# Paediatric Fall and Entrapment Prevention and Management Guideline

Version 1.0

October 2020

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

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# Contents

# Introduction

The purpose of this guideline is to provide paediatric specific fall and entrapment prevention and risk mitigation guidance for Local Health Districts (LHD) and Specialty Health Networks (SHN). This guideline applies to all staff who deliver/are responsible for care delivery for infants, children and young people in hospital. This guideline has been developed by the Clinical Excellence Commission (CEC) in response to recommendations from a coronial inquest where a child fell out of bed and became entrapped.

# Expected outcome

- To reduce falls and entrapment, and subsequent harm by identifying, minimising, and managing the individual fall and entrapment risk factors of infants, children and young people in hospital.
- Address elements of the National Safety and Quality Health Service (NSQHS) Standard 5 on Comprehensive Care.

# Background

Falling is a normal part of a child's development as they learn to walk, climb, jump, run and play. In hospital, children are at risk of falling however many of these can be prevented. Most children who fall in hospital do not suffer serious injury. The majority of incidents involving children younger than 10 years of age are related to falls from beds and cots when parents and carers may be distracted briefly and leave the child unattended, not recognising that hospital cots and beds are higher than the usual home furniture. Child curiosity, development of motors skills, cognitive impairment, neurological deficit (e.g. seizure disorders, traumatic brain injury) or poor insight may contribute to a child falling. In addition, infants and children who are unable to reposition themselves independently, for example children with a mobility disorder, are at a higher risk of entrapment.

In the hospital environment the consequences of a fall or entrapment can result in a range of harms:

- Death – extremely rare
- Minor to serious injury
- Increased hospital length of stay
- Impact on family/carer
- Potential change in mobility and/or function on discharge
- Increase in child/family/carer costs.

On admission, the potential fall and entrapment risks needs to be discussed with every child and their family as part of orientation to the ward.

The NSQHS Comprehensive Care Standard supports the delivery of care for patients that is coordinated and aligned with the patient's, carer's and family's expressed goals of care. One criterion of the NSQHS Comprehensive Care Standard is minimising the risk of harm to patients when receiving care by using screening and assessment processes. The Standard requires all patients admitted to hospital to be screened for a fall risk and, if identified as a high risk, an

indvidualised fall prevention management plan is to be implemented in consultation with the child and their family. 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.

## Definitions

| | |
|---|---|
| **Bed** | General ward bed is used in the facility for the majority of patients, usually defined by state contract, and indicated for patients that do not require a prescribed bed for care delivery.<br><br>Adjustable height beds can be lowered to minimum heights to reduce risk of falling out of bed for those children who are considered at risk.<br>The bed base heights range approximately from minimum (100mm) to maximum (750mm).<br>Bed bases in height order:<br>• Hi-Lo (base to floor approx. min height 390mm)<br>• Lo-Lo (base to floor approx. min height 250mm)<br>• Floor level (base to floor approx. min height 100mm)<br>*Different types of bed mattresses will vary the overall height from the floor.<br><br>For the purpose of this guideline, bed is used collectively to include the above and cots. |
| **Carer** | Carers are people who provide ongoing, unpaid support to a child who needs help with everyday aspects of life. This includes parent/s. |
| **Clinical Emergency Response System (CERS)** | A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit-based responses (Clinical Review and Rapid Response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility). |
| **Clinical judgement** | The ability to make a logical, rational decision based on clinical knowledge, experience and skill. This decision should be based on the ability to draw on a variety of sources of information; this includes actual observation (environment) of a patient combined with objective (screening tools) and subjective data. |
| **Child** | For the purpose of this guideline, a child is an inpatient under the age of 16 years or any child cared for in a healthcare facility |
| **Entrapment** | Incident involving a child's head or limb being caught, trapped, or entangled in bedding or the spaces in or about the bed rail, mattress, or hospital bed frame. Entrapment can result in serious injury or death. |
| **Fall** | An unintended event resulting in a person coming to rest on the ground/floor or other lower level. These can be 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. A fall can also include assisted or guided falls. |
| **Unattended** | No direct supervision is being provided to the child by a carer or staff. |

# Governance

LHD/SHN executives/leaders are responsible for ensuring the facility/organisation is set up to maintain systems and processes to support staff to assess children for risk of a fall and /or entrapment, implement a prevention management plan to reduce risk of, and harm from a fall or entrapment; and instigate appropriate post-fall management in the event a fall has occurred.

