Distinct Newborn Identification

Dr. Alana McGolrick and Lori Matich

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About PeriGen

Comprehensive labor and delivery patient safety platform incorporating PeriGen's ***NICHD-validated Artificial Intelligence decision support tools.***

Leveraging evidence -based medicine with 50 peer-reviewed publications: *American Journal of Obstetrics and Gynecology, Becker's, Journal of Healthcare Information Management.*

PeriWatch Vigilance ™ is an early warning system that works with an existing EFM to ***quickly & consistently*** identify patients who may be developing a potentially worsening condition.

330 clients nationally

Disclaimer

This presentation includes information from The Joint Commission and other sources (designated on the slides). The following studies were not conducted by PeriGen and all of the details on the Distinct Newborn Identification were provided by The Joint Commission website.

PC.06

The Joint Commission released a new Perinatal Care Performance Measure, also effective January 1, 2019

Recording: PeriGen.com/Joint-Commission-Perinatal-Measures

Our Presenter

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With significant perinatal experience, Dr. McGolrick leads PeriGen's efforts to expand and enhance clinical training, customer outcomes reporting and publishing.

PeriGen

Advanced Perinatal Systems

Co Presenter

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Agenda

- Introduction
- Objectives
- Medical Errors
- Newborn Misidentification
- Element of Performance 3
- Program Implementation
- Challenges
- Summary

Objectives

To correctly identify risk factors associated with non-distinct newborn naming conventions.

To accurately assess your organization's naming convention and identify process gaps in care.

To verbalize understanding of recommended distinct newborn naming convention.

To identify three steps required to implement a distinct newborn naming convention at your organization.

Introduction

Patient safety is paramount

Duty to accurately identify patients and deliver correct care

Newborn identification challenges

Multi-factorial approach to newborn patient safety

To Err is Human

Medical Error

- Failure of a planned action to be completes as intended or the use of a wrong plan to achieve an aim

Examples:

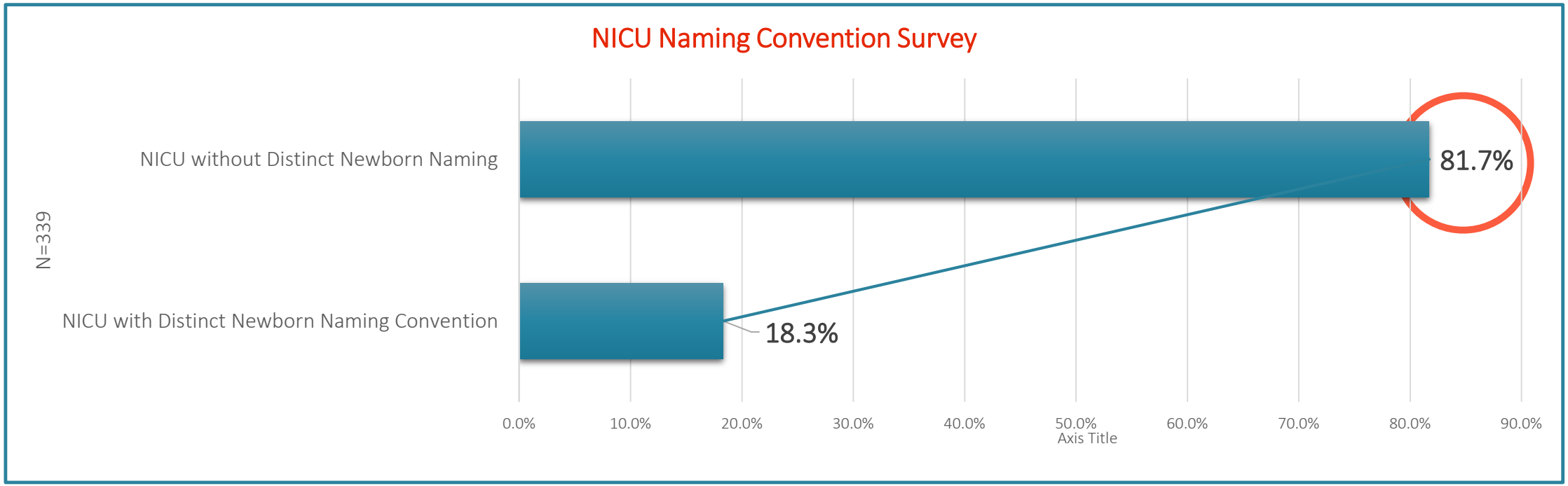
- Adverse drug events
- Surgical injuries and wrong-site surgery
- Restraint-related injuries or death
- Falls
- Pressure ulcers

http://nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf

- Medication and TPN
- Respiratory care, resuscitation-related and ventilator care-related events
- Invasive procedures and healthcare-associated infections
- Patient identification
- Diagnostic

