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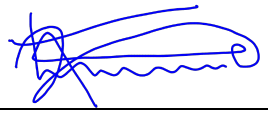
Validated by:		**Approved by:**	
Name:	Dr. Qamra Al Sariri	**Name:**	Dr. Jamal Al Khadhuri
Designation:	Director General of Quality Assurance Center	**Designation:**	Director General of Nursing Affairs
Signature:		**Signature:**	
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Acknowledgments:

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Name	Designation	Institute
Ms. Shakila Ahmed Al Habsi	Senior Nurse (A), Head Section of Clinical Support	Royal hospital
Ms. Ibtaism Mohammed Al Siyabi	Clinical Nurse Educator	Royal hospital
Ms. Aathar Salim Al Jabri	Senior Nurse (A)	Khoula hospital
Ms. Fatma Said AL Manji	Senior Nurse (A)	Khoula hospital
Ms. Haifaa Mohammed Al Saadi	Senior Nurse Specialist, Director of Professional Practice	DGNA, MOH (HQ)

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Name	Designation	Institute
Mr. Najeem Hassan Al Balushi	Senior Nurse (A), Section Head of Primary Healthcare Nursing Practice	Directorate of Professional Practice, DGNA, MOH (HQ)
Ms. Debbie Rawcliffee	Senior Nurse Specialist	Directorate of Professional Practice, DGNA, MOH (HQ)
Ms. Manal Al Rahbi	Senior Nurse (A)	DGNA

Ms. Mary Sheeba	Senior Tutor (A)	Directorate of Professional Practice, DGNA, MOH (HQ)
Ms. Afaf Mohammed Al Farsi	Senior General Nurse (B)	Directorate of Professional Practice, DGNA, MOH (HQ)
Ms. Azza Khalid Al Hajri	Senior Nurse (A),	DGNA
Ms. Heba Khamis AL Farsi	Senior Nurse (A), The Head Section of Quality Management and Patient Safety	DGNA
Directorate General of Primary Health Care, MoH		
Directorate General of Specialized Medical Services, MoH		
Medical Rehabilitation Services - Directorate General of Specialized Medical Care, MoH		
Director General of Legal Affairs		

Acronyms:

MOH	Ministry of Health
ED	Emergency Department
OPDs	Outpatient Departments
HDFS	Humpty Dumpty Fall Scale
OFRAS	Obstetric Fall Prevention Assessment Scale
NICU	Neonatal Intensive Care Units
IRLS	Incident Reporting & learning System
KPIs	Key Performance Indicator
CCIDB	Color Coded Identification Band
GCS	Glasgow coma scale
MOH	Ministry of Health

1. Purpose:

- To provide a standardized practice to prevent patient falls and injury using a patient-centered approach to reduce fall risk and promote patient safety.
- To guide healthcare providers to identify patients accurately and systematically at risk for falls and direct the implementation of individualized fall prevention plan.
- To create a strong governance and process to ensure falls are monitored and results are communicated at the service level.

2. Scope:

This policy applies to all health care professionals working in health care institution of Ministry of Health (MOH).

3. Definitions:

3.1. **A fall:** an involuntary event that results in the person coming to rest on the floor, or other surfaces lower than the person, whether or not an injury is sustained.

3.2. **AMAN System:** is a national Incident Report & Learning System which **is** a web-based system to register/ report and investigate incidents (general, sentinel, near-miss) and set actions for improvements and monitoring.

3.3. **Anticipated fall:** Fall that occurs in patients whose risk factor score indicates the patient is at risk of falling.

3.4. **Unanticipated fall:** Fall that occurs when the physical cause of the fall is not reflected in the patient's assessed risk factors for falls. These falls are created by conditions that cannot be predicted before their first occurrence (example: seizure, stroke).

3.5. **Accidental fall**: occur when a patient falls unintentionally, usually as a result of tripping or slipping because of equipment failure or other environmental factors. These falls cannot be identified prior to a fall and generally do not score at risk for falling on a predictive instrument

3.6. **John Hopkins Fall Assessment Tool (JHFRAT):** A scale used to assess the risk of an anticipated physiological inpatient fall and enable early fall risk detection so that timely preventive action could protect at risk adults from harm (Appendix No 1)

3.7. **Humpty Dumpty Fall Scale (HDFS):** is a seven-item assessment scale used to document age, gender, diagnosis, cognitive impairment, environmental factors response to surgery/ sedation and medication usage is one of the several tools developed to assess fall risk in pediatric patients **aged 0-18 years.** (Appendix No 2).

