Summary of Infant Fall Prevention and Management  
Current Practices and Resources

Introduction

It is estimated that approximately 600 to 1,600 newborn in-hospital falls (hereafter referred to as infant falls) occur annually in the United States (Helsley, 2010). Discussion of this problem has only recently become part of the national patient safety dialogue, and there is limited research on infant falls reported in the literature. In November 2010, the Connecticut Hospital Association (CHA) convened the Infant Fall Prevention Work Group (hereafter referred to as the Work Group) to share knowledge and best practices on the subject, and to identify some key considerations for prevention and management in conjunction with the Connecticut Department of Public Health (DPH).

This document summarizes multiple content areas of Work Group discussions, and includes examples of current practices utilized to prevent infant falls. This document is also cited as a reference in the Guidance Related to Infant Falls Prevention and Management that articulates key consensus considerations agreed to by DPH and CHA as elements that may be incorporated into a hospital’s policies and practices. Neither document is intended to represent the full spectrum of possible practices or strategies related to the evolving area of infant fall prevention.

As hospitals are aware, development of infant fall prevention policies and practices is encompassed in Joint Commission standards that require hospitals to assess and manage patients’ risks for falls (PC.01.02.08) as appropriate for patient populations and setting, and to implement interventions to reduce falls based upon risk assessment. These materials are intended to co-exist with Joint Commission standards and guidance.

Education and Information for Parents/Family

It is important to inform parents, family members, and support individuals (i.e. friends, birthing coaches, doulas) accompanying the patient about the possibility of infant falls, explaining that they can occur, particularly when fatigued parents or others fall asleep with the baby in bed or in their arms. A variety of methods are used by hospitals as part of a standard process to inform parents and families about infant falls, their prevention, and relevant hospital procedures, including:

- Incorporation of information in packets of written materials provided pre-admission through physicians’ offices, pre-natal classes, or via regular mail.
- Incorporation of information within pre-admission material available on the hospital website or sent to parents via electronic newsletter.
- Signage/posters placed in patient/parent areas at the hospital.
- Parent/family teaching at the time of admission, or as soon as appropriate, dependent upon individual patient course, as determined by a registered nurse or other appropriate hospital personnel.

In addition to the education process for all parents/families that are, or will be, admitted to the maternity/birthing unit, information about practices to prevent infant falls is presented and reinforced by staff according to the plan of care that has been developed for parents and family.
Prevention of Infant Falls – Initial Assessment of a Mother Upon Admission to the Maternity/Birthing Unit

In conducting the initial assessment of a mother on admission to the maternity/birthing unit, information is ascertained with regard to factors that have potential to affect the risk of an infant fall. The nine factors listed below are included in the basic guidance for hospitals, and agreed to by DPH. These factors are not an exhaustive list, and hospitals may use other factors. A registered nurse, or higher-licensed individual such as an advanced-practice nurse, utilizes these and other factors as determined by hospital policy to conduct the assessment and develop the component of the plan of care related to infant fall prevention. Examples of how the plan of care may be used from information gathered through assessment are: a finding of a lack of experience with newborns may drive a plan element for specific teaching and support; a high level of sedation may result in an aspect of the plan that calls for more frequent observation, reassessment, and adjustment of timing with regard to breast feeding; and the presence of family support may generate a plan in which family members are educated and specifically engaged in helping to prevent an infant fall.

Infant Fall Risk Basic Assessment Factors

- Mother’s age, developmental status, previous experience with newborns
- Mental status/orientation
- Medication/sedation
- Level of fatigue
- Physical or mental disability/limitation
- Maternal history of substance abuse or positive prenatal drug screen
- History of falls (maternal or infant)
- Knowledge/understanding of care and safety information provided
- Family/significant other support
- Mother’s level of pain
- Maternal blood loss

Other Infant Fall Risk Factors that Practitioners May Consider in Assessment

- Positioning and mother-baby comfort during breast feeding
- Maternal obesity, which can affect ability to hold and position infants
- Specific issues that may create more fatigue such as a “fussy baby” or extensive schedule of visitors

Consideration of the Physical Environment

An aspect of assessment for fall prevention is the consideration of the physical environment. While there may be general actions hospitals can take toward creating a safe environment, (through room design or other factors), each individual patient may have specific situations to address as well, such as the presence of intravenous pumps, or other equipment and possible items in the room that may hamper ambulation or maneuvering with a newborn.

Prevention of Infant Falls - Development of an Infant Falls Prevention Plan

The component of the plan of care related to infant fall prevention flows from the initial assessment, and is adjusted as appropriate through subsequent assessments.

Education

The plan of care related to infant fall prevention includes provision of information to parents and family regarding the problem of infant falls and the hospital’s related policies and procedures. In addition, further education and reinforcement of this information is included in the individual plan of care, dependent upon the results of the initial assessment. As part of general education, some hospitals have instituted use of a “safety contract” or “pledge” for the prevention of infant falls that is signed by parents and family to validate awareness and understanding of the issue, and willingness to abide by certain safety practices (such as placing the newborn in the bassinet and not “co-sleeping”). Parent/family-specific
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education, based on assessment findings, might include reinforcement of expected safety practices at specific time intervals, or explanation with regard to plans ensuring staff are in attendance to assist in managing the infant until the effects of sedation are no longer a concern. Another example of specific education is additional instructional attention to how to safely hold and position an infant if assessment demonstrates this need.

