FALLS AND ENTRAPMENT 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 in Power Chart.
- There are identifiable falls risk factors for all children when admitted to hospital.
- All children require "Care Actions" to be implemented in response to their risk assessment score.
- A falls prevention and management plan must be completed and implemented on Powerchart if a child scores a risk assessment result of 12 or higher.
- 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 IMS+. A medical officer should be notified for review of the child.
- Measures should be taken to reduce the risk of entrapment. If a child does suffer from an entrapment incident they must be clinically assessed for injury or harm and an incident report is required to be entered into IMS+. A medical officer should be notified for review of the child.
- After a fall, a full set of observations, including neurological observations 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.

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 August 2021	**Review Period**: 3 years
Team Leader:	Clinical Nurse Consultant	**Area/Dept**: Skin Integrity

CHANGE SUMMARY

- Inclusion of identification of the risk of entrapment and management post entrapment incident
- Inclusion of the Cot and Bed Allocation Guide (CaBAG)
- Inclusion of the consideration of children falling in outpatients and other non-ward treatment areas
- Inclusion of the SCHN educational video Paediatric Falls Prevention Management | learning.kids (nsw.gov.au)
- **25/08/22:** Minor review. Updated link to Clinical Excellence Committee (CEC) factsheets: https://www.cec.health.nsw.gov.au/keep-patients-safe/paediatrics/fall-and-entrapment

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 in children. Falls are a major preventable risk factor for paediatric patients in hospital.

Falls prevention and management is a priority for New South Wales health and one of the key components of the National Safety and Quality Health Service (NSQHS) Standards, standard 5, comprehensive care (Australian Commission on Safety and Quality in Health Care, 2017).

On admission and ward orientation, families and carers should be made aware of the differences between the home and hospital environments, including furniture heights and other environmental risks.

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 for use in eMR Power Chart.

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.

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**/ muscle tone and/or strength.
- 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, anti-epileptic medications.

Children at High Risk

- Pre-school age/ unaware of their own limitations
- difficulty with mobility and/or balance
- Neurological diagnosis
- Psychological and/or behavioural disorders
- Confusion, delirium or neurological impairment
- Limited or difficult communication abilities

- Poor vision
- Use of assistance technology
- Following anaesthesia or sedation
- Multiple medications or strong analgesics e.g. morphine
- Lack of supervision
- Carer's own mobility and/or function to provide care or supervision
- Need for frequent/assisted toileting in ambulant children.

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. In the hospital environment the consequences of a fall can result in:

- Death – extremely rare.
- Minor to serious injury.
- Increased stay in hospital.
- Impact on family/carer.
- Potential changes to base line physical function.
- 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 individualized to each patient.

The tool uses a cumulative calculation model.

- There are seven parameters; each parameter receives a score.
- If 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 will 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

(Clinical Excellence Commission, 2020)

Age: Is auto populated from electronic medical records.

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: 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: other diagnosis 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 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 maladapted behaviour such as erratic movements, 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, walking frames (or other assistive devices),wheelchairs, splints, walking belts
- 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/Anesthesia:

- Patient has had Surgery/Sedation/Anaesthesia within in the allotted time frames.
- This does not include 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. Or in the case of laxatives/ diuretics, medication that may result in the sudden need to get out of bed

Mobility

Ambulant Mobility: Children with impaired or limited mobility for transfers and ambulation are at increased risk of a fall, inclusive of those who have received sedation or general anaesthetic.

Bed Mobility: Children with impaired or limited mobility within the bed/cot are at an increased risk of entrapment between equipment such as bed rails and mattresses due to the inability to reposition self. Similarly, children with uncontrolled movements (e.g. movement disorder or seizures) are at increased risk of injury and entrapment.

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

Quick starts available from Learning.kids

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

3 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 regardless of identified risk. These include the Care Actions for Falls Prevention and the following:

- Children commonly fall from standing on beds and fold out couches, please ensure patients and families know this risk exists and that children are reminded not to stand, climb or jump on furniture.
- When using a high chair/ pram in hospital, the chair must meet the Australian Standards (https://www.techstreet.com/sa/standards/as-4684-2009?product_id=2052276): including 5 point harness straps, must be washable with universal detergent and all patients need to be secured, 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. If unsure, consider referral to Allied Health (Physiotherapist – for concerns with mobilisation including walking aids, Occupational Therapy – for concerns with equipment and ADLS).

