

PROVIDING A SAFE HAVEN: STAFF RESPONSE TO A SIMULATED INFANT RELINQUISHMENT IN THE EMERGENCY DEPARTMENT



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Abstract

Every state in the United States has established laws that allow an unharmed newborn to be relinquished to personnel in a safe haven, such as hospital emergency departments, without legal penalty to the parents. These Safe Haven, Baby Moses, or Safe Surrender laws are in place so that mothers in crisis can safely and legally relinquish their babies at a designated location where they can be protected and given medical care until a permanent home can be found. It is important for health care professionals to know about and understand their state's law and how to respond should an infant be surrendered at their facility. No articles were

found in the peer-reviewed literature that describe a method to evaluate nurse competency during infant relinquishment at a Safe Haven location. This article will describe commonalities and differences among these Safe Haven Laws, responsibilities of the hospital and staff receiving a relinquished infant, and 1 hospital's experience when running an infant relinquishment drill in their emergency department.

Key words: In situ simulation, Infant relinquishment, Newborn abandonment, Safe Haven Law, Baby safe haven, Competency

Background

In response to 13 newborn abandonments in less than a year's time, legislators in Texas introduced and then passed the first Safe Haven Law in 1999.¹ The vast majority of states quickly followed, and by 2009, every state had a similar version of the law. On a national scale, more than 4100 babies have been legally relinquished in the United States since the passing of this first law in Texas, per the National Safe Haven Alliance (NSHA),² most into the arms of health care personnel in emergency departments, according to D. Geras, President, Illinois Save Abandoned Babies Organization, in a phone communication of January 14, 2020. During this same time period, 1567 babies were reported as illegally aban-

doned, 885 of whom died, according to D. Geras, President, Illinois Save Abandoned Babies Organization, in a phone communication of December 1, 2020. It is impossible to know exactly how many babies have been illegally abandoned in the US, as many remain unknown by authorities and not all states track these statistics.

Commonalities and Differences Among the State Laws

Specific components of these laws can vary among states and may even change as of the time of this writing. These variations relate to definitions of a safe haven, who may relinquish the baby, age limit of the baby, whether the relinquishing person can remain anonymous, and if medical information is requested of the parents. The most updated version of each state's law can be found on the NSHA website (see Resources) or from state hospital associations.

SAFE HAVEN LOCATIONS

Given that Safe Haven Laws were put in place to protect newborns and give them the medical care they need to stay safe, all states, the District of Columbia, and Puerto Rico authorize health care providers at hospitals to accept an infant.³ Approximately 42 states also authorize emergency services personnel,

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such as those at fire stations and police stations, to accept an infant and/or allow relinquishment through the 911 emergency systems. Several states designate locations such as a licensed adoption facility or faith organization (eg, church, temple, mosque) as safe havens with a caveat that personnel are known to be present at the time the infant is left.⁴

WHO MAY LEAVE A BABY AT A SAFE HAVEN

In most states, either parent may surrender their baby to a safe haven, whereas some states stipulate that only the biological mother, or birthing person, may do so. Nineteen states specify that someone who has approval of the parent may bring a baby to a safe haven,³ whereas 8 states do not specify.⁴ Parents may remain anonymous in most states, and if information is voluntarily provided by a parent, 15 states offer an assurance of confidentiality with regard to this information.⁴ Parental anonymity is forfeited if there is evidence of child abuse or neglect. For states where safe haven personnel are required to ask parents for their name and family history, but parents decline, the hospital should still accept the baby, attempt to give the parent a way to provide information anonymously, and allow them to leave. When anonymity cannot be maintained, such as when a relinquishing mother or birthing person delivers the baby at the hospital while an inpatient, the nursing staff may contact the social worker/case manager to speak with the patient about developing a formal adoption plan. Another option for the mother or birthing person is to be discharged from the hospital with the baby and then immediately return to the emergency department to relinquish the baby under the law.

