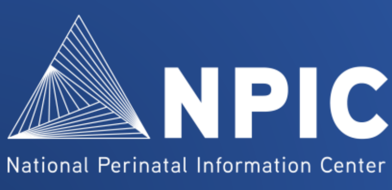
Newborn Falls :

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: 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) practice changes that can support the prevention of newborn falls in the immediate postpartum period

0.5 Contact Hours

This activity has been approved by the Northeast Multistate Division for 0.5 contact hours. This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Disclosures and Successful Completion

Disclosures:

- This educational activity was supported by an unrestricted educational grant from GE HealthCare
- 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

Conversation & Discussion

Part I: Overview and Etiology of Newborn Falls

- Science of Maternal Sleep
- Strategies and Solutions for Prevention and Response

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

Newborns are Falling?

March 2021

Key points:

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

CONTENT NOT FOR REUSE

DOI: 10.1097/JPN.0000000000000542

PARTING THOUGHTS...

M. Terese Verklan, PhD, CCNS, RNC, FAAN

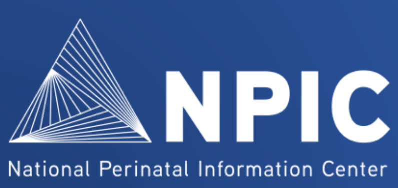
Newborns Are Falling?

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



“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 child protective services call. Nobody was saying, ‘Accidents happen. It’s not your fault.’ 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 this kind of trauma.”*

***Names have been changed**

Newborn Falls

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…

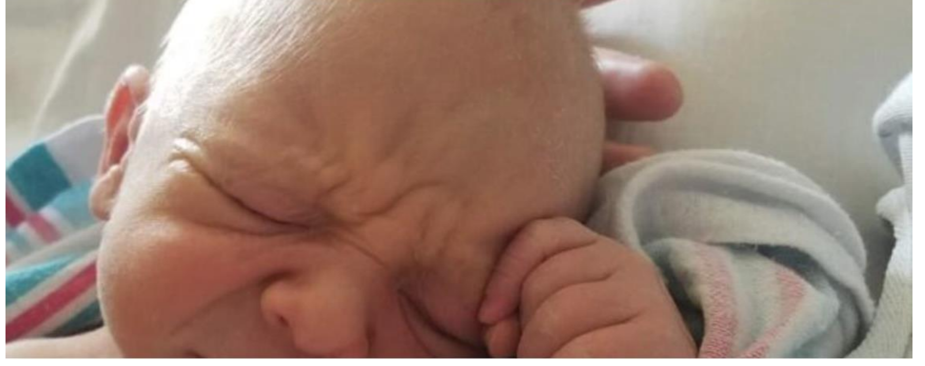
PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

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.

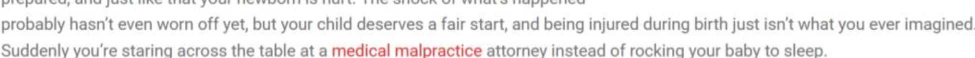
https://fedisbest.org/2020/11/i-dropped-my-baby-in-a-baby-friendly-hospital-while-i-was-alone-recovering-from-a-cesarean-section/

And…

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.

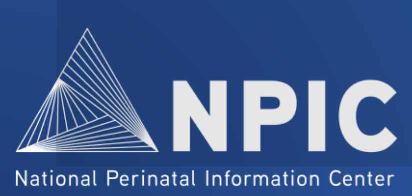
Blog Categories

- 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.*"



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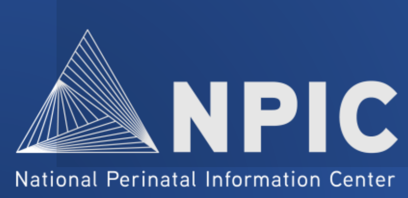
For this discussion, we will use the term "newborn fall" to cover the constellation of falls and drops



Patient falls are no longer listed specifically as in the past

Identify patient safety risks

2024 Hospital National Patient Safety Goals

(Easy-To-Read)

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.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Improve health care equity	
NPSG.16.01.01	Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.
Prevent mistakes in surgery	
UP01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP01.03.01	Pause before the surgery to make sure that a mistake is not being made.

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Joint Commission QuickSafety! March 2018

Issue 40 March 2018

Preventing newborn falls and drops

Issue:

Inpatient falls have been well studied in the adult population, and there is a large body of research on fall prevention and cost reduction.[1] Conversely, there is little attention to falls in the newborn population, although it has been estimated that 600 to 1,600 newborns in the United States experience an in-hospital fall every year.[2] Infant falls can escalate into conditions of serious harm to the newborn as well as emotional distress to parents and caregivers.[3]

What defines a newborn fall or drop?

The Agency for Healthcare Research and Quality (AHRQ) defines a fall as: An unplanned descent to the floor with or without injury to the patient.[4] The National Database for Nursing Quality Indicators (NDNQI) defines both newborn falls and newborn drops. 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 health care professional, parent, family member, or visitor falls or slips from that person's hands, arms, lap, etc. This can occur when a child is being transferred from one person to another. The fall is counted regardless of the surface on which the child lands and regardless of whether or not the fall resulted in injury."[5] Current literature supports that this patient safety concern, defined as a newborn fall or a newborn drop, are synonymous; organizations should follow the same patient safety analysis process for both a fall and a drop.

Risk factors for newborn falls drops

The literature supports that the most prevalent maternal risk factors associated with newborn falls and drops include:

- Cesarean birth
- Use of pain medication within four hours
- Second or third postpartum night, specifically around midnight to early morning hours
- Breastfeeding

Numerous maternal infant units promote exclusive breastfeeding as the ideal method of infant feeding in the first six months of life. To help facilitate early attachment between the mother and her newborn, skin-to-skin care is recommended. There is good evidence that normal term newborns who are placed skin to skin with their mothers immediately after birth make the transition from fetal to newborn life with greater respiratory, temperature, and glucose stability and significantly less crying indicating decreased stress.[6]

Yes, It Can Be Done

RESEARCH ARTICLE | VOLUME 48, ISSUE 10, P521-528, OCTOBER 2022

Download Full Issue

A Longitudinal Study of a Multifaceted Intervention to Reduce Newborn Falls While Preserving Rooming-In on a Mother-Baby Unit

Colleen Whatley, MSN, CNS-BC • Josia Schlogl, MD • Bonny L. Whalen, MD • Alison Volpe Holmes, MD, MPH