All LHDs/SHNs should take reasonable steps to have a fall risk screening, assessment and prevention management plan process in place. This should be consistent with best-practice guidelines and include fall prevention, minimising harm from a fall, and post-fall management.

# Preventing a fall

## NSW Paediatric Fall Risk Assessment Tool

The NSW Paediatric Fall Risk Assessment Tool (Appendix A) used by NSW Health services has been adopted from the Humpty Dumpty Fall Program used by the Miami Children's Hospital. The tool requires clinical judgment and should be individualised to each child. The NSW Paediatric Fall Risk Assessment Tool is available through electronic medical records (eMR) or in paper format as a stand-alone risk assessment form (SMR060.020). The tool is also embedded in the Paediatric Risk Assessment form (SMR060.994 and SMR060.995) that is used during the admission process for every child.

**NOTE**: the tool is not validated for use in neonatal or paediatric intensive care units.

Every child should be considered a potential fall risk and the NSW Paediatric Fall Risk Assessment Tool is to be completed. **Staff can deem a child at a higher risk based on clinical judgement.** The assessment tool can also help to identify children who are at a higher risk of falling. Factors that may increase a child's risk of a fall include:

- Pre-school age
- Disabilities or limited mobility
- Neurological diagnosis
- Psychological and/or behavioural disorders
- Confusion, delirium or neurological impairment
- Limitied 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.

## When to complete the NSW Paediatric Fall Risk Assessment Tool:

- Planned pre-admission for a child with a chronic condition
- On admission to a ward or unit – within 8 hours
- Change in location
- **Whenever the child's condition changes**, for example following surgery or a change in behaviour
- After a fall
- Every 3 days after admission.

## Completing the NSW Paediatric Fall Risk Assessment Tool

The NSW Paediatric Fall Risk Assessment Tool uses a cumulative calculation model. There are seven parameters and each parameter receives a score*; age, gender, diagnosis, cognitive impairments, environmental factors, surgery/sedation/anaesthesia considerations, and medication usage*. If a child falls into multiple categories in a parameter, the highest possible score is allocated for the parameter.

**Age**

**Gender**

**Diagnosis or conditions:**

- If the child has multiple, secondary or underlying diagnoses or conditions, then the score is based on the highest acuity diagnosis (for example: a child with sickle cell anaemia with a history of strokes or seizures would receive the higher neurological score).
- Examples of diagnoses or conditions that may place a child at higher risk of a fall include but are not limited to:
    - Neurological: seizures, brain injury, hydrocephalus, cerebral palsy, spinal cord injury etc. This would include children 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, anaemia, anorexia, syncope, etc.
    - Psychiatric/behavioral disorders: can include mood disorders (major depression, bi-polar disorder) and impulse control disorders.
    - Other diagnoses: anything that does not come into the other categories (examples include but are not limited to cellulitis, fracture, impaired vision).

**Cognitive impairment**:

- Not aware of limitations: can be any age group and is dependent on ability to understand the consequences of their actions. (For example: post severe brain injury, acute delirium).
- 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. This can include children prone to tantrums and 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 current or previous admission.
- Infant/toddler placed in bed: creates an increased falls risk.
- Child uses assistance technology: includes but not limited to crutches, walkers, canes, splints or requires assistance to mobilise.
- Inpatient receiving services off the ward, such as an outpatient area. For example, child placed on examination tables without bed rails.

**Surgery/deep sedation:**

- Child has had recent surgery/deep sedation.
- Not including bedside procedures without anaesthesia.

**Medication:**

- Identify children who may be at risk of alteration in level of consciousness or impaired mobilisation as a result of their medication. This may also include polypharmacy including but not limited to; sedatives/hypnotics (excluding general anaesthetics), anti-epiletics, antidepressants, antipsychotics, opioids, laxatives, and diuretics which could increase the risk of a fall.

