HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Quality Management and Patient Safety		
Document:	Administrative Policy and Procedure		
Title:	Patient Fall Prevention		
Applies To:	All Healthcare Provider		
Preparation Date:	November 10, 2024	**Index No:**	QM&PS-APP-006
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1. PURPOSE:

1.1 Prevention of fall policy is designed to increase awareness of healthcare provider for:
- 1.1.1 Factors that increase the risk of fall.
- 1.1.2 Identify patient who are at high risk of fall.
- 1.1.3 When to conduct risk management.
- 1.1.4 Intervention and prevention aimed to minimize the risk of falling.

2. DEFINITIONS:

2.1 **Fall** – is unexpected change in position that causes a person to land on an object on the floor or the ground. A fall can happen when other people are present or when no one is there to see it.

3. POLICY:

3.1 All patient cared for should have their health needs identified.

3.2 Fall risk assessment to all patient upon admission and reassessment every shift, or any changes of patient's status, post – operative and other procedure, whenever fall occurs and including transfer to another patient care unit.

3.3 All aspects of assessment and reassessment for all patient at risk of fall shall be documented in the fall risk assessment and reassessment form.
- 3.3.1 Part 1: Morse Fall Scale – Adult patients (form GDOH – NUR – FRAT – 209, page 1 of 2).
- 3.3.2 Part 2 Humpty Dumpty Scale – Pediatrics patients (form GDOH – NUR – FRAT – 209, page 2 of 2)

3.4 Standard precaution for fall prevention (protect against accidental injuries) will be applied to all patients admitted to the hospital.
- 3.4.1 Orientation to room, use of call bell.
- 3.4.2 Bed in low position, side rails up, bed brakes on.
- 3.4.3 Newborn/ infant crib in low position, brakes on.
- 3.4.4 Room free of clutter and spills.
- 3.4.5 Personal items within reach (telephone, bedside table).
- 3.4.6 Place fall precaution signs on patient bed or head rest.
- 3.4.7 Place an ID Band to patient according to risk category (Red for High risk and Yellow for Moderate Risk).

3.5 All healthcare providers are responsible for providing patient/ family education to the relative to cause of fall risk factors, general safety intervention he/ she must consider during hospitalization.

3.6 **Monitoring according to the following:**
- 3.6.1 Adult patient at Low risk (Score 0 – 25) every 24 hours (0800H).
- 3.6.2 Adult patient at Medium Risk (Score 30 – 55) every 4 hours (0800H – 1200H – 1600H – 2000H – 0000H – 0400H).
- 3.6.3 Adult patient at High Risk (above 55) every 2 hours (0800H – 1000H – 1200H – 1400H –1600H – 1800H – 2000H – 2200H – 0000H – 0200H – 0400H – 0600H).
- 3.6.4 Pediatric patient at Low Risk (Score 7 – 11) every 24 hours (0800H).

3.6.5 Pediatric patient at High Risk (Score 12 or above) – every 4 hours (0800H – 1200H – 1600H – 2000H – 2400H - 0400H).
3.6.6 Neonate - every 8 hours (0800H – 1600H – 2400H).

4. PROCEDURE:

4.1 Fall Prevention Intervention:

4.1.1 Instruct the patient to request assistance as needed.
4.1.2 Ensure that the pathway to the restroom is free of obstacle and properly lighted.
4.1.3 Ensure the hallway are clear of obstacles.
4.1.4 Raise the side rails as appropriate for access to bed controls, support and repositioning.
4.1.5 Evaluate chair and bed height.
4.1.6 Consider peak effect for prescribed medications that affect level of consciousness, gait and elimination when planning patient care.
4.1.7 Observe environment for potentially unsafe conditions such as loose carpeting and water on the floor. Notify appropriate department(s) of hazardous conditions.
4.1.8 Do not leave "at risk" patients unattended.
4.1.9 Ensure patients being transported by stretcher/ bed have all side rails in the up position during transport, or if left unattended briefly while awaiting test or procedures.
4.1.10 Inform and educate patients and/ or family members regarding a plan of care to prevent falls.
4.1.11 Include the patient's family in the development of an individualized safety plan, considering age – specific criteria and patient cognition when planning care.
4.1.12 Collaborate with the patient's family to provide assistance as needed while maintaining the patient's independent functioning.
4.1.13 Communicate the patient's "at risk" status during shift report and with other disciplines as appropriate.

