Unravel Patient Misidentification Issues for Your Attorney-Clients
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## UNRAVEL PATIENT MISIDENTIFICATION ISSUES FOR YOUR ATTORNEY-CLIENTS

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UNRAVEL PATIENT MISIDENTIFICATION ISSUES FOR YOUR ATTORNEY-CLIENTS

I. INTRODUCTION

A. Patient Identification Breakthrough

   a. Raised awareness of medical errors and poor patient care.
   b. Patient misidentification identified in many medical errors.
   c. Responsible for prompting first patient safety movements.

B. Patient Identification in Patient Safety

1. Patient identification is a fundamental aspect of patient safety.
   a. It is critical that the patient is accurately identified.
   b. Failure to positively identify a patient can cause confusion regarding actual identity of patient.

C. Patient Safety Movement

1. Increased awareness of problems.
2. Established Patient Safety Foundation.
3. Resulted in presidential mandate to improve patient safety.
   a. Evidence-based error reduction programs.
   b. Internal incident reports.
   c. Reporting of preventable errors.

D. National Patient Safety Goals

   a. At least two patient identifiers not including the patient's room number, should be used when blood samples are obtained or medications or blood are administered.
   b. Conduct a final verification during which active communication is used to confirm identity before the start of a procedure.
2. **Recommendations expanded.**
   a. **Goal one** is to improve accuracy of patient identification.
   b. Use at least two patient identifiers when providing care, treatment and services (NPSG.01.01.01).
      (1) Applies to ambulatory, behavioral healthcare, critical access hospital, home care, lab, long term care and office-based surgery.
   c. Eliminate transfusion errors related to patient misidentification (NPSG.01.03.01).
      (1) Applies to ambulatory, critical access hospitals and office-based surgery.

**E. Patient Identification Is Critical for Uncomplicated Patient Care**

1. Treatments.
2. Medications.
3. Invasive or noninvasive procedures.
5. Specimens.
6. Reports.
7. Diagnosis.
8. Documentation.
11. Discharge of infants to wrong families.

**F. Major Areas Where Misidentification Can Occur**

1. Medications.
2. Phlebotomy.
G. How Serious Is It?

1. National Center for Patient Safety.
   a. Patient misidentification cited in more than 100 individual root cause analyses.

H. Traditional Wristband Identification

1. Name.
2. Age and date of birth.
3. Date of admission.
4. Physician name.
5. Medical records number.

I. Potential Problems with Accuracy of Traditional Adult Wristband

1. May be completely absent.
2. Wrong wristband (another patient’s wristband).
3. Multiple wristbands containing conflicting information.
4. Partially missing information (illegible or light printing).
5. Partially erroneous information.
6. Misreading the information printed on the wristband.

J. Potential Problems with Accuracy of Newborn Wristbands

1. May be completely absent (cases of babies switched at birth).
2. Wrong wristband (another infant’s wristband).
3. Multiple wristbands containing conflicting information.
4. Partially missing information (illegible or light printing).
5. Partially erroneous information.
6. Misreading the information printed on the wristband.
7. Wristbands may fall off as baby’s arms and legs may shrink after birth.
8. Parents may not be able to read the English on the wristband.
9. Does not provide any level of security.

K. Problems with Color-Coded Wristbands
1. There are no standardized color codes for wristbands.
2. Color meaning of wristband is not consistent from facility to facility.
3. Patient safety organizations have developed their own colors and schemes.

L. Newer Patient Identification Methods
1. Radiofrequency.
2. Barcoding.
   a. Fingerprints.
   b. Iris mapping.
   c. Facial recognition.

M. Policies and Procedures Instituted to Decrease Incidence of Patient Misidentification
1. Nothing replaces physically checking patient’s identification.
2. Time-out in surgery.
3. Involve the patient and his or her family members in identifying the patient and correct procedure.
4. Use appropriate communication techniques for any identified language or communication barriers.
5. Use a verification checklist to note verbal identification with the patient and his or her family members; review of the medical documents (e.g., face sheet, history and physical examination); documentation of informed consent; and verification that the designated identification method contains correct information.
6. Require verbal confirmation of the correct patient and procedure in the OR by each member of the surgical team.
N. Identification Problems with Electronic Medical Records

1. Duplicate records.
   a. If an admitted patient is not linked to an existing record.
   b. Data filing errors can cause two corrupted records.
   c. Relying on the wrong record.
   d. Benefits fraud and identity theft.