After allocating a score to each of the seven categories, the cumulative total will provide an indication to the degree at which the child is at risk of a fall. It is important to note that a child's mobility is not included in the assessment tool but can influence the child's risk of fall. For this reason it is essential to consider a child's mobility when determining the level of risk.

**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.

# Fall prevention and maintaining a safe environment

## Routine care for fall prevention

All children are considered at risk of falling. To minimise the risk of a fall, simple prevention interventions should be put in place and be clearly documented in the child's medical record. This is to be done in collaboration with the child (where appropriate) and their carers. The following should be considered routine care for all children to prevent a fall:

**Child/Carer:**

- Educate the child and carers about the potential risk of a fall, interventions to reduce a fall, harm from a fall, and how they can help prevent a fall. An information leaflet is available in multiple languages on the CEC website, providing information to carers on fall prevention for children in hospital.
- Orientate child and their carers to the bedspace, i.e. how to control bed and bed rails etc
- Ensure the child has non-slip footwear and clothing that does not pose a risk of tripping.
- Discourage children from standing on beds and/or furniture, including carer pull-out beds.
- Discourage carers from sleeping while holding their child, whilst in a chair or bed.

**Staff:**

- Ensure the child is placed appropriately in a bed or cot based on their developmental needs. Refer to the Cot and Bed Allocation Guide (CaBAG) (Appendix B) for assistance in determining an appropriate bed or cot for the child and use of bed rails:
    - If the child requires a cot, cot rails are to be placed upright in the highest position.
    - For children requiring a bed, bed rails are to be placed in the down position unless clinically indicated.
- Assess the child's and/or carers ability to attend to activities of daily living independently and provide assistance as required.
- Assist unsteady children with ambulation. Children who have received sedation or general anaesthetic are at greater risk of falling and require assistance with ambulation.
- Recommend nursing staff conduct hourly checks on sleeping children.

**Environment and equipment:**

- Ensure the environment is clear of clutter and the bed area is clear of trip hazards:
    - Pull back curtains during the day and ensuring a full view of the child unless otherwise indicated
    - Ensure adequate lighting, including the use of a nightlight where appropriate
    - Keep the door to the room open at all times unless specific isolation precautions are in use or as clinically indicated
- Ensure bed heads and foot ends are in place on all beds where a child is placed and that bed/cot brakes are on.
- For children who mobilise with an IV pole, place equipment close to the centre of the pole and check IV lines are secure. Note: IV poles should not be used as a mobility aid.
- Ensure regular reviews of environmental hazards in bedrooms, bathrooms and passageways and ensure appropriate safety measures are in place. For example, signage; rails; shower hoses; soap dispensers; call bells, etc.
- 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), where possible.

**NOTE:** Use equipment according to the manufacturer's instructions.

### Fall prevention interventions for High Risk Children (Score 12 and above)

Any child scoring 12 or above on the NSW Paediatric Fall Risk Assessment Tool is at high risk of a fall and must have a fall prevention management plan outlining the fall prevention interventions to be implemented. The plan is to be developed in collaboration with the child (where appropriate) and their carers, be clearly documented in 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).
- 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

## Post-fall management

Following a fall, it is important to clinically assess the child for injury. In addition to this, the mechanism of the fall should be assessed, and interventions implemented to mitigate the risk of the fall recurring.

The local Clinical Emergency Response System (CERS) should be activated to ensure prompt escalation and assessment of the child following a fall.

It is recommended that the CEC Post Fall Guide - Paediatrics (Appendix C) be used to guide the post fall care phase and management of a child following a fall.

If there is a possibility that the child may have hit their head, perform a systematic A-G assessment and commence neurological observations (hourly for 4 hours), then as clinically indicated. The medical team should determine the frequency and type of ongoing observations following a fall.

All falls and details of post-fall management must be documented in the child's medical record, as well as entering the fall into the incident management system.

# Outpatients

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

In outpatient 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 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 CERS procedure followed. The CEC Post Fall Guide - Paediatrics (Appendix C) 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.

# Reducing the risk of entrapment

## Assessing 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 clinicial judgement to determine a child's risk of entrapment, in consultation with the child and their carers.

