Institution Name: Al Masarra Hospital

Document Title: Policy and Procedure to Fall Prevention and Management

Approval Process

	Name	Title/ Designation	Institution	Date	Signature
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Content Table:

Acronyms:

A&E	Accident and Emergency Department
ADL	Activities of Daily Living
AMRH	Al Masarra Hospital
MOH	Ministry of Health
OPD	Outpatient Department
ROM	Range-of-Motion
SSN	Senior Staff Nurse
WHO	World Health Organization

Policy and Procedure of Fall Prevention and Management

1. Introduction

Fall is a major cause of injury and death among psychiatric clients and elderly people. It is the most common safety incident in the hospital. In a health care facility, an accidental fall can change a short stay for a minor problem into a prolonged stay for serious and possibly life threatening problems. Management of fall requires an approach that increases patient safety in hospital by identifying patients at risk and implementing interventions that reduce patient falls, including consideration and assessment of environmental risk factors. It is, however, recognized that patient safety should be balanced with the promotion of patient recovery and independence, with the aim of discharging patients home safely.

2. Scope

This document applies to all healthcare professionals in Al Masarra Hospital (AMRH) who work directly or has an impact to the welfare of patients at risk of fall. This covers all clients at risk of fall who attend to AMRH.

3. Purpose

3.1 To provide a framework to enable health care professionals to effectively assess, formulate and develop management plans for patients at risk of fall.

3.2 To ensure that the environment of care in AMRH is safe in order to meet the specific needs of patients identified with higher risk of fall.

3.3 To reduce the total number of falls occurring in AMRH by providing an evidence-based, patient-centered approach to reducing the risks of fall and promoting patient safety.

3.4 To enhance healthcare provider's knowledge of fall prevention and management strategies for all patients (geriatric and adult) admitted in AMRH.

4. Definitions

4.1 **Fall:** loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair; excluding falls resulting from violent blows or other purposeful actions.

4.2 **Johns 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 action could protect at risk adults from harm.

5. Policy

5.1 AMRH is committed in providing an efficient process of initial and ongoing assessment of patients at risk of falling, identifying them, and establishing proactive risk management to reduce risk of falls, thus, all healthcare professionals with direct contact to patient care must adhere to this policy and procedure at all times.

6. Procedure

6.1 **Fall risk factor**

Identification of common potentially reversible risk factors on admission and implementation of a management/care plan appropriate to the risk factor identified

6.1.1 Factors that contribute to fall among elderly patients include:

6.1.1.1 Lengthy convalescent periods

6.1.1.2 Incomplete recovery

6.1.1.3 Medication known to affect balance/cognition or polypharmacy

6.1.1.4 Increasing physical disability

6.1.1.5 Impaired vision, hearing, or mental status

6.1.2 Fall can not only cause physical injuries, but also trigger such psychological issues as a loss of self-confidence, which hastens

dependence and makes it more likely that an older person will need to move to a long-term care facility.

6.1.3 Extrinsic factors that increase the risk of falling include:

6.1.3.1 Poor lighting

6.1.3.2 Highly waxed floors

6.1.3.3 Unfamiliar surroundings

6.1.3.4 Living in an environment that contains fall hazards

6.1.3.5 Misuse of assistive devices

6.1.4 Intrinsic or physiologic risk factors include:

6.1.4.1 Age eighty (80) years or older

6.1.4.2 Lower extremity weakness

6.1.4.3 A history of a recent fall

6.1.4.4 Functional or cognitive impairment

6.1.4.5 Dizziness

6.1.4.6 Gait or balance impairment

6.1.4.7 Depression 6

6.1.4.8 Low body mass index

6.1.4.9 Urinary incontinence

6.1.4.10 Sensory deficits, particularly visual deficits and orthostatic hypotension

6.1.4.11 Neurological changes

6.1.5 Medication association with fall. This list highlights some classes of drugs and the possible adverse effects of each that may increase a patient's risk of falling.