II. COMMON PATIENT MISIDENTIFICATION CASES

A. Wrong Site Surgery

1. A recent sentinel event alert reported that 13% of wrong-site surgeries involved surgery on the wrong patient.

B. Transfusion Related Adverse-Reactions

C. Medication Reaction or Anaphylaxis

D. Worsening of Disease or Infection

E. Baby Sent Home with the Wrong Parents

F. Baby Mix-up in Hospital

G. Wrong Patient Surgeries

H. Performing CPR or Not Performing CPR on the Wrong Patient

III. COMMON PLAINTIFF ALLEGATIONS IN PATIENT MISIDENTIFICATION CASES

A. Wrong Labwork Due to Improper Identification

B. Failure to Follow Policies and Procedures Regarding Patient Identification Prior to Hanging Blood Products, Resulting In Anaphylactic Shock and Death of the Patient
C. Failure to Properly Identify the Patient Resulting In the Wrong Patient Receiving a Specific Treatment

D. Failure to Properly Identify the Newborn’s Wristband with the Mother’s Wristband, Resulting in the Newborn Being Sent Home with the Wrong Family

E. Failure to Properly Identify the Correct Patient, Resulting In Unnecessary Amputation of the Patient’s Leg

F. Failure to Use the Correct Biopsy Results Resulting In a Delay of Diagnosis and Treatment of Breast Cancer

G. Failure to Identify the Correct Patient’s Blood Culture Results Resulting In the Patient’s Death

H. Failure to Properly Identify the Correct Code Status for the Correct Patient, Resulting in Resuscitation Against the Patient’s Wishes

I. Failure to Properly Identity the Correct Patient with the Correct Medication, Resulting In Anaphylactic Reaction

J. Failure to Properly Identify the Patient Resulting in Misdiagnosis

K. Failure to Properly Identify the Patient Resulting in Delayed Diagnosis

L. Failure to Identify the Correct Patient Resulting in Patient Death

IV. COMMON DEFENSES IN PATIENT MISIDENTIFICATION CASES

A. Even with Defenses – Patient Misidentification Is a Form of Negligence

1. Miscommunication is the chief culprit because there are so many people involved in a single procedure.
   a. We were given the patient identification information by the EMS/ambulance crew.
2. Time is sometimes cited as a cause for surgical errors when a procedure is performed on the wrong patient.
   a. We adhered to the standard of care by performing a time-out.
   b. The patient arrived to the operating room from the emergency department without an identification wristband.

3. Two patients with the same last name.
   a. The patient’s middle initial on their identification wristband was not printed clearly.

V. THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT® IN PATIENT MISIDENTIFICATION CASES

A. Review All Medical Records
   1. Organize, tab and bind medical records per attorney-client preference.
   2. Identify missing records.
   3. Perform a comprehensive review and analysis.
   4. Evaluate the records for merit.
   5. Summarize events.
   6. Prepare report based on the attorney-client’s preference.
   7. Review the documentation of the error or incident to determine if it was a direct result of improper patient identification including electronic medical records, physician progress notes, nursing notes and any supplemental notes.
   8. Review documentation of the case related to patient misidentification and make a list of all of the policies and procedures the attorney should obtain from the defendant.
   9. Review the applicable policies and procedures related to patient identification specific to the area.

B. Identify and Interpret the Standards of Care
   2. Hospital policies and procedures.
C. Educate Attorney-Client
   1. The importance of proper patient identification.
   2. The recommended standards of practice and policies and procedures related to patient identification.
   3. The required standards of practice and policies and procedures related to patient identification.

