How to use these course materials

- Review the entire syllabus, including any glossary, linked videos, and articles.
    - Mousing over a Lesson title allows you to left-click and go to that Lesson.
    - The bottom of each page displays the page number and Lesson title.
- Hold down the 'Ctrl' key while pressing the 'F' key to view a 'Find' dialog box.
    - Type in a key word or phrase to find it in the text.
    - Remember that 'Find' will find all instances of the word or phrase in the entire document. Before using 'Find', consider navigating to the proper Lesson first, in order to be as close as possible to the information you want to 'Find'.

IMPORTANT NOTE on the limitations of this material: This content is not localized to a particular healthcare environment, system, or entity. Since local system and administrative processes are crucial to patient safety, it is imperative that the learner be familiar with local, facility/entity practices such as: policies and procedures, equipment, patient identification and validation procedures, communication and handoff practices, etc. Adhere to your organization's policies and procedures.

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Infant Abduction

The standard hospital emergency code for Infant Abduction is Code Pink. Yours may differ, so know your emergency codes.

One of the most serious incidents that can occur in a healthcare facility is the abduction of an infant or child. Between 1965 -may 2019 there were 327 confirmed infant abductions in the United States. Of the 327 cases, 140 were taken from healthcare facilities. There are criteria that can be used to identify a potential abductor**.**

Remember that a potential kidnapper could be a visitor or an employee. In Pediatrics, the most serious concern is that a child might be taken by a non-custodial parent. Your facility may have policies restricting visitors. In addition, when children are admitted, it is important to find out who is legally allowed to visit.

Preventing abduction

There are measures that can help to reduce the risk of infant or child abduction:

- Parent education

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- Visiting procedures
- Engineering controls.

Teach mothers how to identify nursery and other staff and inform them about usual routines. This is an important step in the protection of newborn and infant children. Your facility may also have visiting procedures stating who can visit and providing methods of identifying visitors. Engineering controls, such as closed-circuit TV cameras, exit-door and wrist-band alarms, and other security devices may also be in place.

One of the most important components in the prevention of infant and child abduction is an alert staff. It is important that staff involved with care of infants and children are aware of security issues and suspicious of anyone who does not belong in the area.

If you discover that an infant is missing, follow your institution's infant abduction procedures. These usually include:

- Securing all exits from the facility
- Inspecting all stairwells, rooms, and other areas where someone might hide.

The ‘typical’ abductor

(Developed from an analysis of 256 cases)

- Female of “childbearing” age (range now 12 to 53), often overweight or appearing to be pregnant
- Most likely compulsive; most often relies on manipulation, lying, and deception.
- Frequently indicates she has lost a baby or is incapable of having one.
- Often married or cohabitating; companion’s desire for a child or the abductor’s desire to provide her companion with “his” child may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently initially visits nursery and maternity units at more than one healthcare facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire-exit stairwell for her escape; and may also try to abduct from the home setting.
- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present.
- Frequently impersonates a nurse or other allied healthcare personnel.
- Often becomes familiar with healthcare staff members, staff members work routines, and victim parents.
- Demonstrates a capability to provide “good” care to the baby once the abduction occurs. In addition an abductor who abducts from the home setting is more likely to be single while claiming to have a partner.
- Often targets a mother whom she may find by visiting healthcare facilities and tries to meet the target family.

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- Often both plans the abduction and brings a weapon, although the weapon may not be used.
- Often impersonates a healthcare or social-services professional when visiting the home.
- More likely to be single while claiming to have a partner

There is no guarantee an infant abductor will fit this description.

The Joint Commission (TJC), an accrediting agency, is a private, not-for-profit organization dedicated to improving the quality and safety of medical care provided to the public. It is an agency that sets the principal standards and evaluations for a variety of healthcare organizations. Infant/pediatric security is an area of concern to TJC as a high-risk security area often referred to as “security-sensitive area.” Such areas require a specific access-control plan, initial and periodic security-related training for staff members working in those designated areas, and a critical-incident response plan. It is common for TJC surveyors to ask in-depth questions regarding the implementation of infant/pediatric security plans. infant/pediatric abductions or discharge to the wrong family are reviewable sentinel events under the sentinel-event standards of TJC.

