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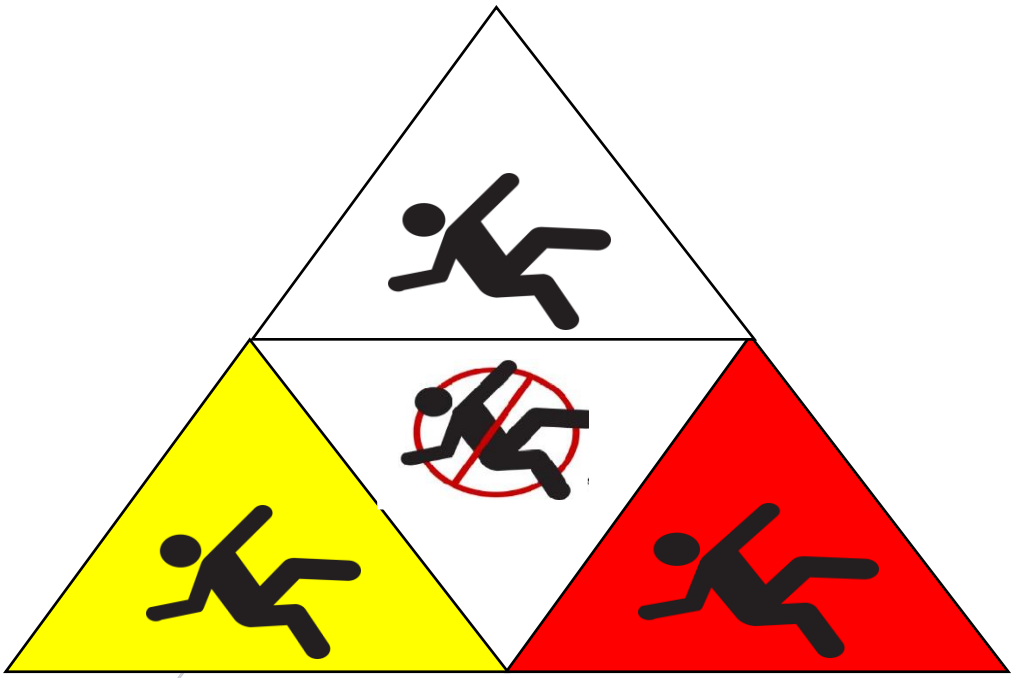
Reference Guide for Nurses in the Prevention Of Patient Fall



Fall Prevention Is the Responsibility of All Healthcare Workers

BAHAGIAN KEJURURAWATAN
KEMENTERIAN KESIHATAN MALAYSIA

2nd Edition
Reviewed December 2018

FORWARD

BY THE DIRECTOR GENERAL OF HEALTH MALAYSIA

Falls are the second leading cause of accidental or unintentional injury deaths worldwide. Adults older than 65 years of age made up an estimated 646,000 individuals who die from fall globally and 37.3 million falls are severe enough to require medical attention each year(WHO,2018).

Patient fall is a major concern for any hospitals. The enthusiasm shown by Nursing Division staff in devoting their precious time in making the "Reference Guide for Nurses in Prevention of Patient Fall" is one of their quest to maintain and uphold quality in their nursing profession.

Thus, effective fall prevention intervention initiated by the Nursing Division Ministry of Health Malaysia such as adopting the use of risk assessment tools like the Morse Falls Scale Assessment (Adult), the Humpty Dumpty Falls Risk Assessment Scale (Paediatric) and the intervention tools are essential components to a comprehensive falls reduction and prevention methods in hospitals. The purpose of a falls risk assessment is to identify patient's intrinsic risk for falling, minimize risk-factors and most importantly to prevent falls and injuries.

However, it is important to note that risk assessment tools does not replace good nursing judgement, nor does it contain the instruments to identify every instance when a fall may take place.

Through the effort of this Reference Guide book, I wish to extend my gratitude and thanks to the leadership and invaluable support of the Director of Nursing Ministry of Health Malaysia, and her team members in developing this Reference Guide book for the nurses into reality.

In conclusion, I would like to extend my heartiest congratulations to the Nursing Division for producing yet another milestone within their department.

YBhg. Datuk Dr. Noor Hisham bin Abdullah
Director General
Ministry of Health, Malaysia

MESSAGE

BY THE DIRECTOR OF NURSING, MALAYSIA

FALLS, are a major safety concern for hospitalized patients. Falls can increase length of stay, reduce quality of life and are costly both to patients and hospitals. Therefore, falls have been included as one of the Malaysian Patient Safety Goals. Nurses are responsible for providing direct care to patients and for meeting the hospitals' patient safety goal. They play a vital role in the prevention of falls, intervention post falls and the education of others about falls.

Both genders are at risk of falls across all age groups and the health of each individual can affect the type and severity of injury. However, older people have the highest risk of death or serious injury caused by falls and this increases with age.

Another high risk group for fall is children due to their evolving developmental stages, curiosity of their surroundings and their increasing levels of independence and risk taking behaviours.

Therefore, nurses play a pivotal role in developing or adopting an effective falls risk assessment, prevention and intervention strategies aiming at the reduction in the number of patients from falls and to prevent the severity of injury sustained, should a fall occur. Using a reliable and valid tool for falls risk assessment is essential and the Nursing Division Ministry of Health Malaysia has identified and adopted the Morse Falls Risk Assessment Scale for adult and the Humpty Dumpty Falls Risk Assessment Scale for the Paediatric population as tools to assess patients.

This Reference Guide for Nurses in Prevention of Fall text is comprehensive, clear and concise and the instructions on how to use the two falls risk assessment tools are clearly explained.

I strongly believe that this reference guide book will be of tremendous help to the nurses in not only improving their knowledge and nursing skills but also to inculcate a sense of professionalism in handling and performing their noble duties accordingly for patients' safety.

