RTI #3044 – Documents relating to newborn baby mix-ups including mothers given to the wrong babies for breastfeeding in Queensland public hospitals.

Purpose of report

The purpose of the release notes is to provide further context on the information provided.

Attachment 1 provides all clinical incidents reported in Queensland public hospitals where the newborn was accidentally breastfed by the wrong mother and where the newborn was given to the wrong parent (not discharged with the wrong family) for the period 1 January 2012 to 15 February 2016 in the PRIME Clinical Incidents (CI) information system. This information was extracted from PRIME CI on 15 February 2016 to fulfil RTI #3044.

Attachment 2 provides a Briefing Note for the period 1 January 2010 to 23 June 2014 in relation to clinical incidents reported in Queensland public hospitals where the newborn was accidentally breastfed by the wrong mother. This briefing note was prepared in December 2014.

Interpretation Notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of reported clinical incidents, comparing the number of reported clinical incidents between Hospital and Health Services (HHS), or using the number of reported clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a Severity Assessment Code (SAC) 1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of an adverse patient outcome as a reported clinical incident does not describe 'negligence' or 'fault' on behalf of our staff or systems.
- Not all reported clinical incidents are preventable.

- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.
- SAC 2 and SAC 3 clinical incidents are not mandatorily required to be reported.

Data source

- Attachment 1 - Data
  - The data presented was extracted from PRIME CI on 15 February 2016 and is subject to change.
  - Statewide data has been extracted by facility.
- Attachment 2 – Briefing Note
  - The data was extracted from PRIME CI on 24 June 2014 and provided to the Office of the Chief Health Officer & DDG Prevention Division.
- PRIME CI is the Clinical Incident component of the Queensland Health PRIME information system. It is designed to enable reporting, investigation and management of clinical incidents reported by HHS staff.
- PRIME CI data is self-reported by HHS staff.

Data Provided

- Attachment 1 - Data
  - Time Period: 1 January 2012 to 15 February 2016
  - All reported clinical incidents in Queensland public hospitals where the newborn was accidentally breastfed by the wrong mother and where the newborn was given to the wrong parent (not discharged with the wrong family).
  - Search Criteria:
    - the location of the clinical incident had a ward ID recorded where paediatric or obstetric care was given (excludes mental health);
    - age of patient at the reported time of the clinical incident was <50 years;
    - the following key words were in the "What Happened" field, the "Description of Event" field, the "Current Diagnosis" field or the "Clinical Review" field: *"wrong mother", "wrong mum", "Incorrect mother", "Incorrect mum", "incorrect bab*", "wrong bab*", "Incorrect father", "Incorrect dad", "Wrong father", "wrong dad", "wrong family", "Incorrect family", "mix-up", "mix up", "cot card", "ID band", "Identi*", "Legband", "leg band", "arm band", "armband", "name band" "nameband", "incorrect UR", "wrong UR", "FOB", "ID" and "identification".*
  - A total of five (5) cases [six (6) reported clinical incidents] were identified. Two (2) cases where the newborn was accidentally breastfed by the wrong mother and three (3) cases where the newborn was given to the wrong parent.
- Attachment 2 – Briefing Note
  - Time Period: 1 January 2010 to 23 June 2014
  - All reported clinical incidents in Queensland public hospitals where the newborn was accidentally breastfed by the wrong mother.
  - The Briefing Note states there were four cases for the period of 1 January 2010 to 23 June 2014. Of these cases:
    - three cases are outside the date range of the RTI application of 1 January 2012 to 26 February 2016;
    - one case (mother and baby combined) is included in Attachment 2. .

Important Caveats

- Due to different key word searches undertaken in PRIME CI, Attachment 1 has one (1) case included in 2012 that was not included in Attachment 2.
- Metro South HHS and Gold Coast HHS also received the RTI request.
- Metro South HHS's response has included information on expressed breast milk cases in addition to the two (2) cases included in Attachment 1. There is also an additional case included by Metro South where a family member intentionally breastfed the baby with the birth mothers consent.
- A recent story by Channel 7, aired on 2 March 2016, labelled 'Queensland hospital breast feeding bungle' differs from this RTI request due to different date ranges (however there is an overlap of dates) and the inclusion of incorrect expressed breast milk in the recent story. The date range of the story was 1 January 2010 to 31 December 2015. Please note:
    - there are four cases [five (5) reported clinical incidents] included in both the recent story and Attachment 1 (where there is an overlap of dates) where babies were accidentally breastfed by the wrong mother or where the newborn was given to the wrong parent for the date range of 2012 to 2015.
    - due to different key word searches undertaken in PRIME CI, Attachment 1 includes one (1) case in 2012 that was not included in the recent story.
- Table 1 provides the report parameters of recently requested data.
- Table 2 provides a list of the data included in the most recent Channel 7 request (RTI 3044).