AGE LIMITS OF THE BABY

Nebraska's Safe Haven Legislative Bill, when initially enacted in 2008, did not include a limit on the age of a child who could be legally relinquished. After 19 children between the ages of 10 and 17 were left with hospital employees during a 6-week time period, the Bill was quickly amended to include an age limit.⁵ Infant age limits across the US range from 3 to 90 days. Although a shorter window for surrendering an infant may appear to limit options to parents, it helps reduce a newborn's exposure to adverse conditions in an unsafe home environment.⁶

RESPONSIBILITIES OF SAFE HAVEN PROVIDERS

Personnel at designated safe havens are required to take emergency protective custody of the infant, provide medical care as indicated, and immediately notify the local child welfare department that an infant has been relinquished under the law.⁴ Safe Haven laws in a handful of

states require personnel to also call local law enforcement agencies to check if the baby is a missing child, but unless there is actual or suspected evidence of child abuse or neglect, or coercion to relinquish the baby, police involvement is rarely, if ever, necessary. Nearly half the states require that personnel at the safe haven ask parents for family/medical history, whereas approximately a third need to offer parents a packet that includes information on parent legal rights, postpartum care of the mother or birthing person, and community resources such as family planning, psychological counseling, and local health clinics. Packets need to also contain instructions on how parents can anonymously report family/medical/birth history.^{3,4} A copy of the infant's identification bracelet should be offered to the relinquishing parent in 4 states to help link a parent with their child if reunification is sought at a later date.^{3,4}

Once the parent leaves the hospital premises and personnel notify the local child welfare agency that a baby was legally relinquished, the agency assumes custody and begins the task of placing the infant, initially in a preadoptive home. Many states require that the agency first determine if the baby has been reported as a missing child and/or if the baby's father is listed in the state's putative father's registry, which would protect the parental rights of an unmarried father.^{3,4} In many states, the act of relinquishing an infant to a safe haven is presumed to be a relinquishment of parental rights, whereas approximately 20 states have procedures in place for a parent to reclaim their child within a specified amount of time, before parental rights have been terminated.⁴

IMMEDIATE RESPONSE TO RELINQUISHMENT

A nurse may only have a few moments to reassure the parent that they are in a safe place and that staff are there to assist. When nurses are prepared, caring, and knowledgeable of the law at the time of a relinquishment, they can help to ensure a smooth transition and improve outcomes for both the parent and the baby. Research shows, however, that many nurses may not feel prepared to receive a baby.¹ Of 605 nurses in Texas who responded to a survey about the Safe Haven Law soon after it was enacted in their state, 92% reported feeling unprepared to receive an infant and scored an average of 40% on a test of knowledge about the law. In addition, 70% of the nurses surveyed reported that they had a negative attitude toward women who would relinquish an infant.¹ Physicians too, may not be prepared to receive an infant under a Safe Haven Law.⁷ Emergency medicine residents in the state of New York were surveyed to determine the

percentage who were familiar with their state's Safe Haven Law and the level of their knowledge. Findings showed that 71% had never heard of the law. Of the 29% who did hear of it, more than a third did not understand it correctly. Researchers reported that both police and fire departments in New York include information on the Safe Haven Law in their training, whereas emergency medicine residencies do not.⁷

Protocol Components

Hospital policy and protocols should follow state law and clearly describe the roles and actions of personnel at the time of a legal infant relinquishment. Although protocols will vary slightly depending on institutional resources, all need to include similar components (Supplementary Box).

Simulation

LOCAL BACKGROUND

When Safe Haven laws were passed, hospitals around the US created policies and developed staff education. However, assessing staffs' potential reaction if someone were to hand them a baby and ask, "You are a Safe Haven hospital, right?" is done less frequently. NSHA has developed online education modules as well as simulation checklists and other materials that hospital educators can use to assess staff competency.² Similar to regularly occurring infant hospital abduction drills, infant relinquishment drills can identify gaps in knowledge and prepare staff to ensure the safety of a relinquished baby and support the parent at this challenging time in their life.

The needs assessment at our large academic medical center in the Midwest began when hospital educators presented on the Safe Haven Law at a Women's and Children's Nursing Grand Rounds. Staff had misperceptions and asked many questions at this presentation. It became clear that the best way to know if staff would correctly assess a relinquishment situation, contact the team, and take appropriate action was to run an infant relinquishment drill in the emergency department, using equipment and resources from that unit and involving actual members of the health care team.⁸ This in-situ drill would evaluate for 3 factors: (1) what the staff knew, (2) how they would respond

without previous knowledge of the drill, and (3) opportunities for immediate improvement.

Methods

Following the best practice standards established by the International Nursing Association for Clinical Simulation and Learning,⁹ the intervention was the development and feasibility testing of an educational in-situ drill for infant relinquishment in the emergency department (Table). In-situ, live actor simulation can be used to identify knowledge gaps, solidify teamwork, and highlight the importance of communication in a unique situation.¹⁰ This initiative was deemed quality improvement, nonhuman subjects research by the institutional review board.

