

Newborn Falls and Drops: An Interactive Discussion to Achieve Best Practices

Part 1

**Elizabeth Rochin, Ph.D., RN, NE-BC
President/CEO, National Perinatal
Information Center**



Part I: Overview and Etiology of Newborn Falls

Learner Outcome

Newborn Falls and Drops: An Interactive Discussion to Achieve Best Practices Part 1: Overview and Etiology of Newborn Falls

The purpose/goal(s) of this activity is for participants to be able to:

Describe two (2) situations that increase the risk of newborn falls and drops in the immediate postpartum period

0.5 Contact Hours

This activity has been approved by Georgia Nurses Association for 0.5 contact hours. Georgia Nurses Association is accredited as an approver of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation

Disclosures and Successful Completion

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Conversation & Discussion

**Part I: Overview and
Etiology of Newborn Falls**

**Part II: Bridging Science to
Action in Reducing and
Responding to Newborn
Falls**

- **Introduce “Elephants in the Room”**
- **Strategies and Solutions for Prevention and Response**

Newborns are Falling?

March 2021

Key points:

- Not much science or research
- Newborn falls not tracked
- NICU and Postpartum variations



Newborns Are Falling?

Yes, that was my question too when I was asked to develop a presentation on newborn falls and environmental safety risks in postpartum and newborn areas. As you are aware, we have been encouraging new mothers to room-in to promote breastfeeding and mother-baby bonding through the Baby Friendly Hospital Initiative and our professional associations. Traditionally, new mothers stayed in their hospital rooms to rest after giving birth and only saw their baby at feeding times. Today, many hospitals no longer have a newborn nursery to encourage the mother-baby dyad to remain together. Policies have been changed to facilitate skin-to-skin contact and breastfeeding on demand. However, trying to care for a newborn leaves a tired mother little time for uninterrupted rest, increasing the risk that she may fall asleep while holding her baby. Recently, newborn falls have been recognized as a postpartum safety risk.

The 2013 National Database of Nursing Quality Indicators defines a newborn fall or baby drop as:

a newborn fall rate of 3.94 to 4.14 per 10 000 births and estimated that 600 to 1600 newborn falls occur in the United States annually. The Pennsylvania Patient Safety Authority concluded that newborn falls were the most common event affecting newborn safety according to its Pennsylvania Patient Safety Reporting System.⁴ It was found that 55.1% of falls occurred when a family member fell asleep, 27.2% occurred when the baby slipped out of the arms of a family member, and 17.7% of falls were related to the newborn falling from a hospital bed or incubator, dropped while being transferred, or slipped off a family member's lap.⁴ It was also established that the majority of newborn falls occurred between 24:00 and 07:00, with the highest percentage of falls occurring between 05:00 and 06:00.⁴ In total, 42.7% of newborn falls occurred on day 1 and 32.8% on day 2.⁴

The fall rate is reflective of newborn falls that occur in the postpartum areas. I could locate no literature that provided any information about newborn falls in



“When the nurse came in, I was explaining what had happened. Nobody said, ‘This was an accident.’ I was afraid that I was going to get a social worker call. Nobody was saying, ‘Accidents happen. It’s not uncommon.’ Nobody was consoling. My husband Brad* was completely mute, and he was just crying in the corner. Absolutely horrible. No one, not a counselor or a nurse, was with us from the time that they took Connor* down to CT to the time that they came and told us his update. I paced the hallway. I called my aunt to come. I didn’t know what was going on. I think hospitals need to not only provide education to parents and caregivers, but also show some care and concern for the parents who experience a fall accident with their newborn.”

***Names have been changed**

Newborn Falls and Drops

Increase in neonatal falls in hospitals increasingly recognized as a postpartum safety risk

Associated with fatigued mothers who fall asleep while holding their newborn

Baby Friendly Hospital Initiative and the American Academy of Pediatrics have focused on rooming-in care, to increase breastfeeding rates

Rooming-in may compromise the mother's opportunity for uninterrupted rest

And then there was this...

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Case Report

In-hospital Neonatal Falls: An Unintended Consequence of Efforts to Improve Breastfeeding

Colleen A. Hughes Driscoll, Nicola Pereira and Richard Lichenstein

Pediatrics January 2019, 143 (1) e20182488; DOI: <https://doi.org/10.1542/peds.2018-2488>

“Our case series is the first in which an *increase in neonatal falls coincided with improved metrics related to the 10 Steps.*”



I DROPPED MY BABY IN A BABY-FRIENDLY HOSPITAL WHILE I WAS ALONE RECOVERING FROM A CESAREAN SECTION

STEP 7 OF THE BABY-FRIENDLY HOSPITAL INITIATIVE (BFHI) POLICY REQUIRES PARENTS TO ROOM IN WITH THEIR BABY 24 HOURS A DAY IMMEDIATELY AFTER DELIVERY.

<https://fedisbest.org/2020/11/i-dropped-my-baby-in-a-baby-friendly-hospital-while-i-was-alone-recovering-from-a-cesarean-section/>

And of course...

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When Doctors Drop Babies During Delivery

A soon-to-be-mother thinks about what the birth of her child will be like throughout her entire pregnancy. No matter how many stories she hears or videos she watches, she knows it's one of those things that you have to experience to really know how it's going to work. Babies just aren't predictable. Still, she knows the basics: she'll go into labor, rush to the hospital or birthing center, go through delivery, and her baby will be gently caught, cleaned up and placed into her loving arms.



For some babies, that gentle catch isn't part of their grand entrance into life. Babies are sometimes dropped immediately upon that final push because doctors just aren't prepared, and just like that your newborn is hurt. The shock of what's happened probably hasn't even worn off yet, but your child deserves a fair start, and being injured during birth just isn't what you ever imagined. Suddenly you're staring across the table at a **medical malpractice** attorney instead of rocking your baby to sleep.

The standard of care has to be followed

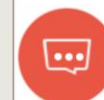
Delivery rooms can become chaotic at times. That's par for the course and obstetricians and labor and delivery nurses know the drill. It also doesn't absolve them from upholding the proper medical standard of care. When that standard has been diminished, careless mistakes are made.

An obstetrician or labor and delivery nurse is negligent if he or she fails to use the level of skill, knowledge, and care in diagnosis and treatment that others of the profession commonly possess and exercise in the same or similar circumstances. For example, if most obstetricians in the community wear a particular style of glove to prevent a baby from **slipping and falling** while being caught, and a doctor who drops a baby wore another glove style, he or she deviated from the standard of care.