In conclusion, I wish to take this opportunity to express my sincere thanks to all the technical working members, contributors and the reviewers who refined the contents of this text in making it a reality for all the nurses in the Ministry of Health, Malaysia.

Matron Hjh. Tumble@Tomblow binti Ngadiran
Director of Nursing
Ministry of Health, Malaysia

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ADVISOR

Puan Hjh. Tumble@Tomblow Ngadiran
Director of Nursing Division
Ministry of Health Malaysia

EDITOR

Puan Monica Chee Soon Nyuk
Senior Assistant Director of Nursing
Nursing Division
Ministry of Health Malaysia

TECHNICAL WORKING GROUP

Puan Tan Ai Lian@Irene
Senior Assistant Director of Nursing
Nursing Division
Ministry of Health Malaysia

Puan Saibiah@Salbiah Sindot
Senior Assistant Director of Nursing
Nursing Division
Ministry of Health Malaysia

Puan Sarimah binti Abdul Rahman
Nursing Matron
Nursing Division
Ministry of Health Malaysia

Puan Siti Fazilah binti Sheikh Abdullah
Nursing Matron
Nursing Division
Ministry of Health Malaysia

Puan Aishah Ibrahim
Nursing Matron
Shah Alam Hospital, Selangor

Puan Romiza binti Abd Manap
Nursing Matron
Serdang Hospital, Selangor

Puan Hasnah Selamat
Nursing Matron
Sungai Buloh Hospital, Selangor

Puan Norinah Binti Md Hashim
Nursing Matron
Kuala Lumpur General Hospital

Puan Wan Rahayu binti Wan Hassan
Nursing Matron
National Cancer Institute, Malaysia
Putrajaya.

Puan Syabina Puteh
Nursing Matron
Kajang Hospital, Selangor

Puan Yusliza binti Ishak
Nursing Sister
Rehabilitation Hospital, Cheras
Kuala Lumpur

Puan Muszaabah binti Musa
Nursing Sister
Rehabilitation Hospital, Cheras
Kuala Lumpur

Puan Faezah Nordin
Nursing Sister
Serdang Hospital, Selangor

Puan Hoe Bee Yng
Nursing Sister
Serdang Hospital, Selangor

Puan Emiza Binti Abd Zahid
Staff Nurse (KUP)
Kajang Hospital, Selangor

REVIEWERS

Dr. Nor'Aishah binti Abu Bakar
Public Health Physician
Head of Patients Safety Unit
Quality in medical Care Section
Medical Development Division
Ministry of Health, Malaysia

Dr. Elizabeth Chong Gar Mit
Consultant Geriatrician
Hospital Kuala Lumpur

Dr. Nordiana binti Nordin
Consultant Geriatrician
Hospital Sungai Buloh

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1. INTRODUCTION

World Health Organisation places great emphasis on Patient Safety and had launched the World Alliance for Patient Safety in 2004. Malaysia adopted this programme in May 2006 and became one of the pioneer members of this global effort to enhance Patient Safety which is now an ongoing responsibility of all hospital staff.

As quoted by our Director-General of Health Malaysia in his "Forward" in the Malaysian Patient Safety Goal Guidelines on Implementation & Surveillance book, 1st Edition 2013:

"Safety is everyone's business! Let us all work together in the spirit of teamwork and learning to make our health care system a safer one in 2013 and beyond. Success does not consist in never making mistakes but in never making the same one a second time."

The Falls Risk Interventions for adult and paediatric populations are to be practiced across all hospital areas to help safeguard patients. Failure to maintain a safe and conducive environment can put patients at risk for falls. Thus, implementation of the Falls Risk Interventions requires training of all hospital staff who interact with patients to reduce the risk of patient injuries due to falls. The hospital staff especially nurses, will need to assess and reassess the patient's level of risk for falls to ensure that his/her patients are safe during their stay in the hospital.

2. OBJECTIVES OF THE GUIDELINES

- To identify patients who are at risk of falls
- To prevent falls incidences from occurring
- To implement preventive strategies

3. PURPOSE

A process exists to prevent patient falls by:

i) establishing a consistent mechanism to identify patients who are at risk of falls upon admission using the Morse Falls Scale Assessment Chart(BKJ-BOR-PPK-Fall 2 Pind. 1/2018) and the Humpty Dumpty Falls Risk Assessment Chart for Paediatric (BKJ-BOR-PPK-Fall 6 pind.1/2018).

ii) providing an on-going assessment to those patients identified as a falls risk by utilising the Daily Morse Falls Scale Assessment Chart and the Humpty Dumpty Falls Risk Assessment Chart for Paediatric.

iii) establishing a comprehensive standard of care for the initiation of appropriate safety measures and interventions.

4. DEFINITION OF FALL

Fall : A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient. All types of falls are to be included whether it is from physiological reasons(fainting) or environmental reasons(slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall. (NCPS Concept Dictionary)

5. CLASSIFICATION OF FALL :

5.1 **Accidental Fall:** Fall that occurs unintentionally (e.g. slip, trip). Patients at risk for these falls cannot be identified prior to a fall and generally do not score as having a high risk of fall. These falls maybe prevented if a safe environment is provided.

5.2 **Unanticipated Fall:** Fall that occurs when the physical cause of the fall is not reflected in the patient's assessed risk factors for fall.

5.3 **Anticipated Fall:** Fall that occurs in patient whose risk factor score indicated the patient is at risk of falling.

5.4 **Near fall:** An event in which a person feels a fall is imminent but avoids it by compensatory action, such as grabbing a nearby object or controlling the fall.

(Medical Dictionary)

5.5 **Repeat fall:** More than one fall by the same patient after admission to this unit, may be classified as a repeat fall

(NDNQI 2012)

6. Falls occurs due to a combination of **intrinsic** and **extrinsic** risk factors. Intrinsic factors are pathology affecting the body systems involve in e.g. balance, vision and reduction in muscle strength. . Extrinsic factors are things within the environment contributing to falls of which most of them can be avoided.