Planning the Simulation

The authors invited the clinical nurse specialists from the emergency and obstetrics departments and the assistant security director to assist with planning of the drill. The discussions considered the likely entrance points and places where it might be challenging to process the request of relinquishing a baby. The situation would be a young mother entering the hospital at the information desk and asking the staff if this was a Safe Haven hospital. The "relinquishing mother," a volunteer from the volunteer services department, met with the team a day before the drill to review the Safe Haven Law and her role as the young mom who is afraid and knows she cannot keep the baby. Her goal was twofold: find someone at the hospital to take her baby without having to answer too many questions and stay in the scenario long enough that it could end in the emergency department. Because it was in situ and took place in an actual patient care unit, the only equipment needed was a realistic-looking baby doll and blanket. The authors, clinical specialists, and security served as facilitators at different points during the drill: 2 near the information desk to ensure the drill had a good start and the mother was escorted to the emergency department, 1 near the ED admission/triage area to observe the activity of the staff and clients in the waiting room, and the final 2 inside the emergency department to meet the staff and mother for the final counseling discussion and infant examination. The lead facilitator developed a checklist of key steps and points that

TABLE

Logic model - infant relinquishment in-situ simulation drill

Resources/Inputs	Activities	Outputs	Outcomes
Policy	Review policy for needed resources and consistency with state law	Determined objectives/checklist of critical points	Short-term: Amend policy to be feasible, safe, and consistent
Illinois state law	Review state law	Policy consistent with state law	Short-term: Materials to be available to parent
Personnel: OB & ED CNS, volunteer services, security, guest services, ED staff	Needs assessment Plan simulation • Live unit • Two contact points • Facilitator locations	Identify gaps in knowledge Propose simulation to ED leadership Develop the scenario Details and roles of simulation personnel finalized	Support received from ED leadership for simulation drill Scenario complete Roles clarified Fidelity to policy assessed
Interprofessional staff: Emergency nurses, social worker, case manager, security	Hold prebrief Walk-through In-situ simulation drill	Minor change to start of the drill based on walk-through On unit simulation of parent relinquishing her infant	
Equipment: Doll Blanket Checklist	Secure materials from childbirth class Develop checklist on the basis of policy and simulation objectives	Contributed to realism of the scenario Assess for fidelity	Staff responses that did not match policy were noted
Room for debrief	Postsimulation debrief to review staff response	Areas for improvement identified and discussed	Short-term: Summarize event/make recommendations Update policy Make immediate corrections as indicated Intermediate: Repeat drill Long-term: Standardize annual drill/education

OB, obstetrical; ED, emergency department; CNS, Clinical Nurse Specialist.

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should occur during the simulation to assess for fidelity to the policy and if the team met the objectives of the simulation (Supplementary Table).

Stages of the Simulation

PREBRIEFING

The simulation experience began with a prebriefing. The facilitators and volunteer met to discuss final details and alternate plans if the staff were unable to progress at any point. This was followed by a walk-through with the volunteer to identify the route and the staff she would most likely encounter. The goal of the walk-through was to “identify any confusing, missing, or

underdeveloped elements of the simulation-based experience.”⁹ During the walk-through, it became evident that there would likely be a wait at the information desk and that the volunteer would need to move closer to the guest services person to be recognized more quickly than waiting in the line.

IN-SITU DRILL

To begin the unannounced in-situ drill, the mother entered the hospital through the parking garage into the main entrance. She stood a little off to the side of the waiting line holding the baby doll, which was wrapped in a blanket, and waited to be noticed. When the guest services staff acknowledged her, the relinquishing person stated: “Are you a Safe Haven hospital?” This was a defining moment.

The guest services staff asked the volunteer to stand closer to her and then called for a security escort. The volunteer acted nervous to hearing the word “security” but was quickly reassured that they would be escorting her and her baby to the correct location for Safe Haven. Quietly, the security officer met the relinquishing person and asked her to follow him. Not speaking, they left to head toward the emergency department.

In the busy emergency department, the security officer stepped up to the intake desk to inform the triage nurse that there was a request to relinquish a baby. The triage nurse correctly observed a young woman with a doll who was acting as if the doll was a real baby. The nurse quickly assessed the situation and contacted the hospital’s psychiatric team, an unforeseen consequence of an unannounced in-situ simulation. One of the facilitators was able to step in behind the nurse to explain this was a Safe Haven drill. The alert was changed from the psychiatric team to the social worker, case manager, and charge nurse. The relinquishing person was escorted to a consult room where she was met by the charge nurse who asked the patient her name. The baby doll was carried to an examination room.

