FALLS PREVENTION AND MANAGEMENT POLICY ©

DOCUMENT SUMMARY/KEY POINTS

- All patients must have a **Falls Risk Assessment within 8 hours of admission** to the facility, on change of ward and every three days (72 hours) thereafter, unless condition changes, through the Falls Assessment tool or Paediatric Risk Assessment Tool (PRAT) in PowerChart
- There are identifiable falls risk factors for all children when admitted to hospital.
- SCHN has adopted the NSW Paediatric Fall Risk Assessment tool, which is based on the Miami Children's Hospital's Humpty Dumpty Fall Prevention Program to identify children at risk of falls.
- The NSW Paediatric Fall Risk Assessment tool is a cumulative calculation of seven parameters.
- All children require "Care Actions" to be implemented in response to their risk assessment score.
- If a child has a fall whilst in Hospital, the fall is to be documented in the medical record and an incident report must be entered into IIMS.
- After a fall, a full set of observations, including neurological Observation and BGL (if indicated) should be taken.
    - If the child has hit their head, the Head Injury – Acute Management practice guideline should be followed
    - If the child has not hit their head a full set of observations should be conducted, hourly for 4 hours
    - Observations should continue 4 hourly thereafter, unless clinically indicated
- Another policy is being developed for ambulatory care patients.

All Children are at Risk of Falls.

However, children with Scores 12 and above are at High Risk of Falling

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st June 2017	**Review Period**: 3 years
Team Leader:	Network Manager Patient Safety	**Area/Dept**: Clinical Governance Unit

CHANGE SUMMARY

- Inclusion of: “All children aged less than three years must be placed in a cot. If the decision is made to place the child in a bed, this must be authorised by the Nurse Unit Manager (NUM), After Hours Nurse Manager (AHNM) or team leader.”

READ ACKNOWLEDGEMENT

- The following staff should read and acknowledge they understand the contents of this policy: Nursing, Allied Health & Medical staff working in clinical areas.

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1 Background

Falls have been identified as the leading cause of unintentional injury for children and falls are major preventable risk factor for paediatric patients. In the financial year 2015-2016 there were 148 patients falls (133 reported to the Incident Information Management System, IIMS). What we do know from analysis over time, majority of incidents have occurred whilst patients are in the care of the parent/ carer. Many of these occur as a result of cot-sides/ bedrails not being put up and recognising that hospital cot/ beds are a lot higher than the usual home furniture. Curiosity and motor developmental skills have also been related to paediatric falls.

On admission, families should be made familiar with the differences between the home and hospital environments and furniture when they are being orientated to the ward. This is also supported by Falls Prevention posters around the wards and hospital lifts.

NSW Health and SCHN have adopted the Humpty Dumpty Fall Program from Miami Children's Hospital as the NSW Paediatric Fall Risk Assessment tool and this has been developed into the electronic eMR Paediatric Risk Assessment Tool (PRAT) within PowerChart, as the tool to identify and reduce falls risk.

NSW Falls Prevention Program and Paediatric Quality and Safety team, in consultation with the NSW Chief Paediatrician and representatives from key paediatric partners have developed the Paediatric Falls Prevention Program to assist Local Health Districts/Networks with the implementation of the National Safety and Quality Health Service Standards (NSQHSS) Standard 10: *Preventing falls and harm from falls.*

The NSQHS Standard 10 requires all patients admitted to hospital to be screened for falls risk (10.5) and if any falls risk is identified a falls plan is to be implemented. The NSW Paediatric Fall Risk Assessment Tool will assist SCHN to comply with these requirements and support fall prevention initiatives.

Definition of a Fall

Falls: An unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or reported to have landed on the floor (un-witnessed) not due to any intentional movement or extrinsic force such as a stroke, fainting, seizure. (FHA)

Adjusted Fall: An unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or reported to have landed on the floor (un-witnessed).

Children at High Risk

- Pre-schoolers.
- Children under ten are twice at risk for falls compared with the total population.
- Children with disabilities and minimal mobility.
- Children in wheelchairs, regardless of cognitive ability are at risk from wheelchair tips and falls.
- Children with a neurological diagnosis.
- Children with Challenging and /or impulsive behaviours.

Paediatric Fall Risk Factors

Risks factors to consider when completing the NSW Paediatric Fall Risk Assessment tool:

- History of **previous falls** related to illness.
- **Cognitive impairment** from sedation, anaesthesia, disorientation, developmental delay.
- Impaired **mobility**/ inadequate muscle tone.
- Central nervous system disorders.
- Sensory impairment e.g. poor vision.
- Likelihood of frequent toileting.
- **Post-operative restrictions** such as pain, casts/splints, mobility aids etc.
- Taking **medications** that are associated with increased risk of falls e.g. psychoactive, anticonvulsants.

