

# Critical Care Multidisciplinary Daily Goals

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Complete this section daily**

- All lines reviewed and considered for discontinuation
- Antibiotics reviewed for need to continue
- Foley catheter reviewed and considered for discontinuation
- Pain and sedation medication order reviewed and renewal ordered as needed
- Education Record updated today

Forms completed     Medication reconciliation     Advance directive     Admission data base

**Fall Risk assessment and Interventions** (See reverse page)      GWUH fall scale score

- Not applicable: patient comatose, complete paralysis or completely immobilized
- Standard Fall Risk prevention interventions implemented (GWUH Fall Scale 50 and less)
- High Fall Risk prevention intervention implemented (GWUH fall Scale greater than 51)

**For intubated patients:**

- Sedation Interruption done. If no, reason must be explained
- HOB at 30 degrees or more. If no, reason must be explained

**Indicate Daily Goal in areas below as appropriate**

Neuro/Psych/pain:  
Stroke Scale (if CVA patient)

CV:  
Hemodynamic Goals

Laboratory/Radiological:

Pulmonary:

GI:  
Nutrition:

GU/Renal:

Skin:

Lines:

Isolation:

Antibiotics:

Rehab: (PT/OT/Speech)

Case Management:

Family:

Nurse Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



**Critical Care  
Multidisciplinary Daily  
Goals**

Patient Label

**GWUH FALL SCALE**

ITEM	SCALE	SCORING
1. History of falling, immediate or within 3 months	No 0 Yes 25	_____
2. Secondary diagnosis	No 0 Yes 15	_____
3. Ambulatory Aid • Bed rest/nurse assist/WC • Crutches/cane/walker • Holds onto furniture	0 15 30	_____
4. IV with tubing	No 0 Yes 15	_____
5. Gait/Transferring • Normal/bed/rest/immobile • Unsteady/weak • Impaired	0 15 20	_____
6. Mental Status • Oriented to own ability • Forgets own limitations	0 15	_____
7. Medications • Anesthesia w/in past 48hrs • Anticoagulants • Antidepressants • Benzodiazepines • Laxative/diuretics • Opioids (narcotics) • Sedatives/hypnotics • Vasodilators	4 or more meds = 25	_____
<b>TOTAL SCORE</b> ▶		_____

<b>Standard Fall Risk Prevention Intervention</b>	<b>High Fall Risk Prevention Intervention</b>
<ul style="list-style-type: none"> <li>• Assess the patient's coordination and balance before assisting with transfer and mobility activities.</li> <li>• Encourage and assist patient to exit bed towards his/her stronger side whenever possible.</li> <li>• Instruct the patient in medication time/dose, side effects, and interactions with food/medication, and document the education.</li> <li>• Use treaded socks or rubber soled footwear for all patients.</li> <li>• Provide comfort measures to effectively manage patient's pain.</li> <li>• Reorient the patient to his/her surroundings.</li> <li>• Provide patients with unsteady gait with a walker or other assistive device while in the hospital. Use PT/OT to address balance and issues influencing falls.</li> <li>• Consider the use of restraints in accordance with policy, keeping in mind that restraints are always used as the last recourse.</li> <li>• Ensure there is a <u>Fall Risk Prevention Sign</u> on the wall above the patient's bed.</li> </ul>	<ul style="list-style-type: none"> <li>• Implement all of the measures listed for Standard Fall Risk Prevention in addition to the following interventions.</li> <li>• Place a <b>Watchful Eye Sticker</b> on the front of the patient's chart.</li> <li>• Place <b>Watchful Eye Magnet</b> on the patient's door.</li> <li>• Place a <b>yellow ID band</b> on the patient's wrist.</li> <li>• Assess the need for use of the bed alarms.</li> <li>• Assess the need for alternative bedding (e.g., low beds, sided mattresses, etc.) and provide when appropriate.</li> <li>• Assess the need for and provide increased monitoring, as indicated.</li> </ul>