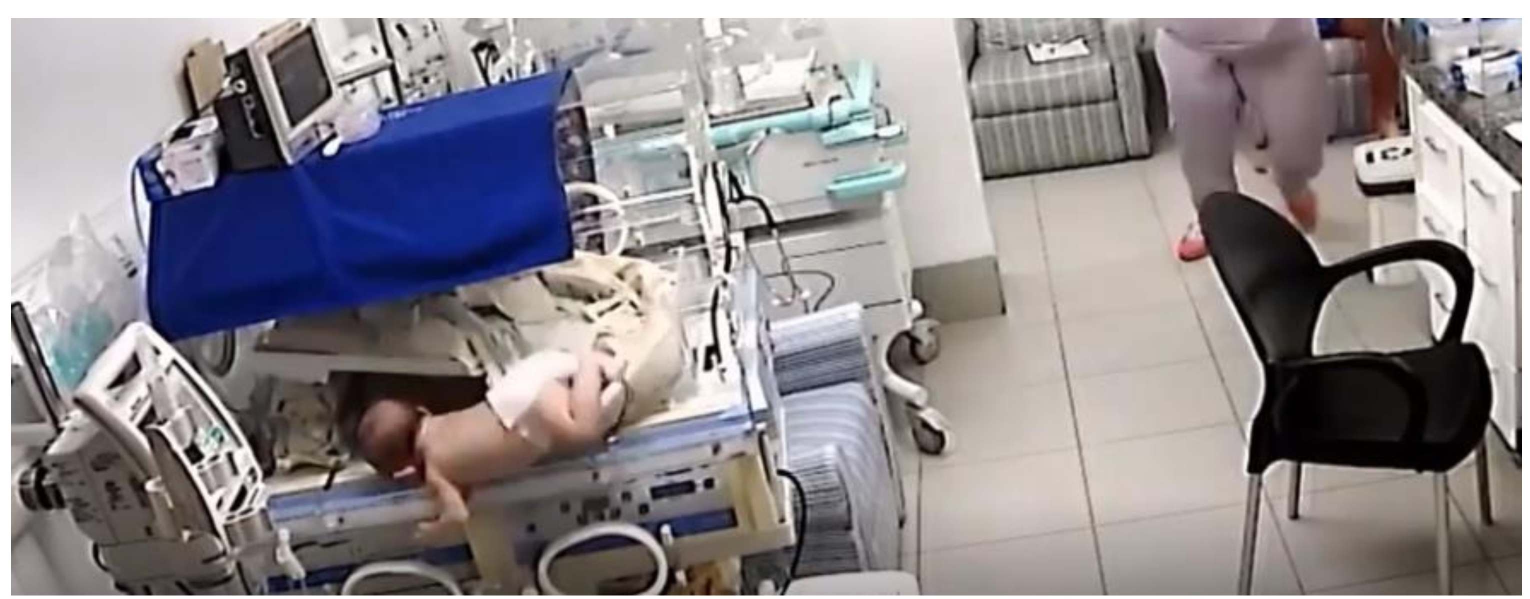
Published: June 14, 2022 • DOI: https://doi.org/10.1016/j.jcjq.2022.06.007

In 2017, the facility newborn fall rate increased to 71.8 falls per 10,000 births

Days between newborn falls increased from 9 days to 467 days to 700+ days

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

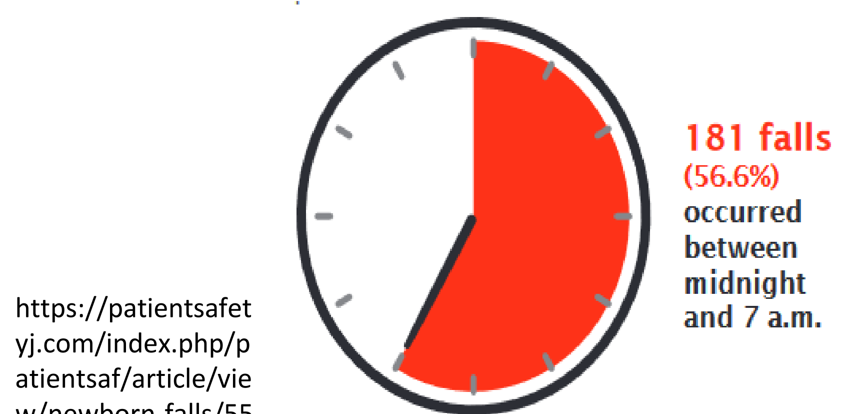


Maternal Characteristics

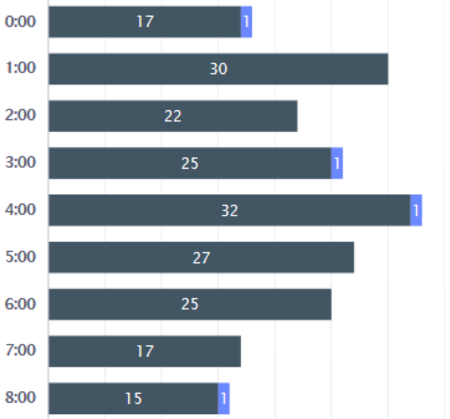
Studies have shown the following characteristics of mothers/birthing people who have been involved in a newborn fall:

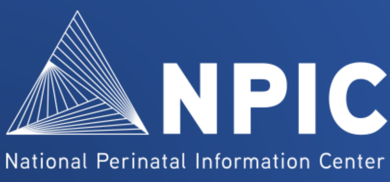
- Breastfeeding or breast/formula feeding
- Delivered by Cesarean Section
- Second or third postpartum night
- Receiving opioid pain relief, and had received last dose 2-3 hours previous to fall

- **PA study of newborn falls (*n* = 320) (2014 – 2018): Most newborn falls occurred during the following time frames:**



https://patientsafetyj.com/index.php/patientsaf/article/view/newborn-falls/55





Speaking of Pennsylvania…

Open access | CC BY NC | Research article | First published online January 23, 2021

Post-Partum Skin-to-Skin Care and Infant Safety: Results of a State-Wide Hospital Survey

Eileen Tyrala, MD, Michael H. Goodstein, MD, […], and Ted Bell, MS +3 View all authors and affiliations

Statewide survey of skin-to-skin care (SSC)

(2017 – 2018) 64/95 hospitals participated

28% of hospitals reported newborn fall events

Hospital training for safe sleep practices and fall prevention:

- 75% reported training nurses
- 23% reported training MDs/providers
- 28% reported training CNAs

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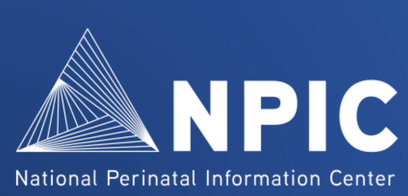
Call to Action…Where Do Babies Fall?

- 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



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 or falling asleep
- ✓ 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
- ✓ Parent or staff tripping over hazards while cradling baby

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

Interrupted sleep

Unstable ambulation

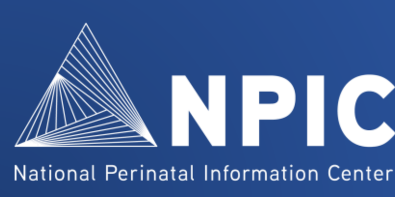
Using bassinette without moving

Sedating medications

Cesarean birth

Unfamiliar environment

Maternal Fatigue



Anatomy of the Breast and Why It’s Important

Estrogen stimulation of duct growth

Progesterone stimulation of formation of secretory alveoli

Hypothalamus

Block of prolactin-inhibiting hormone

Anterior pituitary

Posterior pituitary

Neural stimulus from suckling

Prolactin release

Oxytocin release

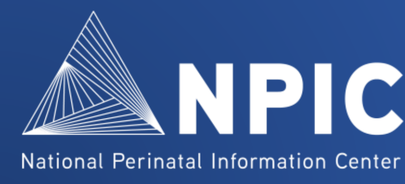
Milk protein and fat synthesis

Milk letdown

(A) (B) (C) (D) (E)

Prolactin and Oxytocin and the Connection to Sleep

Carlson, B.M. (2019). The reproductive cycle. In *The Human Body*. https://www.sciencedirect.com/topics/medicine-and-dentistry/thelarche



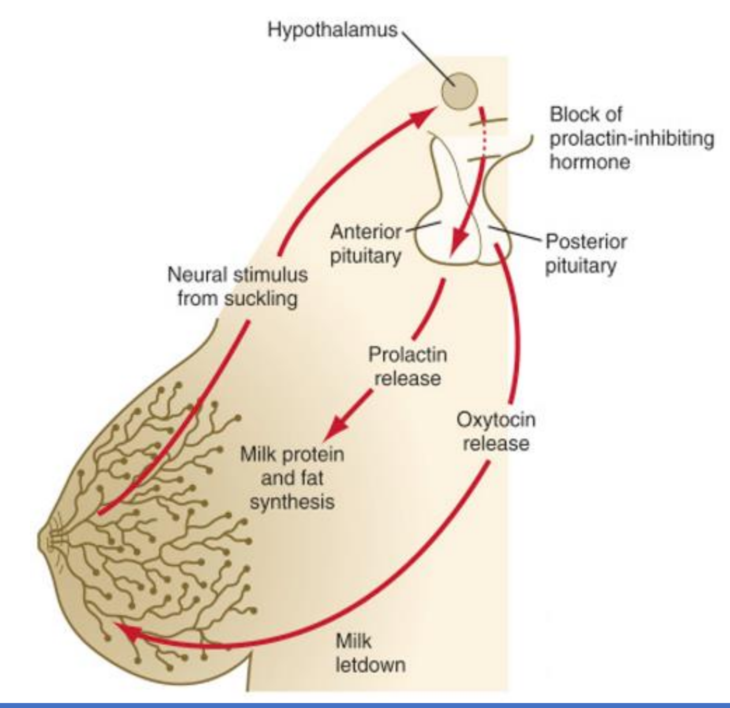
Physiology of Breastfeeding and Sleepiness