Definitions

SAC 1 – Death or likely permanent harm which is not reasonably expected as an outcome of healthcare;

SAC 2 – Temporary harm which is not reasonably expected as an outcome of healthcare; and

SAC 3 – Minimal harm or no harm which is not reasonably expected as an outcome of healthcare.

Table 1 Report Parameters of Requested Data

	PRIME * data	CHO Report**	Metro South HHS	Gold Coast HHS	Channel 7 story aired 2 March 2016
Date Range	1 January 2012 to 15 February 2016	1 January 2010 to 23 June 2014	1 January 2012 to 26 February 2016	1 January 2012 to 26 February 2016	1 January 2010 to 31 December 2015
Search string text	Key word search terms: wrong mother, wrong mum, Incorrect mother, Incorrect mum, incorrect bab*, wrong bab*, Incorrect father, Incorrect dad, Wrong father, wrong dad, wrong family, Incorrect family, mix-up, mix up, cot card, ID band, Identi*, Legband, leg band, arm band, armband, name band, nameband, incorrect UR, wrong UR, FOB and identification, ID	Key word search terms: *wrong breast*,*wrong milk*, *wrong baby*, *wrong infant*, *breastfe*, *breast fe*, *breast milk* and *express	Logan and Beaudesert Hospitals: Key word search terms of Breast*, Milk*, Mother*, Baby*, Infant* Redland Hospital: No search string used. All maternity incidents (in Women's and Children Division) for the above date range were reviewed.	No search string used. All maternity incidents for the above date range were reviewed.	Issue Category of "wrong breast milk"; and key word search terms: *EBM*, *BreastMilk*, *Breast Milk*, *Incorrect UR*, *Identification*, *Wrong Bab*, *Identity*, * ID *, *Cot Card*, *Legband*, *Leg Band*, *ArmBand*, *Arm Band*, *NameBand* and *Name Band*
Incident type included	Breastfed by wrong mother	Breastfed by wrong mother	Breastfed by wrong mother	Breastfed by wrong mother	Breastfed by wrong mother
	Newborn given to wrong parent		Newborn given to wrong parent	Newborn given to wrong parent	Newborn given to wrong parent
			Incorrect expressed breast milk		Incorrect expressed breast milk

* PRIME = PRIME CI Information System
** CHO = Office of the Chief Health Officer

Table 2 Data included in this most recent Channel 7 Request (RTI 3044)

	PRIME * data (Att 1) (included in this request)	CHO Report** (Att 2) (included in this request)	Metro South HHS (provided by Metro South)	Gold Coast HHS (provided by Gold Coast)
PRIME INCIDENT 1		This case was not originally included in the CHO Report as the 2014 request did not include "newborn given to wrong parent'		
PRIME INCIDENT 2		This case was not originally included in the CHO Report as the 2014 Search String used did not include "Identi*".		
PRIME INCIDENT 3, PRIME INCIDENT 4 & CHO INCIDENT 4	One case (two clinical incidents reported i.e. one for the mother and one for the baby	One case (mother and baby combined)		
PRIME INCIDENT 5		This case was not originally included in the CHO Report as the 2014 request did not include "newborn given to wrong parent'		
PRIME INCIDENT 6		This case was not originally included in the CHO Report as the 2014 request did not include "newborn given to wrong parent'		
CHO INCIDENT 1	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Redacted from the CHO Report as the date for this case is outside of the most recent Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range
CHO INCIDENT 2	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Redacted from the CHO Report as the date for this most recent case is outside of the Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range
CHO INCIDENT 3	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Redacted from the CHO Report as the date for this case is outside of the most recent Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range	Case not included as this case occurred prior to the most recent Channel 7 RTI requested date range

Legend

	Case provided in most recent Channel 7 RTI
	Case not provided in most recent Channel 7 RTI
	Not applicable for the HHS

