Document Control

Title **Baby Falls – Management and Prevention: Standard Operating Procedure**			
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Directorate Women's and Children's			**Department** **Team/Specialty** Maternity Services
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1. Background

There will be occasions when a baby falls. A consistent standard of care is required This SOP has been developed in response to MHRA CAS Alert: NHS/PSA/RE/2019/002 https://www.cas.mhra.gov.uk.

2. Purpose

2.1. The Standard Operating Procedure (SOP) has been written to:

- Identify the procedure for the assessment and delivery of basic safe care when a baby falls.
- Ensure a consistently high quality of care for babies who fall.

3. Scope

3.1. This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the assessment and delivery of safe care on the wards:

- All Staff on Central Delivery Suite
- All Staff on Bassett Ward
- All Staff on Special Care Baby Unit

4. Location

4.1. All Northern Devon Healthcare NHS Trust premises.

5. Procedure content

5.1. Post Fall Guidance:

Falls may occur on the Maternity Unit or on the Neonatal Unit. On initial presentation following a baby fall:

1. If the baby is stable the nurse or midwife should perform a set of routine observations and inform the paediatrician after determining that the baby is safe and stable.
2. Inform the parents/carer as soon as possible if not present during the fall.
3. The neonatal doctor should be asked review the baby.
4. The neonatal doctor should take a detailed history from the nurse or midwife caring for the baby, and from the parents or people present at the time of the fall. This should include:
   - Who was caring for the baby at the time of the fall?
   - If the baby was being held at the time of the fall, who was holding the baby.
   - Time of the fall.
   - Time of reporting.
   - The position to which the baby fell.
   - An estimate of the height of the fall and the type of surface onto which the baby fell.

- The circumstances around the fall.
- Any witnesses to the fall. The last time a professional saw the baby prior to the fall.

5. The neonatal doctor should carefully document the neurological examination and any bruises or skin markings. These should be documented on a body map. An occipito frontal head circumference (OFC) should be measured and documented.
6. The doctor should note the mode of delivery and any bruising ascribed to the delivery on the body map to differentiate these from any other bruising.
7. The doctor should ensure that vitamin K was given at birth.
8. A neonatal consultant should be informed of the event as soon as possible to ensure that there is an appropriate care plan in place and to consider further treatment and investigations that may be required e.g. discussion with neurology team, appropriate duration of neuro observations, need for x-ray and/or CT scan.

All aspects of safeguarding the patient should be considered. The parents must be informed of this.

The Baby Falls Analysis Form (APPENDIX 1) must be completed.

The Neonatal Body Map (APPENDIX 2) must be used to identify and describe any injury.

6. Risk Factors and Prevention

Limited maternal mobility:

Mothers with limited mobility due to:

- low haemoglobin
- effective regional analgesia,
- severe perineal pain or
- following caesarean section

Mothers should be advised to use the call buzzer for assistance when wishing to mobilise or transfer the baby in or out of the cot. The call buzzer should be within easy reach of the mother.

Co-Sleeping:

Mothers should be advised about the risks of co-sleeping in accordance with the health promotion recommendations by UNICEF, 2019.

Overnight there is a recommendation for two hourly rounds, where a health professional observes the mother and baby to ensure they are sleeping safely. If a baby is found to be co-sleeping the mother should be woken and advised. With consent, the baby should be placed in the cot.

Cot sides:

The mother should be advised that there is no evidence that the use of cot sides prevents or reduces the risk of baby falls. There is the potential risk of strangulation of the baby between the bars of the cot side although there is no documented evidence.

Unrestricted View for Observation:

The actions and recommendations from a high level investigation into baby falls suggested that women should be encouraged to keep their curtains open around their bed. This will enable health professionals to observe them and their babies more easily and could reduce the risk of baby falls, particularly if safe sleeping recommendations are not being adhered to.

This does however, contrasts with the woman's need for privacy and dignity.

