

“MAY I SEE YOUR ID, Please?”

PATIENT AND MEDICATION MISIDENTIFICATION

By Ron Stoker

More than 20 years ago, I was awakened in the middle of a sweltering-hot August night by a phone call from our neighbor calling for help. She had been awakened by a sound coming from her open basement bedroom window. She looked up to see a man's face peering through her basement window. She had called me on the phone to ask for my urgent assistance. I got up, dressed and walked outside to check around our house as well as the neighbor's house.

Unbeknownst to me, my neighbor had also called the police. As I walked around our house I heard a click behind

my head and a flashlight was pointed directly into my eyes. The flashlight belonged to two police officers who had responded quickly to the distress call. They wanted to know who I was and what I was doing walking around the neighborhood at 2 o'clock in the morning.

I explained that my neighbor had sought my help and I was patrolling for the prowler. They, on the other hand, were beginning to believe that I was the intruder. They asked for my identification and then called my neighbor to verify my story. At the same time they were confirming my identity, a man screamed from the backyard, "I've got him, I've got him!"

The officers and I ran behind the house to find another man from the neighborhood who had also received a distress call; he had cornered a young man who was hiding in a tree in the backyard behind the house. This young man matched the "peeping Tom" description and, to make a long story short, the police finally handcuffed the real intruder.

That night I was grateful to have been carrying proper identification. It identified me to the authorities and protected me from being accused of being "the stalker." Identification is just as important to properly identify each patient and the medications that each patient is to receive. Proper identification can also prevent hospital child abduction, improper blood transfusion, and a myriad of other problems.

Each year between 44,000 and 98,000 patients die in the United States from medically related errors. The leading cause of hospital deaths in the United States is due to medical errors caused by patient misidentification, and specimen or medication misidentification.

This is not just a problem restricted to the United States. A recent report indicated that approximately 850,000 adverse events occur in hospitals in the United Kingdom each year, and many of these adverse events involve patient misidentification. A recent Australian study estimated that adverse events accounted for 8% of hospital bed days, and cost the Australian public a sum of \$4 billion to \$7 billion a year. The U.K. study estimates that nearly 5% of the 8 million to 5 million patients admitted to hospitals in England and Wales each year experience preventable adverse events, leading to an additional three million bed days, costing £1 billion each year just for extra bed days alone.



There are many stories in the literature of patient or medication misidentification. For instance, a hospital in St. Paul admitted to a laboratory mix-up that led doctors to perform a double mastectomy on a 46-year-old woman they had mistakenly diagnosed with an aggressive form of cancer. Linda McDougal, one of their patients, was diagnosed with breast cancer several years ago and was told that her cancer was so aggressive that a double mastectomy, chemotherapy and radiation were her only chances for survival. Two days following the surgery, she was approached by her physician who indicated to her that follow-up tests on her tissues revealed *no* malignant tumors in her breast tissues. The tissue used from McDougal's biopsy was switched with tissue from another woman. She had been operated on unnecessarily! The other woman was eventually contacted and treated.



In another incident, a 6-day-old boy died at Stony Brook University Hospital in New York after he was injected with a lethal dosage of potassium chloride administered by a nurse. The boy's parents claim the prescription for the drug read 35 milligrams instead of 3.5 milligrams, and that neither the nurse practitioner nor the nurse who administered the drug recognized that it was a lethal dose for a child that size.

In yet another incident, a woman who swapped beds with another patient in their hospital room so she could be nearer the window died after receiving the wrong type of blood during surgery. In preparation for her surgery, a technician mistakenly took a blood sample from the woman's roommate. Although the women had switched beds, the death was the result of human error by a hospital employee. The technician did not follow the hospital's established procedures for identifying patients, which requires examining each patient's wristband and having the patient state his or her name.

"The technician doesn't recall whether she asked the patient her name or not or whether she checked the armband," reported Russell Seneca, chairman of surgery at the hospital, in an interview with *The Washington Post*. "I'm not certain what transpired between the technician and the patient whose blood was drawn."

The hospital now requires a second person to accompany a technician when blood is drawn as a safeguard against misidentification.

Misidentification has obviously caught the eye of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO tracks the mistakes from nearly 17,000 healthcare organizations that report the information voluntarily.

In 2003, JCAHO emphasized the importance of correctly identifying patients with the organization's "Improve the accuracy of patient identification Safety Goals" for 2003.

This safety goal applied to all JCAHO-accredited healthcare organizations and those seeking JCAHO accreditation. Failure to comply could result in a special Type I recommendation and jeopardize a facility's accreditation status.

There are many scenarios in a hospital where patient misidentification can occur. These include transfusion of blood products, administration of medication, chemotherapy, administration of radionuclide materials, invasive procedures, and phlebotomy administered to in-patients and out-patients, linking pathology specimens to the correct patient, and the provision of emergency medical services.

