Prevention, assessment and management of babies who accidentally fall or drop in the Maternity Unit

University Hospitals of Leicester NHS
NHS Trust

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Contents

1. Introduction and who the guideline applies to:

Definition;
"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. 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" (BAPM 2020)

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 new parents on how to safely feed, carry and change their babies, on rare occasions babies are accidentally dropped.

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 is based on the NICE guideline CG176 (2014) Head injury: assessment and early management and the British Association of Perinatatal Medicine (BAPM) (2020) The Prevention, Assessment and Management of in-Hospital Newborn Falls and Drops. It is aimed at all Health Care Professionals involved in the care of babies in the hospital setting.

Babies who are accidentally dropped at the stand alone Birth Centre at St Marys will need to be transferred to the Postnatal Ward at the LRI by ambulance as per the "Maternity Responsible Clinician, Referral, Handover of Care and Transfer" guideline.

Related documents;

- **Reducing the Risk of Sudden Unexpected Postnatal Collapse of the Newborn UHL Obstetrics Guideline.pdf**
- **Safer Sleeping and Reducing the Risk of Sudden Infant Death Syndrome LPT Midwifery and Neonatal Guidelines.pdf**
- **Breast Feeding Support UHL Obstetric Guideline.pdf**
- **Resuscitation at Birth UHL Neonatal Guideline.pdf**

2. Prevention

2.1 Risk factors: Based on (BAPM 2020)

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

2.2 Prevention

Assessment of birth parent and baby dyad for potential falls or drops whilst in hospital should be based on individual risk considering the risk factors listed above.

- Advice should be given verbally as soon as possible after delivery regarding safe positions to feed baby and safe sleeping recommendations (this must be repeated at postnatal checks)
- Advice on prevention of accidently dropping the baby should be given to parents on admission to the postnatal ward
- Parents should be directed to the information posters within the ward area
- Parents and babies should not co-sleep or co-bed
- Parents with, clinical risk factors should be advised to ask for help when wishing to transfer the baby to and from the cot
- Parents with clinical risk factors should be advised to leave the curtains around the bed open so that they can be observed more easily. The exception is when privacy and dignity is required
- Babies should be placed back into the cot if the baby is asleep and the parent is feeling tired
- Communicate assessment of risk between care givers at hand over
- Ensure parents can reach call buzzers, side rails and cots
- Lower bed to the lowest possible level before bringing a baby to the parent
- Bed sides (if available) should be raised when the baby is in the bed with the parent
- Cots must be used to transfer babies from area to area

3. Initial stabilisation and assessment following a baby being dropped

3.1 Assessment:

- Move the baby to a resuscitaire or another safe surface
- Urgent assessment of the baby must be performed as per national guidance (NLS). This includes neonatal observations including heart rate and respiratory rate
- Contact the neonatal team for urgent review. If the baby is unresponsive, the neonatal team should be bleeped as an emergency (2222).
- Babies who are accidently dropped at St Marys Birth Centre should be transferred in to the LRI by dialling 999 for an ambulance
- Keep the parents / carer informed of progress

Neonatal assessment:

If baby is conscious:

- Take a full history of the event
- Perform a full examination of the baby including a detailed neurological examination on the baby. This should be clearly documented in the notes of the baby.
- Measure the head circumference and compare with the initial head circumference (if performed).
- If there is a step-like deformity or evidence of a skull fracture, consider performing a CT scan. Discuss this with the neonatal consultant on service/call.
- Document any bruising on the body map.
- Discuss with parents regarding need for monitoring baby.
- Consider giving appropriate analgesia to the baby i.e. paracetamol.

If baby is unconscious:

- If the baby has altered consciousness or is unresponsive, cyanosed or not breathing then manage in accordance with neonatal resuscitation guideline

3.2 Following initial assessment:

- Document the findings in the notes of the baby and in the health care record.
- Baby will require neuro-observations half hourly for the first 2 hours and hourly for the following 4 hours following the incident.
- The baby will be admitted to the special care baby unit for these neuro-observations. If these are normal, the baby will require NEWTT2 observations 2 hourly for the next 6 hours, which can be performed on the postnatal ward. They can be stopped if they have been normal following this time interval.
- Check if there are any safeguarding issues please notify safeguarding team if there are.
- Complete incident form.

