple comorbidities ☐ Surgery lasting > 4 hours ☐ Admitted from location other than own home ☐ At nutrition risk (see MST below) ☐ Pressure Injury present on admission ☐ Not at risk ☐ Yes – at risk Reassess if change in condition, update daily Patient Care Record and document in Clinical Notes **Skin assessment - mark skin abnormalities on diagrams:** ☐ Nil skin abnormalities detected ☐ Incontinence Associated Dermatitis (IAD) ☐ Pressure Injury (P) ☐ Skin tear (S) ☐ Wound / other (W)	Standard pressure injury prevention ALL patients • Encourage mobilisation • Daily skin inspection • Use skin emollients to hydrate dry skin • Assess nutritional status • Use transfer aids to reduce friction / shear • Document skin assessments in clinical notes **If at risk, also:** ☐ Monitor skin each shift for signs of redness ☐ Reposition if unable to turn independently ☐ Refer to Dietitian and provide nutrition support ☐ Refer to Occupational Therapist ☐ Specialised mattress / cushion required **Plus – If Pressure Injury present, also:** ☐ Document stage, location and if hospital acquired in clinical notes ☐ If Stage 3, 4, Unstageable or SDTI – refer to Skin Integrity Services ☐ Initiate *Wound Care Plan* ☐ Complete *PRIME* Incident Report & document
Nutrition Risk Is patient very overweight (e.g. >150kg) ☐ No ☐ Yes Is patient very underweight (e.g. <50kg) ☐ No ☐ Yes **Malnutrition Screening Tool – MST** (score & add for total) Score 1. Has the patient lost weight recently without trying? ☐ No = 0 ☐ Unsure = 2 ☐ Yes = ↓ score as below How much weight has the patient lost? 1-5kg = 1; 6-10kg = 2; 11-15kg = 3; >15kg = 4 2. Has the patient been eating poorly because of a decreased appetite? ☐ No = 0 ☐ Yes = 1 Total Score	☐ If > 150kg refer to Dietitian If MST score 2 or more or <50kg, patient at malnutrition risk ☐ Order suitable diet eg. High Protein / Energy ☐ Notify Nutrition Support of nutrition risk & diet ☐ Refer to Dietitian ☐ Record intake If patient has wound or pressure injury, follow actions as for nutrition risk above
RBWH Dysphagia Screening Tool Indicators of Dysphagia / Aspiration Risk Altered LOC / reduced responsiveness ☐ No ☐ Yes Respiratory rate >30 bpm ☐ No ☐ Yes Slurred speech (dysarthria) ☐ No ☐ Yes Weak / absent volitional cough ☐ No ☐ Yes Not managing oral secretions, drooling, wet voice ☐ No ☐ Yes Weak voice (dysphonia) ☐ No ☐ Yes Suspected aspiration pneumonia / recurrent chest infection ☐ No ☐ Yes History dysphagia / aspiration risk ☐ No ☐ Yes Reports difficulty swallowing ☐ No ☐ Yes Reported coughing / choking episodes while eating / drinking ☐ No ☐ Yes	Document patient's usual diet texture and fluid consistency _____ **If yes to any indicators:** ☐ Refer to Speech Pathology ☐ Place NBM in consultation with Medical Team **If no to all indicators of dysphagia:** ☐ Proceed to **Water Test** **If yes to the Water Test:** ☐ Refer to Speech Pathology ☐ Place NBM in consultation with Medical Team **If no to all of the Water Test** ☐ Place on usual diet / fluids
Water Test : If 'no' has been ticked for all indicators of dysphagia, give patient 85mls (1/3 cup) water & observe for: Coughing during or between swallows or up to one minute after swallowing ☐ No ☐ Yes Wet / gurgly or hoarse voice after swallowing ☐ No ☐ Yes Increased respiratory rate after swallowing ☐ No ☐ Yes	

Name (print): _____ Sign: _____ Designation: _____ Date: / / Time: :

