1.0  PURPOSE AND INTENT

1.1 To describe the practices that all staff follow that help minimize fall risks for patients seen in both in-patient and out-patient departments that care for newborns, infants and children in the Shared Health/WRHA.

2.0  PRACTICE OUTCOME

2.1 To minimize developmentally inappropriate falls and any injury from falls.

3.0  DEFINITIONS

3.1 Fall: an unexpected event where a person comes to rest on the ground, object, or a lower level with or without injury.

3.2 Fall Risk Factors: variables that may contribute to falls or increase risk for falls, for example developmental age, environment, medication and diagnosis.

4.0  GUIDELINES

4.1 If patient is admitted at Children’s Hospital, assess using the Pediatric Patient Handling and Movement form (Form # NS01188) for risk factors with mobility and transferring of the patient. Implement appropriate care plan.

See Appendix A: Pediatric Fall Risk Factors and Universal Falls Precautions for additional fall risk factors to consider.

4.1.1 Complete and post the pediatric patient handling and movement sign (Form #NS01189) or the adult patient handling and movement sign (Form #NS01064) (for the mother/parent of a newborn) at the bedside or designated spot.

4.2 Verbally educate the patient and families about risks for falls while in hospital and what they can do to minimize these risks. See 7.0 Resources for patient education resources for your program.

Universal Fall Precautions –see Appendix A: Pediatric Fall Risk Factors and Universal Falls Precautions for a list of precautions. Note: this list is subject to periodic review and may not be inclusive to all precautions applicable to your clinical area.

4.2.1 Document patient/parent/caregiver education related to infant/child falls safety in the medical record.

4.2.2 Document on-going infant falls assessment in the medical record.
4.3 For Children’s Hospital, confirm availability of well-fitting non-skid footwear and ensure that if hospital clothing is too big for patient (example pants are too long), encourage family to bring in patient’s clothing from home.

4.4 Orientate patient and family to hospital surroundings, bathroom and how to use the call bell.

4.5 Keep environment clear of hazards and clutter, remove unnecessary equipment from patient care environment.

4.6 Minimum hourly checks on patient, with proactive assessments of patient needs such as elimination, nutrition, and pain relief. Document risk factors in the patient record.
   4.6.1 On postpartum units, pay special attention to parental exhaustion and maternal use of narcotics as risk factors for falls.
   4.6.2 On postpartum units, minimize risk of falls by ensuring that infants are not carried in the parent/caregiver arms outside of the hospital room.

4.7 Assess need for additional lighting at night with patient and family.

4.8 Disconnect patient from medical equipment or tubing as soon as possible. If still required, secure tubing or cables through clothing or with burn netting, reduce tubing length and convert IVs to saline lock.

4.9 Infants/children under 3 require a crib. Side rails shall remain up while the infant/child is in the crib and secure crib canopies for all infants/children in cribs who may be capable of climbing or pulling themselves to a standing position.
   4.9.1 Exception: When patient is under constant attendance in PICU, NICU, PSCU, and monitored rooms.
   4.9.2 Exception: Canopies are removed for emergency care.
   4.9.3 Exception: A bassinette, infant incubator, and radiant bed warmer are appropriate alternate sleeping surfaces for neonates in some clinical situations, e.g. phototherapy.

4.10 For children using beds, lower the bed completely and keep the side rails down to prevent the child climbing over the railing and falling.
   4.10.1 A documented rationale is needed if rails are to be kept up. An attendant may be needed if the child demonstrates risk for climbing over the rails.
   4.10.2 In some cases a bed may be pushed up against a wall.

4.11 Infants and young children on examining table or other elevated surfaces should be attended at all times.
   4.11.1 Operating room: The perioperative RN shall remain at patient’s side until induction or emergence of anesthesia and until the patient is safely secured on the OR bed. See current Operating Room Nurses Association of Canada (ORNAC) Standards, Guidelines, and Position Statements for Perioperative Registered Nurses for more information.
   4.11.2 When appropriate, caregivers are cautioned regarding the risk of leaving young children unattended on examining table or other elevated surfaces.

4.12 Place infant alone in a crib to sleep. Infants and young children are not to share a bed or other sleeping surface (chair, sofa, stretcher, cot) with a sleeping adult and should be removed to a safe sleep environment. An informed decision making conversation should be had with the parent/family and the conversation documented in the patient record.
   4.12.1 Exception: Infant/Child in palliative care situations.
   4.12.2 Exception: If skin-to-skin/kangaroo care is occurring. See Shared Health/WRHA Skin-to-Skin/Kangaroo Care Clinical Practice Guideline for more instructions.
4.12.3 Education is to be provided to caregivers regarding the risks of bed sharing in the hospital. If a caregiver chooses to bed share despite the risks, refer to the WRHA/Shared Health Policy 350.135.116 Infant/Child-Parent Bed Sharing in the Hospital Setting.