3.8. **Environmental Safety Assessment Checklist:** Is a checklist used to assess and predict the common risk factors involved in falls as well as considers a preventable measure (Refer to Appendix No 3)

3.9. **Intrinsic Risk Factor:** Is a variable caused by the individual- patient (within the entire body) and not by outside variable. It is the physical aspect of a patient's body that can cause a fall. It includes advanced age, muscle weakness, gait & balance problems, poor vision, postural hypotension, chronic conditions including arthritis, stroke, incontinence, diabetes, Parkinson's disease, dementia, anemia etc.

3.10. **Extrinsic Risk Factor:** Is an outside body variable (environmental) that a patient is sometimes unable to control to prevent him/ herself from injury. It includes slippery or uneven surfaces, improper use of an assistive device, psychoactive medications, dim lighting or glare.

3.11. **Glasgow Coma Score (GCS):** is a neurological scale that 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).

3.12. **Bedrails/ Bedside Rails**: rails attached to sides of patient bed within the healthcare institutions. It may also be referred as safety rails.

3.13. **Ambulatory services** refers to medical service performed on an outpatient basis, without admission to a hospital or other facility. It includes: primary care centers, hospital outpatient departments.

3.14. **Service day** means a measure of time during which a beneficiary receives covered service and which occurs when a bed is occupied as of 12:00 midnight, or when a patient is admitted and discharged within the same day.

3.15. **Manual handling** means transporting or supporting a load by hand or bodily force. It includes lifting, putting down, pushing, pulling, carrying or moving loads. A load can be an object or a person.

4. Procedure:

4.1. **Fall Risk Assessment:**

4.1.1 All patients entering the health care institution will be assessed for risk of fall including:

4.1.1.1 In-patients admitted in different departments.

4.1.1.2 Ambulatory services such as Emergency Departments (ED), Outpatient Department (OPDs), Renal Medicine units (RMUs) and Radiology department.

4.1.2 If risk is identified, an individual falls care pathway is completed. This would be communicated at every point of transitions of care, i.e. between departments and at inpatient bedside handovers

4.1.3 The patient & caregiver /family are included in falls screening /assessment and are provided with information and education material regarding falls prevention.

4.1.4 Patients with special considerations who may classified as a high risk for fall: neonates in Neonatal Intensive Care Units (NICU), elderly people (at age 60 years old and above), patients with postural hypotension and patients with cognitive impairments.

4.1.5 John Hopkins Fall Assessment Tool (JHFRAT) is used to assess risk of fall for adult and elderly patients and Humpty Dumpty Fall Scale (HDFS) for pediatric patients

4.1.6 All children are at risk of falls; children with HDFS **scores 12 and above are at high risk of falling.**

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

4.1.8 All surgical patients are considered at high risk for fall due the medication (e.g. sedative) received and undergo through surgical procedure.

4.1.9 All inpatients must be assessed for fall risk assessment:

a. Upon admission.

b. Upon transfer from unit/ward to another.

c. When a change in patients' condition occurs.

d. Following surgery or any procedure requiring medication that causes sedation or instability.

e. Updated once a week.

f. After a patient had a fall.

4.1.10 Environmental Safety Assessment must be ensured for the aim of maintaining a safe environment.

4.1.11 In Emergency Department (ED): all patients will be assessed for fall risk factor by the triage nurse. The criteria for assessment include fall within 30 days, dizziness, changes in mental status, current seizures or syncope, age ≥ 60 years or ≤ 3 years impaired gait, impaired vision, in-use of medication, etc.

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

4.1.13 Clear handover on fall score to be given to receiving shift or admitting ward using handover tool.

4.1.14 Upon admission to the ward, the nurse conducts and completes fall risk assessment within 7 hours of admission using appropriate tool in Al Shifa system.

4.1.15 For surgical patients, conduct a frequent fall risk assessment (pre, intra, and post operation/surgical procedure).

4.1.16 In Ambulatory Service, the staff nurse will assess patients at risk of a fall through the following:

a. Patient presentation (advanced age, weakness or frailness, requiring assistance, assistive devices (walker, cane, crutches and wheelchair), accompanying equipment (Intravenous pumps, oxygen), and inappropriate footwear.

b. Patient /family who have self-identified to a health care provider that they require assistance with standing and/or walking.