Carers should not co-sleep with their young children. Co-sleeping increases the risk of entrapment for the child and is not recommeded. Refer to NSW Health Policy PD2019_038 – Babies - Safe Sleeping Practices.

It is recommended that beds are not routinely fitted with bed rail protectors/bumpers unless staff have determined the child's potential risk of injury increases in the absence of fitted bed rail protectors/bumpers. Therefore, bed rail protectors/bumpers may be used in certain circumstances, following a risk assessment, to reduce the risk of bed rail protector/bumper entrapment and/or suffocation.

A risk assessment must be completed to determine if bed rail protectors/bumpers are required for a child to reduce the potential risk from bed rail injury or entrapment. **Bed rail protectors/bumpers and pillows are not to be used in cots.** Staff must use their clinical judgement to determine a child's risk based on:

- Medical condition of the child – acute and chronic/long term.
- Bed Mobility of the child: 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.
- Age of the child.
- Staffing levels and skill mix.

## Maintaining a safe environment

Children who are at risk of entrapment must have a prevention management plan implemented in collaboration with the child (where appropriate) and their carers. The management plan must be clearly documented in the child's medical record and communicated to staff through multidisciplinary handovers, bedside clinical handovers and safety huddles. Interventions to reduce a child's risk of entrapment are to be implemented in addition to any interventions required to prevent their risk of a fall.

Refer to the Cot and Bed Allocation Guide (CaBAG) (Appendix B) for assistance in assessing appropriate use of bed rail protectors/bumpers.

### Safe use of bed rail protectors/bumpers

For children who require bed rail protectors/bumpers:

- Must 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.
- Pillows and/or blankets can create a risk of suffocation and should be used with caution.

The use of bed rail protectors/bumpers does not mitigate the requirement for regular observation and assessment of the child. There may be other observations recommended depending on the child's medical condition and admission purpose e.g. Neurosurgical Observations.

### 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 matress 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.

# Post-entrapment management

In the event a child becomes entraped, safely release and clinically assess the child for injury. In addition to this, the mechanism of the entrapment should be assessed, and interventions implemented to mitigate the risk of the entrapment recurring.

The local Clinical Emergency Response System (CERS) should be activated to ensure prompt escalation and assessment of the child following entrapment.

Details of the entrapment and post-entrapment management plan must be documented in the child's medical record, as well as entering the entrapment into the incident management system.

# Cot and Bed Allocation Guide (CaBAG)

The CaBAG (Appendix B) 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.

## Education

LHDs/SHNs are responsible for assessing the training needs of the workforce and are to provide access to training on comprehensive care and minimising harm, including reducing risk of, and harm from fall or entrapment, in accordance with NSQHS Action 5.1. Additionally, staff participation in education and training that focuses on culturally appropriate engagement of children, carers and families and shared-decision making to ensure culturally sensitive delivery of care is recommended.

Education resources are available on the CEC Paediatric Falls Prevention webpage.

## Evaluation

Monitoring the use of the NSW Paediatric Fall Risk Assessment Tool is the responsibility of the LHD/SHN in accordance with NSQHS Action 5.2. This is to include:

- Audit compliance with completion of the NSW Paediatric Fall Risk Assessment Tool.
- Audit compliance with documentation of a management plan and actioning interventions for children identified at risk of a fall and/or entrapment.
- Implement quality and safety improvement strategies to target issues identified via the audit process. The outcomes of these quality and safety improvement strategies should be made availble to the governing body, staff and consumers.

