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

Part 2

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President/CEO, National Perinatal Information Center

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

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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

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

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Disclosures and Successful Completion

Disclosures:

- No relevant financial relationships were identified for any other individuals with the ability to control the content of the activity.
- There will be no discussion of off-label usage of any products

Successful Completion:

- To successfully complete this activity and receive 0.5 Contact Hour(s), you must attend the entirety of the program and complete the post-test and evaluation at the end of the session

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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

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

ReCalculate

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

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

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

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.

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Bringing the Science to Practice

Rose Ainsworth, RN, Cathy Mog RN, and colleagues

Mother/Baby Units at Huntsville Hospital for Women/Children

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Nursing Resources for Prevention of Newborn Falls

ACTICE 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.

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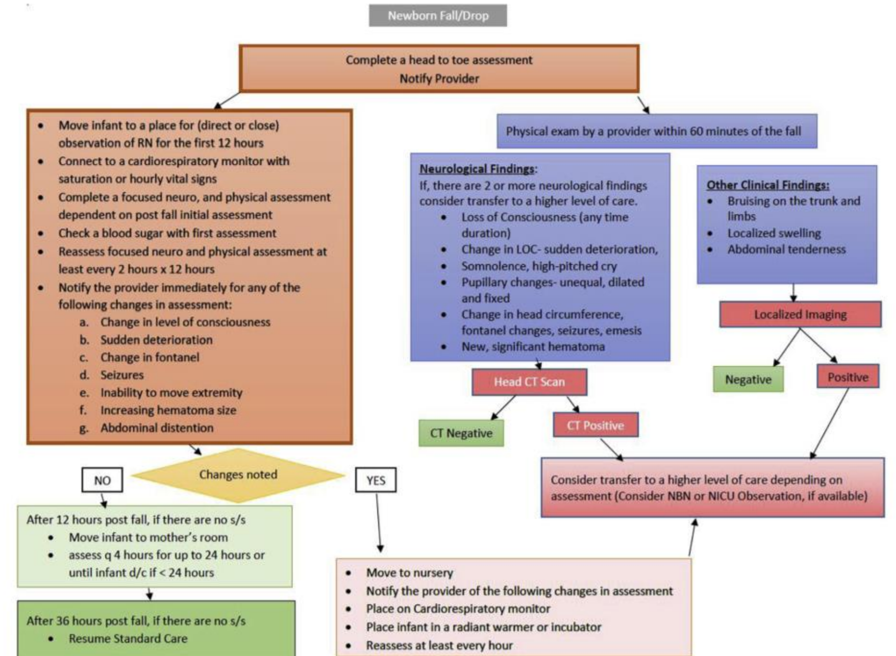
Nursing Resources for Prevention of Newborn Falls

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

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Nursing Resources for Prevention of Newborn Falls

Antepartum

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

	Admissi 10/ 07
Maternal Newborn Falls Risk	
Maternal Newborn Automatic High Risk Category	
Patient Fall Risk Level	
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 (Curr... 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 (Curr... 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	
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

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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 & Sa

Background

- Infant could fall or be
  - Being held or carrie
  - Being passed from
- Risks of a fall or infant
  - Following cesarean
  - When using pain me
  - Placing your infant
  - During breastfeedi

Preventing Falls

Fall Navigator (Prevention and Post-Fall Management)

- **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 inablility to stabilize and maintain body positions.
  - Potential to roll of of the bed if left unattended.
  - Maternal sleepiness and/or analgesia. Mother of baby/patent will be educted to monitor self for sleepiness while in bed or chair and holding infant, and encourageed to place baby in bassinet at bedside when she needs to rest. Safety interventions re noted in the Standard of Care/Standard of Practice Plicy 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