4.1.17 Assess obstetric risk factors for obstetric patients when assessing risk of falls:

a. History of bedrest during current pregnancy
b. History/diagnosis of epilepsy.
c. History/diagnosis of Pre-eclampsia or anemia or thrombocytopenia
d. Bleeding or a diagnosis of a placental abruption or placenta previa
e. Postpartum hemorrhage for vaginal birth of 1000 mL to 1,500 mL
f. On antihypertensive anticonvulsants

g. Positive Orthostatic

4.2 Fall prevention strategies:

4.2.1 Standard fall prevention strategies and measures will be implemented for all patients entering health care institutions.

4.2.2 If the adult patient's (JHFRAT) fall score is ≥13, pediatric patient's (HDFA) fall score ≥12, initiate fall precautions measures.

4.2.3 All patients and their family will be engaged and educated regarding fall prevention strategies on admission and on discharge.

4.2.4 Staff having patient contact are provided with education on falls, falls screening and assessment, and prevention and management strategies during their orientation to the organization and at regular intervals.

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

4.2.6 All patients who have had a lower extremity nerve block anesthetic will be automatically placed on fall precautions until the nerve block is discontinued. The patient will then be re-evaluated to determine his/her fall risk.

4.2.7 Initiate appropriate fall prevention interventions to minimize the patient's risk of fall.

4.2.8 Document appropriate intervention on patient's Kardex in Al shifa system.

4.2.9 Patient identified **as a low risk for falls** will maintain universal fall precautions, and staff implement plan of care strategies based on the identified area(s) of risk.

4.2.10 Develop care plan for patients identified at risk for fall and implement multidisciplinary plan of care, intervention is based on the level of risk.

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

4.2.12 Patient identified as a high risk for fall will have a Color-Coded Identification Band (CCIDB), yellow color-coded band indicating high fall risk.

4.2.13 Patient at high risk for fall should be attended and assisted during mobility and physical activity

4.2.14 Sign board should be kept for patient who is at high fall risk (Figures No 1).

4.3 Implement standard fall prevention strategies and measures for patients including:

4.3.1 Provide the patient/ relative orientation about physical structure, bed adjustment, light switch, bathroom, and the use of call bells.

4.3.2 Educate patient and the family on fall prevention measures.

4.3.3 Ensure patient's surrounding area is clean, dry and unclutter.

4.3.4 Place the bed in lower position and brakes locked

4.3.5 Ensure the call bell is working and reachable.

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

4.3.7 Instruct patient to wear ware non-slip footwear.

4.3.8 Instruct the patient if he/she feel unsteady or unbalanced, to call for help and sit down again.

4.3.9 Ensure patients personal items (e.g. eyeglasses, hearing aids), are clean and within reach.

4.3.10 Conduct 2 hourly round using 4 Ps approach (Pain, Position, Personal possession & Personal needs.

4.3.11 Ensure bed side rails are used when patient is on a trolley during transportation or when sedated during pre or post operation.

4.3.12 Ensure that the chair is at appropriate height for patient.

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

4.3.14 Use proper technique for patient transfer or ambulation such as gait belt, walker, and lift devices.

4.3.15 Instruct the patient or relative to request assistance as needed

4.4 Special consideration for pediatric patients:

4.4.1 Keep infant or child in a suitable bed.

4.4.2 Children under 12 months are directly to be placed in a cradle and for children under 18 months a cradle is encouraged if no contraindication.

4.4.3 If the child is 2 years or under, the assigned staff nurse is responsible to discuss with the parents or care giver if they would prefer a bed or a cot at the time of admission, this discussion must be documented in the medical record. If the decision is made to place the child in a bed, this need to be authorized by the Nurse Ward In-charge or shift duty in-charge.

4.4.4 Ensure children on trolleys are under the direct supervision of a staff member or a caregiver.

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

4.4.6 The parent or the caregiver should always be with the child and they should inform nursing staff when their child is unattended**.**

4.4.7 **Instruct parents/caregivers to:**

a. Maintain close supervision with their infant when cradle sides are down, when bathing, etc.
b. Ensure bed side rails or cradle sides are secured where appropriate when leaving children.
c. Inform nursing staff when their child is unattended**.**
d. Staff should also remind the parents/care giver of the importance of the cradle sides being up, irrespective of them being at the cradle side.
e. Safety precaution when changing nappies, bathing, feeding and other potential falls risk situations need to be taken.
f. Inform nursing staff when the side rails are not working

4.5 Fall and Post fall assessment and Management/ If patient experiences a fall:

4.5.1 Immediate management should be performed for patient who had a fall incident.

4.5.2 Ensure the patient is made safe and comfortable.

4.5.3 Perform immediate assessment at the place of fall prior moving the patient, evaluate level of consciousness (GCS), airway, breathing and circulation.

