LRI Children's Hospital

Accidentally dropped baby within the Children's Hospital guideline

Staff relevant to:	All UHL staff working within the Children's Hospital
Team approval date:	October 2023
Version:	2
Revision due:	October 2026
Written by:	R Joyce
Trust Ref:	C8/2022

Contents

1. Introduction and Who Guideline applies to

NHS England published a Patient Safety Alert in 2019 for the Assessment and management of babies who are accidentally dropped in hospital. The risks of accidentally dropping a baby are well known, particularly when a parent falls asleep while holding a baby; or when a parent or healthcare worker holding the baby slips, trips or falls. However, despite healthcare staff routinely using a range of approaches to make handling of babies as safe as possible, and advising parents on how to safely feed, carry and change their babies, on rare occasions babies are accidentally dropped.

National Reporting and Learning System (NRLS) for a recent 12 month period identified 66 babies had been accidentally dropped on paediatric wards, and two in mother and baby units in mental health trusts and 182 babies who had been accidentally dropped in obstetric/midwifery inpatient settings (eight with significant reported injuries, including fractured skulls and/or intracranial bleeds), Almost all of these 250 incidents occurred when the baby was in the care of parents or visiting family members.

The immediate response is vital to ensuring any injuries to an accidentally dropped baby are detected and treated as quickly as possible, but as automatic transfer of the baby to the emergency department is not always appropriate, clinical staff in these clinical areas need easily accessible practical advice in managing this situation.

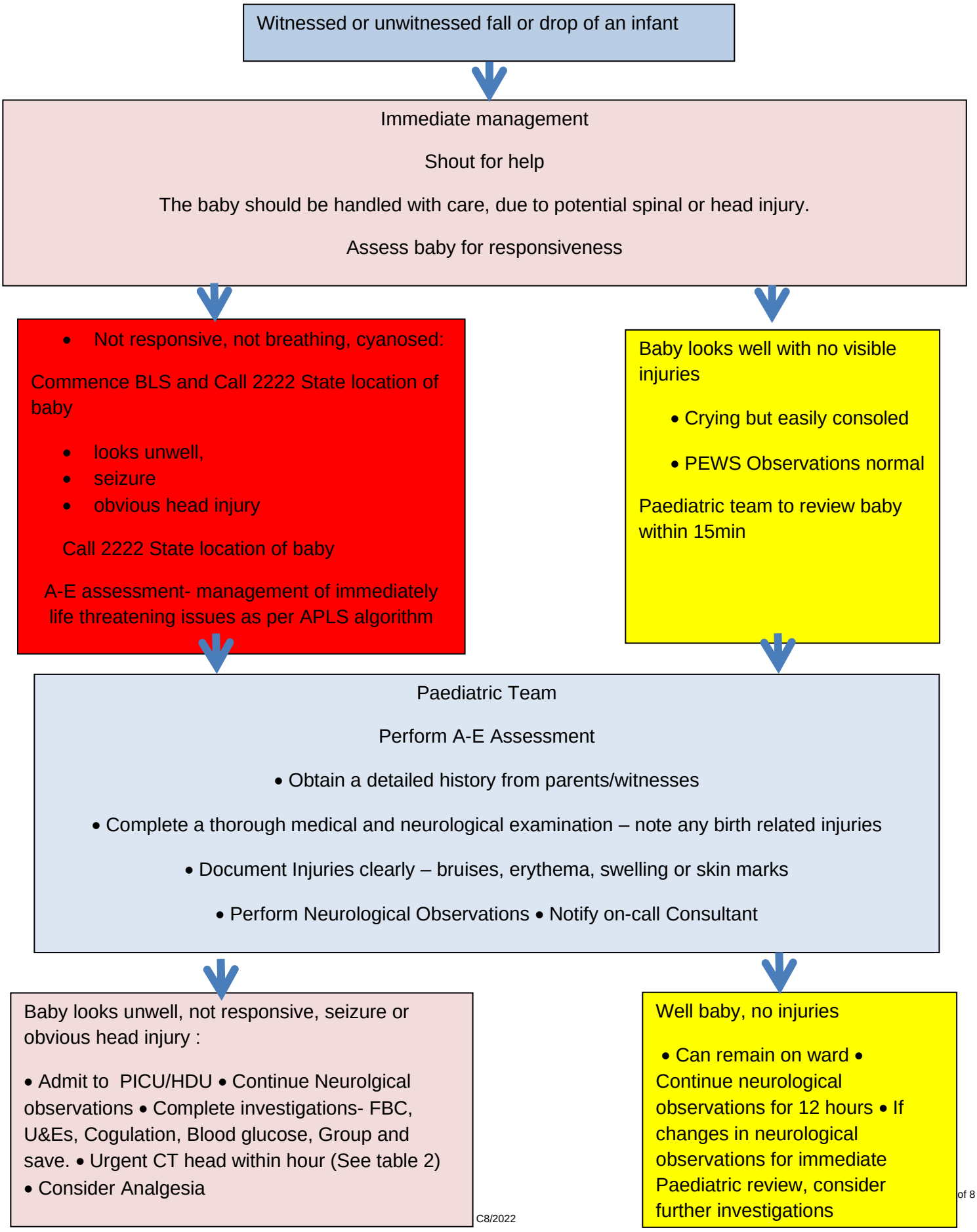
This guideline was developed from the document - Creating a local guide for assessment and management of dropped babies published by NHS Improvement in 2019.