Consequences of Falls

Falling is a normal part of a young child's development as they learn to walk, climb, jump, run and play. Fortunately, most children who fall are not injured, other than a few bruises and scrapes. However, falls are the most common cause of admission to hospital for children 0–4 years of age. Children living in country areas are admitted to hospital for falls at a rate of 1.5 times more than children living in metropolitan areas. In the hospital environment the consequences of a fall can result in:

- Death – extremely rarely.
- Minor to serious injury.
- Increased stay in hospital.
- Impact on family/carer.
- Potential change in independence on discharge.
- Increase in patient/family/carer costs.

2 NSW Paediatric Fall Risk Assessment tool

The NSW Paediatric Fall Risk Assessment tool can help to predict the possibility of a child falling. It requires nursing clinical judgment and should be individualised to each patient.

The tool uses a cumulative calculation model.

- There are seven parameters; each parameter receives a score.
- If for some reason the items in any parameter are not applicable the child would receive the lowest score of 1.
- If a child falls into multiple categories in a parameter, the highest score of the possible choices would be given.
- The NSW Paediatric Fall Risk Assessment tool must be completed within 8 hours of admission to the facility, change of ward and/ or when condition changes; e.g. following surgery or a fall and every 72 hours.

Parameters

The NSW Paediatric Fall Risk Assessment tool parameters include:

- Age
- Gender
- Diagnosis
- Cognitive impairments
- Environmental Factors
- Response to Surgery / Sedation / Anaesthesia
- Medication usage

2.1 Guide to completing each parameter

Age: Can be based on chronological or developmental age of the patient.

Gender: Self-explanatory.

Diagnosis:

- 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 trauma, hydrocephalus, cerebral palsy, spinal cord injury etc. This would include patients with a possible neurological diagnosis.
  - Alterations in oxygenation: This category encompasses any diagnosis that can result in a decrease in oxygenation. Alteration in oxygenation goes beyond respiratory diseases and may include dehydration, anemia, anorexia, syncope, etc.
  - Psychiatric/Behavioral disorders: can include mood disorders (major depression, bi-polar disorder) and impulse control disorders
  - Other diagnosis: anything that does not come into the other categories (examples include but not limited to cellulitis, fracture, impaired vision)
  - Malnutrition/malnutrition screening

Cognitive Impairments:

- Not aware of limitations: can be any age group and is dependent on ability to understand the consequences to their actions. (Example- post 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 hypoglycemia) the child forgets their limitations. Can include children prone to temper tantrums, children receiving sedative or analgesic medications (see below).
- 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 or cot.
- 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: inpatient receiving services in an outpatient area.

Response to Surgery/Sedation/Anaesthesia:

- Patient has had Surgery/Sedation/Anaesthesia within in the allotted time frames.
- Not including bedside procedures without anaesthesia.

Medication Usages:

- The 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.

3 Completing the NSW Paediatric Fall Risk Assessment tool

The NSW Paediatric Fall Risk Assessment tool is completed in PowerChart by the admitting nurse. This is accessed via the Ad Hoc Forms.

Quickstarts for CHW:

- Movie Demonstration – How to Use Adhoc Charting
- Adhoc Charting – How to enter, modify or cancel

Quickstarts for SCH:

- Adhoc - Quick Ref Guide online

The Falls Risk Assessment tool must be completed within 8 hours of admission to the facility, change of location and/ or when condition changes; e.g. following surgery or a fall and every 72 hours

4 Maintaining a Safe Environment

All paediatric patients are considered at risk of falling and simple prevention strategies should be put in place to ensure the risk of injury is minimized. A safe environment should be maintained for all patients and standard safety measures should be put place for all patients regardless of identified risk, these include the Care Actions for Falls Prevention and:

- When using a high chair/ prams in hospital, the chair must meet the Australian Standards; with 5 point harness straps, are washable with universal detergent and all patients need to be secured and supervised and cannot be left unattended.
- Secure and supervise all children with a safety belt or harness in wheelchairs, infant seats and any specialist seating (e.g. Tumbleforms)
- Assist unsteady patients with ambulation. Patients who have received sedation or general anaesthetic are at greater risk of falls and require supervision with ambulation
- Appropriate non slip footwear for ambulating patients
- Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes). Equipment should only be used for its intended purpose (e.g. children should not ride on IV poles). Clinical judgement should be used to determine appropriate levels of supervision for children that are using equipment to assist with their mobility.

