A Cross System Collaboration to Address Infant Falls

**Purpose for the Program**

Newborn falls and drops can be traumatic for parents, caregivers, and nursing staff. Concern over an increase in infant falls led to development of an interdisciplinary, system-wide collaborative team with the goal of developing a standardized evidence-based approach to decrease the incidence of infant falls/drops and provide a consistent response to a fall/drop within our hospital system.

**Proposed Change**

To develop an infant fall/drop algorithm to guide the care of an infant after a fall and review recommended interventions to decrease falls. The comprehensive algorithm includes moving the infant to a higher level of care based on the height of the fall and other clinical criteria.

**Implementation, Outcomes and Evaluation**

Nurse leaders engaged medical leaders from the NICU, level II nursery unit, and mother–baby unit during the algorithm development. The team created an order set for the electronic medical record to further guide care after a fall. Additional stakeholders reviewed the initiative before implementation. During the implementation of the algorithm and order set, interventions aimed at fall risk reduction also took place. A review of infant falls/drops that occurred since the implementation indicates that the algorithm and order sets are being followed as designed.

**Implications for Nursing Practice**

Nurses are critical in creating environments and programs to improve patient safety. This initiative (led by nurse leaders) engaged interprofessional stakeholders and nursing staff, who created change across the hospital system that started with an increase in concern and trends related to infant falls/drops.

A Strategy to Prevent Infant Abduction Using a Green Pass System

**Purpose for the Program**

To prevent infant abduction by ensuring the last step of the discharge process is the removal of the infant security sensor, which should only be done immediately before exiting the unit.

**Proposed Change**

Infant security sensors were not being removed immediately before discharge but instead were removed randomly during the discharge process. This gap in practice left the infant vulnerable to abduction. The last step in the sequence of a discharge process is to provide the parent with a green pass to present upon exiting the unit, at which time the security sensor is removed.

**Implementation, Outcomes and Evaluation**

We created a green pass as a tool to be attached to the footprint identification record. Upon completion of the multifaceted discharge process, the nurse provides the parent with a green pass. The green pass symbolizes that all discharge processes have been completed. The parent presents the green pass upon exiting the unit, and the security sensor is removed at that time. Only upon presentation of the green pass to a staff member should the security sensor be removed and the infant be allowed to exit the unit. Since the implementation of the green pass, no infants have been discharged without the completion of the multifaceted discharge process.

**Implications for Nursing Practice**

Use of a green pass is an effective preventative strategy against infant abduction and a visual indicator that the discharge process is complete.