This document provides guidance on how staff should respond after a baby is accidentally dropped by a parent, relative, visitor or healthcare professional, or slips from that person's hold or lap, regardless of the surface onto which the baby falls or if there are obvious signs of injury. This guideline is NOT to be used not for babies who are dropped at home, in public places or while visiting hospitals, as normal processes for accessing emergency care will be followed for these cases; nor for toddlers or older children who fall, as the risks of injury and clinical considerations in these groups will be very different.

For babies who are dropped on the maternity wards will be reviewed by the neonatal team, in these cases please refer to; Babies Who Have Been Accidently Dropped in the Maternity Unit UHL Obstetric Guideline

Related documents:
Neurological Observation Following Minor Head Injury UHL Childrens Nursing Guideline

2. Management following the drop or fall of an infant



Risk Factors associated with falls (BAPM 2020) (table 1)

- Co-bedding/co-sleeping while breastfeeding
- Impaired awareness of mother (e.g. fatigue/sedation/mobile phones/dim lighting)
- Impaired mobility of mother (e.g. epidural, post-surgery, disability)
- Primiparous mother
- Underlying maternal medical conditions (e.g. epilepsy, diabetes, disability, anaemia, high BMI)
- Social issues (e.g. young parents, single mother, drug misuse, language barriers)
- Time of day (e.g. night-time, limited family support outside visiting hours)

- Mothers and babies should not sleep in the same bed together
- If a mother has limited mobility, she should call for help when moving baby to and from the cot
- Cot-sides (if available) should be raised when the baby is in bed with mother
- Parents and visitors should not carry baby between ward areas without using a cot or pushchair.

Part 2: Initial stabilisation and assessment

In all areas on report of a baby falling, professionals should respond immediately.

If the baby is unconscious

If on initial assessment:

- The baby is unresponsive or
- The baby appears to be having a seizure or
- The baby has any obvious signs of external injury (any swelling over scalp /new bruise/suspected limb fracture/ clear fluid draining from nose or ear)

Commence APLS per ALSG guidelines.

An **Emergency call should be made on 2222**, requesting the Paediatric Team and giving the Precise location of the baby

The baby should be handled with care, due to potential spinal or head injury, and examined on a safe flat surface (Like a resuscitaire) and emergency equipment brought to the area.

If the baby is conscious

Physical examination and ongoing assessment of a child with possible traumatic brain injury must be quick and safe, and consists of key steps:

- Assessment of airway breathing and circulation.
- Evaluation of level of consciousness, and pupillary size and reaction to light
- Assessment of local traumatic injuries
- Full neurological examination and enhanced observations

The attending paediatric medical team should

1. Obtain a detailed history of the Fall including time, details of the fall, estimated height of fall.

2. Document if the fall was witnessed (and by whom) or unwitnessed
   The majority of drops are unwitnessed with limited history available to explain mechanism of injury. The vast majority are accidental. However clinical staff need to be alert to the possibility of non-accidental injury or an element of neglect in accidental drops. As such attention should be given to ensuring consistency of history, consistency between injury and the proposed mechanism of injury, any other associated injuries, and the wider social situation, safeguarding risk factors and information known by other agencies.

3. Complete a thorough medical and neurological examination checking for signs of injury

   a. Use body maps to document any bruises, erythema, swelling, or skin marks.

   b. Perform neurological assessment

   - Paediatric Modified Glasgow Coma Score
   - Anterior fontanelle and sutures,
   - pupil size, symmetry and response to light,
   - tone, power, primitive reflexes,
   - measure head circumference and plot.

   c. Decisions about severity of brain injury, management or prognosis should not be based on Modified GCS scoring alone.

   d. If any non-accidental injury (NAI) suspected, ensure baby is in a safe place, inform the attending consultant and agree management plan

   e. Spinal immobilisation is rarely useful, and is impractical (BAPM 2020).

