In my opinion the best defense against infant abduction is a vigilant staff, educated parents, and a well-choreographed response to the perceived or real threat of infant abduction. Electronic security systems play a key technological role in supporting a hospital’s infant security program through monitoring, surveillance, and response time.

Technology-based infant security systems generally fall within three categories: closed-circuit television with back-up recordings, access control to secure areas, and infant bracelet or umbilical cord tag alarms (Cesario, 2003). These systems are constantly vigilant and unaffected by distractions, rest/lunch breaks, and shift changes (Rabun, 2003). The choice of an infant security system (whether alone or in combination) should be based on a hospital’s needs assessment of its physical plant, review of unit and security policies, interviews with staff and families, and an extensive study of hospital and unit traffic patterns. Furthermore, the Joint Commission of Accreditation of Healthcare Organizations considers infant abduction to be a “sentinel event,” designates particular areas in healthcare facilities to be security sensitive, and stipulates that these areas require a specific access control plan (JCAHO, 1999). Maternity and pediatric units meet these criteria. In addition, the National Center for Missing & Exploited Children (Rabun, 2003) considers essential the installation of security-camera systems, alarms, locks, and self-closing hardware on all stairwell and exit doors leading to, from, or in proximity to maternity, nursery, neonatal-intensive-care, and pediatric units for prevention and documentation.

Electronic infant security systems provide constant monitoring, with video of everyone entering or leaving the unit, thus providing a photographic record of an abduction and subsequent identification. They can also continuously monitor entry points and areas that may be out of the clear line of sight of nursing stations. Controlled access to units can be maintained through magnetic swipe cards, key-pad access, and electronic release locks. Umbilical cord or bracelet transponders send signals to sensors strategically located around the perimeter of the established secure area. Some sensors can actually track the constant movement of an infant. Thus, response can occur within seconds rather than the minutes it could take for members of the hospital security team to achieve the same results.

It is imperative for every healthcare facility to have a written proactive infant abduction prevention policy and response plan that extends beyond security and the maternity and pediatric units. The policy should include other hospital departments such as facilities management, public relations, communication and information systems, and local law enforcement. Mock abduction drills should be conducted unannounced once or twice each year involving all personnel to critique and evaluate the identification of an infant abduction and the facility and local law enforcement response.

The cost of electronic infant security systems may seem prohibitive; however, in the event of an infant abduction the financial cost due to liability will likely exceed the initial investment. The cost of electronic infant security systems may seem prohibitive; however, in the event of an infant abduction the financial cost due to liability will likely exceed the initial investment. Abduction of one infant could precipitate dramatic decreases in hospital census and significant losses in patient volume and revenue. An institution’s reputation for safety is key to its survival in the current healthcare environment. Thus, purchase of an electronic system is part of an overall strategy to secure the environment. Successful implementation of a system may be key to an organization’s financial health.

The devastating impact of an attempted or successful infant abduction includes the physical, psychological, and financial costs it takes on the infant’s parents and family, maternity and hospital staff, and the surrounding community. Few hospitals truly recover from the stigma of such an event. Therefore, in my opinion hospitals should take every measure, including the installation of electronic security systems, to ensure the safety of its most vulnerable patients: infants and children.

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Every unit that cares for newborns strives to maintain stringent security measures to protect their smallest patients. The abduction of even one infant is too many, resulting in anguish for parents and staff members as well as repercussions including lawsuits and negative consumer opinion.

A popular recent practice has become the installation of complex, high-tech security alarms, called electronic asset surveillance (EAS) systems. Once one facility in a community installs such a system, other area facilities feel a need to follow suit in order to remain competitive. However, this type of response is neither evidence based nor cost effective.

EAS systems are not perfect. Their sizeable monitors consume limited space in nurses stations; large and clunky transponders placed on infants cause some parents to worry about the comfort of their newborns; bracelets loosen and fall off; some complain that these items make it seem that the infant is a piece of merchandise, like an expensive designer outfit in a department store. In addition, these systems consume an inordinate amount of valuable nursing time with the effort of placing, inputting, and recording each transponder; replacement of loose and lost bands; response to frequent false alarms; and the removal, cleaning, and proper storage of each transponder.

Clearly, obstetric and pediatric units must have comprehensive security protocols, policies, and procedures in place to meet the requirements of the JCAHO as well as the expectations of the community. These procedures do not need to include electronic security systems to be effective. Many alternative proactive measures can and should be instituted to meet these needs. A comprehensive listing of recommended strategies can be found on the Web site of the National Center for Missing and Exploited Children (NCMEC) (Rabun, 2003). Among the recommendations are the use of unique badges and uniforms as identifiers, four bracelet identification systems for the infant and parents, and lock, swipe, and video surveillance technologies.

Education of staff and patients is also highly important. Education of the patient and their family should begin prior to admission, in childbirth classes, clinics and doctor’s offices, and should inform parents of the unit’s security policies and procedures. Such information could include instructions that no one will pick up their baby and attempt to carry the infant out of the room in their arms (a behavior that might be expected of an abductor). Once the infant is born, the patient needs reinforcement of this information as well as instructions regarding safety measures related to rooming-in with their infant. Closing the door of the room and leaving the bathroom door open is essential to maintain line-of-sight contact with the infant, for Joint Commission guidelines do not require EAS systems. In its Infant Security Sentinel Event Alert (1999), JCAHO identified certain issues that led to abductions. The first item on the list was that security equipment had never been “available, operational or used as intended” due to system failures and/or user error.

In my opinion, EAS systems may be providing a false sense of security to staff and to parents. Parents have been known to react to this system as if it will protect their infants and, therefore, believe they needn’t be vigilant about their infant’s safety. Staff might also feel that they can be secure in the safety of infants, believing that the alarms from the EAS will always function in the case of an attempted abduction. This, of course, is not true, for even with the best security alarm system, all of the other security protocols must be followed for the infant to remain safe from abduction. Not one of our current security procedures can be replaced by the use of these expensive and cumbersome technologies.

I believe that we are relying far too much on complex technologies and not enough on the resources already available to us. In these financially challenging times, healthcare funds that are currently being used to purchase and maintain EAS systems might be better utilized for the purpose of recruiting and retaining staff that can use their own eyes, ears, and intuition to protect our precious newborns from harm.

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References