* PRIME = PRIME CI Information System
** CHO = Office of the Chief Health Officer

PRIME Clinical Incident Database 01/01/2012 - 15/02/2016

Incident ID	Date Of Incident	HHS	Facility	Description Of Event	Suggestions to prevent reoccurrence	ClinicalReview
	/2012	West Moreton	Ipswich Hospital	A father presented to nd asked to see his infant. I believed he said " quot; and I took him to baby o was being prepared for a bottle fed. I asked if he would like to nurse and feed baby a bottle. He did and I assisted with the commencement of this and then t the time I returned fi saw baby at their infants beside when it became apparent that I had confused infants. The gentleman was to see his infant baby spoke with both sets of parents and apologised. At the time both parents identified they did not want to take the matter further	Ensure there is better clarification of baby's name	
	/2012	Metro South	Redland Hospital	Baby taken from mother to feed. No identification check. Mother fed baby before it was determined that it was not her baby.	Patient ID check of newborn prior to being taken to	Ongoing testing for with Paeds in 3 months.
 HEAPS investigation to follow
	/2014	Metro North	Redcliffe Hospital	• Baby given to wrong mother for breast feed . Baby of Patient was taken to Patient to ed. • Baby was fed by Patient for a short time, before mistake was realized by Midwife. • Baby was removed and taken to correct Mother Patrient • oth Mothers were informed immediately. • Paediatric Registrar notified. • NUM discussed case with Medical Staff, including Director of O&G • On call ND notified • Executive Director notified • Both Mothers have had clinical disclosure with Consultant & Registrar.	ENTIRE SHIFT WORKED WITHOUT APPROPRIATE LIGHTING DUE TO POWER OUTAGE. ALL AREAS BUSY- CASUAL RN WORKING IN THE AREA.	Executive Director:as SAC 2 and proceed with a HEAPS
	/2014	Metro North	Redcliffe Hospital	GIVEN WRONG BABY TO BREAST FEED IN POOR LIGHTING- MOTHER FED INCORRECT BABY. MOTHER INFORMED SHE WAS FEEDING INCORRECT BABY. WHEN MOTHER INFORMED REPORTED SHE COULD NOT SEE BABY DUE TO POOR LIGHTING DUE TO POWER OUTAGE.	ENTIRE SHIFT UNTIL THIS POINT WORKED IN VERY POOR LIGHTING. ALL AREAS BUSY, CASUAL STAFF EMPLOYED IN AREA.	INcident to be reviewed as part of Analysis PRIME CI report
	/2014	Metro South	Redland Hospital	B/O requiring taken to for Shift became busy and baby minded in ~ hrs when mother rang call bell to ask for baby back. RM (myself) went into and asked for B/O aken back to oom. Did not check baby ID tags out of hen taken to m, baby nappy changed and baby handed to mother prior to checking ID tags. ed if this baby was hers as she noticed nil d baby was heavier than her own. ID tags checked with matching. Apologised to and baby taken out of room back to sequently realised there were two visiting babies in same time with Mother's name hich remained in back room of was taken back to d ID tags confirmed correct baby. Documented incident on . Informed CM of error and other RM caring for other baby.	Staff to manage own fatigue levels at 0400h Remember to check ID tags when returning baby to mother at all times. Use pt's full name when collecting baby from future and double check baby's tag w ff.	staff fatigue has lead to a baby been taken to mother t id not checked and 2 mums with same name in ward at time
	/2014	Gold Coast	Gold Coast University Hospital	Patient RN on break, buddy RN informed FOB to one of ients would be visiting baby and all was approved. May need a hand to cuddle baby. FOB shown in by another staff member. FOB standing outside room of Baby, buddy RN thought this was the room of baby belonging to this father as other nurse had left him at this room. RN asked if FOB needed a hand. Father left with baby to cuddle. Buddy RN went back to own patients. Upon return from primary RN break was noticed this was incorrect father for this baby and father was holding wrong baby.	* Upon entering all visitors should be identified to ensure correct room/patient by ALL nursing staff coming into contact with visitor. * Prior to allowing any parent to hold/visit baby, confirmation of ID of baby and visitor. * Bold ID of baby in room/outside room for early and easy ID of baby. * Wrist band or other easily accessible ID for family visiting baby in unit, to be seen clearly by all staff in unit. * Vigilance in visitor ID to ensure correct cot/patient upon entering * Wrist band/ID to be shown upon entering or all visitors/parents * Bold SURNAME of baby visible to all staff and parents/carers in room.	Staff need to establish the identity of the parents prior to letting them in the unit and then letting them into the babies" room. It was assumed that the correct father was being escorted to the baby but it was incorrect. Review into access and security of the unit will be undertaken in