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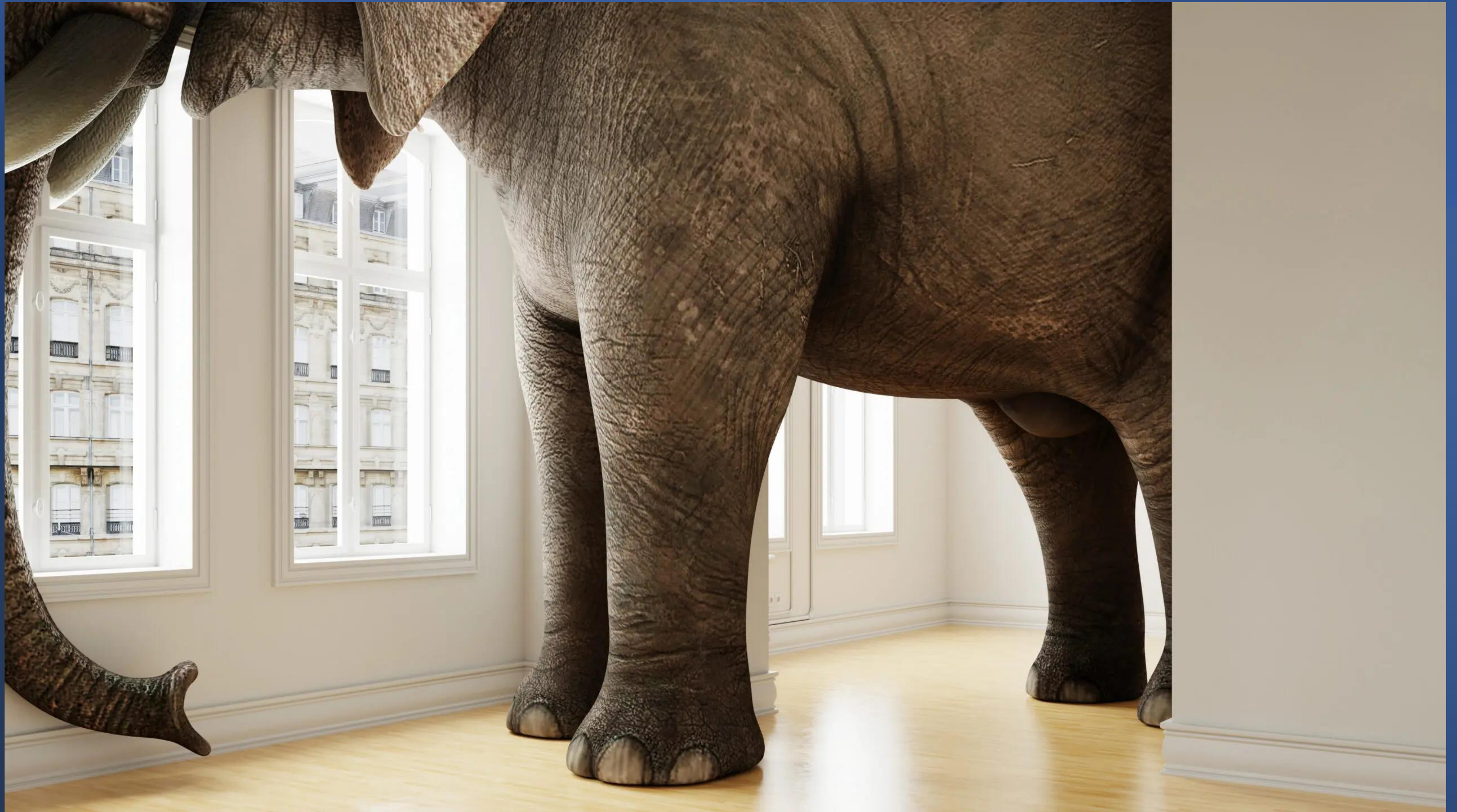

Elephant in the Room: Nurse Staffing at Night/Labor and Delivery

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

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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 Cinncinati

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.*

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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.***

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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