Neonatology Domains of Error

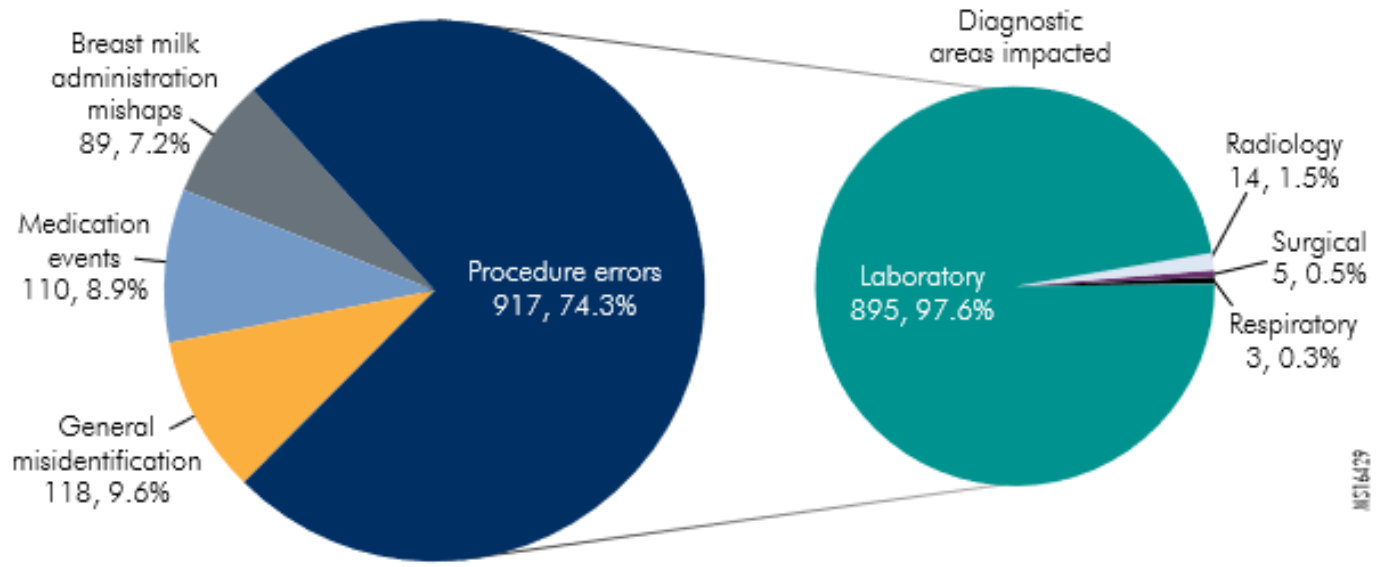
(Ragu et al. 2011)



NICU Naming Convention Survey

(Adelman et al. 2015)

Figure. Misidentification Error Types, January 2014 through December 2015, as reported to the Pennsylvania Patient Safety Authority (n = 1,234)*

