Making It Easier for Nurses to Identify Patients Before Giving Medications

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**Problem:** After receiving a call to send a patient to physical therapy, a nurse interrupted her typical sequence of administering medications to prepare medications for this patient. She found the correct patient’s Medication Administration Record (MAR) in a book on top of the medication cart, selected the correct medications for the patient, and placed the medications into a small white cup. However, she took the cup of medications into the room of the patient to whom she would have administered medications next in her usual sequence. Then she gave the medications to the wrong patient. The error was detected when the nurse went to document the medications. The patient was transferred to the intensive-care unit because antihypertensive drugs were among the medications given in error.

Errors relating to patient misidentification also have been reported when nurses have relied on patients’ verbal affirmation of their name. For example, one inpatient received her roommate’s medications after she misheared the nurse’s pronunciation of her roommate’s name and “verified” that she was, indeed, her roommate.

In outpatient settings, where identification bracelets might not be used, nurses typically rely on patients to verify their identity. However, this seemingly obvious method can lead to errors. For instance, one patient in the oncology clinic who wanted to speed up his appointment intentionally responded when the name of the patient scheduled ahead of him was called. Fortunately, the patient’s wife clarified his identity and he did not receive the wrong dose of chemotherapy. Still, the patient, who was frustrated with delays, mistakenly believed that all clinic patients received the same chemotherapy.

**Safe Practice Recommendation:** Nurses know that accurate patient identification is crucial during the process of giving medications. However, if medications are given to the wrong patient, the typical corrective action is to implore nurses to be more careful and to remember to verify the patient’s identity. Some system-based changes can be made in the medication-administration process to make it easier for nurses to correctly identify patients before they administer drugs. Here are a few examples:

- Nurses should involve patients as partners in preventing errors. They should inform patients upon hospital admission about the need to be properly identified before all drugs are administered (and before other procedures as well), even if the staff is well known to them.
- Patients can be encouraged to hold out their name bracelet, spell their name, and give their birth date (especially if they have a common last name) to improve compliance and accuracy with this important step.
- Unit-dose medications should be maintained in the manufacturer or pharmacy’s packaging up to the point of administration at the patient’s bedside. In this way, nurses can show patients the packages and open them at the bedside while stating the drug’s name, the dose, and the purpose. Patients who are educated about their drug therapy are in a better position to alert the staff to potential errors.
- Nurses should bring the MARs to the medication supply areas to select the drugs and to the patient’s bedside to facilitate a final check of the correct drug therapy and patient.
- Strategically planning for future implementation of bar-code systems should take place to help confirm accurate drug administration to the correct patient.
- As a part of the 2004 National Patient Safety Goals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is now requiring at least two pieces of identification for each patient (neither one is to be the patient’s room number) whenever patients are receiving medications or blood products.
- In outpatient settings, the possibility of applying name bracelets to all patients should be considered; alternatively, routine clinic patients, such as those in the oncology unit, should be given registration cards that list their names, record numbers, and birth dates.
- If feasible, pictures of long-term patients should be taken and should appear on their registration cards. Nurses should review the cards to verify every patient’s identity before administering medications rather than relying on the patient’s verbal confirmation alone.

**ISMP, a nonprofit organization located in Huntingdon Valley, Pennsylvania, provides independent practitioner review of medication errors submitted to the national MER program, operated by the U.S. Pharmacopeial (USP) Convention, Inc., of Rockville, Maryland, in cooperation with ISMP. ISMP also reports on progress made in correcting medication errors and problems.**

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