D. Identify Potential Defendants
   1. Identify the healthcare providers who were responsible for confirming the patient’s identity.
   2. Using the medical records, create a list of employees of the defendant facility who may have had contact with the plaintiff.
   3. If the patient was treated by providers not employed directly by the defendant healthcare facility, identify the parent corporation. (Many healthcare facilities are run by corporations who own multiple facilities).

E. Research the Scientific Literature and Standards

F. Assess Damages
   1. Review facility billing records and insurance EOBs (explanation of benefits).
   2. Review documentation related to plaintiff’s physical and emotional issues related to experiencing patient misidentification.
   3. Interview patient and family to ascertain what the patient’s limitations are after the incident, and determine what future therapies, complications, counseling, surgeries and ADL assistive devices may be needed in the patient’s future.

G. Locate Expert Witnesses
   1. Identify types of experts needed.
VI. INTERROGATORIES AND REQUESTS FOR PRODUCTION

A. Interrogatories Directed to the Defense

1. Please list the names, addresses and all telephone numbers of all healthcare providers involved in the care of (Plaintiff) __________ from (Date) __________ to (Date) __________, including nurses, physicians, residents, nurse practitioners, supervisors and ancillary providers.

2. Please list the names, credentials and positions of individuals working at (Facility) __________ on (Date) __________ who personally entered the (Plaintiff) __________’s medical records identification number into the electronic medical record database upon admission.

3. Please identify the manufacturer(s) of the electronic medical records software in use on (Date) __________ at (Facility) __________.

4. Please list the following for all employees who worked in the medical records department at (Facility) __________ from (Date) __________ to (Date) __________.
   a. Name.
   b. Address.
   c. Telephone number.
   d. Credentials.

5. Please identify the staff members who were employed by (Facility) __________ from (Date) __________ to (Date) __________ who were involved in medication administration for (Plaintiff) __________ from (Date) __________ to (Date) __________.

6. Please explain in detail any current or past disciplinary actions taken against the above mentioned staff members from (Date) __________ to (Date) __________.

7. Please explain in detail any and all in-services or continuing education that the staff and supervisors attended from (Date) __________ to (Date) __________ on the topic of patient identification.

8. Please explain in detail the job description and responsibilities of registered nurses who are employed in (Dept) __________ and (Dept) __________ at (Facility) __________ from (Date) __________ to (Date) __________.
9. Please explain in detail the policy and procedure in effect from (Date) __________ to (Date) __________ at (Facility) __________ related to the proper identification of the patient before blood products are administered.

10. Please explain in detail the responsibilities of the preoperative nurses related to patient identification who worked at (Facility) __________ from (Date) __________ to (Date) __________.

B. Interrogatories Directed to the Plaintiff

1. Please describe (Plaintiff) __________’s recollection of the events while being treated in the emergency department (ED) on (Date) __________ at (Facility) __________.

2. Please identify each lay witness you intend to call at the trial of this matter.

3. Please list the following related to (Plaintiff) __________:
   a. Profession and work history.
   b. Earnings before hospitalization, including any lost wages from (Date) __________ to (Date) __________.
   c. Hobbies and leisure activities before hospitalization from (Date) __________ to (Date) __________.

4. Please identify limitations of (Plaintiff) __________’s activities of daily life (ADL) since (Date) __________.

5. Please identify the type of assistive devices necessary for (Plaintiff) __________ to perform ADL since (Date) __________.

6. Please identify any instances of (Plaintiff) __________ being involved with previous litigation of any type and provide the following:
   a. Date of the lawsuit.
   b. Jurisdiction.
   c. Involved party.
   d. Injuries, if any.
   e. Was a complete recovery achieved?

7. Please list the names and addresses of other physicians who treated (Plaintiff) __________ from (Date) __________ to (Date) __________.

8. Please describe any complications (Plaintiff) __________ has experienced related to hospitalization in (Facility) __________ from (Date) __________ to (Date) __________.
9. Please list the names of any physical therapists who have treated (Plaintiff) ________ since (Date) ________, including:
   a. Specialties.
   b. Credentials.
   c. Addresses.
   d. Phone numbers.