Place of further Care

a. Babies under who are responsive, active or crying with no obvious signs of external injury can be managed on the paediatric ward with enhanced observations and regular review by the paediatric team.
b. All other babies (unresponsive, external injuries, abnormal neurological examination) must be admitted to PICU or HDU (as appropriate) for further assessment and management

Observations

Commence neurological observations immediately and continue for a minimum of 12 hours post-injury, as even with no apparent signs or extra risk factors, the risk of having or developing an intracranial injury is not zero (BAPM, 2020)

- *Paediatric Modified Glasgow Coma Score*
- *Anterior fontanelle and sutures,*
- *pupil size, symmetry and response to light,*
- *Muscle tone, power,*

- ½ hourly for 2 hours
- 1 hourly for 4 hours
- 2 hourly for 6 hours

Discontinue formal observations at 12 hours if GCS is equal to 14. If well, the baby can be discharged after 12 hours of normal observations.

If there are abnormal neurological observations at any point immediate review by a senior clinician is required to consider the need for admission and imaging, or whether return to ½ hourly observations is required.

Analgesia

Consider the need for analgesia as per UHL pain guidelines

Investigations

For babies in whom neurological observations remain stable, no further investigations are required

All babies who require PICU or HDU unit admission for clinical concern should have the following investigations undertaken

- FBC, U+E's, group and save, blood gas, clotting and blood glucose
- Urgent CT head scan if intracranial bleed/fracture is suspected (Table 2).

Indications for CT head imaging (Table 2)

Absolute indications:

Any one of the following

- Seizures
- Focal neurological deficit including asymmetric pupils, ptosis, unilateral weakness or posturing
- Loss of consciousness or unresponsive episodes
- Modified Paediatric Coma score < 14- on first assessment
- Any soft tissue injury (bruise, swelling or laceration) not present prior to fall
- Suspicion of non-accidental injury
- Suspected open or depressed skull fracture
- Tense/bulging fontanelle
- Any sign of basal skull fracture (haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign- a large bruise that extends across the entire backside of the ear, and it may also extend out to the upper part of the neck

Relative indications (urgent review and consider CT):

- Two or more of the following risk factors:
- Vomiting ≥ 3 episodes in 1 hour that is forceful/projectile
- Abnormal drowsiness or irritability >5 minutes
- Fall from height ≥ 90 cm
- If there is clinical suspicion of spinal injury, consider MRI head and spine instead of CT spine after discussion with specialist services

(BAPM 2020)

If CT imaging is indicated this should be performed and reported within an hour of suspicion of intracranial injury after stabilisation has taken place.

Evidence of injury on imaging

Any abnormality identified following CT scan should be referred for specialist advice as per

UHL Guidance. This includes neurosurgical referral as well as to determine the optimal location for ongoing care and management.

No Evidence of injury on imaging

Infants who have a normal CT head with no other clinical concerns should be considered for observation on the paediatric wards with neurological observations (See section Observations above).

The responsible paediatric consultant should be informed of all falls and drops, and a DATIX/adverse event form should be completed.

Communication

a. Parents: Ensure communication with parents (or caregivers) includes the provision of emotional support and information about the immediate plan of management

b. Staff: Debrief with staff involved as soon as possible after the event when baby assessed as stable. Ensure staff know to seek support from their line manager or other identified staff member

Care pathway - Discharge and follow up

Criteria

a. If observations are normal for 12 hours, the Tier 2 paediatric trainee or Consultant should review whether it is appropriate to discontinue observations and discharge.
b. When relevant, after further evaluation, with imaging and/or neurosurgical consultation as indicated, discharge should be appropriate if there are
    - No significant extracranial injuries
    - No safeguarding concerns

If either of the above are present, the timing of discharge may be delayed while further information is sought, or management is undertaken

Parent information

Give parents advice on preventing further falls.

Professional information

a. Community midwife and/or health visitor should be informed before discharge. Ensure a full discharge summary is sent to all professionals involved, GP, community midwife, and health visitor. Enter this episode in the child health record if available.

b. If there are any social concerns discuss with social services prior to discharge.

c. All infants who have had abnormalities on CT imaging:

- Neurosurgical follow-up should be as per the advice of the neurosurgical team
- If no neurosurgical follow up required, arrange follow up under a named consultant to monitor progress

3. Education and Training

None

4. Supporting References

British Association of Perinatal Medicine (BAPM) (2020) The Prevention, Assessment and Management of in-Hospital Newborn Falls and Drops A BAPM Framework for Practice.

https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/98/Baby_Falls_-_FINAL_VERSION_19-03-20.pdf

NHS Improvement (2019) Creating a local guide for assessment and management of dropped babies. https://www.england.nhs.uk/wp-content/uploads/2019/12/Supporting_information_-_management_of_babies_accidentally_dropped_in_a_hospital_FINAL.pdf

NICE (2014- updated 2019. Head injury: assessment and early management Clinical guideline [CG176] https://www.nice.org.uk/guidance/cg176/chapter/About-this-guideline

5. Key Words

Head injury, Neurological observations

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Ruth Joyce - Clinical Skills Facilitator	**Executive Lead** Chief Nurse
Details of Changes made during review: No changes	