Physical Environment

Managing the physical environment of parents/family to promote safety is part of the plan of care and may include interventions such as locking the bassinette to the side of the bed when mothers are breastfeeding, monitoring for obstacles that may hamper movement within the room, or limiting the number of visitors that may be in the room at one time.

Monitoring and Observation

The nature and frequency of monitoring and observation included in the plan of care are determined based upon the initial assessment and subsequent assessments that are conducted by a registered nurse or higher-licensed individual. Various types of assessment findings (for example, heavy sedation or physical disability) may result in a plan for increased frequency of reassessment by the registered nurse. Hospitals may choose to involve various members of the care team in carrying out monitoring and observation as appropriate to their scope of practice. Examples of observations/data collection agreed upon by DPH that may be conducted by licensed practical nurses and unlicensed assistive personnel are:

- Observation of mother/baby comfort, positioning and sleep status
- Patient reports of fatigue
- Vital signs
- Presence of family/visitors
- Presence of circumstances potentially elevating risk of falls (e.g. equipment in room, potentially dangerous interactions of family/visitors)

Managing Fatigue

Work Group discussion and commentary in the literature suggest that managing fatigue is significant to the prevention of infant falls. Some suggested interventions for incorporation into the plan of care include:

- Frequent checks/observation to view mother/baby comfort, positioning, and sleep status.
- Advising mothers/parents to pay close attention to when they may feel sleepy, and to call the nurse/staff at these times.
- Moving infants to the bassinet when mothers are drowsy or need to sleep, and reinforcing a “no co-sleeping” policy.
- Developing a plan/schedule of rest for mothers that involves undisturbed nap time and management of visitor time.

Post-Infant Fall Clinical Assessment and Management

While definitive and broadly disseminated evidence-based guidelines have yet to be established with regard to post infant fall management, some consistency in approach can be found through the literature, Work Group discussions, and expert consultation. This approach involves a physical examination, a period of observation with neurological checks, and imaging of the head if certain clinical symptoms are present.

In addition to the post-infant fall actions agreed upon by DPH as listed below, consideration must be given to compassionate care for parents, such that they are included in discussions as actions are taken to address the fall, and are supported as they deal with their concerns and emotions.

The following reflects information drawn from DPH expectations, consultation with Connecticut pediatric trauma experts, and the literature. If an infant falls in the hospital while in the care of the mother or a family member, prompt assessment of the infant shall be made.

Such prompt assessment/notification of the physician responsible for the infant shall include:

- If a mother or other family member, a licensed practical nurse, or unlicensed assistive personnel becomes aware of an infant fall, such individual should immediately notify a registered nurse.
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- The registered nurse will conduct a prompt assessment and ensure the notification of a physician responsible for the infant. In some hospitals, an advanced practice nurse or physician assistant may conduct an assessment and then notify the physician.
- Ultimately, the responsible physician will establish the subsequent plan of care, in terms of monitoring and potential diagnostic tests.

Considerations in Clinical Management

- An infant who has fallen in a face-down position should be turned over onto his/her back.
- There is no literature to suggest an infant should be immobilized or placed in a cervical collar, as neck injuries are uncommon in newborns that have suffered a fall. A cervical collar can have unintended consequences. If the collar is ill-fitting, the wrong size, or incorrectly placed, it can cause an airway obstruction.
- The responsible physician may conduct a physical examination.
- A 12 to 24-hour observation period with neurologic checks may be indicated.
- If clinical symptoms present, skull radiographs or CT scan of the head may be indicated.
  » Examples of indications for imaging of the head include: loss of consciousness of any time duration, evidence of seizure activity, crepitus, boggy scalp, bulging fontanel, abnormal behavior per parent or clinician opinion, change in feeding or sucking, and vomiting.
- The responsible physician may consider the inclusion of specific fall-related information/recommended activity in discharge instructions as appropriate.

Post-Infant Fall Debriefing/Evaluation

Hospitals should conduct a systematic review and evaluation of an infant fall to identify factors that may have contributed to the event. This debriefing and evaluation can assist the hospital to identify system problems and areas for improvement, as well as to provide support for those close to the event. Of particular importance with regard to the issue of infant falls is the capture of findings that can foster better understanding of causative factors and effective preventive practices.

As hospitals fulfill Joint Commission and CMS Conditions of Participation requirements to have organization-wide safety programs as part of their performance improvement activities, they may choose to incorporate infant fall prevention and related reviews within their safety and performance improvement programs.

References and Available Resources


- The Joint Commission requires that hospitals assess and manage patients’ risks for falls (PC.01.02.08) as appropriate for patient populations and setting and implement interventions to reduce falls based upon risk assessment. The Joint Commission also requires that hospitals have an organization-wide safety program as part of their performance improvement activities (LD.04.04.05).