10. Please list the names, addresses and phone numbers of each expert that you intend to use in this matter.

C. Requests for Production Directed to the Defense

1. Please provide a copy of the table of contents of the policy and procedure (P&P) manual in effect at (Facility) ________ from (Date) ________ to (Date) ________.

2. Please provide a copy of all critical pathways in effect at (Facility) ________ for the care of patients undergoing surgery that were in effect from (Date) ________ to (Date) ________.

3. Please provide names, addresses and telephone numbers of (Facility) ________’s personnel involved in the care of (Plaintiff) ________ on (Date) ________.

4. Please provide copies of documentation maintained in pharmacy or other departments responsible for tracking errors in medication administration within (Facility) ________ between (Date) ________ and (Date) ________.

5. Please provide copies of the most recent Joint Commission evaluation of (Facility) ________ from (Date) ________ to (Date) ________.

6. Please provide a copy of entire chart pertaining to (Plaintiff) ________ including, without limitation, any writings of any kind or nature whatsoever pertaining to the treatment (Plaintiff) ________ received on (Date) ________ to (Date) ________ at (Facility) ________.

7. Please provide the names of nurses with advanced biometrics training working at (Facility) ________ from (Date) ________ to (Date) ________.

8. Please provide the job descriptions of nurses, nurse aides and assistants working at (Facility) ________ in the quality assurance risk management department from (Date) ________ to (Date) ________.
9. Please provide the name of identification systems used (if any) in obstetrics (or specific to the case) at (Facility) __________ from (Date) __________ to (Date) __________.

10. Please provide a copy of the orientation manual in effect from (Date) __________ to (Date) __________ received by nurses employed by (Facility) __________ in the obstetrics and newborn nursery.

D. Requests for Production Directed to the Plaintiff

1. Please provide copies of any texts, treatises, magazines, journal articles, pamphlets, brochures, practice guidelines or policies or other publications or writings known to the plaintiffs or their attorneys upon which any of the testifying experts will rely.

2. Please provide each and every document you intend to use in any deposition or to introduce into evidence at the hearing or trial of this matter.

3. Please provide copies of medical records from all other treating physicians involved in the care of (Plaintiff) __________ related to the complications of administration of the wrong blood products from (Date) __________ to (Date) __________ at (Facility) __________.

4. Please provide any notes, diaries or journals that (Plaintiff) __________ kept regarding the incident on (Date) __________ at (Facility) __________.

5. Please provide copies of any and all medical bills and EOBs (Plaintiff) __________ has received from (Date) __________ to (Date) __________, related to the incident that is the subject of the plaintiff’s complaint herein including but not limited to:
   a. Hospital.
   b. Physical therapy.
   c. Pharmacy.
   d. Diagnostic evaluation.
   e. Physicians.
   f. Surgeons.

6. Please provide any economic or other reports predicting or in any way relating to future expenses, losses or damages for which (Plaintiff) __________ intends to make a claim.
7. Please provide copies of any and all documents and materials (including drafts and working papers) prepared by any person whom you expect to call as an expert witness at trial.

8. Please provide a copy of (Plaintiff) _________’s health insurance policy to include coverage related to hospitalization from (Date) _________ to (Date) _________.

9. Please provide any release, settlement agreement or other document which limits, reduces or extinguishes (and potentially reduces or extinguishes) the actual or potential liability of any other party in this matter.

10. Please provide copies of any and all documents which support, refer to, or otherwise document any position you intend to take, or any claim for damages you intend to make in this action.

VII. RECOMMENDED QUALIFICATIONS FOR CLNC® SUBCONTRACTORS FOR PATIENT MISIDENTIFICATION CASES

A. Subcontractor Should Have Expertise in the Specialty Area That Is the Subject of the Case

1. The CLNC® subcontractor should have a minimum of three years’ full-time experience. Try to match the subcontractor as closely as possible with the topic and setting of the case.