4 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.

Engagement with the child and their family should be conducted in a culturally appropriate manner that is respectful of the child's cultural values, language and kinship systems. It is also important that this is delivered in a way that is understood by the child (if appropriate) and/or their carer. Interpreting services should be used if required to offer falls education.

4.1 Care Actions on Admission

- Orientate child/parents/carers to room.
- Research support the need for child/parents/carers education on admission and opportunistically during admission about the potential fall risk and interventions and provide information [8 9].
- Place child in developmentally appropriate sized bed (may require low bed), brakes on.
- Use the Cot and Bed allocation guide to determine if a cot/bed is required and if relevant if the bed rails need to be kept up or down on the bed
- Staff should also remind parents of the importance of the cot sides being up, irrespective of them being at the cot side.
- If beds are designed to have Bed heads and foot ends they must be in place.
- Ensure child has appropriate non-slip footwear and appropriate clothing to prevent tripping.

4.2 Care Actions for Routine Care

- Assess toileting needs and assist as required.
- 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 trip hazards.
- Curtains should remain open to enable full view of child, unless otherwise indicated.
- Ensure adequate lighting is available 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.
- Secure and supervise all children using high chairs/prams that meet the Australian Standards with 5-point harness straps.
- Secure and supervise all children in wheelchairs, infant seats and any specialist seating (e.g. Tumbleforms).

4.3 Care Actions for High Risk Patients

Any child scoring 12 or above on the NSW Paediatric Fall Risk Assessment Tool is at high risk of a fall and should have a fall prevention management plan outlining the fall prevention interventions to be implemented.

The high risk of falls should be communicated to parents/carers and the child.

Care plans should be developed in partnership with the child (where appropriate) and their parents/carers.

Documentation of the falls prevention plan should be entered into the child's medical record and communicated to staff through multidisciplinary handovers, bedside clinical handovers and safety huddles.

In addition to the routine interventions listed above, additional interventions include:

- Assess need for 1:1 nursing care.
- Place the child in a high observation area, wherever possible.
- Engage the child and their carer in prevention of a fall and harm from a fall.
- Develop, communicate and document interventions with input from the child, carer and family.
- Communicate at clinical handover and safety huddles children at high risk of a fall and prevention interventions implemented as part of their fall prevention management plan.
- Accompany the child when mobilising for the first time following a procedure and/or when assistance has been specified in the care plan.
- Check the child every hour if they are unattended (as a minimum), including if they have a carer with them who may be asleep.
- Review current medication list and administration times that may contribute to an increased fall risk e.g. frequency of medication to support adequate sleep rest periods, medications that may affect cognitive function.
- Where possible, ensure bed height is at the lowest possible setting to the ground
- Utilise appropriate mobility equipment.
- Refer to allied health (e.g. physiotherapy, occupational therapy) as required for mobility assessment and equipment recommendations, the referral and plan for mobilisation should be communicated at team handovers.
- Complete regular nutrition screening on admission and weekly thereafter

5 High Risk Patients Handover

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.

