Victorian Infant Hearing Screening Program

The Royal Children's Hospital Melbourne

Centre for Community Child Health

Are We Screening The Correct Baby?

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The Children's
Excellence in clinical care, research and education

The Royal Children's Hospital Melbourne

Murdoch Childrens Research Institute

The University of Melbourne

Overview

- Evidence that demonstrates why it is important to check a patient's identification before providing any care or service
- Actions implemented within Australia to improve the quality & safety of patient care
- The process implemented by VIHSP for checking babies identification
- Audit results of the VIHSP process

Of Course I Can Recognise My Own Baby

Newborn babies each have their own individual characteristics


Reality

Multiple births create even greater challenges

Patient Misidentification In the Neonatal Intensive Care Unit:

James E. Gray et al

Paediatrics 2006; 117; e43

Findings

- There is an extreme risk for errors & adverse events related to these errors
- A common error is due to patient misidentification often as a result of similarities in standard identifiers eg: Twins or triplets
- Accurate patient identification is a necessary component of providing safe and effective services.

DAILY NEWS

PUBLISHED: 12:32 GMT, 4 April 2012 | **UPDATED:**08:08 GMT, 5 April 2012

Indian Maternity Ward Mixes Up Baby Boy and Girl... and Now BOTH Parents Claim The Little boy is Theirs

A maternity ward mix-up of a baby boy and girl in India has led to a furious row between the parents - with both sets claiming the boy is theirs.

The babies were born on the same day, in the same maternity ward, at Umaid Hospital in the western India city of Jodhpur.

But **midwives accidentally mixed-up the babies** shortly after their birth - giving the boy and the girl to the wrong parents.

Star Tribune:

December 6, 2012

Baby Switched At Minneapolis Hospital, Breastfed By Wrong Mom

A newborn baby will have to undergo a year of medical tests for HIV and hepatitis because he was **accidentally put in the wrong bassinet** by a Minneapolis hospital and then breastfed by the wrong mother.

The mix-up happened Wednesday in Abbott Northwestern Hospital when the little boy was accidentally switched to the wrong bassinet, Staff at the Abbott Northwestern Hospital had placed the baby in the wrong crib in the hospital nursery. .

The baby that was breastfed by the wrong mother has to be tested for HIV and hepatitis, and will continue to receive the tests every three months for the next year. So far, the results have been negative.

The hospital is investigating the incident to identify how this error could have occurred.

Herald Sun July 19 2011

The World's Favourite Newspaper

Victorian Hospital Gives Wrong Babies to Mothers

The hospital that gave two newborn babies to the wrong mothers to breastfeed may have done it before.

In the wake of revelations of a baby bungle on Friday, another woman claims her baby was also handed to the wrong mother who began breastfeeding her at the hospital.

The investigation uncovered dozens of errors with **identification tags of newborns in Victorian public hospitals.**

In the latest incident, two newborns were mistakenly given to the wrong mothers and breastfed by them at the hospital on Friday.

The babies spent more than eight hours with the wrong mothers. A family member alerted staff.

CANADIAN NEWS

www.dailynews.com THE WORLDS FAVORITE NEWSPAPER - since 1879 -

MD Disciplined After Wrong Baby Circumcised:

A Winnipeg doctor, who didn't check a newborn's identification before a circumcision was performed on the wrong baby at St. Boniface General Hospital, later duped the baby's parents into believing the operation wasn't performed until after they gave consent, a College of Physicians and Surgeons investigation has concluded.

Dr. Matthew Howard Lazar **failed to check the identification of a newborn baby boy** before his trainee performed surgery to remove the child's foreskin on Nov. 8, 2005. The baby's parents had not signed a consent form, and the mother later told the College she was still "undecided" about the surgery because of the pain.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Legislation & Standards

NSQHS STANDARDS

A better way to care

- **2011~** ACSQH developed National Safety and Quality Health Service (**NSQHS) Standards**
- **Aim~** to drive the implementation and use of safety & quality systems and improve the quality of health service provision in Australia
- **Why~** There was a known gap between the current situation and best practice outcomes