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DATE 10/12 BY dd
3 DEC 2014

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Brief for Approval

Department RecFind No:	BR
Division/HHS:	HSCID
File Ref No:	

Requested by:

☒ Department ☐ Minister's office

SUBJECT: Information removed - not relevant to the scope of the application

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Issues

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3. During the period 1 January 2010 to 23 June 2014, there were Information removed - not relevant to the scope of th four incidents where an infant was accidently fed by the wrong mother.

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4/6 TRS

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Department RecFind No:	BR
Division/HHS:	HSCID
File Ref No:	

APPROVED/NOT APPROVED NOTED

DR MICHAEL CLEARY
Chief Operations Officer

9 / 12 / 2014

To Minister's Office for Approval ☐
for Noting ☑

Chief Operations Officer's comments

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Information removed - not relevant to the scope of the application

LAWRENCE SPRINGBORG
Minister for Health

/ /

for Chief of Staff

8 / 12 / 14

Minister's comments

Briefing note rating
1↑2↑3↑4↑(1 = poor and 4 = excellent)

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Dr Suzanne Huxley	Sophie Dwyer	Dr Jeannette Young
Senior Medical Officer	Executive Director	Chief Health Officer
Health Protection Unit	Health Protection Unit	Chief Health Officer Branch
33289606	3328 9266	3234 1137
18 November 2014	1 December 2014	2 December 2014

Pages 9 through 11 redacted for the following reasons:
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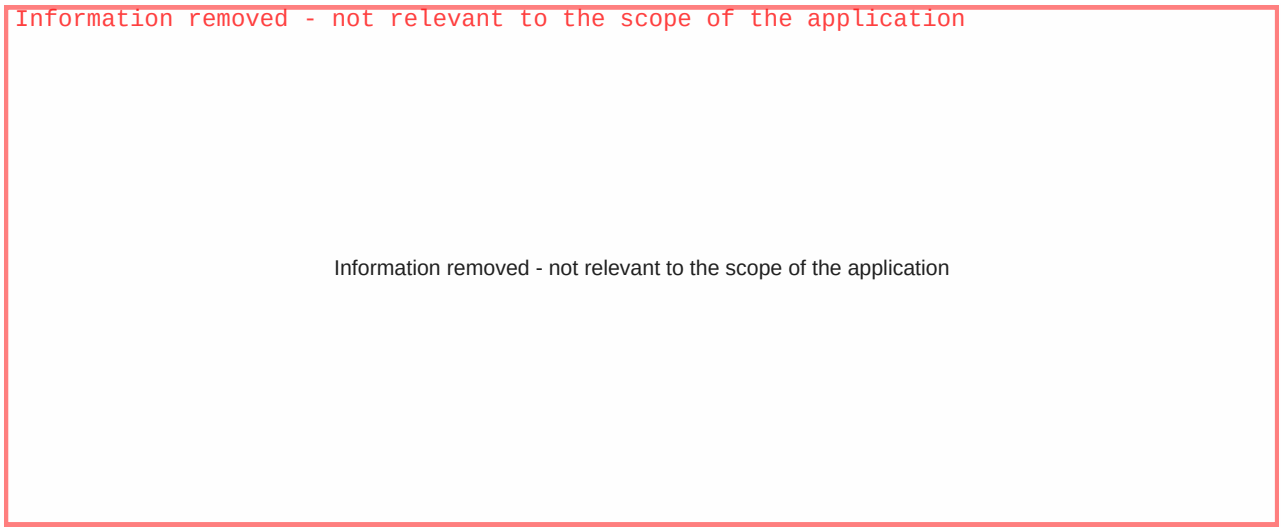

During the period 1/1/2010 to 23/06/2014, there were Information removed - not relevant to the scope of the application four (4) incidents where an infant was accidently fed by the wrong mother.

