UCSF Health

PEDIATRIC
NURSING PROCEDURE

FALLS PREVENTION PROGRAM (PEDIATRICS)

Table of Contents

Critical Points

1. **All patients**, **including infants**, and regardless of other risk factors, are subject to **Universal Safety Precautions**
   a. Orient patient and family to environment on admission and throughout stay, as needed.
   b. Keep beds in low position with wheels locked unless treatment needs require otherwise
   c. Keep environment clear of hazards (including medical equipment, electrical cords, patient personal belongings, hospital furniture, etc.) especially on frequently used paths, such as from the bed to the bathroom or commode.
   d. Ensure that the sensory aids (e.g. glasses, hearing aids), call light, bedside table, telephone, and other frequently used items are within reach of the patient, as developmentally appropriate.
   e. Place all infant and toddler patients under 90 cm (35 inches) or under 2 years of age in cribs, per Pediatric Safety policy.
   f. All patients should have minimum of two side rails toward the head of the bed in the up position. If patient is at risk for falling out of bed, it is appropriate to have four rails up. Four rails should not be used to restrict a patient from getting out of bed (See policy on Restraints).
   g. Ambulating patients must wear short or non-skid footwear.
   h. Use built-in safety straps for infants placed in infant seats and children using wheelchairs. An adult caregiver must supervise children using wagons or infant activity centers continuously.
   i. Keep nightlight, if available, on during "P" shift.
   j. Children and infants should not be placed or allowed to play in unsafe areas such as windowsills, on top of tables, etc.

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

   k. Educate the patient and family on and throughout admission regarding safety precautions and fall prevention strategies
2. All patients must be assessed for risk factors on admission and every shift.
3. Patients identified as at increased risk for falls are placed on **Falls Precautions** and an individualized Falls Care Plan is initiated.
   a. **Exception**: Side rails may be down as clinically necessary to accommodate tubes, drains and/or equipment (i.e., ECMO, ECLS).

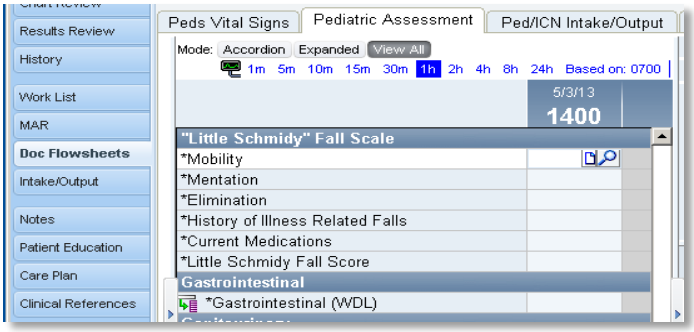
Falls Definitions & Categories

- ***Fall***: "A patient fall is a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface, on another person, or on an object" (American Nurses Association, 2013, p. 2). "If a patient who is attempting to stand or sit falls back onto a bed, chair, commode, this is only counted as a fall if the patient is injured"
- ***Documentable:*** A documentable fall is an event resulting in an injury OR could possibly have been preventable through nursing interventions or patient education (e.g. physiological falls and accidental falls). Documentation of a fall should occur in the medical record and the incident reporting (IR) system.
- ***Accidental:*** An accidental fall is defined as when a patient has no physiological risk factors, but rolls out of bed or trips/slips due to environmental risk factors. This is *documentable regardless of whether an injury occurred.*
- ***Anticipated physiological:*** A fall related to patient diagnosis or characteristics that may predispose a patient to falling. This is *documentable regardless of whether an injury occurred*.
- ***Unanticipated physiological:*** A fall that is unpredictable because there is no previous history of illness related falls and no risk factors identified from assessment. This is *documentable regardless of whether an injury occurred.*
- ***Developmental:*** A fall by an infant, toddler, or preschooler who is learning to stand, walk, run, or pivot . This is *only documentable if an injury has occurred.*
- ***Falls during play (and physical therapy):*** A fall that occurs during normal play or therapeutic activities in *designated play or physical therapy areas is documentable only when it results in injury*. A fall that occurs while playing in the patient's room or in the hallway, if it is not a developmental fall, should be *documented as a fall regardless of whether an injury occurred*
- ***Baby/child drop: "***A fall in which a newborn, infant, or child being held or carried by a healthcare professional, patient, family member, or visitor falls or slips from that person's hands, arms, lap, etc." *regardless of whether an injury was sustained is a documentable fall*

