Brighton and Sussex University Hospitals NHS Trust

Assessment and Management of babies accidentally dropped in hospital

Maternity Protocol: MP074

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Contents

Key Principles:

A protocol is a set of measurable, objective standards used to determine a course of action. Professional judgement and clinical context should be considered in the application of a protocol.

Scope:

This protocol applies to

- All babies who are dropped by any person be it a member of staff, visitor or parent whilst in hospital. This is not applicable to those that are dropped at home or outside of hospital premises.
- It is not applicable to older children over one year who would follow the normal Accident and Emergency pathway in the event of a fall injury.

Responsibilities

Midwives, Obstetricians & Neonatologists:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure that protocols are available for service users on request

1 Rationale

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 majority of incidents were in obstetric/maternity inpatient units by mothers who were drowsy or asleep or accidentally lost hold of their babies. Some occurred on neonatal wards and others admitted from home as a result of an unplanned home delivery with a precipitate labour. A number of these babies suffered significant harm, fractured skulls, intracranial bleeding and seizures.

Recent surveys by NHS Improvements using the National Reporting and Learning System (NRLS) identified 250 babies accidentally dropped in 2017/18. 91% whilst babies were in the care of their parents or family members, 4% due to a precipitate birth, 1% during delivery with staff present, and 1% whilst the baby was being cared for by staff. The remaining 3% of reports of dropped babies were unclear.

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 need easily accessible practical advice in managing this situation.

2 Prevention

New parents can be very tired and advice should be given regarding not to fall asleep with babies in the bed or chair. Whilst in the hospital setting staff can support this by regularly reviewing women and help to place babies into the cots. This also supports the sudden infant death syndrome advice SIDS regarding co sleeping.
Parents should be advised not leave the baby unattended on a bed, sofa or changing table, even for a second, as they could roll off.

3 Management of a dropped newborn infant

This guideline is only targeting newborn infants that are dropped whilst on labour ward, postnatal ward or neonatal unit. Any baby that is at home or elsewhere outside the hospital setting fall under the responsibility of the children's emergency department (CED) for assessment.

3.1 Within the hospital settings babies should be moved either in the mother's arms on a bed/chair or in a cot for longer distances (i.e. from one level to another). They should only be carried for short distances.

3.2 Any inpatient newborn infant that has been reported to the staff as dropped must be immediately reviewed by a midwife, nursery nurse or neonatal nurse, a full set of observations should be taken and a neonatal doctor/ANNP should be asked urgently to attend for a full clinical assessment. If the infant is unconscious, unresponsive, cyanosed or not breathing a neonatal emergency 2222' call should be put out. The baby should be safely moved to the resuscitaire and have immediate resuscitation measures initiated according to the NLS algorithm.

3.3 Whilst waiting for the neonatal assessment the staff member present (midwife, nursery or neonatal nurse) should undertake neonatal observations; saturation level, heart rate, temperature and level of response to stimuli and record on the NEWS chart with a visual assessment and immediate treatment of any obvious injury.

3.4 If there is no available neonatal doctor/ANNP to review the baby, consider the use of a senior neonatal nurse. Consider transfer to the children's emergency department (CED) for assessment if a member of the neonatal team is not available

3.5 A full clinical and neurological assessment with a documented management plan and a history of the incident should be made by the neonatal doctor/ANNP in the presence of a parent and communicated to the allocated midwife if the assessment shows abnormal findings or there are any other concerns such as suspected non-accidental injury a senior neonatal doctor should be informed.

3.6 The baby may have to be admitted to the neonatal unit.

3.7 Medication and Vitamin K administration should be reviewed.

3.8 It may be necessary to have photographs taken of any injury sustained and stored in the notes for future reference

3.9 For a suspected severe head injury a CT scan may be ordered by a senior neonatal doctor dependent on neurological and clinical findings and considerations. (see 4. CT scan criteria). A cranial ultrasound scan may alternatively be considered by the neonatal doctor/ANNP in infants where the CT indications are ambiguous but this should not delay a CT scan if indicated. The indication needs to be discussed with the radiologist on call.

3.10 Dependent on the CT results further specialist advice/ possible transfer to the most appropriate place should be sought by the neonatal team including a senior neonatal doctor.

3.11 Infants that fulfill no indications for CT scan should continue to have regular observations by the midwife/nursery nurse as per the management plan made by the neonatal doctor/ANNP, the frequency and extent depending on the findings and observations already taken. If a skull fracture is suspected an X-ray investigation might be indicated.

3.12 The neonatal doctor/ANNP should continue to review these babies until reassured there are no sequelae before considering discharge home.

3.13 All dropped newborn infants should have normal observations for at least 12 hours prior to discharge and be discharged by the neonatal doctor/ANNP.

3.14 For infants that require neonatal follow up appointments should be arranged prior to going home.

3.15 On discharge parents should be made aware of any observational changes that they need to be concerned about and the where to seek advice / help taking into account the possibility of late presentation of intracranial bleeds.

3.16 The discharge summary/baby notes should contain clear documentation of the event and any injury the baby sustained treatment and follow up required for other health professionals involved with the family.

3.17 Complete a Datix

3.18 Communicate incident to social worker if patient known to them, clear documentation in the notes.

4 CT scan Criteria in line with NICE recommendations

The recommendations have been modified for the neonatal population

4.1 Suspicion of non-accidental injury (also see 6. Safeguarding Issues)

4.2 Post-traumatic seizure

4.3 Suspected open or depressed skull fracture or tense fontanelle

4.4 Any sign of basal skull fracture (haemotympanum, 'panda' eyes = periorbital ecchymosis, cerebrospinal fluid leakage from the ear or nose, Battle's sign = mastoid ecchymosis).

4.5 Focal neurological deficit.

4.6 For children under 1 year, presence of bruise, swelling or laceration of more than 5 cm on the head (in the case of a newborn infant consider that these may be birth injuries rather than related to the fall)

4.7 Fall directly on the head from more than 3ft (90 cm)

4.8 Clinically relevant observations/signs/circumstances as judged by neonatal doctor/ANNP (abnormal drowsiness, witnessed prolonged loss of consciousness, persistent vomiting, height of the fall)

5 Safeguarding Issues

Any suspicion of non-accidental injury should be escalated to the safeguarding team for further advice and investigation.

6 References

NHS Improvement; Patient Safety Alert; *Assessment and management of babies who are accidentally dropped in hospital* 9th may 2019

National Institute for Health and Care Excellence. (Nice) *Head Injury: Assessment and early management Clinical Guideline* (CG176) June 2017.

https://www.nhs.uk/conditions/sudden-infant-death-syndrome-sids/

https://www.nhs.uk/conditions/pregnancy-and-baby/baby-safety-tips/#falls-in-babies