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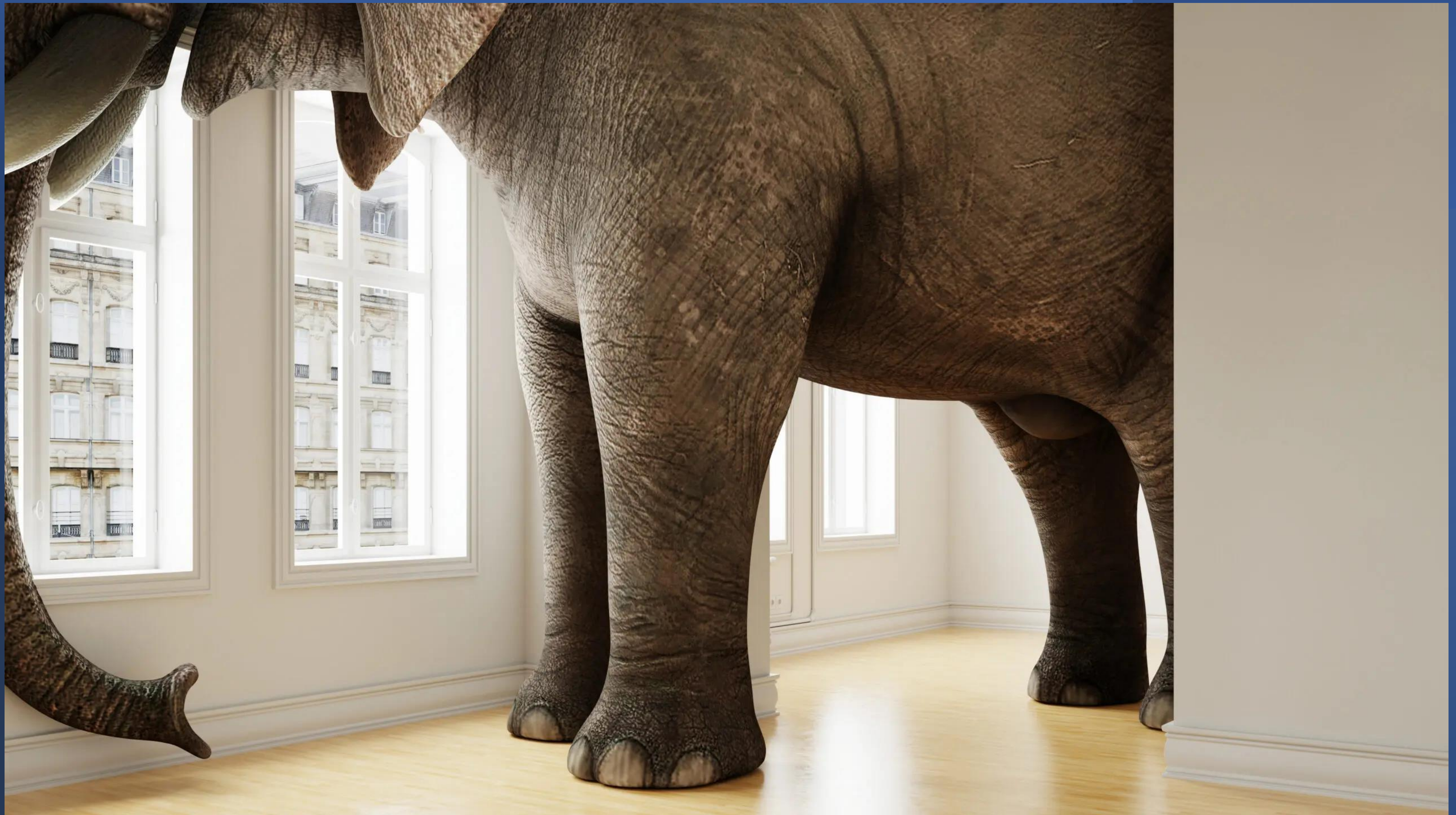

Create a Safe Environment for Reporting

Grailey *et al. BMC Health Services Research* (2021) 21:773
https://doi.org/10.1186/s12913-021-06740-6

BMC Health Services Research

RESEARCH Open Access

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

K. E. Grailey[1*], E. Murray[2], T. Reader[3] and S. J. Brett[1]

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.

