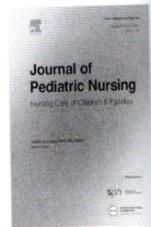




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## Children's falls inside the inpatient setting: A qualitative study of parent perceptions and the implications for falls prevention messaging

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### ABSTRACT

**Purpose:** To explore how parents understand their children's falls during hospitalization and how they perceive hospital interventions and messaging related to fall risk and prevention.

**Design and methods:** Semi-structured interviews were conducted to explore parent-caregiver descriptions of their children's falls during hospitalization. Prospective purposive sampling was used to identify eligible participants. Interviews were conducted with the parent-caregiver who was present at the time of the fall event. Themes were coded both inductively and deductively using a constant comparative method.

**Results:** Twelve parent-child groupings participated. Three themes emerged: parental knowledge of risk, parent sense of threat to the identity of the child, and age differences in perception of level of controllability of risk.

**Conclusions:** Falls prevention education is usually delivered as a straightforward presentation of generic factual information about risk factors, with the assumption that families need more information. Findings from this study challenge this approach. This study indicates that parent-caregivers have fairly high levels of knowledge about children's fall risks; parent-caregiver beliefs about the controllability of falls may differ based on age of the child; finally, as has been found in previous studies of adult falls, parent-caregivers may perceive hospital falls prevention measures as a source of potential threat to their child's already vulnerable social identity.

**Practice implications:** Involving the parent-caregiver in the fall risk assessment and collaborative development of falls prevention interventions may increase family alliance with health advice and reduce the incidence of falls in hospitalized children.

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### Introduction

Nurses routinely assess fall risk and educate patients on falls prevention during hospitalization. In the pediatric inpatient care setting, however, evidence indicates that patients continue to fall, and that many pediatric inpatient falls episodes are probably preventable (Jamerson et al., 2014; Neiman et al., 2011). Parents are the most common recipients of falls prevention education and risk messaging in pediatric inpatient settings (Almis et al., 2017; Fujita et al., 2013; Lee et al., 2013), but the persistence of falls in these settings suggests that messaging as currently practiced may be less effective than providers would hope. Several research studies and quality improvement projects have aimed at identifying specific risks associated with pediatric inpatient

falls, including age, developmental level, cognition, environmental conditions, and patient level of activity (Jamerson et al., 2014; Schaffer et al., 2012). Additionally, research has addressed the general subject of parental perceptions of child fall risk (Hoffman et al., 2019; Hogan et al., 2018; Shala et al., 2019; Siu et al., 2019). Very little is currently known, however, about how parents understand children's falls within the hospital setting. The aim of this study was to explore how parents understand their children's falls during inpatient hospitalization and perceive hospital interventions and messaging about falls risk and prevention. Findings from this study have important implications for the design and delivery of falls risk education for pediatric caregivers.

### Theoretical framework

A growing body of research over the past half century suggests that patients' beliefs and perceptions play a key role in guiding their health-related behaviors. The Health Belief Model (Barley & Lawson, 2016), the

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Theory of Planned Behavior (Ajzen, 1991), and Protection Motivation Theory (Rogers, 1975), for example, are widely referenced theories that stress the importance of understanding patient appraisals of threat severity, personal vulnerability, and the level of control that can be achieved over risk situations. Leventhal et al.'s (2016) Common-Sense Model of Self-Regulation frequently cited in health behavior research, holds that patients develop "common-sense" mental representations of illness situations that shape their strategies of management, coping, treatment seeking, and treatment adherence. Illness "representations" are often complex and highly idiosyncratic, combining beliefs about the nature of a health threat (what an illness is, its associated symptoms), causes, timelines, life consequences, and controllability (who can control it and how much it can be controlled) (Leventhal et al., 2016, p. 935). Strong associations have been found between mental representations and patterns of patient behavior across a wide range of chronic and acute health conditions and situations including falls prevention (Dryhurst et al., 2020; Hagger & Orbell, 2021; Hayes et al., 2020). Child et al. (2012), for example, found that elderly patients tend to ignore falls prevention guidance when they perceive it as socially disempowering, dismissive of their expertise, or fear it might lead to loss in social status. Gettens et al. (2018) similarly, found that adult patients feel a deep sense of concern for their own self-image following fall events, which impacts the way they receive subsequent medical advice. Gustavsson et al. (2018) found that elderly patients fear falling and are interested in preventing falls, but they avoid taking action toward risk reduction because of an even greater concern with preserving their identity and autonomy. In a study of pediatric falls, one research team found that many adult caregivers perceive pediatric falls as normal and inevitable – a mental model which led to interruptions in parental supervision (Ablewhite et al., 2015). Hogan et al. (2018) described the concept of "parental optimism bias" – a parent's beliefs regarding their child's vulnerability which can influence the choice to ignore or adhere to safety precautions. As Clancy et al. have emphasized in their qualitative research on the experience of falls (Clancy et al., 2015), falls do not simply happen within a physical risk environment. Rather, they take place in a symbolically meaningful environment, a context of personal belief systems that frame how they are experienced and responded to. Within nursing, Donovan and Ward (2001) have argued that behavior-change interventions cannot be effective without first addressing the underlying belief systems that drive them. Even when patients learn new strategies for responding to health risks, these writers note, they are unlikely to translate that knowledge into behavior change if the strategies are inconsistent or incompatible with existing beliefs. An understanding of patients' existing underlying beliefs is thus useful as a guide for developing interventions that patients find meaningful and are willing to adopt. This concept was the starting point for our study.

