Preventing Falls in the Pediatric Surgical Population

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Identification of Risk using a Validated Pediatric Fall Prevention Assessment Scale

Pediatric Falls - A Brief Review

- Result of improper use of cot (crib) side rails
- Falls in 3 to less than 7 yrs old
- Increased incidence of Fall Events on the Inpatient Surgical Unit
- Less than 3 yrs old
- Male: 2:1 ratio
- Age: 19-24 months old

Pediatric Falls Program Development

- Graf-PiF was developed after chart reviews of actual patients who fell and a
  Less than one year tended to fall out of gurneys while adolescents tended to
  Result of improper use of cot (crib) side rails either partially raised or incorrectly

• 3 Hospital Collaborative (Kingston, Bryant, Speer 2010)
• Control group. Graf (2005) concluded that pediatric falls were associated with-
  (Razmus, et al, 2006)

- Unattended with the side rail down (Hendrich 2007)
- Attendance most of the time (Cooper and Nolt, 2007)
- Included slipping on a wet surface or tripping over an object. Parents were in
  secured (Levene and Bonfield, 1991)

A Brief Review

Thorough literature research

- Related to equipment
- Fell on a Monday, followed by Thursday
- Gender- (Male 2:1 ratio)
- Age- 19-24 months old

Problem

• Increased incidence of fall Events on the Inpatient Surgical Unit (2010)
  • 6 out of 7 occurred in the room
  • 2-3 Non-Developmental
  • 4 Non-Developmental Anticipated Physiologic
  • Related to equipment
  • 1 Non-Developmental Accidental
  • 1 Pre-operative
  • Non-Developmental Accidental
  • Slippy surface due to Chlorhexidine pre-wash shampoo
  • Other event

Action Plan

• Nurse Manager and Clinical Specialist met with the Nursing-wide Fall Prevention Team
  • Each event is documented in detail

- Identification of trends
- Staff meeting held to discuss scenarios with the Nursing-wide Fall Prevention Team lead
- Staff driven action plan developed

Action Plan Initiatives and Interventions

- Unit Specific Action Plans Developed by direct care RNs
  - Re-education of all unit staff on Fall Prevention
- Chlor-Non-skid, non-skid mats
- Ensure a non-cluttered environment to prevent accidental fall events while ambulating post operatively
- Utilize a validated Falls Prevention Scale to potentially identify types of fall events
- Borstelmann et al (2007) demonstrated increased fall events such as gait belts to prevent injury
  if the patient falls from bed
- Include direct care RNs in developing protocols

References


• Get Well Network Humpty Dumpty Education Pathway
• Developed- piloted on the Surgical Unit
• Fell in liquid

- Other (missing from data- musculoskeletal, skin [cellulitis] and
- 66.2% sustained no injury
- 26.8% Other (missing from data- musculoskeletal, skin [cellulitis] and
- Children who fell were- equally divided between all age groups (Infants,
- 782 Fall events; Prevalence- 0.88/1000
- 3 to less than 7 yrs old
- Diagnoses most associated with falls Neurlogic (seizures) and respiratory
- • Parents were present 57% of the time
- Accidental falls occurred more often in children less than 10 and
- Parents were in
- • 66.2% sustained no injury
- • 3 to less than 7 yrs old
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- • 1 Non-Developmental Accidental
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