Blog Categories

- Auto Accidents
- Birth Injury
- Brain Injury
- Child Abuse
- Class Action Lawsuits
- Consumer Privacy Rights
- Consumer Protection
- COVID-19
- Cybersecurity
- Defective Drugs and Medical Devices
- Defects and Recalls
- Distracted Driving
- FTCA
- In the Community
- In the Media
- Law Blog
- Legal Malpractice
- Litigation



Definition of Newborn Fall and Drop

A newborn **fall** is *"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 another surface, on another person or object."*

A newborn **drop** is defined as *"a fall in which a baby being held or carried by a healthcare professional, parent, family member, or visitor falls or slips from that person's hands, arms, lap, etc."*

Definition of Newborn Fall and Drop

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A newborn **drop** is defined as *“a fall in which a baby being held or carried by a healthcare professional, parent, family member, or visitor falls or slips from that person’s hands, arms, lap, etc.”*

For this discussion, we will use the term “newborn fall” to cover the constellation of falls and drops

Patient falls are no longer listed specifically as in the past

Identify patient safety risks

2022 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

Pictures are worth 1,000 words

<https://www.kidspot.com.au/news/horrific-footage-reveals-premature-baby-falling-out-of-incubator-at-nicu/news-story/ec4c81c3722957522d644514c6718fae>



Call to Action...Where Do Babies Fall?

- Labor and Delivery
- Operating Rooms
- Post-Anesthesia Care Unit/PACU
- Postpartum/Mother & Baby
- Newborn Nursery
- Neonatal ICU
- Adult ICU (maternal admit)
- Emergency Room
- Radiology

Anywhere a newborn may be located in the hospital

Maternal Characteristics

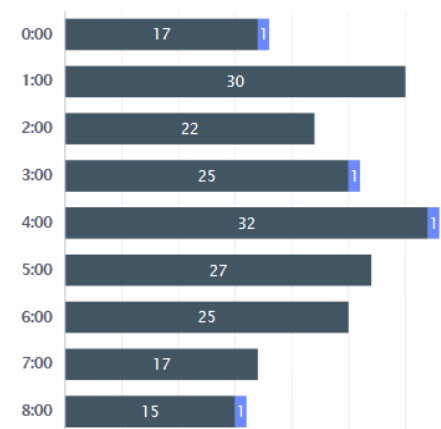
Studies have shown the following characteristics of mothers/birthing people who have been involved in a newborn fall:

- Breastfeeding or breast/formula feeding
 - Delivered by Cesarean Section
 - Second or third postpartum night
 - Receiving opioid pain relief, and had received last dose 2-3 hours previous to fall
- **PA study of newborn falls ($n = 320$) (2014 – 2018): Most newborn falls occurred during the following time frames:**

<https://patientsafety.com/index.php/patientsaf/article/view/newborn-falls/55>



**181 falls
(56.6%)
occurred
between
midnight
and 7 a.m.**



Digging In...Areas of Interest

Labor and Delivery/Operating Room

- Immediately after birth, placing baby onto mother's chest
- Mother becomes drowsy while skin-to-skin and/or breastfeeding
- Transfer from warmer to scale and vice versa
- During maternal transfer from bed to wheelchair while holding newborn

Post Anesthesia Care Unit

- Mother becomes drowsy while skin-to-skin and/or breastfeeding
- Mother receives IV narcotics while holding baby

Simpson, K. R. (2010). Patient falls in the perinatal setting. *MCN: The American Journal of Maternal/Child Nursing*, 35(6), 364.

Digging In...Areas of Interest

Mother/Baby Units (MBU's)

- **Highest risk of falls/drops**
 - 2.3 days of life
 - Between 2am and 7am
 - Pennsylvania study: 4am – 5am most frequent (2014 – 2018)
- Falls out of mother's arms while breastfeeding after receiving pain medication
- Falls out of father's/significant other's arms while sleeping
- Visitors passing around baby during visiting periods
- Newborn dropped in hallway when cradled in the arms and not in bassinette