VIHSP

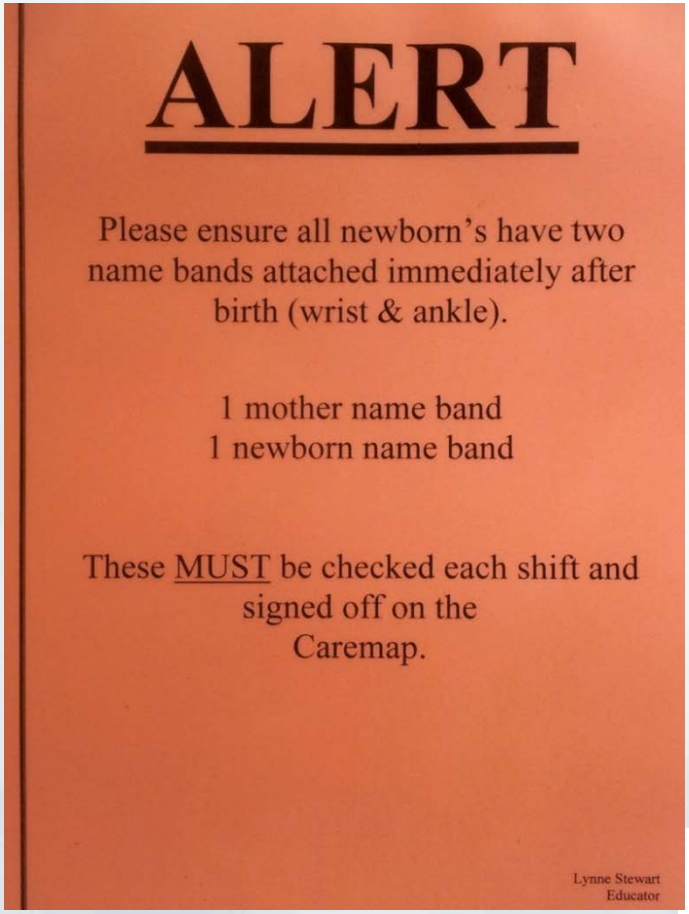
Standard 5: Patient Identification & Procedure matching

The standard mandates: at least three (3) approved patient identifiers are checked before providing care, therapy or other services

- Full name
- Date of Birth
- Medical Record Number or Unit Record Number

VIHSP

What are hospitals doing?



VIHSP Procedure

Prior to commencing the screen

- the hearing screener, checks the baby's identification band against information on the SRF
- babies **without an ID band** are not screened until the midwife confirms the baby's identity

Q: Does this wake the baby?

