Confusing Newborn Naming Methodologies

There are a wide variety of complex newborn naming methodologies employed by institutions. Newborns are typically given a temporary first name and the mother's maiden name immediately at birth for identification purposes. This often results in multiple patients with similar identifiers which can result in patient errors. Twins and multiple births are at an even higher risk since they have the same birthdate, gender, and last name as well as a medical record number that often differs by only one digit.

Other factors that can lead to newborn misidentification include:

- Newborns look very similar and they cannot verbally confirm their identity
- Each newborn electronic health record (EHR) must be changed from the temporary name to the permanent name after completing the birth certificate
- Long temporary newborn names might be shortened or truncated in the EHR and on other documents (i.e. name bands, labels) leading to loss of characters that help distinguish between multiples or mother and newborn

A recent survey found for a single birth, or **singleton**, over 75 different naming conventions used. The most common examples are:

- Mother's last name Girl (or Boy) mother first name
- Mother's last name BG (or BB) mother first name
- Mother's last name Baby Girl (or Boy)

Other naming systems include:

- Newborns indicated by "B" or "NB"
- Mother's first name such as "baby of Jane", "Janes", "Janesgirl", "mom Jane", "mother Jane"
- Assignment of a letter A(a) or number identifier: "Smith G1 Jane", "Smith Girl A Jane"

For **multiple** births (siblings of the same or different gender), the survey found over 130 different naming conventions with the most common being:

- Smith Girl (or Boy) A Jane and Smith Girl (or Boy) B Jane
- Smith Baby Girl (or Boy) A and Smith Baby Girl (or Boy) B
- Smith BG (or BB) A Jane and Smith BG (or BB) B Jane
- Single letter identifier (A, B, C…) or single number (1, 2, 3…) to distinguish between multiples
- Double or triple letters (AA, BBB…), Roman numerals (I, II, III…), number sign # before a number, or number written out (One, Two, Three…)

Most survey respondents commented that the naming methodologies were consistently used except with handwritten wrist bands, crib cards, and name plates. However, documentation systems may use given names while prescribing systems use temporary names. Pharmacy labels might differ from identification bracelets, two name bands on newborns may not match, and identification may differ among patients. When a newborn received his or her given name, few clinicians changed the name mid-admission or added the given name in quotation marks to the end of the naming convention. Usually the name is not changed until the newborn is discharged or transferred out of the facility, or if the

Reference

1. Institute for Safe Medication Practices. (2019). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201912pdf

newborn length of stay was greater than one week. Some argue that changing the name mid-admission and creating a new medical record causes more confusion.

Strategies

Strategies to reduce misidentifying mother and newborns when prescribing, dispensing, and administering medications include:

- Utilize bedside barcode scanning systems for mothers and newborns
- Institute name alerts
- Limit who can modify/merge newborn EHRs
- Limit access to patient records to only those appropriate for the clinician
- Implement blocks or require documentation of reason for overriding electronic alerts that signal potential mix-ups between mother and newborn
- Utilize different text formats (i.e. types, cases, font size, bold, color) to distinguish newborns
- Modify screen backgrounds (i.e. color, highlight text of newborn and age) to better differentiate between mother and newborn records
- Increase size, width, character spaces used for identification
- Double banding newborns (wrist and ankle)
- Use different automated dispensing cabinets (ADCs)/medication storage for mothers and newborns
- Employ independent double checks
- Mandate verification of a second identification number such as medical record number
- Involve the parents, when possible, in the newborn identification process
- Use the correct naming convention with every newborn encounter
- Assign different nurses to unrelated newborns with the same last name

These strategies have several notable limitations:

- Many clinicians do not correctly utilize bar code scanning, instead scanning after medication administration for documentation purposes
- Identification bands are often removed from newborns and attached to cribs, or reattached to the wrong infant
- Medication errors occur between mothers and newborns rooming together as syringes can be mixed up after barcode scanning
- Physical alerts (signs in medication areas, patient lists, labels) are more commonly used than electronic alerts within the health record
- Name alerts outside the neonatal intensive care unit are not helpful since mothers' and newborns' names are the same
- Name alerts are often used only for unrelated patients
- Limiting access to patient records could be dangerous during an emergency

Reference

1. Institute for Safe Medication Practices. (2019). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201912pdf