4.2 In Case of Fall Event:

4.2.1 Carefully place the patient in comfortable position.
4.2.2 Call for help and assistance.
4.2.3 Check for possible injuries that might result fall, check the following signs and symptoms (pain, bleeding, abrasions, bruises, swelling, and redness).
4.2.4 Check vital signs.
4.2.5 Notify the following healthcare member immediately (Head/Charge Nurse, Physician, Nursing Supervisor).
4.2.6 Carry out physician's order if any.
4.2.7 Keep the patient under close observation, till patient will be stabilized.
4.2.8 Take the vital signs hourly and check the consciousness level.
4.2.9 Complete the assessment in fall form (Morse Fall Assessment/ Humpty Dumpty).
4.2.10 Complete OVR (Occurrence Variance Report) form within the shift.
4.2.11 Document the fall incident in patient's medical record as shown in the flow chart.
4.2.12 Educate the patient/family about fall prevention.

4.3 Monitoring and Interventions according to the following:

4.3.1 Morse Fall Scale:
4.3.1.1 Patient at low risk (Score 0 – 25) every 24 hours (0800H).
4.3.1.1.1 All side rails up, bed brakes on.
4.3.1.1.2 Call bell within the reach, telephone place within the reach.
4.3.1.2 Patient at medium risk (Score 30 - 55) every 4 hours (0800H – 1200H – 1600H – 2000H – 2400H – 0400H).
4.3.1.2.1 All side rails up, bed brakes on.
4.3.1.2.2 Call bell within the reach, telephone place within the reach.
4.3.1.2.3 Place fall precaution signs on bed or head rest.
4.3.1.2.4 Check patient needs for bathroom every 2 hours, especially after meals and upon awakening.

4.3.1.3 Patient at high risk (above 55) every 2 hours (0800H – 1000H – 1200H – 1400H – 1600H – 1800H – 2000H – 2200H – 0000H – 0200H – 0400H – 0600H)

4.3.1.3.1 Place patient nearest to nurse's station.

4.3.1.3.2 Never leave patient unattended in bathroom or upon any activity.

4.3.1.3.3 All side rails up, bed brakes on.

4.3.1.3.4 Call bell within the reach, telephone place within reach.

4.3.1.3.5 Place fall precaution sign on patient bed or head rest.

4.3.1.4 Humpty Dumpty Scale

4.3.1.4.1 Low Risk (Score 7 – 11) every 24 hours (0800H)

4.3.1.4.1.1 Assess elimination needs, assist as needed.

4.3.1.4.1.2 Call light is within reach, educate patient/ family on its functionality.

4.3.1.4.1.3 Environment clear of unused equipment, furniture's in place, clear of hazards.

4.3.1.4.1.4 Orientation to room.

4.3.1.4.1.5 Bed in low position, breaks on.

4.3.1.4.1.6 Side rails up, assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety precautions.

4.3.1.4.1.7 Use of non – skid footwear for ambulating patients.

4.3.1.4.1.8 Use of appropriate size clothing to prevent risk of tripping.

4.3.1.4.1.9 Assess for adequate lighting, leave night lights on.

4.3.1.4.1.10 Patient and family education available to parents and patients.

4.3.1.4.1.11 Document fall prevention teaching and include in the plan of care.

4.3.1.4.2 High Risk (Score 12 or above)

4.3.1.4.2.1 Neonate – every 8 hours (0800H – 1600H – 2400H).

4.3.1.4.2.2 Infant and Children – every 4 hours (0800H – 1200H – 1600H – 2000H – 0000H – 0400H).

4.3.1.4.2.2.1 Remove all unused equipment out of room.

4.3.1.4.2.2.2 Protective barriers to close off spaces, gaps in the bed.

4.3.1.4.2.2.3 Keep door open at all times unless specified isolation precaution are in use.

4.3.1.4.2.2.4 Keep bed in lowest position, unless patient is directly attended.

4.3.1.4.2.2.5 Educate patient/family regarding fall prevention.

4.3.1.4.2.2.6 Document in the nursing narrative teaching and plan of care.

4.3.1.4.2.2.7 Identify with high alert fall sticker in patient file and fall precaution sign in patient bed or head rest.