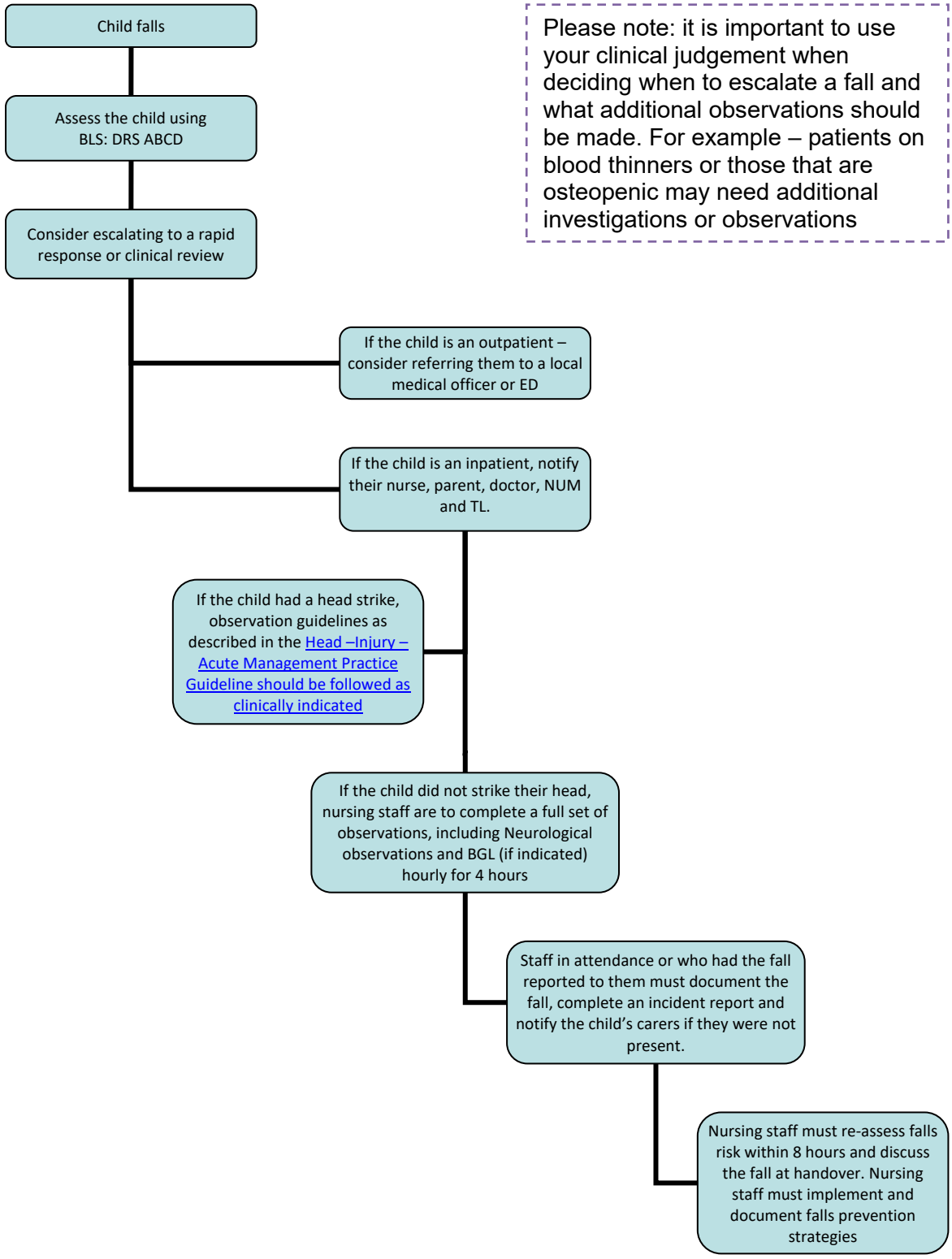
For more information please go to the Clinical Excellence Commission (CEC) website on Falls Prevention.

6 When a Child Falls

If a child suffers from a fall:

- Follow the Flow Chart on page 11.
- Assess child; provide immediate care conduct a full set of observations, including Neurological observations and BGL (if indicated)
  - Consider referring to the Head Injury - Acute Management Practice Guideline if required
  - Consider escalation to a clinical review or rapid response as per the Between the Flags (BTF) - Clinical Emergency Response System (CERS) procedure document
- 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
- Complete a clinical incident report on IMS+ and record the incident number in the medical record.
- Promptly inform parents/guardian if not present at time of fall.
- Reassess the child using the Falls Risk Assessment.
  - Communicate the fall incident at clinical handover.
  - As directed in the Head Injury – Acute Management Practice Guideline if a head strike has occurred or if no head strike, continue observations hourly for a minimum of 4 hours.
  - Then resume 4 hourly observations thereafter unless clinically indicated.

6.1 Figure 1. Falls Decision Tree



7 Falls Prevention and Management in the Neonatal and Paediatric/Children's Intensive Care Units (ICU) and post anaesthetic care units

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. When the patient is awake and alert, ensure call bells, bedside tables and frequently used objects are within easy reach if appropriate.
- 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:

- Parents should not be allowed to sleep with their baby in a bed or chair.
- Education should be offered to parents, ensuring they understand that sleeping with their baby in in a bed or chair introduces the risk of their baby falling or suffering from suffocation/ entrapment injury.
- 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.

Documentation:

- All care actions must be documented in the medical record.