6.1 INTRINSIC FACTOR:

- Advanced age
- Previous history of falls
- Muscle weakness
- Chronic medical conditions like stroke, arthritis, incontinence, dementia and Parkinson Disease
- Poor vision
- Gait and balance problems
- Medications E.g. psychotropics, sedatives

6.2 **EXTRINSIC FACTOR:**

- Lack of bathroom grab bars
- Slippery surface
- Uneven surface
- Loose electrical cords or mats
- Dim lighting or glare
- Improper use of assistive device
- Lack of stair handrails

In the **paediatric group**, children younger than five years of age are at the greatest risk for falls due to contributing factors such as curiosity and immature motor skills and lack of judgement (e.g. climbing on a chair to obtain toys that are out of reach or from playground equipment).

Additional predisposing factors for paediatric fall injuries identified include history of previous unintentional injury, neurological disorders like seizures, developmental delay, hyperactivity and documented parental neglect.

Infants are at risk for falling from furniture, adult beds or stairs and toddlers are at risk for falling from windows especially in low-income families where safety equipment is lacking (e.g. window guards)

7. PROCEDURE

7.1 The registered nurse will screen every patient for potential falls risk upon admission or transferred in by utilizing the Daily Morse Falls Assessment Chart (BKJ-BOR-PPK Fall 2 Pind.2/2018) for adults and the Humpty Dumpty Falls Risk Assessment Chart (BKJ-BOR-PPK-Fall 6 pind.2/2018) for the Paediatric population.

7.2 Each patient will be reassessed on daily basis.

7.3 Reassessment must be completed if there is a change in the patient's mental status or physical condition.

8. INSTRUCTION FOR COMPLETION OF THE DAILY FALLS RISK ASSESSMENT FORM

8.1. The nurse will evaluate the patient by scoring each of the "At Risk" criteria the patient presents with. The total score of the assessment, along with the nurse's clinical judgement, will assist the nurse in risk stratification of the patient's level of risk for falls. Should the nurse based upon her clinical judgement chooses to deviate from the risk level determined by the falls risk assessment, he/she must document in the patient's case notes the reason which supported his/her decision.

8.2. The nurse will then identify and adhere to the Falls Risk Intervention Strategies for patients at either low, moderate or high risk for falls based upon:

8.2.1. Identified Level of Risk

8.2.2. Individualized patient needs and limitations

8.2.3. Patient's history of falls and use of safety devices

8.2.4. Daily Morse Falls Assessment (Adult) and Humpty Dumpty Fall Risk Assessment Scale Chart (Paediatric)

8.3. The Falls Risk Intervention for patients at either low, moderate or high risk must be Initiated and appropriate equipment required must be utilised.

8.4 Documentation of the falls risk should be done in the Daily Morse Falls Assessment Chart for adult and the Humpty Dumpty Falls Risk Assessment Scale Chart for the Paediatric population and also in the patient's case notes.

8.5 Communication: Each patient's assessed data risk for falls will be communicated at every shift through end- of- shift report.

8.6 Reassessment:

8.6.1 Patient with risk for falls will be reassessed daily.

8.6.2 Any change in the patient's level of risk will be recorded into the Daily Morse Falls Scale Assessment Chart or Humpty Dumpty Falls Risk Assessment Scale Chart and documented in the patient's case note.

9. EDUCATE THE PATIENT, THEIR FAMILY AND CARERS ON FALLS RISK INTERVENTIONS

Provide education on falls risk interventions to the patient, their family and carers. Talk to them about their knowledge and perceptions of falls risk and things they could help to do to reduce the risk of falls such as the followings:

9.1 STANDARD FALLS RISK INTERVENTIONS FOR ALL PATIENTS (ADULT)

9.1.1 Orientate the patient to his/her new surrounding including the toilet and to provide regular reorientation (daily) for patients with cognitive impairment.

9.1.2 Ensure that the patient uses his /her glasses and / or hearing aids (if required).

9.1.3 Advice the use of covered shoes or nonslip footwear to prevent slipping.

9.1.4 Avoid oversize clothing as patient can tripped and fall.

9.1.5 Instruct the patient to call for assistance when necessary.

9.1.6 Place a call bell at the bedside locker within patient's reach (if available).

9.1.7 Make sure that the bed or wheelchair is locked when the patient is transferred from the bed.

9.1.8 Assist patient with toileting when required.

9.1.9 Conduct regular environmental rounds to look out for hazards that can cause falls, to keep the bathroom light on and the floor dry.

9.1.10 Evaluate if medications are appropriate /required and consult with doctor and pharmacist as needed.

9.2. MODERATE FALLS RISK INTERVENTIONS FOR ADULT

9.2.1 Identify delirium and observe closely.
9.2.2 Check for postural hypotension and manage appropriately.
9.2.3 Reinforce instructions to always call for assistance
9.2.4 Supervise and assist ambulation and activities of daily living when necessary.
9.2.5 Conduct 4 hourly safety checks where appropriate.
9.2.6 Check the patient when visitors leave.
9.2.7 Apply a "YELLOW" signage at the patient's bed.

*** All the above measures for the standard and moderate falls risk interventions strategies should be performed if the assessment score is between 1- 45 during admission.**

9.3 HIGH FALLS RISK INTERVENTIONS FOR ADULT

9.3.1 Place patient near nurses' station (if possible)
9.3.2 Raised both bed rails (if appropriate) and lower the bed to the lowest position
9.3.3 Reinforce education to the patient and caregiver on measures to prevent fall.
9.3.4 Apply a "RED" signage at the patient's bed.
9.3.5 Ensure that patient is assisted at all times during activities of daily living (ADL).