5 Care Actions for Falls Prevention

All children will receive a falls risk score after the assessment has been completed. Once the falls risk score has been identified, the following management and interventions must be initiated and documented within the clinical notes.

5.1 Care Actions on Admission

- Orientate child/parents/carers to room.
- Educate child/parents/carers about the potential fall risk and interventions and provide information.
- Place child in developmentally appropriate sized bed (may require low bed), brakes on.
- Bed/cot rails must be fully up. Assess for any gaps where a child could be injured or trapped; consider the use of additional safety precautions, such as bolster.
- Bed heads and foot ends must be in place on all beds.
- Ensure child has appropriate non-slip footwear and appropriate clothing to prevent tripping.

5.2 Care Actions for Routine Care

- Assess toileting needs and assist as needed.
- If child mobilises with IV pole, ensure equipment is placed close to the centre of the pole, and IV lines are secure.
- Ensure nurse call bell and light is within easy reach. Educate child/parents/ carers on how to use the call bell.
- Ensure environment is clear of clutter and bed area is clear of trip hazards.
- Curtains should be pulled back to enable full view of child, unless otherwise indicated.
- Ensure adequate lighting and leave nightlight on where appropriate.
- Document the plan of care that has been discussed with the child/parents/carer in clinical progress notes.
- Keep room door open at all times unless specified isolation precautions are in use.
- All children aged less than three years must be placed in a cot. If the decision is made to place the child in a bed, this must be authorised by the Nurse Unit Manager (NUM), After Hours Nurse Manager (AHNM) or team leader.

5.3 Care Actions for Routine Care for High Risk Patients

- At clinical handover communicate high fall risk status and interventions in place.
- At a minimum check the child every hour if they are unattended.
- Accompany the child when they are ambulating.
- Consider moving child closer to nurses' station.
- Assess need for 1:1 general observation.
- Review medication administration times for children at high risk.
- Engage child's parents/carers/medical team in falls prevention interventions.
- Consider referring the child to physiotherapy, occupational therapy or nutrition and dietetics.
- Complete regular nutrition screening on admission and weekly thereafter

6 High Risk Patients

Patients at HIGH RISK should be:

- Identified and discussed at general "***Handover***".
- Identified on the ***Bedside Handover Tool***
- Identified during ***bedside handover*** discussions:
  - Discuss if the falls risk assessment is completed and if it is up to date.
  - Discuss what risk minimisation factors have been implemented.

- Involve parents/carers in your discussions.

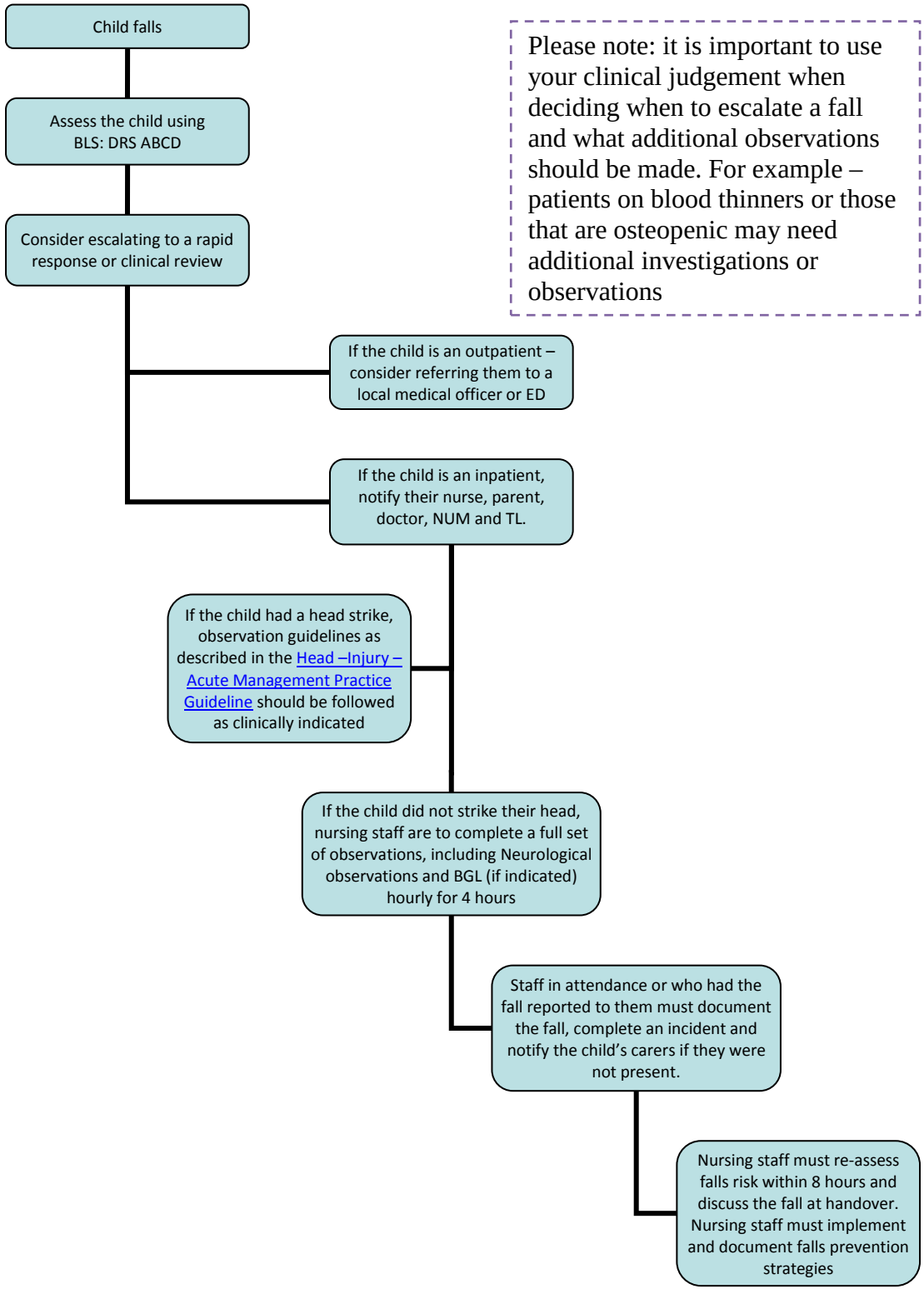
For more information please go to the Clinical Excellence Commission (CEC) website on Falls Prevention.