4.3.1.4.2.2.8 Move patient closer to nurse's station.

4.4 **Pharmacist:**

4.4.1 They are responsible to screen the patient's medication record, triggering an alert if medications are found to have increased high risk for fall.

4.5 **Housekeeper:**

4.5.1 General awareness of environment hazard, by placing (wet area) sign on wet floor.

4.6 **Sitters/ Watcher:**

4.6.2 Patients with an impaired ability to understand or follow directions, or appropriate the potential for self – harm as a consequence of his/ her actions, may have a sitter prescribed by physician to provide continuous one – to – one observation. Sitters are responsible for observing the

patient and maintaining a safe environment. When sitters are around, they are under the direction and delegation of a nurse who monitors the patient's actions.

5. MATERIALS AND EQUIPMENT:

5.1 Flow Chart for Fall
5.2 Fall Risk Signage
5.3 Fall Risk Band

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse
6.3 Pharmacist
6.4 Housekeeper

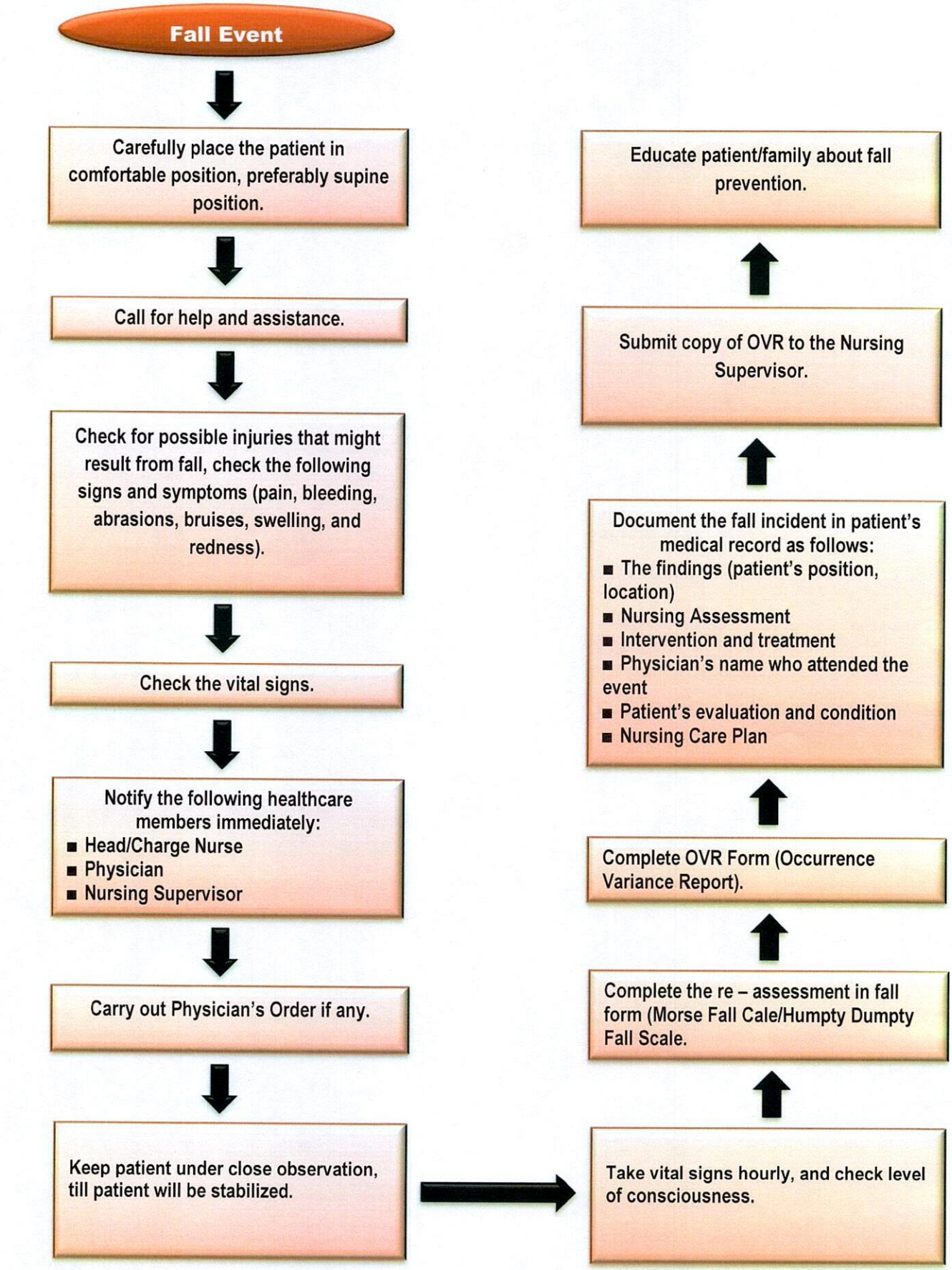
7. APPENDICES:

7.1 Flow Chart for Fall
7.2 Fall Risk Assessment and Re – Assessment Tools
7.3 Fall Risk Signage

8. REFERENCES:

8.1 Ministry of Health – General Nursing Risk Management Group, Policies and Procedures (Index No. N. R. M001) 2007/2208.
8.2 CBAHI – Quality Standard Nursing Leadership Workshop, Title: How to Develop Nursing Falls Protocols – June, 2009.
8.3 Internet – https://www.premierinc.com.
8.4 Miami Children's Hospital "Preventing Fall, Enhancing Safety".
8.5 Clinical Risk Management Standard #33.

Flow Chart for Fall



KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: _____ رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

FALL RISK ASSESSMENT AND RE-ASSESSMENT TOOLS

(choose a tool appropriate to the patient age group, draw a line across other tool and write N/A)

I . "MORSE" FALLS RISK ASSESSMENT (Write appropriate answer and sum up from "a" to "f" to get the total score)

(ADULT PATIENTS)

Category	Parameters	Score			
		TIME			
a) History of falling (immediate & in not less than three (3) month time)	No	0			
	Yes	25			
b) Secondary diagnosis (include meds risk): diuretics; benzodiazepines; antihypertensive; corticosteroids; drugs treating diabetes mellitus; polypharmacy (4 or more drugs	No	0			
	Yes	15			
c) Ambulatory aids	None/ Bed rest/ Nurse assist	0			
	Crutches/stick/frame	15			
	Furniture/walls	30			
d) Intravenous therapy	No	0			
	Yes	20			
e) Gait	Normal/ Bed rest/ Wheelchair	0			
	Weak	10			
	Impaired	20			
f) Mental Status	Oriented to own ability	0			
	Over estimates/ forgets limitations PATIENT' S SCORE DATE INITIAL JOB NUMBER	15			
	PATIENT›S SCORE:				
	DATE:				
	INITIAL:				
	JOB Number:				

SCORING: 0-25 (Low risk) 30-55 (Medium risk) >55 (High risk)

Perform "Morse fall risk" re-assessment every shift, if there is a change of patient clinical status, post operative and other procedure, and after a fall. If the score is medium or high risk, educate and implement the intervention guide for fall risk prevention.