Two of the facilitators joined the charge nurse as they waited for the social worker, who was looking for the packet of information. Not finding it, they checked the hospital policy on legal infant relinquishment and were able to access information by searching the internet for The Safe Haven Law (Illinois law: 325 ILCS 2/1-70). The online site allows full access to the Act, the brochure “Taking Care of Yourself After Giving Birth,” a summary of the law, and the brochure “Help is Here,” which includes the optional health history form and instructions in case the relinquishing person changes their mind within 72 hours or wishes to petition the court within 60 days.¹¹

While waiting for the social worker, the charge nurse sensitively spoke to the relinquishing person to check on her physical health, offering a free postpartum check. The nurse also asked if she was comfortable to share whether she felt safe in her home environment. The social worker entered with the packet and informed the mother that her baby was healthy and that the Department of Children and Family Services would ensure a safe transfer to an adoption agency. At that point, the mother had stayed in the scenario long enough to meet the goals and asked to leave. She was asked to complete the health history form and mail it in the stamped envelope to the local child welfare agency as it would help the adopting family to better care for her child. That ended the single-event, 20-minute simulation.

DEBRIEF

In a debrief, all personnel involved with the simulation come together to reflect on the expectations and consequences of staff response. The facilitators, volunteer mother, emergency charge nurse, social worker, and case manager met to openly communicate about what was learned as a result of the drill. Using the fidelity checklist to guide the discussion, the lead facilitator compared the responses of all personnel during the drill with the simulation objectives and the procedural steps outlined in the policy: the initial situational awareness at the guest services desk, the prompt response from security to escort the volunteer to the emergency department, that although she was asked to provide her name, the anonymity of the mother was maintained, the information packet was not immediately available, the mother was escorted to a private room while the child was examined, and the social worker was aware of the need to call the local child welfare department. The emergency triage nurse was unable to attend the debrief owing to needs of the unit but shared her thinking when she saw a woman with a doll and called the psychiatric team. Because this hospital is a large medical center with easy access from anywhere in Chicago, it is not unusual for a client with mental health needs to come to the emergency department. The ED team asked if it would be just as effective if the team knew beforehand that there was going to be a drill so that they could practice the correct steps. The ED team recognized infant relinquishment was a high-risk, low-volume event and requested more information about their responsibilities.

EVALUATION

In the debrief, the team concluded that the drill was executed as planned and for the most part, the ED team adhered to the policy. The drill uncovered areas of the policy that needed updating or reviewing such as making information packets immediately available at the triage desk and in the case management office and not asking the relinquishing person their name. It also became evident that because of the extra time that the staff took to learn more about the mother and search for the packet of information, they risked that she would leave, possibly with the baby. After the evaluation, the plan was to revise the policy to improve efficiency, educate the staff, and inform all involved personnel that the drill would be repeated at a future date.

Here, we have added uniquely to the published literature by describing a method to evaluate emergency nurse competency during infant relinquishment at a safe haven location. We determined the simulation was feasible,

recommended the intervention should be repeated routinely, and relayed several lessons learned and recommended intervention adjustments to future replications of our live actor simulation. Future work should also measure knowledge, skill, attitude, and behavior changes of the clinical nurse participants with the intervention and provide more detail from the clinical nurse participant perspective.

Implications for Emergency Clinical Practice

On the basis of our findings, we recommend that hospital and ED educators establish a plan to regularly evaluate interprofessional staff response to simulated infant relinquishment. On the basis of our lessons learned, hospital educators who plan to run an infant relinquishment simulation should inform staff of the drill in advance. If available, include a person experienced with simulation that can provide additional guidance during development, running, and evaluation of the drill. Using a timed checklist during the drill, as recommended by NSHA,² allows hospital educators to record the length of time it takes for staff to complete each critical step of the relinquishment process. This establishes a baseline from which improvements can be noted in subsequent drills. We recommend attempting to have all involved personnel attend the debrief session as this is when misperceptions and misinformation are clarified. We recommend the simulation team circle back to those who could not attend the debrief to see if they have any questions. Once identified, address the gaps in knowledge and resources that can be immediately corrected. We also recommend that individual clinical nurses and emergency care teams review policy, revise as needed, inform staff or colleagues, and repeat infant relinquishment simulations.