4.5.4 Assess for obvious signs of body part injury (e.g. deformities, pain, cuts, or abrasions, swelling, fracture) and inform the assigned doctor.

4.5.5 If no serious injury, ensure proper manual handling for patient when transferring to the bed.

4.5.6 Conduct complete physical assessment and assess patient's vital signs. Document findings in patient's records.

4.5.7 Environmental safety assessment to identify any environmental risk factors**.**

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

4.5.9 In case if the fall happens in the outpatient department call the physician, assess the patient and shift the patient to ED for further management.

4.5.10 If suspected head injury:

a. Conduct neurological assessment every 15 minutes for the first one hour, followed by once every half an hour for the second hour, once every hour for the next eight hours, once every two hours for the following 24 hours or as per doctor order/institution's guideline.

b. Start medical management as per hospital guideline or doctor's order.

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

4.5.12 If the patient is hemodynamically stable, ensure she/he is assessed 4 hourly for 24 hours post fall.

4.5.13 Document the finding and intervention taken in the patient Kardex.

4.5.14 Update fall risk assessment in the system post fall.

4.5.15 Report fall incident in AMAN system (refer to the policy and procedure of Incident Reporting and Learning system -MoH/DGQAC/P&P/002/Vers.01)

4.5.16 Communicate the incidence to the following shift nurse to avoid further fall.

4.5.17 Feedback from patient/family/staff needs to be included in the incident report

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

4.5.19 If an environmental hazard has contributed to the fall incidence, all the concerned team to be involved for rapid corrective action to avoid similar incidences.

4.6 Audit and monitoring

4.6.1 Analysis of fall related data includes identifying causes of fall, factors leading to the fall incident, type of the fall incident & severity of the injury.

4.6.2 All fall incidences within the health care institution will be reported on the Incident Report and Learning System (AMAN system) in Al Shifa.

4.6.3 Monitoring of fall incidences is highly encouraged as it is considered as one of the nursing sensitive Key Performance Indicator (KPIs) using the following formula

Fall Rate = Number of Patient Falls /Number of Service Days × 1000

4.6.4 Fall incidents with the corrective measures should be reported in the annual nursing report.

4.6.5 Quarterly audit on staff compliance to the national procedure is highly recommended (Appendix No. 4).

5. Responsibilities:

5.1 Hospital Director:

5.1.1 Oversee dissemination and implementation of the policy.

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

5.1.3 Ensure that fall and fall-related injury prevention is a high priority at the health care institution

5.1.4 Ensure that a safe environment is provided for the patients and staff

5.2 Director of Nursing/HoN:

5.2.1 Ensure that the policy is disseminated to all nurses and medical orderlies.

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

5.2.3 Ensure resources are available for proper compliance to the policy

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

5.3 Unit Head/ Nursing In-Charges:

5.3.1 Assist nurses in the implementation of the policy.

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

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

5.3.4 Conduct quarterly audit and monitoring of the policy implementation and compliance, and submit a report to top management.

5.3.5 Ensure equipment in the unit is working properly and receiving scheduled maintenance. This is done in collaboration with Engineering and Maintenance Department and Biomedical Department.

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

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

5.4 Staff Nurse:

5.4.1 Comply with fall prevention procedure and fall-related injury interventions.

5.4.2 Ensure that environment is assessed and corrected from any hazards.

5.4.3 Develop an individualized fall and injury prevention care plan.

5.4.4 Collaborate with interdisciplinary team members for implementation and evaluation of the individualized care plan.

5.4.5 Communicate patient's fall and injury history, risk factors, treatment plan during handover.

5.4.6 Implement patient education based on health literacy to assure patient engagement as partner in care, along with family / caregiver as appropriate.

5.4.7 Report any fall incident in AMAN system and inform the in-charge and unit supervisor.

5.4.8 Attend training and awareness sessions related to fall prevention such as manual handling.

5.4.9 Participate in quality improvement to evaluate patient safety and quality of care.

5.5 Physicians:

5.5.1 Identify and implement medical interventions to reduce fall and fall-related injury risk such as taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls.