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Queensland Government

Royal Brisbane & Women's Hospital

PATIENT RISK ASSESSMENT

Ward: _____

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

ISSUE	ACTION
Pain / Discomfort: Does the patient have pain or discomfort ☐ No ☐ Yes Current level of pain: _____ (score 0-10, 0 being no pain & 10 worst imaginable) ☐ Acute ☐ Chronic Site: Duration (how long had pain): Description:	☐ Document pain score on *Observation Record* ☐ Record frequency of pain obs on *Daily Patient Care Record* ☐ Adequate analgesia ordered ☐ Record other pain relief strategies in *Clinical Notes*
Function (tick if assistance needed with the following) **2 weeks prior to admission** ☐ Nil assistance required ☐ Dressing ☐ Bathing ☐ Eating ☐ Toileting ☐ Transfers ☐ Mobility ☐ Independent with aid _____ ☐ Supervision ☐ Assist x 1 ☐ Assist x 2 **On admission** ☐ Nil assistance required ☐ Dressing ☐ Bathing ☐ Eating ☐ Toileting ☐ Transfers ☐ Mobility ☐ Independent with aid _____ ☐ Supervision ☐ Assist x 1 ☐ Assist x 2	☐ Encourage /support independence with ADL's ☐ Supervise / assist mobility, transfers, ADL's if requires assistance. ☐ Obtain any required mobility aid If increased assistance required: ☐ Refer to OT / Physio for assessment
Falls – standard fall prevention strategies to be instigated for all patients → Also ASSESS individual falls risk factors ☐ Age over 65 ☐ Falls in last 12 months ☐ Dizziness / postural hypotension / vertigo (consider MDT referral) ☐ Confusion / agitation / cognitive impairment (see *Cognition/Delirium* section) ☐ Leg weakness / imbalance / gait problems (see *Function* section) ☐ Needing assistance with mobility / transfer ☐ Incontinence / frequency / urgency (see *Elimination* section) ☐ Psychotropic medications (consider MDT referral) **Risk of falling:** based on assessment of above risk factors, would you consider patient at risk of falling? ☐ No ☐ Yes	• Environment clear of clutter • Buzzer within reach • Bed at appropriate height • Appropriate footwear is worn while mobilising • Aids (walker, glasses) are within reach • Patient orientated to bed and bathroom **If falls risk** ☐ Confirm individual risk factors being addressed. ☐ Refer to multidisciplinary team (MDT)
Elimination ☐ Continent ☐ Urinary incontinence ☐ Faecal incontinence ☐ Continence aids / Toileting aids required: ☐ Stoma: ☐ Urinary catheter: When did bowels last move? _____ days ☐ Constipation ☐ Diarrhoea	☐ Record admission urinalysis ☐ Record evidence of Incontinence Associated Dermatitis (IAD) ☐ Document toileting / aids required ☐ Notify concerns to Medical Officer
VTE (Venous Thromboembolism) Risk: (tick relevant criteria) ☐ Major joint / cancer / abdominal / pelvic / thoracic surgery ☐ History of DVT or PE ☐ Prolonged surgery ☐ Active cancer ☐ Prolonged immobility ☐ Age >60 years ☐ Chest infection / Myocardial infarction ☐ On oestrogen therapy ☐ Thrombophilia conditions ☐ Pregnancy / Obesity / recent Ischaemic Stroke / Heart Failure ☐ Leg injury requiring surgery (>60mins) or prolonged immobilisation ☐ No to all = not at risk	Yes to one or more criteria = at risk **If patient 'at risk':** *Refer to RBWH guidelines for further information* ☐ Graduated Compression Stockings applied if required – unless contraindicated ☐ RMO notified to consider VTE chemical Prophylaxis if not prescribed – unless contraindicated

Name (print): _____ Sign: _____ Designation: _____ Date: / / Time: :

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3. Falls Prevention Plan (FPP)

A falls prevention plan documents interventions that systematically address the risk factors identified.

Note: You will need to look at the assessment tools and compare the risk factors identified to what strategies are recorded in the care plan and/or on the assessment tool.

Actions in a FPP are located on the right of the Plan. For the FPP to be complete, the date and signature are required for ALL risks or as actions documented in the nursing care plan.

Select **YES** if there is evidence at the bedside that all risk factor/s identified in the falls assessment have a relevant strategy or strategies identified in the care plan. Select **NO** if one or more risk factor/s identified on the falls assessment does not have at least one relevant strategy identified in the care plan.

For Queensland Health staff, please go to QHEPS for further information on Preventing Falls.