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Procedure

ASSESSING FOR FALLS RISK



Adapted from the Schmid Fall Score Tool for UCSF Benioff Children's Hospital

1. Assess the patient for his/her risk for falling on admission and every shift and whenever a change in the patients condition affects his/ her risk for falling
    1. Complete the Pediatric Schmid Fall Scale ("**Little Schmidy**") on the **Pediatric Assessment Flowsheet** (Appendix B).
    2. If the total score is 3 or greater, ***or*** based on clinical judgment, initiate an individualized fall prevention program (Appendix B).
2. Education
    1. Provide patient and family education using the **Falls Prevention Education Flyer** found in the patient rooms (Appendix B).
3. ***Scoring Criteria for Increased Fall Risks***:
    1. Mobility. Patient uses assistive devices or needs assistance for ambulation/transfer. Evidence of generalized weakness or decreased mobility in lower extremities, poor balance, and dizziness.
    2. Mentation. Patient is developmentally delayed or is disoriented.
    3. Elimination. Patient has need to get to toilet frequently or urgently. Needs assistance with toileting.
    4. History of Falls Related to Illness. Patient has fallen within the last year related to illness, including falls at home or a previous admission or during this admission.
    5. Current Medications. Patient anticonvulsants, opioids, benzodiazepines. *Also consider antihistamines, diuretics, antihypertensives, analgesics, and bowel preps.*
    6. Clinical Judgment. Patient diagnosis or condition not measured by the assessment tool places patient at increased risk for falling. Some patients are at **Increased Risk for Injury** due to a physiological (e.g. osteosarcoma in lower extremity, coagulopathy) or treatment (e.g. anticoagulant therapy) related factor. It may be reasonable to place these patients on falls precautions despite having a low assessment score.

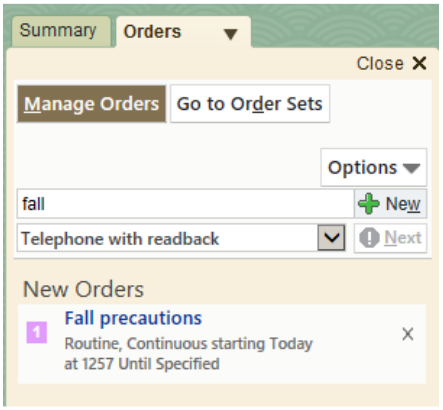
Categories	**Scoring Options** *Select one from each category. Add all scores together to calculate Little Schmidy Fall Score.*
Mobility	0 – Ambulates with no gait disturbance 0 – Unable to ambulate or transfer 1 – Ambulates or transfers with assistive device 1 – Ambulates with unsteady gait and no assistive device
Mentation	0 – Developmentally appropriate and alert 0 – Coma, unresponsive 1 – Developmentally delayed 2 – Disoriented
Elimination	0 – Independent 0 – Diapers 1 – Independent with frequency or diarrhea 1 – Needs assist with toilet

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

History of Falls Related to Illness	0 – No 1 – Yes, before admission 2 – Yes, during admission
Current Medications	0 – None (e.g. anticonvulsant, opioids, benzodiazepines) 1 – Anticonvulsants, opioids, benzodiazepines

