

Indiana University Health

**The Unthinkable:
Using Risk Resilience to Eliminate Newborn Falls**


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Objectives 

- Describe how risk resilience is used to analyze newborn fall events
- Discuss prevention strategies for newborn falls

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Disclosure 

- I have no conflict of interest




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Patient Population and Hospital 

- Mother-Baby Unit caring for stable postpartum mothers and healthy newborn infants
- Indiana University Health Methodist Hospital in Indianapolis, Indiana
 - Delivers 3,000 infants annually
 - Urban Level One Trauma Center
 - Culturally diverse patient population
 - Baby-Friendly Hospital Designation

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Unit Environment 

- 26-bed unit
- Newborn nursery with rooming-in emphasis
- RN staffing ratio
 - 1:3 couplets 16 out of 24 hours per day
 - 1:4 couplets 8 out of 24 hours per day


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Event Analyzed based on Outcome 

- Incident rate is low due to lack of national reporting
- Oregon Patient Safety Committee demonstrated 1 fall per 2,500 births in a retrospective review
- Intermountain Healthcare System demonstrated 14 falls per 88,000 births
- IU Health Methodist Hospital demonstrated
 - 5 incidents within a 6-month timeframe
 - 5 falls per 1,481 births
 - Average of 62 days between events

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Analysis of Event



- Leadership initiated a tactical response to examine the failures in infant falls
- Reviewed variables of the 5 events to identify patterns
 - Age of mom
 - Weight and height of mom
 - Maternal gravida/para
 - Gestation and amount of prenatal care
 - Onset of labor and delivery time
 - Maternal medical history including smoking and/or drug use
 - Recent medication administration including narcotics
 - Breast or bottle fed infant
 - Maternal lab values of hemoglobin and hematocrit
 - Baby weight
 - Date and time of infant fall
 - Birth type
 - Epidural use
 - Maternal home medications

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Cross Analysis of Falls



Infant Falls on Mother-Baby					
	Mom 1	Mom 2	Mom 3	Mom 4	Mom 5
Age of Mom					
Weight of Mom					
Height of Mom					
Gravida/Para					
Gestation					
Prenatal Care					
Birth Type					
Epidural					
Onset of Labor					
Full Epidural					
Delivery of Infant					
Baby Weight					
Admission & D/C Dates					
Fall Date					

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Review of the Literature and Summary of Case Findings



<i>Risk Factors from Literature</i>	<i>Findings based on Risk Factors</i>
<ul style="list-style-type: none"> • 2-3rd post delivery night between 12 am and 9 am • Cesarean section • Received opioids • 18-28 years old • Breast feeding 	<ul style="list-style-type: none"> • 100% • 100% SVD • 40% received opioids • Average age 23 (min 15; max 27) • 80% breast fed

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Hidden Assumptions

- Co-bedding
- Baby-Friendly status not a factor
- Maternal fatigue a huge indication in the pattern of infant falls
 - Did not assume patient was able to realize or recognize their own fatigue
- Average BMI 35 (morbid obesity >30). Min 32 and max 43

Pre-designed Defenses

- Patient education "sleep safety"
- Bedside signage communicating the risks of falling asleep while holding a newborn

Keeping your baby safe
 After giving birth, you may not know how tired you are.
 You may be at risk for falling asleep when holding your baby. This may lead to your baby falling from your arms.
 Please place your baby in the crib anytime you feel tired or call us and we will help.

Strong or weak defense?

Pre-designed Defense

- Mother's nap time
 - Afternoon and/or night nap time
 - Verbal contract with patient for time to sleep with no interruptions
 - Privacy sign placed on door to patient room
 - Baby rooms-in with mother during nap time

Mother's Nap Time
 Please do not enter room. My mom and I are taking well deserved naps. If you have any questions, please see my mom's nurse.

Strengthening the Defense



- Students and RNs taught to recognize signs of fatigue and partner with mother to safely place the baby in crib
- Nap time initiated around the mother's need for sleep, not set intervals
- Shift safety huddles to identify mothers who might be at risk. Team heightened awareness of patients at risk.

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13

Pre-designed Defense



- Hired 5 student nurses (11 pm-7 am)
 - Mother's helper
 - Student nurses rounded during the night to identify mothers displaying signs of fatigue
 - Deliberate interventions with mothers when they became fatigued
 - Bed checks for infants
 - Sensitivity to mothers who were morbidly obese



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14

Highly Reliable Processes




- 311 days (as of 11/13/2012) without an infant fall
- Instead of "just an event," it is really about the nursing care we give
- Risk of infant falls now woven into culture of the unit
- Mindset: It is not going to happen again



11/28/2012

15

	<p>Thank you! Questions?</p>
	<p>Contact me at khodges3@iuhealth.org or 317.962.5322</p>

<p>References</p>	
<ul style="list-style-type: none">Galuska, L. 2011. Prevention of in-hospital newborn falls. AWHONN: 2/3: 59.	