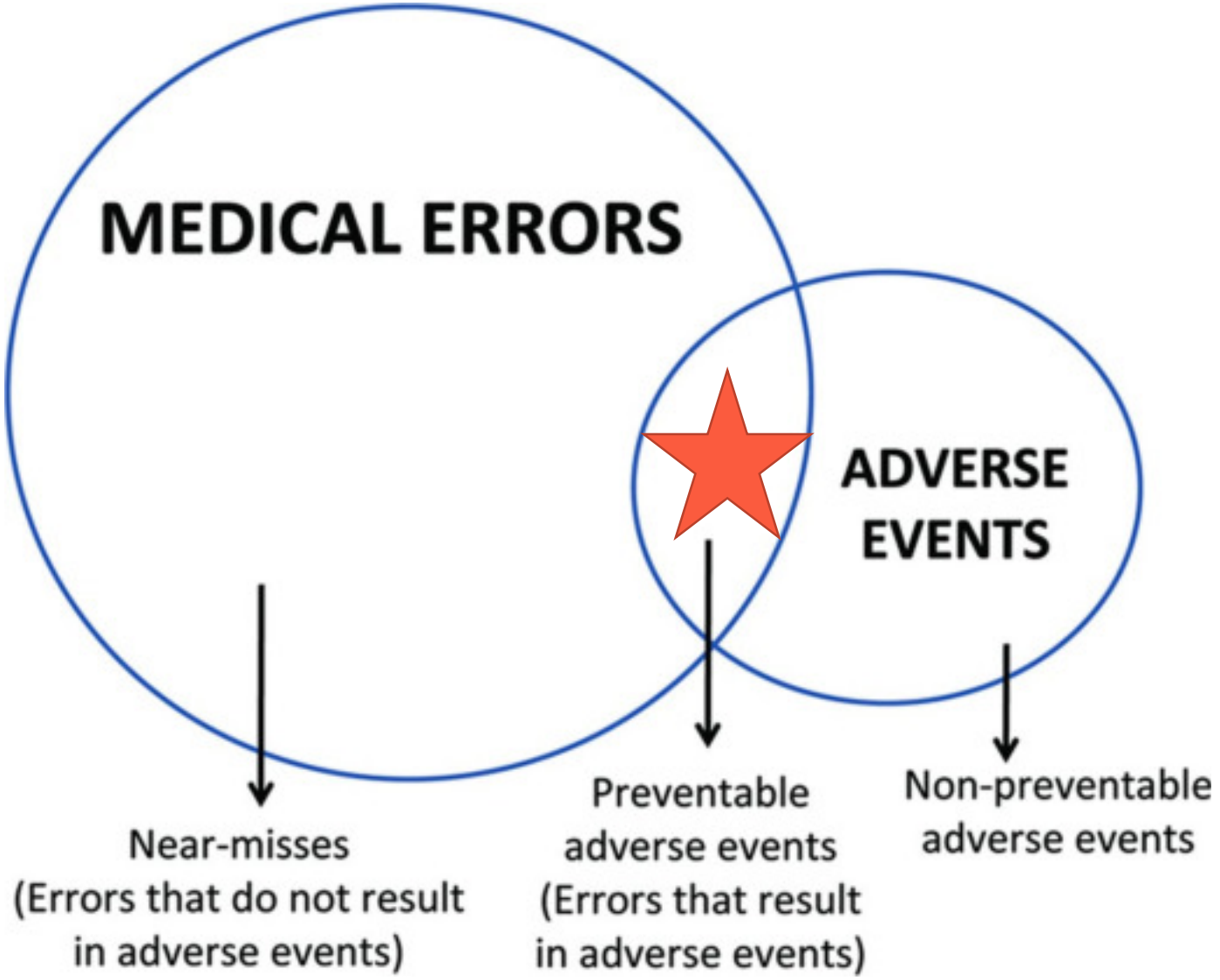


*Total percentage listed is less than 100% due to rounding.

Patient Identification Errors in Infants and Neonates

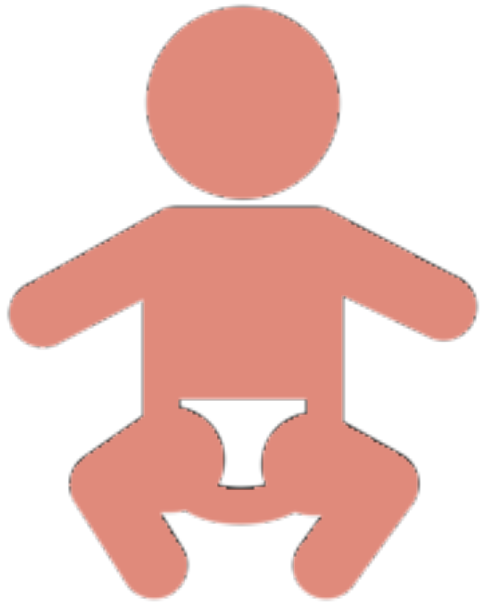
(Wallace, 2016)