Pages 13 through 15 redacted for the following reasons:
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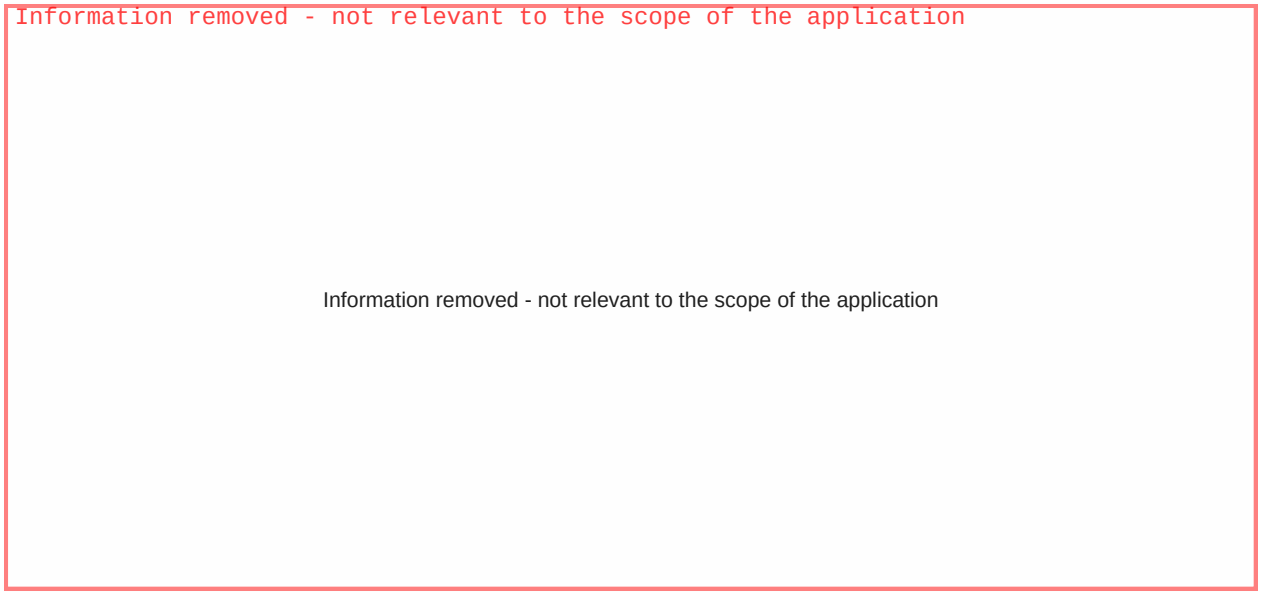
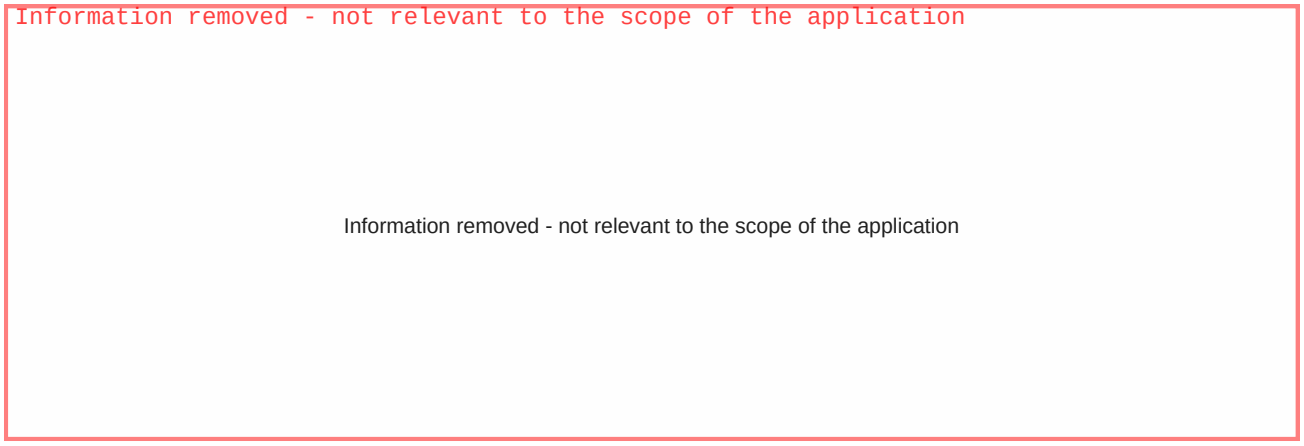
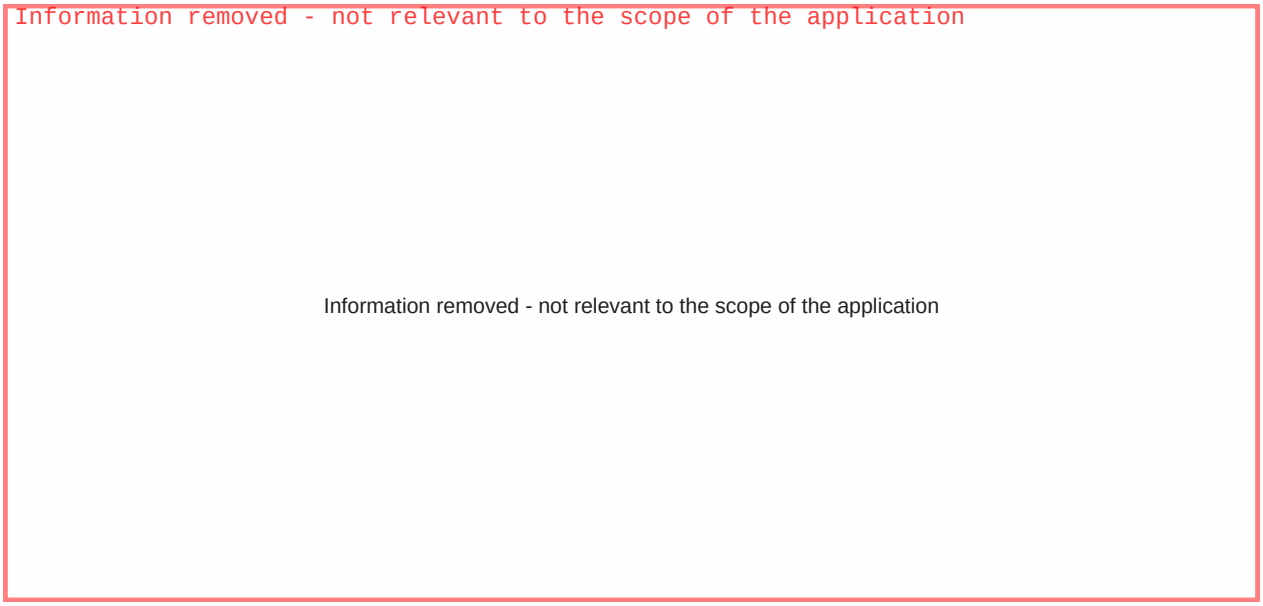