9.4 LOW FALLS RISK INTERVENTIONS FOR PAEDIATRIC POPULATION (Score 7-11)

9.4.1 Use of non-skid footwear for patients who ambulate.
9.4.2 Use appropriate size clothing to prevent risk of tripping.
9.4.3 Assess for adequate lighting, leave nightlights on.
9.4.4 Patient and family education available to parents and patients.
9.4.5 Document falls prevention teaching in the nursing narrative notes and care plan.

9.5 HIGH FALLS RISK INTERVENTIONS FOR PAEDIATRIC POPULATION (Score 12 or more)

9.5.1 Put up "Red" signage at the patient's bed.
9.5.2 Remove all unused equipment from the room.
9.5.3 Keep doors open unless specified isolation precaution are in use.
9.5.4 Keep bed in lowest position.
9.5.5 Evaluate medication administration times.
9.5.6 Educate patient/caregiver regarding falls prevention
9.5.7 Document in the nursing narrative notes and care plan

10. IN THE EVENT OF A PATIENT FALL, WITH OR WITHOUT INJURY:

The staff member who discovered the fall will attend to the patient's immediate needs:

10.1 A nurse will assess the patient immediately and notify the ward sister or sister on call.

10.2 The doctor on duty should be notified to determine the need for further evaluation.

10.3 The nurse follows the doctor's treatment orders post-fall and implement the nursing care according to the patient fall care plan.

10.4 Move the patient closer to the nurse's station if a bed is available and put up bedside rails (if required and appropriate).

10.5 If the patient is demonstrating some degree of cognitive dysfunction, observe/monitor patient closely.

10.6 Neurological checks and vital signs should be performed as ordered.

10.7 Patient is to be observed closely and assistance should be provided for the first 24 hours and reassessment should be performed.

10.8 All falls should be notified to the family/caregivers as soon as possible after the patient is assessed by a doctor with the outcome report of the level of injury.

10.9 The incident should be documented in patient's case note and Incident Report Form (IR2.0/2017) is to be filled in. The patient's case note will be completed to include:

- 10.9.1 Patient's appearance at time of discovery
- 10.9.2 Patient's response to event
- 10.9.3 Evidence of injury
- 10.9.4 Location of incidence
- 10.9.5 Notification
- 10.9.6 Medical/nursing actions taken

10.10 The nurse who witness the fall or found patient after an un-witness fall should complete an incident report and send to the Ward Sister. The ward sister will then send the incident report to the Incident Report Committee/ Co-ordinator collecting the Incident Report for the hospital.

10.11 Teachings about falls and safety measures will be reinforced to patient/caregiver as needed.

10.12 Patient's falls risk will be reassessed utilizing the "Daily Morse Falls Scale Assessment Chart" (BKJ-BOR-PPK-Fall 2 Pind.3/2018) or "Humpty Dumpty Falls risk Assessment Scale Chart (Paediatric population) (BKJ-BOR-PPK-Fall 6 Pind.2/2018) immediately after the fall and identification of appropriate interventions should be performed.

NOTE: ***For a specialised hospital or special wards where Morse FallsScale Assessment Chart is not feasible or suitable to be used to assess their patients, the facility concerned is allowed to use their own Falls Risk Assessment Scale Chart.***

HOW TO USE THE MORSE FALLS SCALE RISK ASSESSMENT TOOL

Every patient will be assessed:

- On admission
- Daily on the morning shift
- When patient's condition changes or there has been a change in the patient's medication regimen that could put the patient at risk of a fall.
- When a patient is transferred to another unit.
- After a fall

1. **History of Falling:**
   If the patient has fallen during the present hospital admission or there was an immediate history of physiological falls, such as seizures or an impaired gait, **score 25**. If the patient has not fallen**, score 0**.

2. **Secondary Diagnosis:**
   If the patient has more than one medical diagnosis and is active for current admission**, score15**; if only 1 active medical diagnosis, **score 0**.

3. **Ambulatory Aid:**
   If patient is clutching on the furniture for support, **score 30**. If the patient uses crutches, a cane or a walker, **score 15**. If the patient walks without walking aid, uses a wheelchair or is on bed rest, nurse assisted and does not get up at all, **score 0.**

4. **Intravenous Therapy/Heparin lock (IV devices):**
   If patient has intravenous therapy attached to an equipment or a heparin lock inserted, **score 20**; if none **score 0.**

5. **Gait:**
   If patient had an impaired gait; has difficulty rising from a chair, uses the arms of the chair to push off, head is down, eyes focus on the floor, uses moderate to heavy assistance for balance through use of furniture, persons or walking aids and steps are short or shuffled, **score 20.**
   If patient walks with a weak gait; patient is stooped; unable to lift head without losing balance or support is required with limited assistance and steps are short and shuffled, **score 10**. If the patient walks with a normal gait, **score 0.**

6. **Mental status:**
   Identifying the patient's self- assessment of his/her ability to walk. If the patient over estimates his/her physical ability, **score 15**.
   If the patient's assessment is consistent with his/her ability, **score 0**

Definitions to Assist in Grading the Humpty Dumpty Falls Assessment Scale

The Humpty Dumpty Falls Assessment Scale requires nursing judgment and individualization to each patient.

❖ Age- Parameter can be based on chronological or developmental age of the patient.