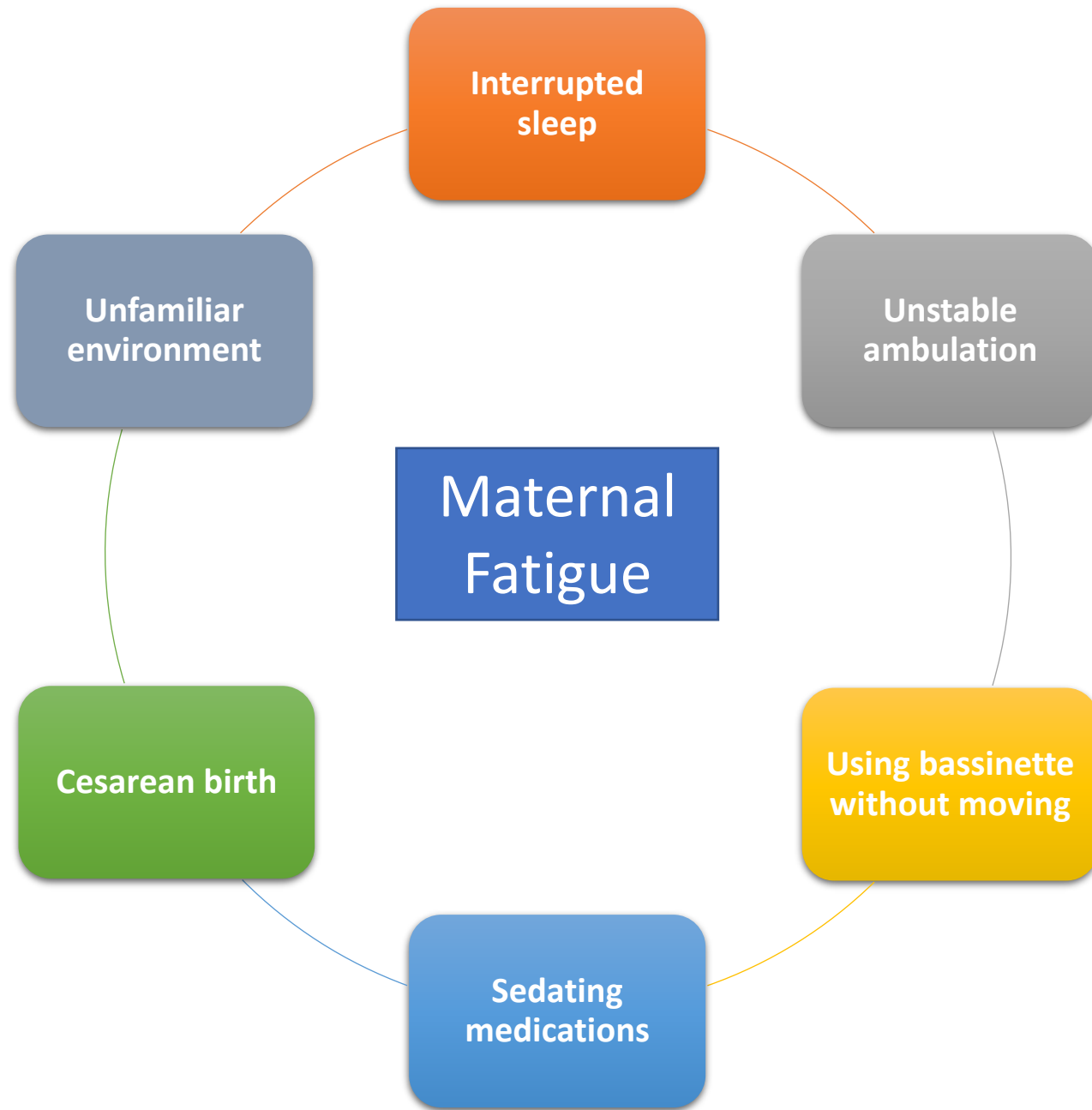
Potential Causal Factors

Equipment

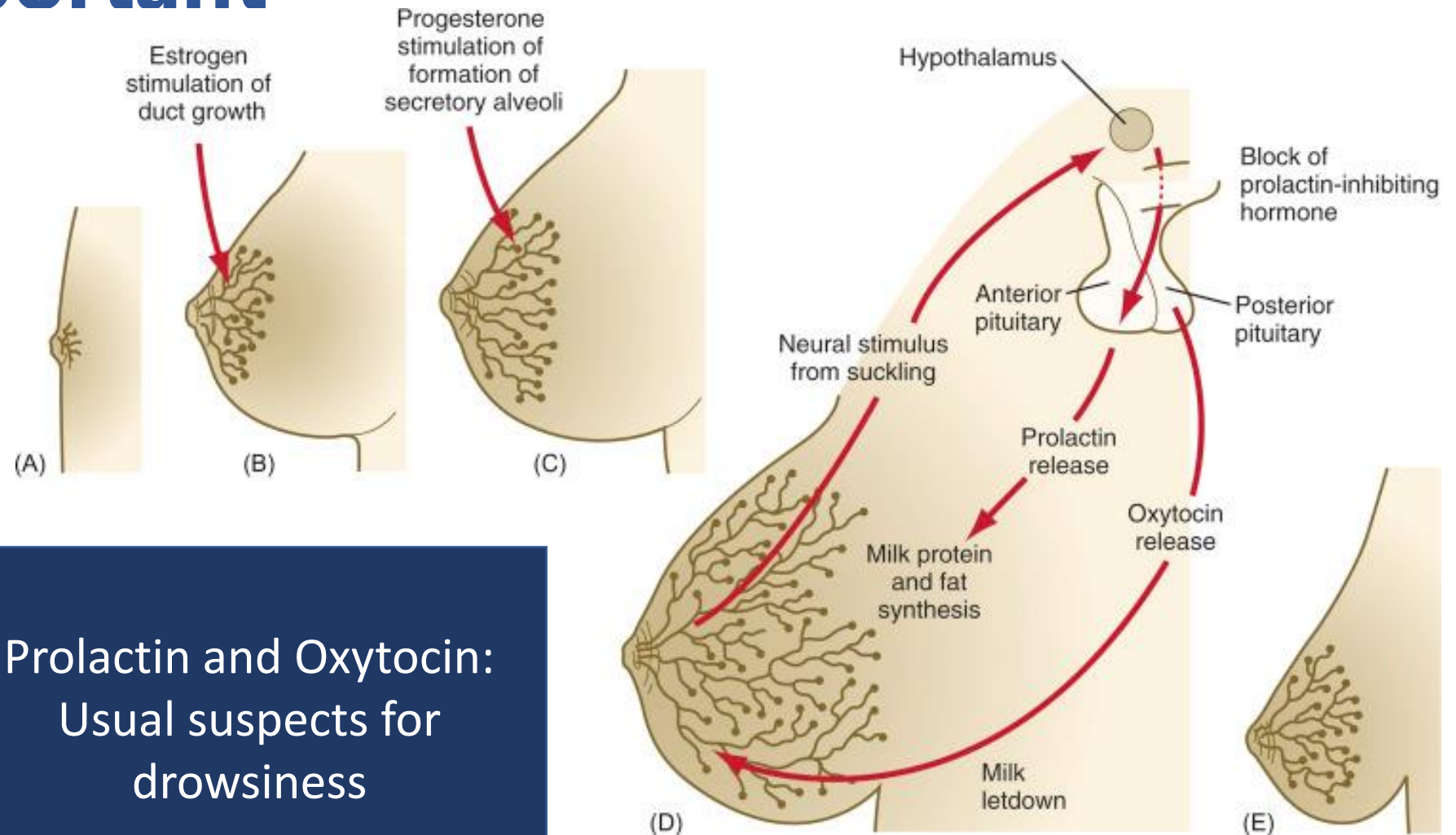
- ✓ Height of mother's bed with open side rails
- ✓ Hard floors
- ✓ Hospital equipment near the bed
- ✓ Incubator doors not being latched securely (for hospitals that have NICU and PP care together)

NICU

- Single-family rooms versus open pods
- Studies from NANN, ANN, and others show varied nurse experience with single-family rooms:
 - Reported reduced line of sight
 - Isolation
- These same studies show positive nursing experiences, including
 - Privacy
 - Quiet environment



Anatomy of the Breast and Why It's Important



Prolactin and Oxytocin:
Usual suspects for
drowsiness

Physiology of Breastfeeding and Sleepiness

Pituitary Gland

Oxytocin (Posterior Lobe):
Responsible for aiding in the muscular responses for breastfeeding (muscles around milk glands contract, sending milk into milk ducts)

Prolactin (Anterior Lobe) :
Hormone that assists with release of milk by cells, and responsible for milk production

- **More Prolactin is produced at night, and therefore important to breastfeed/pump at night to encourage milk production**