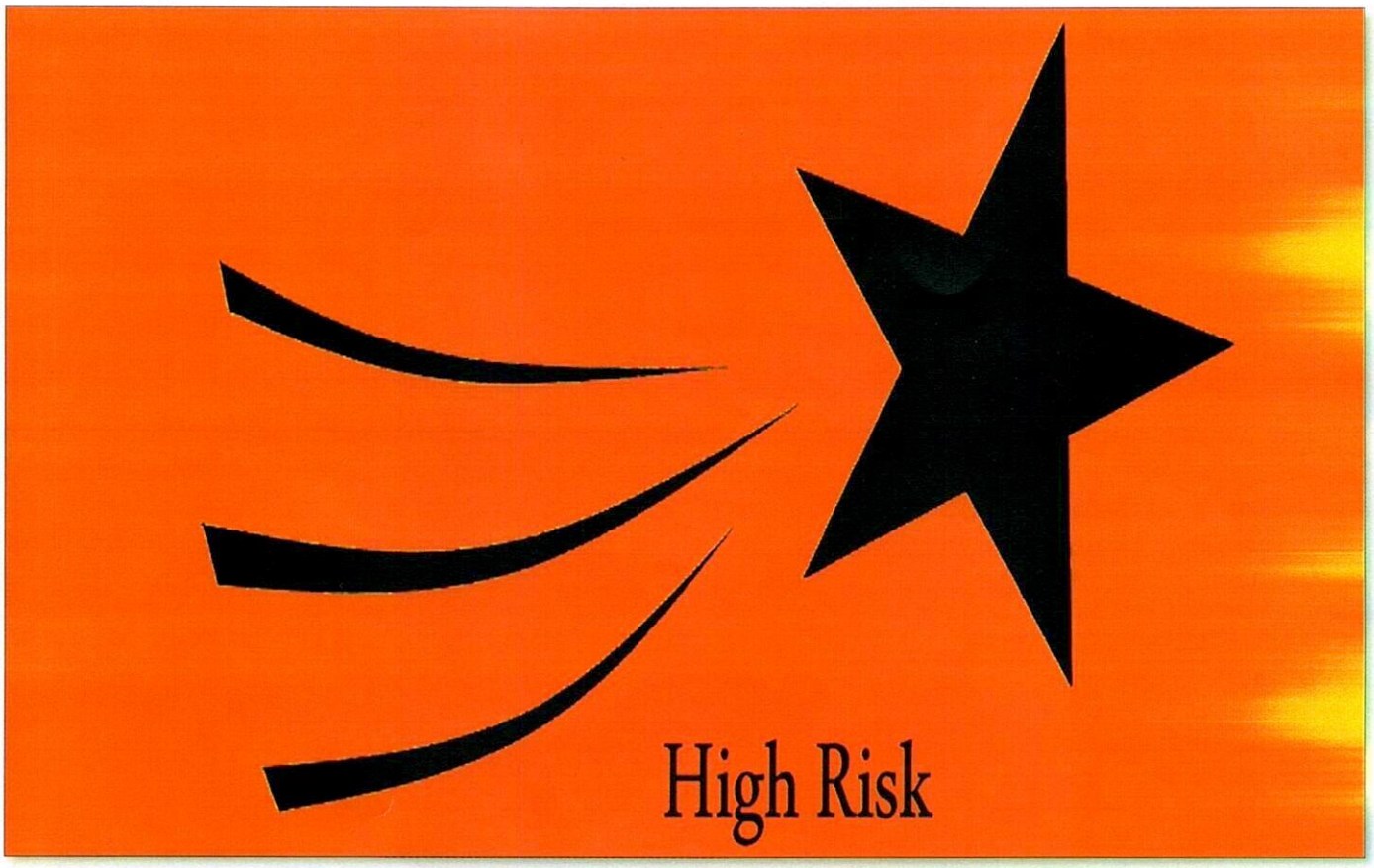
Name: الاسم	MRN: رقم الملف الطبي

II . "HUMPTY DUMPTY" FALL RISK RE-ASSESSMENT (Write & sum up the appropriate answer from "a" to 'g' to get the total SCORE: _____ (If score is 12 or above at risk for falls) Minimum Score = 7 Maximum Score = 23

(PEDIATRIC PATIENTS)

Parameters	Criteria	Score / Time			
a) Age	Less than 3 years old	4			
	3 to less than 7 years old	3			
	7 to less than 13 years old	2			
	13 years and above	1			
b) Gender	Male	2			
	Female	1			
c) Diagnosis	Neurological Diagnosis	4			
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3			
	Psychological/Behavioral Disorders	2			
	Other Diagnosis	1			
d) Cognitive Impairments	Not aware of Limitation	3			
	Forgets Limitations	2			
	Oriented to own ability	1			
e)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			
f)Response to Surgery/ Sedation/Anesthesia	Within 24 hours	3			
	Within 48 hours	2			
	More than 48 hours/None	1			
g) Medication Usage	Multiple usage of : Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotics	3			
	One of the medications listed above	2			
	Other medications/None	1			
Patient's Score					
Date					
Initial					
Job number					

Note: Perform "Humpty Dumpty" falls risk re-assessment every shift, if there is a change of patient clinical status, post operative and other procedure, and after a fall. If the score is high risk educate and implement the intervention guide for fall risk prevention.


