SARASOTA MEMORIAL HOSPITAL
NURSING DEPARTMENT POLICY

TITLE:	PEDIATRIC FALL PREVENTION PROGRAM	**POLICY #:**	126.853 (pediatrics)
		EFFECTIVE DATE:	6/09
		REVISED DATE:	10/09
		POLICY TYPE:	☒ DEPARTMENTAL ☐ INTERDEPARTMENTAL ☒ DEPARTMENTS PROVIDING NURSING CARE
		PAGE:	1 of 6
Job Title of Reviewer:	Director, Women & Children's Department		

PURPOSE:

To identify patients who are risk for falling and to outline strategies used to develop patient specific or individualized plans of care to reduce inpatient falls and fall-related injuries. To involve the patient, family, and caregiver in falls prevention through education.

POLICY STATEMENT:

Pediatric falls are predominately the function of extrinsic factors, including accidental and environmental hazards. The etiology of a fall in the pediatric patient is typically different than adults and therefore requires a separate policy, fall risk scale, and set of interventions.

EXCEPTIONS:

This applies **only** to pediatric patients located on the Pediatric Unit.

DEFINITION(S):

Anticipated physiological/intrinsic: patient diagnosis or characteristics that may predict patient's likelihood of falling.
Unanticipated physiologic/intrinsic: unpredictable if no previous history is present and no risk factors identified from assessment.
Extrinsic/Accidental: an accidental fall is defined as when a patient is oriented but rolls out of bed or trips/slips due to environmental risk factors; or, an infant is dropped by a parent or caregiver
Developmental: non-injurious falls that are common to infants/toddlers as they are learning to walk, pivot and run.

STANDARD SAFETY PRECAUTIONS:

1. Orient patient and family to environment.
2. Beds will be in low position with brakes on unless treatment needs require otherwise. After procedures, the bed will be returned to the low position.
3. Children under the age of 4 will be placed in cribs. If parents request otherwise, a written release must be obtained, with the understanding that they will have to continually attend the child.
4. High-sided or bubble tops cribs will be used when patient/parents state or the child demonstrates that s/he might climb out.
5. Call light (assure patient can use), bedside table, telephone, and other frequently used items will be kept within reach of the patient, as developmentally appropriate.
6. Sensory aids, i.e. eyeglasses, hearing aids, etc. will be accessible to the patient.

7. Provide assistance, as appropriate, to child requiring assistive devices (e.g. walker, crutches, etc.).
8. Ambulating patients must wear shoes or non-slip, non-skid footwear. Patients will be accompanied when ambulating for the first time or whenever their clinical status indicates that they are at risk for falling. This would include but not be limited to medication side effects, neurological impairment and/or developmental stage.
9. Built-in safety straps will be used for babies placed in infant seats and children using their personal wheelchairs. Children using a wagon or infant activity center must be supervised continuously.
10. Children being transported by gurney or crib will have the side rails up at all times as a safety precaution; children transported off the unit will be continuously supervised.
11. Children and infants should not be placed or allowed to play in unsafe areas, such as on windowsills, on top of tables, etc.
12. Keep environment clear of hazards.
13. Consider use of nightlight during night shift.
14. Assist with elimination as needed.
15. Implement evaluation of medications that predispose patients to falls. This includes anticonvulsants, opioids, benzodiazepines, diuretics, anti-hypertensives, analgesics, and bowel preps.
16. Educate patient and family regarding fall prevention strategies (and document this education in the Pediatric Education Flowsheet).

FALL PREVENTION PROGRAM:

1. The Humpty Dumpty Falls ™ Scale (HDFS) will be used for fall risk assessment on admission of pediatric patients (Pediatric Assessment/Reassessment Flowsheet). See Appendix A for a copy of the HDFS.
2. Patient's fall risk will be reassessed and documented by nursing every shift, or more frequently if changes in condition or high-risk medication regimen (e.g. narcotics, sedatives, anti-hypertensives, etc.).
3. Patients are scored on the HDFS (range 7-23) and may be low risk (score 7-11 points) or high risk (score 12 and above). Patients scored "low risk" should continue with use of safety precautions as above.
4. The following interventions constitute high risk interventions and are appropriate for patients with a HDFS of 12 or above:
    a. Identify patient's fall risk with Humpty Dumpty sign on door frame and sticker on patient's gown.
    b. Include patient's high risk status in all hand off communication reports
    c. Educate patient and family on fall prevention precautions
    d. Consider commode at bedside
    e. Continuous supervision while toileting. Do not leave patient with high risk alone in bathroom or on bedside commode.

   f. Accompany patient with ambulation, including in hallways and within room/bathroom
   g. Consider moving patient closer to nurses' station
   h. Provide continuity of staff
   i. Assess your patient's need for 1:1 supervision. Encourage family, friends, or sitter to remain present at all times, and request notification if not present. Educate family or others on fall prevention strategies.
   j. Evaluate medication administration times
   k. Remove all unused equipment and furniture out of the room
   l. Use protective barriers to close off any gaps in bed where patient may be able to attempt escape
   m. Keep door open at all times unless droplet or airborne precautions are in use
   n. Consider obtaining consult for physical therapy and/or occupational therapy, i.e. for assistive devices.
   o. Document fall prevention interventions. Consider fall prevention in nursing care plan.
5. In the event of a fall:
   a. Assess patient for signs of injury
   b. Assess and document vital signs; consider Accu-check if no known cause for fall
   c. Assess environment and consult with patient/family for potentially contributing factors
   d. Notify physician if fall with injury
   e. Complete occurrence report online (via Pulse, under Application links on right).
   f. Objectively describe incident and results in patient's record.
   g. Modify patient's plan of care based on risk factors leading to fall.
   h. Communicate in all hand off communication reports.

RESPONSIBILITY: It is the responsibility of the pediatric nursing staff to adhere to this policy.

REFERENCE(S):

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Razmus, I, Wilson, D, Smith, R & Newman, E. (2006). Falls in hospitalized children. *Pediatric Nursing, 32*(6), 568-572.

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ATTACHMENT(S): Appendix A: Humpty Dumpty Falls ™ Scale

Appendix A: Humpty Dumpty Falls™ Scale Inpatient

Parameter	Criteria	Score
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope, dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not aware of limitations	3
	Forgets limitations	2
	Oriented to own ability	1
Environmental factors	History of falls or Infant-Toddler places in Adult Bed	4
	Patient uses assistive devices or infant-toddler in crib or furniture/lighting (tripled room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/ Sedation/ Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/ None	1
Medication Usage	Multiple usage of: Sedatives, hypnotics, barbiturates, phenothiazines, antidepressants, laxatives, diuretics, narcotics	3
	One of the meds listed above	2
	Other medications/None	1

APPROVALS:

Signatures indicate approval of the new or reviewed/revised policy	**Date**
Signature: **Title:** Pam Beitlich, Director, Women's and Children's Services	
Signature: **Title:**	
Signature: **Title:**	
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Committee/Sections (*if applicable*):	
Nursing Standards and Practice Council	10/1/09
Vice President/Administrative Director (*if applicable*): **Signature:** **Title:**	
Signature: **Title:** Jan Mauck, Vice President, Chief Nursing Officer	