QuickSafety
An advisory on safety & quality issues

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Temporary names put newborns at risk

Issue:

In 2015, The Joint Commission issued a *Quick Safety* newsletter on temporary names for newborns putting them at risk for medical errors. The persistence of this problem spurred The Joint Commission in 2019 to implement a new element of performance at National Patient Safety Goal (NPSG) 01.01.01 requiring organizations to use distinct methods of identification for newborns. Unfortunately, medical errors involving newborns continue to occur, especially for multiple births and newborns placed in neonatal intensive care units (NICUs).[1]

Newborns are unable to participate in the identification process, requiring hospitals to implement a reliable system that is hardwired among all providers to prevent error. An example of a typical but non-distinct temporary name is "Babyboy Smith," using the baby's gender and the parent's last name. While more distinct temporary names are being used for newborns, some of the naming conventions still are not distinct enough to prevent patient identification errors that could result in harm. In fact, some naming conventions make the mother's name and the baby's temporary name too similar (e.g., "Smith, Jane Girl 1"), which has resulted in some close calls.[1]

A 2017 article of a quality improvement study identified risks related to the unique characteristics of neonates that increases the risk of wrong-patient errors in NICUs, including:[2]

- The use of non-distinct temporary first names for newborns (e.g., "Babyboy" or "Babygirl").[2]
- Medical record numbers being assigned sequentially, resulting in infants born in close temporal proximity having similar medical record numbers.[2]
- The large population of multiples in NICUs with nearly identical names and medical record numbers.[2]

In addition, misidentification of newborns can be propagated by the electronic health record (EHR) when:

- Changing the newborn's EHR from a temporary name to permanent given name before discharge.[1]
- Long temporary newborn names become truncated in the EHR, on name bracelets and on medication administration records (MARs).[1]

Newborn misidentification errors include:[1]

- Medication errors
- Misfeeding breast milk
- Order entry and documentation errors
- Misidentification of diagnostic results
- Wrong person surgery, procedures, and diagnostic tests
- Infants switched at birth and discharged to the wrong parents

Between 2010-2020, The Joint Commission received 18 sentinel event reports related to wrong procedure (circumcision) being performed on neonates, with the main contributing factor being misidentification.

In high-risk settings such as the NICU, distinct naming conventions may need to be combined with other strategies to help ensure safety. One medical center achieved a combined total reduction of 61.1% in wrong-patient orders in the NICU compared with baseline by implementing two interventions. The first intervention used ID reentry, a health information technology-based intervention, which required users to actively reenter patient identifiers (i.e., initials, age, and sex) before placing orders. This intervention resulted in a 48.7% relative reduction in wrong-patient orders (using the Wrong-Patient Retract-and-Reorder, or RAR, tool) in both the NICU and non-NICU pediatric units. The second intervention added a distinct naming convention. Before

(Cont.)

either intervention, patients in the NICU were at significantly higher risk for a wrong-patient order compared with patients in non-NICU pediatric units, with the risk being even higher for multiples.[2]

The reduction in wrong-patient orders with the ID reentry intervention in the NICU was similar for singletons and multiples; however, the addition of the distinct naming convention was observed to further reduce wrong-patient errors only for singletons.[2]

Safety Actions to Consider:

In addition to using the combined strategies of using ID reentry plus distinct temporary naming conventions to help protect babies of multiple births and those in the NICU, hospitals can take the following actions to protect all newborns from adverse events related to patient misidentification:

- Use distinct temporary naming conventions, with special attention to temporary names used for multiple births. One way to do this is to employ different formatting of text (e.g., types, cases, and/or sizes of fonts; bolding; color) to distinguish newborns (e.g., Baby **GIRL**, Baby**girl**).[2]
- Train staff on the distinct naming convention used by your organization.
- Follow requirements in National Patient Safety Goal 01.01.01 – implement to use of two patient identifiers at all times.
- Employ bedside barcode scanning systems for mothers and newborns.[2]
- Employ name alerts.[2]
- Limit who can change or merge newborn EHRs.[2]
- Limit access to patient records to only those appropriate for the practitioner.[2]
- Establish hard stops or require documentation of a reason overriding electronic alerts that may signal a potential mix-up between mother and newborn.[2]
- Customize screen backgrounds (e.g., color, highlighting of newborn and age) to better distinguish between mother and newborn records.[2]
- Increase the size, width, character spaces used for identification to enhance the display of complete information.

Resources:

1. Institute for Safe Medication Practices. What's in a Name? Newborn Naming Conventions and Wrong-Patient Errors. April 25, 2019.
2. Adelman JS, Aschner JL, Schechter CB, et al. Evaluating Serial Strategies for Preventing Wrong-Patient Orders in the NICU. Pediatrics. 2017;139(5):e20162863.
3. ISMP. What's in a Name? Survey Finds Wide Variety of Error-Prone Newborn Naming Conventions in Use Today. Nov. 21, 2019.

Note: This is not an all-inclusive list.