## Design and methods

Semi-structured interviews were used to explore parent-caregiver descriptions of their children's falls during inpatient hospitalization. The setting was a 600-bed free-standing quaternary-care pediatric academic medical center with an average daily census of approximately 575 patients. The patient population spans a wide variety of subspecialties including Oncology, Pulmonology, Endocrine, Neurology, Nephrology, and General Medicine, with an age range of birth to young adult. Purposive sampling was used to identify recruitment-eligible patients and their parent-caregivers, who were recruited as dyads so that the interviews could be conducted with the parent-caregiver who was present at the time of the fall event and could provide a firsthand account. Criteria for dyad eligibility included: (a) the child experienced a fall event while inside the assigned clinical unit. A fall event is defined as "A sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another

person, or on an object (e.g., a trash can) (National Database of Nursing Quality Indicators (NDNQI), 2020), (b) in the presence of at least one parent-caregiver who had previously received falls risk education from a hospital provider, and (c) the child was not in protective services or other state or federal agency custody. Participants had to have verbal proficiency in English.

Dyads were recruited prospectively on a rolling basis between February 2020 and September 2021. The lead investigator (KD) monitored the institution's safety event monitoring system for fall events on inpatient units to identify potential participants. When a fall was reported, eligible participants were contacted, and the study protocol explained. If the parent-caregiver agreed to further contact, a member of the research team scheduled an interview in a location chosen by the parent-caregiver and scheduled at a mutually agreeable time. Recruitment continued until additional interviews no longer produced significantly different new themes or insights.

The research team was led by Principal Investigator (KD), with input and guidance by a nurse scientist (WF) and an experienced qualitative nurse-researcher (SB). The authors had no relationship with any of the study participants. All participants provided informed consent after receiving written information and a briefing about the project scope and protocol. Interviews were conducted face to face using a semi-structured interview guide consisting of open-ended questions aimed at eliciting parent-caregiver descriptions, labels, and explanations of the fall event, including perceived causal attributions and whether the event was believed to be amenable to control or prevention. All interviews were conducted by KD or WF and lasted an average of 20–30 min. Interviews were audio-recorded, and audio file recording from the interviews were transcribed using NVivo© Transcription. Participants also provided demographic information. Interview transcripts were each assigned a unique numerical identifier and anonymized by removal of all formal names. Transcripts were verified by the lead investigator to ensure accuracy of transcription.

## Ethical considerations

The study protocol was reviewed and approved by the facility Institutional Review Board (IRB).

## Data analysis

Initial familiarization with the data was achieved through iterative re-reading of the interview transcripts. Analysis was then conducted recursively in a process combining both inductive and deductive elements. Inductive, data-driven coding enabled the team to identify falls-related definitions and ideas unique to each participant, in participants' own language. Deductive, theory-driven coding enabled the team to elicit causality, efficacy, and control-related attributions that could be compared with health behavior models in existing literature. First-level codes were identified independently by each of the three authors in separate analyses of each transcript as each interview was completed. The authors then met as a group to compare initial analyses and assign names to each code. This was followed by a higher level of coding during which links and associations were drawn between and among codes. A constant comparative approach (Charmaz & Thornberg, 2021) was used to iteratively review and refine the analysis as new interview transcripts were added, and resulting thematic considerations were applied to the transcripts as a whole.