6.1.5.1 **Alcohol**: Intoxication, motor incoordination, agitation, sedation and confusion

6.1.5.2 **Anti-diabetic drugs**: Acute hypoglycemia

6.1.5.3 **Antihistamines:** Excessive sedation, confusion, paradoxical agitation and loss of balance

6.1.5.4 **Anti-hypertensive**: Hypotension and syncope

6.1.5.5 **Antipsychotics**: Orthostatic hypotension, muscle rigidity and sedation

6.1.5.6 **Benzodiazepines:** Excessive sedation, confusion, paradoxical agitation, loss of balance

6.1.5.7 **Beta-adrenergic blockers**: Hypotension and syncope

6.1.5.8 **Diuretics:** Hypovolemia, orthostatic hypotension, electrolyte imbalance and urinary incontinence

6.1.5.9 **Hypnotics**: Excessive sedation, ataxia, poor balance, confusion and paradoxical agitation

6.1.5.10 **Nitrates**: Hypotension and syncope

6.1.5.11 **Opioids:** Hypotension, sedation, motor incoordination and agitation

6.1.5.12 **Tricyclic antidepressants**: Orthostatic hypotension

6.1.5.13 **Vasodilators:** Hypotension and syncope

6.2 Risk of Fall Assessment

6.2.1 Outpatient and A&E Assessment

6.2.1.1 For Outpatients: At the time of registration, all patients will be assessed for fall risk factors by triage nurse. And if the patients are having outpatient procedures, they will be assessed and documentation will occur in the outpatient identified at risk for falling by utilizing the following three (3) questions:

6.2.1.1.1 Do you have dizziness or vertigo?

6.2.1.1.2 Do you need help standing or walking?

6.2.1.1.3 Have you fallen within the last six (6) months?

6.2.1.2 If the patient, answers “yes” to any of these questions, the patient is considered to be at high risk for falling.

6.2.1.3 Assess and reassess fall risk using the fall risk assessment. *(See Appendix 1. Fall Risk Assessment)*

6.2.1.4 Maintain a safe environment

6.2.1.5 Monitor gait and mobility.

6.2.1.6 If the patient is being transferred to another ward, the nurse shall document and a clear handover shall be given to the receiving staff or admitting ward.

6.2.2 **Inpatient Assessment**

6.2.2.1 For Inpatients: A registered nurse will assess the inpatient immediately upon admission within six (6) hours of admission using John Hopkins fall scale in Al Shifa 3+ system. *(See Appendix 1. Fall Risk Assessment)*

6.2.2.2 Assess the client if he/she has a change in condition or is transferred to another level of care, by utilizing the Fall Risk Assessment in order to determine the inpatient's potential risk for falls. This assessment will also indicate which patients require the initiation of an appropriate fall prevention program.

6.2.2.3 Inpatients identified as being at high risk for fall which is designated Fall Risk Assessment Score of ten (10) or greater or has sustained a fall within the last six (6) months, will be placed on the fall prevention program.

6.2.2.4 Ask a patient whose age is sixty-five (65) or older or a patient who demonstrates unsteadiness or difficulty walking if he/she has fallen in the past twelve (12) months. If the patient has, ask the patient about the frequency and circumstances of the fall, and evaluate him for gait and balance deficits.

6.2.2.5 Assess for proper use of assistive devices.

6.2.2.6 Assess factors such as the patient's history of falling, his mobility, what medications he/she takes, and his mental status.

6.2.2.7 Make sure that fall prevention techniques (such as performing a fall risk assessment and instituting fall precautions) are used to reduce the risk of injury from patient falls.

6.2.2.8 Make sure the patient is checked for potential dangers in the following frequency:

6.2.2.8.1 Hourly during the daytime and evening.

6.2.2.8.2 Every two (2) hours overnight to comply with universal fall precautions.

6.2.2.8.3 Assess the need for one-on-one patient monitoring, and arrange for it as needed.

6.3 **Fall prevention**

6.3.1 If the client fall score is ≥13, the nurse shall initiate fall prevention precaution.

6.3.2 Initiate appropriate interventions to minimize the patient's risk of falling and implement multidisciplinary plan of care. Intervention is based on the level of risk.

6.3.3 Orient the patient to room and ward.

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

6.3.5 Correct potential dangers in the patient's room.

6.3.6 Provide adequate nighttime lighting.

6.3.7 Keep the bed in its lowest position so the patient can reach the floor easily when he gets out of bed. This position also reduces the distance to the floor in case the patient falls. Lock the bed's wheels.

