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ISMP Survey Finds Hospitals and Birthing Centers Are Using Error-Prone Naming Conventions for Newborns

Horsham, Pa.—Results of a recent survey conducted by the Institute for Safe Medication Practices (ISMP) show that hospitals and birthing centers use a wide range of methods to assign temporary names to newborn infants for identification purposes, and many of those naming procedures can lead to errors where the wrong patient receives a medication.

Healthcare providers typically assign a nondistinct first name (e.g., Baby Boy), plus the mother's name immediately after birth, which results in babies who have similar identifiers. ISMP conducted a survey in April through September of 2019 to learn more about the challenges associated with proper identification of mothers and newborns. The majority of the 384 respondents were nurses who work in neonatal intensive care units (69%), and integrated labor, delivery, recovery, postpartum, and newborn units (32%). Results were published in this week's ISMP Medication *Safety Alert!*® Acute Care newsletter.

For single newborns, respondents reported **75 different naming conventions**, with more than half being used in only one unique facility. Most respondents (84%) embedded the mother's first name in the naming convention.

Even more extensive variation in newborn naming conventions was reported for multiple siblings (twins, triplets, etc.). Respondents reported **138 different naming conventions**, with almost three-quarters being unique to a single facility. While most respondents (70%) used single letter identifiers to distinguish between multiples, some (12%) used single numbers, and the remainder a variety of different methods.

Potential for Errors to Occur

Almost one-third of all respondents reported that they were aware of medication errors or close calls associated with their newborn naming convention within the past five years. The most frequent types of reported events involved confusion between newborn siblings or unrelated newborns with similar or the last names. Most of the reported events occurred when medications were administered, but some involved prescribing errors where the wrong newborn record was selected in the electronic medical record (EMR) or there was a mix-up between mothers and their newborns.

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In the past five years, 55% of respondents also were aware of issues with expressing the full identity of newborns. Many commented that their process results in long temporary names that are difficult to read or have truncated or missing information due to character limitations in the EMR, particularly with hyphenated last names. They reported that characters have dropped off the end of newborns' names, resulting in the inability to distinguish between multiple siblings (70%) or between the mother and newborn (34%).

Prevention Strategies and Recommendations

According to the survey, the most common strategies used to reduce the risk of misidentifying mothers and newborns are employing barcode scanning systems, utilizing name alerts, and limiting who can change/merge newborn EMRs. However, respondents provided numerous examples of conditions that still allowed errors to occur despite these strategies. Barcode scanning may not happen in real time, often only physical name alerts are used and not electronic alerts in the EMR, and limiting access to newborn EMRs can be dangerous during an emergency.

ISMP plans to convene an expert advisory group in 2020 to review the survey findings in more depth and make recommendations to prevent misidentification and wrong-patient medication errors with mothers and newborns.

For a copy of the full article on the survey, visit ISMP's website at: https://www.ismp.org/acute-care/medication-safety-alert-november-21-2019 (subscription required), or contact Renee Brehio at rbrehio@ismp.org.

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. In 2019, ISMP is celebrating its 25th anniversary of helping healthcare practitioners keep patients safe and leading efforts to improve the medication use process. ISMP recently announced that it has formally affiliated with ECRI Institute to create one of the largest patient safety organizations in the world. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

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