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Patient Safety Tip of the Week

December 20, 2011 Infant Abduction

In our November 17, 2009 Patient Safety Tip of the Week "Switched Babies" we noted that, for at least the last 10 years, most hospitals have had fairly sophisticated systems in place to avoid infant abductions and to respond promptly if one occurs. And most hospitals feel confident with those systems.

However, all it takes to shake that confidence is reviewing an infant abduction that takes place elsewhere. You'll find yourself saying "Wow. I wonder if that could have happened here."

Every year about this time the California Department of Public Health releases a report on significant incidents that have taken place in California hospitals. We read them, not to see which hospitals have had such events, but rather to look at the root cause analyses (RCA's) that were done. There are so few publicly available RCA's yet the lessons learned from them can be very powerful and applicable at hundreds of other hospitals. In the group released this year, one dealing with an infant abduction really got out attention.

Briefly, an individual dressed in scrubs entered the room of a mother and newborn, identified herself as a student nurse and told the mother she needed to take the infant to be footprinted. The individual was able to completely exit the hospital with the abducted infant in a large handbag/tote.

When a real hospital nurse entered the room and found the bassinette empty except for the intact infant security band, a "Code Pink" was immediately initiated.

Authorities were able to reconstruct the movements of the abductor through review of various surveillance videos and the individual and the infant were eventually tracked down because the parking lot attendant wrote down the license plate number when she had no money to pay her parking fee.

But as you read through the health department's description of the incident and contributing factors and the hospital's plan of correction you will likely find yourself saying "that could have been us".

The abductor had been seen on the mother infant unit (MIU) on at least 3 consecutive days prior to the abduction. Each time she was dressed in a nurse's uniform or scrubs. When asked by staff what she was doing there her reply was "visiting a friend" but no one apparently ever questioned who the friend was. There was no security guard on the

unit at the time and apparently no access control policy. The video surveillance system was not actively monitored but rather only used for retrospective viewing if the need arose. There were also apparently multiple points of potential entrance and egress to and from the MIU (including stairwells, elevators, etc.). The stairwells were not equipped with door alarms or one-way locks to restrict access to the MIU. And the only alarm system would be triggered by the infant security band (a tag transmitter band), which had been removed intact in this case. An alarm would also be triggered if this security band is broken but in this case the abductor was able to remove the security band from the infant's ankle intact.

Apparently, nursing staff were expected to serve as the access control mechanism but there was apparently suboptimal training for that. Additionally, when all nurses were busy there would be no one accountable for access control. There was also no signage identifying the unit as having restricted access and requiring visitors or non-authorized personnel to check in at the nurses' station. The facility did have a visitors' hours policy but it was seldom enforced (the event took place outside of the visitors' hours in that policy).

Nurses on the MIU wore the same uniform and standard hospital badge used by all other nurses in the hospital. There was no distinctive feature that identified them as belonging on the MIU. Similarly there were no distinctive features that would identify personnel who could transport an infant in the hospital.

The hospital did regularly conduct drills on their "Code Pink". In fact, they did 4 in the two years prior to the incident. In each of those 4 drills, the "abductor" was able to successfully exit the facility. Numerous drill evaluations were either incomplete or identified items needing improvement but lacked verification that those items were corrected.

The hospital's "Code Pink" response began with notification of the switchboard by dialing "599" and giving a specific location. The switchboard operator would then send out a group page. This was apparently a "silent" page that would be delivered to designated cell phones as a text message. There apparently was no hospital-wide overhead page or alert given. If cell phones were not operational, no message would be delivered.

The "Code Pink" policy did have specific assignments for staff on the various units. Security would respond to the location, call 911 and notify the security manager and VP of facility management. Facilities management staff would meet at a designated location and be assigned to various posts throughout the facility. And although the policy stated that all possible suspects would be stopped and detained, there was no formal training on what to look for, what a "possible suspect" looked like, and what to do if they stopped someone.

In the actual event, the request did go to the switchboard operator to send out the silent alarm. However, several attempts failed to get out the specific message. Apparently prior discussions about scripting messages for the operators had never been followed up on.

The adjacent parking structure was operated by an independent company. None of the parking attendants, nor the valets who sometimes parked cars for patients and visitors, had ever been included in training for "Code Pink" events. Fortunately, the parking lot's own procedures for dealing with patrons unable to pay included writing down the license plate number and that facilitated finding the abductor and infant.

There was also no documentation that parent awareness training (including infant security and safe transportation guidelines within the hospital) had taken place.