❖ Gender- Self explanatory

❖ Diagnosis- (Associated symptoms that put patient at risk for falls)

- If the patient has multiple, secondary or underlying diagnosis then the score is based on the highest acuity diagnosis. (example- a sickle cell patient with history of strokes or seizures would receive the higher neurological score)

Examples of diagnosis include but are not limited to-

o ***Neurological***-seizures, head traumas, hydrocephalus, cerebral palsy, etc. This would include patients being worked up for neurological diagnosis.

o ***Alterations in oxygenation***- This category encompasses any diagnosis that can result in the decrease in oxygenation to the brain or a decrease in oxygen carrying ability of the red blood cells. Alteration in oxygenation goes beyond respiratory diseases and may include dehydration, anaemia, anorexia and syncope.

o ***Psychiatric/Behavioural disorders***- can include mood disorders (major depression, bi-polar disorder) and impulse control disorders e.g. ADHD (attention-deficit/hyperactivity disorder)

o ***Other diagnosis***- anything that does not fall into the other categories (examples include but not limited to cellulites, orthopaedics)

❖ **Cognitive Impairments**- (1- Awareness of one's ability to function and perform ADLs; 2- Not necessarily based on age rather on physiologic components that affect cognitive awareness)

- Not aware of limitations- Can be any age group and is dependent on inability to understand the consequences to their actions. (Example- severe head trauma, infancy)
- Forgets limitations- Can be any age group. The child has the ability to be aware of their limitations however do to the factors such as age, diagnosis, current presenting symptoms, or current alteration in function (such as weakness or hypoglycaemia) the child forgets their limitations. Can include children prone to temper tantrums.
- Oriented to ability- Able to make appropriate decisions, understanding consequences of actions.

- Environmental Factors -
    - History of Falls- during admission or previous admission.
    - Infant/toddler placed in bed- Inappropriate placement of infant/toddler in a bed versus a proper placement in a crib.
    - Patient uses assistive devices- includes but not limited to crutches, walkers, canes, splints.
    - Infant/toddler in crib- appropriate crib placement.
    - Furniture/Lighting- multiple pieces of furniture or pumps/low lighting in the room.
    - Patient placed in bed- appropriate bed placement.
    - Outpatient area- in-patient receiving services in an outpatient area.

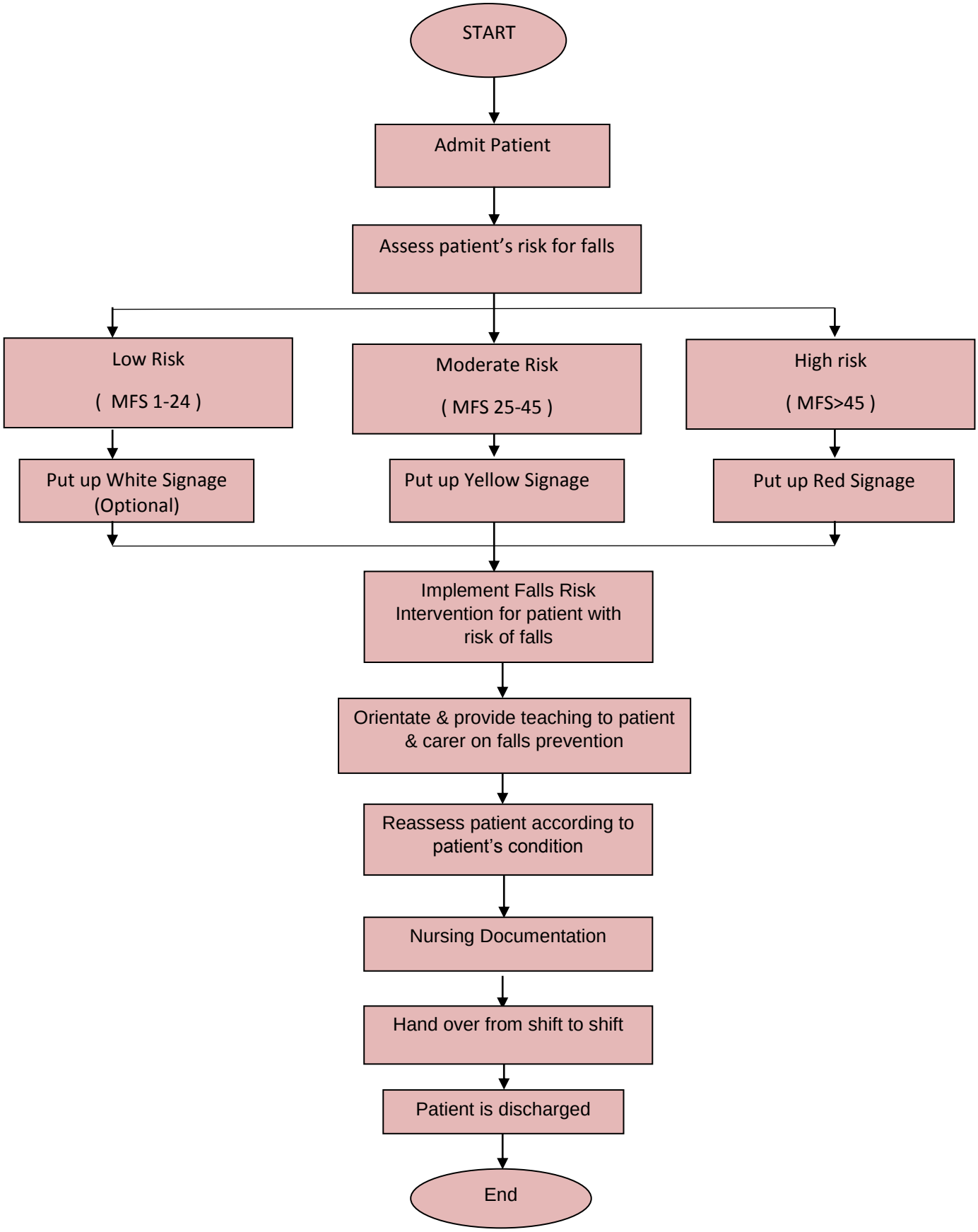
- Response to Surgery/Sedation/Anaesthesia- Patient received one within in the allotted time frames. No including bedside procedures without anaesthesia.

