Patients with cancer are at risk for patient misidentification, or “wrong patient” incidents. Patient misidentification can result in medication and transfusion errors, unnecessary testing or procedures, and, in some cases, death. Patients may be misidentified when nurses mispronounce their names, refer to them by their first or last names only, are complacent and fail to check armbands, or encounter language or communication barriers. Errors caused by patient misidentification can be prevented when healthcare providers consistently use two unique patient identifiers (other than the patient’s room, examination, or chair number) to verify identities.

Patient misidentification errors can occur when nurses mispronounce patients’ names or refer to patients by their first or last names only. When nurses passively receive name verification instead of asking for the patient’s name (e.g., “Mary Doe,
please follow me”), they create a risk that the wrong patient will respond. In addition, patient armbands taped to the side rails of hospital beds leave patients without identification when they depart the unit for testing or procedures. Armbands kept in patients’ pockets, purses, or wallets make them less accessible as well. Patients are vulnerable for error when busy healthcare providers decide to rely on other types of patient identification (e.g., verbal name verification or face recognition) rather than wait until patients locate the armbands.

Complacency can cause nurses to take shortcuts in patient identification, such as checking a patient’s armband during the initial medication administration but not checking it again at subsequent medication administrations. Similarly, nurses may believe that they know their patients, particularly those who receive frequent outpatient treatments or have been hospitalized for a long period of time. In addition, joking around and not taking the patient identification process seriously can lead to errors. Figure 1 lists examples of patient misidentification incidents that were anecdotally reported to the author.

**Patient Registration**

In most facilities, the patient identification process begins with patient registration. Errors can occur if the wrong patient is selected from the master patient list and the wrong armband is placed on the patient or if new patient information is incorrectly entered, which then appears on the armband. Researchers at the Johns Hopkins Hospital examined the extent to which the registration process contributed to patient misidentification and found that misidentification errors occurred 7–15 times per month, with the root causes being deficiencies in the information systems, inadequate personnel training, and lack of a master patient index. The researchers noted that patient registration tended to focus on the technical aspects of the process (e.g., entering data) and that little attention was given to actually verifying patient identity (Bittle, Charache, & Wassilchalk, 2007).

The question of whether or not a nurse can verify patient identity is a valid one. Is the patient really who he says he is? Has the

- A nurse opened the door of a pediatric oncology waiting room and called out the name “Jennifer.” A teenager listening to music via earphones followed the nurse to an examination room. A few minutes later, a woman opened the examination room door and said, “That’s not my daughter.” Two patients with the first name Jennifer were scheduled to be seen that morning.

- A nurse asked Mrs. Jackson to come back to the treatment room of an oncologist’s office for chemotherapy. The nurse checked the chemotherapy orders against the medical record the receptionist had handed to her and prepared and administered the chemotherapy. Four hours later, when another Mrs. Jackson arrived for chemotherapy, the nurse realized that she had administered chemotherapy to the wrong patient.

- John Jones Jr. was being registered to donate stem cells for his father, John Jones, and was asked whether he had ever received care at that facility. He had, so the registration clerk looked for his name in the master patient list, found it, and placed an armband on his wrist. A clerk discovered that the chart corresponding to the medical record number on the man’s armband was already on the transplant unit. Both father and son were wearing identical armbands.

- An oncologist asked a nurse to “talk to the new patient in examination room 2 about an implanted port.” The nurse began by asking the woman in the examination room whether the oncologist had mentioned port insertion, and the woman said “yes.” The nurse proceeded to describe the insertion procedure and had been talking for about five minutes when the woman said, “You better talk to my sister about this; she’s the patient and she’s at the front desk scheduling the procedure.”

- In a busy outpatient clinic, Juan Ramirez was called to the treatment room. When the nurse checked the patient’s armband prior to chemotherapy administration, she was surprised to find that it said Juan Hernandez.

- A patient grew tired of waiting for his name to be called, so when a nursing assistant called for the next patient, he jumped up and followed the nursing assistant to the treatment area. His vital signs were taken and he was settled into his recliner when an RN checked his armband and found that she had the wrong patient. The patient said he had been waiting a long time and “figured that if he got to the back, then the nurses would have to take him.”

- On St. Patrick’s Day, nurses at an outpatient oncology center decided to call patients back to the treatment room by saying their “Irish names.” When “Mr. O’Brezinski” was called to the back, Mr. Kruzinski followed the nurse and had unnecessary lab work drawn.

- A nursing student was asked to prepare “703B” for a lumbar puncture and place the needed supplies at the bedside. When the neurologist entered the room, he pointed to the patient in the other bed and said, “That’s 703B.” The nursing student said she “got mixed up” because at this hospital the B bed was by the window; at the previous hospital where she did a clinical rotation, the B bed was by the bathroom.