High Risk

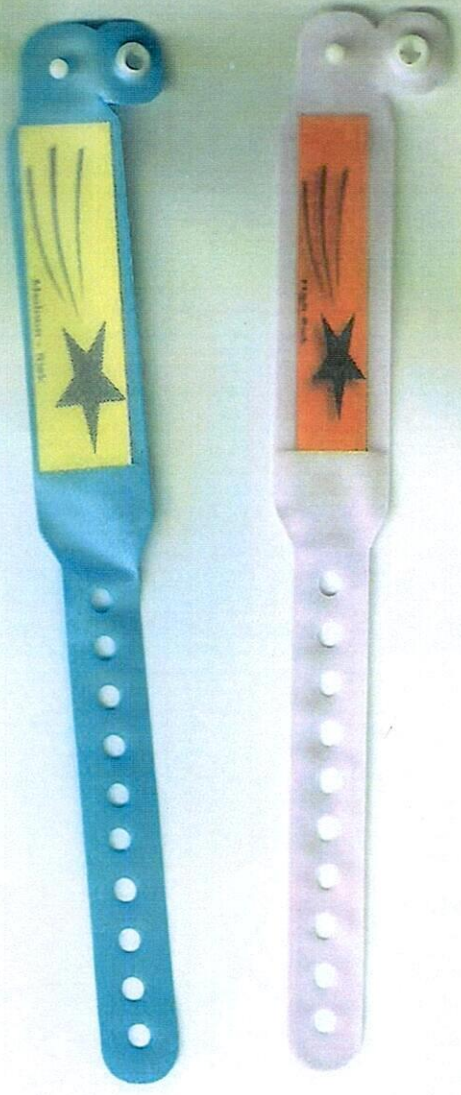

Medium - Risk

Kingdom of Saudi Arabia
Hafar Al Batin Health Cluster
Maternity and Children Hospital

المملكة العربية السعودية
التجمع الصحي بحفر الباطن
مستشفى الولادة والأطفال

PATIENT FALL INVESTIGATION FORM

HOSPITAL : ..... WARD/UNIT :	
MEDICAL RECORD NUMBER :	NAME : .....
AGE : ..... GENDER :	DIAGNOSIS : .....
CONSULTANT IN – CHARGE :	.....
DATE OF FALL :	TIME OF FALL : O AM O PM
LOCATION : O BEDROOM O TOILET O CORRIDOR/ HALLWAY O DIAGNOSTIC AREA O OTHER :	
TYPE OF FALL : O FROM BED O FROM CHAIR O FROM COMMODE O TRAPPED IN THE BED RAIL O NEAR FALL O FIRST FALL O REPEATED FALL O FROM WHEELCHAIR O BABY/ CHILD DROPPED	
ASSISTED : O YES O NO	
WITNESSED : O YES O NO	THE PATIENT HAS A SITTER : O YES O NO
WITNESS/S RELATIONSHIP: O ANOTHER PATIENT O VISITOR O STAFF O SITTER	SITTER AROUND THE PATIENT DURING THE FALL : O YES O NO
FALL RISK ASSESSMENT BEFORE THE FALL : O HIGH RISK O STANDARD	
BRIEF DESCRIPTION OF THE FALL :	
ACTIVITY AT TIME OF FALL :	
WAS THE PATIENT USING ASSISTIVE DEVICE SUCH : O HIGH RISK O STANDARD	
HARM POST FALL :	INTERVENTION DONE BY PHYSICIAN :
MEDICATION RECEIVED WITH THE LAST 72 HOURS : O ANTIHYPERTENSIVE O ANTISEIZURE O DIURETICS O LAXATIVES O NARCOTICS O ANTIPSYCHOTICS O HYPOGLYCEMIC O ANTIDEPRESSANTS O ANTIHISTAMINE O CARDIOVASCULAR	
PATIENT/SITTER RECEIVED FALLS PREVENTION EDUCATION ON ADMISSION : O YES O NO	
HIGH RISK FOR FALL SIGNAGE IS THERE : O YES O NO	
THE PATIENT/SITTER UNDERSTANDS THE FALL SIGNAGE : O YES O NO	
CAUSE OF FALL :	
RECOMMENDATIONS :	
NAME OF INVESTIGATOR : COMPUTER NUMBER : DATE : SIGNATURE :	



9. APPROVALS:

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