Reflection

Description: Yesterday, while receiving report from an off-going nurse in another patient's room, my primary nurse and I were informed by the nurse practitioner that the charge nurse was responding to a fall event. Upon returning to the nurses' station, we immediately inquired about which patient was involved. The charge nurse then informed us that the patient who had fallen was under our care. We entered the patient's room and spoke with the mother, who reported that her daughter had jumped off the bed and struck her head. The patient was immediately assessed for injury. No injuries were noted at that time. The physician was notified immediately of the event and arrived at bedside to examine the patient. An incident report was conducted, by the primary nurse and I. This was the primary's nurse for fall incident.

Feeling: At the beginning of the incident, I became worried because the patient was already admitted for a head injury and had undergone an MRI with sedation earlier that same day. My first thought was the possibility of complications from sedation or monitoring equipment, especially since she was still in a post-op recovery phase. The patient, who is young, had been playing around in the room when she jumped off the bed and struck her head. This immediately reminded me the importance of consistent rounding and close observation, especially in pediatric patients who may not fully understand their risks. It also highlighted the need for thorough family education about sedation, post-anesthesia effects, and fall prevention measures. During the event, there was concern from staff regarding how the fall occurred despite family being at the bedside. I reminded myself that accidents can still happen, even when caregivers are present. Ultimately, the outcome was positive. After our bedside assessment revealed no neuro changes, the physician was notified and immediately examined the patient. The physician determined it was safe to proceed with discharge. All incident reports and required documentation were completed. This experience emphasized the importance of proactive patient safety rounds, reinforcing education for families, and working collaboratively with the team during stressful events.

Evaluation: Communication among staff played a key role in the response. The charge nurse, who was close to the room, was able to respond immediately. When my primary nurse and I arrived, we assessed the patient and spoke with the mother, who described the fall. We reinforced education with the mother about monitoring her child closely, especially after sedation, and advised her to keep a careful eye on the patient. Although our assessment and the physician's examination revealed no new neuro changes, I was surprised that no additional imaging was ordered and that the patient was discharged shortly after. Later on, the mother later reported another bump to the head. One of the more difficult task of this case was completing the fall documentation, both on paper and electronically. Since this was my primary nurse's first fall event, I was able to guide and assist her through the process using my past experience with fall incident reports.

Analysis: Several factors contributed to this fall event. The patient's age, recent sedation, and playful behavior increased her risk for impulsivity and decreased awareness of safety. Despite family being present at the bedside, direct supervision at every moment was not maintained, which illustrates the challenge of fall prevention in pediatric care. From a systems perspective, communication played a key role in the timely response. The charge nurse's proximity to the room allowed for an immediate initial assessment, while my nurse and I quickly followed up with further evaluation and physician notification. This highlights the importance of teamwork and situational awareness across the unit. Overall, this incident demonstrates the importance of fall

prevention in pediatric care, the value of clear communication and teamwork, and the importance of being competent in both clinical response and documentation.

Conclusion: I could have been more concise with frequent rounding on this patient, especially knowing she had undergone sedation and was already at risk due to a recent head injury. Anticipating her activity level as a young child, I could have reinforced safety measures earlier with the family, such as reminding them to keep her in bed or supervised closely. I could have provided stronger education to the family immediately after the MRI and sedation, highlighting the potential for unsteady movements and impulsive behavior. I learned that pediatric patients are at higher risk of falls due to impulsivity, especially after sedation and that clear, immediate education can empower families to be active partners in patient safety.

Action Plan: Overall, this situation was stressful initially because the patient was already vulnerable due to a recent head injury and sedation. In conclusion, I would also provide clearer education about the risks of unsteady movement following sedation. From this event, I learned the importance of anticipating risk rather than only reacting after an incident occurs. In future situations, I will be more proactive in identifying high-risk patients, communicating with families, and reinforcing safety precautions. I will also approach documentation with greater preparedness and confidence.