

Complete Screening Tool on admission to unit for patients ≥ 65 years.
Please use \checkmark for "YES" and X for "No"

SPICES		Screening parameters	Follow-up plan
S	Stability/Falls	<input type="checkbox"/> Did you have any falls in the last 3 months? <input type="checkbox"/> Do you have any vision/hearing problems? <input type="checkbox"/> Do you need to go to the toilet frequently? <input type="checkbox"/> Do you need at least 1 other person to help you transfer from bed to chair? <input type="checkbox"/> Do you need to walk with at least 1 other person or aids? <input type="checkbox"/> Observe any signs of agitation (e.g. climbing out of bed)	<input type="checkbox"/> Leave message for OT/PT for falls prevention program referral if $\geq 3/6$ items are \checkmark checked
P	Polypharmacy	<input type="checkbox"/> Do you take 5 or more medications? <input type="checkbox"/> Is it difficult for you to follow your medication instructions? <input type="checkbox"/> Do you take any of the following medications: carbamazepine, lithium, phenytoin, digoxin, warfarin, benzodiazepines (e.g. lorazepam)?	<input type="checkbox"/> Refer to clinical pharmacist if all 3 items are checked
P	Pain	<input type="checkbox"/> Do you have any pain? <input type="checkbox"/> Rate pain: verbal 0-10 or VAS	<input type="checkbox"/> Give PRN pain meds and evaluate <input type="checkbox"/> Discuss with MD
I	Incontinence	<input type="checkbox"/> Do you have problem passing water/getting to the bathroom on time? <input type="checkbox"/> Did you wear incontinence products at home? <input type="checkbox"/> If there is a catheter, is it still needed? <input type="checkbox"/> Was your last bowel movement ≥ 3 days ago?	<input type="checkbox"/> Initiate continence care decision tree and implement strategies <input type="checkbox"/> Remove catheter if possible <input type="checkbox"/> Activate bowel protocol if last BM ≥ 3 days ago
C	Confusion (cognitive impairment)	<input type="checkbox"/> Do you notice any memory problems? (or history of dementia) <input type="checkbox"/> Do you notice a sudden onset or worsening of confusion (Delirium) <input type="checkbox"/> Do you feel depressed?	<input type="checkbox"/> Inform MD of sudden onset of confusion <input type="checkbox"/> Consider geriatric consult <input type="checkbox"/> Consider OT consult
E	Eating and nutrition	<input type="checkbox"/> Are you losing weight? ___lbs in ___month(s) <input type="checkbox"/> Does the nutrition section on the Braden scale score 1?	<input type="checkbox"/> Consult Registered Dietitian <input type="checkbox"/> Wt: _____ kg <input type="checkbox"/> Height: _____ cm
S	Skin breakdown	<input type="checkbox"/> Presence of skin/wound problems <input type="checkbox"/> Braden score < 16	<input type="checkbox"/> Initiate Skin Integrity Guidelines

Signature: _____

Date: _____