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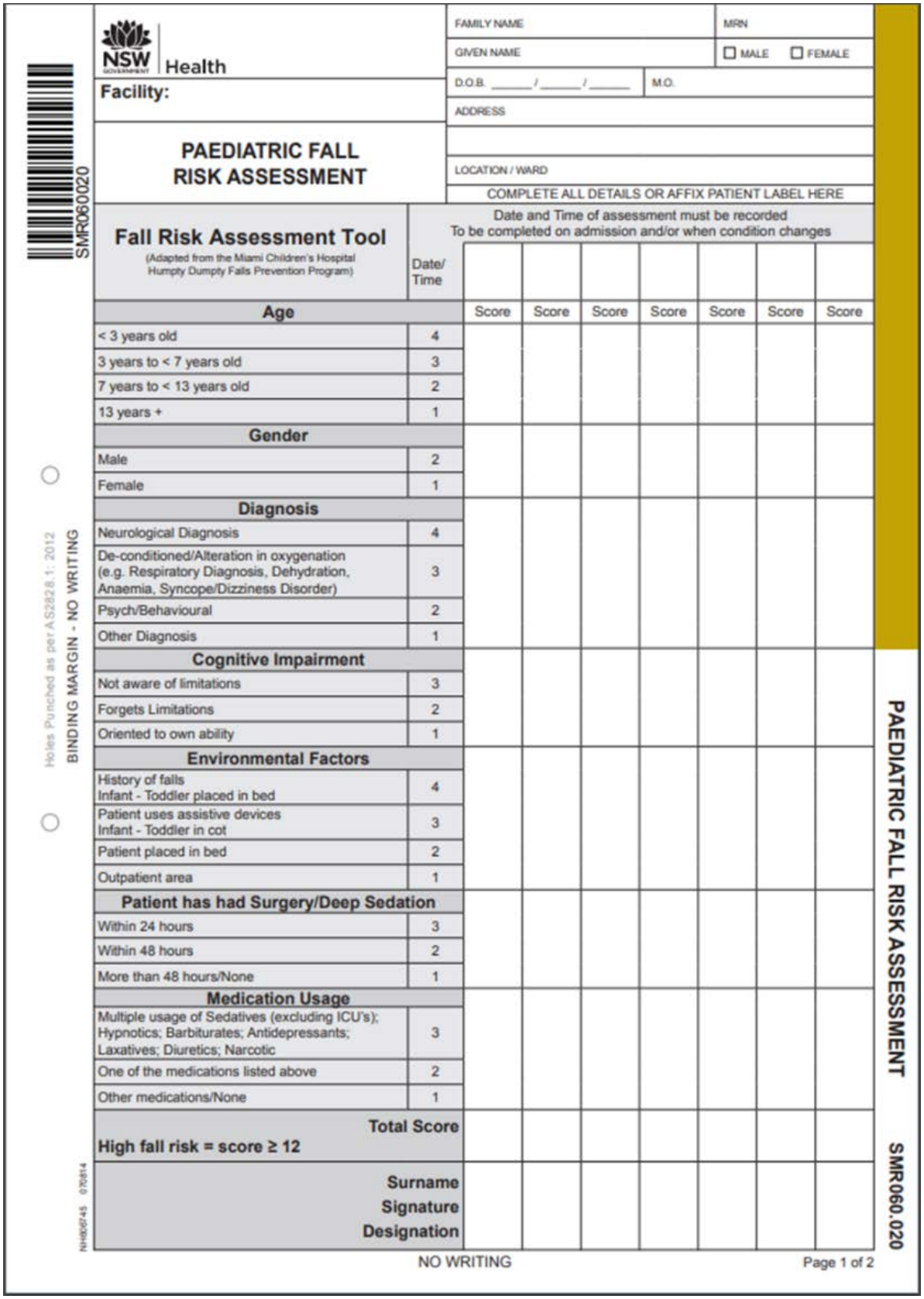
## Additional resources

- NSW Paediatric Fall Risk Assessment Tool
- CEC Post Fall Guide – Paediatrics
- Information for Parents & Carers: Falls Prevention for Children in Hospital (multiple languages available)
- CEC Posters and Flyers (multiple options available)
- NSW Paediatric Fall Risk Assessment Education and Paediatric Falls Education Case Study

# Appendix A: NSW Paediatric Fall Risk Assessment Tool



NSW Health

Facility:

**PAEDIATRIC FALL RISK ASSESSMENT**

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR060020

**Fall Risk Assessment Tool**

(Adapted from the Miami Children's Hospital Humpty Dumpty Falls Prevention Program)