6.3.8 Ensure that bed rails are used when patient is nursed on a trolley or during transportation on a bed or trolley.

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

6.3.10 Keep the patient's area uncluttered.

6.3.11 Keep floor surfaces clean and dry. Make sure spills are cleaned up immediately. (*Refer to Policy and Procedure of Blood and Body Fluid Spillage Management -AMRH/IC/P&P/003/Vers.02 and Policy and Procedure of Housekeeping - AMRH/GST/P&P/001/Vers.02)*

6.3.12 Instruct the patient to rise slowly from a supine position to avoid possible dizziness and loss of balance.

6.3.13 Advise the patient to wear well-fitting, nonskid footwear.

6.3.14 Alert other caregivers to the patient's risk of falling and to the interventions you've implemented.

6.3.15 Encourage the patient to perform active range-of-motion (ROM) exercises to improve flexibility and coordination.

6.3.16 Assist the patient with early and regular ambulation if his condition allows because exercise reduces the risk of falling in older people.

6.3.17 Encourage the patient to use his regular assistive device for ambulation, such as a walker or cane or other equipment recommended by physical or occupational therapy.

6.3.18 If needed, regularly schedule assistance with toileting.

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

6.3.20 Review medications that may contribute to a fall.

6.3.21 Document the procedure in Al Shifa 3+ System.

6.3.22 Document appropriate interventions for fall in the patient's file.

6.4 **Fall Management**

6.4.1 There are two key elements of the post fall procedure/management:

6.4.1.1 Initial post-fall assessment

6.4.1.2 Documentation and follow-up

6.4.2 Post Fall Assessment

6.4.2.1 **Immediate**

6.4.2.1.1 Ensure the patient is made safe and comfortable

6.4.2.1.2 Perform immediate assessment at the place of fall prior to moving the patient, evaluate the level of consciousness using the Glasgow coma scale, assess for obvious signs of body part injury. *(See Appendix 2.*

Glasgow Coma Scale)

6.4.2.1.3 Observations that may be undertaken include:

6.4.2.1.3.1 Temperature

6.4.2.1.3.2 Pulse

6.4.2.1.3.3 Blood Pressure

6.4.2.1.3.4 Respiration rate

6.4.2.1.3.5 Oxygen saturation

6.4.2.1.4 Check the blood sugar if patient is diabetic

6.4.2.1.5 Document findings in patient's records in Al Shifa 3+ system.

6.4.2.1.6 Follow the post-fall assessment and any immediate measure to protect the patient.

6.4.2.1.7 An incident report should be completed. *(Refer to Policy and Procedure of Incident Reporting and Learning System (IRLS) – AMRH/DGQAC/P&P/002/Vers.01)*

6.4.2.1.8 A detailed progress note should be entered into the patient's record including the results of the post-fall assessment in the Al Shifa 3+ system.

6.4.2.1.9 Refer the patient for further evaluation by physician to ensure other serious injuries have not occurred.

6.4.2.1.10 Notify the treating doctor on the fall incident to ensure immediate medical assessment and treatment is ordered and performed.

6.4.2.1.10.1 The Doctor should be fully informed of the findings of the nurse's clinical assessment following the fall.

6.4.2.1.10.2 The Doctor must be made aware that a Post Fall Medical Assessment should be recorded in the Medical notes.

6.4.2.1.11 Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care plans as appropriate.

6.4.2.1.12 All equipment/mobility aids should be checked for damage before reuse.

6.4.2.2 **Within 24 Hours**

6.4.2.2.1 Review Falls Risk assessment and implement relevant care plans.

6.4.2.2.2 Check postural blood pressure (if appropriate).

6.4.2.2.3 Consider referral to Occupational Therapy/Physiotherapy (if appropriate).

6.4.2.2.4 Post Fall Medical Assessment

6.4.2.2.5 Examine the patient for any obvious injury.

6.4.2.2.6 Document baseline observations.

6.4.2.2.7 Assess cognitive state and behavior and record Glasgow Coma Scale if there is evidence of head injury. *(See Appendix 2. Glasgow Coma Scale)*

6.4.2.2.8 Take a fall history and witness account which should include symptoms preceding fall and/or after fall:

6.4.2.2.8.1 Weakness

6.4.2.2.8.2 Light headedness

6.4.2.2.8.3 Vertigo

6.4.2.2.8.4 Seizure

6.4.2.2.8.5 Loss of consciousness

6.4.2.2.8.6 Pain

6.4.2.2.8.7 Nausea

6.4.2.2.9 Position: fall from bed/chair, from standing/from walking, witnessed, in toilet?

6.4.2.2.9.1 Detailed examination

6.4.2.2.9.2 Neurological examinations (has the patient had a stroke?) including gait if ambulant.

6.4.2.2.9.3 Examine the drug chart for causative drugs.

6.4.2.2.9.4 Review recent blood results.

6.4.2.2.9.5 Investigate according to findings.

6.4.2.2.10 Document any injury and organize X-rays if needed.

6.4.2.2.11 If in pain, provide appropriate analgesia. *(Refer to Policy and Procedure of Pain Management and Access Controls to Narcotic Medications - AMRH/PHARM/P&P/013/Vers.02)* Document all in patient's records in Al Shifa 3+ system.

6.4.2.2.12 Provide a fall debriefing after every patient fall, with the assistance of the manager or nursing supervisor, whether or not the patient sustains an injury.

6.4.3 **Documentation**

6.4.3.1 Incident Reports: If a patient experiences a fall, with or without an injury during their hospitalization, notify the physician, complete an incident report, notify the immediate supervisor, and notify the family.

6.4.3.2 All inpatient falls must be reported in accordance to the Incident Reporting and Learning System (IRLS) Policy. *(Refer to Policy and Procedure of Incident Reporting and Learning System (IRLS) – AMRH/DGQAC/P&P/002/Vers.01)*

6.4.3.3 Staff should discuss the actions and learning points that have arisen from any incidents at team meetings.

6.4.3.4 Document the data describing the number of falls and associated information.

6.4.3.5 Document any measures taken to help prevent a fall, including patient and family teaching and their understanding of the teaching.

6.4.3.6 If the patient refuses the use of a bed side rail, protective device, or safety advice, explain again to the patient the potential for injury due to

a fall. The conversation and/or refusal with the patient will be documented as a patient note in the appropriate medical record/kardex in Al Shifa 3+ system.

6.4.3.7 Document the post-fall assessment and any immediate measures to protect the patient.

6.4.3.8 A detailed progress note shall be entered into the patient's record by doctors including the results of the post-fall assessment.

6.5 **Patient Information/Education**

6.5.1 It is important to ensure that patient information is provided to maintain and promote patient safety in relation to fall prevention. Nurses must ensure that appropriate written advice is given to patients with a risk of fall and that this is documented in the health record.

6.5.2 Teach the patient about:

6.5.2.1 Reducing Patient Falls

6.5.2.2 Postural Hypotension

6.5.2.3 Safe use of bedrails in hospital

6.5.2.4 Staying Steady; Improving the patient's strength and balance

6.5.2.5 Healthy Bones

6.5.2.6 How to call for help if they fall.

6.5.3 Before discharge, teach the patient and his family how to prevent accidental falls at home by correcting common household hazards.

7. Responsibility

7.1 **Clinical Staff Shall**:

7.1.1. Make fall and fall-related injury prevention a standard of care and Service.

7.1.2. Implement fall and injury prevention specific to specialty patients' risk factors, for example Geriatric Unit.

7.1.3. 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.

7.1.4. Complete the fall-risk assessment on admission.

7.1.5. Ensure that rooms with vulnerable patients are assessed and corrected if necessary for slip and trip hazards.

7.1.6. Assess factors that make patients more or less at risk for falling.

7.1.7. Communicate patient's fall and injury history, risk factors, treatment plan during hand off processes.

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

7.1.9. Ensure a safe environment for the patient to protect from injury

7.1.10. Participate in post fall management.

7.2 **Ward/Shift in-charge Nurse Shall:**

7.2.1 Be responsible for the implementation of this policy within own areas of management accountability.

7.2.2 Take action to make the care environment safe to promote the safety of service users/patients by physical round in department.

7.2.3 Provide training of their staff in the applicable mandatory courses related to fall Risk Assessment and Fall Risk Management.

7.2.4 Facilitate and support their staff to use applicable fall prevention and management strategies and carrying out the completion of risk assessments.

