

# Hospital baby mix-up renews old fears

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## Officials cite 'human error'

By Stephen Smith, Globe Staff, 9/26/2003

When a hungry newborn was given to the wrong mother for nursing this week, it sparked concerns beyond the maternity ward at Melrose-Wakefield Hospital.

The state Department of Public Health is investigating whether the error on Wednesday suggests broader problems at the hospital in keeping track of patients -- whether it's an infant scheduled for a feeding or an adult preparing for surgery.

Last night, a hospital spokeswoman said that the mother has told her obstetrician that she instantly recognized the infant was not her own and that no milk was passed to the child.

Hospital administrators, in a statement, attributed the mix-up to "human error" and pledged to immediately adopt more safeguards to prevent such mistakes from happening again.

Still, errors in identifying patients and the consequences -- giving the wrong drug to a patient or operating on the wrong limb -- rank among the greatest fears of hospital administrators because the outcome can be so severe.

The Melrose error also reflects a wider range of problems at hospitals across the nation, said Nancy Ridley, an assistant commissioner in the Department of Public Health.

"What happened with this baby may seem unique, and it is a rare event," Ridley said. "But it's related to a bigger family of patient identification problems. For instance, if you get a unit of blood meant for another patient and if your blood types aren't the same, it could have tragic ramifications."

Patient identification became a hot-button subject for hospitals in 1995 when within a few weeks at a hospital in Tampa, Fla., the wrong leg of one patient was amputated and the wrong respirator was switched off, leading to a patient's death.

The issue has stoked such alarm that the Joint Commission on Accreditation of Healthcare Organizations, which monitors and evaluates thousands of hospitals, has made improving the accuracy of patient identification its top safety goal in 2003. Reducing medical errors is also a leading concern of the Massachusetts Hospital Association.

"There's no room for error," said Chuck Mowll, the commission's executive vice president for business development, government and external relations. "We've asked hospitals that before you go forward with a procedure or a test or administer medicines or in this case handle an infant, take a time out and

make sure you have the right match."

A state investigator went to Melrose-Wakefield yesterday to gather details about this week's error and to review the hospital's patient-identification policies, said Roseanne Pawelec, public health spokeswoman. A report is expected in seven to 10 days.

Public health records show that the last time a similar mistake happened with a newborn was in 1998 at Lowell General Hospital. Ridley estimated that the agency investigates 10 to 20 errors annually that are blamed on patient misidentification, mostly related to patients getting someone else's medicine.

In a statement released last night, Melrose-Wakefield administrators provided preliminary findings from their own review.

"Early results of our investigation suggest that the incident -- the placement of an infant with the wrong mother -- was a result of human error stemming from an inaccurate check of the identification bracelets on the mother and infant," the statement said.

At UMass Memorial Medical Center in Worcester, ID bracelets are put on every infant's wrist and an ankle. That's standard procedure in most maternity units. The child's mother also gets a bracelet, as does the father or the person identified as a primary caregiver. Each bracelet carries an identifying number.

"If the number on the mom's band is 4250, the number on the baby's two bands says 4250," said Kathy Teeple, director of women and infant services at UMass Memorial. "It's ingrained in everyone here -- you never, ever give a baby to anyone without checking those bands."

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