FALLS PREVENTION INTERVENTIONS FOR PATIENTS IDENTIFIED AS AT RISK FOR FALLS

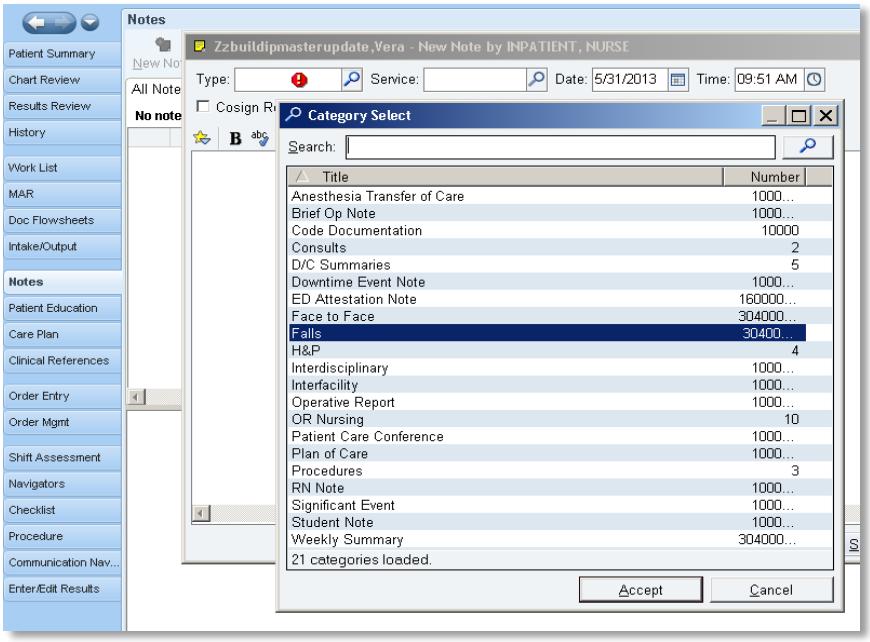
1. Continue **universal safety precautions** as detailed above in Critical Points 1
2. Identify the patient's risk status by: Placing a ***yellow*** armband on the patient's wrist. Patients are also required to wear yellow non-slip socks when out of bed.
    a. Activating "Risk for Fall" external indicator light on the patient's Responder 5 console in room (see Appendix A);
    b. Initiating a Falls Precautions order in electronic medical record
3. Communicating that patient is at increased risk for falls during:
    a. At each shift change
    b. At other handoffs of care during the shift (unit to unit or nurse to other staff).
4. Initiate and maintain an individualized falls risk care plan (see Appendix B). Interventions for fall prevention should be patient specific, i.e. directed towards the factors that make them at risk for fall.
5. Implement additional safety precautions:
    a. Complete and document Hourly Rounding - 4 Ps
        i. Potty: Offer patient assistance to bathroom or commode.
        ii. Possessions: Ensure patient can reach his/her belongings (call light, sensory aids, cell phone, etc.)
        iii. Position: Ask if patient needs to be moved or would like to be set up for a walk.
        iv. Pain: Assess pain and if necessary, offer medication and education on applicable side effects such as dizziness of lightheadedness.
    b. Provide assistance when patient is up and out of bed or toileting/showering. Patients should not be left alone while toileting/showering.
    c. Consider activation of bed exit alarm (Appendix F) for:
        i. Inconsistent use of call light or failed teach back of falls prevention
            1. Document initiation and discontinuation of exit alarm in electronic medical record.
6. Education
    a. Educate the patient and family about fall prevention at admission and throughout duration of stay. Document education provided on falls prevention.
    b. Consider using **Your Health Matters: Tips to Prevent Falls** in the Children's Hospital handout (Appendix E)
    c. Start an education topic "Risk of Falls" under the Patient Education Activity tab in patient medical record.
    d. Remind patient and family to use call light for assistance when toileting/showering



POST- FALL RESPONSE

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

1. Immediately upon discovering that a patient has fallen, ensure that the patient is returned to or maintained in a safe position.
2. Perform physical assessment and assess patient for injury. Notify provider of all falls.
3. Complete a Falls Note in the Notes activity in the electronic medical record (below).



4. Complete an Incident Report (IR).
5. Fill out a Post-Fall Huddle form (See Appendix C) and submit to manager.
6. Update care plan and integrate new interventions.
7. Communicate inpatient fall during hand-off communication

References

Level of Evidence (FAME*)	Level*	Reference
	E4	American Nurses Association. (2020). *NDNQI Guidelines for Data Collection and Submission on Patient Falls*. American Nurses Association. Pp 1-14.
	E4	Bras, M., Lourenco-Quitero, M., and Nunes, E. (2020). Nurse's interventions in preventing falls in hospitalized children: scoping review. *Rev Bras Enferm,* 73(suppl 6), 1-7.
	E4	Franck, L.S., Gay, C.L., Cooper, B., Ezzre, S., Murphy, B., Chan, J.S., . . . Meer, C.R. The Little Schmidy pediatric hospital fall risk assessment index: A diagnostic accuracy study. *International Journal of Nursing Studies*, *68*, 51-59. doi:10.1016/j.ijnurstu.2016.12.011
	E4	Kim, E., Kim, G., & Lim, J (2021). A systematic review and meta-analysis of fall prevention programs for pediatric inpatients. *Journal of Environmental Research and Public Health.*