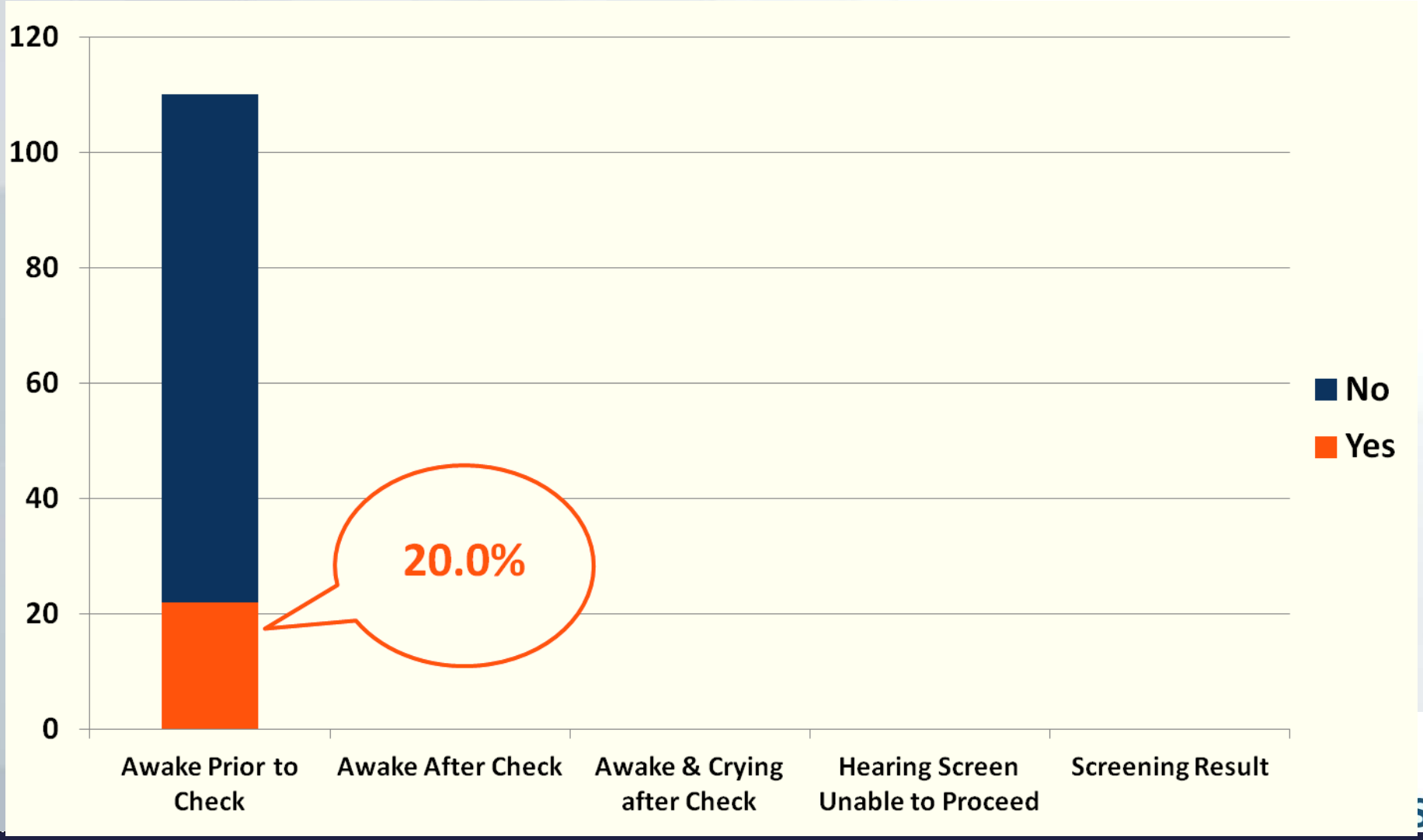
A: Yes it can

- Some babies rouse
- Some babies awake and cry
- Some babies **cannot** be resettled
- The majority of babies after they are swaddled go back to sleep
- Some parents are not happy to have the baby disturbed

Audit of Identification Checking Procedure

- Number of babies awake prior to checking