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 remember to breastfeed/pump at night to encourage milk production**



Creates a feeling of drowsiness and relaxation

Carlson, B.M. (2019). The reproductive cycle. In *The Human Body*.
https://www.sciencedirect.com/topics/medicine-and-dentistry/thelarche

Interruptions
Non-REM sleep
Hormonal influences

Oxytocin &
Prolactin

Sleepiness

Hormonal changes

Frequent feedings

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

Maternal Sleep and Sleep Science

› Jt Comm J Qual Patient Saf. 2019 May;45(5):337-347. doi: 10.1016/j.jcjq.2018.12.001.
Epub 2019 May 15.

Maternal Sleepiness and Risk of Infant Drops in the Postpartum Period

Marianne D Bittle, Helen Knapp, Rosemary C Polomano, Nicholas A Giordano, Jason Brown, Marilyn Stringer

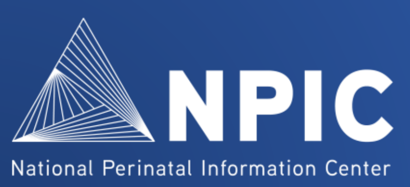
PMID: 31103475 DOI: 10.1016/j.jcjq.2018.12.001

101 postpartum mother-infant dyads

Stanford Sleepiness Scale

N = 4,550 observations

- Mothers slept on average 3.7 hours/day (median: 5 hrs)
- Peak sleepiness 4:00am
- 2% of mothers were found to be sleeping with baby in their arms



Clinical validation of nursing diagnosis fatigue (00093) in women in the immediate hospital postpartum period

Bruna Valentina Zuchatti,[1] Raisa Camilo Ferreira,[1] Elaine Ribeiro,[1] and Erika Christiane Marocco Duran[1]

▾ Author information ▸ Article notes ▸ Copyright and License information PMC Disclaimer

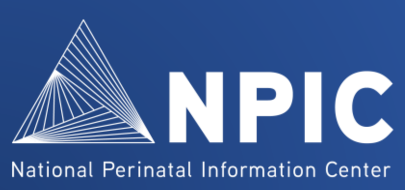
Tiredness and fatigue are different and unique

Tiredness is a clinical indicator of fatigue

Fatigue is more severe and not so easily relieved

Fragmented and poor quality sleep associated with fatigue

This is an area of postpartum care that deserves more attention… There IS a difference between immediate postpartum tiredness and fatigue



Clinical validation of nursing diagnosis fatigue (00093) in women in the immediate hospital postpartum period - PMC (nih.gov)

Sleepiness and Sleep Science

SPECIAL ARTICLE | DECEMBER 01 2020

In-Hospital Newborn Falls Associated With a Sleeping Parent: The Case for a New Paradigm FREE

Elizabeth A. Duthie, RN, PhD, CPPS

Address correspondence to Elizabeth A. Duthie, RN, PhD, CPPS, Montefiore Medical Center Network Performance Group, 6 Executive Plaza, Suite 112A, Yonkers, NY 10407. E-mail: eduthie@montefiore.org

- 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**

Key Takeaways from Duthie (2020)

- “Moving away from the illusion that we can keep mothers/parents awake”
- Frequency of newborn slips/drops measured, not number of times mother falls asleep with baby
- Sensation of sleepiness precedes sleep by seconds

Connecting Sleep Science to Patient Safety

Labor and Delivery

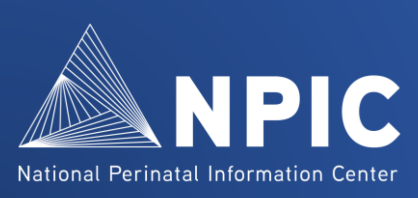
- How would you describe your sleep over the past few nights?
- On average, how many hours of sleep do you get per night?
- Do you feel well-rested? Or are you tired?

Postpartum

- How long was labor? Pushing?
- Were you able to get any rest before delivery of your newborn?
- Do you feel energized? Tired?
- Do you have someone to support you at night?

Overview of Part I

- Understand the science of sleep and its impact on maternal sleepiness
- 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)
- Don't forget your CNA/ancillary care team members in newborn fall prevention training…



Questions?

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

Elizabeth.Rochin@npic.org

Newborn Falls:

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: Prevention of and Response to Newborn Falls

Learner Outcome

Newborn Falls: An Interactive Discussion to Achieve Best Practices
Part II Bridging Science to Action: Prevention of and Response to Newborn Falls

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

Describe two (2) practice changes that can support the prevention of newborn falls in the immediate postpartum period

0.5 Contact Hours

This activity has been approved by the Northeast Multistate Division for 0.5 contact hours. This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Disclosures and Successful Completion

Disclosures:

- This educational activity was supported by an unrestricted educational grant from GE HealthCare
- 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

Conversation & Discussion

Part I: Overview and Etiology of Newborn Falls

Part II Bridging Science to Action: Prevention of and Response 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

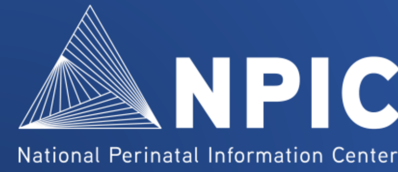
Teach Infant Falls Prevention Safety
- Mom needs to be aware and alert when holding baby without support person in room
- Mom's bed to be in a low position
- Safety Provisions Reviewed per ID/Safety Sheet
- Head of Crib to be flat when moving the cart
- Put baby in cart if walking.
- Educated about thick 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

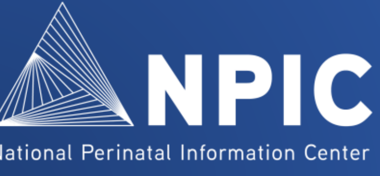
Ainsworth, R.M., Summerlin-Long, S. & Mog, C. (2016). A comprehensive initiative to prevent falls among newborns. *Nursing for Women's Health, 20*(3), 247-257.



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

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.

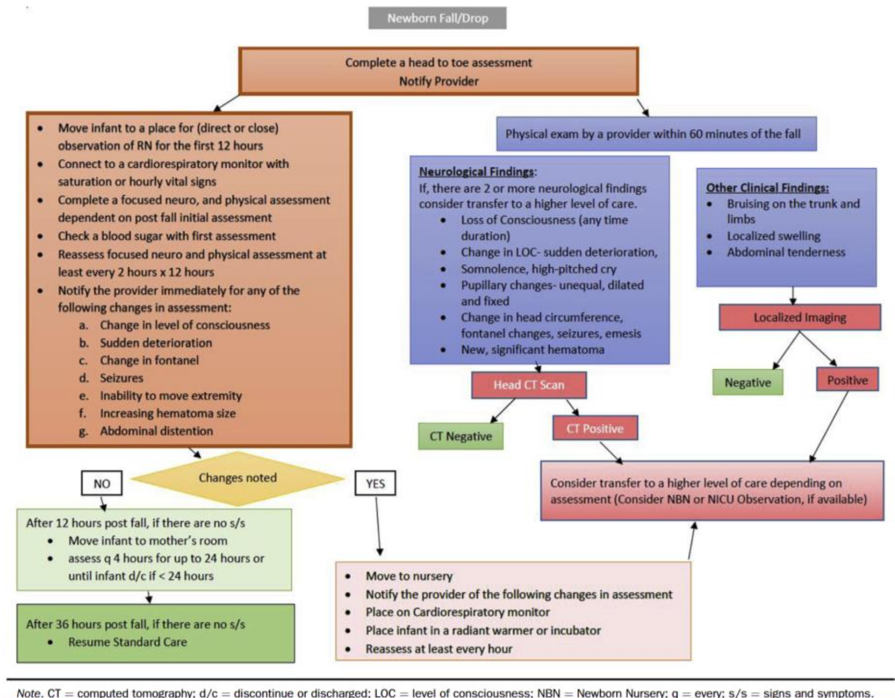
Nursing Resources for Prevention of Newborn Falls