The Halo Effect



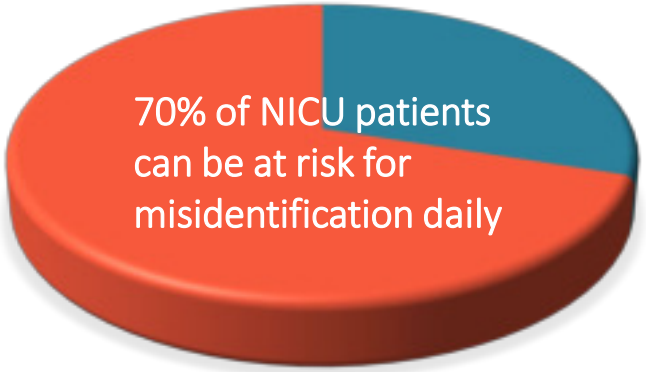
Vul-ner-a-ble

1. Susceptible to physical or emotional attack or harm
2. (of a person) in need of special care, support, or protection because of age, disability, or risk of abuse or neglect



https://www.merriam-webster.com/dictionary/vulnerable

Current Identification Process



Newborn registration is immediate

Bands are placed in the delivery room or operating room

Temporary first names are assigned

What band?

National Patient Safety Goal

- NPSG.01.01.01
- Effective January 1, 2015
- Two Patient Identifier
  - Use at least two patient identifiers when providing care, treatment, and services
  - Difficult to apply to the newborn population

(https://www.jointcommission.org/assets/1/6/2015_NPSG_HAP.pdf)

Element of Performance 3

National Patient Safety Goal NPSG.01.01.01, EP3

Effective January 1, 2019

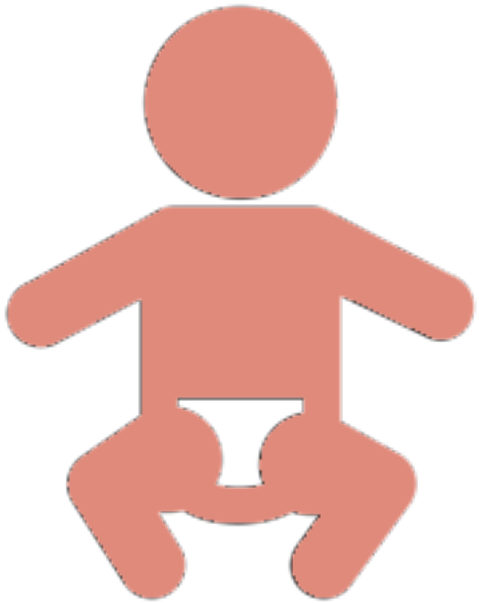
- Use at least two patient identifiers when providing care, treatment, and services

Newborn Patients

- Use distinct methods to identify newborns
- Consider including using mother's first and last names and the newborn's gender
- Standardize practices for banding identification
- Establish communication tools amongst caregivers

(https://www.jointcommission.org/assets/1/18/R3_17_Newborn_identification_6_22_18_FINAL.pdf)

Naming Convention Examples



Newborns are registered as Mom's Last Name, Baby B/G, Mom's First Name

Example: Brown, BabyBSally
Brown, BabyGSally

**B for Boy and G for Girl*

Numbers are used instead of letters for multiples

Example: Smith, BabyG1Lisa
Smith, BabyB2Lisa

(https://www.jointcommission.org/assets/1/18/R3_17_Newborn_identification_6_22_18_FINAL.pdf)

Program Implementation Example

Hospital 1

- Labor & Delivery
- Mother Baby
- Level II NICU (5 beds)
- General Pediatrics (8 beds)
- Approximately 1200 deliveries per year

Hospital 2

- Labor & Delivery
- Mother Baby
- Level II NICU
- Approximately 900 deliveries per year

Epic: Infant Naming Convention | Steps to Success in Newborn Chart Documentation

Goal: To determine a newborn naming convention for the legal newborn chart as defined by The Joint Commission and mitigate the risk of newborn identification errors

a. Example: Smith, Julie Baby Boy (single birth) and /or

b. Example: Smith, Julie Baby Girl A and Smith, Julie Baby Girl B (multiple birth)

Newborn Naming Convention Team

Project Lead

Clinical Experts from all Stakeholder Departments

Regulatory and Compliance

Risk Management

EMR Analysts/Applications:

- Clinical Documentation Team
- ADT (Grand Central/Registration) Team

Epic EMR documentation points and impacts to consider with this change:

Infant ID bands placed on infant and parents at birth – Staff education as these are handwritten bands.

Hospital ID bracelets – EMR programming considerations for the font size/ spacing on band to fit the entire name and the scan bars for scanning medications, breast milk and procedures.