- Number of babies awakened by checking procedure
- Number of babies awakened and crying after the checking procedure
- Number of babies where screen unable to proceed (baby too unsettled)
- Time taken to complete identification check

AUDIT RESULTS



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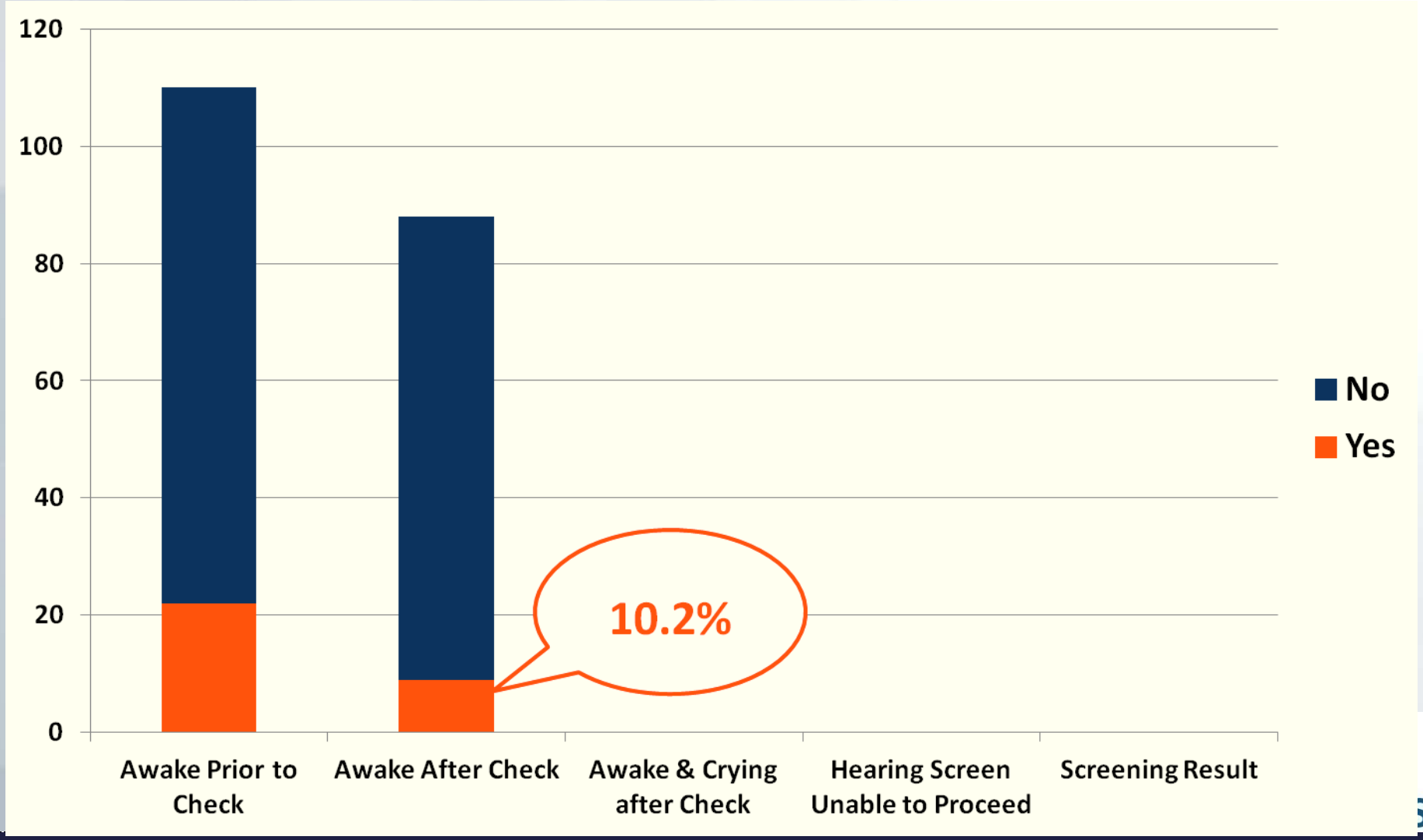

