Frimley Health
NHS Foundation Trust

The assessment and management of babies who are accidentally dropped or fall in hospital

Key Points

- This document provides guidance for the assessment and management of babies who are confirmed or are suspected of being dropped or sustaining a fall whilst in a hospital setting.
- If you suspect that the baby has sustained a serious injury or is unresponsive, put out a 2222 Neonatal Emergency call and commence resuscitation as per UK Newborn Life Support algorithm
- If the baby is moving and crying, move the baby to a safe surface with good lighting, such as the resuscitaire, for a full assessment, and a paediatrician should attend as soon as possible. The paediatrician should perform and document a neurological examination. Any bruises or skin markings should be documented on a body map.
- Any concerns must be discussed with the consultant paediatrician regarding the need for radiological investigation, such as CT scans, and further management.

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Abbreviations

CT scan	Computerised Tomography scan
NNU	Neonatal Unit
OFC	Occipital Frontal Circumference

Contents

1. Background

1.1 This document provides guidance for the assessment and management of babies who are confirmed or are suspected of being dropped or sustaining a fall whilst in a hospital setting. This includes how staff should respond after a baby is accidentally dropped by a parent, relative, visitor or healthcare professional, regardless of the surface onto which the baby falls or if there are obvious signs of injury. For practical purposes 'fall' and 'drop' are used interchangeably in this document.

1.2 The risks of accidentally dropping a baby include fractured skulls and intracranial bleeds. Newborn babies are especially vulnerable to head injury because of the relative weight of the head. Immediate response following an incident of a dropped baby is essential to detect and treat any injury (NHS Improvement, 2019).

1.3 If a baby sustains an injury (bruise or suspicious mark) whilst an inpatient that was not witnessed or reported by a health professional, parent, relative or visitor. Please follow the Bruising protocol 'Bruising in children who are not independently Mobile'

2. Initial assessment and stabilisation

2.1 Assessment

If you suspect that the baby has sustained a serious injury or is unresponsive, put out a 2222 Neonatal Emergency call and commence resuscitation as per UK Newborn Life Support algorithm. This includes abnormal movements or any indications of seizure activity, as well as babies that are floppy or have no movement. Once stable the baby should be admitted to the NNU for further investigation and assessment

If the baby is moving and crying, move the baby to a safe surface with good lighting, such as the resuscitaire, for a full assessment.

Initial midwifery/nursing observations to be recorded on the baby: temperature, pulse, respirations, oxygen saturation rate and behaviour response as per NEWTT chart.

Call a paediatric registrar or above to assess the baby urgently providing the information of the fall using the communication tool SBAR (situation, background, assessment and recommendation).

Paediatric response to a baby that is responsive, active or crying with no obvious signs of external injury:

1. The paediatrician should review the baby within 15 minutes of the fall

2. The paediatrician should take a detailed history from the midwife/neonatal nurse caring for the baby and from the parents or people present at time of fall. This should include:
    - who was caring for the baby at the time of the fall
    - if the baby was being held at the time of the fall, who was holding the baby
    - time of fall
    - time of reporting

- the position to which the baby fell
- an estimate of the height of the fall and the type of surface onto which the baby fell
- the circumstances surrounding the fall
- any witnesses to the fall
- the last time a professional saw the baby prior to the fall

The majority of drops are unwitnessed with limited history available to explain mechanism of injury. The vast majority are accidental. However clinical staff need to be alert to the possibility of non-accidental injury or an element of neglect in accidental drops. As such attention should be e given to ensuring consistency of history, consistency between injury and the proposed mechanism of injury, any other associated injuries, and the wider social situation and safeguarding risk factors

1. The paediatrician should perform and document a neurological examination. Any bruises or skin markings should be documented on a body map. An occipital frontal head circumference (OFC) should be measured and documented.

2. The paediatrician should note mode of delivery and any bruising ascribed to delivery on the body map to differentiate these from any other bruising.

3. The paediatrician should check that vitamin K was given at birth. If not given or administered orally, offer IM Vitamin K if no medical contraindications and document administration.

4. A neonatal consultant should be informed of the event as soon as possible to ensure there is an appropriate care plan in place, and to consider further treatment and investigations that may be required, e.g., discussion with neurology team, appropriate duration of neuro observations, need for x-ray and/or computerised tomography scan (CT scan). Any proposed care plan should be discussed with parent(s) and informed consent sought.