4.13 Remove unsupervised sleeping infants and small children from strollers, car seats, seating devices, playpens or swings to a more appropriate and safer environment for sleep.
4.13.1 Exception: Infants in the NICU may sleep in a swing if vital signs are constantly being monitored.

4.14 Secure infants and children in a stroller with a safety belt. Use age and developmentally appropriate restraints.

4.15 Use a carriage for transportation only if the infant/child is incapable of climbing or pulling themselves to a sitting position.

4.16 Position stretcher and bed side rails in uppermost position when transporting a patient. Walk alongside the patient and consider alternate transportation if the patient will not remain recumbent during transport on a stretcher or bed.

4.17 Transport infant/child off the unit in a stroller, carriage, bassinette, a wheelchair, or on the stretcher skin-to-skin with their parent after delivery. Younger patients may be held by a caregiver while the caregiver is pushed in a wheelchair/stretcher. Staff should not carry patients to transport them.
4.17.1 Exception: caregivers who prefer to carry their infant/child (not including a newborn on a postpartum unit or NICU); older children who prefer to walk.
4.17.2 Exception: Operating Room, when it is necessary for a nurse to carry a child into the operating room.
4.17.3 Newborns should be moved by bassinette to the resuscitation room from the operating room or the delivery room.

4.18 In the event that an infant/child falls, document the fall and post management actions in the medical record and RL6 and follow the appropriate algorithm for post-fall management.
4.18.1 See Appendix B Pediatric Post Fall Assessment and Management Algorithm for post fall assessment and management algorithm for pediatrics.
4.18.2 See Appendix C Newborn Fall/Drop Clinical Work Up Algorithm for post falls assessment and management algorithm for newborns and provide family with the "Caring For Your Newborn Baby After A Minor Head Injury." See Appendix D: Caring For Your Newborn Baby After A Minor Head Injury.
4.18.3 See WRHA Entries into the Health Records 70.00.060
http://home.wrha.mb.ca/corp/policy/files/75.00.060.pdf

5.0 PRIMARY AUTHORS:

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7.0 RESOURCES:
7.1 HSC Children’s Hospital Safety in the Hospital – Information for Families and Caregivers Handout (Index # 140.03.01)
7.2 HSC/St. Boniface Women’s Health Program We Care About Your Safety: Here’s How You Can Help (Form # W-00486)
7.3 Caring for Your Newborn Baby after a Head Injury” (Form # W-00634)

8.0 REFERENCES:
8.1 Accreditation Canada. Required Organizational Practices Handbook 2017
8.6 Association of Women’s Health, Obstetrics, and Neonatal Nurses. Prevention of Newborn Falls/Drops in the Hospital: AWHONN Practice Brief Number 9. 2020 doi. 10.1016/j.jogn.2020.06.004
APPENDIX A: Pediatric Fall Risk Factors and Universal Falls Precautions

Fall Risk Factors:
- **Developmental age or cognition**, are they learning to walk, run or climb, recent changes in mentation, confusion, restlessness and those with higher activity level or impulsivity.
- **Mobility impairment** for example – muscle weakness or unusual muscle tone and gait disturbance that can impact balance and coordination, use of assistive devices or transfer aids.
- **Diagnosis** – neurological diagnoses that can affect level of consciousness for example seizures, gastrointestinal illnesses that can increase urgency to use the bathroom, lead to dehydration, respiratory illnesses that can impact level of consciousness
- **Medication** – any medication that has sedative side effects, for example pain medication, seizure medications and anesthetics (can affect ambulation and coordination for up to 48 hours).

Pediatric Universal Falls Precautions

Preventive strategies need to be linked with developmental assessment of the child and engagement of the caregivers.

