This article demonstrates how the review of chemotherapy orders by a designated nurse known as a verification nurse (VN) at a National Cancer Institute-designated comprehensive cancer center helps to identify prescribing errors…" Baldwin and Rodriguez (2016).

Abstract:

BACKGROUND: The prevalence of medication errors associated with chemotherapy administration is not precisely known. Little evidence exists concerning the extent or nature of errors; however, some evidence demonstrates that errors are related to prescribing. This article demonstrates how the review of chemotherapy orders by a designated nurse known as a verification nurse (VN) at a National Cancer Institute-designated comprehensive cancer center helps to identify prescribing errors that may prevent chemotherapy administration mistakes and improve patient safety in outpatient infusion units.

OBJECTIVES: This article will describe the role of the VN and details of the verification process.

METHODS: To identify benefits of the VN role, a retrospective review and analysis of chemotherapy near-miss events from 2009-2014 was performed.

FINDINGS: A total of 4,282 events related to chemotherapy were entered into the Reporting to Improve Safety and Quality system. A majority of the events were categorized as near-miss events, or those that, because of chance, did not result in patient injury, and were identified at the point of prescribing.

Reference:

Baldwin, A. and Rodriguez, E.S. (2016) Improving Patient Safety With Error Identification in Chemotherapy Orders by Verification Nurses. Clinical Journal of Oncology Nursing. 20(1), p.59-65.

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