Babies under who are responsive, active or crying with no obvious signs of external injury can be managed on the postnatal ward with enhanced observations and regular review by the paediatric team. All other babies (unresponsive, external injuries, abnormal neurological examination) must be admitted to the neonatal unit for further assessment and management

2.2 Actions following the paediatric assessment and if baby is to remain on the Postnatal Ward:

- Keep the baby in hospital for a minimum of 24 hours from the time of fall
- Observations
  - Temperature, pulse, respirations, oxygen saturation and behaviour response as per NEWTT chart.
    - Half-hourly for 2 hours.
    - Then 1-hourly for 4 hours.
    - Then 2-hourly for 4 hours
    - Then 4-hourly for up to 24hrs

A second examination should be performed by the paediatrician at 24 hours including a thorough neurological examination and examination for any new bruising particularly on the head. A repeat OFC should be performed.

Staff to complete a RL incident form.

2.3 Actions if the baby is not stable or becomes unstable at any time:

Put out a 2222 Neonatal Emergency Team call.

The neonatal team should respond promptly to any concerns from the midwives regarding any subsequent altered neurological behaviour.

When clinically appropriate, transfer to the NNU by the neonatal team for observations (including neuro observations) and further management.

Any concerns must be discussed with the consultant paediatrician regarding the need for radiological investigation and further management. Indications for CT head imaging include (BAPM, 2020):

- Seizures
- Focal neurological deficit including asymmetric pupils, ptosis, unilateral weakness or posturing
- Loss of consciousness or unresponsive episodes
- Infant Coma score < 14- on first assessment
- Any soft tissue injury (bruise, swelling or laceration) not present prior to fall
- Suspicion of non-accidental injury
- Suspected open or depressed skull fracture
- Tense/bulging fontanelle A
- Any sign of basal skull fracture (haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign- a large bruise that extends across the entire backside of the ear, and it may also extend out to the upper part of the neck)

CT should also be considered if there are two or more of the following risk factors:

- Vomiting ≥ 3 episodes in 1 hour that is forceful/projectile
- Abnormal drowsiness or irritability >5 minutes
- Fall from height ≥ 90 cm

If there is clinical suspicion of spinal injury, consider MRI head and spine instead of CT spine after discussion with specialist services

2.4 Discharge criteria

Examination and neurological assessment must be undertaken by a paediatric clinician 24 hours after the fall and prior to discharge.

A copy of the body map must be provided for the parents, community midwifery services, health visitor and GP records. The discharge summary should include clear documentation of the fall, investigations and findings.

If there are any social concerns discuss with social services prior to discharge and ensure the Trust safeguarding team are aware.

The attending consultant should determine if any follow up is required and ensure arrangements are made if required. All infants who have abnormalities on CT imaging should have a follow up with a named consultant to monitor progress.

Advice for parents about signs to be aware of and any extra observation or checks they need to make, to be discussed on discharge.

If the baby is dropped by a healthcare professional or an individual acting on behalf of the Trust (e.g., a volunteer) both verbal and written Duty of Candour will need to be provided to the parents. The matron of the clinical area where the incident occurred must be informed immediately so that Duty of Candour requirements can be assessed and fulfilled.

3. Auditable standards

Completion of baby's observations
Baby examined by paediatric registrar or consultant Completion of RL incident form.

4. Monitoring

All cases of accidentally dropped babies in hospital will be reviewed by a senior midwife as part of the maternity department's patient safety processes. Where risk issues are identified the case will be reviewed in the maternity patient safety and quality meeting, with on-going management in accordance with the Trust risk management policies.

5. Communication

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the parent (and her partner, if appropriate) understand the actions and rationale behind them.

6. References

NHS Improvement 9 May 2019 Assessment and management of babies who are accidentally dropped in hospital

British Association of Perinatal Medicine (BAPM) (2020) The prevention, Assessment and Management of in-hospital Newborn Falls and Drops

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Nov 2019	Joyce Cruse, Inpatient Matron WPH Tanya Santacaterina, Inpatient Matron, FPH		
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Related Documents

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