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

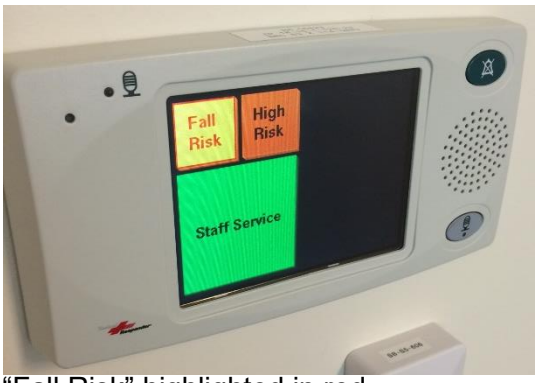
	E4	Oh, W, Kin, E., Im, Y., Han, J., & Kim, M. (2019). Developing a Conceptual model of Pediatric Inpatient Safety Accidents: A Mixed Methods Approach. *Nursing Health Science,* 22, 777 – 786.	
	E4	Parker, C., Kellaway, J., & Stockton, K. (2020). Analysis of Fall within Paediatric Hospital and Community Healthcare Settings. *Journal of Pediatric Nursing,* 50, 31-369.	
	E4	Quigley, P. (2011). *Enhancing Fall and Injury Prevention Programs | Recommendations: Program Redesign and Outcomes* (pp. 1–13). University of California, San Francisco	
	E4	Strini, V., Schiavolin, R., & Prendin, A. (2021). Fall Risk Assessment Scales: A Systematic Literature Review. *Nursing Reports,* 11, 430 – 443.	
* FAME Scale details: See nursing policy *Policy, Procedure, & Competency Development, Review, & Approval*			

Procedure History

Author:	Christina Atwood, MPH; Maureen Buick, RN, MS; Jim O'Brien, RN; Mary Passeri, RN, MA; Inez Wieging, RN. (Adapted from Adult Falls Procedure by Fall Prevention Committee.)
Originated:	3/05
Resources:	Suzanne Ezrre, RN, MSN; Unit-based Falls Resource Nurses
Reviewed:	
Reviewed / Revised:	1/06 1/08: Lisa Purser, RN 4/13: Suzanne Ezrre, RN, MSN; Christine Moreno, RN, MSN; Linda LeFrak, RN, MS, CNS; Shannon Fitzpatrick, RN, MS, PCM; Lisa Tsang, RN, MN, APN; Elizabeth Kennalley, RN, MS, CNS 12/14: Suzanne Ezrre, RN, MSN 2/19 Mary Nottingham, MSN, RN 3/22 Mary Nottingham, MSN, RN

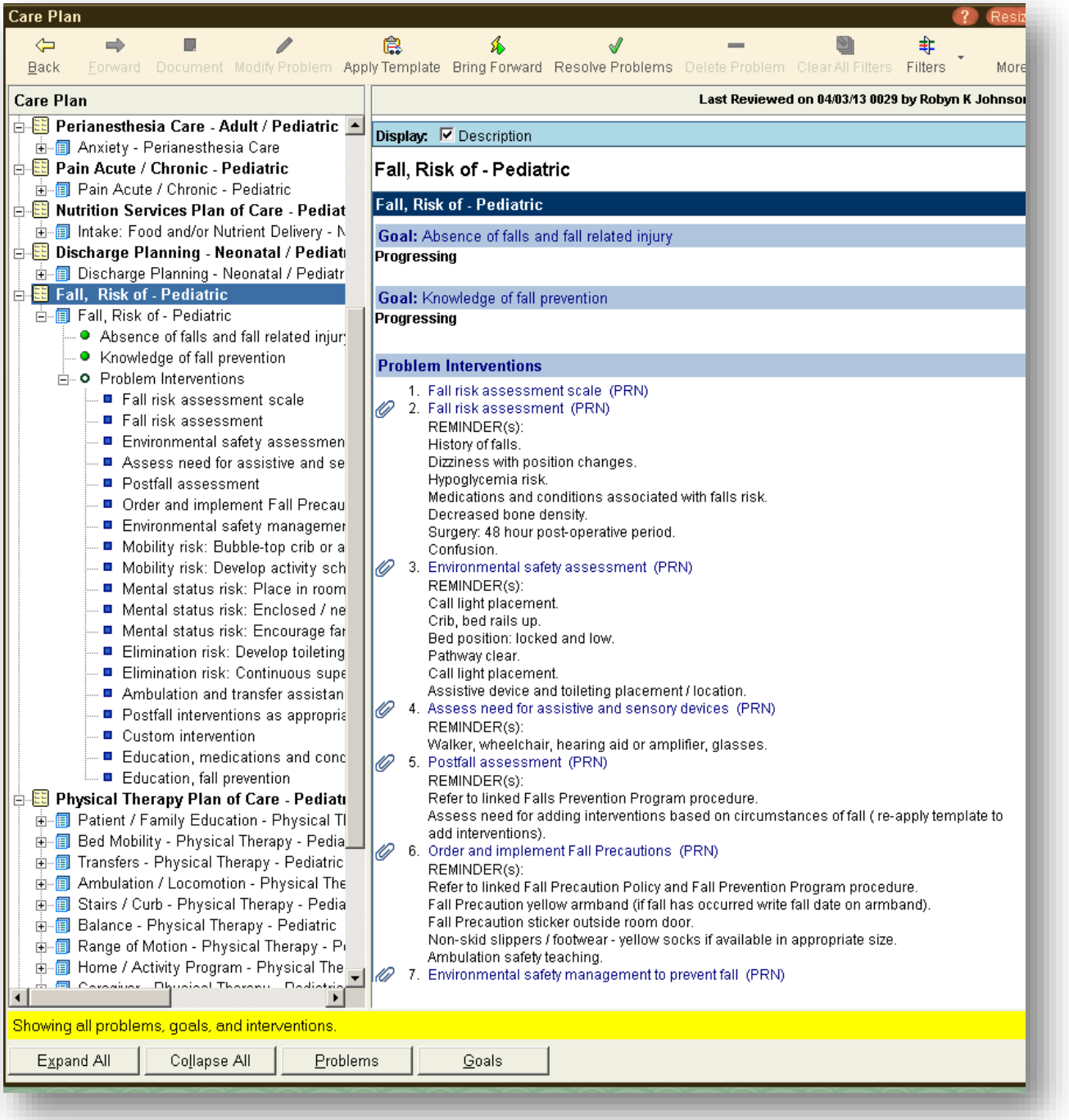
FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Appendix A: “Risk for Fall” AND “High Risk” External Indicator Lights

