Codify
BY AAPC

Long-Term Care Survey Alert

PATIENT SAFETY: Right Medication + Wrong Patient = Avoidable Med Error And F Tag

Combat patient misidentification with these key strategies.

A facility's first mistake in administering medications is to think a patient ID error is a remote risk because the nursing staff knows all of the residents. The second mistake may be a dangerous medication error that causes a resident serious harm--and lands your facility with a G-level citation or even immediate jeopardy.

Real-life example: An LPN accidentally gave an elderly patient with documented hypotension another's patient's Zyprexa. The resident became woozy when he later got up unassisted, fell and fractured his skull. When the QA team did its root-cause analysis of the incident, they identified the med error as contributing to the resident's fall. The nurse said the mix-up occurred because she was late in getting the meds out and didn't check the resident's ID band because she knew him. But she admitted the man had always reminded her of the gentleman whose meds she gave him.

Lesson learned: "Even when facilities have procedures for double checking residents' wristbands, identification errors can occur for any number of reasons," says **Janet Feldkamp, RN, JD**, with **Benesch, Friedlander, Coplan & Aronoff LLP** in Columbus, OH.

For example, facilities with high staff turnover and temp agency nurses or new resident admissions will be more prone to mix-ups. Nurses who feel pressured to complete the med pass may also bypass the safety ID checks.

The solution: Develop and implement a reliable, consistent policy and procedure to positively identify residents before administering their medications, advises Feldkamp. Then inservice nursing staff about the policy/procedure and monitor nurses to ensure they are following it.

"Follow the **Joint Commission on Accreditation of Healthcare Organizations** requirements for patient identification, which direct providers to use two identifiers, such as the patient's name and medical record number," suggests **Stuart Levine**, **PharmD,** informatics specialist for the **Institute for Safe Medication Practices**. "The nurse matches the name and medical record number on the patient ID band to the medication administration record which lists the medications for the patient or resident," he says.

Nurses should also ask the patient to state his name before they administer a medication--even if it sounds silly to do so when they know the person. But that tactic only works if the person can reliably state his name on a consistent basis. "Cognitively impaired residents may misidentify themselves or say they are Mrs. Smith, etc," cautions Feldkamp. Thus, facilities should consider implementing an added identity check for residents with dementia--for example, the nurse can ask the resident's regular caregiver to validate the person's identity. Or some facilities use a pictorial identification method to identify residents at the bedside.

Consider Electronic Technology

A few nursing facilities are leading the way with bar coding and other electronic technology to identify patients for administering medications, treatments--and passing out dietary trays.

Examples: The Veterans' Affairs nursing home environment uses a wristband that has the patient's demographics and picture bar coded on it, reports **Robert Finizio** with **Care Fusion** in MacLean, VA, which supplies the patient identification technology for the VA's self-built system. "The nurse scans the wristband, which pulls up the electronic

medical record with the patient's picture, name, medical record number, date of birth, height and weight, etc. to identify the patient before administering medications or even taking the person's vital signs," he says.

The **Agency for Healthcare Research & Quality** is also funding an ongoing study looking at use of an electronic point-of-care system to prevent medication errors in nursing homes (for more information, see the next article).

The notion of a more technologically driven approach to medication management is a good one, says **Alan Rosenbloom**, president and CEO of the **Pennsylvania Health Care Association**, which is participating in the Pennsylvania eHealth Initiative, a collaboration of providers, insurers and government to develop uniform electronic health records and improve use of electronic communications in healthcare settings. If a nursing facility invests in the technology and appropriate implementation, including training, it's a great way to improve care, Rosenbloom emphasizes.