VIII. EXHIBIT

A. Switched Babies Case Side-by-Side Mom-Baby Documentation (Exhibit A)

IX. RESOURCES

A. Associations and Organizations

   jointcommission.org/assets/1/18/2011-2012_npsg_presentation_final_8-4-11.pdf
   jointcommission.org/standards_information/tjc_requirements.aspx

3. WHO Collaborating Centre for Patient Safety Solutions.  
   who.int/patientsafety/news/High_5_Release.pdf

   psqh.com/mayjun08/identification.html

B. Journal Articles


   Archives of Pathology and Laboratory Medicine 2003; 127:541-8.  
   ncbi.nlm.nih.gov/pubmed/12708895?dopt=Abstract

C. Internet Articles

   dailyfinance.com/2010/08/12/your-social-security-number-may-not-be-unique-to-you/

   jpathinformatics.org/article.asp?issn=2153-3539;year=2011;volume=2;issue=1;spage=22;epage=22;aulast=Alreja

   online.wsj.com/article/SB10001424052970204124204577154661814932978.html
D. Verification Product Websites

1. BD – Becton, Dickinson and Company (formerly CareFusion).
      bd.com

2. RACO Industries. Patient point of care products including:
   a. 21 CFR compliance.
   b. Blood bag ID.
   c. Patient admittance.
   d. Wristband printing.
      racoindustries.com/solutions/point-of-care-poc

3. General Data point of care barcode verification system.
   general-data.com/industry/healthcare/point-of-care
### Exhibit A
Switched Babies – Mother/Baby Documentation