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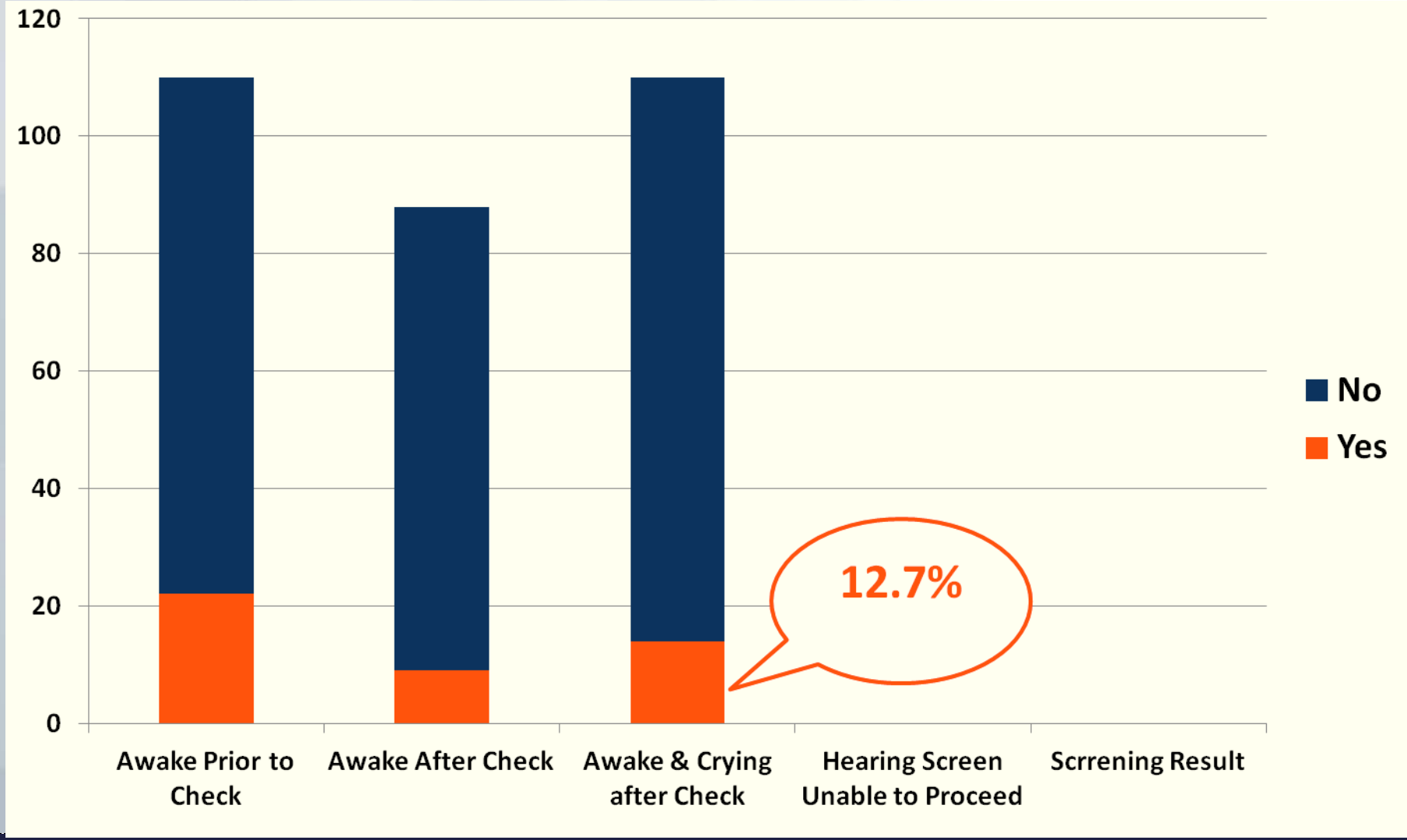