Conclusion

Infant relinquishment is a rare event, and there is little room for error should it arise at your institution. Outcomes may be improved for both parent and baby if they are met by a knowledgeable nurse at the time of relinquishment. Training and simulation are excellent ways to ensure that safe and best practice is implemented in the event that a parent wishes to relinquish their baby under the Safe Haven Law. This article describes 1 hospital's experience in running an in-situ drill so that other institutions can prepare staff to accept a relinquished baby in a way that adheres to their state's law and provides a safe haven to both parent and newborn. Individual clinical nurses can also cognitively rehearse to prepare for a potential infant relinquishment in their practice.

Outside of the hospital, nurses are in a position to educate staff at other safe haven locations and raise the public's awareness about Safe Haven laws. See the Resources provided to order pamphlets and posters, which can be shared and displayed at health fairs and community congregating areas such as hair salons, faith community buildings, or high schools. Inform parents, teachers, neighbors, and friends about the law, particularly in networks where people may know someone who is trying to conceal a pregnancy.

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Author Disclosures

Conflicts of interest: none to report.

J. B. Rousseau is a volunteer with the Illinois Save Abandoned Babies Foundation.

Resources

Find a safe haven location. National Safe Haven Alliance. Accessed September 15, 2020. <https://www.nationalsafehavenalliance.org/safe-haven-locations>

Save Abandoned Babies Foundation. Accessed September 15, 2020. www.Saveabandonedbabies.org

National Safe Haven hotline: 888-510-BABY.

Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jen.2020.12.005>.

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Submissions to this column are encouraged and may be submitted atjenonline.org. Authors are encouraged to contact Section Editor Jacqueline Stewart, DNP, RN, CEN CCRN, FAEN Jacqueline.stewart@wilkes.edu for presubmission guidance.

Supplementary Data

Supplementary Box. Infant relinquishment policy and procedure template

Purpose of the policy - To provide a mechanism for an unharmed newborn to be relinquished to a safe environment and for the parents of the infant to remain anonymous and free from civil or criminal liability for the act of relinquishing the infant.

Definitions – relinquishment, anonymous, unharmed infant, reclaiming.

Information about the law and how it affects hospital personnel, such as hospital personnel being immune from criminal liability for acting in good faith, that the hospital has temporary protective custody, and if the law applies to mothers who give birth while they are in the hospital.

Regulatory elements – Include a link to the state's Safe Haven law.

Outcomes – The optimal outcomes are that the relinquishing parent is given the option to provide medical history (anonymously if they choose), and the healthy infant is turned over to a child-placing agency, which could include the parent making a formal adoption plan.

Responsibilities and procedures – This section identifies the specific steps hospital personnel take to enact the policy; includes security personnel, front desk personnel, triage/charge nurses, physician/nurse practitioner, child protection staff, and patient liaison (case manager, social worker). Depending on state law and institutional resources, steps may include placing an ID bracelet on the baby, a medical examination of the infant, use of an interpreter when indicated, providing a professional to support and attend to relinquishing person's needs, calling child-placing agency and/or law enforcement, and materials to give to the relinquishing person that describes their rights and a way to provide medical history on the baby. Should the baby's mother be the one presenting to your institution, a professional such as a social worker should be available to assess for medical needs, emotional well-being, and safety.

Related hospital policies – such as child abuse and neglect, admission of a newborn, and interpreter services.¹²

Guidance on what to do in situations that are less clear, which will be state/hospital dependent:

- The baby is obviously older than state law allows.
- There is evidence of harm/positive drug screen.
- The infant is born in the hospital, and the mother or the birthing person wants to leave the baby.
- The parent returns to reclaim the baby soon after relinquishment.

Supplementary Table. Fidelity checklist

Action	Met/Not Met	Time
The team, wherever this simulation would begin, will recognize the serious nature and work to protect the relinquishing person by activating the Security team.		
The Security team will respectfully guide the relinquishing person to the emergency department without hesitation.		
ED personnel will offer to bring the relinquishing person and infant to a private room and provide a counselor or a nurse to remain with them.		
At no time will staff ask the patient's name, until given permission by the patient to do so.		
The nurse and counselor will provide the designated packet of information (described earlier) as per state law to support the relinquishing person in their decision and guide them in the next steps.		
The infant will be moved to an exam room to be assessed for health, safety, and age.		
The relinquishing person would be offered emergency health care related to post-partum complications if indicated.		