Some pediatric falls may be the result of improper use of cot (crib) side rails, either partially raised or incorrectly secured. Two studies in Korea (Cho, et. al, 2013 and Ju Shin, et. al. 2014) identified the most common predictors of fall events in children. A study of 29 Children’s Hospital Corporation of America (CHCA) Hospitals concluded that 69% of hospitals had no fall prevention scale. The 2009 published CHA study by Jamerson, et al., led to a CHA Study of 782 fall events with a prevalence- 0.88/1000; the children who fell were evenly distributed among infants (20%), toddler/preschool (25%), and school-age (25%). In preoperative patients, the 95.8% had no extended length of stay, and 27.5% mild injuries. Seventy Five (75) % were supervised by a parent and the children who fell were evenly distributed among infants (20%), toddler/preschool (25%).

Latest studies have focused on appropriate falls assessment tools and EBP interventions needed; Out of this 26 pediatric hospitals participated in a 6 month fall event review and fall event review. The scale is composed of seven parameters that were identified as placing a patient at risk for falls. One of the identified parameters was the presence of a history of falls in the previous year. The scale also included factors such as age, gender, history of falls, and medications. The scale is used to assess patients at risk for falls and to identify the need for further evaluation and intervention.

Pediatric Falls Prevention Program Development

- **Humpty Dumpty Falls Prevention Program**
  - **2004**: Executive leadership championed a multidisciplinary approach to pediatric falls prevention.
  - **2005**: Pediatric Falls Prevention Program developed and implemented a comprehensive approach to falls prevention in all levels of care.
  - **2006**: Developed and implemented a comprehensive approach to falls prevention in all levels of care.

- **Developmental Fall Events**
  - **Accidental**: Falls that occur as a result of accidental slips, trips, or falls. These falls are not always preventable.
  - **Physiologic**: Falls that occur due to a patient’s response to surgery, anesthesia, or medication. These falls are often preventable.
  - **Cognitive**: Falls that occur due to a patient’s cognitive impairments, such as confusion or a recent diagnosis of PT/OT. These falls are often preventable.

- **Problem**
  - Increased incidence of fall events on the inpatient surgical unit (2010).
  - Fall prevention strategies were not effective.

- **Solution**
  - Nursing and clinical staff met with the Nursing-wide Fall Prevention Team.
  - Each event was reviewed in detail.
  - Identification of trends.
  - Staff meeting held to discuss scenarios with the Nursing-wide Fall Prevention Team lead.
  - Staff-driven action plan developed.

- **Outcome**
  - Fall rates reduced by 25%.
  - Patient and family education specific to the hospital, at the time of the article the falls rate had been reduced.

- **Nursing Implications**
  - Nurses on an inpatient pediatric surgical unit need to be able to identify patients at risk for falling.
  - Assess patients for risk of falling based on the patient’s characteristics.
  - Consider the patient’s environment and the support system in place.
  - Use a validated Falls Prevention Scale to potentially identify types of falls events.
  - Ensure a non-cluttered environment to prevent accidental fall events while embarking post-operative recovery and the hospital-wide implementation of hand-off checklist.

- **New Outcome**
  - Falls rate reduced by 25%.
  - Patient and family education specific to the hospital, at the time of the article the falls rate had been reduced.

- **References**
  - Messmer (2013) states that fall prevention scales should be a standardized part of the electronic medical record to ensure proper identification of patients at risk and prompting for implementing of prevention interventions.