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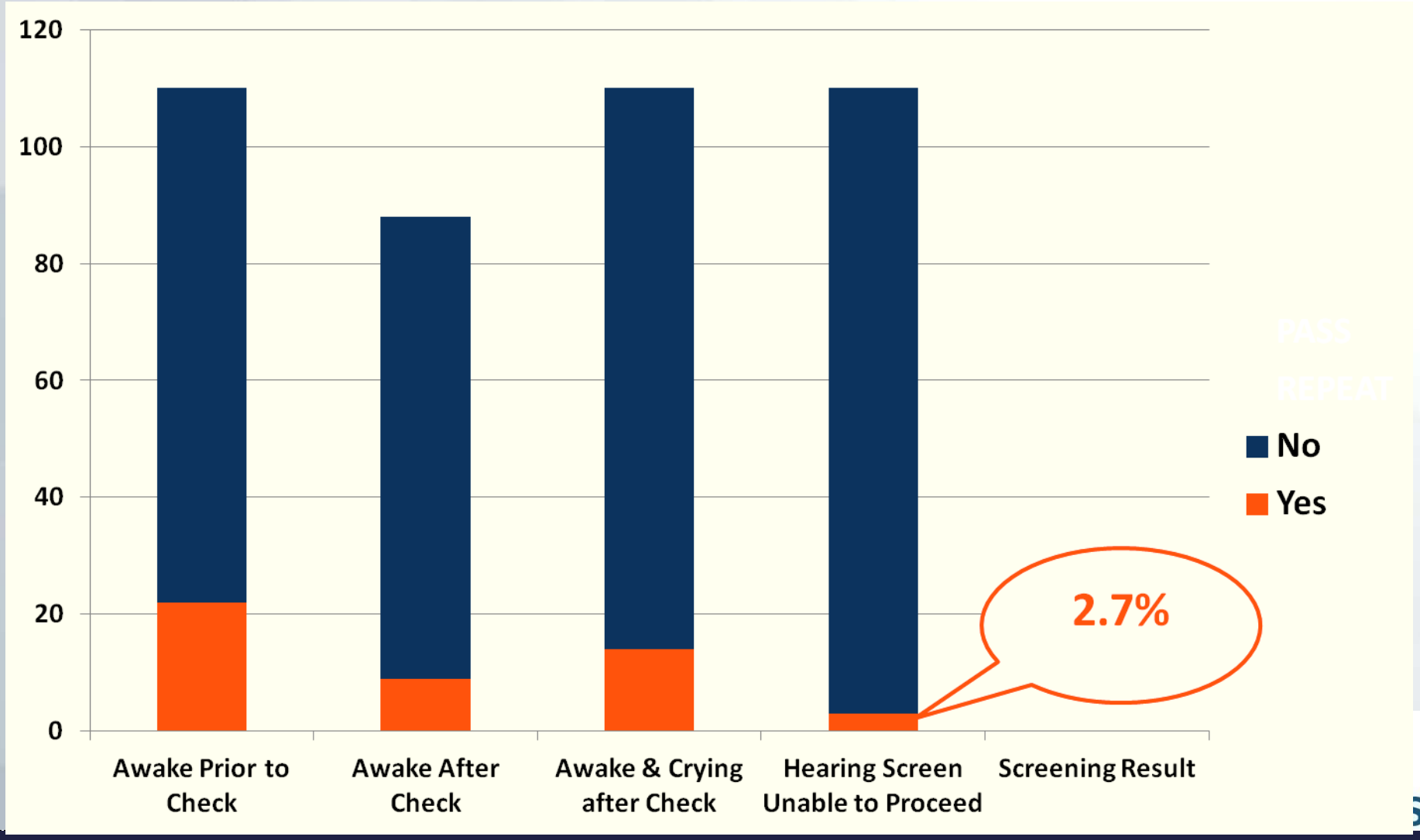