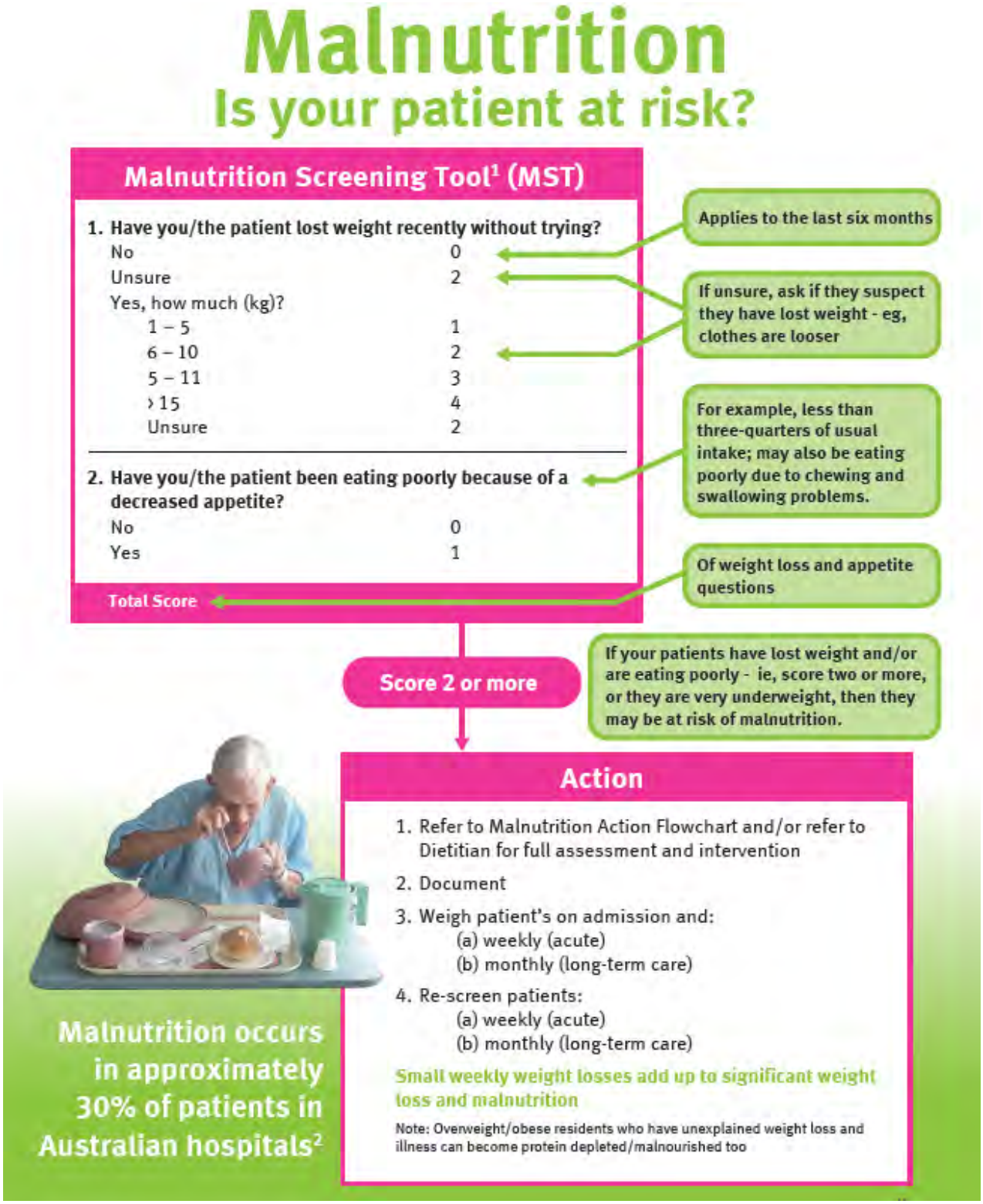
- Queensland Stay On Your Feet, http://www.health.qld.gov.au/stayonyourfeet/facts/statistics.asp
- Queensland Stay On Your Feet Resources, http://www.health.qld.gov.au/stayonyourfeet/for-professionals/resources-prof.asp
- Australian Commission on Safety and Quality in Health Care (ACSQHC), Preventing falls and harm from falls in older people – Best Practice Guidelines, 2009 http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf
- Australian Commission on Safety and Quality in Health Care (ACSQHC), Falls Prevention. http://www.safetyandquality.gov.au/our-work/falls-prevention

References:

1. Australian Commission on Safety and Quality in Health Care (ACSQHC), Preventing falls and harm from falls in older people – Best Practice Guideline. 2009, p.31. https://safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf
2. FROP-Com Screening Tool http://www.mednwh.unimelb.edu.au/nari_research/pdf_docs/FropCom2009/FROP-Com-Screen-Dec09.pdf
3. Queensland Health Falls Assessment and Management Plan
4. Australian Commission on Safety and Quality in Health Care (ACSQHC), Preventing falls and harm from falls in older people – Best Practice Guideline, Appendix 2.3 Ontario Modified STRATIFY (Sydney Scoring), p. 147-148. http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf

Nutrition and Hydration

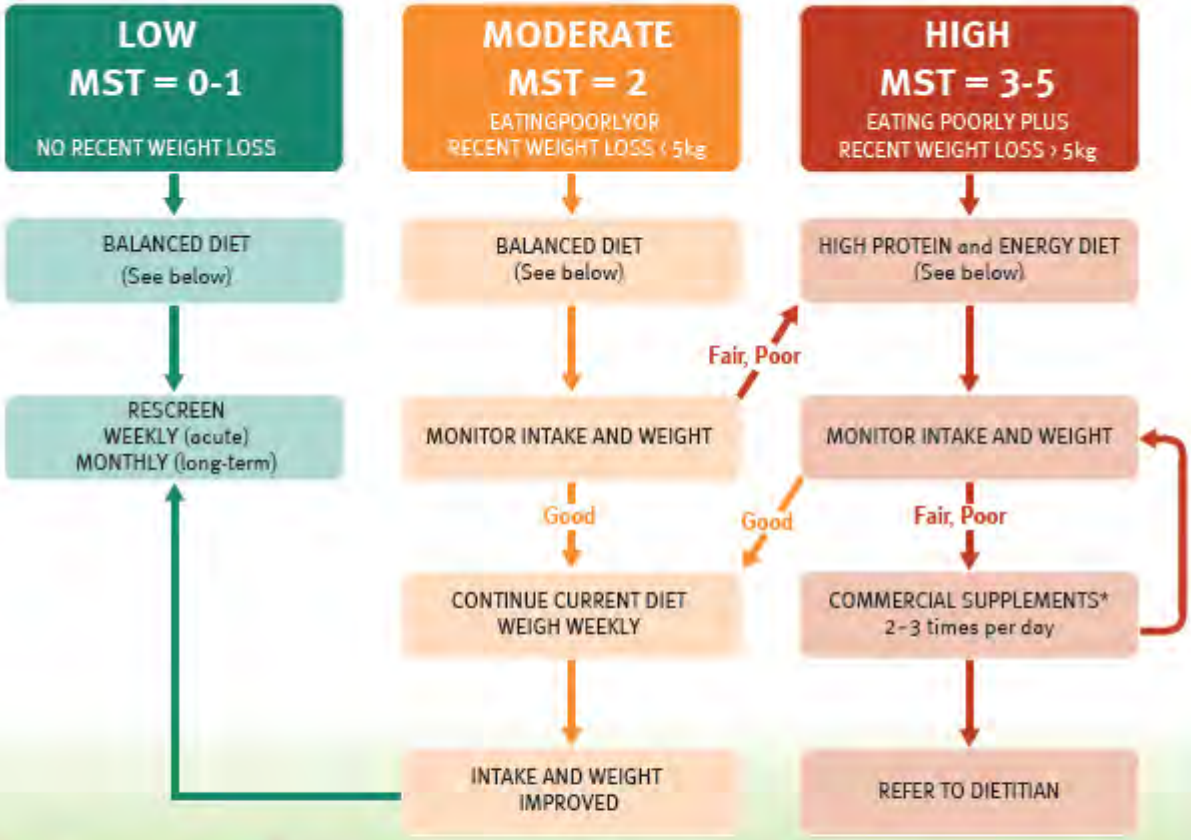
https://www.health.qld.gov.au/nutrition/clinicians



https://www.health.qld.gov.au/__data/assets/pdf_file/0029/148826/hphe_mst_pstr.pdf

Malnutrition Action Flowchart (MAF)

What is your patient's malnutrition risk?
Malnutrition Screening Tool Score:



High protein and energy diet

- Try serving six smaller meals per day
- Include 3–4 extra serves of protein and energy-rich foods or drinks daily. Some examples include:
  - Extra serves of meat, eggs, baked beans, cheese
  - Milk or soy-based drinks, eg milk shakes
  - Extra desserts, eg ice cream, custard, cakes, biscuits
  - Dried fruit, nuts, chocolate bars, chips
  - Fortify foods by adding milk powder, eggs, cream, butter
- Extra foods are consumed better if given between main meals
- For more ideas, contact your Dietitian or refer to your facility's policies

https://www.health.qld.gov.au/__data/assets/pdf_file/0015/143502/hphe_maf.pdf

Statewide Dementia Clinical Network cognitive impairment screening toolkit

https://qheps.health.qld.gov.au/caru/networks/dementia/cognitive-impairment-screening-toolkit

Delirium clinical care standard 2016, https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as the audit tools are a constant **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Queensland Health facilities. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on mars@health.qld.gov.au for feedback or comments.