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Quality Improvement Activity: Same-Name Patient Mix-Up

A 41-year-old man with nausea and vomiting for 4 days was on the general medical service at an academic medical center. Overnight, another man with the identical name was admitted to the same room. Usually, this coincidence would have been prevented, but the hospital had a bed shortage. Moreover, the admission occurred at 0630, around the time for shift change, so the outgoing staff did not notice that this patient was being placed in a room with another patient with the same name. This new patient was a 60-year-old man admitted for treatment of alcohol withdrawal. He was scheduled to receive a dose of IV haloperidol at 0700. The nurse retrieved the pre-filled medication from the correct patient's medication list, but as the nurse entered the room, she confused the two patients. She was about to administer the haloperidol to the wrong patient until a student with the nurse asked what type of medication the patient was about to receive. When the student questioned the medication for the patient, the nurse checked the patient's EMAR and recognized the error. The haloperidol was given to the right patient and the other patient with the identical name was moved to another room to reduce the chance of another error.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above the patients with the same name were placed in the same room due to a bed shortage. The nurse caring for both patients almost gave the wrong medication to the wrong patient but was caught by a student and the error was prevented. The patient care was lacking during the period of shift change and admission. If the incoming and outgoing nurses were diligent in observing the potential concern for error, they would have noticed the patients had identical names. The problem of same name errors is common but unstudied.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the hospital bed shortage and the admission during shift change. The outgoing staff did not take time to notice both patients had identical names. Although the error was detected before reaching the patient and causing any harm, the error is serious enough to warrant the term "near miss."

In what way could you measure the frequency of the occurrence?(interviewing nurses, examining charts, patient surveys, observations, etc.)

The frequency of same-name errors could be measured by a few ways such as interviewing nurses, observation, and reviewing incident reports. One study of medication errors and adverse drug events, the stages of serious medication were as follows: 49% at the ordering stage, 26% at administration, 14% upon dispensing, and 11% from transcribing. Errors were much more likely to be intercepted if they occurred at an early stage of the process.

What evidence-based ideas do you have for implementing interventions to address the problem?

Implement nursing “name alert” protocols, these alerts often appear only in one or two places, the patient roster board or in the charts.

- Barcoding, nurses scan the patient barcoded wrist identification and scan the intended medication prior to administration
- Patient identifiers such as gender, first and last name, and date of birth.
- Place visible alerts (“NAME ALERT”) not just on the census sheets and roster boards, but also on charts of the patients with similar/identical names, patient rooms, etc.

How will you measure the efficacy of the interventions?

Measuring the efficacy of the interventions can be done by looking at the number of same name incident reports after implementing the “name alert” protocols and implementing studies regarding same name errors.