Console	External Indicator Light
 “Fall Risk” highlighted in red.	 Two top lights lit in white, not blinking.

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Appendix B: Fall, Risk of- Pediatric Care Plan



UCSF Benioff Children's Hospital San Francisco

Patient Name:

Medical Record:

Date of Birth:

POST FALL HUDDLE

SECTION A: Fall Information
Date of Fall: **Time of Fall:**
Location of Fall: **Unit:** **Room:** **RN:** **PCA:**
Fall Risk Assessment Prior to Fall: **Little Schmidy score:** **Risk for Injury? Yes No**
Time last rounded on: _____Time last toileted: _____Time patient last slept:_____ **#of hours**__ **Which of the following were assessed during the last round:** ❑ Pain ❑ Personal needs (toileting, etc.) ❑ Position ❑ Placement of possessions ❑ Prevention of falls
If fall assisted, transfer equipment in use at time of fall: ❑ None ❑ Gait/Transfer belt ❑ Walker ❑ Cane ❑ Sliding sheet/board ❑ Lift equipment/Other
If patient/baby fell from bed, number of side rails up at time of fall:_____ ❑ Infant dropped while held
Medications received within 8 hours prior to fall: ❑ None ❑ PNI ❑ PCA/PCEA/Epidural ❑ Opiates ❑ Anticonvulsants ❑ Antihypertensive ❑ Antiarrhythmic ❑ Sedatives ❑ Diuretics ❑ Laxatives ❑ Antidepressants ❑ Antipsychotics ❑ Benzodiazepines ❑ Antihistamines **Is patient on anticoagulant/antiplatelet therapy?** ❑ No ❑ Yes ❑ Medication name:_____
Preventative measures already in place at time of fall: ❑ Bed in low position ❑Respite care offered to post-partum mothers ❑ Bed alarm ❑ Chair alarm ❑ Restraints ❑ Safety attendant ❑ Number of Side rails Up: _____ ❑ Yellow Arm Band & Yellow non-skid socks ❑ Fall Sign at Door ❑ Fall Sign at HOB ❑ Fall Care Plan active/appropriate interventions Other:_____

SECTION B: POST FALL HUDDLE -- MINI ROOT CAUSE ANALYSIS

Huddle Team Members	First & Last Name	Title	Home Unit
Charge Nurse			
Primary Nurse			
Provider			
Other			

