	HOSPITAL SULTAN ABDUL AZIZ SHAH UNIVERSITI PUTRA MALAYSIA Code Document: HSAAS/NURS/BR123	Patient's sticker
	HUMPTY DUMPTY FALL ASSESSMENT	

DIAGNOSIS:	AGE:			DATE OF ADMISSION:				
PARAMETER	**DATE**							
	TIME							
	SCALE							
Age								
13 years old and above	4							
3 to < 7 years old	3							
7 to < 13 years old	2							
Less than 3 years old	1							
Diagnosis								
Neurologic Diagnosis	4							
Others Diagnosis	3							
Psychological/Behavioral Disorders	2							
Alterations in Oxygenation(Respiratory diagnosis, Dehydration, Anemia, Anorexia,Syncope/Dizziness, etc)	1							
Cognitive Impairments								
Forget Limitations	4							
Not aware of 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								
More than 48 hours/None	4							
Within 48 hours	2							
Within 24 hours	1							
Total Score								
Name of Assessor								

Risk Level	Score	Signages Coding	Patient assessment **MUST** be done **DAILY** and during :
Low Risk	5-11	WHITE △ Low Risk Protocol	1.Patient Fall 2.Change in clinical condition
High Risk	12 and above	RED ▲ High Risk Protocol	3. Transfer to another unit/ward

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

Reference: Sarik, D. A., Hill-Rodriguez, D., Gattamorta, K. A., Gonzalez, J. L., Esteves, J., Zamora, K., & Cordo, J. (2022). The revised Humpty Dumpty Fall Scale: An update to improve tool performance and predictive validity. *Journal of pediatric nursing*, *67*, 34-37.

HOW TO USE THE HUMPTY DUMPTY FALL ASSESSMENT CHART

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

2. **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-
   - **Neurological-** seizures, head traumas, hydrocephalus, cerebral palsy, etc. This would include patients being worked up for neurological diagnosis.
   - **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, anemia, anorexia and syncope.
   - **Psychiatric/Behavioural disorders**- can include mood disorders (major depression, bi-polar disorder) and impulse control disorders eg. ADHD (attention- deficit/hyperactivity disorder)
   - **Other diagnosis**- anything that does not fall into the other categories (examples include but not limited to cellulites, orthopedics)

3. **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 due 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.

4. **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.

5. **Response to Surgery/Sedation/Anesthesia**- Patient received one within the allotted time frames. No including bedside procedures without anesthesia.

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FALL PREVENTION AND INTERVENTIONS PROTOCOL (PAEDIATRIC)

Instruction: Tick (√) for appropriate intervention task	
1.	**STANDARD LOW RISK PROTOCOL (PATIENT EDUCATIONS)**
	Orient the Child/mother to ward surroundings including bathroom, use of bed and call bell
	Explain fall risk to mother *(**Fall informations form**)*
	Patient and family education available to parents and patient
	Encourage mother to call for assistance- Do not leave child unattended and nurses should be informed by mother before leaving/ **Let staff know if your child will be left alone**
	Ensure bed rails are raised and keep bed at lowest positions
	Secure lock on bed. Wheel, stretchers and wheelchair
	Keep floor and surroundings free from clutter and obstacles and clean all spills immediately
	Ensure adequate lighting and leave nightlight on
	Advice child to use proper non-slip footwear/wear shoes or non -skid sock while out of bed and use appropriate-size clothing to prevent tripping
	Tagged child risk with Fall signages accordingly
2.	**HIGH RISK PROTOCOL**
	All actions in Standard low -risk protocol
	Identify patient with a "Humpty Dumpty Sticker" on the bed and wrist band
	Evaluate medication administration times
	Supervise and assist bedside sitting, personal hygiene and toileting
	Accompany patient with ambulation
	Mother to remain in the cubicle with high risk child- do not leave child without replacement/inform nurse -Nurse to check patient minimum every 1 hour