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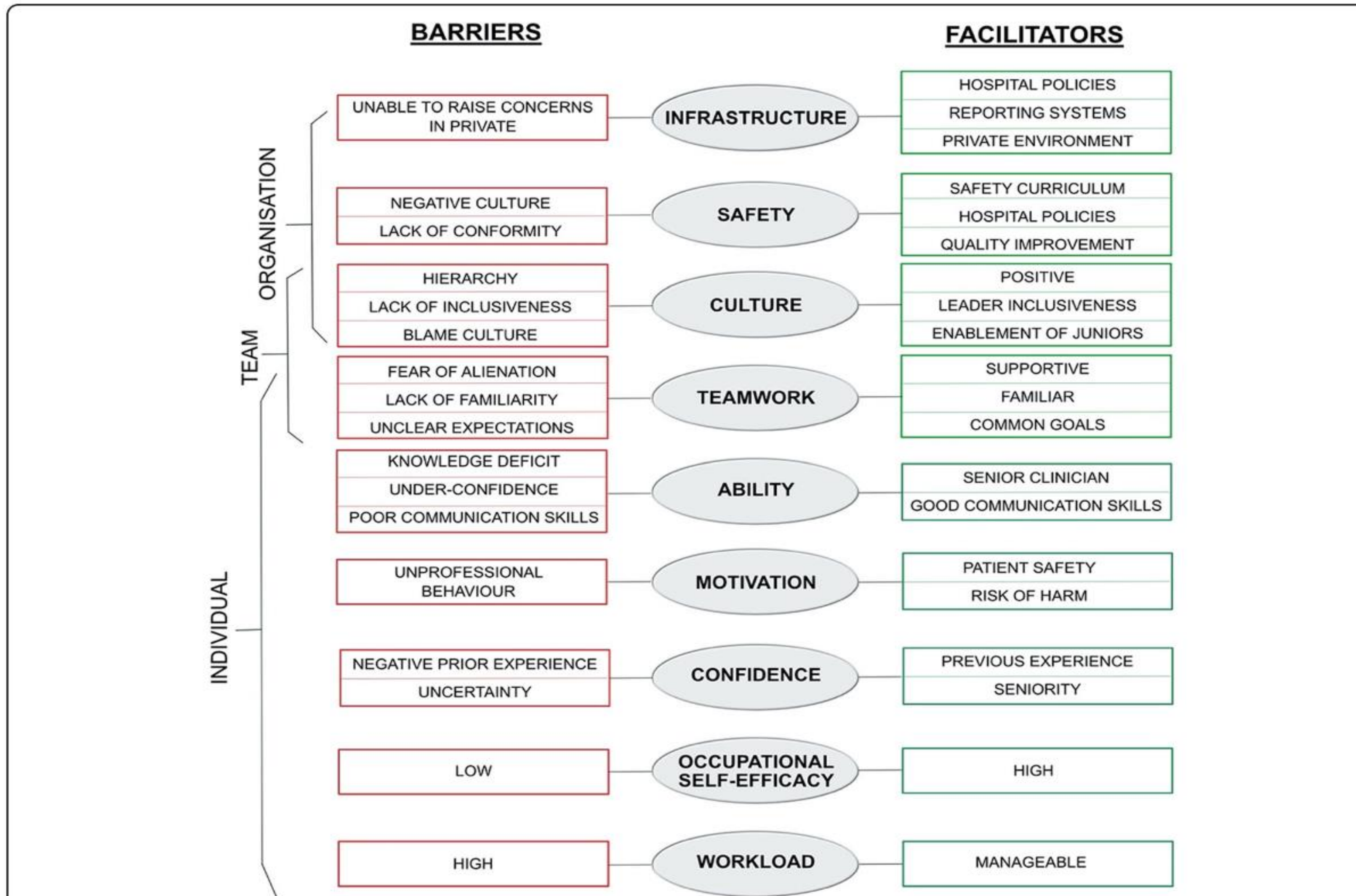

Fig. 2 Diagram illustrating the barriers and facilitators to psychological safety and where they were significant within the workplace

Grailey, K. E., Murray, E., Reader, T., & Brett, S. J. (2021). The presence and potential impact of psychological safety in the healthcare setting: An evidence synthesis. *BMC Health Services Research*, *21*(1), 1–15. https://doi.org/10.1186/s12913-021-06740-6

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

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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

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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 Indi-

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

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 andaddress 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

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Questions?

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