Government of **Western Australia**
Department of **Health**

Interprofessional Post Fall Review in Hospital ISOBAR Guide

I Identify

3-point ID check – as per local policy
Identify entry as a Interprofessional post falls review

S Situation

Details of fall, time, location, mechanism

Obtain history from reviewing notes & speaking to patient & relevant staff

Determine circumstances of fall & contributing risk factors including balance, mobility, cognition, continence, footwear, postural BP, vertigo, medications, vision, environment, other risk factors

Document date/time of fall

Imaging results

Ensure the patient has been medically cleared to mobilise. This can be verbally obtained.

- Review any imaging done post-fall (e.g., x-ray, CT head)
- If head strike or Loss of Consciousness, consider whether investigations completed
- Name of doctor & designation

O/ Observations

Vital signs, including postural BPs
Blood results

Cognitive screen: Orientation, attention, recall, insight, safety awareness and, AMT 4 and 4AT (local assessment tool)

Review of patient's immediate environment: shared or single room, proximity to nurses station (consider visual room), equipment (bed, mattress, chair, drains, etc), access to call bell, clutter

Document falls risk status

B/ Background

Past medical history

Preadmission level of function: Social history /cognition, falls history /mobility and walking aids used/ home environment

A Assessment

Identify patients falls risk factors and **Falls Risk status**

Other assessments as appropriate

- Current Mobility and transfers: report changes in pain and weight bearing status, including walk aids
- Current function including level of assistance with personal care
- Balance & Strength Assessment: e.g., Berg Balance, Static Balance, functional balance
- Vestibular assessment

Assess Patients' activities of daily living (ADLs) such as showering, toileting, and feeding including vision that are relevant to falls risk

Intervention:

Update the patient's mobility chart (as per local policy), including **falls risk status** and personal care

Liaise with nursing staff and relevant MDT members re falls risk status and interventions to minimise falls risk

Consultation with medical team if change in mobility status, cognition, and function

Identify and eliminate/ control for risk factors where possible (e.g., walk aids, medications, incontinence, impaired balance, footwear, malnutrition, impaired insight, delirium, lighting, footwear, environment))

Provide equipment as appropriate, refer to local guidelines when making clinical decisions regarding bed rails, ultra-low beds, falls mats and out of bed alarms

Falls education provided to patient and carer

Falls risk assessment tool reviewed and individualised falls prevention strategies updated & documented, including need for visual room, ultra-low bed & falls alarm mats

Provide patient with Stay on Your Feet WA falls pamphlet / pack, or local falls prevention pamphlets as appropriate

Monitor any changes in cognition that could indicate delirium and escalate concerns

R Recommendation

Recommendations to further reduce risk of falls i.e., review by Pharmacist/ Dietician/ Podiatrist; recommend companion; low-low bed, etc
Further Physiotherapy and Occupational Therapy reviews/ interventions as appropriate
Outpatient referrals as indicated e.g., Falls clinic, home visit, other.

Acknowledgement: Fiona Stanley Hospital, South Metropolitan Health Service, Perth, Western Australia.