- Orientate patient and family to hospital surroundings, bathroom and how to use the call bell and crib or bed side rails
- Keep crib side rails and stretcher side rails in the uppermost position when patients are left unattended in the crib or stretcher.
- Place bed in the lowest position. If child is unattended, lower side rails
- Ensure brakes are locked on bed and crib
- Keep environment clear of hazards and clutter, remove unnecessary equipment from patient care environment
- Secure infants and children in a stroller or wheelchair with a safety belt
- Minimum hourly checks on patient, with proactive assessments of patient needs such as elimination, nutrition and pain relief
- Assess need for additional lighting at night with patient and family
- Disconnect patient from medical equipment or tubing as soon as possible. If still required, secure tubing or cables through clothing or with burn netting, reduce tubing length and saline lock IVs
- Infants and young children on examining table or other elevated surfaces should be attended at all times
APPENDIX B: Pediatric Post Fall Assessment and Management Algorithm

Patient Fall has occurred:
- Call for help if needed
- Note position of patient and surrounding environment
- Assess for pain, decreased sensation or numbness, airway, breathing, circulation and level of consciousness

No Injury

Injury has occurred: Assess for degree of injury before moving the patient
- Suspected minor injuries include:
  - Skin lacerations, bruising, broken bones of the toes or fingers
- Suspected major injuries include:
  - Head injury, loss of consciousness
  - Large bone fracture like leg or arm.

Assess for contributing factors and determine if:
- a prevention plan is needed
- there is a need to notify service and document fall

Can the patient get up from their fall on their own?
** Follow WRHA safe patient handling and movement manual**

Yes – independently
- Into wheelchair or bed

No – total assistance needed
- Mechanical lift
- Sliders and spinal board
- Determine number of staff required to safely lift patient

Post Falls Algorithm:
- Assessment
- Injury Management
- Recovery from Position of Fall
- Communication

NOTIFY
- Patient’s service, program team manager or supervisor, and the patient’s caregivers

DOCUMENT
- Progress Note and RL6 report

FOLLOW UP
- Post fall safety huddle to discuss, debrief and determine if care plan needs to be changed/implemented
- Ongoing monitoring of status
Appendix C: Newborn Fall/Drop Clinical Work Up Algorithm

**Newborn Fall / Drop**
- Notify Pediatric Care Provider
- Notify the Neonatal in-house physician
- Consider transfer to NICU, if not already admitted.

1. Initial physical examination by Nurse
2. Complete physical examination by Physician
3. Close observation for 12 hours for potential signs and symptoms of neurological deterioration or changes in neurological status. See “Potential Signs & Symptoms of Neurological Deterioration” (*below)*
4. Head circumference and vital signs (including temperature, heart rate, respiratory rate, blood pressure):
   - q1h x3 then
   - q3h x3 (or prior to each feed) until 12 hours post fall

**Infant displays signs or symptoms of injury or neurological deterioration**
- Consider an ultrasound assessment and/or a skull x-ray.

**Head CT or MRI**
- Exam positive: Further evaluation and treatment
- Exam negative: Follow-up plan as per Pediatric Care provider

**No signs or symptoms of injury**
- Resume standard care

**Provide parents with education about importance of follow up after discharge. Provide written pamphlet “Caring for Your Newborn Baby after a Head Injury” (FORM # W-00634) to reinforce this teaching.**

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*Potential Signs & Symptoms of Neurological Deterioration*
1. Vital signs abnormalities
2. Loss of consciousness (at any time/ duration)
3. Seizure activity or abnormal movements
4. Crepitus, boggy scalp, bulging fontanel
5. Behaviour changes as per nursing or parents
6. Change in feeding or sucking, and vomiting
Appendix D: Caring for Your Newborn Baby After A Minor Head Injury

Caring for Your Newborn Baby after a

MINOR HEAD INJURY

Your baby fell while in hospital and had a minor head injury.
This information sheet will tell you what to look for at home.
It is important that a responsible person is always watching your baby in the next several days to 1 week after the fall.

SIGNS OF A MINOR HEAD INJURY

Your baby may
• Be fussy and irritable
• Be very sleepy or lethargic
• Have poor feeding
• Vomit after eating

What to watch for and do:
• Check that your baby wakes up easily every 2 to 3 hours
• Make sure that your baby eats well from the breast or bottle

See a physician or nurse right away if your baby:
• Vomits repeatedly
• Has a high-pitched cry
• Has a bulging soft spot on his head

Call 911 and go to nearest emergency if your baby:
• Cannot be wakened
• Has a seizure (convulsion or abnormal movements)
• Loses consciousness, eyes roll back, stiffens body, limbs twitch

Signs to look for later on include:
• Bulging soft spot on baby's head
• Soft lump or soft area on baby's head where he fell
• Baby's head seems larger than normal
• Baby's head has very visible veins
• Baby's eyes "sunset" (look downward)

Make sure your baby's doctor knows about your baby's head injury so that follow-up care can happen.