



Patient Safety Alert

Assessment and management of babies who are accidentally dropped in hospital

9 May 2019

Alert reference number: NHS/PSA/RE/2019/002

Resource Alert

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 babies¹, on rare occasions babies are accidentally dropped.

After a consultant neonatologist raised concerns about an increase in the number of accidentally dropped babies in his organisation, a search of the National Reporting and Learning System (NRLS) for a recent 12 month period identified; 182 babies who had been accidentally dropped in obstetric/ midwifery inpatient settings (eight with significant reported injuries, including fractured skulls and/or intracranial bleeds), 66 babies accidentally dropped on paediatric wards, and two in mother and baby units in mental health trusts. Almost all of these 250 incidents occurred when the baby was in the care of parents or visiting family members (see page 2 for details).

Review of these reports highlighted inconsistencies in the immediate review, investigation and observation of the babies for signs of neurological trauma.

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 in these clinical areas need easily accessible practical advice in managing this situation. NICE guidelines² provide the core advice on assessment and early management of head injury.

This alert provides a [resource](#) (see page 2) to support providers to develop or update a tailored local guide on the initial actions to take when a baby has been accidentally dropped. The resource includes information on how to apply the NICE guidelines and special considerations for newborn babies.

The British Association of Perinatal Medicine (BAPM), working with the Royal College of Midwives and the Royal College of Paediatrics and Child Health, is developing further resources to help staff and parents reduce the risk of babies being accidentally dropped; to reduce the risk of sudden unexpected collapse of babies in the postnatal period; and to provide further clinical advice on care processes if a baby is accidentally dropped. These resources will be available on the BAPM website (<https://www.bapm.org>).

Actions

Who: All organisations providing NHS-funded inpatient hospital care for babies aged under one year, including on labour wards, postnatal wards, midwifery-led units, paediatric and neonatal units, and mother and baby units in mental health trusts

When: To commence immediately and be completed by 8 November 2019

- 1** Identify a clinical leader who will bring together key individuals from maternity, neonatal, paediatric and emergency care to plan the implementation of this alert
- 2** Use the resource provided to develop or update local guidance for initial actions after a baby has been accidentally dropped; adapted for all types of local unit where babies receive inpatient care
- 3** Ensure all relevant staff are aware of the key messages in this alert and the new or updated local protocols/easy reference guides through routes such as team updates, newsletters, local awareness campaigns, etc
- 4** Ensure the new or updated local protocols/easy reference guides are included in local training, including staff induction

Sharing resources and examples of work

If there are any resources or examples of work developed in relation to this alert you think would be useful to others, please share them with us by emailing patientsafety.enquiries@nhs.net

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Patient safety incident data

We searched the NRLS for incident dates between 1 September 2017 and 31 August 2018, reported before 12 November 2018, initially within obstetric specialties and reported as 'slips trips and falls' in infant ages, or reported as any incident type or age and including the words [baby fell] or [baby slip] or [baby drop]. Using similar criteria (NRLS reference 4072) we then searched for incidents in other inpatient settings.

We identified a total of 250 reports of babies being accidentally dropped. 227 (91%) occurred when the baby was in the care of parents or visiting family members, 11 (4%) during precipitate birth, 3 (1%) during delivery when staff were present and 3 (1%) when the baby was being cared for by staff. Remaining reports were unclear on who had been holding the baby.

182 reports were from obstetric/midwifery inpatient settings, including eight with significant injury (two unclear; five fractured skulls, with intracranial bleeding confirmed in three of these; and one seizure). Most incidents in obstetric/midwifery units were the result of mothers accidentally dropping their baby or losing hold of their babies when drowsy or asleep. A further four babies brought to obstetric units had been dropped in unplanned precipitate deliveries at home without healthcare staff present; two had a fractured skull.

We also identified 66 babies accidentally dropped in paediatric wards and two in mother and baby units in mental health trusts. While no fractures were described among these incidents, babies typically landed on their heads and two injuries were reported as moderate harm. Most incidents in paediatric wards involved babies slipping from the grasp of parents who fell asleep while holding them or falling off surfaces, including cots without their sides raised or only partially raised, when parents glanced away for a second.

Resources

- Supporting information on creating a local guide for the assessment and management of babies who are accidentally dropped in hospital is available on the NHS Improvement website <https://improvement.nhs.uk/news-alerts/assessment-and-management-of-babies-who-are-accidentally-dropped-in-hospital>

References

- NHS Choices, Baby and toddler safety <https://www.nhs.uk/conditions/pregnancy-and-baby/baby-safety-tips/#falls-in-babies>
- NICE guidance CG176; Head injury: assessment and early management, last updated June 2017 <https://www.nice.org.uk/guidance/cg176>

Stakeholder engagement

- British Association of Perinatal Medicine (BAPM)
- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see improvement.nhs.uk/resources/patient-safety-alerts/)

Advice for Central Alerting System officers and risk managers

This alert asks for a systematic approach to deciding how your organisation will arrange for review and management of these babies, and therefore needs co-ordinated implementation rather than separate action by individual teams or departments. Neonatal, midwifery, paediatric and emergency teams will need to provide coordinated care for these babies. If you are unsure who will co-ordinate implementation of this alert, seek initial advice from the head of midwifery in trusts with maternity provision, the senior nurse on paediatric wards in trusts without maternity units, or the nurse in charge of mother and baby units in mental health trusts; they will be able to identify the key individuals needed to lead and co-ordinate implementation.

Acknowledgement

Many thanks to the following for their work on this alert and their agreement to develop additional BAPM resources:

- Julie-Claire Becher, consultant neonatologist, Edinburgh Royal Infirmary; BAPM
- Anoop Pahuja, consultant neonatologist, Chelsea and Westminster Hospital NHS Foundation Trust
- Helen Janiszewski, midwife researcher, Coventry University and Nottingham University Hospitals NHS Trust.