Where staff are concerned that a mother may require additional supervision and assistance with handling their baby (e.g. after administration of an opiate) the mother may be advised that her curtains remain open.

7. Ongoing Responsibilities

Ongoing Nurse or Midwife Responsibility

The nurse or midwife caring for the baby should inform the safeguarding midwife of the fall to ensure that there are no previously known safeguarding concerns, unless the baby was being held by a healthcare professional at the time of the fall.

If the history and examination are compatible with an accidental injury the baby should have 24 hours of observations, charted on the Neonatal Early Warning score observation chart. This should include documentation of concerns regarding irritability, lethargy and vomiting.

If there are any symptoms of altered neurological behaviour and urgent review should be requested from the neonatal team.

Ongoing Neonatal Team Responsibility

The neonatal team will respond to any concerns from the nurses or midwives regarding altered neurological behaviour.

A second examination should be performed at 24 hours including a thorough neurological examination and an examination for any new bruising, particularly on the head. A repeat OFC should be documented.

If during any examination there are findings consistent with a skull injury including bruising; depressed skull bones or injury unaccounted for by birth history, the need for a CT scan must be discussed with the Paediatric consultant.

Administration:

All babies who fall out of bed in hospital should have their own set of hospital notes generated.

All medical notes and observation charts for the baby should be filed in the baby's notes. A DATIX must be completed. The Baby Falls Analysis Form (APPENDIX 1) must be completed.

The community midwife/nurse caring for the mother and baby should be informed by the discharging midwife/nurse. The fall must be noted on the discharge summary on Trakcare.

8. References

1. Monson et al. In-Hospital Falls of Newborn Infants: Data from a Multihospital Health care System. Pediatrics2008; 122; e277
2. Helsley I, McDonald JV, Stewart VT. Addressing In-Hospital “Falls” of Newborn Infants. The joint Commission Journal on Quality and Patient Safety. July 2010;36(7):327
3. CO-SLEEPING AND SIDS - A GUIDE FOR HEALTH PROFESSIONALS, UNICEF 2019 https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/sleep-and-night-time-resources/co-sleeping-and-sids/