Physiology of Breastfeeding and Sleepiness

Pituitary Gland

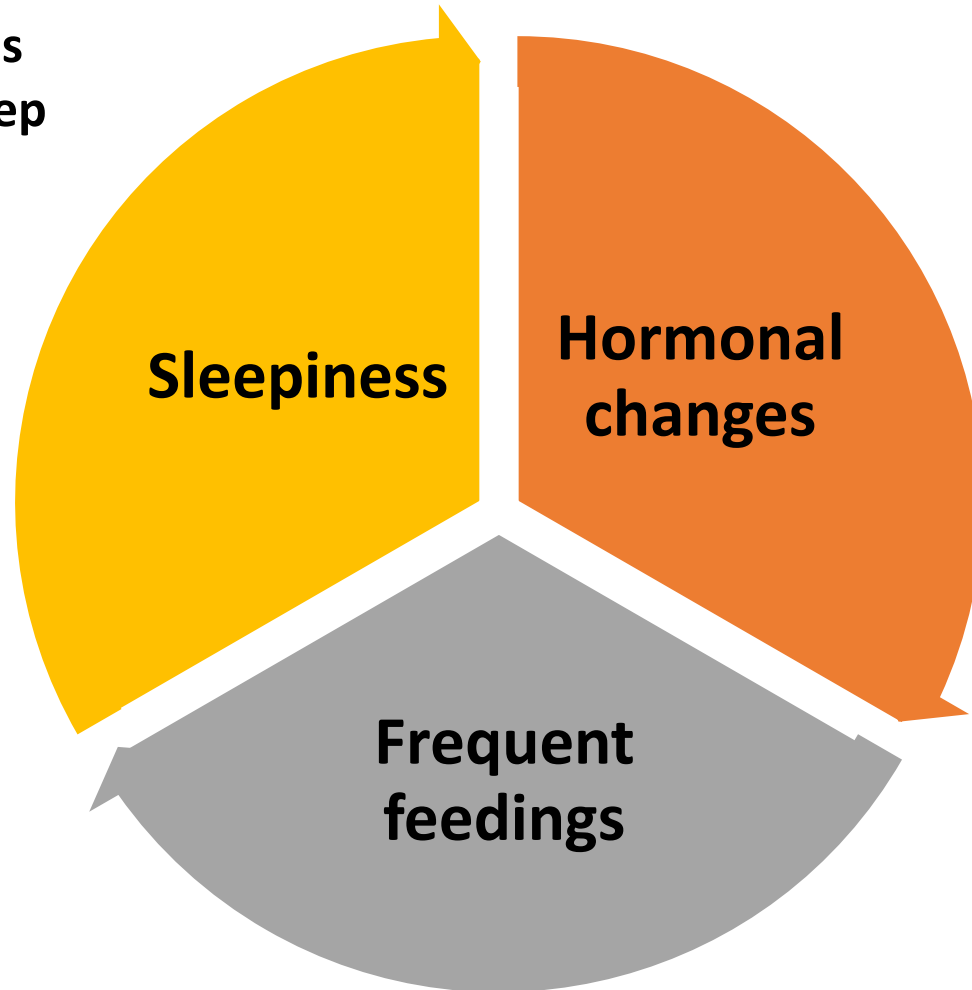
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- **More Prolactin is produced at night, and therefore important to breastfeed/pump at night to encourage milk production**

Creates a feeling of drowsiness and relaxation

**Interruptions
Non-REM sleep
Hormonal
influences**



**Oxytocin &
Prolactin**

**Nighttime feedings important to
encourage milk production
(Prolactin)**

“

The definition of insanity
is doing the same thing
over and over again, but
expecting different results.

”

— Albert Einstein

Creating an Impossible Situation

**Important to
understand
what sleep and
sleep science
can offer this
discussion**



Sleepiness and Sleep Science

Duthie (2020)

- Mothers slept on average of 3.7 hours per night while in hospital
- Sleepiness scores peaked at 4am, and trended downward by 7am
- Circadian rhythms create challenges for wakefulness at night
- **Onset of sleep is a physiologic response and not a decision**



<https://thrivingmum.com/signs-that-labor-is-24-to-48-hours-away/>
<https://thrivingmum.com/signs-that-labor-is-24-to-48-hours-away/>

Key Takeaways from Duthie (2020)

- Newborn slips and defining them
- Frequency of newborn slips/drops measured, not number of times mother falls asleep with baby
- Sensation of sleepiness precedes sleep by seconds



Overview of Part I

- Understand the science of sleep and its impact on maternal fatigue
- Recognize the physiological factors that are impacted during breastfeeding, and the importance of frequent monitoring for fatigue/sleepiness
- Awareness that newborn falls can occur in ANY location where a newborn may be located (hint: anywhere in a hospital)

Questions?

Elizabeth Rochin, Ph.D., RN, NE-BC

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Newborn Falls and Drops: An Interactive Discussion to Achieve Best Practices

Part 2

**Elizabeth Rochin, Ph.D., RN, NE-BC
President/CEO, National Perinatal
Information Center**



Part II: Bridging Science to Action to Prevent and Respond to Newborn Falls

Learner Outcome

Newborn Falls and Drops: An Interactive Discussion to Achieve Best Practices Part II: Bridging Science to Action in Reducing and Responding to Newborn Falls

The purpose/goal(s) of this activity is for participants to be able to:

**Explain two (2) newborn fall prevention programs and how to engage families in
reduction strategies**

0.5 Contact Hours

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Conversation & Discussion

**Part I: Overview and
Etiology of Newborn Falls**

**Part II: Bridging Science to
Action in Reducing and
Responding to Newborn
Falls**

- **Introduce “Elephants in the Room”**
- **Strategies and Solutions for Prevention and Response**

Bringing Nursing Science to Newborn Falls

Date/Time: 6/8/2015 11:45

New Charting **COPY** **Chart View** **Normal Values** **ReCalculate**

If you copy, you need to verify and Confirm Charting when done.

Fall NB Assess Mom

0 Mom Awake, Alert or Easily Roused
 5 Mom Drowsy with Alert/Awake Support Person
 10 Mom Drowsy without an Alert/Awake Support Person
 30 Mom Difficult to Arouse, Alert/Awake Support Person in Room
 50 Mom Difficult to Arouse, No Alert/Awake Support Person in Room

Fall NB Assess Mom's Sedation

0 Mom NOT taking PCA Analgesia or Oral Medications that are sedating
 30 Mom taking PCA Analgesia or Oral Medications that are sedating

Fall NB Assess Environment

0 Mom bed in low position; Environment hazards observed/eliminated; Head of Crib flat in holder during transport; Crib free of pillows and thick blankets.
 50 Mom bed in high position to assist with breastfeeding/other care; Environment hazards observed; Head of Crib Not flat in holder during transport; Crib Not free of pillows and thick blankets.

Fall NB Language Barrier

0 No Language Barrier
 5 Language Barrier with Mother

Interpreter Name: _____

Interpreter Title or Number: _____

Fall Risk Newborn Score

Newborn Fall Risk Explanation

<30 = Infant Fall Management Protocol Not Indicated
 30-45 = Infant may be left in Mother's Room with an Alert, Awake Support Person At the Bedside
 50-135 = Nurse Will Remain at the Bedside or the Infant Will be Removed via Crib to the Nursery

Teach Infant Falls Prevention Safety

Mom needs to be aware and alert when holding baby without support person in room
 Mom's bed to be in a low position
 Safety Provisions Reviewed per ID/Safety Sheet
 Head of Crib to be flat when moving the cart
 Put baby in cart if walking.
 Educated about thick blankets/pillows, stuffed animals in crib.
 Mom's support person may raise/lower the side rails on the bed once they have been instructed on the operation of the bed by a staff member and feel comfortable taking the responsibility to perform this safety measure.
 Other

Newborn Falls Prevention Nursing Actions

Mother Alone and follows directions for Falls Prevention of Newborn
 Support Person Assisting Mother and Agreed not to leave mother alone with baby.
 Nursing staff remaining at bedside to assist mother with newborn feeding and care.
 Baby to Nursery in Crib

Who was taught & Evaluation of Teaching

Taught to Mother
 Taught to Father
 Taught to Caretaker
 Taught to Other, comment
 Received Information and Verbalizes Understanding
 Return Demonstration
 Reinforcement Needed
 Needs Assistance
 Performs Alone
 Declined Instruction
 Other

Newborn Falls Prevention Comments: _____

CONFIRM **OK**

Ainsworth, R.M., Summerlin-Long, S. & Mog, C. (2016). A comprehensive initiative to prevent falls among newborns. *Nursing for Women's Health*, 20(3), 247-257.