7.3 **Triage Doctor/SHO of caring psychiatry unit/First on-call psychiatrist Shall:**

7.3.1 Identify and implement medical interventions to reduce fall and fall-related injury risk.

7.3.2 Ensure all patients are screened for risk factors for fall.

7.3.3 Document care plan clearly in patient's progress notes in Al Shifa 3+ system.

7.3.4 Communicate treatment plan with multidisciplinary team accordingly.

7.4 **Physical and Occupational Therapists Shall**:

7.4.1 Conduct patient assessments of rehabilitation needs and fall risks.

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

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

7.5 **Environment Health and Occupational Safety Officer Shall**:

7.5.1 Be responsible to conduct rounds and check for the following:

7.5.1.1 Hallways and patient areas are well lit.

7.5.1.2 Hallways and patient areas are uncluttered and free of spills.

7.5.1.3 Locked doors are kept locked when unattended.

7.5.1.4 Handrails are secured, non-skid and unobstructed.

7.5.1.5 Tables and chairs are sturdy.

7.5.1.6 Chairs are at proper height with arm rests.

7.5.1.7 Beds are height adjustable to raise the bed at the proper height for patient standing, lowering, and transfers.

7.5.1.8 Bathrooms have raised toilets

7.5.1.9 Furniture with sharp edges are padded.

7.5.2 Ensure that all assistive devices are working properly by inspecting them on a regular basis.

7.5.3 Ensure that devices to secure cords off floors are operational.

7.5.4 Ensure proper lighting, motion-sensor lighting is working.

7.5.5 Ensure the availability of non-skid flooring or padded flooring in bathrooms.

7.6 **Quality Management and Patient Safety Department Shall**:

7.6.1 Promote awareness of this policy to support implementation of evidence-based best practice. This will involve the training in the use of fall risk assessment and management.

7.6.2 Provide advice and support to Directors and Senior Managers to facilitate effective implementation and monitoring of the policy. Ensuring the key

recommendations of the policy is followed.

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

8. Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
1	Initial Release	Badriya Al Ghammari	January 2021
2	Reviewed & Updated	Badriya Al Ghammari	May 2025
Written by	**Reviewed by**	**Approved by**	
Badriya Al Ghammari	Dr. Said Al Kaabi	Dr. Bader Al Habsi	

9. Related Documents

9.1 Policy and Procedure of Blood and Body Fluid Spillage Management – AMRH/IC/P&P/003/Vers.02

9.2 Policy and Procedure of Housekeeping - AMRH/GST/P&P/001/Vers.02

9.3 Policy and Procedure of Incident Reporting and Learning System (IRLS) – AMRH/DGQAC/P&P/002/Vers.01

9.4 Policy and Procedure of Pain Management and Access Controls to Narcotic Medications - AMRH/PHARM/P&P/013/Vers.02

9.5 Appendix 1. Johns Hopkins Fall Risk Assessment Form

9.6 Appendix 2. Glasgow Coma Scale

9.7 Appendix 3. Audit Tool

10. References

Title of book/journal/articles/ Website	Author	Year of Publication	Page
Nursing protocol, Fall Prevention	MOH, The Directorate General for Nursing Affairs	2015	1-7
Nursing protocol, Fall management	MOH, The Directorate General for Nursing Affairs	2015	1-11
Falls Policy for Reducing and Managing Inpatient Falls	NHS Shetland/Shetland Islands Council Falls Strategy Group, Co-ordinated by Jo Robinson	2014	1-17
CH patient fall prevention Policies & Procedures	SJMC, SMMC, Carondelet Health Policies & Procedures	2011	1-8

Appendices

Appendix 1. Johns Hopkins Fall Risk Assessment Tool

Sultanate of Oman
Ministry of health
Al Masarra Hospital

سلطنة عمان
وزارة الصحة
مستشفى المسرة

Johns Hopkins Fall Risk Assessment Tool		
Patient Details: **If patient has any of the following conditions, 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 - (If no option is selected, score for category is 0)		
Options	**Selection**	**Score**
Age (single-select) 60-69 Years (1 point) 70-79 Years (2 points) >=80 Years (3 points)	**Total Score :**	
Fall History One fall within 6 months before admission (5 points)		
Elimination, Bowel & Urine (single select) Incontinence (2 points)		

Urgency or Frequency (2 points) Urgency / Frequency & Incontinence (4 points)		
Medications (single select) On 1 high fall risk drug (3 points) On 2 or more high risk drugs (5 points) Sedated Procedure with past 24 hours (7 points)		
Patient Care Equip. (single select) One Present (1 points) Two Present (2 points) Three or more Present (3 points)		
Mobility (multi select) Require 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) Altered Awareness of immediate physical environment (1 point) Impulsive (2 points) Lack of understanding of one's physical & cognitive limitations (4 points)		
Fall Risk Band Applied:		

Appendix 2. Glasgow Coma Scale

The Glasgow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. This scale measures three responses to stimuli—eye opening, motor response, and verbal response—and assigns a number to each of the possible responses within these categories. The lowest possible total score is 3; the highest, 15. A total score of 7 or less indicates coma. The Glasgow Coma Scale is commonly used in the department, at the scene of an accident, and for evaluating the hospitalized patient.