The typical abduction from a healthcare facility involves an “unknown” abductor impersonating a nurse, healthcare employee, volunteer, or relative in order to gain access to an infant. The obstetrics unit is an open and inviting one where patients’ decreased length of stay, from one to three days, gives them less time to know staff members. In addition it can be filled with medical and nursing staff members, visitors, students, volunteers, and participants in parenting and newborn-care classes.

The number of new and changing faces on the unit is high, thus making the unit an area where a “stranger” is unlikely to be noticed. Because there is generally easier access to a mother’s room than to the newborn nursery and a newborn infant spends increasingly more time with his or her mother rather than in the traditional nursery setting, **most abductors “con” the infant directly from the mother’s arms.**

All healthcare personnel should be alert to any unusual behavior they encounter from individuals such a:

- Repeated visiting or requests “just to see” or “hold” the infants.
- Close questioning about healthcare-facility procedures, security devices, and layout of the floor such as, “When is feeding time?” “When are the babies taken to the mothers?” “Where are the emergency exits?” “Where do the stairwells lead?” “How late are visitors allowed on the floor?” “Do babies stay with their mothers at all times?”
- Taking uniforms or other means of identification within that facility.
- Physically carrying an infant in the facility’s corridor instead of using the bassinet to transport the infant, or leaving the facility with an infant while on foot rather than in a wheelchair.
- Carrying large packages off the maternity unit (e.g., gym bags, suitcases, backpacks), particularly if the person carrying the bag is “cradling” or “talking” to it.

Be aware that a disturbance may occur in another area of the healthcare facility creating a diversion to facilitate an infant abduction (e.g., fire in a closet near the nursery or loud, threatening argument in the

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waiting area). Healthcare facilities need to be mindful of the fact that infants can stay in or need to be taken to many areas within the facility. Thus vigilance for infant safety must be maintained in all areas of the facility when infants are present.

General Guidelines (You MUST review your facility guidelines; these are non-specific and lack the details necessary for full compliance with your local facility and regional standards.)

- Persons exhibiting the behaviors described above should be immediately asked why they are in that area of the facility. Immediately report the person's behavior and response to the nurse manager/supervisor, security, and administration. The person needs to be positively identified, kept under close observation, and interviewed by the nursing manager/supervisor and security. Remember, caution needs to be exercised when interacting with people who exhibit these behaviors.

- Report and interview records on the incident should be preserved in accordance with the organization's internal procedures. (Many suggest records should be kept from a minimum of seven years up to the child reaching adulthood.)

- Each facility should designate a staff person in their critical-incident response plan who will have the responsibility to alert other birthing facilities in the area when there is an attempted abduction or someone is identified whom demonstrates the behaviors described above, but who has not yet made an attempt to abduct an infant.

Proactive Practices (Again, these are general. Know your facilities standards.)
As part of contingency planning, the backbone of prevention, every healthcare facility must develop, test, and critique a written proactive-prevention plan for infant abductions that includes all of the elements listed in this section. In addition measures must be taken to inform new or rotating (temporary) employees of these procedures as they join the staff. This plan needs to be tested, documented, and critiqued at least annually.

Immediately after the birth of the infant and before the mother and infant are separated, attach identically numbered ID bands to both the infant (2 bands) and mother (1 band) and 1 band to the father or mother's significant other when appropriate. Inform parents of the reason or need for the bands. If the fourth band is not used by the father/mother's significant other, that fact must be documented. This band may be stapled to the chart or cut and placed in the "sharps box."

An infant's band needs to be verified with the mother when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered. The caregiver must examine and verify both the baby and the mother's (or significant other's) identification bands and have the mother (or significant other) do the same.

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If an infant band is removed for medical treatment or comes off for any reason, immediately reband the infant after identifying the infant, using objective means such as footprint comparisons or blood testing, and change all bands, mother's, father's/significant other's, and infant's, so once again the bands all have the same number. If the band is cut or entirely removed, parents should be present at the removal and replacement.

