

Temporary names put newborns at risk

Issue:

A common practice in hospitals is to give newborns temporary names at birth, since the parents may not have decided on the baby's name. While the practice is intended to identify newborns, it results in a large number of patients with similar identifiers and who could potentially have the same date of birth, gender and surname – circumstances that put newborns at risk for patient identification errors.^{1,2}

Newborns also are a unique patient population as they are unable to participate in the identification process. This unique need requires a reliable system that is hardwired among all providers to prevent error. An example of a typical temporary name is Babyboy Smith, using the baby's gender and the parent's last name. This naming convention is not distinct enough to prevent patient identification errors that could result in harm.

Newborn misidentification errors include:

- Feeding a mother's expressed breast milk to the wrong infant²
- Reading imaging tests or pathology specimens for the wrong patient¹
- Incorrect documentation of medications, vascular lines, and patient weight²
- Administering blood products to the wrong patient¹
- Collecting lab specimens from the wrong patient
- Wrong person surgery

The Joint Commission's Sentinel Event database includes 10 reports since 2010 of sentinel events that occurred due to the misidentification of newborns. All 10 reports are wrong person surgeries and all 10 resulted in circumcision being performed on the wrong patient.

A recent study¹ published in *Pediatrics* highlights how one hospital experienced a 36.3 percent reduction in Retract-and-Reorder (RAR) events after implementing a distinct naming convention for newborns requiring admission to the neonatal intensive care unit (NICU). (RAR is an automated tool for detecting the outcome of wrong-patient electronic orders.) The distinct naming convention used the mother's first name, followed by the letter "s" and the baby's gender, then the parent's last name (ex: Judysgirl Smith). In the case of multiple births, the hospital adds a number in front of the mother's first name (ex: 1Judysgirl and 2Judysgirl).¹

The high potential for error due to the misidentification of newborns was illustrated in a study published in 2006.² Over a one-year period, a NICU discovered that not a single day was free of risk for patient identification. The mean number of patients who were at risk on any given day was 17, representing just over 50 percent of the average daily census. During the entire calendar year, the risk ranged from 20.6 percent to a high of 72.9 percent. The most common causes of misidentification risk were:

- Similar-appearing medical record numbers (MRNs)
- Identical surnames
- Similar-sounding names

Safety Actions to Consider:

Hospitals can take the following simple and effective actions to protect vulnerable newborns from adverse events related to patient misidentification:

- Stop using Babyboy or Babygirl as part of the temporary name.

(Cont.)

- Change to a more distinct naming convention.
- Train staff on the distinct naming convention.
- Follow the recommendation in National Patient Safety Goal 01.01.01 and implement use of two patient identifiers at all times.
- As soon as parents decide on their baby's name, enter that name into the medical record instead of the temporary name.

Resources:

1. Adelman J, et al: Use of Temporary Names for Newborns and Associated Risks. *Pediatrics* 136(2); August 2015
2. Gray JE, et al: Patient Misidentification in the Neonatal Intensive Care Unit: Quantification of Risk. *Pediatrics* 117(1); January 2006

Note: This is not an all-inclusive list.



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The information in this publication is derived from actual events that occur in health care.