sentara nurse

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Preventing Newborn Falls in the Hospital Setting

Heike Nicks, MSN, RNC-LRN & Cindy Gagne, BSN, RNC-OB

SENTARA®

Introduction

Newborn falls include instances when a newborn falls from an adult bed/chair or is dropped by a caregiver onto a hospital floor accidently. Nationally, a disturbing trend surrounding newborn falls in the hospital has been noted. Historically, newborn falls have not been tracked in the same manner as adult falls, resulting in incomplete data. Because of under-reporting, falls are estimated nationally at 1.6 to 4.4 falls per 10,000 births (Hodges & Gilbert, 2015).

In 2016, the Maternal Infant Nursing Practice Forum (MINPF) system committee for Sentara Healthcare voted to add newborn fall data collection to the National Database of Nursing Quality Indicators (NDNQI) in the health system.

Background

Sentara Norfolk General Hospital Family Maternity Center (SNGH FMC) is part of a twelve hospital healthcare system located in Virginia and North Carolina. SNGH FMC has a birth rate of approximately 3,000 births per year. As a system, Sentara Healthcare reported 10 newborn falls in 2016. SNGH FMC alone accounted for 5 of the total falls.

After noting an increased number of infant falls, the Mother-Baby Unit Clinical Practice Council (CPC) chose newborn fall prevention as a safety and quality improvement project.

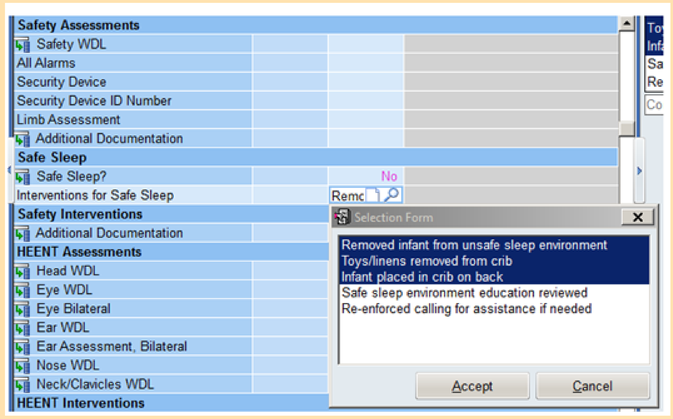
Methods

The Mother-Baby Unit CPC performed a literature search and identified interventions to prevent newborn falls. These interventions included:

- Implementing quiet time daily between 2 and 4 p.m. to promote rest of the new mother and family
- Educating mother and family on side effects of opioid administration
- Rounding every hour during the day and every two hours at night
- One hour post opioid administration with pain assessment and two hour situational assessment to ensure the safety of mom and baby
- Document every instance when an infant is found in an unsafe position
- Educating parents and family members of the importance of maintaining a safe sleep environment to prevent injury

Methods continued

The SNGH FMC Mother-Baby team proposed adding rows for documentation of safe sleep environment in the Electronic Medical Record (EMR). This suggestion was approved and implemented by the entire health system.



The MINPF team then created a sub-group to address newborn fall prevention at the system level for all maternity facilities. The group developed a staff education plan that included:

- Using poster as a teaching tool to reinforce safe sleep/infant safety with every parent and family interaction (See poster below)
- Reinforcing safe sleep row documentation in Epic
- Documentation of patient education and reinforcement of any unsafe situation is addressed and corrected
- Reinforcement of infant safety during rounds by managers, pediatricians, and the lactation team
- Utilization of the Patient Education Video system to ensure parents watch Safe Sleep Video

Findings

The safety assessment safe sleep rows were added to the EMR in August of 2016. The MINPF newborn fall prevention sub-committee implemented the poster and staff training plan in May-June, 2017. The initial work of the Mother-Baby Clinical Practice Council was elevated and shared with all Sentara hospitals providing maternity services.

Staff nurses used a literature review and successfully applied evidence-based interventions to impact patient safety. Key elements to maintaining a culture of safety included implementation of quiet time and standardization of patient education.

SNGH FMC Newborn Falls 2016	Jan 16	Feb 16	Mar 16	April 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	YTD
Total Falls	0	0	0	0	2	0	0	2	0	0	0	1	
Falls with Injury	0	0	0	0	0	0	0	0	0	0	0	0	5
SNGH FMC Newborn Falls 2017	**Jan 17**	**Feb 17**	**Mar 17**	**April 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sept 17**	**Oct 17**	**Nov 17**	**Dec 17**	**YTD**
Total Falls	0	0	1	0	0	0	0	0	0	0	0	0	
Falls with Injury	0	0	0	0	0	0	0	0	0	0	0	0	1

Conclusion and Implications

The eastern region of Virginia had the highest number of sleep related deaths in the Commonwealth. In 2016, out of 57 sleep related infant deaths investigated by the Virginia State Child Fatality Review Team, 32 occurred in the eastern region of Virginia (Norton, 2017). All efforts to eliminate newborn falls are founded in safe sleep. Infants must sleep alone, on their back, in a crib every sleep time. Nurses model safe sleep to parents in the hospital and repeat education as necessary to ensure a safe sleep environment.

In 2017, SNGH FMC had 1 newborn fall, and 2 falls total, system-wide. There have been no newborn falls reported, to date, since the implementation of this safety project in June, 2017.

It should be noted that in response to the opioid crisis, providers have limited the majority of postpartum opioid prescriptions to cesarean deliveries, thus reducing the amount of opioids given during and after the hospital stay. The reduction of opioid use may be an additional factor in the success of this project to date.

Acknowledgements

Tanisha Alston; Diana Behling, DNP, RN, MJ, CPPS; Sylvia Crawford, RN; Leanne Dahl, BSN Suzi Dunn, RN; ; Sharon Fickley, MSN, RNC; Dorothy Garrison, BSN, RN; Lori Holleman, MSN, RNC; Nikki Lowery, BSN, RNC; Kristine Montagna, BSN; Janel Moore, MSN, RNC; Grace Myers, MSN, CNS, RNC, NE-BC; Jennifer Toombs, BSN, RN; Mable Wallace, RT; Autumn Weaver, BSN, RN

References

Available Upon Request

Contact: hmnicks@sentara.com cmgagne@sentara.com