Bringing the Science to Practice

Rose Ainsworth, RN, Cathy
Mog RN, and colleagues

Mother/Baby Units at Huntsville
Hospital for Women/Children



Nursing Resources for Prevention of Newborn Falls

PRACTICE BRIEF



Prevention of Newborn Falls/ Drops in the Hospital: AWHONN Practice Brief Number 9

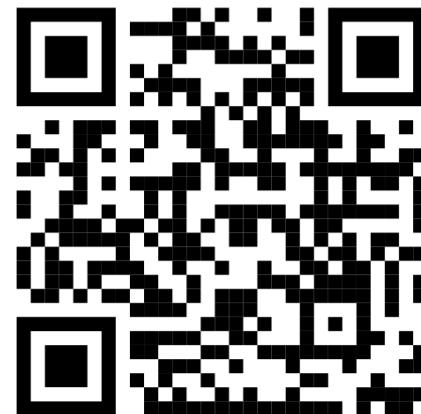
Recommendations

- Consider all newborns at risk of experiencing in-hospital fall/drop events.
- Develop strategies to reduce variation in practice related to the prevention of in-hospital newborn fall/drop events.

Abington Hospital Jefferson Health
Abington, PA

Newborn Fall Prevention Program:

- 1) Staff awareness and education, including ancillary services, to notify nursing staff of unsafe sleep situations
- 2) Days since last fall noted during huddles



Martin, D.J., Chwal, C., & Ward, M. (2020). A newborn fall prevention program. *JOGNN, 49*, S71-S81.

Nursing Resources for Prevention of Newborn Falls

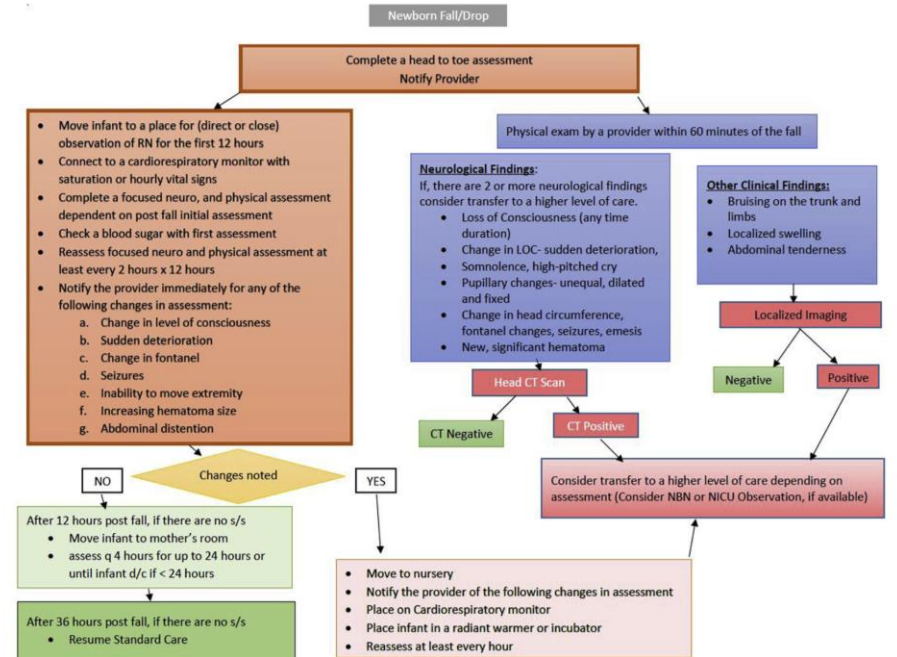
St. Luke's Health System, Idaho

Newborn Fall-Drop Prevention and Response

Newborn Fall Safety Bundle

- Staff and MD education
- Intentional rounding
- Safety posters
- Post-fall care algorithm

Pilot site reduced newborn fall/drop events from 21.95/10,000 births in FY16 to 0 in FY17



Note. CT = computed tomography; d/c = discontinue or discharged; LOC = level of consciousness; NBN = Newborn Nursery; q = every; s/s = signs and symptoms.



Nursing Resources for Prevention of Newborn Falls

Antepartum

The first part of the assessment is used if these factors are met, the patient must place.

Admission (Current)	10/28/21
0700	
Maternal Newborn Falls Risk	
Maternal Newborn Automatic High Risk Category	Not Applicable
Mom LOC and Support Person	1
Mom High Fall Risk Medications	6
Language Barrier	1
Mom Risk Factors	6
Environment	4
Fall Risk Score Antenatal	18
Patient Fall Risk Level	High fall risk
Maternal Newborn Fall Risk Interventions	

Maternal Newborn Fall Risk Interventions

High fall risk medications include PCA pumps, magnesium sulfate, opioids, and psychotropics. Select the corresponding number of medications that your patient is receiving.

Add Wording for Medication Risk

Admission (Current)	10/28/21
0700	
Maternal Newborn Falls Risk	
Maternal Newborn Automatic High Risk Category	Not Applicable
Mom LOC and Support Person	1
Mom High Fall Risk Medications	6
Language Barrier	1
Mom Risk Factors	6
Environment	4
Fall Risk Score Antenatal	18
Patient Fall Risk Level	High fall risk
Maternal Newborn Fall Risk Interventions	

Mom High Fall Risk Medications

6

Select Single Option: (F5)

0=No high risk medications
 2=One (1) high fall risk medication
 4=Two (2) high fall risk medications
6=Three(3) high fall risk medications
 8=Four (4) high fall risk medications

Comment (F6)

Want to see the future?

Value Information

Row Information

Medications within 4 hours:

- PCA
- Magnesium Sulfate
- Opioids
- Psychotropics

Although a patient is at an increased risk of falling due to a language barrier, it is the responsibility of the staff to ensure the patient receives translation services to understand fall prevention education. Turn the in-room fall prevention signage to the appropriate side for English and Spanish-speaking patients.

Admission (Current)	10/28/21
0700	
Maternal Newborn Falls Risk	
Maternal Newborn Automatic High Risk Category	Not Applicable
Mom LOC and Support Person	1
Mom High Fall Risk Medications	6
Language Barrier	1
Mom Risk Factors	
Environment	
Fall Risk Score Antenatal	
Patient Fall Risk Level	

Select Single Option: (F5)

0=There is no language barrier
 1=There is a language barrier

Comment (F6)

Want to see the future?

Try the new Hyperspace Web Flowsheets activity

Row Information

Is there a language barrier?