Post falls management in the neonatal ICU, paediatric ICU or post anaesthetic care unit

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

8 Falls Prevention and Management in Outpatients and other non-ward treatment areas

A fall can occur anywhere in the hospital environment and it is the responsibility of all staff to prevent a fall.

In hospital environments, this includes examination tables that do not have bed rails (in addition, examination tables with electronic height controls can be an entrapment risk). These risks should be minimised where possible. Close supervision by a capable person of children in these areas is key in preventing a fall.

If a child does have a fall in an outpatient setting, prompt assessment should take place and local Between the Flags (BTF) - Clinical Emergency Response System (CERS) procedures followed. The post falls decision tree (Figure 1) can be used to assist in the post fall management of a child in a non-inpatient setting. Consider transferring the child to the Emergency Department for a full assessment and ongoing monitoring if there is evidence of a head injury or other injury.

9 Reducing the risk of entrapment

A child's risk of entrapment is to be assessed in addition to their potential fall risk. Staff are required to use their clinical judgement to determine a child's risk of entrapment, in consultation with the child and their carer's.

Carers should not co-sleep with their young children. Co-sleeping increases the risk of entrapment for the child and is not recommended. Please see the SCHN Safer Sleeping Practices for Babies Policy.

It is recommended that beds are not routinely fitted with bed rail protectors/bumpers due to the increased risk of entrapment unless staff have determined the child's potential risk of injury increases in the absence of fitted bed rail protectors/bumpers. When bed rails are in use full length bed rails are recommended, rather than 3/4 length.

Staff must use their clinical judgement to determine a child's risk based on:

- Medical condition of the child
- Mobility in the bed
- Age of the child
- Staffing and supervision levels

Bed rail protectors/bumpers and pillows are not to be used in cots

Safe use of bed rail protectors/bumpers for children who require bed rail protectors/bumpers:

- Should be clearly documented in the child's medical record and communicated to staff through multidisciplinary handovers, bedside clinical handovers and safety huddles.
- Must be placed in a bed/room that can be closely supervised by staff.
- Require close and frequent observation/supervision.
- Bed rail protectors/bumpers must be fitted according to the manufacturer's instructions.
- Only use bed rail protectors/bumpers endorsed by the manufacturer of the bed.

The use of bed rail protectors/bumpers does not mitigate the requirement for regular observation and assessment of the child.

High or extreme risk of entrapment

If a child's risk of entrapment and injury from bed ends or bed rails is assessed as very high or extreme, consider placing the mattress on the floor.

Placing a mattress on the floor is a potential Work Health and Safety (WHS) risk and requires a WHS risk assessment. Risks must be assessed and control measures implemented to eliminate or effectively mitigate risk so far as reasonably practicable in accordance with WHS legislation, Codes of Practice and Standards.

10 Post-entrapment management

In the event a child becomes entrapped:

- Safely release and clinically assess the child for injury.
- Assess the patient and conduct a set of observations
- Inform a medical officer and escalate appropriately for a medical review depending on the level of harm, Consider escalation to a clinical review or rapid response as per the Between the Flags (BTF) - Clinical Emergency Response System (CERS) procedure document
- The mechanism of the entrapment should be assessed, and interventions implemented to mitigate the risk of the entrapment recurring.
- Details of the entrapment and post-entrapment management plan must be documented in the child's medical record.
- Document this incident into ims+.

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Appendix A

Cot and Bed Allocation Guide (CaBAG) is designed to reduce the risk of harm to a child whilst in a bed or cot. This not only includes risk of a fall from a bed, but also risk of entrapment.

The CaBAG is intended to be used alongside the NSW Paediatric Fall Risk Assessment Tool and assessment of entrapment risk, to assist staff in determining the safest bed or cot arrangement for children cared for in the hospital environment.

Appendix B

Falls and Entrapment Education

SCHN developed educational video can be found here Paediatric Falls Prevention Management | learning.kids (nsw.gov.au)

Further education regarding paediatric falls and entrapment is available from:

Clinical Excellence Commission including family and patient education and factsheets

- https://www.cec.health.nsw.gov.au/keep-patients-safe/paediatrics/fall-and-entrapment

Learning.Kids

- https://learning.schn.health.nsw.gov.au/paediatric-falls-prevention-management