

Quality Improvement Activity: Twins Neonate Identification in NICU

On December 2, 2020, a set of identical twin boys were born and transferred to the Neonatal Intensive Care Unit. The infants were delivered via cesarean at 32 weeks gestation due to placental insufficiency and admitted to the NICU for monitoring. The infant's first names were only 2 letters different, they had the same middle initial, and same last name. The numbers on their identification bracelets were different by only 1 number. The infants were removed from their incubators for a brief period to assess, then incorrectly placed in the other's incubator. Infant A was not maintaining sufficient thermoregulation, but infant B's temperature was stable. The parents were requesting to hold infant B since he was stable. As the nurse retrieved the infant, they misread the identification bracelet, but remembered that infant B was in the incubator on the left. However, since the infants were not placed in the correct incubators after the assessments, the nurse mistakenly grabbed infant A. After a period of 5 minutes, the parents stated that the infant in their arms suddenly became lethargic and had a weak cry. The UAP in the hall entered the room and realized that the parents were holding infant A, who was showing symptoms of cold stress. The infant was rapidly placed into the correct incubator and the nurse was notified to assess and call the physician. The nurse and UAP then placed a red dot on infant A's identification and a blue dot on infant B's bracelet, the colored dots were also placed on each incubator and chart for quick identification for the remainder of their hospitalization.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In this scenario, the infants are incorrectly identified multiple times causing an infant to be in danger of cold stress. The patient care was lacking when the Nurse failed to carefully check if each infant was in the correct place after the assessment. If the Nurse had double checked the identification bracelets after, they would have realized the infants were switched. In addition, the Nurse also went off her memory and removed the wrong infant when the correct thing to do was verify through identification that the stable infant was being given to the parents. This is a common occurrence as it becomes a habit for Nurses to not identify the patient after multiple interactions with them for many reasons such as, long complex identifiers, comfortability with the patient, prolonged care, and rushed. Nonetheless, it is a critical step every time because it prevents many unsafe practices and provides the highest quality of care.

What circumstances led to the occurrence?

The circumstance that led to this occurrence was when the NICU Nurse who assessed them did not take the time to properly identify each neonate before placing them in their designated incubator. This led to the other Nurse picking up the unstable neonate because once again, there was no verification of the ID bracelet. It's easier to make a mistake when caring for neonates considering their identifiers can run closely together, they look physically similar, and they are unable to talk and identify themselves.

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In what way could you measure the frequency of the occurrence?(interviewing nurses, examining charts, patient surveys, observations, etc.)

The frequency of occurrence of misidentification among neonate twins could be measured in multiple ways: reviewing incident reports, patient surveys, and interviewing the staff. Neonate identification has always been an issue, if we understand the root cause of this issue by analyzing the factors involved it helps determine the reasoning behind high recurrence of wrong identification.

What ideas do you have for implementing interventions to address the problem?

One of the main reasons NICU patients are at a great risk for errors is due to the huge similarities in identifiers. Implementing patient identification protocols that easily distinguishes each neonate from another could address this issue.

- Alerting the staff verbally and visually with signs that newborns have similar identifiers
- Using a more distinct newborn naming identification system
- Additional patient identifiers such as, utilization of bar-coding systems and scanning every time a neonate is moved or undergoes a procedure
- Applying color coordination stickers on the baby and their incubator

How will you measure the efficacy of the interventions?

The efficacy of the interventions can be measured by looking at the reason and number of reported incidents related to misidentification after implementing new interventions regarding proper identification of neonate twins. In addition, the Nurses can be interviewed and questioned whether the new protocols are helpful or cause things to be more complex when providing care for this population.