- Medication Usages- Purpose of this section is to identify patients who may be at risk for alteration in level of consciousness due to medications that affect cognitive awareness. Medications that are included in any for the medications categories are included, including seizure medications.

https://www.nicklauschildrens.org/NCH/media/docs/pdf/Nursing/HDFS-definitions-cheat-sheet.pdf. Date retrieved on 8/3/2018

APPENDIX 1

FLOW CHART ON MANAGEMENT OF PATIENT WITH RISK FOR FALLS



APPENDIX 2

SIGNAGES TO USE FOR PATIENT WITH RISK FOR FALLS

SIGNAGE - LOW RISK FOR FALLS

Morse Falls Scale - Score 1 - 24

SIGNAGE-MODERATE RISK FOR FALLS

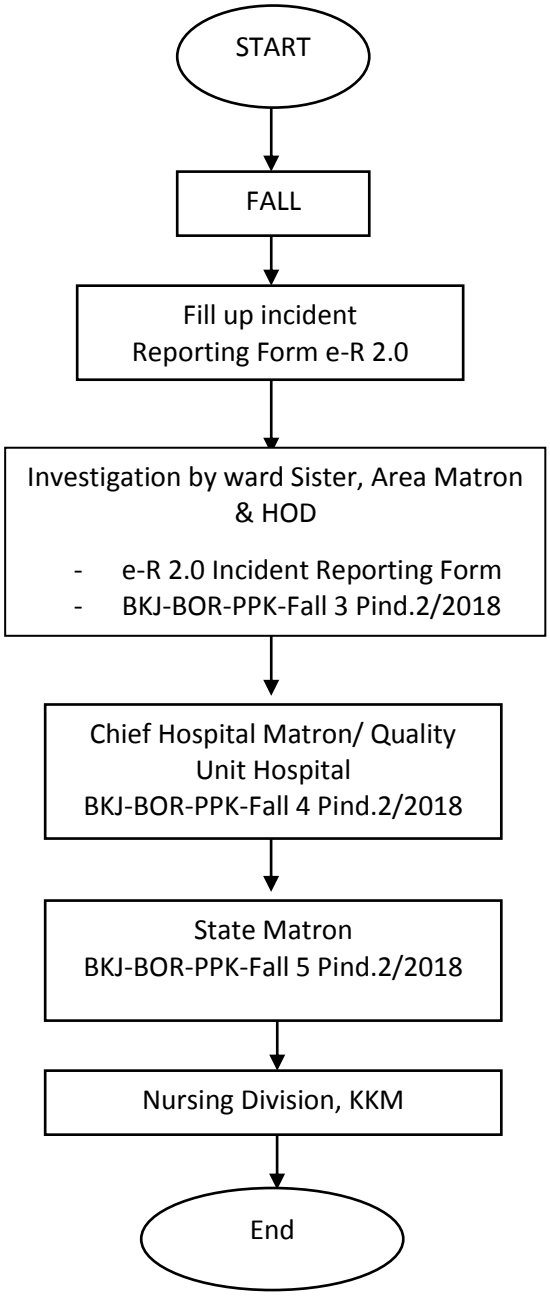
Morse Falls Scale - Score 25 - 45

SIGNAGE–HIGH RISK FOR FALLS

Morse Falls Scale - Score> 45

APPENDIX 3

FLOW CHART FOR DATA COLLECTION



APPENDIX 4

BKJ-BOR-PPK- Fall-1(Pind.2/2018

NURSING DIVISION

MINISTRY OF HEALTH MALAYSIA

CHECK LIST FOR PATIENT AT RISK FOR FALLS

NAMA :	**RN:**		
BIL	**PERKARA**	**YES (√)**	**NO (X)**
1.	Nurse performed Nursing Assessment On Admission For Adult or Paediatric patients: - BKJ-BOR-PPK-20 Adult (Pind.1/2016) - BKJ-BOR-PPK-21 Paediatric (Pind.1/2017)		
2.	Nurse assessed risk for falls using the Daily Morse Falls Scale Assessment chart(BKJ-BOR-PPK-Fall 2 Pind.3/2018) or the Humpty Dumpty Falls Risk Assessment Scale Chart (BKJ-BOR-PPK-Fall 6 Pind.2/2018)		
3.	High risk patient is placed near nurses' counter with both bedrails put up at all times		
4	Put up Signage according to risk assessment: **For adults:** **Low Risk** - White colour(Optional); **Moderate Risk** - Yellow colour **High Risk** - Red colour (Refer Appendix 2) **For Paediatric patients:** **Low Risk** - Yellow colour **High Risk** - Red colour		
5.	Did the nurse explain to patient or carer on the risk of falls prevention?		
7.	Was the written consent taken from the patient's relative for the patient who is restless and needed to be restrained? Documented in patient's case note?		
8.	Was documentation done accordingly & correctly in the above mentioned forms?		

Comments:

_____

_____

_____

***To be used by Nursing Sister or Area Matron to check on nurse's compliance on implementation of risk for falls intervention**

APPENDIX 5

BKJ-BOR-PPK-Fall 2(Pind.2/2018)

NURSING DIVISION

MINISTRY OF HEALTH MALAYSIA

DAILY MORSE FALLS SCALE ASSESSMENT CHART

NAME:	REG NO.:	WARD:
DIAGNOSIS:	Age:	ADMISSION DATE:

ITEMS		DATE							
		TIME							
		SCORE							
History of Fall: NO	0								
YES	25								
Secondary Diagnosis If only 1 active medical diagnosis	0								
Secondary diagnosis ≥2 medical diagnosis in chart	15								
Ambulatory Aids None/Bedrest /Nurse assist	0								
Crutches/Cane/Walker	15								
Furniture (Patient clutched onto the furniture for support)	30								
IV Therapy / Heparin Lock (IV Devices)	No : 0								
	Yes: 20								
Gait Normal/Bedrest/ immobile	0								
Weak	10								
Impaired	20								
Mental Status Oriented to own ability	0								
Over estimates or forgets limitations	15								
Total Score:									
Signature of Staff:									

