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PSO Monthly Brief

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A Patient By Any Other Name

Roses might smell as sweet if you call them any other name, but misidentifying a patient is a risky business. Incorrect patient identification, due to confusion stemming from similar surnames, room number mix-up, similar medication regimens, or other factors can result in a variety of near misses or adverse events.

ECRI Institute PSO has seen events stemming from patients' similar or identical last names and events resulting from patients' proximity to each other. It is for these and other such reasons that one of the Joint Commission's National Patient Safety Goals is to "improve the accuracy of patient identification."

Using two patient-specific identifiers can help ensure the correct identification of the patient prior to the administration of any medication, the collection of any samples for testing, and the provision of any treatment. Acceptable identifiers can be the patient's name, assigned identification number, birthday, or telephone number, for example. Unacceptable identifiers include the patient's room number and physical location—these may not be specific enough, such as in cases when the patient is not alone in the room. Likewise, do not ask the patient for his or her identifier in a yes/no format; that is, do not ask, "Is your name Jane Smith?" Rather, ask the patient, "What is your name?" This small difference creates large results by preventing confirmation bias on the part of the staff member and precludes any opportunity for the patient to mishear the name spoken.

Another strategy is to implement systems-based solutions to act as failsafes. When properly used, a bar-coded medication administration (BCMA) system will alert the staff member to such discrepancies as a patient identification error. For this reason, it is vital that workarounds are not permitted with BCMA systems. If the medication is scanned at the patient's bedside, potential errors are more likely to be caught, while the use of a workaround, such as scanning the patient's chart in the hallway as opposed to his or her bracelet at the bedside, can allow an error to go undetected.

A third strategy is to enforce a zero-tolerance policy for patient wristbands, specimen labels, or medication labels that have errors or cannot be scanned. BCMA and other systems are designed to catch inconsistencies, and administering medication outside of these systems prevents failsafes from being able to function as such.

Review patient identification policies with staff members, and encourage anyone who experiences difficulty with an electronic system to report it. Review such reports thoroughly and strive to keep the system functioning smoothly.

Remember, roses are roses whatever you call them. But Jane Smith and Jane Smyth are very different.

Contact us, and let us demonstrate how we can help you.

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How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at pso@ecri.org or call (610) 825-6000, ext. 5558.