

Quality Improvement Activity: Transporting Patient

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

On October 12th, 2001, a mother had just delivered her baby and was being transported into the postpartum unit with her child in her arms. The delivery had taken over 36 hours from start to finish, so the mother was extremely exhausted. Unfortunately, her husband was away at war and her family lived far away, so there was no one to help her with the child except for the nurses. The night before her discharge, the mother rested between the time the nurses came in to check her and her baby, but on one occasion she slightly remembered a nurse that came in and held her baby. She tried to remain awake, but when the nurse told her she would transport the baby to the nursery for a hearing test, the mother fell into a deep sleep. A few hours later, the mother was awakened by an alarm sounding "code pink, cold pink, code pink" and swarm of nurses flying into the room to check every crevice of the room, while security asked her what seemed like a million questions. After an intense investigation, police found that a patient from the mental hospital across the street had escaped and stole a pair of scrubs from the employee locker room. After, she snuck into the postpartum ward and went into the mother's room and came out with a baby shortly after. Cameras showed the patient sneak into an empty room nearby then remerge with no baby insight and left through the front entrance with no issue. Sadly, the mother was never able to regain her newborn and the mental health patient was never found.

What circumstances led to the occurrence?

In the scenario above the patient underwent a delivery that took over 36 hours. Not only did the patient have a long and tiring labor, but she also had to experience it alone without the help or support of her husband or any family members. In one circumstance the patient was dozing off and in between being awake and asleep she saw a nurse whom was wearing the appropriate color scrubs that indicated she belong to the transportation faculty. The patient trusted this was a hospital employee and fell asleep allowing a stranger to take her newborn without any hesitation.

In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observations, etc.)

The frequency of occurrence of newborn abductions due to failure of correct identification of transportation employees could be measured in a number of ways: interviewing nurses, reviewing incident reports on the post-partum units, and researching how many newborn abductions there are nationwide. Research has shown infant abductions from hospitals to be rare, but staff members from any facility caring for infants should be aware of the threat. Staff should be alert at all times of any visitors on the floor.

What ideas do you have for implementing interventions to address the problem?

Between the Lubbock and Plainview hospitals, we have seen an array of precautions being taken. For example, in Lubbock the ID badges of the OB nurses are vertical instead of horizontal and in Plainview, the ID badges are purple instead of white. Also, the newborns get monitors wrapped around their ankle or umbilical cord that sound alarms and lock doors when the monitor approaches a certain distance from the door. Lastly, in both hospitals, we have seen and heard the nurse formulate a code word with the mother and attach an ID band to the visitor as well. However, we believe more can be done. For instance, facial/fingerprint recognition in the nursery doors, as well as cameras can be installed in each doorway of the postpartum ward. Finally, testing and anything that revolves with the child leaving to the nursery should be done only during the day and if needed at night every test must be performed in the same room as the mother.

A couple more ideas we have that can be implemented are ensuring the infant never leaves the mothers room in the arms of someone. The infant should always leave the room inside their bassinet and be supervised by a staff member during the transfer. We can also implement the use of a bed alarm under the infant's bassinet. This would assist with waking the mother when someone is in the room and lifts the baby out of the bassinet. By waking the mother, it could reduce the incidence of the infant being taken by someone who is pretending to be a staff member because the mother is awake and able to verify the individual claiming to be there for transport of the infant is wearing the appropriate color badge.

How will you measure the efficacy of the interventions?

We can measure the efficacy of the interventions by comparing how many infant abductions are reported before and after the interventions have been set in place.