7 When a Child Falls

Staff need to:

- Follow the Flow Chart on page 11.
- Assess child; provide immediate care and do a full set of observations.
  - Consider, does this patient have a head injury? Should the Head Injury - Acute Management Practice Guideline be followed?
  - Consider escalation to a clinical review or rapid response.
- Notify child's medical team to review child and document plan of care.
- If the child is an outpatient, consider referring them to a local medical officer or ED to be assessed
- Notify Nursing Unit Manager or Team Leader.
- When appropriate document the fall in child's medical record, incorporating the following:
  - Child's appearance and response to event at time of discovery
  - Activity at time of fall (if known)
  - Evidence of injury
  - Where the fall occurred
  - Medical and nursing actions taken
- Full set of observations, including Neurological observations and BGL (if indicated):
  - As directed in the Head Injury – Acute Management Practice Guideline if a head strike has occurred or if no head strike, hourly for a minimum of 4 hours.
  - 4 hourly thereafter unless clinically indicated.
- Complete a clinical incident report and record the incident number in the medical record.
- Promptly inform parents/guardian if not present at time of fall.
- Falls Risk Assessment should be re-assessed and documented within 8 hours.
- Communicate fall incident at clinical handover.

7.1 Figure 1. Falls Decision Tree



8 Falls Prevention and Management in the Neonatal and Paediatric/Children's Intensive Care Units (ICU)

There are no validated falls risk assessment tools for the neonatal and paediatric intensive care environment. Subsequently, the Network treats all patients in this environment as at high risk of falls.

The following care actions must be implemented:

- Patients must have assistance with all transfers and mobilisations.
- Patients should be supervised whilst positioned in a bed/cot/chair/other equipment by either a staff member or carer. The patient is awake and alert, ensure call bells, bedside tables and frequently used objects are within easy reach
- Bed/cot sides must be raised unless direct care is being delivered.
- All carers must be educated on the risks of falls and how they can help prevent them in the ICU
- The environment must be free from potential trip hazards

In addition for the neonatal ICU:

- New parents should be made aware of the risks of a baby slipping from the maternal bed or chair if they fall asleep while holding their baby.
- New parents should also be advised never to leave their baby unattended on an adult bed or another surface from which they may fall.
- Adequate guidance and assistance should be provided to the new mother and partner/support person when moving a newborn from cot to the mother/partner/support person for feeding and cuddling.
- Parents and visitors should be discouraged from walking with the baby in their arms
- New parents should be guided about safety issues when changing nappies, bathing and other potential falls risk situations.

This has been adapted from the Falls prevention and management for people admitted to acute and sub-acute care Procedure SESLHDPR/380

Documentation:

ALL care actions must be documented in the medical record.

Post falls management in the neonatal ICU or paediatric ICU

Any patient that falls whilst in the neonatal ICU or paediatric ICU must be assessed by a doctor and a clinical incident report must be completed.

9 Bibliography

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