- An infectious disease physician was consulted to see a patient on the oncology unit. The patient and his chart were in the imaging department. The physician wrote several laboratory orders for “the patient in 302” and handed them to the unit secretary so she could imprint them with the patient’s information. It is unknown whether the physician gave an incorrect room number or whether the secretary stamped the orders with another patient’s information; however, a patient underwent unnecessary laboratory studies and the patient who needed the studies performed did not have them done.

- To prepare to draw blood from the central venous catheters of four patients, a nurse printed out several stickers containing the patients’ information. She stuck the stickers to her uniform, went room to room to draw the blood, and inadvertently mislabeled some of the vials. The error was detected by an oncologist who questioned the laboratory values for one of his patients (his patient’s white blood cell count was inexplicably low). The complete blood count was repeated for this patient and was within normal limits. The staff concluded that blood vials had been mislabeled, and laboratory studies for all four patients were redrawn.

**Figure 1. Examples of Patient Misidentification**

Note. Names have been changed to protect patients’ privacy.
Patient Identification

The Joint Commission (2008) National Patient Safety Goal 1 is to improve the accuracy of patient identification by reliably identifying the individual as the person for whom the service or treatment is intended and to match the service or treatment to the individual. Clinicians are advised to use two unique patient identifiers when providing care (Joint Commission, 2008), such as the information contained on the patient’s armband, driver’s license, or other type of photo identification. The patient’s room number, chair number, and examination room number are not acceptable patient identifiers. Patients also can be asked to state their full names, addresses, telephone numbers, date of birth, medical record numbers, or assigned identification numbers. Bar codes that include two or more person-specific identifiers (not room numbers) comply with Joint Commission (2007) requirements.

Many simple strategies can be implemented to reduce the risk of patient misidentification. One of the easiest is to instruct patients to show their armbands to healthcare providers rather than passively wait to be asked to see their armbands. Another is to consistently check armbands before administering medications, performing procedures, or sending patients for testing. It is vital that patients’ identities are verified in settings in which armbands are not verified. Getting into the habit of consistently asking for two unique patient identifiers may reduce the risk of error. Nurses should never rely solely on memory or familiarity with patients (see Figure 2).

The Joint Commission mandate to verify patient identify even extends to the delivery of patients’ meals and snacks. At a minimum, it applies whenever patients have particular diets or snacks that are being delivered as part of a diet plan (Joint Commission, 2007).

Batch processing or, for example, prelabeling a batch of specimens containers, can lead to patient, treatment, or specimen misidentification. Continuous flow processing, such as placing specimen labels on containers at the time of collection, not only is safer, but also has been found to be more time efficient than batch processing. The Joint Commission allows prelabeling on a patient-specific basis, but it is acceptable only when performed in the presence of the patient (Joint Commission, 2007).

The role of bar codes in reducing medical errors has received considerable attention; however, technology alone cannot ensure safety. Process changes that accompany the technology may introduce new sources of error. Wrong patient errors may still occur despite the use of bar codes. From January 1, 2000, to December 31, 2005, MEDMARX® (U.S. Pharmaceuticals) received reports of 2,783 medication errors associated with bar
code technology from 65 hospitals. Two percent of the reports were for medications administered to the wrong patient. Causes of the errors included “stat” medications that were administered without being entered into the system, medications scanned after administration instead of prior to administration, and scanning a patient’s ID from the wrong medical record instead of the patient’s armband (Cochran, Jones, Brockman, Skinner, & Hicks, 2007).

Biometric authentication, or use of a biometric that is permanently associated with a patient (e.g., fingerprint, retinal, 3D facial characteristics), is currently being examined as another way to confirm patient identity. Although biometric authentication has the potential to eliminate wrong patient errors, privacy and security concerns, negative patient feedback, high cost, and unreliable technology have limited its use (Li, Barreto, Chin, & Zhai, 2006; Mordini & Ottolini, 2007; Pothen & Parmanto, 2001).

The Prevention of Bedside Errors in Transfusion Medicine (PROBE-TM) study, a randomized matched-pair clinical trial conducted at 12 hospitals, found that a barrier warning on blood transfusion bags reminding staff to check the patient’s armband failed to improve bedside transfusion practice. Despite the barrier warning tag being affixed in such a way that the transfusionist had to remove the tag to spike the blood, bedside checks of patients’ armbands were performed only 37% of the time (Murphy et al., 2007).

As the PROBE-TM study findings suggest, safety initiatives are not always successful. Human behavior and habit are hard to change. Time pressures, distractions, and complacency may prompt nurses to omit verifying patient identity before administering medications, transfusing blood, or performing procedures. Nurses caring for patients who are well-known to them may rely on facial recognition rather than other forms of identification. It is easy to understand how patient misidentification can occur.

**Conclusion**

Patient misidentification and wrong patient errors can be prevented when healthcare providers consistently verify patient identity using two unique patient identifiers. Patients play an important role in the process and can be engaged as partners in safety. Correctly identifying patients in today’s complex healthcare system is a fundamental step in helping to ensure safe patient care.

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