LEVEL OF RISK	**MFS**	**COLOUR CODE**	**Action**	Patient assessment **MUST be done Daily** and during change of patient's status
NO RISKS FOR FALLS	0	NONE	Implement Standard Falls Risk Interventions	
LOW RISK	1 - 24	WHITE		
MODERATE RISK	25 - 45	YELLOW	Implement Moderate Falls Risk Interventions	
HIGH RISK	>45	RED	Implement High Falls Risk Interventions	

Adopted Source: Morse, J.M (1997). Preventing Patient falls. Thousand Oaks: Sage Broda. 1999 Safety Operating Instruction

APPENDIX 6

BKJ-BOR-PPK-Fall 3(Pind.2/2018)

NURSING DIVISION
MINISTRY OF HEALTH MALAYSIA
QUARTERLY DATA COLLECTION OF PATIENT FALL

WARD:_____ MONTH:_____

No.	Month	Total no. of patient falls		Rate	Total no. of patient falls		Rate	No. of patient falls with injuries		Brief summary of incident & Please send RCA report	Action taken
		Adult			Paediatric			Adult	Paeds		
		N	D		N	D					
	JAN										
	FEB										
	MAC										
	APR										
	MEI										
	JUN										
	JUL										
	OGOS										
	SEPT										
	OCT										
	NOV										
	DIS										
	JUMLAH										

To be filled up by Ward Nursing Sister and send to Hospital Coordinator

N = Numerator (No. of fall per month) **D** = **Denominator** (No. of occupied bed days for the month)

Eg. If all 28 beds (include extension beds & trolleys if any) were occupied on all 30 days in April, then, 28 x 30 = 840 occupied bed days

Calculation of Rate of Falls per month:

$$\frac{\text{No. of Falls per month}}{\text{No. of occupied bed days for the month}} \times 1{,}000 = _____ \text{ fall rate/1,000 occupied bed days}$$

Prepared By:

_____
(Ward Nursing Sister)

Date :

Checked By:

_____
(Area Matron)

Date:

APPENDIX 7

BKJ-BOR-PPK-Fall 4 (Pind.2/2018)

NURSING DIVISION
MINISTRY OF HEALTH MALAYSIA
QUARTERLY DATA COLLECTION OF PATIENT FALL

HOSPITAL:_____ MONTH:_____

No.	Month	Total no. of patient falls		Rate	Total no. of patient falls		Rate	No. of patient falls **with injuries**		Brief summary of incident & Please send RCA report	Action taken
		Adult			Paediatric			Adult	Paeds		
		N	D		N	D					
	JAN										
	FEB										
	MAC										
	APR										
	MEI										
	JUN										
	JUL										
	OGOS										
	SEPT										
	OCT										
	NOV										
	DIS										
	JUMLAH										

To be filled up by Hospital Co-ordinator and send to State Matron (JKN)

N = Numerator (No. of fall per month) **D** = **Denominator** (No. of occupied bed days for the month)

Eg. If all 28 beds (include extension beds & trolleys if any) were occupied on all 30 days in April, then, 28 x 30 = 840 occupied bed days

Calculation of Rate of Falls per month:

$$\frac{\text{No. of Falls per month}}{\text{No. of occupied bed days for the month}} \times 1{,}000 = _____ \text{ fall rate/1,000 occupied bed days}$$

Prepared By:

_____

(KPJH / Hospital Co-ordinator)

Date:

Verified By:

_____

(Hospital Director /Deputy Hospital Director)

Date:

APPENDIX 8

BKJ-BOR-PPK-Fall 5 (Pind.2/2018)

NURSING DIVISION
MINISTRY OF HEALTH MALAYSIA
QUARTERLY DATA COLLECTION OF PATIENT FALLS

STATE :_____ MONTH:_____

No.	Hospital	Month	Total no. of patient falls		Rate	Total no. of patient falls		Rate	No. of patient with Injuries		Summary on the causes of falls (RCA) Please attach a RCA report
			Adult			Paediatric			Adult	Paeds	
			N	D		N	D				
		JAN									
		FEB									
		MAC									
	TOTAL =										
		JAN									
		FEB									
		MAC									
	TOTAL=										
		JAN									
		FEB									
		MAC									
	TOTAL=										
		JAN									
		FEB									
		MAC									
	TOTAL=										
		JAN									
		FEB									
		MAC									
	TOTAL=										

To be filled in by JKN Co-ordinator and send to Nursing Division Ministry of Health Malaysia

N = Numerator (No. of fall per month) **D** = **Denominator** (No. of occupied bed days for the month)

Eg. If all 28 beds (include extension beds & trolleys if any) were occupied on all 30 days in April, then, 28 x 30 = 840 occupied bed days

Calculation of Rate of Falls per month:

$$\frac{\text{No. of Falls per month}}{\text{No. of occupied bed days for the month}} \times 1{,}000 = _____ \text{ fall rate/1,000 occupied bed days}$$

Prepared By:

_____
(State Matron / JKN Co-ordinator)

Date:

Verified By:

_____
(Director of JKN/Deputy Director JKN)

Date:

APPENDIX 9
BKJ-BOR-PPK-Fall 6 Pind.2/2018

NURSING DIVISION
MINISTRY OF HEALTH MALAYSIA

HUMPTY DUMPTY FALLS RISK ASSESSMENT SCALE CHART (PAEDIATRIC)