Acute care hospitals probably have the greatest potential for these types of errors, since a wide range of patient interventions can be administered in a large number of locations by staff members who work in shifts

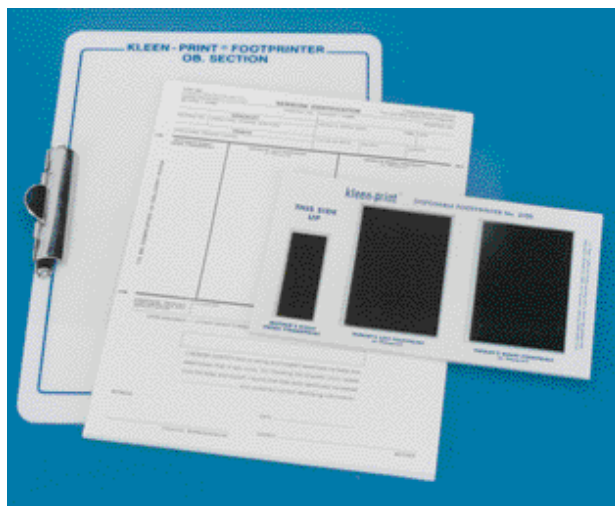
So what are some of the potential solutions to improving the safety of patients through the increase in identification? Several companies have made patient and medication identification core technologies. Let's look at several products that can help assist in proper identification.

One company that has come to the forefront of patient and drug identification is Medi-Dose, Inc. and its sister organization, EPS, Inc.

Medi-Dose was formed in 1971 as a family business and has made a strong business providing products that properly label and provide evidence of any tampering prior to use.

The LiquiDose Labeling System helps hospital pharmacies that package any liquid medication with a method of providing IVs, chemotherapy or other syringe filling with the appropriate tamper-evident labeling. The label can be added to vials, ampules, and syringes to clearly identify their contents.

In addition, a unique shrink band system is available that can be used for any High Alert Medications. The EPS® SHRINKSAFE® BANDS immediately call attention to the medication, increasing awareness of personnel to specific high risk medications. It helps to standardize procedures and allows for the printing of the name of the medication as well as the patient it is intended to be administered to.



One specific application of the EPS® SHRINKSAFE® BANDS is the Paralytic Agent ID Band. It comes in a bright orange color signifying that it is a paralytic agent. Since the majority of the band is clear, it allows for easy viewing of the manufacturer's label. It features an easy, "pull-tab" design that the clinician must pull prior to administering to patient. This forces the clinician to look at the label and recognize that it is a paralytic agent, prior to proceeding with administering to patient. This helps to reduce life-threatening errors as well as reduce "look-alike" errors.

The Shrink-Safe bands are easy to apply. They simply slip over the drug vial and a heat gun is aimed at the vial from 6-10 inches away. The band shrinks around the vial providing an additional safety to the product. This product is being marketed by Medi-Dose – EPS as well as by Baxa Corporation.

With the importance of patient identification, Medi-Dose developed the EPS Mother/Infant and Mother/Father/Infant identification bands that provide positive identification of parents and newborns. Matching serial numbers ensures that the infant is correlated with the proper parents. The extra-soft plastic and the plastic snap provide comfort for the parents and child.

The kleen-print® Mother-Infant ID System

Another EPS identification product is the kleen-print Mother-Infant ID System. The kleen-print is designed to provide positive identification and correlation of mother and newborn by permanently recording the mother's fingerprint and baby's footprint without the usual mess and bother. *It puts the ink on the form...not on the people.* In the past, busy O.B. nurses have had to clean ink from the baby, themselves, or their uniforms. The kleen-print eliminates this extra work.

So how does this product allow for the printing of footprints without causing a mess? The secret is in the micro-thin film—so thin it conforms to even the smallest footprint ridges. The film has a scientifically determined amount of fingerprint ink that has been preapplied to the underside of the film, leaving the top side clean. When the baby's foot is pressed on the clean side of the film, the inked side makes the print. Since only the underside of the film is inked, the ink never touches the mother or the baby, or for that matter, the nurse.

Lab Guard Specimen Bag

The EPS Lab Guard specimen bag prevents the exposure to blood, urine, or other bodily fluids. The Lab Guard reduces the risk of messy specimen spills and leaks. It has a unique double pouch design that allows specimen and paperwork to be kept together, reducing clerical errors. The specimen is placed in one pouch and the documentation identifying the sample is placed in a special documentation pocket. This prevents the contamination of records and protects healthcare professionals.

Conclusion

There are many products that can help in the proper identification of patients, medications, tissue samples, specimen samples, and lab reports. Each of these products can be a tool in the fight for patient and healthcare worker safety. The author will look at additional products used for patient safety in future columns. †

Ron Stoker, a frequent contributor to Managing Infection Control magazine, is the Executive Director of ISIPS, the International Sharps Injury Prevention Society. He is a frequent speaker on sharps safety and occupational blood exposure at national and international events. For more information about ISIPS and sharps safety products, visit www.isips.org, or email Mr. Stoker at ron@isips.org.

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