There were also apparently 26 hospital exits in all.

The **hospital response** included multiple interventions to control access. These included better signage restricting visitors and unauthorized persons, institution of greeters, more strategically located security guards, and visitor logs and visitor badges. They also added alarms and locking devices for stairway doors and redeployed surveillance video cameras. They educated staff, including warnings not to let others "tailgate" them as they exited elevators to restricted areas and educated the community about new security issues in the hospital. They issued unique identification badges to identify staff working on special units like the MIU.

They also instituted procedures to verify tight fit of the infant security bands and switched to a new security band that can be tightened if the infant loses weight.

They made their "Code Pink" policies more in keeping with the NCMEC (National Center for Missing and Exploited Children) guidelines for missing/abducted children, redid their messaging system and redid their lockdown procedures, including the parking facility in those lockdown requirements. The parking lot staff and valet parking staff were also included in "Code Pink" training and responses.

They standardized written education materials for parents on infant safety and included information on infant security in pre-natal materials to give to parents prior to their labor and delivery. They also developed ways to use the EMR for more detailed description of infants (birthmarks, eye color etc.) and developed policies on holding cord blood for DNA testing, if necessary.

Code Pink drills were also improved by adding specific observers and development of standardized forms to be filled out by observers.

So, do any of these factors apply to your facilities and organizations? We see many recurrent themes that occur at multiple hospitals:

- Hospital switchboard operators are so critical to a variety of different "codes" yet their involvement and training is often an afterthought.
- Bringing non-hospital personnel into training for your "codes" is often overlooked (see our October 25, 2011 Patient Safety Tip of the Week "Renewed Focus on MRI Safety" for another example of how failure to integrate hospital and non-hospital personnel into safety issues can be problematic).
- Take a few minutes some day and see how many non-employees have access to your facilities, including "restricted" areas.
- Do you really have an access control system in place?
- How many of you thought that your infant security bands were "failsafe"?
- How difficult would it be to slide off an infant security band intact?
- Do you have systems in place that ensure action items identified in reviews of your various drills actually get incorporated into you policies, procedures and practices?
- How do you deploy observers for your drills and what do you have them look for?
- When do you educate your moms (and dads) on security issues related to newborns?
- Are you sure that moms understand (i.e. that medications have not impaired their ability to understand)?
- Do you have some special means of identification of personnel who should have access to your restricted units?
- Do you have too many entrances and exits in your facility that could be accessed without an ID badge or other device?
- Would you allow a visitor to bring a big tote bag or duffle bag into any area of the hospital?

The Joint Commission issued a Sentinel Event Alert in 1999 that identified root causes in cases of infant abductions from hospitals and made numerous recommendations for steps to prevent such. Among those recommendations were attaching secure identically numbered identification bands to the baby (wrist and ankle bands), mother, and father or significant other immediately after birth. In addition, the footprint of the infant and a color photograph of the infant are recommended. Some hospitals also use a fingerprint of the mother in the identification process. Prompt recording of the physical examination of the infant is also useful in the identification process (eg. recording of birthmarks may be very helpful in correct identification). Code Pink policies also include conspicuous identification badges for all staff members, good security/surveillance of all access and exit sites, and high tech infant security tags and alarm systems. Note also that you may wish to modify your "Code Pink" policy to also include patients who have eloped or are otherwise missing (see our July 28, 2009 Patient Safety Tip of the Week "Wandering, Elopements, and Missing Patients").

Education of both staff and the family are important in preventing infant abductions but should also be extended to help prevent incorrect identification of infants. When

providing such education to mothers and family, it is important to assess their level of understanding. It is wise to do that education twice with the mother, once in the days or weeks just prior to anticipated delivery and then again immediately after delivery when the ID tags are being placed. You need to keep in mind that the mother's cognition may be impaired by drugs used during labor and delivery and she may not fully comprehend what she is being told at that time. In any case, the identification process should be reinforced on every interaction between mother and baby and staff.

The hospital's plan of correction in the current incident also relied heavily on information and recommendations from the National Center for Missing and Exploited Children.

While we previously had thought that doing a FMEA (failure mode and effects analysis) on the possibility of switched babies was likely to be more fruitful than doing one on infant abduction, this incident raises so many questions about potential vulnerabilities that it is a great topic for a FMEA.

Are you really sure this couldn't happen at your facility?

Update: See also our September 4, 2012 Patient Safety Tip of the Week "More Infant Abductions".

References:

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