5.5.2 Be aware of high fall risk patient, and works within their scope of practice to prevent patient fall.

5.5.3 Document care plan clearly in patient's progress notes in Al Shifa System.

5.5.4 Communicate treatment plan with multidisciplinary team accordingly.

5.5.5 Refer patients, who were recently admitted to the hospital due to a fall, to a pharmacist to review the medication and to physical or occupational therapy to conduct a more thorough assessment of fall risk

5.6 **Pharmacists**:

5.6.1 Review medications and supplements to ensure that the risk of falls is reduced.

5.6.2 Notify the physician and clear the medications with the physician if a drug interaction or medication level increases the likelihood of falls.

5.7 Physical and Occupational Therapists:

5.7.1 Conduct patient assessments of rehabilitation needs and falls risks.

5.7.2 Evaluate patient mobility and safety in the patient's environment to ensure safe transfers, mobility, and activities of daily living.

5.7.3 Develop, implement and evaluate an intervention program for patients to reduce their fall and injury risk.

6.7.4 Examine and provide the unit with the needed resources for fall and injury prevention like rolling seated walkers, wheelchairs brake extenders, non-skid seating, suitable foot wear, etc.

6.7.5 Liaise with other members of the multi-disciplinary team on the best methods of patient movement and mobility.

6.8 All Healthcare providers:

6.8.1 Comply with fall prevention procedure and fall-related injury interventions

6.8.2 Ensure that environment is assessed and corrected from any hazards.

6.9 Fall Team/ Fall Prevention Committee: (Physician, Nurse, Pharmacist, Physiotherapist, risk manager and Quality):

6.9.1 Conduct regular meeting to identify the gaps and works on action plan.

6.9.2 Produce reports which provide thematic and trend analysis of fall and incident data, to inform practice development and organizational learning.

6. Document History and Version Control

Version	Description	Review Date
1	Initial Release, MoH/DGNA/P&P/009/ver.01	**2021**
2	Second version MoH/DGNA/SOP/004/ver.02	**2026**

8. References:

Title of book/ journal/ articles/ Website	Author	Year of publication
(FALLS REDUCTION-INJURY PREVENTION POLICY-REVISED 1-30-2020 Copy of Version 1.1 (Approved and Current) Comments for Version 1.0 (Last Major Revision) Initial Version, n.d.)		2020
(Tool 3B: Scheduled Rounding Protocol |	Agency for Healthcare Research and Quality	2022
Patient falls prevention and management a clinical guideline for nurse's agency for therapeutic services. MOH).	Saudi Arabia	2021
Policy & Procedure of fall Prevention & Management	Al Massarrah Hospital	2021
Policy & Procedure of fall Prevention & Management	Fall Prevention Committee Taskforce- DGNA- MOH	2021
Fall Prevention Policy	Royal Hospital- Nursing Department	2021
Fall Risk Prevention Protocol	Directorate General Khoula Hospital	2017
Oman National Health Accreditation	Oman National Health Accreditation	2021
A Successful ED Fall Risk Program Using the KINDER 1 Fall Risk Assessment Tool	Ann B, Journal of Emergency Nursing	2016
Development of a Tool to Assess Risk for Fall in Women in Obstetric Unit	Heafner, L .et al	2013

Falls Prevention and Management Policy	The Sydney Children Hospital Network	2014
CH Patient Fall Prevention Policies & Procedures	SJMC CNO; SMMC Carondelet Health	2011
Clinical Guidelines (Nursing): Falls Prevention	The Royal Children's Hospital Melbourne	2022
Defining Ambulatory Care	Institute for Patient and family Centered Care	N.D.

Annexes:

Appendix No 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** A) History of more than one fall within 6 months before admission B) Patient has experienced a fall during this hospitalization C) Patient is deemed high fall-risk per protocol (e.g., seizure precautions) **Low Fall Risk- Implement Low Fall Risk interventions per protocol** A) Complete paralysis or completely immobilized Do not continue with Fall Risk Score Calculation if an 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) a) 60 - 69 years (l point) b) 70-79 years (2 points) c) Greater than or equal to 80 years (3 points)	
Fall History (single-select) a) One fall within 6 months before admission 5points)	
Elimination, Bowel and Urine (single-select) a) Incontinence (2 points) b) Urgency or frequency (2 points) c) Urgency /frequency and incontinence (4 points)	
Medications: Includes PCA/opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropic (single-select) a) On I high fall risk drug (3 points) b) On 2 or more high fall risk drugs (5 points) c) 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) a) One present (l point) b) Two presents (2 points) c) 3 or more present (3 points)	
Mobility (multi-select; choose all that apply and add points together) a) Requires assistance or supervision for mobility, transfer, or ambulation (2 points) b) Unsteady gait (2 points) c) Visual or auditory impairment affecting mobility (2 points)	
Cognition (multi-select; choose all that apply and add points together) a) Altered awareness of immediate physical environment (1 point) b) Impulsive (2 points) c) Lack of understanding of one's physical and cognitive limitations (4 points)	
Total Fall Risk Score (Sum of all points per category)	
SCORING: 0-5 Low Fall Risk 6-13 Moderate Fall Risk >13 High Fall Risk	

