Reducing Medication Errors - Patient Photographs as a Second Identifier
Allison L. Mason, RN, BS
JPS Health Network

Problem:
The number one goal of the 2009 National Patient Safety Goals is to improve the accuracy of patient identification. Medication errors frequently occur due to patient misidentification and are especially challenging in psychiatry where patients are frequently non-compliant with wearing identification bands, unable to answer identifying questions, or intentionally answer incorrectly.

Evidence:
Patient safety means that people can expect to receive healthcare with minimal risk of encountering a preventable adverse medical event or medical error.

Strategy:
A multidisciplinary team noted the incidence of medication errors due to patient misidentification in the adolescent psychiatric unit was lower than the adult unit. It was noted that the adolescent unit used patient photographs as the second identifier during medication administration. Medication errors due to misidentification over a five year period were two on the adolescent unit and nineteen on the adult unit.

Practice Change:
The practice of using photographs as an identifier during medication administration was standardized throughout the units.

Evaluation:
The rate of medication errors due to patient misidentification were tracked on both the adult unit and the adolescent unit during the following year.

Results:
In the year following implementation, medication errors due to misidentification were reduced by 100% (zero incidents) on both units.

Recommendations:
The results demonstrate that patient pictures are reliable as a second identifier in certain clinical settings.

Lessons Learned:
Using photographs as a second identifier is effective in reducing medication errors due to patient misidentification.
Bibliography