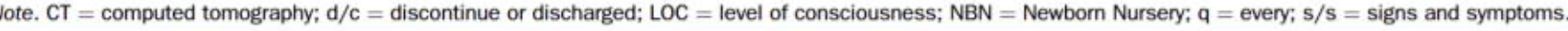
St. Luke's Health System, Idaho

Newborn Fall-Drop Prevention and Response

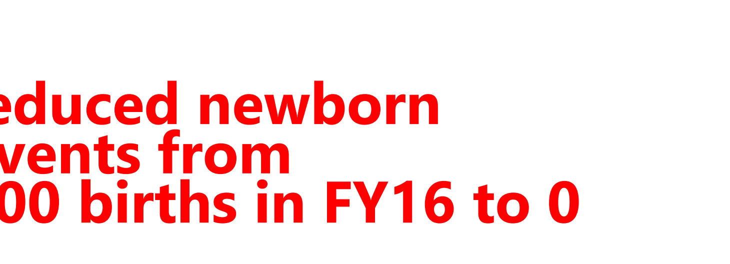
Newborn Fall Safety Bundle

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





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

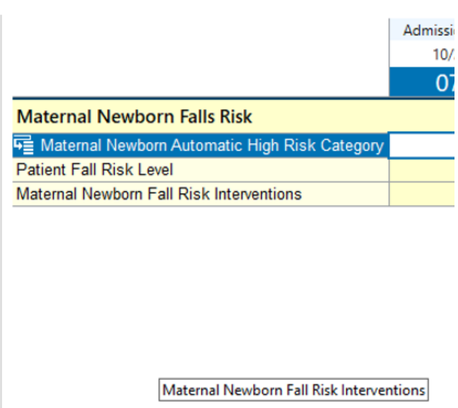


Pilot site reduced newborn fall/drop events from 21.95/10,000 births in FY16 to 0 in FY17

Nursing Resources for Prevention of Newborn Falls

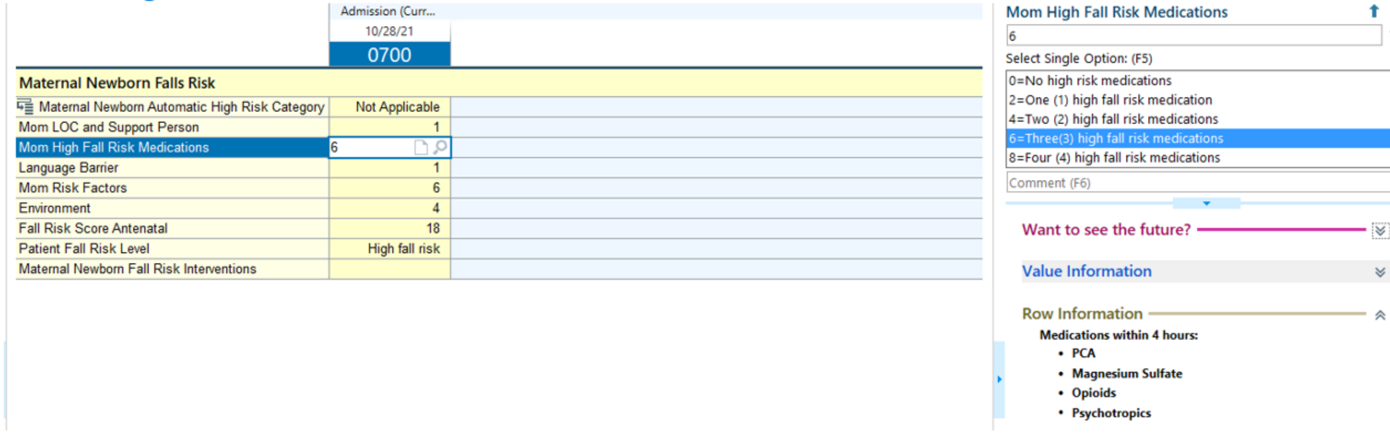
Antepartum

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

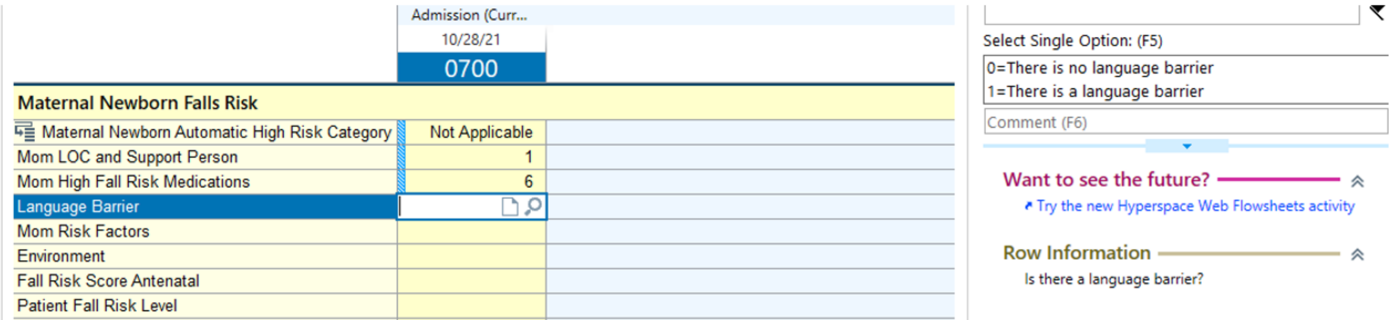


High fall risk medications include PCA pumps, magnesium sulfate, opioids, and psychotropics. Select the corresponding number of medications that your patient is receiving.

