When to use the *Falls and Fall Injury Prevention Risk Review* form (MR58a)

- Commence this form immediately if one or more risk factors marked with a ▲ is present on assessment using MR58 *Falls and Fall Injury Risk Factor Assessment* form.
- Complete this form each shift for acute or weekly for subacute inpatient settings.
- Use of this form is not required if EPAS or equivalent is available.
- Information from this form should be included in handover and other team communication.

How to use the *Falls and Fall Injury Risk Factor Review* form (MR58a)

In **SECTION A**

- Write date and time, then follow down that column;
- Tick if there are no changes this shift, then sign and date at the bottom.
- Note if a fall occurred during the shift and the actions completed.
- Record the current presence or absence of the risk factor by circling ' Yes' or 'No'.
- Write the actions completed. Write the equipment / device(s) in use, or N/A if not applicable.
- Circle the level of assistance required for ADL and mobility (1,2,3,4), (refer to Table 1 below).
- Record discussion of care plan with patient or carer.
- Sign and date.
- Reassess using MR58 if there is a change in the health status or a significant change in medication or environment, after a fall and prior to discharge.

Use **TABLE 2** *Environmental safety for all patients* as a guide to selection of actions to improve safety of patient's environment.

To assist with careplanning, refer to back page of MR58 for *Recommended actions for consideration*. (**TABLE 1**).

In preparation for discharge, complete a re-assessment using MR58 including SECTION B *Discharge actions completed*.

TABLE 1 – Independence / level of assistance required

1. Independent and safe – with or without equipment or aids.
2. Supervision, or assistance with set-up, required for some or all of the activity.
3. Hands-on assistance, or remaining close to the patient (standby), including verbal prompting, is required for some or all of the activity, with or without equipment or aids.
4. Totally dependent.

TABLE 2 – Environmental safety for all patients

Review the patient's set up at every contact. Routinely check for hazards and remove or modify.

Safe ward environment	Safe bedside environment
• Provide aids to promote mobility / function. • Modify or remove tripping or slipping hazards. • Arrange wards / rooms to allow space for mobilising. • Use visible systems to notify all staff of falls risk. • Report equipment faults / breakdown. • Use brakes on mobile equipment, including beds and bed side lockers. • Have clear easily understood signs for patients. • Have way-finding night lighting or night sensor lights. • Mark changes in floor level or doorways with contrast strips.	• Orient patient to the environment. • Have call bell, glasses, walking aid, drink, food, tissues in reach. • Leave bed / chair at correct height (usually hips a little higher than knees with feet flat on floor). • Use bed rails only after assessment of harm vs need (refer to Bedrail decision–making tool). • Ensure clothing and bedding not dragging on floor. • Use lighting, including night lights where appropriate. • Eliminate glare with blinds / curtains.

SECTION A *(continued)*	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Changes this shift	☐ No change	☐ No change	☐ No change	☐ No change
1. FALLS HISTORY				
Patient fall or near miss during this shift	Yes / No	Yes / No	Yes / No	Yes / No
If yes –				
• post fall protocol followed including first aid, obs	Yes / No	Yes / No	Yes / No	Yes / No
• incident reported to SLS	Yes / No	Yes / No	Yes / No	Yes / No
• re-assessment using MR58, and revision of careplan	Yes / No	Yes / No	Yes / No	Yes / No
• post fall team review	Yes / No	Yes / No	Yes / No	Yes / No
2. INJURY / HARM				
Action completed e.g. hip protectors; limb protectors; stump protector, helmet (specify)				
3. BEHAVIOUR / COGNITION				
Delirious; anxiety, agitated; confused; uncooperative	Yes / No	Yes / No	Yes / No	Yes / No
Impaired consciousness / drowsy / intoxicated	Yes / No	Yes / No	Yes / No	Yes / No
Action completed e.g. medical assessment; rounding; delirium management; check hydration (specify)				
4. MEDICATION				
Multiple changes to medication	Yes / No	Yes / No	Yes / No	Yes / No
Sedation within 12/24, General Anaesthetic within 24/24	Yes / No	Yes / No	Yes / No	Yes / No
Psychoactive medication/s	Yes / No	Yes / No	Yes / No	Yes / No
Action completed e.g. rounding; supervise or assist to mobilise; notify MO if side effects provide alternatives to aid sleep (specify)				
5. MOBILITY / TRANSFERS				
Bed mobility (indicate level of assistance) *Equipment required e.g. bed rail/s, bed stick. Bed cradle; lifter; other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Walking / standing / transfers *Equipment required e.g. bed/chair height, walking aid, orthosis, prosthesis, footwear, other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Showering / toileting *Equipment required e.g. shower chair, commode, toilet raiser, other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Pain on mobilisation *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No
Severe foot problems *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No
Continence issues *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No
Dizziness on mobilisation *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No
6. INFORMATION PROVIDED TO CONSUMER, CARER	YES / NO	YES / NO	YES / NO	YES / NO
Action completed - (specify)				
Full name (please print)				
Signature				
Designation (please print)				

FALLS AND FALL-INJURY RISK REVIEW

(MR58a)

Hospital: _____

Affix patient identification label in this box

UR No: _____

Surname: _____

Given Name: _____

Second Given Name: _____

D.O.B: _____ Sex: _____

SECTION A	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Changes this shift	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change
1. FALLS HISTORY											
Patient fall or near miss during this shift	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
If yes –											
• post fall protocol followed including first aid, obs	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
• incident reported to SLS	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
• re-assessment using MR58, and revision of careplan	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
• post fall team review	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
2. INJURY / HARM											
Action completed e.g. hip protectors; limb protectors; stump protector, helmet (specify)											
3. BEHAVIOUR / COGNITION											
Delirious; anxiety, agitated; confused; uncooperative	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Impaired consciousness / drowsy / intoxicated	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Action completed e.g. medical assessment; rounding; delirium management; check hydration (specify)											
4. MEDICATION											
Multiple changes to medication	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Sedation within 12/24, General Anaesthetic within 24/24	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Psychoactive medication/s	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Action completed e.g. rounding; supervise or assist to mobilise; notify MO if side effects provide alternatives to aid sleep (specify)											
5. MOBILITY / TRANSFERS											
Bed mobility (indicate level of assistance) *Equipment required e.g. bed rail/s, bed stick. Bed cradle; lifter; other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Walking / standing / transfers *Equipment required e.g. bed/chair height, walking aid, orthosis, prosthesis, footwear, other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Showering / toileting *Equipment required e.g. shower chair, commode, toilet raiser, other (specify)*	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Pain on mobilisation *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Severe foot problems *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Continence issues *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Dizziness on mobilisation *Action completed - (specify)*	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
6. INFORMATION PROVIDED TO CONSUMER, CARER	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Action completed - (specify)											
Full name (please print)											
Signature											
Designation (please print)											

Continued overleaf