Newborn Patient Mix-ups

Newborn babies are at an increased risk of errors related to patient mix-ups within the hospital setting. Multiple factors that contribute to wrong-patient errors within this population include:

- Newborns cannot confirm the patient identification process since they cannot speak.
- Infants are difficult to distinguish from one another.
- Many newborns aren't given names right away.
- Last names, medical record numbers, and birth dates are very similar to mother and other babies born within the same timeframe.

Hospitals may assign a temporary first name, such as Babyboy/Babygirl, Boy/Girl, or BB/BG with the mother's last name to identify infants. This results in patients with similar identifiers such as infants with the same last names and non-unique first names. Twins and other multiple birth newborns are at an even higher risk since they share the same birthdate, gender, and last name. They are typically distinguished by a letter or number (i.e Babyboy1/Babyboy2) that could be overlooked. In addition, medical record numbers are assigned by numerical order and differ by only one digit between siblings. Infants in the neonatal intensive care units (NICUs) are at an increased risk for errors given the large numbers of medications and treatments they receive – one out of four mistakes results from misidentification. Numerous errors also occur when the temporary name is changed to a permanent name in the electronic health record (EHR) before discharge to prepare the birth certificate. In addition, long temporary names might be shortened in the EHR, on name bracelets, and on medication administration records (MARs) leading to confusion between mother and newborn and/or multiple births.

Errors related to patient mix-ups include:

- Medication errors
- Wrong feedings of breastmilk
- Wrong patient diagnostic tests, procedures or surgery
- Order entry and documentation errors
- Misidentification of diagnostic results
- Infants switched at birth and discharged to the wrong parents

The Joint Commission (TJC) recommends using a more distinct temporary newborn naming system and switching to the infant's given name as soon as it has been selected by the parents. TJC recommends the following strategies to decrease identification errors:

- Use mother's first and last name and the baby's gender (i.e. "Jones, Sara Girl") – this recommendation comes with great criticism as this naming system results in the mother and newborn's names being too similar and if the name is truncated in the EHR, the names of the mother and child appear to be identical
- Use at least two patient identifiers when providing patient care
- Place identification bands and barcoding on two body sites such as wrist and ankle
- Alert staff with signs if newborns have similar names

References

1. Institute for Safe Medication Practices. (2018). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201905.pdf