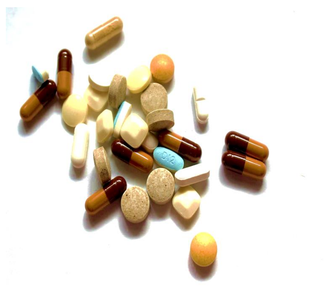
MEDICATION ADMINISTRATION TO WRONG PATIENTS: analysis using incident reports



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Introduction:

Although patient identification has been given high priority in improving patient safety, patient misidentifications and wrong-patient incidents occur.

Objectives:

The aim of this study was to describe the factors related to wrong-patient medication administrations and to describe how patient identification is documented in wrong-patient incident reports.

Methods:

Incident reports related to medication administration (n = 1,012) were collected retrospectively from two hospitals in Finland between 1 January 2013 and 31 December 2014. Of these, only incidents involving wrong-patient medication administration (n = 103) were included in this descriptive content analysis. Research permissions were obtained from the study hospitals in Spring 2015, and the ethics board of the University of Eastern Finland provided an ethical appraisal (6/2015) of this research.

Results:

Many reasons for wrong-patient incidents could be identified, including nurse-related factors (for example tiredness, a lack of skills or negligence), as well as system-related factors (for example rushing or heavy workloads). In 77% (n = 79) of wrong-patient incident reports, the process of identifying the patient was not described at all. (Figure 1)

Types of wrong-patient incidents

- Drugs were administered to neighboring patients or other patients in the same room (n=12)
- Drugs were delivered to the wrong patient's table or trayn (n=5)
- Nurse took the wrong patient's drugs from the medication tray or basket (n=9)
- Patient's bed was changed (n=5)
- Drug label was misspelled (n=4)
- Medication information was misread (n=5)
- Flow of information among health professionals failed (n=4)
- Patients were similar or were mistaken for one other (n=17)
- Patient took another patient's drugs (n=4)

Identification

- Immediately during or just after medication administration (n=11)
- During documentation, verification of the drugs or the reporting of patient information (n=5)
- Other health care professional noticed the incident (n=8)
- Noticed afterwards (n=4)
- Patient or relative noticed (n=12)

Contributing factors

- **UNSAFE ACTS AND OMISSIONS**:
  - Nurse was tired (n=9)
  - Nurse was negligent or made mistake (n=6)
  - Lack of skills (n=3)
- **ERROR PROVOKING CONDITIONS**:
  - Rushing or heavy workload (n=25)
  - Patients' high care intensity (n=9)
  - Division of the work (n=7)
  - Night shift (=11)
  - Patients' characteristics or symptoms (n=9)
  - Changes to the patient's place or bed (n=4)
  - Medications were difficult to identify (n=2)
  - Inadequate marking of drug information (n=9)
  - Inadequate verification or identification (n=5)
  - Communication failed (n=5)

Figure 1. Factors related to wrong-patient incidents

Conclusion:

There is a need to be cognizant of and increase training in correct identification processes to prevent wrong-patient incidents. Active patient identification procedures, double-checking and verification at each stage of the medication process should be implemented. Greater attention should also be paid to organizational factors, such as division of work, rushing and workload, in addition to effective communication. The active participation of nurses in handling incidents could increase risk awareness and facilitate useful protection actions.

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