*Please note - all information contained is fictional, used for example purposes only.

56 year old female, Laurel Johnson was admitted after having a new onset seizure. She was pleasant but worried about the seizure and what it could mean. She had never been on medication before and now was to be started on a medication, Klonipin 1mg. The medication was not up from pharmacy yet, but her nurse had just spent time with her providing education about the medication. Her nurse then went to the desk to document that education. While at the desk, she took a phone call from a physician who gave a verbal order form another patient, Lara Johnstone. The order was for Clonidine 0.1mg. The nurse carefully wrote down the order and then read it back to the physician. The medication was then ordered. When the medication came up from pharmacy via the dummy, the Health Unit Coordinator took that medication, along with several others, off the dummy and placed them on the counter in the medication room. Another nurse came in to the medication room and saw the medications on the counter and placed them in the bins for the patients. The nurse for Laurel Johnson went into the medication room to set up her medication. She noted what she thought was an extra dose of Klonipin in the bin. She thought because it was a new medication, pharmacy had mistakenly sent it up twice, once for the initial dose and again for the dose for that day. This often happened with newly ordered medications which were ordered for once a day. She didn't think anything more about it and continued to set up the patient's medications according to the kardex. She then went into Laurel Johnson's room to give her medication. As she stepped into the room, she asked the patient to state her name and date of birth, October 18, 1952. The nurse then removed the medication from the packaging and gave it to the patient. After giving the medication, the nurse returned to the medication room to set up the medications for another patient. When she arrived at the medication room, she found another nurse searching through the medication bins. When asked what she was doing, the nurse said she was looking for her patient's dose of Clonidine. It was a new dose and she knew it came up from pharmacy as she put it in the patient's bin herself. The nurse for Laurel Johnson had a sick feeling in her stomach and checked the medication wrapper in her hand from the dose she just gave Laurel Johnson. She saw that it was the Clonidine with the name Lara Johnstone and birth date November 18, 1952 clearly stamped on it. The physician for Laurel Johnson was called and informed of the error. The patient's vital signs were ordered to be monitored q hour for 2 hours then every 2 hours for 4 hours. She had a slight drop in her blood pressure, however she recovered well.

During the RCA:

The nurse of Laurel Johnson indicated she had been working there 27 years and this had never happened to her before. She recognizes now that she should have checked the package labeling more carefully when setting up the patient's medication as the information was clearly stamped on it. She thought she had compared the label information to the kardex, but obviously not carefully enough. She remembers thinking there was an extra dose in her patient's medication bin, but it has happened before so she didn't question it further. She had just taken the verbal order for the Clonidine and perhaps that was on her mind when she was setting up the medications for her patient, the names do sound alike. She did not check the patient's arm band as she had the patient for the last 2 days and knew her well. She did ask for the patient's name and date of birth and it sounded right so she didn't think any more about it. Laurel Johnson's date of birth

is October 18, 1952 and Lara Johnstone's date of birth is November 18, 1952. Besides, the information on the identification band was already faded and hard to read. The hospital procedure for verification of patient identification information is according to the Joint Commission National Patient Safety Goals which states there must be two unique patient identifiers and staff must match the treatment to the individual patient. The two unique identifiers the hospital chose were patient name and date of birth. The unit was very busy, however the staff indicted they thought staffing was adequate. The bins in the medication room for these two patients were on top of each other and there was nothing to separate them or warn of the like names. They are set up by room number and although the patient rooms are not close to each other, it just happened that they fell one on top of the other in the cart.