Courtesy: Cone Health,
Greensboro, NC

Nursing Resources for Prevention of Newborn Falls: Innovative Technology

← Infant Safety Reminders - Risk of Falls

Infant Safety Reminders During Hospitalization [Link to Source Document](#)

Return to: [Quality & Safety](#) ← Fall Navigator (Prevention and Post-Fall Management)

Background

- Infant could fall or be injured
 - Being held or carried
 - Being passed from one person to another
- Risks of a fall or infant injury
 - Following cesarean section
 - When using pain medications
 - Placing your infant in a car seat
 - During breastfeeding

Preventing Falls

- **Mother-Baby Unit:** all newly delivered mothers will be considered high risk for falls due to the following (but not limited to):
 - Ambulation - all newly admitted mothers will be assisted when ambulating for the first time after admission until the RN has assessed and determined her to be capable of adequate coordination, strength, and weight bearing to ambulate independently.
 - Analgesia/anesthesia or other medications that are identified in the administrative protocol as placing patients at high risk for falls.
 - NICU visitation - mothers determined to be at risk or high risk for fall will be transported to the NICU for visitation in a wheelchair (both wheels locked when not in motion).
- **Newborn:** all well newborns and NICU patients are considered at high risk for falls due to the following (but not limited):
 - Developmental stage and inability to stabilize and maintain body positions.
 - Potential to roll off of the bed if left unattended.
 - Maternal sleepiness and/or analgesia. Mother of baby/patient will be educated to monitor self for sleepiness while in bed or chair and holding infant, and encouraged to place baby in bassinet at bedside when she needs to rest. Safety interventions re noted in the Standard of Care/Standard of Practice Policy for Mother-Baby Unit and NICU specific nursing care.

Resources [EXPAND SECTION](#) ▾

Other Resources: Patient Safety Movement

Actionable Patient Safety Solutions (APSS) #14B: **Mother/Baby Falls**

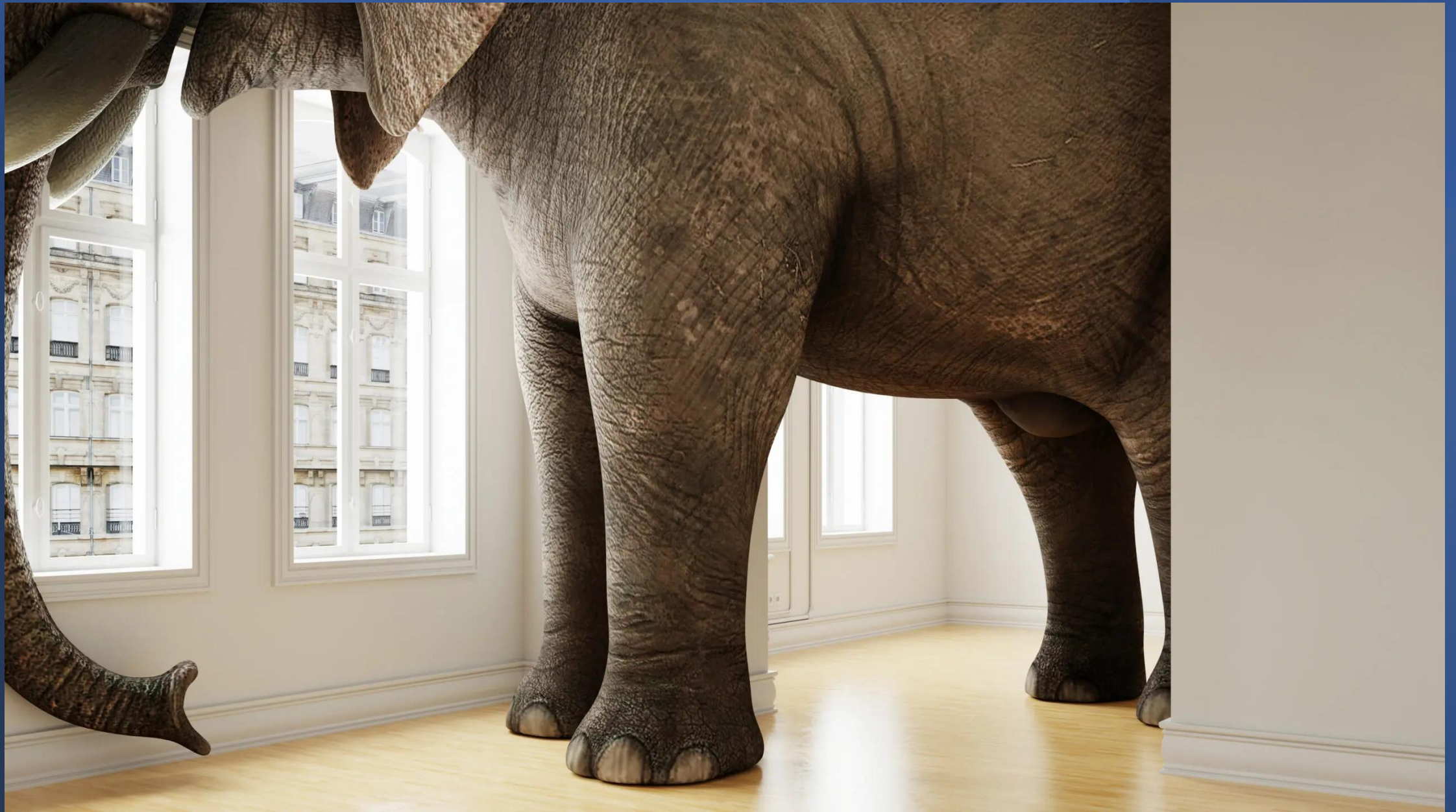
How to use this guide

This guide gives actions and resources for creating and sustaining safe practices to help prevent patient falls. In it, you'll find:

Executive summary checklist.....	422
What we know about falls and fall prevention	423
Leadership plan	425
Action plan	427
Technology plan	431
Measuring outcomes.....	432
Conflicts of interest disclosure	433
Workgroup	433
References	434



<https://patientsafetymovement.org/wp-content/uploads/2021/12/APSS-14B-Mother-Baby-Falls-2020.pdf>



Elephant in the Room: Nurse Staffing at Night/Labor and Delivery

Studies of Missed Care in Labor and Delivery

Dr. Kathleen Rice Simpson and Colleagues

- *Adaptation of the MISSCARE Survey to Labor and Delivery (2019)*
- Frequently or always missed:
 - Assess effectiveness of medications
 - Assess pain status every hour
 - Patient teaching about tests, procedures and other diagnostic tests

Elephant in the Room: Nurse Staffing at Night/NICU

Studies of Missed Care in the NICU

Dr. Heather Tubbs Cooley and colleagues at Ohio State University and University of Cincinnati

Association of Nurse Workload With Missed Nursing Care in the Neonatal Intensive Care Unit (2019)

- In this study of 136 nurses caring for 418 infants during 332 shifts, increased infant-to-nurse ratio during a shift was associated with increased missed nursing care in about half of the measured missed care items. When a measure of subjective workload was considered, the associations of ratios were mostly attenuated; increased subjective workload was consistently associated with increased missed care.*

