Institution Name: Directorate General of Nursing Affairs, MoH

Document Title: Policy & procedure on Fall Prevention and Management

Approval Process

	Name	Title	Institution	Date	Signature
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Contents Table:

Acknowledgement

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Acronyms:

MOH	Ministry of Health
DGNA	Directorate General of Nursing Affairs
DGQAC	Directorate General of Quality Assurance Center
ED	Emergency Department
A & E	Accident and Emergency Department
GCS	Glasgow Coma Scale
SBAR	Situation, Background, Action, Recommendation
DN	Document Number
VERS	Version
KPI	Key Performance Indicators
JHFRAS	Johns Hopkins Fall Risk Assessment scale
HDFS	Humpty Dumpty Fall Scale
e.g.	For example

Policy on Fall Prevention and Management

1. Introduction

Ensuring the provision of safe care and that people have a positive experience of care, is a critical role of all health care providers. Patient fall is the most commonly reported patient safety incidence in healthcare institutions. It is considered as one of the nursing sensitive key performance indicators (KPI), reflecting the quality of care provided to patients. The human cost of patient fall includes injury, pain, distress, loss of confidence in performing activities of daily living, loss of independence and high mortality rate.

This policy is intended to enhance healthcare providers' knowledge on fall prevention and management strategies for all patients (adults and Pediatrics), admitted in Ministry of Health (MoH) care institutions. It guides the healthcare providers to accurately and systematically identify patients at risk for fall and direct the implementation of an individualized fall prevention plan. Compliance to this policy plays a significant role on reducing incidence of falls, promoting patient and environmental safety.

2. Scope

This policy applies to all nurses working in healthcare institutions of Ministry of Health (MOH).

3. Purpose

3.1 To establish a standardized, patient centred approach of fall prevention and management strategies across all MOH institutions.

3.2 To increase healthcare providers awareness of the importance of being proactive in the prevention of fall and fall- related injury.

3.3 To provide directions to all levels of nurses on their roles and responsibilities of fall preventions.

4. Definitions

4.1 Patient fall: A patient fall is an unplanned lineage to the floor with or without injury to the patient, including falls that result when a patient lands on a surface. All unassisted and assisted falls are included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor).

4.2 Bedrails/ Bedside Rails**:** Rails attached to the sides of the adult bed within the hospital setting. It may also be referred as or safety rails.

4.3 John Hopkins Fall Scale: A scale used to assess risk of an unanticipated physiological inpatient fall and enable early fall risk detection so that timely preventive actions could protect at-risk adults from harm.

4.4 Humpty Dumpty Fall Scale (HDFS): A seven-item assessment scale used to document age, gender, diagnosis, cognitive impairments, environmental factors, response to surgery/sedation, and medication usage, to determine and predict falls in children.

4.5 Fall risk factors

4.5.1 Intrinsic risks: Consists of factors related to the patient such as medication effects, medical or health issues.

4.5.2 Extrinsic Risks: Consists of condition related to the environment such as wet or slippery floors, equipment in the patient's way, poor lighting etc.

4.6 Glasgow Coma Score (GCS): Is a neurological scale which gives a reliable and objective method of recording the conscious state of a person for initial as well as subsequent. assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and 15 (full alertness).

5. Policy

5.1 All patients and family receive fall prevention safety education information on admission for potential risk for fall.

5.2 All patients entering the health care institution will have fall risk assessment upon admission, upon transfer from unit/ward to another, when a change in patients' condition occurs.

5.3 Health care providers use their initial assessment to determine how to provide the safest environment for each patient.

5.4 Implement standard fall prevention strategies and measures for all inpatients.

5.5 Continuous patient assessment and monitoring are to be followed until the patient is no longer considered at increased risk for fall.

5.6 All patients with spinal cord, or brain injury, or patients under **sedation**, are considered at high risk for fall, an individualized plan of care to be in place.

5.7 All surgical patients are considered at high risk for fall due to the medications (sedatives) received, and the surgical procedure performed.

5.8 All children are at risk for falls; children with **Scores 12** and above are at high risk of Falling.

5.9 John Hopkins fall risk assessment scale is used to identify fall risk factors for adult patients and Humpty Dumpty scale for pediatric patients.

5.10 Regular periodic audit on staff compliance to policy is highly recommended.

5.11 Any fall incidence within the health care institution is reported on **the event report form** in Al Shifa system as per health care institution policy/procedure.