Of the seven (7) reported incidents where an infant was breast-fed by the wrong mother, one (1) incident was entered twice in the database and in two cases (2) the infant was fed by someone other than its birth mother with the mother's consent. Therefore, the number of incidents where an infant was accidently fed by the wrong mother was four (4).



All incidents relating to an infant accidently being breast fed by other than its birth mother involved human error. The majority of incidents related to inadequate checking of patient identification prior to feeding.



Pages 17 through 40 redacted for the following reasons:
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PRIME ID **Failure to adhere to patient/specimen identification protocols**

Assessment: No evidence of misconduct

This incident involved a baby being taken to and breast fed by wrong mother. An electrical outage generated poor lighting at time of incident. The midwife did not check baby identification with mother. It is unclear why the two babies in question were not with their mothers as per usual practice, however, the staff do try to help the Mothers at times to have some rest by taking crying baby away (with Mother's permission) to try to settle baby for mother. Appropriate staff and skill set on duty when the incident occurred.

Medical Staff assessed infection risk and Antenatal Screening (Pathology) is clear and respective patient has consented to have repeat Pathology. Mother of baby that received wrong breast milk was informed of this. Paediatric Consultant review notes that both Mothers seem understanding at this point in time. Staff suggestion to prevent reoccurrence: Address issue that the entire shift worked without appropriate lighting due to power outage and that all areas were busy with casual RNs working in the area. Corrective Action: Increased staff awareness regarding process for patient identification.

