Fall Care Plan Template Examples

Focus/Problem	Goals	Interventions
I have a potential for falls related to: [reference items triggered on fall risk assessment tool], diagnoses and medications that could directly relate to falls, and clinical details i.e. movement, paralysis, incontinence.	I will have my risk for falling minimized through next review.	I will receive education related to potential fall risks. [If Brief Interview for Mental Status (BIMS) allows education] I will receive education related to fall preventive measures.

Focus/Problem	Goals	Interventions

I have had an actual fall with [SPECIFY: minor injury, serious injury] related to:	I will resume usual activities without further incident through next review. My [SPECIFY: injured areas] will resolve without complication through next review.	• Nursing will check my range of motion [Specify # times daily.]
		• Nursing will continue interventions on my at-risk plan.
		• For no apparent acute injury, nursing will determine and address the causative factors to my fall.
		• I need nursing to observe/ document/report to my physician as needed for 72 hours for signs and symptoms, such as:
		  • Pain, bruises, and/or change in mental status
		  • New onset of confusion, sleepiness, inability to maintain posture, and/or agitation.

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Focus/Problem	Goals	Interventions
I have had an actual fall and am at risk for fall-related injury secondary to: history of falls [fall specifics if necessary]; diagnoses and medications that could directly relate to falls; and/or clinical details such as movement, paralysis, and/or incontinence.	I will be free from [significant] injury from a fall through next review.	• I will have my personal items within easy reach including my call light. • I will wear my adaptive devices as needed [eye glasses, contacts, hearing aides]. • My bed will be kept in the lowest position. • My bed will be kept at wheelchair height. • I will utilize enabler bar(s) during transfers. • I will utilize proper non-skid footwear when transferring/ambulating. • I need my nurse to complete a fall risk assessment in order to identify my risk. • I will participate in therapy as ordered. • Nursing staff will educate me/my family about safety reminders and what to do if a fall occurs. • I will be encouraged by staff to participate in activities that promote exercise, physical activity for strengthening, and improve mobility. • I utilize [specify: chair/bed] electronic alarm(s). Ensure device is in place as needed. • I need nursing to review information on past falls and attempt to determine cause of falls, record possible root causes, and alter or remove any potential causes if possible. • I need staff to anticipate and meet my needs. • I will need staff to ensure my call light is within reach. • I need help making sure I have the proper assistive devices and that I am using them properly. • I need reminders to reinforce my safety awareness [i.e. lock brakes before transfers, sit on side of bed for a few minutes before transferring] • If staff notices I am having side effects from medications that may increase my risk for falls, they will notify my physician. • If staff notices I am having a change in my status that may increase my risk for falls, they will notify my physician. • I will allow staff to offer and assist me with toileting upon rising, before/after meals, with routine care rounds, and as needed. • If I have a fall, I need my nurse to discuss with my physician and representative. [List individualized fall prevention measures and devices ordered]