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>MOM</th>
<th>BABY</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/5/</td>
<td>1740</td>
<td>Birth</td>
<td>Birth</td>
</tr>
<tr>
<td></td>
<td>1742</td>
<td></td>
<td>Vitamin K, Erythromycin ointment to eyes</td>
</tr>
<tr>
<td></td>
<td>1745</td>
<td></td>
<td>APGARS 7.9</td>
</tr>
<tr>
<td></td>
<td>1750</td>
<td></td>
<td>Mom holding NB</td>
</tr>
<tr>
<td></td>
<td>1755</td>
<td></td>
<td>Newborn with pt. while Dr. ___ suturing perineum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weight and footprints</td>
</tr>
<tr>
<td></td>
<td>1800</td>
<td></td>
<td>Feeding newborn</td>
</tr>
<tr>
<td></td>
<td>1805</td>
<td></td>
<td>Bath by Louise ___ PCT</td>
</tr>
<tr>
<td></td>
<td>1810</td>
<td></td>
<td>Drank apple juice</td>
</tr>
<tr>
<td></td>
<td>1815</td>
<td></td>
<td>Helped with latch on left breast</td>
</tr>
<tr>
<td></td>
<td>1850</td>
<td></td>
<td>Drank apple juice</td>
</tr>
<tr>
<td></td>
<td>1900</td>
<td></td>
<td>Holding newborn</td>
</tr>
<tr>
<td></td>
<td>1900</td>
<td></td>
<td>Feeding newborn</td>
</tr>
<tr>
<td></td>
<td>1905</td>
<td></td>
<td>Report to S. ___ RN</td>
</tr>
<tr>
<td></td>
<td>1910</td>
<td></td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>1930</td>
<td></td>
<td>Pt. resting. Multiple visitors in room</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td></td>
<td>Newborn in open crib</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td></td>
<td>Held by Dad</td>
</tr>
<tr>
<td></td>
<td>2100</td>
<td></td>
<td>Holding newborn</td>
</tr>
<tr>
<td></td>
<td>2145</td>
<td></td>
<td>Out of bed. Took shower</td>
</tr>
<tr>
<td></td>
<td>2200</td>
<td></td>
<td>Newborn in open crib</td>
</tr>
<tr>
<td></td>
<td>2240</td>
<td></td>
<td>Held by Mom. Not interested in breast feeding</td>
</tr>
<tr>
<td>10/6/</td>
<td>0030</td>
<td></td>
<td>Holding newborn</td>
</tr>
<tr>
<td></td>
<td>0120</td>
<td></td>
<td>Infant to nursery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lined out documentation: “faint murmur noted”</td>
</tr>
<tr>
<td></td>
<td>0205</td>
<td></td>
<td>Back to eat</td>
</tr>
<tr>
<td></td>
<td>0244</td>
<td></td>
<td>Motrin</td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>MOM</td>
<td>BABY</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>0300</td>
<td>Held infant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 0400 | Feeding newborn  
Holding newborn | | |
| 0415 | | Back to nursery |
| 0500 | Resting. Eyes closed | | |
| 0510 | | Taken to nursery |
| 0700 | Holding newborn | | |
| 0720 | Holding newborn  
Newborn to crib | | |
| 0545 | | Back to Mom for feeding |
| 0606 | Pain medicine | | |
| 0715 | | Baby spit up.  
Jeanie ___ PCT in room  
Newborn to crib |
| 0730 | | Dad holding |
| 0750 | | Mom trying to nurse baby |
| 0800 | Feeding newborn  
Holding newborn | | |
| 0830 | Motrin | Not interested in nursing  
M ___ RN, CLC |
| 1045 | | Infant so sleepy  
G-Grandfather holding infant  
Not interested in nursing  
Does not root/lick  
Clothed for pictures |
| 1000 | Feeding newborn  
Holding newborn | | |
| 1400 | Holding newborn | | |
| 1430 | Motrin | | |
| 1440 | | Dad holding newborn |
| 1500 | Feeding newborn  
Holding newborn | | |
| 1800 | Feeding newborn  
Holding newborn | | |
| 1900 | Feeding newborn  
Holding newborn | | |
<p>| 2000 | Holding newborn | Infant sleepy | |</p>
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>MOM</th>
<th>BABY</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>Tylenol #3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2030</td>
<td>Fleets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2100</td>
<td>Holding newborn</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Back to bed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2200</td>
<td>Feeding newborn</td>
<td>Infant at breast</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holding newborn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>Holding newborn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2335</td>
<td></td>
<td>Infant sleepy</td>
</tr>
<tr>
<td></td>
<td>2340</td>
<td>Motrin</td>
<td></td>
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<tr>
<td>10/7/</td>
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<tr>
<td></td>
<td>2400</td>
<td>Holding newborn</td>
<td></td>
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<td>0045</td>
<td></td>
<td>Infant to nursery</td>
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<td>0100</td>
<td>Newborn in open crib</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0130</td>
<td></td>
<td>Sweetlase given PKU heel stick</td>
</tr>
<tr>
<td></td>
<td>0200</td>
<td>Newborn in open crib</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0245</td>
<td></td>
<td>Infant to Mom’s room per request</td>
</tr>
<tr>
<td></td>
<td>0300</td>
<td>Out of bed to bathroom Holding newborn</td>
<td>Entered room to assist with breastfeeding arm band lay in crib other arm band taped to side of crib noted that name and number did not match mothers. Infant back to nursery via open crib. Footprints on ID sheet verified with baby’s footprints. All other infants on floor with bracelets intact. Infants placed in appropriate cribs</td>