Elephant in the Room: Nurse Staffing at Night/NICU

Eileen Lake and Colleagues at the University of Pennsylvania
*Association of Patient Acuity and Missed Nursing Care in
U.S. Neonatal Intensive Care Units (2018)*

- *In a survey with NICU nurses (n = 5,861), nurses with higher workloads, higher acuity assignments, or in poor work environments were more likely to miss care. **The most common activities missed involved patient comfort and counseling and parent education.***

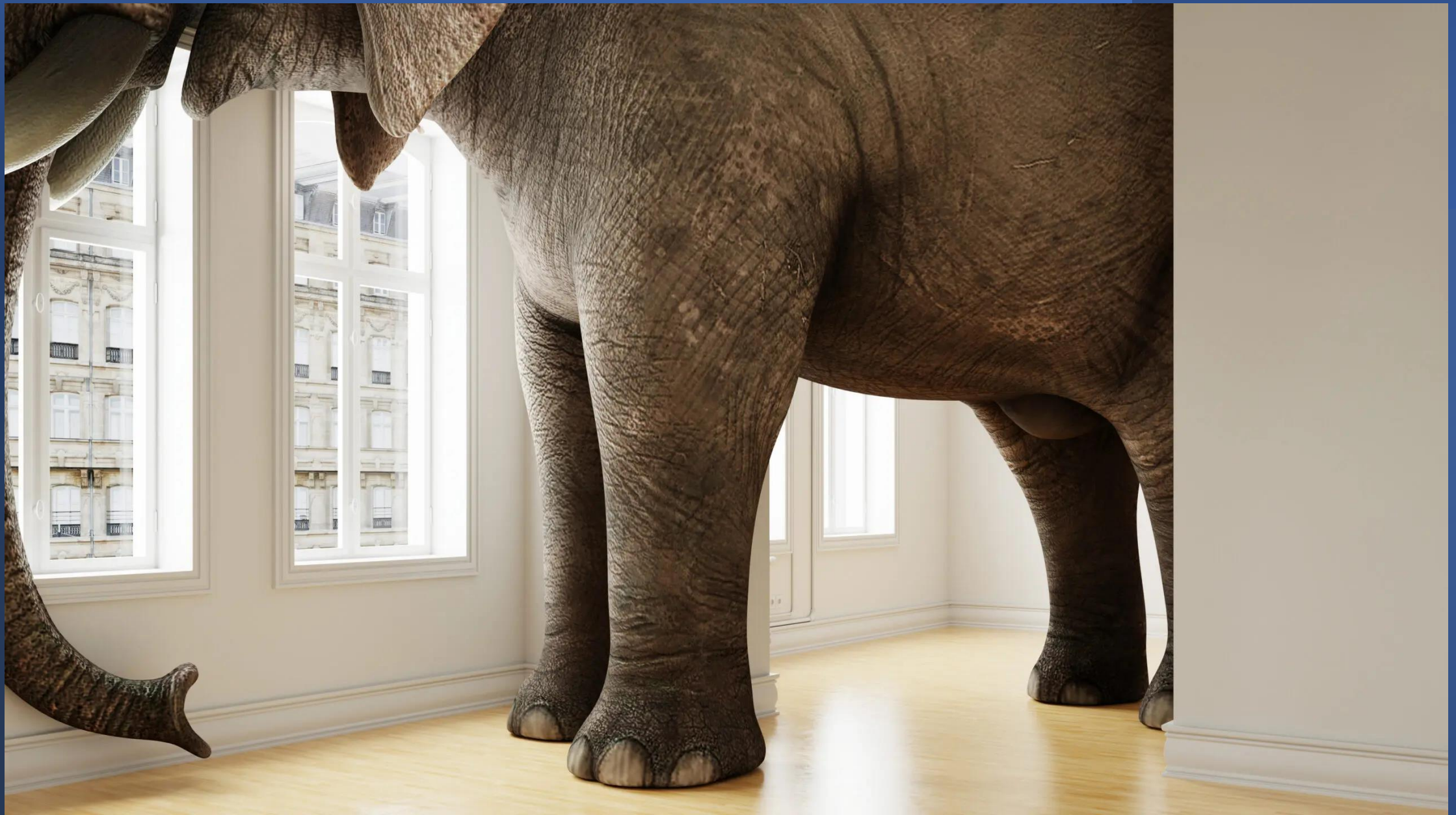
But Wait...You Forgot Mother/Baby and Postpartum!

No, unfortunately, I didn't!!

- Because Perinatal missed care studies are minimal and normally focus on Labor and Delivery/NICU

To the Perinatal Researchers in the Room!

We need you to replicate missed care studies in Postpartum and Mother/Baby units to effectively study the issues surrounding newborn falls and missed care



Create a Safe Environment for Reporting

Grailey *et al.* *BMC Health Services Research* (2021) 21:773
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BMC Health Services Research

RESEARCH

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The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis



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Abstract

Introduction: Psychological safety is the shared belief that the team is safe for interpersonal risk taking. Its presence improves innovation and error prevention. This evidence synthesis had 3 objectives: explore the current literature regarding psychological safety, identify methods used in its assessment and investigate for evidence of consequences of a psychologically safe environment.