Contributory Factors: **Cognitive & Functional Factors (check all that apply):** ❑ Foley d/c date_____ ❑ Incontinent ❑ Previous fall ❑ Fatigued/lack of sleep ❑ Delirium ❑ Seizure ❑ Altered ADL ❑ Altered strength ❑ Altered gait/balance ❑ Dizzy/lightheaded ❑ Orthostatic B/P issues ❑ Confused/memory impaired ❑ Impulsive ❑ Uncooperative/noncompliant ❑ Frequent toileting ❑ Pain ❑ Unable to speak: communication method:_____

Environmental & Equipment (check all that apply):
❑ Needed item out of reach ❑ Clothing issues ❑ Improper footwear: _____❑ Cluttered area ❑ Wet floor ❑ Poor lighting ❑ Low-hanging tubing/catheter ❑ Faulty/broken equipment (chairs, assistive devices, etc.)

Review Findings

❑ Fall Risk Assessment not done/Injury Risk Assessment not done ❑ Call light not available/within reach
❑ Bed not in lowest position ❑ BID diuretic given after 3 PM ❑ Insomnia meds given after midnight
❑ High falls/injury risk pt. left alone/unattended while toileting ❑ Bed alarm/low bed malfunction
❑ Incomplete follow-through with falls risk levels/interventions ❑ Bed alarm not plugged in/turned on
❑ Infant/patient not in appropriate crib/bassinette Other: _____

❑ Updated care plan	❑ Completed a fall event note in APeX
❑ Completed an incident report	❑ Discuss this post fall huddle form during shift hand-off
❑ Patient education reinforced	❑ Was the next of kin notified? ❑Yes ❑ No (why not?)
❑ Physical assessment completed by provider	❑ Provider note completed

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Appendix D: Fall Prevention Education Flyer

UCSF Benioff Children's Hospital
San Francisco

Fall Prevention Reminders

- Keep the call light and bedside table within your or your child's reach
- Keep the side rails up on your child's bed or crib
- Keep a clear pathway in your child's room so there are no tripping hazards
- Hospital furniture are high – please keep your child within your reach
- Always buckle the lap belt when your child is in a stroller, wheelchair, highchair, or wagon
- Use the call button if your child needs help to get to the bathroom; pull the cord in the bathroom to get back to bed from the bathroom
- Do not lean on IV pole or bedside table
- Be sure your child is wearing slip proof socks or rubber soled shoes whenever walking
- Be sure that your child's clothing is not dragging on the floor

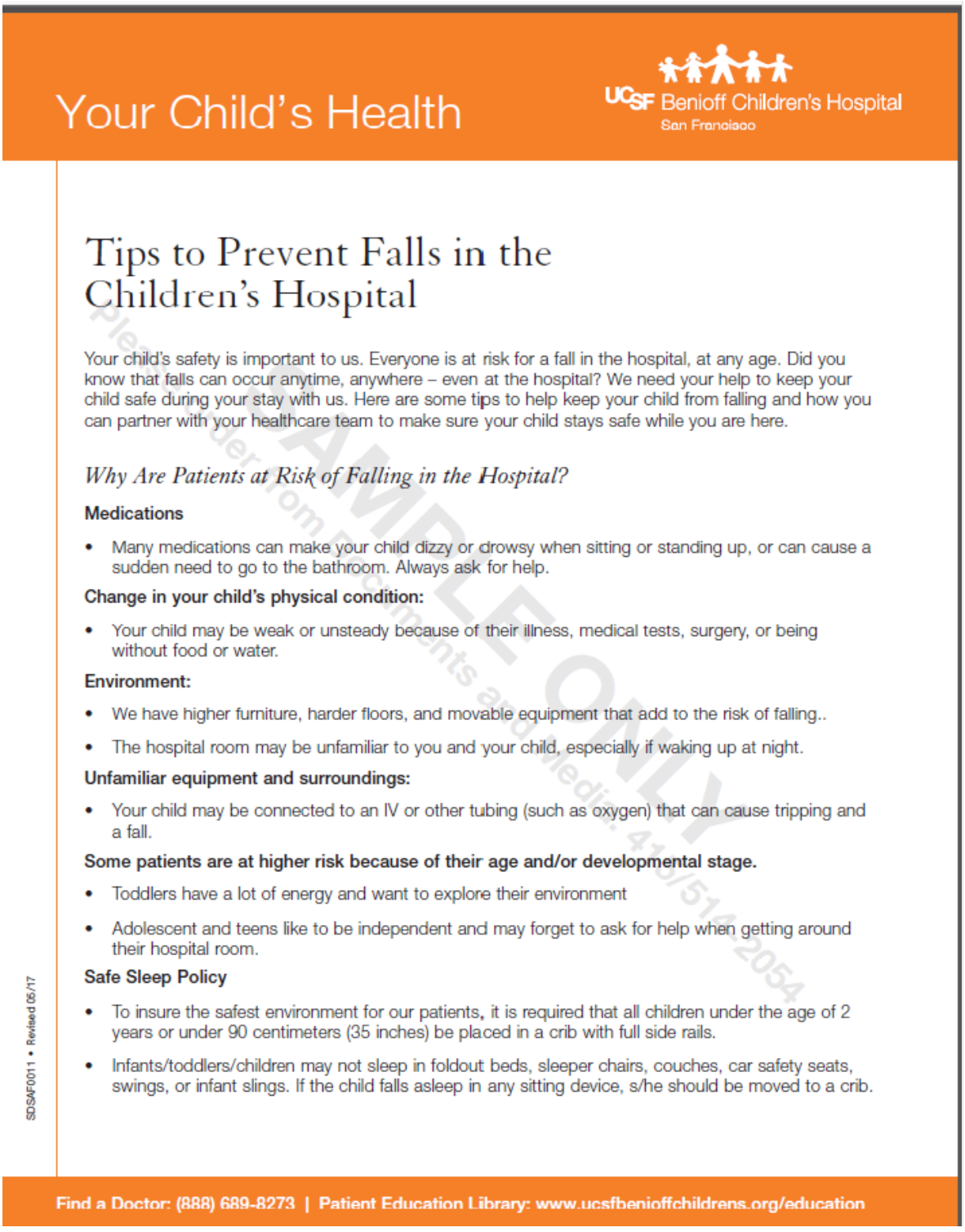
EVERY TIME… CALL BEFORE YOU FALL!