</tr>
<tr>
<td></td>
<td>0400</td>
<td>Holding newborn</td>
<td>Awake holding newborn</td>
</tr>
<tr>
<td></td>
<td>0500</td>
<td>Newborn in open crib</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0600</td>
<td>Newborn in open crib</td>
<td>Mother of infant notified of above and bands verified with mother’s bands</td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>MOM</td>
<td>BABY</td>
</tr>
<tr>
<td>-------</td>
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<td>----------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Newborn to nursery. Bands verified.</td>
<td>Dr. S ____, and RN ____ discussed with mother of baby validation of bands right baby/right mother. Mother of baby voiced understanding Discuss circumcision, consent signed To nursery with Dr and RN Ident-a-band complete Sweetlase given To circumcision board</td>
</tr>
<tr>
<td>0740</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0750</td>
<td></td>
<td></td>
<td>Circumcision complete with 1.3 gomco Newborn open crib, assessment complete Vital signs stable</td>
</tr>
<tr>
<td>0800</td>
<td>Holding newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0805</td>
<td>Holding newborn</td>
<td></td>
<td>No active bleeding To see mother of baby – bands verified</td>
</tr>
<tr>
<td>0810</td>
<td></td>
<td></td>
<td>Dr. ____’s progress note: Notified at 0430 re pat. Being switched with other pat. In the nursery. Apparently pt’s had been switched for some time and I examined the wrong baby yesterday. My pt. was seen by Dr. ____ and vice versa. Documentation was changed to represent who saw the baby. Genetic testing ordered.</td>
</tr>
<tr>
<td>0830</td>
<td></td>
<td></td>
<td>Resting in mother of baby’s arms Circ checked</td>
</tr>
<tr>
<td>0900</td>
<td>Holding newborn Up to bathroom. Sitz bath.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0915</td>
<td></td>
<td></td>
<td>Resting in Dad’s arms</td>
</tr>
<tr>
<td>0919</td>
<td>Motrin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0930</td>
<td></td>
<td></td>
<td>Breast feeding going well States just wants to hold him, even while he sleep S ____ , RN, IBCLC</td>
</tr>
<tr>
<td>1000</td>
<td>Holding newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1100</td>
<td>Holding newborn Lab here for genetic testing</td>
<td></td>
<td>Mother states ate well Lab here for genetic testing Questions answered</td>
</tr>
<tr>
<td>1200</td>
<td>Holding newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1245</td>
<td></td>
<td></td>
<td>Assisted with nursing</td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>MOM</td>
<td>BABY</td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Newborn latched with deep suck pattern Patient content and relaxed – S ____, RN, IBCLC</td>
</tr>
<tr>
<td></td>
<td>1300</td>
<td></td>
<td>Feeding newborn Holding newborn</td>
</tr>
<tr>
<td></td>
<td>1330</td>
<td></td>
<td>Lactating consultant to assist with breast feeding</td>
</tr>
<tr>
<td></td>
<td>1345</td>
<td></td>
<td>Circ WNL No active bleeding Parents voiced understanding circ care</td>
</tr>
<tr>
<td></td>
<td>1350</td>
<td></td>
<td>Regina RN/ L. M__ Director nursery (?) / T. ____ in to discuss incident of mismatched bands. Family at side.</td>
</tr>
<tr>
<td></td>
<td>1400</td>
<td></td>
<td>Feeding newborn Holding newborn Tylenol #3 Consent signed for HIV labs for possible exposure to bodily fluids, pt. voiced understanding Report to ____ at 1450.</td>
</tr>
<tr>
<td></td>
<td>1500</td>
<td></td>
<td>Newborn in open crib Parents to nursery Mother pushed to newborn nursery for hearing test and NP screening Parents remain in nursery Sweetlose given Heel warmer placed on left heel – Lisa ____ RN</td>
</tr>
<tr>
<td></td>
<td>1530</td>
<td></td>
<td>Newborn to hearing screen Parents remain at bedside Screen complete pass x2 – Lisa ____ RN</td>
</tr>
<tr>
<td></td>
<td>1555</td>
<td></td>
<td>Weight obtained 7 lb 11.8 oz No clothes or diaper on</td>
</tr>
<tr>
<td></td>
<td>1600</td>
<td></td>
<td>Feeding newborn Holding newborn Void noted Diaper care explained and demonstrated Discussed bed bath with parents Mother very knowledgeable</td>
</tr>
<tr>
<td></td>
<td>1620</td>
<td></td>
<td>NB – N Suite 6 by bed Parents at crib side – Lisa ____ RN</td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>MOM</td>
<td>BABY</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| 1700 | 1700 | Feeding newborn  
          Holding newborn | |
| 1710 | 1710 | Discharge instructions given.  
          ID bands matched. | Discharge instructions given to parents  
          ID bands matched – Lisa ___ RN |
| 1715 | 1715 | Patient getting discharge instructions from RN  
          Newborn sleeping with Dad  
          Shared info on arms reach co-sleeper  
          Plans to see L.C. 10-12-09 after Dr. ___  
          S ___, RN IBCLC | |
| 1755 | 1755 | Discharged to home. | Newborn in car seat  
          Carried to car by Dad.  
          Click noted on seat in to base –  
          Lisa ___ RN |