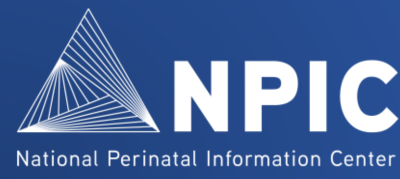
~~Add Wording for Medication Risk~~



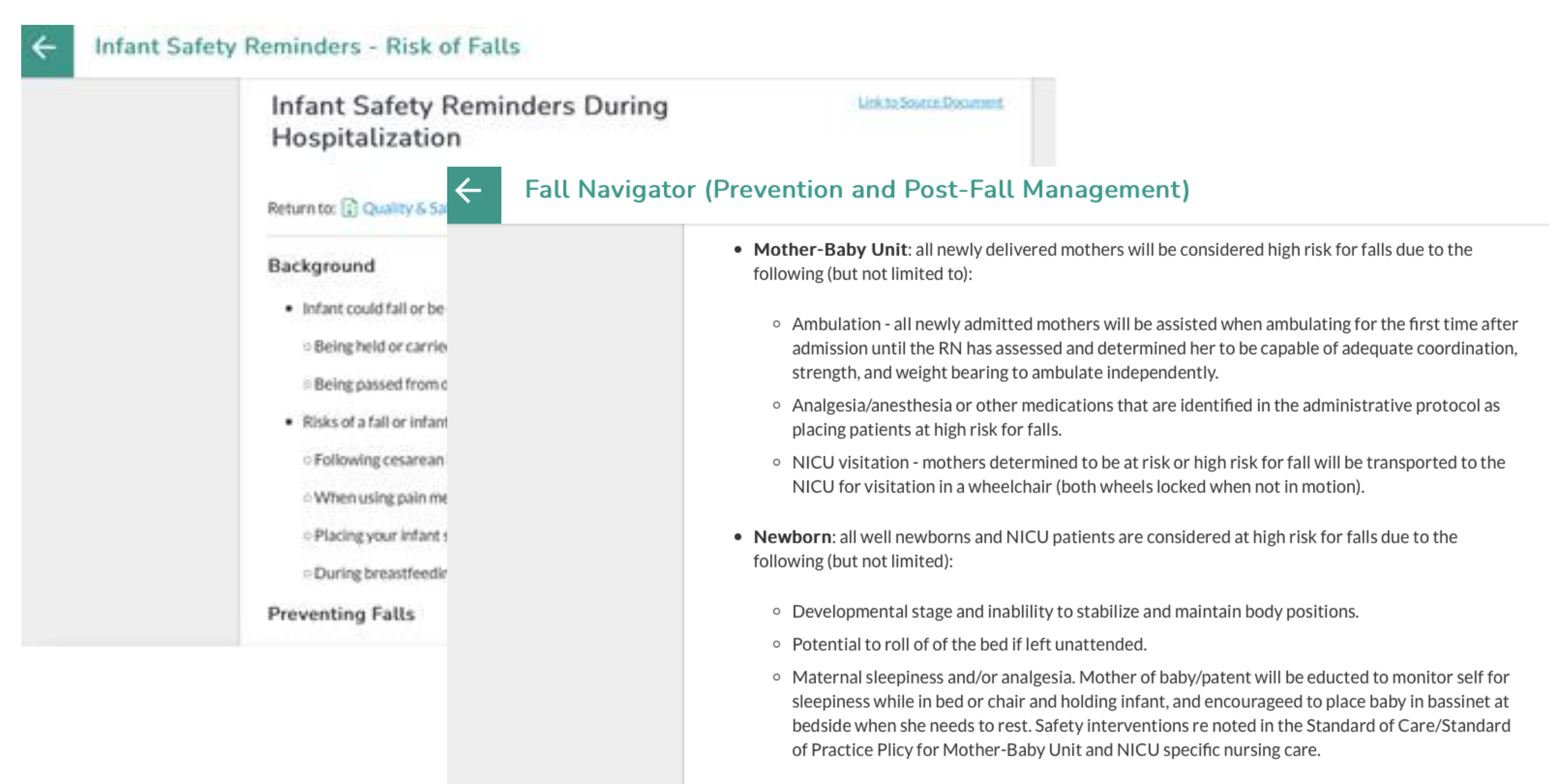
Although a patient is at an increased risk of falling due to a language barrier, it is the responsibility of the staff to ensure the patient receives translation services to understand fall prevention education. Turn the in-room fall prevention signage to the appropriate side for English and Spanish-speaking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



Courtesy: Cone Health, Greensboro, NC

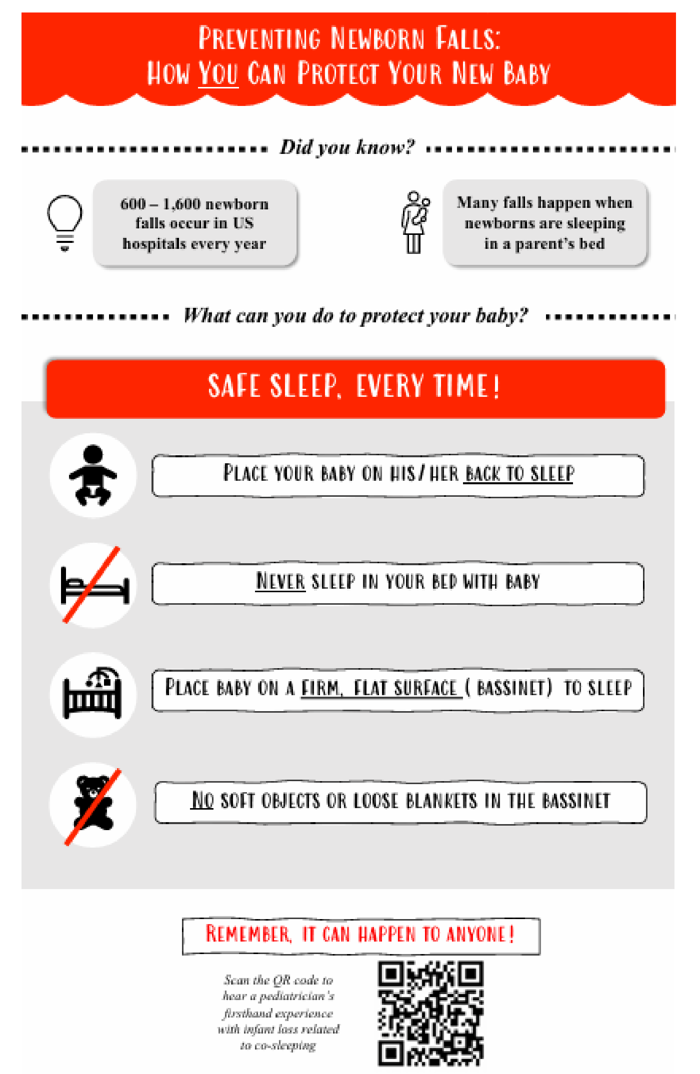


Nursing Resources for Prevention of Newborn Falls: Innovative Technology



NPIC
National Perinatal Information Center

Student Contributions to Newborn Fall Reduction



Dr. Cierra Sullivan
East Carolina University DNP Gateway 2023
content (ecu.edu)

NICE CATCH! An Evidence Based Safety Program for Preventing Postpartum Infant Falls

Sharon Kurtz, BSN, RN

CLINICAL CONCERN

- Approximately 600-1,600 newborn falls occur annually in the United States
- Infant falls can result in serious injury
- Many risk factors can contribute to infant falls
  - Exhaustion
  - Immobility
  - Anesthesia
  - Analgesia
  - Prior near-miss catch of unsafe sleep

PICO QUESTION

Will the implementation of a nurse-led, evidence-based safety program preventing postpartum infant falls reduce the number of falls and/or injuries and lead to better patient safety and parental satisfaction compared to the current standard of care?

REVIEW of the LITERATURE

Databases and Internet Sources Searched

- CINAHL, MEDLINE, ACADEMIC SEARCH COMPLETE
- Professional Organization Websites
- Google, Google Scholar
- Clinical Practice Guidelines

Keywords

- "infant falls and hospitals"
- "postpartum infant falls"

Advanced Search Parameters

- Published within last five years
- English language only

THREE THEMES EMERGED

- Incidences and Outcomes
- Risk Factors
- Evidence-Based Strategies

THEORETICAL FRAMEWORK and SAFETY BUNDLE INTERVENTION

Incorporating care within the Patient- and Family-Centered Care Model

- Dignity and respect will be maintained throughout the postpartum hospital stay
- Participation from the family in all infant care will be anticipated and encouraged
- Information sharing will be offered between the healthcare team and the infant's family
- Collaboration will occur between the healthcare team and the family regarding the infant's care plan and decision-making

NICE CATCH!