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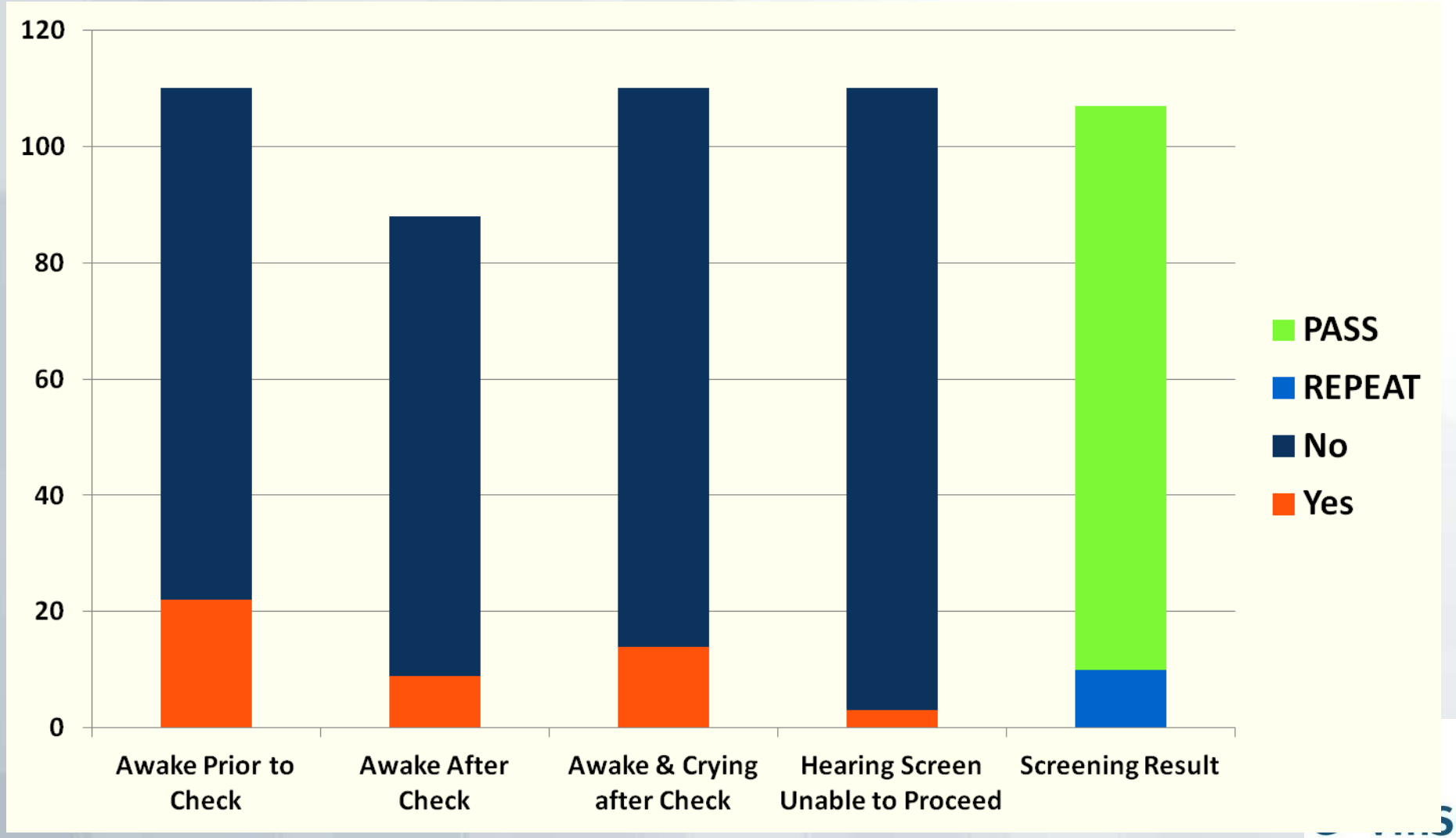
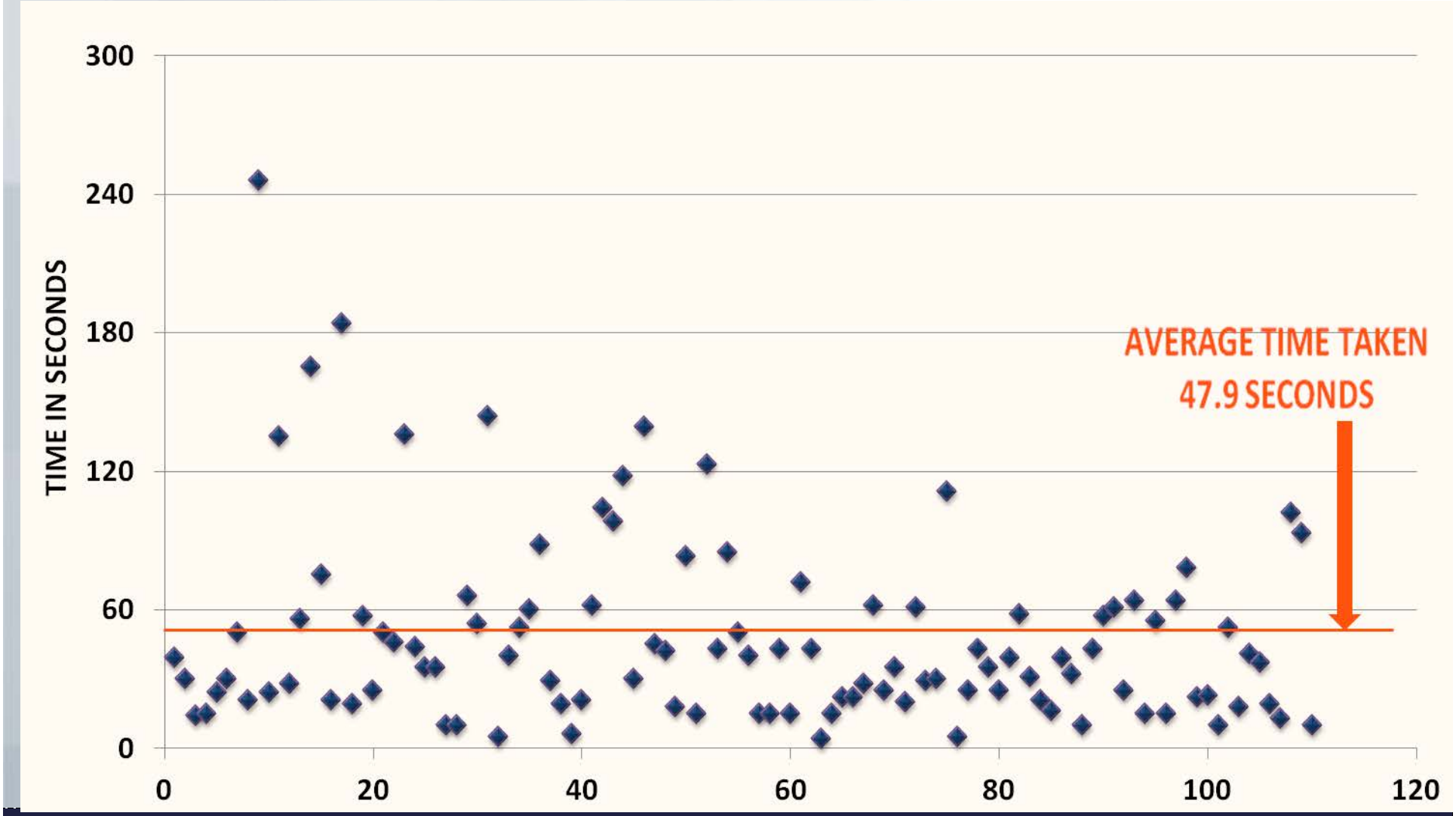
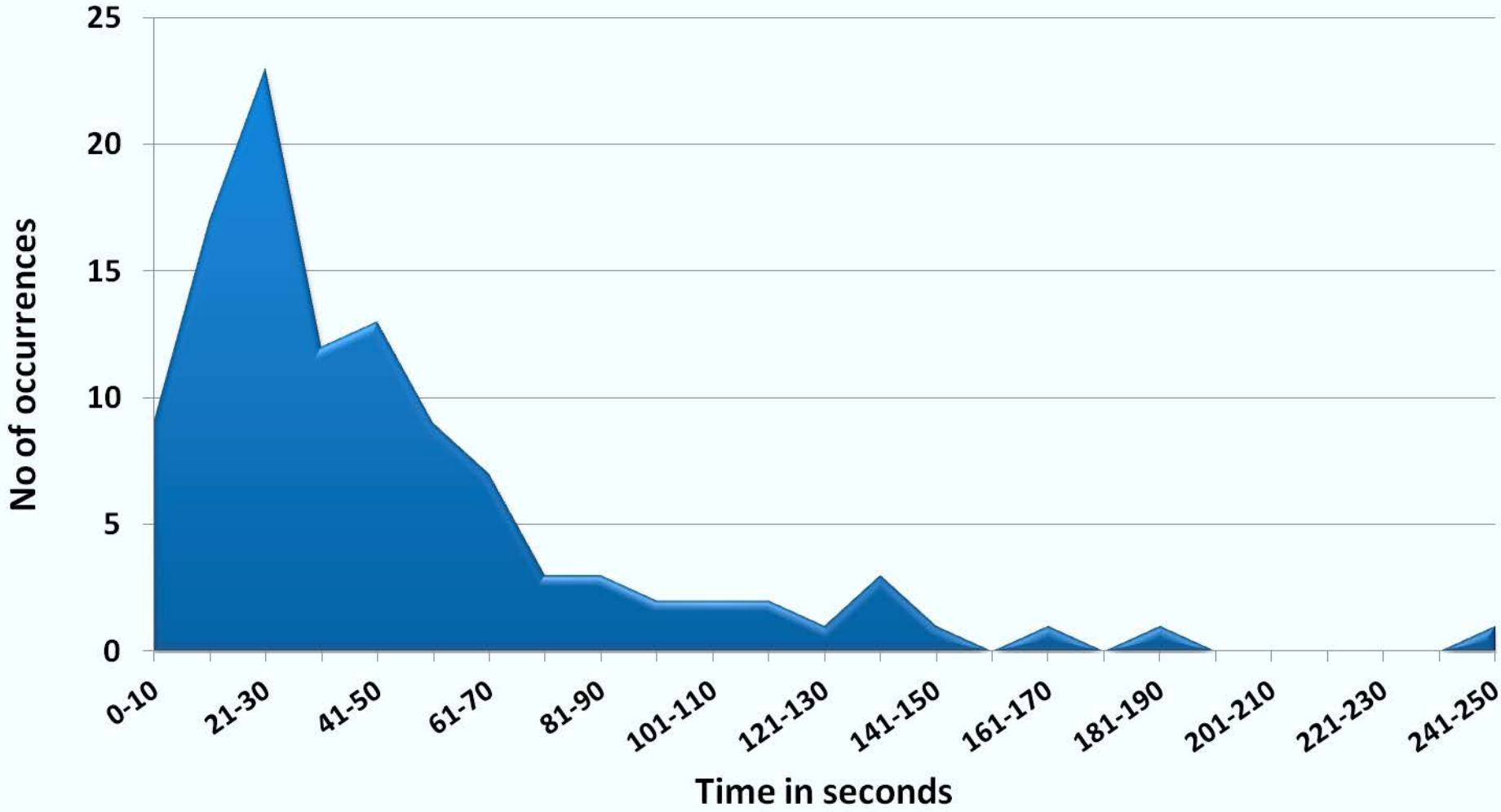


TIME TAKEN TO VALIDATE IDENTITY



Frequency Histogram



Summary

- Newborn babies are not able to participate actively in the identification process
- Misidentification of newborn babies does occur & can lead to errors in the provision of care or service delivery
- Identification prior to completing a hearing screen **does not** impact significantly on the baby or the screening process

Thank You To The Staff Who Participated In the Initial Trial

The Royal Children's Hospital Melbourne

Enza

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& Rachel and the team from the Barwon Region

Photographs of newborn screening supplied by Karen I. Dandenong Region
Photographic images downloaded from Google Image in April & May 2013

VIHSP