## Results

Twelve parent-child groupings were eligible for inclusion and participated in a combined total of about 5h of interviews. Ten of the parent-caregivers were women and two were men. The majority were white, not Hispanic or Latino. All had received falls risk educational materials at the point of admission. Their children ranged in age from

17 months to 16 years. Eight of the children were female and four were male. All of the children's falls had taken place inside the patient room. No obvious trends were observed in time of day of the fall incident. None of the falls resulted in serious injury. Three notable themes emerged from the transcripts: parental knowledge of risk, sense of threat to the identity of the child, and age differences in perception level of controllability of risk.

### Parent understand and can articulate risk

Readily apparent in the interview transcripts was that parents did not lack knowledge and understanding of the sources of fall risks in the hospital. Every one of our interviewees displayed a fairly sophisticated capacity to independently articulate a variety of risk potentials and a clear understanding of how the hospital room environment, child's behavioral dispositions, and health status could combine to create the potential for a fall. For example, without prompting, parents told us that medications are a source of risk and a potential cause of falls for their children. As one said "...it does have something to do with her condition obviously. She might be more tired and maybe a little bit more weak from all the medication." Another put it: "From my perspective I think she is still groggy and weak, I mean she just had a transplant, so she was on medication and, yeh. She has a cut going down the center of her so. She just wasn't back to full strength and everything."

Medical equipment was also mentioned as a potential risk for pediatric falls in an acute environment. One respondent, for example, described her observation that "The mats are great to play on and everything, but to get around and walk, they're actually more of a safety hazard." Parent-caregivers also mentioned the configuration of the space as a potential source of risk. As one said: "If the bed, the so-called couch bed is down she'll climb right in the window and want to play peek a boo behind the curtain. It's presented like it could be a seat. So, it gives them a place to sit down and be comfortable". As another described: "There's no room to play. She's a toddler. There's no room to actually play and be in here. Everything is designed to sit and lie down." Our findings indicated a high general level of awareness of falls risk factors in parent-caregivers of hospitalized pediatric patients.

### Threats to the child's identity

An equally striking finding in all of our interviews was that when asked to talk about what happened during the child's fall event, virtually every parent-caregiver initiated the response not by talking about the fall or the event directly, but rather by first describing something positive about the child – an aspect of the child's strength, individuality, sense of humor, playfulness, or appealing personality traits. Before answering questions about the circumstances of a fall, parent-caregivers talked about their children in ways that emphasized the child as a normal, vibrant, full-fledged individual. This rhetorical pattern of response was a distinctive feature of every interview. For example, one of our participants began our interview by saying: "... she's a very active little girl, strong willed I would say. Loves to play, run, jump climb, all the things toddlers love to do". Another stated: "She is the strongest person you will ever meet." A third said: "a regular normal boy who would want to run around and play with his sister." On a related note, all our transcripts contained participant descriptions of the hospital as an environment where these highly cherished and valued features of a child's individuality or identity could be in danger of being ignored, dismissed, overlooked, or not recognized in the course of falls prevention interventions. Parents were particularly wary of some of the most commonly used falls prevention interventions, such as the requirement that the child wear a fall-risk bracelet and avoid playful frolicking on furniture. "I always say it, she's not an MR [medical record] number," one parent told us. "She's a person. I think if they're gonna be her nurse, then they need to be educated about her as a patient and to not her as 'oh

our hospital policy says she has to wear a bracelet." Concerns about erasure or disregard of a child's individuality and unique personality took the form, in several interviews, of a characterization of falls prevention interventions as potentially dehumanizing to the child. As one parent-caregiver said: "The crib is like, I call it a cage. I do. It's a cage, it's not a crib. Everything is hard. Everything is locked. It's like having a crate for your dog." Another described it: "[the crib] looked like a cage, like it was putting her in a cage. You know, just that it was so confined, like. I think we felt like it would be, feel scary to her in an already kind of scary situation." Another stated: "I mean, he gets up and down our couch just fine at home and he listens to me. He's old enough that he knows he has depth perception. I said he's not going to just roll off the crib." These findings suggest that parent-caregivers of hospitalized children hold mental models in which the inpatient setting is a site where their children may be vulnerable not only in reference to physical health concerns, but also in terms of threats to recognition of their identity as normal, playful individuals. Parents perceived risk mitigation interventions – such as having bars on cribs or a requirement to wear a fall-risk identification bracelet – not as helpful falls risk prevention measures, but rather as situations where their children were at risk of being misunderstood, misrepresented, socially labelled, or treated with less respect than they deserve.