EMR Consents – considerations again for font size and signature lines on all consents where infant name will appear.

EMR Reports – considerations for all report documents that both infant name, MRN and scan bars will appear for proper chart Identification for the HIM department when scanning printed paper documentation back into the EMR upon discharge.

Remember to review and revise all hospital policies that reference newborn identification.

Infant Naming Convention in Epic

Before: Simmons, Baby Boy B

After: Stork, Chelsea Baby Boy C

Now includes mothers first name in the first name.

Additional Methods to Prevent Misidentification

Room	Bed	Name	Nurse	Provider	GTPAL	GA
T510	01	Upgrade, Test Mama Eighteen	—	Yoo, Gr…	G1P0	—
T511	01	Softbank, Mother	—	Ross, G…	G8P4034	—
T512	01	Obpain, Merry Test	—	Siassipo…	G3P1001	—
T513	01	Stork, Chelsea		Dickens,…	G1P1001	43w0d
T513A	01	***Stork, Chelsea Baby Girl -Name Alert***	—	Dickens,…	—	—
T513A	02	***Stork, Chelsea Baby Boy B-Name Alert***	—	Barclay,…	—	—
T513A	03	***Stork, Chelsea Baby Girl C-Name Alert***	—	Barclay,…	—	—
T514	01	Christmas, Abbey C		Ross, G…	G1P0000	40w2d
T514A	03	Christmas, Abbey Baby Girl	—	Ortega,…	—	—

Communication

Critical communication to all Maternal Child Department caregivers

Weekly Dose - 12/7/18 issue

MDoc - 12/10/18 issue

Go LIVE Wednesday, December 12, 2018

Email Alert to ADT Team, All Leadership and Bed Planning Team

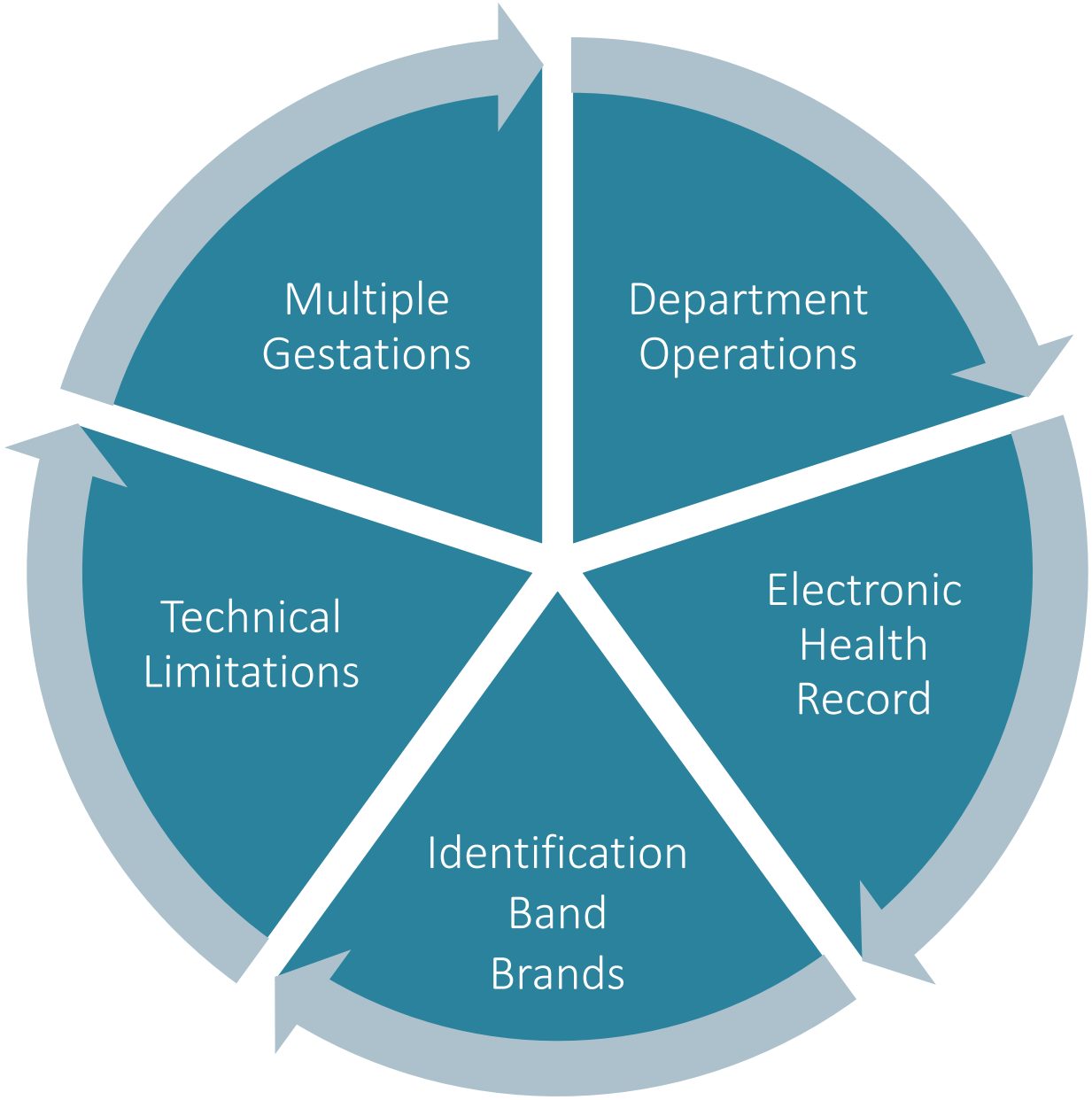
Testing and installation of the changes was smooth without negative workflow impact to caregivers

