Oops, Sorry, Wrong Patient!  
Applying the Joint Commission’s “Two-Identifier” Rule  
Goes beyond the Patient’s Room  

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PROBLEM: When we think of errors involving a wrong patient, the most common scenario that comes to mind is a nurse who walks into a patient’s room and gives a medication intended for one patient to another patient, often a roommate. However, patient errors can also originate during any phase of the medication-use process, not just during drug administration. Other common sources of mix-ups involve referring to the wrong patient profile, confusing one patient’s results with another’s, and misusing the patient’s medication administration record (MAR).

Using the wrong profile. In some cases, pharmacists have inadvertently mixed up patients’ profiles. Most of the time, pharmacists select the correct profile in the pharmacy’s computer by entering either the patient’s name or the patient’s identification (ID) number. However, if the name or the number on copies of paper orders is poorly visible (as when an Addressograph imprint is used), and if the problem is compounded by look-alike names, errors can occasionally be entered into the wrong profile.

One pharmacist reported a similar error with a different twist. To enter a new order for a patient named Franklin Hope (a fictitious name), the pharmacist tried to access the profile using the patient’s ID number; however, the number was almost invisible and the profile could not be located. The pharmacist then entered the patient’s name, and a profile appeared on the screen. While entering the order, the pharmacist noticed that the patient was female, not male. He soon realized that he had been entering the order into the profile of Hope Franklin instead of Franklin Hope.

Similar errors have been reported during electronic prescribing. In one case, the prescriber had spelled the patient’s last name wrong. The misspelled name just happened to correspond to another patient’s last name. Both patients had identical first names, and the orders were subsequently added to the wrong profile.

Mixing up monitoring results. Errors can also result from mixing up monitoring results. Prescribed medications are often based upon recent diagnostic findings or results of patient monitoring. However, at the Institute for Safe Medication Practices, we have received numerous reports of medications being ordered for the wrong patient after laboratory or other diagnostic or monitoring results were mixed up.

In one event, a physician prescribed diltiazem (Cardizem, Biovail) 20 mg IV, followed by 30 mg orally, for a patient in bed “A” after a nurse called to report that his cardiac monitor showed atrial fibrillation and flutter with a heart rate of 140 beats per minute. When the patient exhibited no change in his heart rate or rhythm after receiving the medication, the nurse called the physician again and received an order to administer 150 mg of intravenous amiodarone (Cordarone, Wyeth), followed by an infusion of 60 mg/hour.

A short time later, the nurse realized that the rhythm she was viewing on the monitor at the nurse’s station was for the patient in bed “B.” The names of the patients in bed A and bed B had been transposed and posted on the wrong channel of the central monitoring unit at the nurse’s station.

SAFE PRACTICE RECOMMENDATION: In the following settings, patient’s lives may well depend on rapid and accurate patient identification and treatment. Here are some suggestions to avoid mix-ups:

1. To aid in proper identification, the patient’s MAR should always be brought to the bedside so that a staff member can verify two unique patient identifiers (e.g., the patient’s name and ID number). Yet it is possible to use the wrong patient’s MAR without noticing the discrepancy. One error occurred when the MARs for two infants were interchanged; palivizumab (Synagis, MedImmune), which is used to prevent respiratory syncytial virus, was given to the wrong child. The infants were side by side, and their MARs were on the counter between them. Coincidentally, both infants had the same first name along with similar hospital ID numbers. The nurse had not noticed that she was referring to the wrong MAR, and she administered a dose of Synagis to the wrong infant.

2. Two identifiers (e.g., name, birthdate, and ID number) should be required for all critical processes, especially medication use, diagnosis, and monitoring. Of course, hospitals would have to ensure that two identifiers are available and legible for the staff to confirm. Certainly, pharmacists and pharmacy technicians could compare the patient’s name and ID number on the computer profile and the order when they enter the order, and a clerk or secretary on the unit could compare this information on the order form and MAR when he or she transcribes the order.

3. Making this information available to physicians in a way that allows them to compare the identifiers presents a challenge, but the risk of the wrong patient’s being selected during medication prescribing can be reduced, especially with computerized prescriber order entry (CPOE) systems. The system could be designed in such a way that after physicians are logged on, they would select the correct name from a list of patients.
assigned to themselves only, not from a larger list of all patients. In the ambulatory setting, a comparable list would include the patients who are scheduled to visit the physicians that day.

4. Enhancing or enlarging the font of the patient’s name on the screen can improve accurate order entry for both physicians and pharmacists.

5. The system should be able to alert staff members to the existence of similar names in the registry. In such cases, a second form of identification (e.g., the patient’s birth date and ID number) would be required before the system proceeds.

6. Although the workspace around infants is often insufficient in neonatal intensive-care units, hospitals should find a way to separate the work areas available for each infant into discrete sections in order to help to prevent mix-ups with MARs, flowsheets, medications, specimens, and equipment.

7. For paper prescriptions, Addressograph imprints should be replaced with laser-printed stickers to improve clarity, especially on copies of prescription orders.

8. Cardiac monitors that display the rhythms of more than one patient should be labeled with the patients’ names, and two staff members should use a standardized method to verify each patient.

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAILSAFE or via e-mail at ismpinfo@ismp.org.