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PRIME ID [redacted] **Not a separate incident**

Linked to incident [redacted] – incident entered twice in PRIME database

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Pages 44 through 49 redacted for the following reasons:
- -
Information removed - not relevant to the scope of the application

Department of Health

Queensland Government

MEMORANDUM

To: Chief Executives, Hospital and Health Services

Copies to:

From: Dr Jeannette Young **Contact No:** 3234

Chief Health Officer **Fax No:** 3235 9573

Subject: Information removed - not relevant to the scope of the application

File Ref:

Information removed - not relevant to the scope of the application

During the period 1 January 2010 to 23 June 2014, Information removed - not relevant to the scope of the application

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- four incidents occurred when an infant was accidently fed by the wrong mother

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11. Baby taken to and breast fed by wrong mother
Electrical outage generating poor lighting at time of incident. Midwife did not check baby identification with mother. It is unclear why the two babies in question were not with their mothers as per usual practice, however, the staff do try to help the Mothers at times to have some rest by taking crying baby away (with Mother's permission) to try to settle baby for mother. Appropriate staff and skill set on duty; 2 Midwives, 1 RN (Meal relief). Medical Staff assessed infection risk and Antenatal Screening (Pathology) is clear and respective patient has consented to have repeat Pathology. Mother of baby that received wrong breast milk was informed of this. Paediatric Consultant review notes that both Mothers seem understanding at this point in time. Staff suggestion to prevent reoccurrence: Address issue that the entire shift worked without appropriate lighting due to power outage and that all areas were busy with casual RNs working in the area. Corrective Action: Increased staff awareness regarding process for patient identification.
11. Linked to incident [redacted] - same response
Linked to incident [redacted] - same response

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11. Baby taken to and breast fed by wrong mother
Electrical outage generating poor lighting at time of incident. Midwife did not check baby identification with mother. It is unclear why the two babies in question were not with their mothers as per usual practice, however, the staff do try to help the Mothers at times to have some rest by taking crying baby away (with Mother's permission) to try to settle baby for mother. Appropriate staff and skill set on duty; 2 Midwives, 1 RN (Meal relief). Medical Staff assessed infection risk and Antenatal Screening (Pathology) is clear and respective patient has consented to have repeat Pathology. Mother of baby that received wrong breast milk was informed of this. Paediatric Consultant review notes that both Mothers seem understanding at this point in time. Staff suggestion to prevent reoccurrence: Address issue that the entire shift worked without appropriate lighting due to power outage and that all areas were busy with casual RNs working in the area. Corrective Action: Increased staff awareness regarding process for patient identification.
11. Linked to incident [redacted] - same response
Linked to incident [redacted] - same response

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printed 3 July 2014

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Baby Fed by Other Than Own Mother

PRIME ID	Hospital and Health Service	Location	Date
Irrelevant information - not within date range/irrelevant			
	Irrelevant information - not within date range/irrelevant		
	Metro North	Redcliffe Hospital	2014
	Metro North	Redcliffe Hospital	2014
Irrelevant information - not within date range/irrelevant			
	Irrelevant information - not within date range/irrelevant		

Investigation: Information removed - not relevant t
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Prime Number	Facility	Incident Date	What went wrong (what occurred/contributing factors)	How the incident was managed
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Information removed - not relevant to the scope of the application					
[redacted]	Redcliffe	/2014 [redacted]	Baby taken to and breast fed by wrong mother	El	ectrical outage generating poor lighting at time of incident. Midwife did not check baby identification with mother. It is unclear why the two babies in question were not with their mothers as per usual practice, however, the staff do try to help the Mothers at times to have some rest by taking crying baby away (with Mother's permission) to try to settle baby for mother. Appropriate staff and skill set on duty; 2 Midwives, 1 RN (Meal relief). Medical Staff assessed infection risk and Antenatal Screening (Pathology) is clear and respective patient has consented to have repeat Pathology. Mother of baby that received wrong breast milk was informed of this. Paediatric Consultant review notes that both Mothers seem understanding at this point in time. Staff suggestion to prevent reoccurrence: Address issue that the entire shift worked without appropriate lighting due to power outage and that all areas were busy with casual RNs working in the area. Corrective Action: Increased staff awareness regarding process for patient identification.
[redacted]	Redcliffe	/2014 [redacted]	Linked to	incident [redacted]	- same response	Linked to incident [redacted]	- same response

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