	Characteristic	Response/Score		Total
1	Eye opening	□ Spontaneous	4	
		□To verbal command	3	
		□To pain	2	
		□No response	1	
2	Best motor response	Obeys commands To	6	
		□ painful stimuli Localizes pain; pushes stimulus away	5	
		□ Flexes and withdraws	4	
		□ Abnormal flexion	3	
		□ Abnormal extension response	2	
		□ No response	1	
3	Best verbal response (Arouse patient with painful stimuli if necessary.)	□ Oriented and converses	5	
		□ Disoriented and converses	4	
		□ Uses inappropriate words	3	
		□ Makes incomprehensible sounds	2	
		□ No response	1	
	Total: 3 to 15			

Appendix 3. Fall Risk Assessment and Fall Management Audit Tool

Department: _____ **Date: _____**

S.N.	Audit Process	Standard / Criteria	Yes	Partial	No	N/A	Comment
1.	Interview Document review	Does health care giver aware about fall P&P.					
2.	Observation Interview Document review	Does Triage nurse assessed identify client at risk for fall using risk assessment tool.					
3.	Observation Interview	Does Triage doctor assess the patient of fall risk and develop a treatment plan accordingly.					
4.	Interview Document	Does Triage nurse & doctor Identify of common potentially reversible risk factors on admission and					

	review	implementation of a management/care plan appropriate to the risk factor identified					
5.	Observation Interview Document review	Does Treatment plan to is clearly documented in the system before sending the client to the concerned ward					
6.	Observation Document review	Does assigned nurse Complete the fall-risk assessment on admission					
7.	Observation Interview Document review	Does assigned nurse took appropriate action to make the environment safe to promote the safety of service users/patients.					
8.	Observation Interview	Is the patients assessed fall risk every shift using formal risk					

	Document review	assessment form					
9.	Observation Interview Document review	Is the patient observed closely, at irregular intervals					
10.	Observation Interview	Does the nurse Observe changes in the client mood, elation, withdrawal and document in nursing kardex. Notifies treating doctor of patient at risk of fall					
11.	Interview Document review	Does the nurse Ensuring equipment on the unit is working properly and receiving scheduled maintenance.					

12.	Observation Interview	Does the nurse ensuring that rooms with vulnerable patients are assessed and corrected if necessary for slip and trip hazards					
13	Document review	Does the nurse Implement patient education based on health literacy to assure patient engagement in care, along with family / caregiver as appropriate					
14	Document review	Does the nurse Following the post-fall assessment					
15	Observation Document review	Does the nurse Participate in post fall management					

Appendix 5. Document Request Form

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Badriya Al Ghammari	Date of Request	May 2022
Institute	Al Masarra Hospital	Mobile	95268636
Department	Nursing Affairs Department	Email	-
The Purpose of Request			
☐ Develop New Document	☑ Modification of Document	☐ Cancelling of Document	
1. Document Information			
Document Title	Policy and Procedure of Fall Prevention and Management		
Document Code	AMRH/NSG/P&P/003/Vers.02		
Section B: Completed by Document Controller			
☑ Approved	☐ Cancelled	☐ Forward To:……..	
Comment and Recommendation:			
Name	Ruvilee Ramel-Bueno	Date	May 2022
Signature	RBueno	Stamp	

AL-MASARRA HOSPITAL
QUALITY MANAGEMENT DEPT.
SULTANATE OF OMAN- MINISTRY OF HEALTH

Appendix 6. Document Validation Checklist

Document Validation Checklist

Document Title: Policy and Procedure of Fall Prevention and Management		**Document Code:** AMRH/NSG/P&P/003/Vers.02			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp				
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)	✓			
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms	✓			
3.4	Procedures to define flowchart		✓		CAN BE ADDED IN THE NEXT VERSION
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			
Recommendations…✓…. For implementation ……. More revision …….. To be cancelled……..					
Reviewed by: Kunooz Al Balushi		**Reviewed by:** Ruvilee Ramel-Bueno			

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