### Heterogeneity in perception of controllability of falls

A third distinct theme was related to perceived level of control over children's fall risks. We found distinctions between parent-caregivers of younger children and those of older children. For the parents of younger children, falls were seen as expected and inevitable events – "normal" elements of the child's growth and development. For these parents, a child falling was no surprise. As one said: "He falls so much that, like, it's not really ever surprising unless it was like literally over nothing. But, you know, he's moving around being silly." As another put it: "You can only prevent so much, unfortunately, with them unless we put them in a bubble." A third parent-caregiver told us: "It's just because he's four and, you know, he's just he's just being a kid." Another put it this way: "... It's just one of those normal incidences. She would have fallen off the couch at some point anyway. Just because ya know she's four." In contrast, parents of children in our sample over the age of four or five showed a certain level of ambivalence about the controllability of a fall. As the parent of a 10-year-old expressed it: "It was unexpected from my perspective. After that, of course, again, 20/20 hindsight, it wasn't a real surprise. What would be the chance? What are the chances of that happening? No idea." Another said: "So, like, if I thought, like, oh, he's about to fall, like, I could have kept my hands there. So, it's not like I was like as it was before it happened. I wasn't thinking, oh, you're going to fall any second now." Another said: "I mean, I wasn't expecting him to fall, like I was right there." Our findings suggest that parent perceptions about ability to control children's falls risk may differ to some extent based on the age of the child.

### Discussion

In this qualitative study of the families of children who fell while hospitalized in a large pediatric medical center, we explored how parent-caregivers understand their children's falls and perceive hospital interventions and messaging around fall risk and prevention. Three themes emerged. First, parent-caregivers were knowledgeable about fall risk and could identify a range of nuanced situational factors that contribute to risk. Second, parent-caregivers displayed deep concerns that their children be recognized as normal individuals with personalities and social identities of their own, deserving of recognition and respect. Parent-caregivers in our study all displayed a sense of their children as vulnerable to being seen as "less than," or "different" from other children due to a fall event or from being recipients of falls prevention interventions. Finally, we found that parent-caregivers views on

controllability of fall risk varied by age of the child. Falls were seen as normal and inevitable in younger children. Parent-caregivers of older children expressed ambivalence about their ability to foresee or prevent a fall.

A hallmark of all hospital falls prevention programs is the provision of education about fall risk. Risk messaging tends to focus on providing basic information, with the assumption that parent-caregivers may be lacking in knowledge and in the ability to identify and assess risk (CHCA, 2009; Lee et al., 2013). Our findings, by contrast, show that parents are not ignorant of fall risk; lack of knowledge is not the problem. This suggests a need to rethink conventional approaches to how we educate parents and caregivers about fall risk in pediatric hospitals. Standard practice at this time is for care providers to explain the sources of risk, providing factual, generic information to families at the time of admission. Our findings point to the potential benefits of a more collaborative and nuanced approach that begins, instead, by asking families what they know, validating their existing understanding, and initiating interventions that tap into and build on their insights, expertise, and awareness. Several researchers have found that understanding the parent or caregivers' perceptions of injury risk allows for more detailed tailoring of information based upon what parents believe and know about preventive behaviors (Hoffman et al., 2019; Hogan et al., 2018). Our study lends further support to this idea.

