

Decreasing Patient Misidentification Before Chemotherapy Administration

Angela Spruill, RN, BSN, OCN®, Barbara Eron, RN, BSN, OCN®, CPON®,
Amy Coghill, RN, MSN, OCN®, CNL, and Gayl Talbert, RN, MEd, CPON®

More accurate patient identification is a Joint Commission National Patient Safety Goal. To decrease the possibility of patient misidentification during chemotherapy administration, nurses on the Bone Marrow Transplant Unit at the University of North Carolina–Chapel Hill instituted a bedside check and measured compliance.

The risk for significant patient harm from inadvertent or incorrect administration of chemotherapy in the Bone Marrow Transplant Unit at the University of North Carolina (UNC)–Chapel Hill was identified as a preventable problem. According to the Institute for Safe Medication Practices (ISMP) (2008), high-alert medications, such as chemotherapeutic agents, can lead to significant patient harm, possibly death, if used in error. In a medication analysis published in 2004 by the United States Pharmacopeia, 3,871 errors involving chemotherapy were reported; 5% (n = 194) of those involved patients who received the incorrect chemotherapy (United States Pharmacopeia, 2004). Schulmeister (2006) found that 14% of 140 errors reported involved improper patient identification. Schulmeister (2008) wrote that the actual incidence of patient misidentification is unknown because it is under-reported.

After peer discussion of anecdotal actual and potential medication errors related to chemotherapy administration, and after the clinical nurse III group attended the Agency for Healthcare Research and Quality (AHRQ) TeamSTEPPS training in October 2008, the clinical nurse III staff designed and implemented a nursing practice change. TeamSTEPPS is an evidence-based teamwork system developed by the Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research

and Quality that focuses on communication and teamwork skills of a group to improve patient safety.

The change in practice was intended to prevent possible medication errors related to patient misidentification. Currently, institutional policy requires that all chemotherapy doses be independently double-checked by two chemotherapy-competent nurses prior to administration. The policy does not require it to be completed at the bedside (UNC Health Care, 2008). Institutional policy also requires that two unique patient identifiers (e.g., patient name, medical record number) be confirmed at the bedside and compared with the patient's identification armband prior to medication administration (UNC Health Care, 2009). Additionally, improvement in the accuracy of patient identification with two patient identifiers is one of the National Patient Safety Goals of the Joint Commission (2008). Therefore, we initiated a bedside check with two chemotherapy-competent registered nurses of all chemotherapy doses (see Figure 1).

For this project, the team at UNC–Chapel Hill defined a bedside check as two chemotherapy-competent nurses com-

paring and verifying a patient's name and medical record number printed on the patient's identification armband against the same identifiers on the chemotherapy product label. The bedside check confirms that the drug name and correct dose are correctly indicated on the printed chemotherapy product label when compared to the medication administration record. A chemotherapy-competent nurse was defined as a nurse who has attended and successfully completed the Oncology Nursing Society Chemotherapy and Biotherapy Provider Course and hands-on precepting on the unit.

The patient-safety project was designed to address two questions: "Does the implementation of a bedside check of patient identification by two chemotherapy-competent nurses prior to administering chemotherapy decrease the incidence of wrong patient-related chemotherapy medication errors in the Bone Marrow Transplant Unit?" and "How consistently are these bedside checks performed?"

An evaluation tool was designed with a "brief/debrief" model and was used to collect data from November 1, 2008, to February 1, 2009. The tool captured

Angela Spruill, RN, BSN, OCN®, and Barbara Eron, RN, BSN, OCN®, CPON®, are clinical nurse III's; Amy Coghill, RN, MSN, OCN®, CNL, is a nurse educator; and Gayl Talbert, RN, MEd, CPON®, is a nurse manager, all at the University of North Carolina–Chapel Hill.

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