We are ALWAYS here to help you!

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Appendix E: Your Health Matters Educational Handout

Access Here: http://campuslifeservices.ucsf.edu/dmx/PatientEd/SDSAF0011.



Your Child's Health

UCSF Benioff Children's Hospital San Francisco

Tips to Prevent Falls in the Children's Hospital

Your child's safety is important to us. Everyone is at risk for a fall in the hospital, at any age. Did you know that falls can occur anytime, anywhere – even at the hospital? We need your help to keep your child safe during your stay with us. Here are some tips to help keep your child from falling and how you can partner with your healthcare team to make sure your child stays safe while you are here.

Why Are Patients at Risk of Falling in the Hospital?

Medications

- Many medications can make your child dizzy or drowsy when sitting or standing up, or can cause a sudden need to go to the bathroom. Always ask for help.

Change in your child's physical condition:

- Your child may be weak or unsteady because of their illness, medical tests, surgery, or being without food or water.

Environment:

- We have higher furniture, harder floors, and movable equipment that add to the risk of falling..
- The hospital room may be unfamiliar to you and your child, especially if waking up at night.

Unfamiliar equipment and surroundings:

- Your child may be connected to an IV or other tubing (such as oxygen) that can cause tripping and a fall.

Some patients are at higher risk because of their age and/or developmental stage.

- Toddlers have a lot of energy and want to explore their environment
- Adolescent and teens like to be independent and may forget to ask for help when getting around their hospital room.