Another implication is related to our understanding of how risk messaging is received and processed. When asked about falling, parents in our study all started their responses by emphasizing their child's strengths, playfulness, exuberance, normality, and so on. This pattern of response exemplified what the sociologist Erving Goffman, in his classic study of social stigma, described as the "management" of threats to identity (Goffman, 1959, 1974). Goffman observed that hospitalized patients and those with chronic illness, who bear various burdens of stigma and discrimination, often take steps to build and preserve a public image of normalcy and dignity, diminishing the extent of their illness or difference from others. For people who perceive themselves to be vulnerable to stigma, Goffman wrote, social interactions often involve efforts to manage and preserve a sense of power and "regular" selfhood. Our findings here suggest that a similar dynamic may be at play in the families of pediatric patients who fall. Research on adults has found that many adults who fall are reluctant to talk about the experience, as they do not want to be defined by it (Clancy et al., 2015; Gettens et al., 2018; Gustavsson et al., 2018; Kiyoshi-Teo et al., 2020). Similarly, parents of hospitalized children in our study seemed highly concerned about actions or interventions that might classify or label their child as a fall risk. Pediatric falls risk education (Fujita et al., 2013) is typically based on the risk factors identified from a fall risk assessment. Our study, by contrast, suggests that there are more than just objective physical risk factors influencing a parent's response to fall risk. Also, potentially at play are parental mental representations of the inpatient setting as a site where children's unique identities might not be fully appreciated.

Finally, even though most risk messaging and education tends to treat all families essentially the same, our findings show that appraisals of risk and controllability may differ based on age of the child. Parents in our small study regarded falls and injuries as natural and inevitable in young children, which is consistent with what others have reported in the pediatric literature (Ablewhite et al., 2015; Hogan et al., 2018; Whitehead & Owens, 2012). In the case of older children, however, our findings indicate that parents were somewhat more ambivalent in their assessments of the ability to exert control over risk. This suggests a need to consider individualizing falls prevention risk messaging so that it becomes sensitive to perceptions differentiated by age. Donovan and Ward (2001) have argued that health behavior-change interventions often tend to be designed to teach new coping skills, without first addressing the underlying belief systems that drive them. Referencing Leventhal's Common-Sense Model (Leventhal et al., 2016), they suggest that patients' preexisting representations of illness

must be understood and accommodated in order for new information to be truly integrated in patients' health behavior decision-making. In the pediatric context, healthcare providers thus far have been concerned primarily with measuring objective risk and safety issues and delivering factual information. But findings here suggest that parent-caregivers may be just as concerned that their children's social and emotional needs be recognized – so they retain the sense of their "kids being kids" (Nyman et al., 2011) and have access to normalcy-affirming activities. Our study supports the research that falls prevention strategies need to intertwine with the patient's sense of identity (Kiyoshi-Teo et al., 2020). Learning is not just the acquisition of knowledge handed over by experts; rather, it involves conceptual change. More importantly, as Donovan and Ward (2001) have argued, a conceptual change is more likely to be accepted when the recipient of the change is part of the change. Starting with a conversation that enables a genuine, empathic assessment of the family and caregiver representations of fall risk, including concerns for avoiding labels and preserving and protecting the child's connection to previous life patterns and "normal" social status, nurses and other healthcare providers can build an approach to risk education specific to the needs of the individual patient and family.

### Practice implications

Our study highlights the need for falls prevention education to include the parent-caregiver perspective. Portrayals of risk should acknowledge and build on what parent-caregivers already know and understand about their child and the risk factors of hospitalization, treating parent-caregivers as insightful partners in the risk assessment process. Involving them as co-participants in the fall risk assessment and in collaborative development of fall prevention interventions may build their sense of alliance in care and reduce the incidence of falls in hospitalized children.

### Limitations

Our study was limited by small sample size, involving only 12 parent-child dyads, and may not fully capture or represent the range of concerns and experiences of families beyond our single site. However, our findings nonetheless are highly suggestive and hold potentially significant implications for the design and delivery of falls risk education and messaging in the pediatric setting.

### Conclusion

Parents are the most common recipients of falls prevention education and risk messaging in pediatric inpatient settings. Falls prevention education is usually delivered as a straightforward presentation of generic factual information about fall risk factors, with the assumption that families need more information. Findings from this study challenge this approach and its underlying assumptions. This study indicates that parent-caregivers have fairly high levels of knowledge about children's fall risks; parent-caregiver beliefs about the controllability of falls may differ based on age of the child; most importantly, parent-caregivers may perceive hospital falls prevention measures as a source of potential threat to their child's already vulnerable social identity.

### Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## CRediT authorship contribution statement

**Kimberly A. DiGerolamo:** Conceptualization, Investigation, Formal analysis, Writing – original draft, Writing – review & editing. **Warren Frankenberger:** Investigation, Formal analysis, Writing – original draft, Writing – review & editing. **Shira Birnbaum:** Methodology, Formal analysis, Writing – review & editing.

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