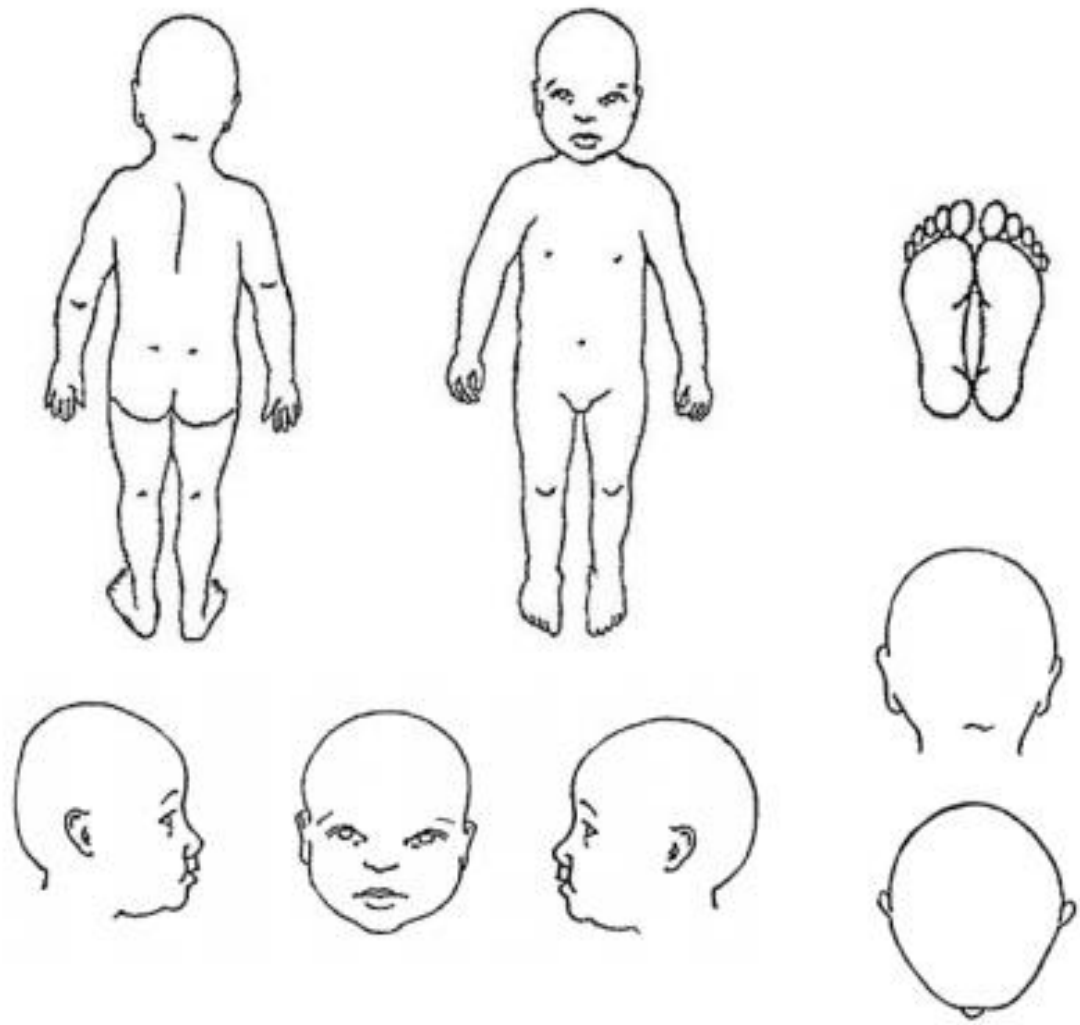
APPENDIX 1 Baby Falls Analysis Form

<table>
<tr><th colspan="6">Baby Falls Analysis Form</th></tr>
<tr><th colspan="6">Datix IR_____</th></tr>
<tr><td colspan="3">Infant Addressograph or ID details</td><td colspan="3">Maternal Addressograph or ID details</td></tr>
<tr><td>Date of fall:</td><td colspan="2"></td><td>Time of fall:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Clinical Concerns (baby) prior to fall:</td><td colspan="3">Clinical Concerns (mother) prior to fall:</td></tr>
<tr><td colspan="3">Injuries identified (Body Map Overleaf):</td><td colspan="3">Description of what happened:</td></tr>
<tr><td colspan="2">Occipito-frontal circumference at time of injury.</td><td>cm</td><td colspan="2">Occipito-frontal circumference 24hrs after injury.</td><td>cm</td></tr>
<tr><td colspan="3" rowspan="6">Clinical management required:</td><td>Was mother in a side room?</td><td>Y</td><td>N</td></tr>
<tr><td>Was mother in a bay?</td><td>Y</td><td>N</td></tr>
<tr><td>Were curtains around the bed?</td><td>Y</td><td>N</td></tr>
<tr><td>Was the baby ‘in arms’?</td><td>Y</td><td>N</td></tr>
<tr><td>Was mother asleep?</td><td>Y</td><td>N</td></tr>
<tr><td>Safeguarding concerns*?</td><td>Y</td><td>N</td></tr>
<tr><td colspan="3">Investigations required:
None X-Ray CT Other (Specify)</td><td colspan="3">*Please report Safeguarding concerns in line with the advice on BOB.</td></tr>
<tr><td>Nurse/Midwife</td><td colspan="2">Name</td><td colspan="3">Signed</td></tr>
<tr><td>Doctor</td><td colspan="2">Name</td><td colspan="3">Signed</td></tr>
</table>

APPENDIX 2 Neonatal Body Map

Infant Addressograph or ID details

Please label and describe injury:



Name:

Signature:

Designation:

Date: