PAEDIATRIC FALLS RISK ASSESSMENT (PFRA) SCALE MINISTRY OF HEALTH MALAYSIA

PRESENTATION OUTLINE

1. Paediatric Fall Risk Assessment (PFRA) Scale

2. Paediatric Fall Scale Risk and Action Plan

WHY DO WE USE PAEDIATRIC FALLS RISK ASSESSMENT(PFRA) SCALE?

WHOM SHOULD WE ACCESS

- All children admitted to the Paediatric wards
- Age of more than 36 months and less than 18 years

WHEN TO ACCESS

- On Admission
- Significant change of neurological status or conscious level
- Following a fall

HOW TO USE PFRA SCALE

SCORING

PARAMETERS	
1. Age	4 Marks
2. Gender	2 Marks
3. Diagnosis	3 Marks
4. Fall History	3 Marks
5. Environmental Factors	2 Marks
6. Surgery / Sedation / Anaesthesia	3 Marks
7. Medication Usage	3 Marks

1.AGE

AGE	SCORE
<2 years old	4
2 to 5 years old	3
5 to <12 years old	2
≥ 12 years old	1

2.GENDER

GENDER	SCORE
Male	2
Female /Others	1

3.DIAGNOSIS

DIAGNOSIS	SCORE
Neurological Diagnosis	3
Behavioural disorders	2
Other Disease	1

Neurological Diagnosis

- 1.Seizure, Head trauma, Hydrocephalus, Cerebral palsy
- 2. Patients being worked up for neurological diagnosis.

Behavioural Disorders

- 1.Impulse control disorders, attention-deficit/hyperactivity disorder
- 2.Mood disorders (Major Depression Disorder, Bipolar Disorder).

Other Disease

1. Anything that doesn't fall into the previous categories for example Acute bacterial tonsilitis.

4.FALL HISTORY

FALL HISTORY	SCORE
≥3 Falls over past 3mth	3
1 – 2 Falls over past 3mth	2
No Fall	1

5.ENVIROMENTAL FACTORS

ENVIROMENTAL FACTORS	SCORE
Using aids (e.g., IV Line, wheelchair , IV Stand)	2
Not using aids (e.g., IV Line, wheelchair , IV Stand)	1

Enviromental Factors

- 1. Patient uses assistive devices, -crutches, walkers, canes, splints (such as leg splint or ankle brace)
- 2. Any devices that limits the patient movements such as IV line and stand.

6. SURGERY / SEDATION / ANAESTHESIA

SURGERY/SEDATION/ANAESTHESIA	SCORE
< 24 Hours	3
24-48 Hours	2
≥ 48 Hours or none	1

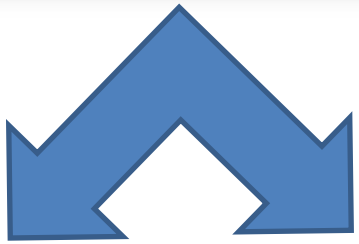
- 1.The parameter assesses the child risk according to recent surgery / sedation/anaesthesia that the child received within a certain period of time.
- 2. Highest mark (3 marks) is given if patient undergone such procedure within 24 hours, 2 mark is given if it is between 24-48 hour and the rest is 1 mark.
- 3.This does not include bedside procedures without anaesthesia.

7. MEDICATION USAGES

MEDICATION USE SUCH AS: SEDATIVES , BARBITURATES , HYPNOTICS , PHENOTHIAZINE , LAXATIVES , DIURETICS , HYPOGLYCEMIC AGENTS , ANTIHISTAMINES	SCORE
≥ 2 of the medications	3
One of the medication	2
None of the medication	1

- 1. The parameter assesses the child risk according to medication usage that might cause an alteration level of consciousness or affect cognitive awareness of the child.
- 2. Risk is higher with multiple usage of such medications
- 3. Sedatives (excluding ICU patients that are sedated and paralyzed).

RANGE OF SCORES



1. Low Fall Risk

(Total of 7 to 11 marks)

2. High Fall Risk

(Total of 12 and above marks)

KEMENTERIAN KESIHATAN MALAYSIA

PAEDIATRIC FALL RISK ASSESSMENT (PFRA)

MINISTRY OF HEALTH MALAYSIA

Name : Age :

RN No. : Ward :

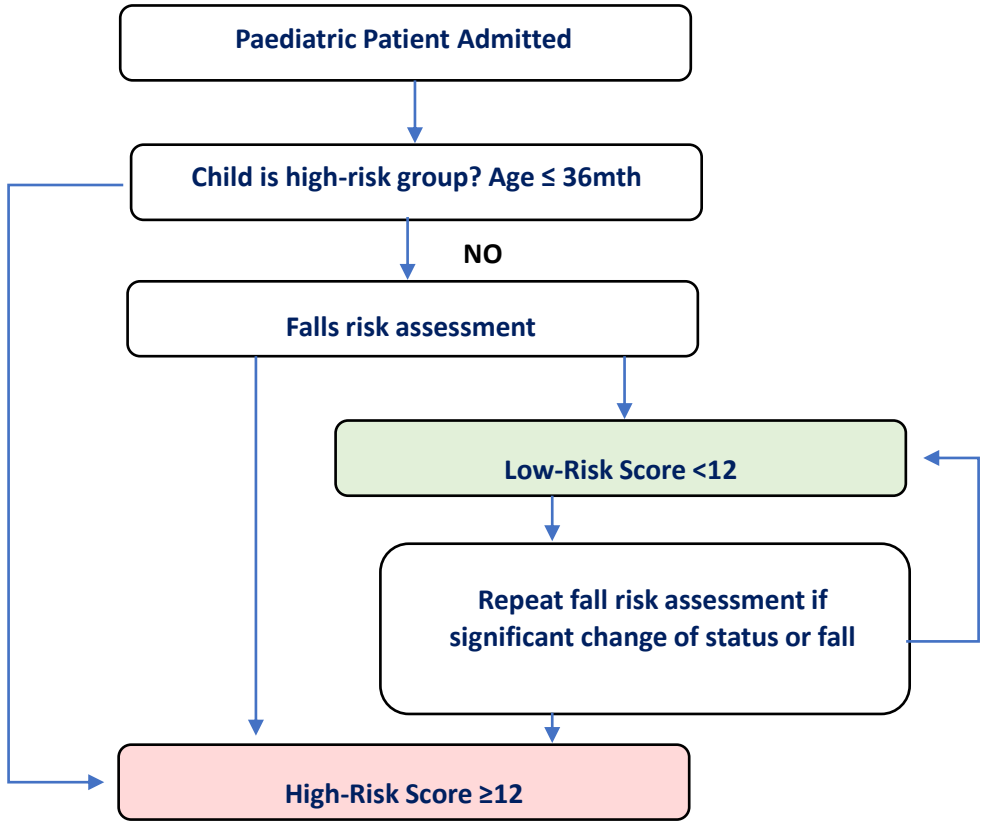
PARAMETER	DATE							
	TIME							
AGE	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE	SCORE
<2 years old	4							
2 to 5 years old	3							
5 to <12 years old	2							
≥ 12 years old	1							
GENDER								
Male	2							
Female / Others	1							
DIAGNOSIS								
Neurological Diagnosis	3							
Behavioural Disorder	2							
Other Disease	1							
FALL HISTORY								
≥3 Falls over past 3mth	3							
1 – 2 Falls over past 3mth	2							
No Fall	1							
ENVIRONMENTAL FACTORS								
Using aids (e.g., IV Line, wheelchair and IV Stand)	2							
Not using aids (e.g., IV Line, wheelchair and IV Stand)	1							
SURGERY / SEDATION / ANAESTHESIA								
< 24 Hours	3							
24 – 48 Hours	2							
≥ 48 Hours or none	1							
MEDICATION USE SUCH AS : SEDATIVES , BARBITURATES , HYPNOTICS , PHENOTHIAZINE , LAXATIVES , DIURETICS , HYPOGLYCEMIC AGENTS , ANTIHISTAMINES								
≥ 2 of the medications	3							
One of the medication	2							
None of the medication	1							
TOTAL SCORE								
NAME & SIGNATURE								

* Low Fall Risk = 7 – 11 (initiate low risk standard protocol)
* High Fall Risk ≥ 12 (initiate high risk standard protocol)

PAEDIATRIC FALLS SCALE RISK AND ACTION PLAN MINISTRY OF HEALTH MALAYSIA

Primary Prevention (General Prevention)

Ensure steps to mitigate the risk and hazards of falls are undertaken (e.g., safety of the environment/ward)
Implement primary prevention strategies (low-risk standard protocol)
Provide falls prevention information (e.g., brochures, leaflets) for patients and their families.



Orientate and educate the child and their family regarding the falls prevention programme. Use audio-visual aids if available.

Use the Paediatric Falls Risk Assessment Scale (PFRA).

Continue implementing primary prevention strategies (low-risk standard protocol)

Implement high-risk standard protocol.
Communicate high falls risk assessment at each shift change or transfer of care to other healthcare providers.

RISK	ACTION
Low risk standard protocol **(score 7-11)**	1. **Identify** patient using a wrist band and sticker, signage at cot/ bed and in patient chart. 2. **Orientate** the caregiver and/or patient to the ward and cubicle 3. **Educate** the caregiver and/or patient on falls and falls prevention protocols 4. **Place the bed** in a **low position** with the brakes on 5. **Raise the side rails** especially if the **child is left alone** on the cot 6. **Assess large gaps** that would allow an extremity of the **patient to slip** through or become entrapped as this may necessitate the use of additional safety measures 7. **Ensure that the call bell** is within reach and educate the caregiver and/or patient on its function. 8. **Clear the environment** of unused equipment. Other non-medical equipment should be hazard-free. 9. Assess for **adequate lighting**. A night light should be left on at night 10. Preferably use non-skid footwear for ambulating children. Use appropriate-sized clothing to prevent tripping 11. Ensure that **caregivers supervise their children** at all times. Caregivers must inform the nurse on duty if he or she is leaving the patient alone, even if it is for a few minutes. 12. **Document falls prevention education and include in the nursing plan**

High risk standard protocol **(score ≥12)**	1. **Identify patient with an ID band on the patient (sticker) and signage on the bed and in patient chart** 2. **Educate the caregiver and/or patient on falls and falls prevention protocols** 3. **Monitor the high-risk patient closely** 4. **Place the patient in a developmentally-appropriate bed** 5. **Consider moving the patient closer to the nurses' station** 6. **Keep the bed in the lowest position with the brakes on, unless patient is directly attended** 7. **Raise the side rails at all times** 8. **Make sure that protective barriers are available to close off spaces and gaps in bed and railings.** 9. **Remove all unused equipment around the patient's bed.** 10. **Always keep the door open unless there is a specific isolation precaution in place** 11. **Ensure that the patient is accompanied during ambulation** 12. **Ensure that caregivers supervise their children at all times. Caregivers must inform the nurse on duty if he or she is leaving the patient alone, even if it is for a few minutes.** 13. **Review the medication administration schedule** 14. **Document in nursing plan**

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BKJ
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