Stop the Drop: Preventing Newborn Falls Through the Implementation of a Baby Drop Bundle

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BACKGROUND

- Between 600 and 1,600 newborns experience falls while hospitalized in the United States annually[1].
- Infant falls, characterized by an infant slipping from the arms of a parent, can have severe consequences and result in emotional distress for families and staff [2].
- Existing research primarily focuses on falls associated with caregivers and children in an inpatient setting, leaving a notable gap in evidence-based solutions that address the unique environment and needs of all pediatric patients cared for within a children's hospital.
- We conducted a literature review to identify risk factors associated with caregivers and preventative measures for newborn drops.

A review of the literature identified:

Risk Factors	Preventative Measures
• >2 days postpartum • C-Section birth • Recent pain medication use • Breastfeeding • Time of day • Statements of increased fatigue	• Support person present • Baby drop prevention education • Use of supportive device • Increased rounding • Promoting caregiver rest

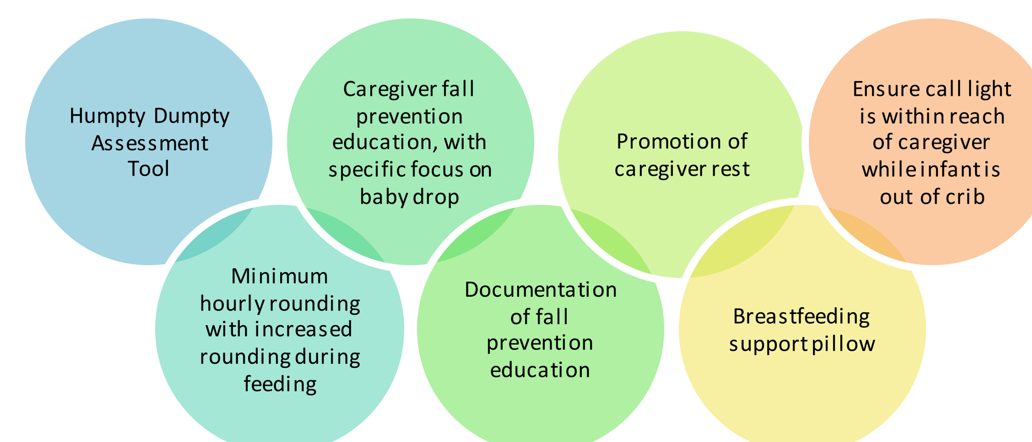
PURPOSE

- To improve the safety and well-being of newborns in our care, this poster presents the results of a quality improvement project at our freestanding children's hospital focused on preventing infants falls through the implementation of a bundled approach to care.

METHODS

- Conducted on a 48 Bed Medical Unit, April 2023
- Established a collaborative workgroup of healthcare professionals and experts.
- Evaluated and selected appropriate equipment and innovative approaches to enhance newborn safety.
- Provided staff education and training.
- Developed patient and family education handouts.
- Identified key evidence-based strategies and created a bundled-approach to care:

Inclusion criteria: Patients 30 days old or less



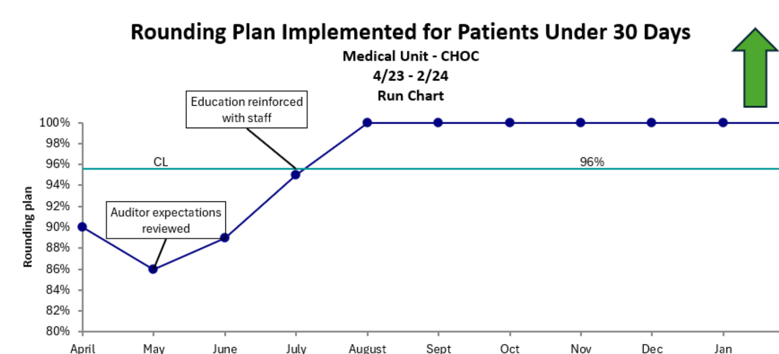
- Identified safe sleep champions to conduct compliance audits and identify opportunities for improvement.
- Utilized the Plan, Do, Study, Act (PDSA) model to facilitate iterative cycles of implementation and evaluation, allowing for continuous improvement.

Measurement Strategy

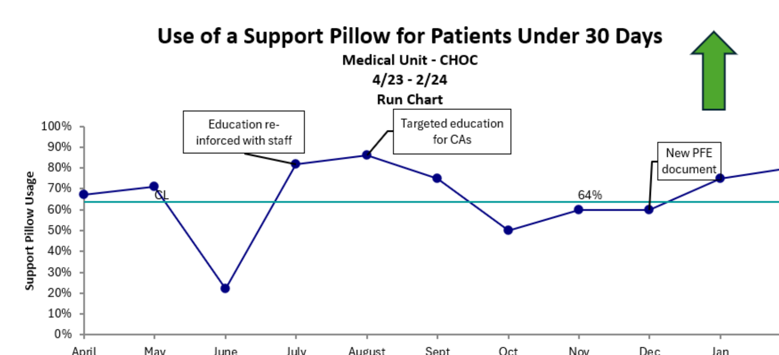
Outcome Measure	Process Measure	Balancing Measure
• Number of newborn drops	• Compliance with hourly rounding plan and proper usage of support pillows	• Near-miss events

RESULTS

- Since the implementation of a bundled approach to care, there have been no reported instances of newborn falls.



Compliance with the rounding plan has remained above the centerline.



Following implementation, there has been a decline in the use of support pillows by caregivers. The safe sleep champions identified an opportunity to enhance education.

- Patient and Family Education has been recently revised to include a visual of the support pillow and evidence-based practice statements for use.
- The balancing measure, tracking near-miss events, has recorded 7 cases reported since July 2023, indicating improved reporting and awareness.
- Data collected from this project is regularly reported to the hospital-wide falls committee to raise awareness and facilitate continuous improvement.
- Based on the success of the Medical Unit, house wide implementation occurred in May 2023.

CONCLUSIONS

- Lessons learned from this initiative highlight the importance of establishing a clear operational definition and streamlined process for reporting near-miss events to optimize patient safety.
- This project reinforced the need for constant awareness of staffing needs, particularly in detecting parental sleep deprivation, which can contribute to infant falls.
- Ongoing staff discussions promote a team-based approach and ensure a culture of safety within the institution.
- The successful house-wide implementation signifies the scalability and adaptability of a bundled approach to care.
- By prioritizing patient safety and fostering a collaborative process among healthcare professionals, we can collectively strive to reduce newborn falls, ultimately creating a safer environment for our most vulnerable patients and their families.

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