Appendix No 2: Humpty Dumpty Fall Risk Assessment Scale

Parameter	Criteria	Score

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 old and above	1
Gender	Male	2
	Female	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
	For et 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 Use	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		

Note: The scale includes 7 parameters with grading criteria based on fall risk. Each parameter has a maximum grading score of 3 to 4. The overall minimum score for the scale is 7 and maximum

score is 23. No zeroing can be done on HDFS. Patients with a score of 12 and above are considered at high risk for fall.

Appendix No 3: Environmental Safety Assessment Checklist

No.		YES	NO	NA	Remarks
1.	All floors & corridors clear from obstacles				
2.	Exit signs exist and are visible				
3.	Beds, wheelchairs & equipment kept locked				
4.	Furniture & equipment suitable for needs of the unit				
5.	Commode/ seat lifts are properly installed (not loose)				
6.	Door handles are secure				
7.	Handrails is present in corridors & toilets and properly secured				
8.	All lights working properly and areas are well lit				
9.	Floors are clean & dry				
10.	Floor is clear of personal items				
11.	Caution signs available in case of wet floor				
12.	Call bells working and within reach				
13.	Beds in low position				
14.	Beds suitable & safe for patients age				
15.	Bedside tables & lockers available & not broken				
16.	There is a two-foot-wide path for the patient to walk in or use wheelchair				
17.	Bed Side rails kept up as per indicated				
18.	Patient personal equipment within reach				
19.	Room furniture arranged to allow patient space when walking and grab bars/hand rails are accessible.				
20.	Patient have footwear present				
21.	Patients clothing does not drag on the floor				
22.	Patient slippers have non-slip soles				
23.	Grab bars next to the toilet				
24.	Toilet seat at a height that allows easy transfer				
25.	Night light exist in the bathroom				

Patient information	Documentation																					observation									Compliance rate $\sum yes \times 100$ (10-*Na*)
	1.Risk assessment completed			2.Patient identified as being risk to fall			3.Assessment conducted on admission			4.Reassessment conducted every week Or as indicated.			5.Fall risk score documented in Kardex and in SBAR			6.Fall prevention plan documented			7.Health education to patient and family documented			8.Preventative tools are available			9.Call bell at reach of the patient and working			10.Patient have risk fall identifier			
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	
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Compliance rate $\frac{\sum yes}{\_\_} \times 100$ *(No of patient - Na)*																														

Appendix No 4: Fall Assessment/ Nursing Adherence Audit Tool

Audited Area: …… Department: ……..…… Date & time: ……

Elements description of Fall Assessment Audit Tool:

1. Risk assessment completed: fall risk assessment is completed and filled properly (adult John Hopkins, Pediatric Humpty Dumpty).

2. Patient identified as being risk to fall: if the patient is categorized as high risk to fall or not. Score 13 and above.

3. Assessment conducted on admission: if the patient assessed for risk of fall on admission within 7 hours.

4. Reassessment conducted every week: if weekly re-assessment is done for the patient or as indicated (post op & whenever patient condition is changed.)

5 .Fall risk score documented in Kardex and in SBAR: documentation in Kardex for patients with high to moderate risk to fall and communicated in each shift handover.

6. Fall prevention plan documented: what all actions is taken to eliminate and reduce the patient risk to fall.

7. Health education to patient and family documented: complete documentation in Kardex.

8. Preventative tools are available: Preventative measures includes low bed level, side rails up, fall risk identifier, non-slippery footwear, any special equipment.

9. Call bell at reach of the patient and working: observe the placement of call bell if near patient and at easy reach or not and the function of the call bell.

10. Patient have risk fall identifier: Patient is wearing a Color-coded ID band for fall risk & fall risk sign is placed near patient side.

Figure No 1: High Risk for Fall Sign Board