Safety Bundle to Prevent Postpartum Infant Falls

- **N** — **Notice unsafe situations**: *Respond quickly to unsafe sleep and unsafe environment*
- **I** — **Infant Safety Agreement**: *Explain thoroughly the risk for infant falls while in hospital*
- **C** — **Continuous hourly rounding**: *Healthcare team performing diligent hourly rounding*
- **E** — **Educate parents and family**: *Reiterate safety education frequently and refer to wall poster for example*
- **C** — **Communicate with the healthcare team**: *Report safety concerns and near-miss catches*
- **A** — **Awareness of risk factors**: *Increase staff awareness of maternal risk factors*
- **T** — **Time for maternal rest**: *Offer two hours of uninterrupted Quiet Time each day*
- **C** — **Chart everything thoroughly**: *Document all education, interventions, near-miss catches, and falls*
- **H** — **Have a policy for an infant fall**: *Follow the Infant Fall Policy if a fall occurs*

CONCLUSIONS/DISCUSSIONS

An evidence-based safety program has the potential to improve the mother-infant couplet experience through decreasing fall rates and/or injuries and increasing parental satisfaction of postpartum care

Hospitals should consider using an evidence-based safety program to prevent postpartum infant falls

REFERENCES

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Janiszewski, H. (2015). Reducing the risk of baby falls in maternity units. *Nursing Times, 111*(28-29), 21–23.

Lipke, B., Gilbert, G., Shimer, H., Consenstein, L., Aris, C., Ponto, L., Lafaver, S., & Kowal, C. (2018). Newborn safety bundle to prevent falls and promote safe sleep. *MCN: The American Journal of Maternal Child Nursing, 43*(1), 32–37.

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Mulligan, C. S., Adams, S., Tzioumi, D., & Brown, J. (2017). Injury from falls in infants under one year. *Journal of Paediatrics & Child Health, 53*(8), 754–760.

CONTACT INFORMATION

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Kurtz_Sharon@roberts.edu

sigma_poster_sharon_kurtz.pdf (roberts.edu)

NICE CATCH! An Evidence Based Safety Program for Preventing Postpartum Infant Falls

Sharon Kurtz, BSN, RN

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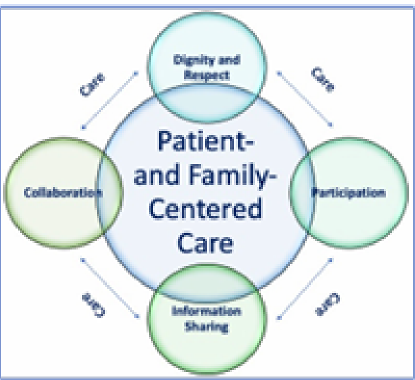
THREE THEMES EMERGED: Incidences and Outcomes; Risk Factors; Evidence-Based Strategies

THEORETICAL FRAMEWORK and SAFETY BUNDLE INTERVENTION



Incorporating care within the Pat[ient- and] Family-Centered Care Mod[el]

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NICE CATCH!

Safety Bundle to Prevent Postpartum Infant Falls

N — Notice unsafe situations
Respond quickly to unsafe sleep and unsafe environment

I — Infant Safety Agreement
Explain thoroughly the risk for infant falls while in hospital

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Kurtz_Sharon@roberts.edu

sigma_poster_sharon_kurtz.pdf (roberts.edu)

Near Misses: What and How to Measure

2013

> Nurs Womens Health. 2013 Jun-Jul;17(3):219-23. doi: 10.1111/1751-486X.12035.

Tracking 'near misses' to keep newborns safe from falls

Ann Slogar [1], Debra Gargiulo, Judy Bodrock

Preventing In-Hospital Newborn Falls

A Literature Review

Matteson, Tara MS, RN, CBS; Henderson-Williams, Audery MS, RN; Nelson, Jessica DNP, RN

Author Information

MCN, The American Journal of Maternal/Child Nursing 38(6):p 359-366, November/December 2013. | **DOI:** 10.1097/NMC.0b013e3182a1fb91

2017

Variation in management of in-hospital newborn falls: a single-center experience

Doron J. Kahn MD, Paul D. Fisher MD, and Dean A. Hertzler II MD

View More +

Publication Date: 19 May 2017
Page Range: 176–182
Volume/Issue: Volume 20: Issue 2
DOI link: https://doi.org/10.3171/2017.3.PEDS16651

2018

RESEARCH ARTICLES | SEPTEMBER 01 2018

Newborn Falls in a Large Tertiary Academic Center Over 13 Years

Jaspreet Loyal, MD, MS; Christian M. Pettker, MD; Cheryl A. Raab, RNC; Elizabeth O'Mara, BSN, RN, CNML; Heather S. Lipkind, MD, MS

2019

A System-Wide Approach to Prevention of In-Hospital Newborn Falls

Carr, Hester MN, RNC, CNS; Crotto, Joshua BSN, RN; Demirel, Shaban BScOptom, PhD; Fisher, Stephanie BSPH; Logue, Leona MN, RNC, CNS; Marcott, Meghan MSN, RN; Miller, Lacey Rose DNP, CNS, APRN, RNC-OB; Mochnal, Mar BSN, MBA, RN, NEA-BC; Scheans, Patricia DNP, NNP-BC

Author Information

MCN, The American Journal of Maternal/Child Nursing 44(2):p 100-107, March/April 2019. | **DOI:** 10.1097/NMC.0000000000000516

Newborn Falls in Pennsylvania:

An Analysis of Recent Events and a Review of Prevention Strategies

By Elizabeth Kukielka, PharmD, MA, RPh & Susan C. Wallace, MPH
DOI: 10.33940/falls/2019.12.5

2021

> MCN Am J Matern Child Nurs. 2021 May-Jun;46(3):161-167. doi: 10.1097/NMC.0000000000000708.

What a Catch: Safety Intervention to Reframe Newborn Falls and Drops

Nora P Knipper, Heather Condo DiCioccio, Nancy M Albert

2022

The Joint Commission Journal on Quality and Patient Safety
Volume 48, Issue 10, October 2022, Pages 521-528

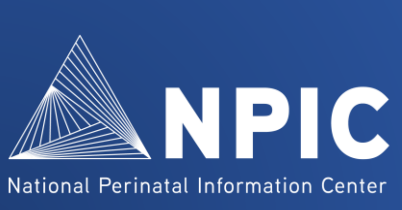
A Longitudinal Study of a Multifaceted Intervention to Reduce Newborn Falls While Preserving Rooming-In on a Mother-Baby Unit

DOI: 10.1055/s-0043-1764209 • Corpus ID: 257230501

In-Hospital Newborn Falls and Near Miss Events: A Need to Report

S. Unal, N. Demirel, +3 authors A. Bas • Published in American Journal of... 29 November 2022 • Medicine

TLDR In-hospital newborn fall may occur in the postpartum period, and near miss events should warn clinicians for a probable fall event.