Date and Time of assessment must be recorded
To be completed on admission and/or when condition changes

| | | Date/ Time | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Age** | | Score | Score | Score | Score | Score | Score | Score |
| < 3 years old | 4 | | | | | | | |
| 3 years to < 7 years old | 3 | | | | | | | |
| 7 years to < 13 years old | 2 | | | | | | | |
| 13 years + | 1 | | | | | | | |
| **Gender** | | | | | | | | |
| Male | 2 | | | | | | | |
| Female | 1 | | | | | | | |
| **Diagnosis** | | | | | | | | |
| Neurological Diagnosis | 4 | | | | | | | |
| De-conditioned/Alteration in oxygenation (e.g. Respiratory Diagnosis, Dehydration, Anaemia, Syncope/Dizziness Disorder) | 3 | | | | | | | |
| Psych/Behavioural | 2 | | | | | | | |
| Other Diagnosis | 1 | | | | | | | |
| **Cognitive Impairment** | | | | | | | | |
| Not aware of limitations | 3 | | | | | | | |
| Forgets Limitations | 2 | | | | | | | |
| Oriented to own ability | 1 | | | | | | | |
| **Environmental Factors** | | | | | | | | |
| History of falls<br>Infant - Toddler placed in bed | 4 | | | | | | | |
| Patient uses assistive devices<br>Infant - Toddler in cot | 3 | | | | | | | |
| Patient placed in bed | 2 | | | | | | | |
| Outpatient area | 1 | | | | | | | |
| **Patient has had Surgery/Deep Sedation** | | | | | | | | |
| Within 24 hours | 3 | | | | | | | |
| Within 48 hours | 2 | | | | | | | |
| More than 48 hours/None | 1 | | | | | | | |
| **Medication Usage** | | | | | | | | |
| Multiple usage of Sedatives (excluding ICU's); Hypnotics; Barbiturates; Antidepressants; Laxatives; Diuretics; Narcotic | 3 | | | | | | | |
| One of the medications listed above | 2 | | | | | | | |
| Other medications/None | 1 | | | | | | | |
| **Total Score**<br>**High fall risk = score ≥ 12** | | | | | | | | |
| **Surname**<br>**Signature**<br>**Designation** | | | | | | | | |

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NH050745 070814

PAEDIATRIC FALL RISK ASSESSMENT SMR060.020

NO WRITING

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NSW Health

Facility:

| FAMILY NAME | MRN |
|---|---|
| GIVEN NAME | ☐ MALE ☐ FEMALE |
| D.O.B. _____/_____/_____ | M.O. |
| ADDRESS | |
| | |
| LOCATION / WARD | |
| COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |

**PAEDIATRIC FALL RISK ASSESSMENT**

# Care Actions for all Paediatric Patients

| | ON ADMISSION | *Date / Time* | *Signature* |
|---|---|---|---|
| ON ADMISSION | Orientate child/parents/carers to room | | |
| | Educate child/parents/carers about the potential fall risk and interventions and provide information | | |
| | Educate child/parents/carers on how to use the call bell - ensure nurse call bell and light is within easy reach | | |
| | Document that a plan of care has been discussed with the child/parents/carer in clinical progress notes | | |
| | Bed/cot rails up. Assess for any gaps where a child could be injured or trapped; consider the use of additional safety precautions, such as bolster | | |
| | Place child in developmentally appropriate sized bed (may require low bed), brakes on | | |
| | Ensure child has non-skid footwear and appropriate clothing to prevent tripping | | |

***Care actions relevant for <u>all children</u> as a component of ongoing clinical care***

| | |
|---|---|
| ROUTINE CARE | Assess toileting needs and assist as needed |
| | Bed heads and foot ends must be in place on all beds at as per hospital protocol |
| | If child mobilises with IV pole, ensure equipment is placed close to the centre of the pole, and IV lines are secure |
| | 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 |
| | Keep room door open at all times unless specified isolation precautions are in use |

***Additional considerations for <u>high risk (score of 12 or above) patients</u>:***

| | |
|---|---|
| ROUTINE CARE | 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 |
| | Engage child's parents/carers in falls prevention interventions |

**DOCUMENT CARE ACTIONS IN HEALTHCARE RECORD**

Acknowledgement to:
Miami Children's Hospital Humpty Dumpty Falls Prevention Program.
NSLHD and CCLHD Falls Prevention Program - Paediatrics Group.
The Children's Hospital at Westmead

For more information scan this with your smart phone ⟶

**Email:** falls@cec.health.nsw.gov.au
**Web:** www.cec.health.nsw.gov.au

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR060020



NO WRITING

# Appendix B: Paediatric Cot and Bed Allocation Guide (CaBAG)

**STEP ONE**

Use clinical judgement in selecting the most appropriate bed or cot for the child based on their fall or entrapment risk.
Discuss potential risks and importance of appropriate bed / cot with carers.