3.3 Actions if suspected injury or abnormal signs/observations

- Abnormal signs are babies who are excessively sleepy, poor feeding or not tolerating feeds, floppy or with excessive high pitched crying, seizures or abnormal movements.

- If there is a step-like deformity or evidence of a skull fracture, consider performing a CT scan (see appendix 1 for CT criteria). Discuss this with the neonatal consultant on service/call.
- If there are any concerns regarding possible bleeding, the baby would need to be transferred to the Neonatal Unit after discussion with the Neonatal Consultant on service/ call.

3.4 Ongoing observation and review where there is no indication for CT scanning or scanning does not reveal any injury

- Baby will require neuro-observations half hourly for the first 2 hours and hourly for the following 4 hours following the incident.
- The baby will be admitted to the special care baby unit for these neuro-observations.
- If these are normal, the baby can be transferred to the postnatal ward. They will then require 2 hourly NEWTT2 monitoring for the next 6 hours. They can then be stopped if they have been normal.
- Abnormal observations should be escalated to the Neonatal Team immediately
- Where a cot is unavailable on the Neonatal unit an individual management plan should be made.
- Should transfer to other areas be required follow Referral Handover of Care and Transfer UHL Obstetric Guideline.pdf

3.5 Discharge criteria and information to be provided

- Observations must have been normal for 24 hours following the incident; the baby can then be discharged home with advice to parents.
- The baby must have a final medical and neurological examination
- The baby should be reviewed by the neonatal team and if well, baby can be discharged.
- Full details should be documented in the child health record (red book) including the body map
- A Discharge summary must be done for the GP's reference
- No follow up is required if uncomplicated.
- Give advice for parents (see Appendix 2)

4. Education and Training:

No new skills required in order to implement this guideline
All neonatal nurses should have received training within their nurse training on how to perform neurological observations

5. Supporting References

NHS Improvement. (9th May 2019)"Assessment and management of babies who are accidently dropped in hospital"

NICE guideline CG176 (2014) Head injury: assessment and early management https://www.nice.org.uk/guidance/cg176 - updated Sept 2019

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

https://www.bapm.org/resources/161-the-prevention-assessment-and-management-of-in-hospital-newborn-falls-and-drops (last accessed 16/12/24)

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

6. Key Words

Head injury, babies, fall, dropped

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.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

Contact and review details			
Guideline Lead (Name and Title) Original Author: D Panjwani – Consultant & L Matthews Clinical Risk & Quality Standards Midwife			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
June 2019	**1**		New document
January 2022	**2**	**D Panjwani**	Minimal observations both on NNU and PN ward updated in line with 2020 BAPM guidance
October 2024	**3**	**D Panjwani** **L Taylor**	Risk factors and prevention updated in line with BAPM 2020

Appendix 1: Criteria for CT Scan (Only relevant criteria taken from NICE guidance)

1. **For children who have sustained a head injury and have any of the following risk factors, perform a CT head scan within 1 hour of the risk factor being identified**:

- Post-traumatic seizure
- Suspected open or depressed skull fracture or tense fontanelle.
- Focal neurological deficit.
- For children under 1 year, presence of bruise, swelling or laceration of more than 5 cm on the head.

A provisional written radiology report should be made available within 1 hour of the scan being performed.

Appendix 2: Discharge Information:

Give verbal and printed discharge advice to parents with any degree of head injury who are discharged from Maternity

Printed advice for patients, families and carers should be age-appropriate and include:

- Details of the nature and severity of the injury.
- Signs and symptoms to look out for that mean the baby need to return to the Childrens Emergency department
- Details about the recovery process, including the fact that some patients may appear to make a quick recovery but later experience difficulties or complications.