5.12 Monitoring of fall incidences is highly encouraged as it is a sensitive nursing key performance indicator.

5.13 Fall risk assessment score to be updated once a week (unless patient gets transferred, had a change in condition, or had a fall).

6. Procedure

6.1 Fall Prevention Assessment

6.1.1 In Emergency Department(ED): All patients will be assessed for fall risk factors by the triage nurse. The criteria for assessment includes: fall within 30 days, dizziness, changes in mental status, confusion, current seizures, age > 70 or ≤ 3, impaired gait, impaired vision, in-use of medication, etc.

6.1.2 Fall precautions are initiated in the ED if the patient meets high risk criteria.

6.1.3 Clear handover to be given to receiving shift or admitting ward using hand over tool.

6.1.4 Upon admission to the ward, the nurse conducts and completes fall risk assessment within 6 hours of admission, using John Hopkins Fall Scale (Appendix 1) for adult patients, and Humpty Dumpty fall scale for pediatric patients (Appendix 2) in Al Shifa system.

6.1.5 If the adult patient's fall score is ≥13, pediatric patient's fall score ≥ 12, the nurse initiates fall prevention precautions.

6.1.6 Initiate appropriate interventions to minimize the patient's risk of falling.

6.1.7 Document appropriate interventions on patient's file.

6.1.8 Communicate the fall risk assessment score and action plan in the clinical handover tool.

6.1.9 Reevaluate the fall risk scoring following any sudden change of patients' status, when patient is transferred from one unit to another, and if patient had a fall. According to the patient condition and fall risk assessment score, the nurse may continue or discontinue fall precautions.

6.1.10 For surgical patients, conduct a frequent fall risk assessment (pre, intra, and post-operatively).

6.2 Fall Risk precautions

6.2.1 Orient patients, and carers to room and ward.

6.2.2 Develop interventions for patients identified at risk for falling and implement multi-disciplinary plan of care. Intervention is based on the level of risk.

6.2.3 Prepare initial plan of care for 24 hours and then update if necessary.

6.2.4 Place fall risk label/board on patient's bed.

6.2.5 Place yellow fall risk armband on patients at high risk for fall, and communicate the risk for fall to patients and their attendants.

6.2.6 Implement standard falls prevention strategies and measures for all patients including:

6.2.6.1 Teach patients and families on fall prevention measures, and familiarize them to the surrounding and physical environment.

6.2.6.2 Review patients' medication for side effects that may cause dizziness/vertigo.

6.2.6.3 Place patients in an appropriate bed; children under 2 years in a cot.

6.2.6.4 Ensure the call bell is working, easily reached.

6.2.6.5 Use a proper room light during the day, and night lights during the night.

6.2.6.6 Instruct patients to wear non-slip footwear.

6.2.6.7 Ensure bed side rails are used when patient is anaesthetized/sedated/during post-op recovery.

6.2.6.8 Ensure bed brakes are locked and the bed is in a low position (except when giving care).

6.2.6.9 Ensure that the chair is at appropriate height for patients.

6.2.6.10 Ensure that bed side rails are used when patient is on bed, and a trolley during transportation.

6.2.6.11 Instruct patients to use handrails in bathroom and hallway if needed.

6.2.6.12 Use proper techniques for transfer or ambulation such as gait belt, walker, and lift devices.

6.2.6.13 Ensure patient's surrounding area is clean, dry, and remove clutters.

6.2.6.14 Conduct hourly rounding during the day and bi-hourly in the evening and during the night, to assess patients for pain, personal needs, and reposition if required.

6.2.6.15 Ensure personal items (e.g. eyeglasses, hearing aids), are clean and within easy reach of patient.

6.2.7 Special consideration for pediatric patients:

6.2.7.1 Secure and supervise all children with a safety belt in wheelchairs, highchairs, infant seats, etc.

6.2.7.2 Ensure Children on trolleys are under the immediate and direct supervision of a staff member or a caregiver.

6.2.7.3 Secure infants' incubator and maintain door closed unless directly attended.

6.2.7.4 Keep infant or child in a suitable bed.

6.2.8 Instruct parents/ carers to:

6.2.8.1 Maintain close supervision and physical contact with their infant when cot sides are down, when bathing, etc.

6.2.8.2 Ensure bed side rails or cot sides are secured where appropriate when leaving children.

6.2.8.3 Bedside, even for short periods.

6.2.8.4 Inform nursing staff when their child is unattended.

6.3 Fall and Post Fall Assessment and Management/ if a patient experiences a fall:

6.3.1 Ensure the patient is made safe and comfortable.

6.3.2 Perform immediate assessment at the place of fall prior moving the patient, evaluate level of consciousness (Glasgow coma scale), circulation airway, and breathing.

6.3.3 Assess for obvious signs of body part injury (for fracture, pain, cuts, or abrasions or head injury).

6.3.4 If no serious injury is visible, assist patient in getting up back into the bed.

6.3.5 Conduct full observational assessment covering, heart rate, blood pressure, respiration rate, oxygen saturation, temperature, blood sugar. Document findings in patient's records.

6.3.6 Notify the attending doctor on the fall incidence and observational findings, and ensure immediate medical assessment and treatment is ordered and performed. Any further required investigation is to be done.

6.3.7 If suspecting head injury:

6.3.7.1 Conduct neurological observation- including GCS scoring, pupil reaction/ size, repeat neurological assessment every 30 minute until GCS is 15 and as per doctor recommendation.

6.3.7.2 Start acute neurological Management practice as per hospital guidelines.

6.3.8 If patient has any minor injuries such as cuts and abrasions, treat as per treatment team advice.

6.3.9 If the patient is hemodynamically stable, ensure he/she is reviewed 4 hourly for 24 post fall.

6.3.10 Update fall risk assessment in John Hopkins chart for adult patients, and in Humpty Dumpty chart for pediatric patients.

6.3.11 Fill in fall incident report to in Al Shifa system, being witnessed by the shift in charge.

6.3.12 Document interventions in patient's file.

6.3.13 Communicate the incidence to the following shift nurses to avoid further fall.

6.3.14 Conduct post fall analyses by reviewing the patient's fall risk and factors contributed to the fall incidence, identifying ways to minimize the risk and ensuring appropriate care plan is in place; this involves a multi-disciplinary team.

6.3.15 If an environmental hazard has contributed to the fall incidence, all the concerned teams to be involved for rapid actions and correction to avoid similar incidences.

7. Responsibilities

7.1 Hospital Director

7.1.1 Oversee dissemination and implementation of the policy

7.1.2 Provide adequate resources to ensure proper implementation of the policy.

7.2 Directors/ Head of Nursing

7.2.1 Ensure that the policy is disseminated to all nurses.

7.2.2 Ensure that the policy is implemented and adhered by all level of nurses.

7.2.3 Ensure resources are available for proper compliance to the policy.

7.2.4 Create a mechanism to ensure that the policy is implemented effectively by all staff within HC Institution/Governorate.

7.2.5 Assign teams and internal taskforce for training and monitoring the compliance to the policy and reporting the incidences/ action plans.

7.3 Unit Head and Nursing In-Charges in Health Care Institutions

7.3.1 Assist nurses in the implementation of the policy.

7.3.2 Ensure all nursing staff have received training and awareness in relation to the policy and procedure.

7.3.3 Nominate a link nurse for overall monitoring of compliance and provide support to enable them to fulfil the role.

7.3.4 Conduct monthly audit and monitoring on the policy implementation and compliance, and submit a report to top management (Appendix 3).

7.3.5 Ensure all fall incidences are reported and investigated as per hospital policy, conduct root cause analysis and develop action plans accordingly.

7.3.6 Share information and lessons learned from fall incidence across clinical areas to prevent similar incidences in the future.

7.4 Staff Nurse

7.4.1 Comply with the fall prevention policy and related scales.

7.4.2 Attend the training and awareness sessions, such as manual handling.

7.4.3 Follow all measure to identify those patients at risk of fall, assess their needs, and ensure that appropriate interventions are undertaken.

7.4.4 Provide health education to patients, and carers about fall prevention measures.

7.4.5 Report any environmental hazard to ward in charges to develop action plan accordingly.

8. Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Fall Prevention Document Taskforce	December/ 2021
02			
03			
04			
05			

Written by	**Reviewed by**	**Approved by**
Fall Prevention Document Taskforce	DGNA Team	Dr. Majid Rashid Al Maqbali

9. References:

Title of book/ journal/ articles/ Website	Author	Year of publication	Page
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https://www.utmb.edu/policies_and_procedures/IHOP/Supporting_Documents/IHOP%20-%2009.13.39%20-%20Humpty%20Dumpty%20Fall%20Assessment%20Scale.pdf	Fall Assessment Scale The Humpty Dumpty Scale		

Appendix 1: John Hopkins Fall Risk Assessment Scale

Johns Hopkins Fall Risk Assessment Scale	
If patient has any of the following conditions, check the box and apply Fall Risk interventions as indicated. **High Fall Risk** - Implement High Fall Risk interventions per protocol ☐ History of more than one fall within 6 months before admission ☐ Patient has experienced a fall during this hospitalization ☐ Patient is deemed high fall-risk per protocol (e.g., seizure precautions) **Low Fall Risk** - Implement Low Fall Risk interventions per protocol ☐ Complete paralysis or completely immobilized **Do not continue with Fall Risk Score Calculation if any of the above conditions are checked.**	
FALL RISK SCORE CALCULATION – Select the appropriate option in each category. Add all points to calculate Fall Risk Score. (If no option is selected, score for category is 0)	Points
Age (single-select) ☐ 60 - 69 years (1 point) ☐ 70 -79 years (2 points) ☐ greater than or equal to 80 years (3 points)	
Fall History (single-select) ☐ One fall within 6 months before admission (5 points)	
Elimination, Bowel and Urine (single-select) ☐ Incontinence (2 points) ☐ Urgency or frequency (2 points) ☐ Urgency/frequency and incontinence (4 points)	
Medications: Includes PCA/opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropic (single-select) ☐ On 1 high fall risk drug (3 points) ☐ On 2 or more high fall risk drugs (5 points) ☐ Sedated procedure within past 24 hours (7 points)	
Patient Care Equipment: Any equipment that tethers patient (e.g., IV infusion, chest tube, indwelling catheter, SCDs, etc.) (single-select) ☐ One present (1 point) ☐ Two present (2 points) ☐ 3 or more present (3 points)	
Mobility (multi-select; choose all that apply and add points together) ☐ Requires assistance or supervision for mobility, transfer, or ambulation (2 points) ☐ Unsteady gait (2 points) ☐ Visual or auditory impairment affecting mobility (2 points)	
Cognition (multi-select; choose all that apply and add points together) ☐ Altered awareness of immediate physical environment (1 point) ☐ Impulsive (2 points) ☐ Lack of understanding of one's physical and cognitive limitations (4 points)	
Total Fall Risk Score (Sum of all points per category)	
Total score:	
SCORING: 6-13 Total Points = Moderate Fall Risk, >13 Total Points = High Fall Risk	

Appendix 2: Pediatric Humpty Dumpty Fall Scale

Parameter	Criteria	Score
Age		
Less than 3 years old 4	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	**2**
	13 years old and above	**1**
Gender		
	Male	**2**
	Femal2	**1**
Diagnosis		
	Neurological Diagnosis	**4**
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	**3**
	Psych/Behavioral Disorders	**2**
	Other Diagnosis	**1**
Cognitive Impairments		
	Not Aware of Limitations	**3**
	Forget Limitations	**2**
	Oriented to own Ability	**1**
Environmental Factors		
	History of Falls or Infant- Toddler Placed in Bed	**4**
	Patient uses assistive devices or Infant Toddler in Crib or Furniture/Lighting (Tripled Room)	**3**
	Patient Placed in Bed	**2**
	Outpatient Area	**1**
Response to Surgery/Sedation/ Anesthesia		
	Within 24 hours	**3**
	Within 48 hours	**2**
	More than 48 hours/None	**1**
Medication Usage		
	Multiple Usage of: Sedatives(excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazine's Antidepressants Laxatives /Diuretics Narcotics.	**3**
	One of the Meds listed above	**2**
	Other Medications/None	**1**
	Total score:	
Fall Risk Low Humpty Dumpty Score = 7-11 High Risk Humpty Dumpty Score = 12 or above		

Appendix 3: Patient Fall Prevention Compliance Assessment

Hospital: **Ward:** **Date:**

Patient No.	Assessment form available in patient file	All elements in the assessment form are filled	Assessment conducted within 6 hours of admission	Reassessment, conducted upon patient transfer from unit/ward to another, change in patients' condition	Reassessment is conducted every week	Appropriate preventive measures are available	Calling bell is working and easily reached	Fall risk score documented and communicated in clinical handover	Total		Compliance Rate %
									Yes	No	
1st									0	0	0%
2nd									0	0	0%
3rd									0	0	0%
4th									0	0	0%
5th									0	0	0%
6th									0	0	0%
7th									0	0	0%
8th									0	0	0%
9th									0	0	0%
10th									0	0	0%
Total=Yes	0	0	0	0	0	0	0	0	0	0	
Total= No	0	0	0	0	0	0	0	0			