Name:			Age:						
RN No:			Ward:						
PARAMETER	**DATE**								
	TIME								
AGE	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	
<3 years old	4								
3 years to <7 years old	3								
7 years to 13 years old	2								
13 years+	1								
Gender									
Male	2								
Female	1								
Diagnosis									
Neurological Diagnosis	4								
Alteration in oxygenating e.g. Respiratory Diagnosis, Dehydration, Anaemia, Syncope / Dizziness etc.	3								
Psychological/Behavioural disorders	2								
Other Diagnosis	1								
Cognitive Impairment									
Not aware of limitations	3								
Forgets limitations	2								
Orientated to own ability	1								
Environmental Factors									
History of falls or infant-toddler were placed in bed	4								
Patient uses assistive devices or infant- Toddler in crib or furniture / Lighting	3								
Patient placed in bed	2								
Out-patient areas	1								
Response to Surgery /Sedation Anaesthesia									
Within 24 hours	3								
Within 48 hours	2								
More than 48 hours / None	1								
Medication Usage									
Multiple usage of sedatives (excluding ICU); Hypnotics; Barbiturates; laxatives; Anti-depressants; Diuretics; Narcotics	3								
One of the medications listed above	2								
Other Medications/None	1								
TOTAL SCORE =									
Name & Signature :									

***Low Fall Risk = score 7-11 (Initiate low falls risk interventions)**
***High Fall Risk = score12 or more (Initiate high falls risk interventions)**

Adopted from Deborah H.R. et.al 2008

APPENDIX 10

CALCULATION OF FALL RATE

Example: To calculate the falls rate for the month of March on a 28 bed unit. Rates are calculated as follows:

1. First count the number of falls that occurred during the month of March from your incident reporting system. Let's say there were 4 falls during the month of March.

2. Then figure out, for each day of the month at the same point of time (e.g.12MN-12MN), how many beds were occupied on the unit. For example, on 1st March, there may have been 24 beds occupied; on 2nd March, there may have been 28 beds occupied (formal & informal) and so on.

3. Add up the total occupied beds each day, starting from 1st March till 31st March. Let's say the total adds up to 800 occupied beds for the month of March.

4. Divide the number of falls by the number of occupied bed days for the month of March, which is 4 ÷ 800 = 0.005

5. Multiply the result by 1,000. Then, 0.005 x 1,000 =5.0. Thus, your fall rate was 5.0 falls per 1,000 occupied bed days.

FORMULA :

Rate of fall per month =

No. of fall per month x 1,000=_____ fall rate/1,000 occupied bed days.
No. of occupied bed days for the month

4 x 1,000 = 5.0 fall rate per1,000 occupied bed days.
800

APPENDIX 11

BKJ-BOR-PPK- Fall 7 Pind.1/2018

"SIQ FALL" QUARTERLY REPORT

STATE :_____

HOSPITAL:_____

MONTH:_____

NO.	SUMMARY OF THE INCIDENT	ROOT CAUSE	REMEDIAL ACTION /RECOMMENDATION	RESPONSIBILITY KJ/AREA MATRON

TO BE FILLED UP BY NURSING WARD SISTER

Prepared by: **Checked by Area matron:**

_____ _____

Date:_____ **Date :_____**

APPENDIX 12

Patient Outcome: The impact upon a patient which is wholly or the severity and duration of any harm, and any treatment implications, that result from an incident.

- **None –** patient outcome is not symptomatic or no symptoms detected and no treatment is required.
- *** Mild –**patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term and no or minimal intervention (e.g. extra observation, investigation, review or minor treatment) is required, increase length of stay (up to 72 hours)
- ***Moderate –**patient outcome is symptomatic, requiring intervention (e.g. additional operative procedure; additional therapeutic treatment), an increased length of stay (more than 72 hours to 7 days).
- ***Severe -** patient outcome is symptomatic, requiring life-saving intervention or major surgical / medical intervention, an increased length of stay (more than 7 days), shortening life expectancy or causing major permanent or long term harm or loss of function.
- **Death –**on balance of probabilities, death was caused or brought forward in the short term by the incident.

*Some amendment is made from the original WHO definition in order to prevent confusion. Additional information is used using definition from Government of Western Australia, Department of health –Clinical Incident Management Toolkit, 2016

Adopted from Guidelines on Implementation Incident Reporting & Learning System 2.0 for the Ministry of Health Malaysia Hospitals

APPENDIX 13

Technical Specification

Patient Safety Goal No.9	**:**	**To Reduce Patient Fall**
Rationale	**:**	Patient falls are a potentially serious form of incident and are considered largely preventable.
Strategies & Implementation	**:**	To implement patient falls risk interventions effectively
KPI No. 14	**:**	Rate of patient falls(adults) per 1,000 occupied bed days
Formula	**:**	$\frac{\text{No. of falls per month}}{\text{No. of occupied bed days for the month}} \times 1{,}000 =$ ____ fall rate/1,000 occupied bed days.
Target	**:**	Compliance rate of patient fall ≤ 4.0
KPI No. 15	**:**	Rate of patient falls (paediatrics) per 1,000 occupied bed days
Formula	**:**	$\frac{\text{No. of falls per month}}{\text{No. of occupied bed days for the month}} \times 1{,}000 =$ ____ fall rate/1,000 occupied bed days.
Target	**:**	Compliance rate of fall ≤ 4.0
Definition of Terms	**:**	**Falls**: fall that happens at the facility's premises e.g. hallway, patient's room /ward, bathroom **Paediatric fall**: fall amongst patients aged 12 years old and below
Exclusion Criteria	**:**	i) Exclusion criteria for paediatric falls: non-injurious developmental fall for infant, toddlers as they are learning to walk ii) Visitors, students, staff
Data Collection	**:**	Monthly

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NURSING DIVISION
MINISTRY OF HEALTH MALAYSIA
LEVEL 3, BLOCK E7, PARCEL E, PRECINT 1,
FEDERAL GOVERNMENT ADMINISTRATIVE CENTER
62590 PUTRAJAYA

Tel: 03-8883 3520
Fax: 03-88904149
Website: nursing.moh.gov.my