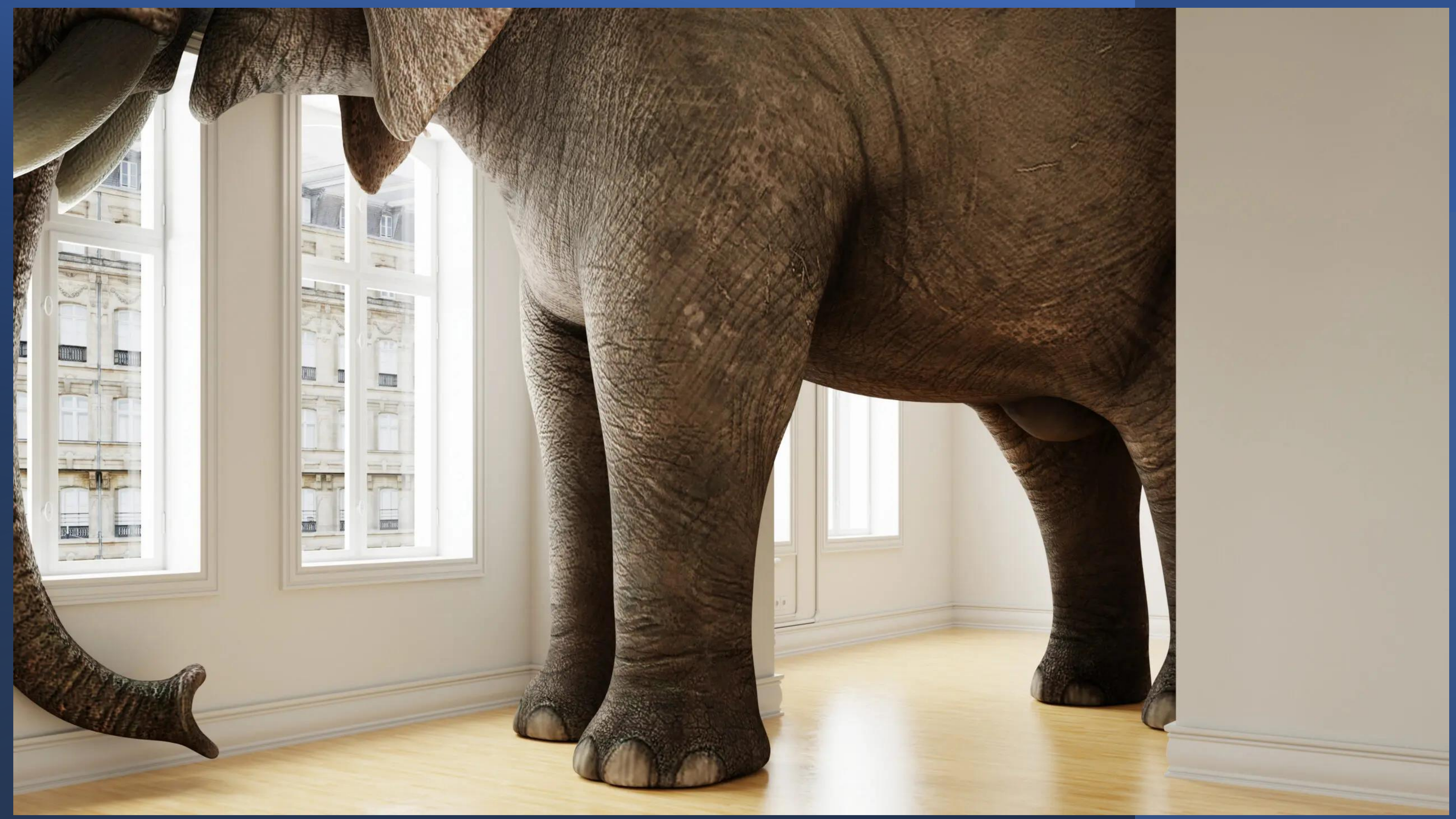


Near Misses: What and How to Measure

Common themes:

- There is not a common definition of a "near miss" for a newborn fall
- Most falls resulted from a parent sleeping with a baby in arms from a bed or chair
- Variation exists in care even within organizations
- Near-misses are woefully underreported

Take home message:
Define near-misses in your organization, track them, and initiate quality improvement initiatives to support near miss reductions



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 Cinncinati

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

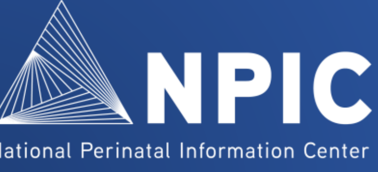
- *In this study of 136 nurses caring for 418 infants during 332 shifts, increased infant-to-nurse ratio during a shift was associated with increased missed nursing care in about half of the measured missed care items. When a measure of subjective workload was considered, the associations of ratios were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

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.***



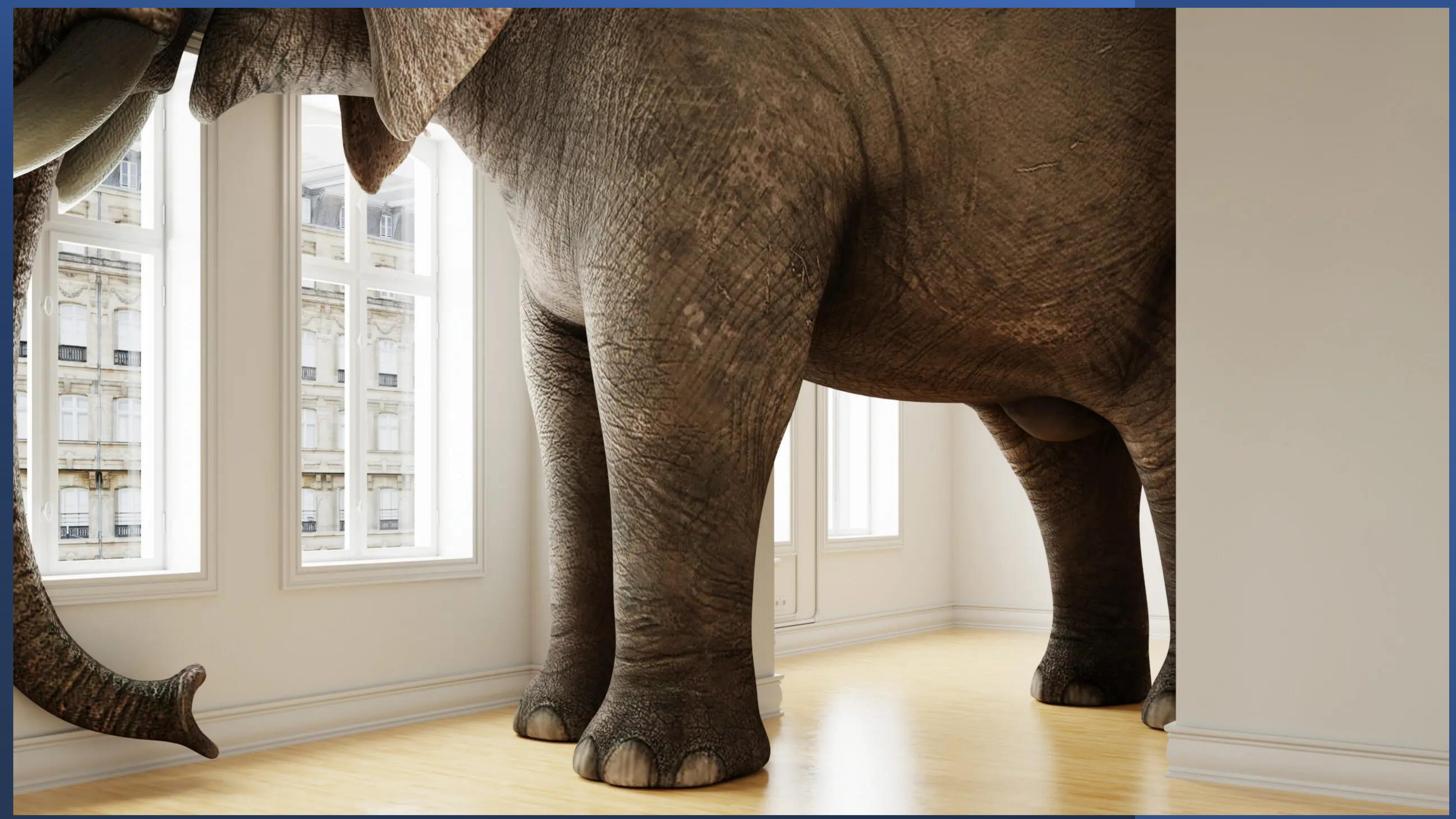
But Wait…You Forgot Mother/Baby and Postpartum!

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!