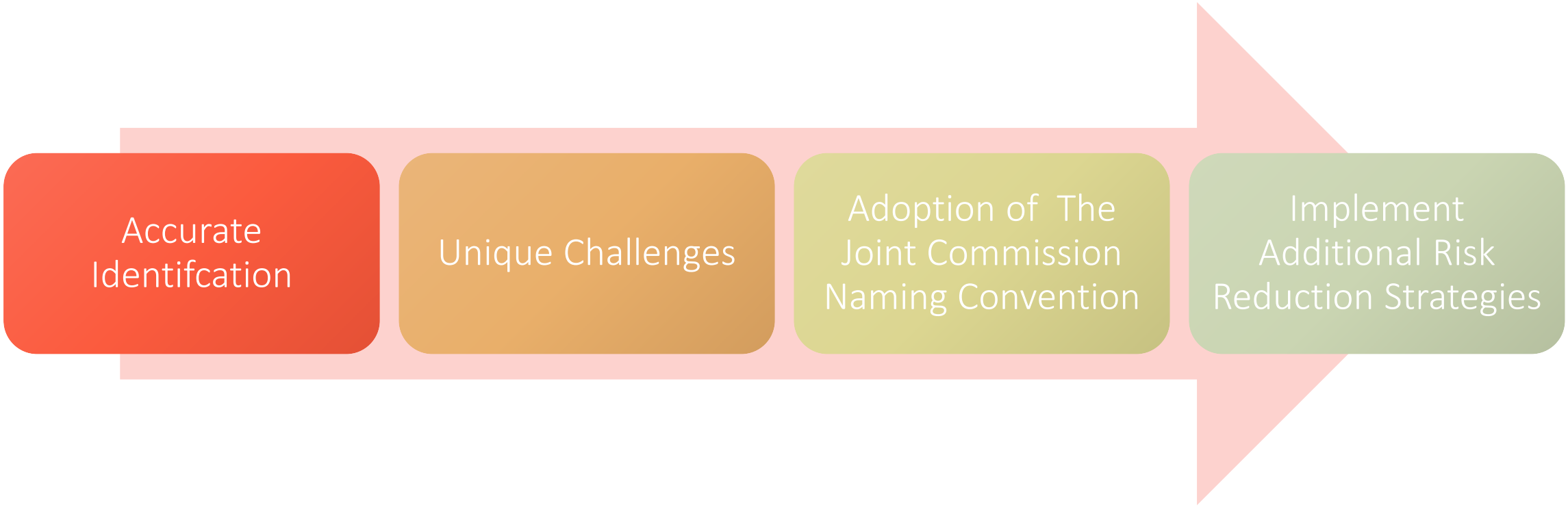
1

Length of time to install changes was 2-3 weeks inclusive of analyst build time, validation and education roll-out to caregivers

Impact of Change

Implementation Challenges




Accurate Identifcation
Unique Challenges
Adoption of The Joint Commission Naming Convention
Implement Additional Risk Reduction Strategies

Summary

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