**STEP TWO: BED ALLOCATION GUIDE**

**1. Is the child younger than 18 months?**

YES

- Place in cot with rails placed in the highest position.
- Bed rail protectors / bumpers are not to be used in cots.
- Pillows should not be used in cots

**Use clinical judgement and discuss with carers if cot required for child 18 months and older.**

NO

**2. Is the child able to get out of bed safely on their own?**

YES

- General ward bed at lowest height, bed rails down.
- **For children 18 months –3 years see below.

NO

**3. Is the child agitated or confused?**

YES

- Floor-line/Lo-Lo bed *with* or *without* additional supervision.
- Follow local guidelines.

NO

**4. Is the child likely to climb over bed rails?**

YES

- General ward bed at lowest height, bed rails down.
- **For children 18 months –3 years see below.

NO

**5. Is the child at risk of injury and /or entrapment of head / neck / torso / limbs from voluntary or involuntary movements / seizure disorder e.g. frequent or intractable seizures?**

YES

- Consider floor-line/Lo-Lo bed, *with* or *without* a crash mat.
- If general ward bed is used, full length bed rails should be in the upright position. **Bed rail protectors / bumpers are required.**
- If risk of entrapment and injury from bed ends or rails is very high or extreme, consider placing mattress on the floor (refer to local WHS guidelines)

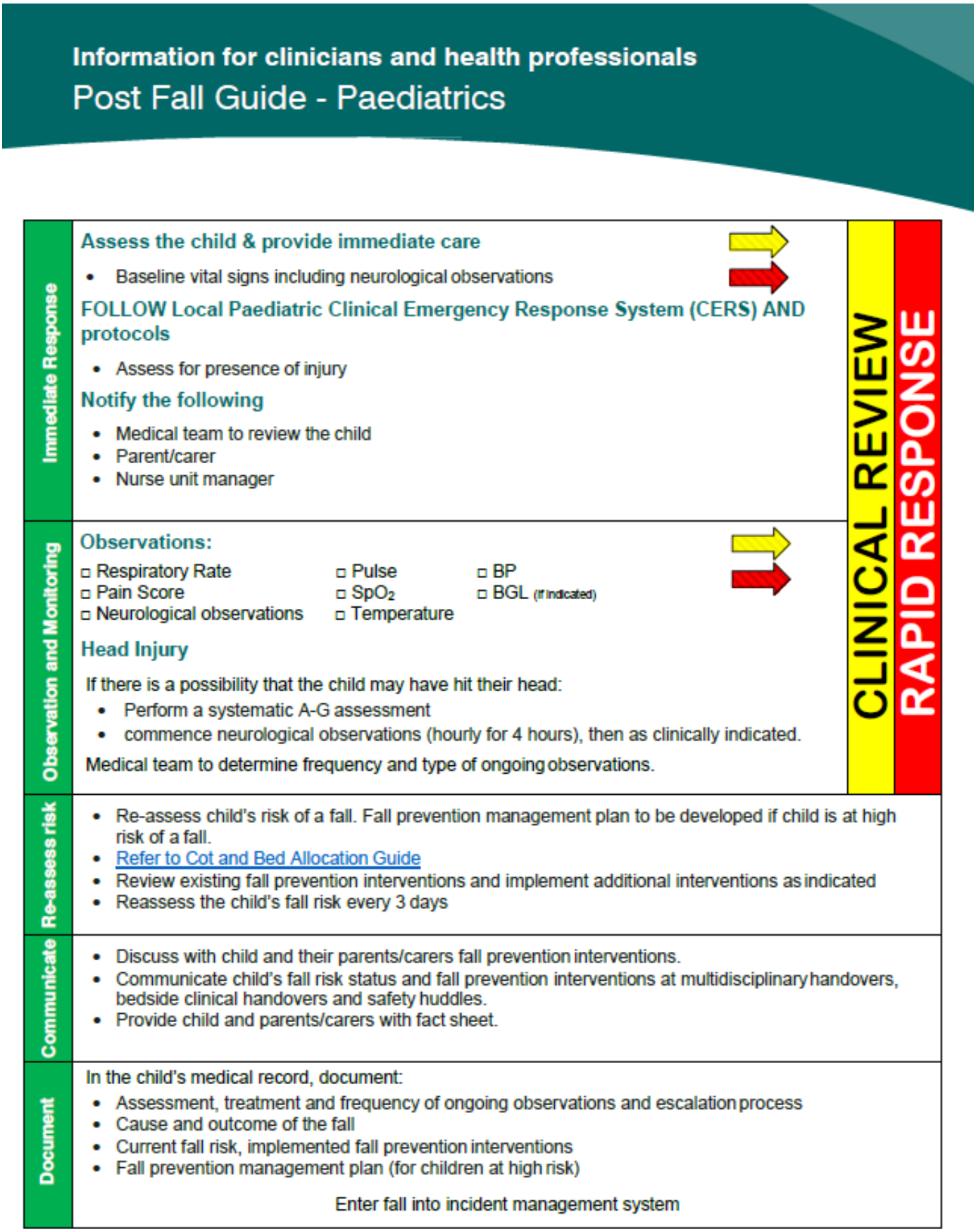
Safe use of bed rail protectors/bumpers:

- Ensure bed rail protectors /bumpers are fitted as per the manufacturer's instructions.
- Only use bed rail protectors/bumpers endorsed by the manufacturer of the bed.
- **Pillows and/or blankets can create risk of suffocation and should be used with caution.**

** **Children 18 months – 3 years** are at risk of climbing and falling out of bed despite bed rail up or down. Discuss required supervision level and the use of bed rails with the carer to determine each child's safety needs.

**IMPORTANT NOTE: If required bed type, rails or protectors /bumpers are not available to meet the child's needs, staff must review the need for additional supervision.**

# Appendix C: CEC Post-Fall – Paediatrics



**Information for clinicians and health professionals**

## Post Fall Guide - Paediatrics

**Immediate Response**

**Assess the child & provide immediate care**

- Baseline vital signs including neurological observations

**FOLLOW Local Paediatric Clinical Emergency Response System (CERS) AND protocols**

- Assess for presence of injury

**Notify the following**

- Medical team to review the child
- Parent/carer
- Nurse unit manager

**Observation and Monitoring**

**Observations:**

- ☐ Respiratory Rate
- ☐ Pain Score
- ☐ Neurological observations
- ☐ Pulse
- ☐ $SpO_2$
- ☐ Temperature
- ☐ BP
- ☐ BGL (if indicated)

**Head Injury**

If there is a possibility that the child may have hit their head:

- Perform a systematic A-G assessment
- commence neurological observations (hourly for 4 hours), then as clinically indicated.

Medical team to determine frequency and type of ongoing observations.

**CLINICAL REVIEW**

**RAPID RESPONSE**

**Re-assess risk**

- Re-assess child's risk of a fall. Fall prevention management plan to be developed if child is at high risk of a fall.
- Refer to Cot and Bed Allocation Guide
- Review existing fall prevention interventions and implement additional interventions as indicated
- Reassess the child's fall risk every 3 days

**Communicate**

- Discuss with child and their parents/carers fall prevention interventions.
- Communicate child's fall risk status and fall prevention interventions at multidisciplinary handovers, bedside clinical handovers and safety huddles.
- Provide child and parents/carers with fact sheet.

**Document**

In the child's medical record, document:

- Assessment, treatment and frequency of ongoing observations and escalation process
- Cause and outcome of the fall
- Current fall risk, implemented fall prevention interventions
- Fall prevention management plan (for children at high risk)

Enter fall into incident management system