Prior to the removal of a newborn from the birthing room or within a maximum of two hours of the birth

- Footprint (with emphasis on the ball and heel of the foot) the infant making sure the print is clear. Repeat if necessary.
- Take a color photograph or color video/digital image of the infant.
- Perform a full, physical assessment of the infant, and record, in the medical chart, the assessment along with a description of the infant.
- Store a sample of the infant's cord blood and any other blood specimens until at least the day after the infant's discharge.
- Place electronic security tags, if such a system is being used.
- The footprints, photograph or video/digital image, physical assessment, and documentation of the placement of the ID bands, including their number, must be noted in the infant's medical chart.
- Require all healthcare-facility personnel to wear, above the waist and "face-side" out, up-to-date, conspicuous, color-photo ID badges. The person's name and title need to be easily identifiable, and the person's photograph needs to be large enough so that he or she is recognizable.

- Update the photograph as the person's appearance changes. These badges need to be returned to Human Resources or the issuing department immediately upon termination of employment.
- Personnel who are permitted to transport infants from the mother's room or nursery, including physicians, should wear a form of unique identification used only by them and known to the parents (e.g., a distinctive and prominent color or marking to designate personnel authorized to transport infants). IDs should be worn above the waist, "face-side" out, on attire that will not be removed or hidden in any way. Paraphernalia should not be worn on name badges (i.e., pins, stickers, and advertisements) that hide name, face, or position. ID systems should include provisions for all personnel, who are permitted to transport infants from the mother's room or nursery including students, "transporters," and temporary staff members, such as the issuance of unique temporary badges that are controlled and assigned each shift (e.g., strict control should be similar to narcotics control). This unique form of identification should be periodically changed.
- Limit infant transportation to an authorized staff member wearing the authorized infant-transportation ID badge.

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- Ensure the mother or father/significant other with an identical ID band for that infant are the only others allowed to transport that infant, and educate the mother and father/significant other about the importance of this precaution.
- Prohibit leaving an infant without direct, line-of-sight supervision.
- Require infants to be taken to mothers one at a time. Prohibit “grouping” infants while transporting them to the mother’s room, nursery, or any other location.
- Prohibit “arm carrying” infants, and require all transports to be via a bassinet. Require family members transporting the infant outside the mother’s room, including the mother, father, or significant other, to wear an ID wristband.
- Distribute the guidelines for parents in preventing infant abductions
- Always place infants in direct, line-of-sight supervision either by a responsible staff member, the mother, or other family member/close friend so designated by the mother, and address the procedure to be followed when the infant is with the mother and she needs to go to sleep/the bathroom and/or is sedated. If the mother is asleep when the infant is returned to the room, staff members should be careful to fully awaken her before leaving the room. In rooming-in situations, place the bassinet so the mother’s bed is between the exit door(s) to the room and the bassinet.
- Do not post the mother’s or infant’s full name where it will be visible to visitors. If necessary, use surnames only. Do not publish the mother’s or infant’s full name on bassinet cards, rooms, status or white boards. Do not leave charts, patient index cards, or any other medical information visible to anyone other than medical personnel. Be aware that identifying information in the bassinet such as ID cards with the infant’s photograph and the family’s name, address, and/or telephone number may put the infant and family at risk after discharge. Keep this information confidential and out of sight. Do not provide patient information via the telephone.
- Conform with an access-control policy for the nursing unit, nursery, maternity, neonatal-intensive care, and pediatrics to maximize safety.
- Require a show of the ID wristband for the person taking the infant home from the healthcare facility and be sure to match the numbers on the infant’s bands, as worn on the wrist and ankle, with the bands worn by the mother and father/significant other.

Know and conform with your facility’s critical-incident-response plan to respond to an infant abduction.

References

Infant Abduction. (2019). Retrieved October 8, 2019, from www.missingkids.org/theissues/infantabductions#bythenumbers.

<u>End of Infant Abduction Lesson</u>

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