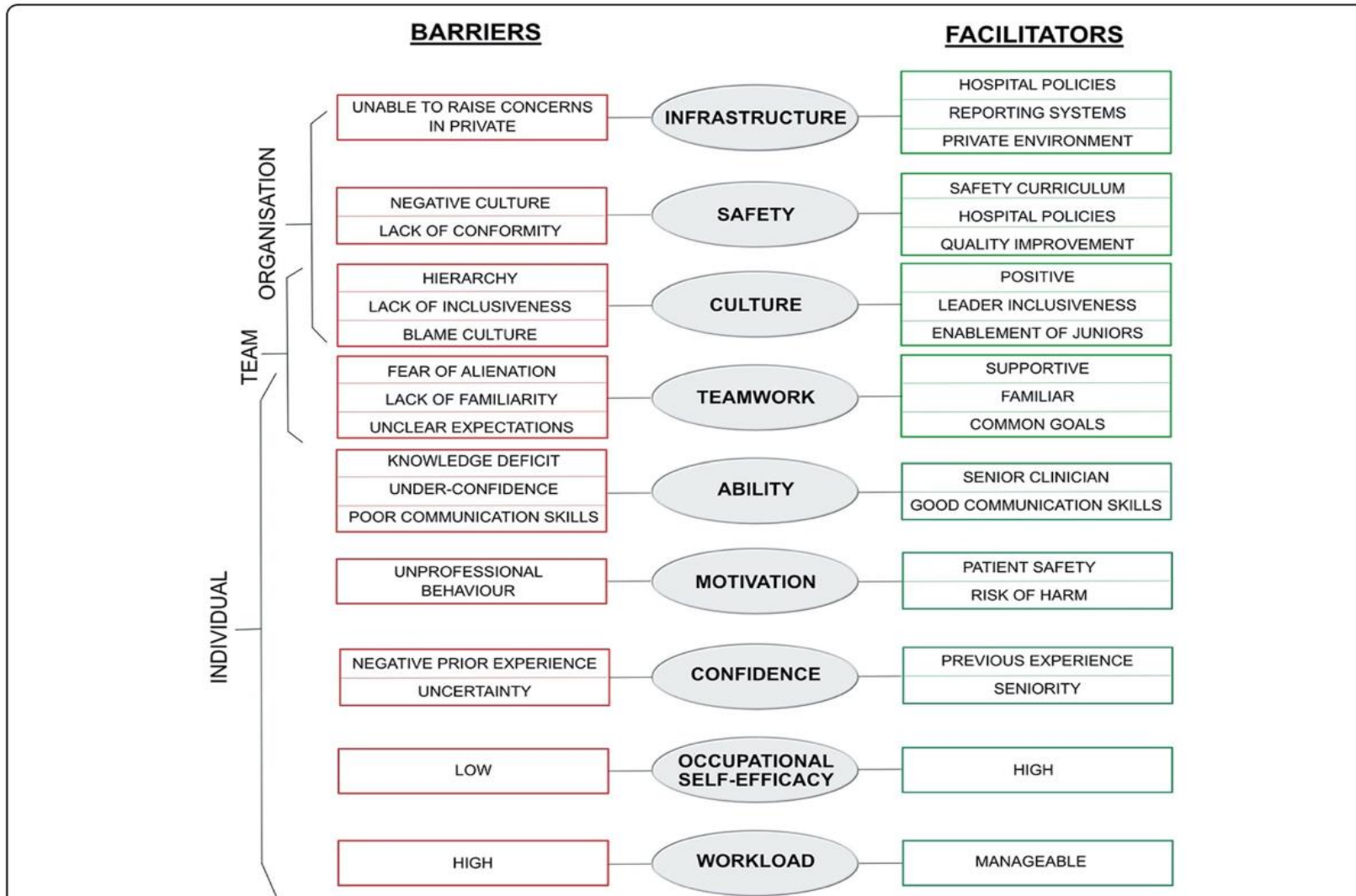


Fig. 2 Diagram illustrating the barriers and facilitators to psychological safety and where they were significant within the workplace

The Immediate Aftermath

Caring for the Parent(s)



[EastEnders: 'Shabnam and Kush will never go back to normal' | TV & Radio | Showbiz & TV | Express.co.uk](#)

Caring for the Staff



[She spent all summer saving lives in Care Homes now she faces deportation from Ireland – The Zimbabwe Mail](#)

Caring for the Parent(s)

If a parent or visitor drops a newborn, it is critical to offer support and guidance

- ✓ Have a staff member stay with the family (doesn't have to be a nurse, but someone who can offer support and be available to listen)
- ✓ Frequent updates and information
- ✓ If transferred to NICU, ensure ability to visit baby ASAP
- ✓ Do not place blame or attack

We Cannot Forget About the Second Victim

- Assure support to the staff member(s)
- Consider a second victim “rapid response” team
- Any patient injury response plan should have a second victim component
- Frequent communication on what is happening to the newborn needs to occur



Newborns are Falling?

Yes, newborns are falling

Opportunity for additional study

Simulating high-risk areas/transfers may be a solution



Newborns Are Falling?

Yes, that was my question too when I was asked to develop a presentation on newborn falls and environmental safety risks in postpartum and newborn areas. As you are aware, we have been encouraging new mothers to room-in to promote breastfeeding and mother-baby bonding through the Baby Friendly Hospital Initiative and our professional associations. Traditionally, new mothers stayed in their hospital rooms to rest after giving birth and only saw their baby at feeding times. Today, many hospitals no longer have a newborn nursery to encourage the mother-baby dyad to remain together. Policies have been changed to facilitate skin-to-skin contact and breastfeeding on demand. However, trying to care for a newborn leaves a tired mother little time for uninterrupted rest, increasing the risk that she may fall asleep while holding her baby. Recently, newborn falls have been recognized as a postpartum safety risk.

The 2013 National Database of Nursing Quality Indicators defines a newborn fall or baby drop as:

a newborn fall rate of 3.94 to 4.14 per 10 000 births and estimated that 600 to 1600 newborn falls occur in the United States annually. The Pennsylvania Patient Safety Authority concluded that newborn falls were the most common event affecting newborn safety according to its Pennsylvania Patient Safety Reporting System.⁴ It was found that 55.1% of falls occurred when a family member fell asleep, 27.2% occurred when the baby slipped out of the arms of a family member, and 17.7% of falls were related to the newborn falling from a hospital bed or incubator, dropped while being transferred, or slipped off a family member's lap.⁴ It was also established that the majority of newborn falls occurred between 24:00 and 07:00, with the highest percentage of falls occurring between 05:00 and 06:00.⁴ In total, 42.7% of newborn falls occurred on day 1 and 32.8% on day 2.⁴

The fall rate is reflective of newborn falls that occur in the postpartum areas. I could locate no literature that provided any information about newborn falls in



Newborn Fall Risk Patient Care Bundle

Readiness

Every Unit

- Consider all newborns at risk for a fall/drop
- Conduct interprofessional and team-based simulation drills and preventive measures with a timely debriefing that includes the use of simulated patients
- Conduct workflow-driven training with the use of in-situ equipment
- All staff awareness of near-miss recognition and accountability
- A fall risk protocol and risk assessment, including patient education, that includes collaboration with patients and families

Recognition & Prevention

Every Patient

- Assess and communicate fall risk to all team members as patient conditions change (maternal fatigue, support person unavailable, new equipment, pre-use equipment checks, etc.)
- Provide ongoing education to all patients and their families regarding newborn fall risk in their preferred language
- Identify and communicate high-risk transfer points and tripping hazards

Response

Every Newborn Fall

- Use a standardized, facility-wide newborn post-fall management algorithm with a checklist and care escalation plan developed by a multidisciplinary team
- Communicate newborn status updates early and often to the patient/family/staff who were directly involved in a newborn fall event, including transfer to a higher level of care, follow-up appointments, etc.
- Provide evidence-based, trauma-informed support for patients, family, and staff involved in a newborn fall

Reporting and Systems Learning

Every Unit

- Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for every newborn fall, which identifies successes, opportunities for improvement, and action planning for future falls
- Perform multidisciplinary reviews of serious complications related to a newborn fall
- Establish processes for mandatory and voluntary event reporting, including near-miss events, and the sharing of events with the care team, providers, and facility stakeholders
- Routinely survey and benchmark psychological safety culture within healthcare teams and address deficiencies and concerns of staff

Respectful, Equitable, and Supportive Care

Every Unit/Provider/Team Member

- Establish a blame-free, shame-free culture surrounding newborn falls
- Assure appropriate translation/interpretation services for debriefing a newborn fall
- Ensure patient/visitor/staff member involved with a newborn fall receives timely psychosocial support and follow-up care
- Assess potential sleep safety needs at home prior to discharge

Questions?

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