Safe Sleep Policy

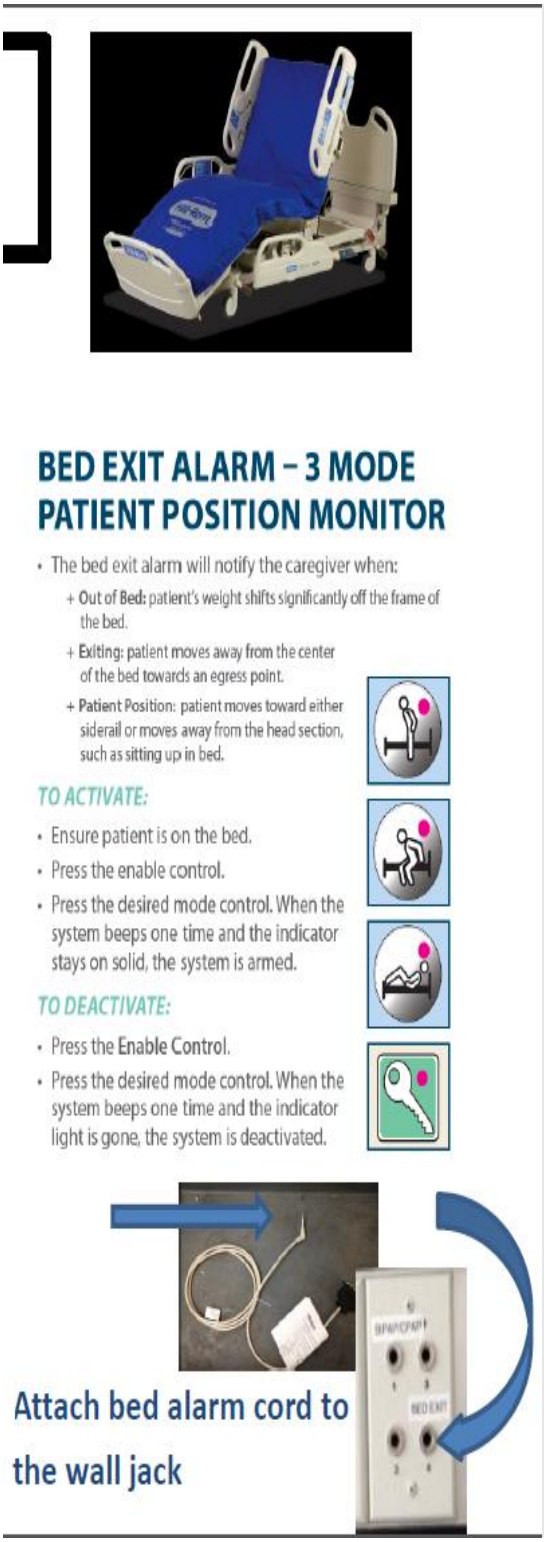
- To insure the safest environment for our patients, it is required that all children under the age of 2 years or under 90 centimeters (35 inches) be placed in a crib with full side rails.
- Infants/toddlers/children may not sleep in foldout beds, sleeper chairs, couches, car safety seats, swings, or infant slings. If the child falls asleep in any sitting device, s/he should be moved to a crib.

SDSAF0011 • Revised 05/17

Find a Doctor: (888) 689-8273 | Patient Education Library: www.ucsfbenioffchildrens.org/education

FALLS PREVENTION PROGRAM (PEDIATRICS) *(continued)*

Appendix F: Hill Rom Versa Care Built-in Bed Exit Alarm



Bed Exit Alarm System

⚠ WARNING:
The Bed Exit Alarm System is not intended as a substitute for good nursing practices. The Bed Exit Alarm System must be used in conjunction with a sound risk assessment and protocol.

The Bed Exit Alarm System (Bed Exit) control is located on the flip-up control pod on the outside of the head-end siderails.

Bed Exit should be used with the treatment/therapy surface in the Normal or Sleep mode only. It should not be used with the Max-Inflate, Turn Assist, or Off modes.

Bed Exit has three modes: Patient Position, Bed Exiting, and Out-of-Bed.

- **Patient Position Mode**—this mode alarms when the patient moves towards either siderail or moves away from the head section, such as sits up in bed. This mode should be used when a caregiver wants to be alerted when the patient begins to move.

- **Bed Exiting Mode**—this mode alarms when a patient moves away from the center of the bed towards an egress point. This mode should be used when a caregiver wants to be alerted when a potential egress is attempted.

- **Out-of-Bed Mode**—this mode alarms when the patient's weight shifts significantly off the frame of the bed. This mode should be used when a caregiver wants the patient to move freely within the bed, but to be alerted when the patient leaves the bed.

When the system is armed and it detects an alarm condition for the set Bed Exit mode, these occur:

- An audible alarm comes on. The alarm sound continues until you press the Alarm Silence control or you deactivate Bed Exit, even if the patient lies down on the bed.
- The indicator for the applicable Bed Exit mode flashes. The flashing indicator continues until you deactivate Bed Exit, even if the patient lies down on the bed.
- A priority nurse call is sent.

To Activate

1. Make sure the patient is centered in the bed and aligned with the hip locator.
2. Press the Enable control until the indicator illuminates.
3. Press the desired mode control. When the system beeps one time and the indicator stays on solid, the system is armed.

NOTE:
The indicator flashes until the system is armed.

If the system does not arm, the system will beep rapidly for a few seconds and the selected mode indicator will flash. This means the patient weighs less than 50 lb (23 kg) or more than 500 lb (227 kg), the patient is not correctly positioned, or the system has malfunctioned.

VersaCare® Bed User Manual (161956 REV 2) 35