

BACKGROUND

Several years ago our hospital's infant fall/drop rate exceeded the 2014 national average for in-hospital fall rate by almost four times. The nation's most current best estimate of infant falls is 1.6-4.4 infant falls per 10,000 births. Therefore, approximately 600-1,600 newborns in the United States experience a hospital fall every year. Even in hospitals that track newborn fall/drops the events may be under reported (Hodges & Gilbert, 2016). In 2014, our hospital's "Risk to Fall Program" was not specifically meeting the needs of our newborns and their care. Since then we have developed a newborn-specific program. This included modeling and emphasizing safe sleep practices, parent and staff education, prevention and management of infant falls/drops in the hospital setting, while focusing on continuing Baby Friendly initiatives. Since the implementation of this program, and receiving national "Safe Sleep Designation," we have seen a Decrease in in-hospital infant falls/drops. Just by simply educating parents and staff the fall rate has decreased significantly, with the longest timeframe consisting of 30 months between an infant fall/drop.

DEFINITION OF INFANT FALL OR DROP

The National Database for Nursing Quality Indicators (NDNQI) defines both newborn fall 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." (Quick Safety, Issue 40).

OUR PROGRAM'S OBJECTIVES

- Increase awareness of the prevalence of in-hospital newborn falls/drops
- Increase awareness of the potential risks for newborn falls/drops as they relate to Baby Friendly initiatives
- Develop a standardized approach to newborn fall/drop prevention
- •Develop a standardized post-fall process for responding when a newborn fall/drop occurs



INPATIENT SAFETY: OUR JOURNEY TO IMPROVE NEWBORN FALL RATES DEBORAH A. DOYLE, MSN, IBCLC AND DONNA SOUZA, BSN, RNC-MNN



Comparison of Bayhealth Fall/Drop to National Fall/Drop Average



IMPLICATIONS FOR PRACTICE

Safe sleep designation: Staff and parental education, ongoing safe sleep audits, and parental literature provided.

Hourly rounding: Staff educated and made aware of the need for more frequent rounding on mother & baby dyads with risk factors.

Bed changes: All beds on the mother/baby unit changed (low beds, taller side rails that can be positioned with no openings and smaller space between the upper and lower rails).

Signs: Placed signage in patient rooms that read, "For the safety of your newborn PLEASE DO NOT sleep with your baby in bed or chair with you, place baby back into crib."

Parent education: Newborn fall prevention education given to perspective parents during quarterly unit tour, breastfeeding classes, parenting classes, and videos assigned to view during inpatient hospitalization.

Newborn fall protocol: Developed a newborn fall risk assessment tool and prevention measures. However realizing all newborns are at risk to fall or risk to be dropped assessment tool was not implemented. Prevention measures are carried out on ALL newborns. Created newborn safety welcome letter for parents, and post-newborn fall physician order set.

Cribs for Kids: Campaign started through a Delaware grant to provide a Pack 'N Play to parents that do not have a safe sleep space for infant in the home.

- Decrease in newborn falls/drops
- Last fall occurring June 5, 2019
- Longest duration without newborn fall/drop has been 30 months

With a significant decrease in infant falls/drops our focus became tracking near-misses. A near-miss can be defined as, "a clinical staff member observing unsafe infant sleep practice while completing hourly rounding."

Data collected from July 2018 to June 2019 resulted in 35 near misses with 1 infant fall/drop.

Where do we go from here?

- Develop consistent electronic documentation to track near misses and unsafe sleep practices.
- •Baby Friendly initiatives.





OUTCOME

CONCLUSION

• Maintain staff competency and engagement by providing SUID (Sudden Unexplained Infant Death) and safe sleep updates.

• Educate parents and ensure safe mother-newborn positioning during skin-to-skin contact and breastfeeding to align with



