

# 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<br>Yes 25      | _____   |
| 2. Secondary diagnosis   | No 0<br>Yes 15      | _____   |
| 3. Ambulatory Aid<br>• Bed rest/nurse assist/WC<br>• Crutches/cane/walker<br>• Holds onto furniture  | 0<br>15<br>30       | _____   |
| 4. IV with tubing  | No 0<br>Yes 15      | _____   |
| 5. Gait/Transferring<br>• Normal/bed/rest/immobile<br>• Unsteady/weak<br>• Impaired  | 0<br>15<br>20       | _____   |
| 6. Mental Status<br>• Oriented to own ability<br>• Forgets own limitations   | 0<br>15             | _____   |
| 7. Medications<br>• Anesthesia w/in past 48hrs<br>• Anticoagulants<br>• Antidepressants<br>• Benzodiazepines<br>• Laxative/diuretics<br>• Opioids (narcotics)<br>• Sedatives/hypnotics<br>• 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> |