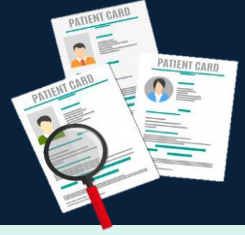


## MEDICATION SAFETY ALERT ISSUE 2/2020

# Identifying The “RIGHT PATIENT”: A Vital Step



**Patient identification** is an essential step that must be performed routinely in all health care settings to ensure the **correct treatment** is given to the **correct patient**. The accuracy of patient identification remains a primary focus of any healthcare organization. The importance of patient identification is featured as the **5<sup>th</sup> goal** (to improve the accuracy of patient identification) in **Malaysian Patient Safety Goals**.

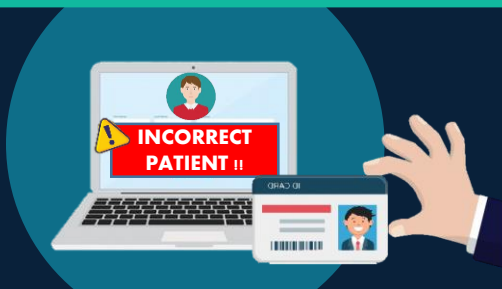
**Correct patient identification** is particularly important during **transitions of care, especially upon admission**, where there is an increased risk of information being miscommunicated or lost, particularly when a patient is transferred to another hospital, clinic or any other health care setting. During this time, information about a person's identity is critical to safeguard patient care.

**Patient identification** can be defined as: “**First a reliable identification** of the individual as the person for whom the service or treatment is intended; **Second to match the service or treatment** to that individual”.

Examples: Wrong details on patient medical records or identification bands, absent identification bands, selection of the incorrect patient on electronic systems or the incorrect labelling of specimens. These mistakes often harm two or more patients.

Hence, identifying the right patient is crucial to assure that the right procedure is carried out on the right patient at the right time, and eventually the consequences of these errors can be prevented.

### Contributing Factors



Same medication



Similar patient name



Confusion with discharged patient



Interruption

### Misidentification of patient can happen at any stage!

#### Registration

The staff at the registration counter gave the wrong medical card to a patient due to similar patient names.

#### Dispensing

A dispensing error occurred in the pharmacy where patient A's full name was called out by the pharmacist but patient B came instead. The pharmacist did not verify patient B's identity and the wrong medicines were dispensed.

#### Prescribing

The doctor wrongly prescribed an incorrect medicine to Patient A, of which actually belongs to Patient B, due to wrong data entry.

#### Administration

The staff nurse mistakenly administered IV Vancomycin to a patient in bed 28 instead of the correct patient in bed 27. The staff nurse did not verify the patient's identity prior to the administration of medicine.



# for Correct Patient Identification



## Use Reliable Methods Of Identification

- Patient's name
- Patient's tag
- Registration no. (RN)
- NRIC
- Date of birth

### Remember !

**DO NOT** use unacceptable methods of identification such as patient's room number and patient's bed number.

## Wear Identity Wristbands With At Least 4 Identifiers

- Full name of the patient
- Date of admission
- Date of birth and/or ID number (last four digit)
- Hospital registration number
- Name of the ward



## Match The Service Or Treatment To The Patient's Condition

Ensure the medication given **matches** the patient's **clinical condition**.

## Independent Double-check

An **independent double-check** that includes patient verification before dispensing or administering medications.



## Ask The Patient To Tell You

- Ask the patient to tell you at least **TWO identifiers**.
- **DO NOT** state their name first & then confirm or deny by a "yes/no" response.

## One At A Time

Prescribe, transcribe, label, dispense or administer **ONE patient's order** at a time.



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