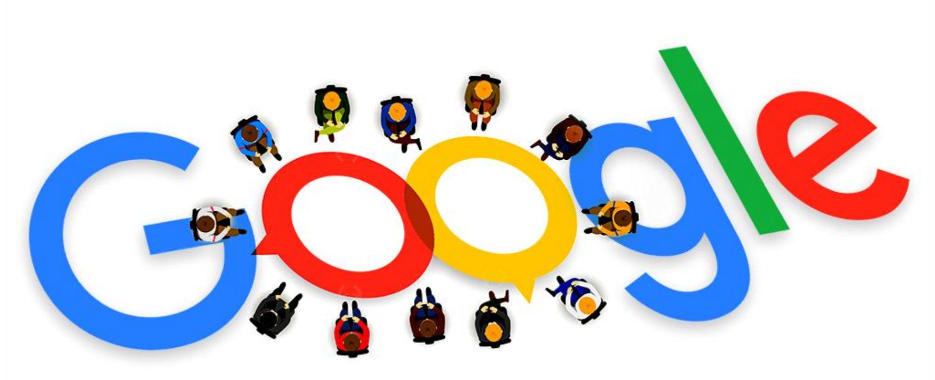
We need you to replicate missed care studies in Postpartum and Mother/Baby units to effectively study the issues surrounding newborn falls and missed care



Project Aristotle—2012

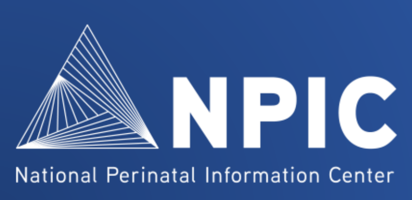
Study of 180 teams within Google that explored the most important elements of productive and enduring teams…

Team members feel safe to take risks and be vulnerable in front of each other



What Google Learned From Its Quest to Build the Perfect Team - The New York Times (nytimes.com)

Project Aristotle ... what Google learned from its quest to build the perfect team ... group dynamics, emotional intelligence and psychological safety - Peter Fisk



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

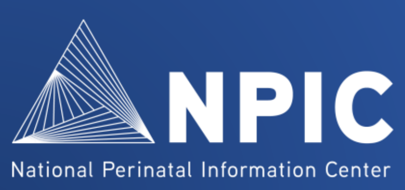
RESEARCH **Open Access**

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.



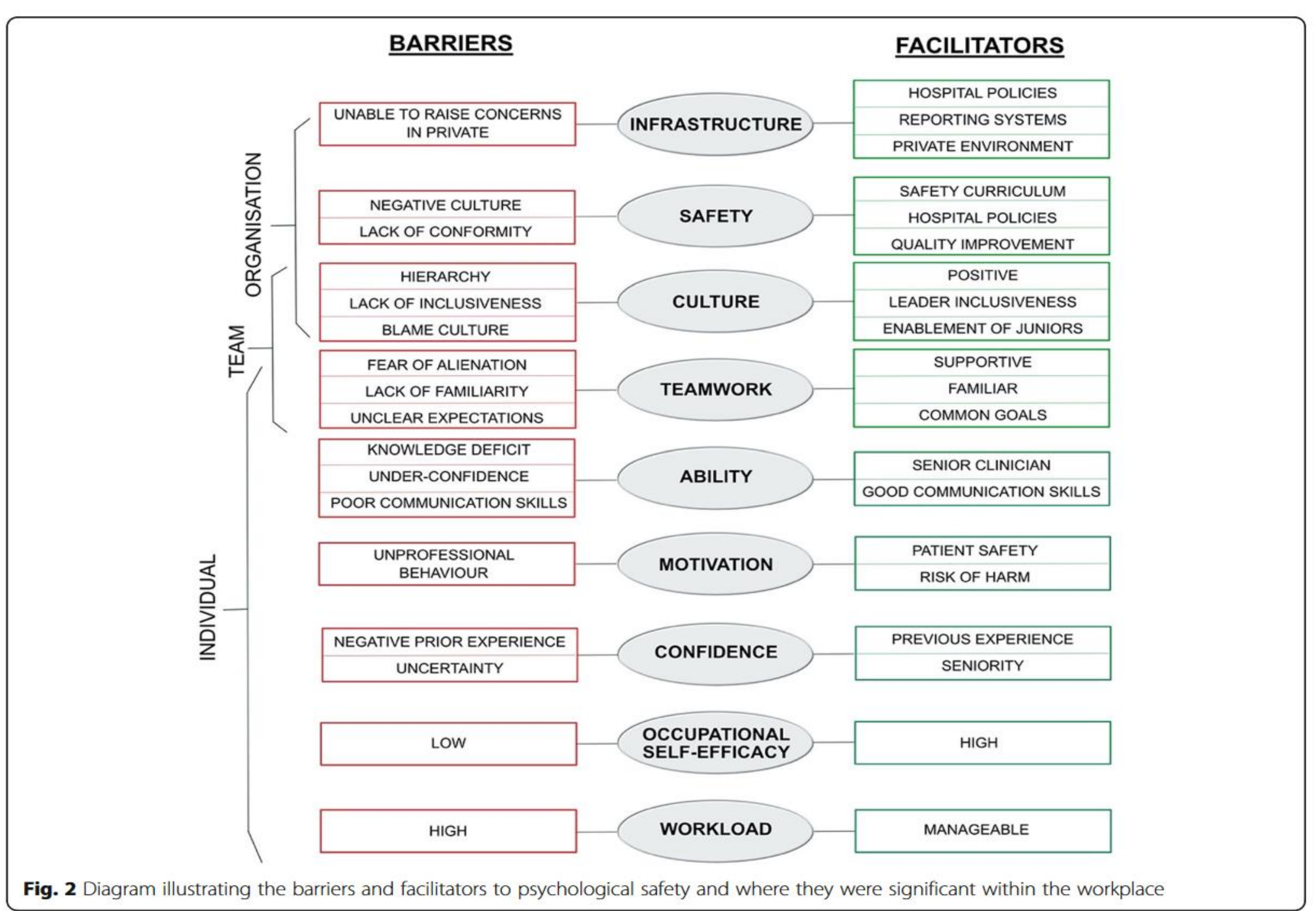


Fig. 2 Diagram illustrating the barriers and facilitators to psychological safety and where they were significant within the workplace

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)

Caring for the Staff

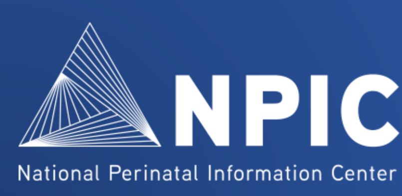
Caring for the Parent(s)

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/staff support component
- Frequent communication to the staff member(s) 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

CONTENT NOT FOR REUSE

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PARTING THOUGHTS...

M. Terese Verklan, PhD, CCNS, RNC, FAAN

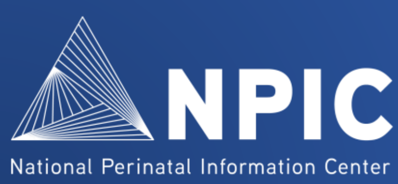
Newborns Are Falling?

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 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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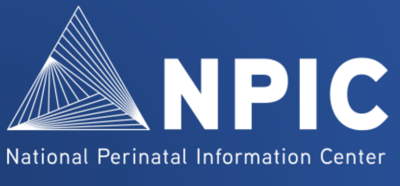

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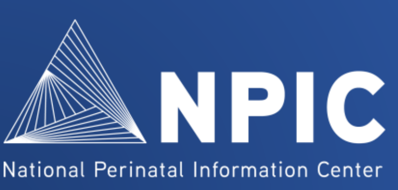
When was the last time you simulated postpartum hemorrhage? Severe hypertension? Sepsis care?

BUT!

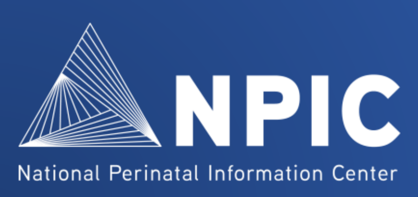
When was the last time you simulated high-risk transfer points for newborns?

Escape Room Simulation for Newborn Fall Risk



Overview of Part II

- Identify maternal/newborn fall risk assessments available
- Define near-miss events in your facility…track them and incorporate PDSA
- Patient education is one of the most often missed care elements in perinatal research
- Broadly share the Newborn Fall Risk Patient Care Bundle
- Incorporate staff support in any patient injury policy



Questions?

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