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PARTNERSHIP for HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update
Winter 2016

We invite you to participate in the *Partnership's* next quarterly teleconference on Tuesday, January 19, 2016 from 3:00–4:00 p.m. eastern time. During that time we will be seeking your endorsement of the four Health IT Safe Practices for Copy and Paste. Learn more about what you can do to promote health IT safe practices within your organization.

The Patient Identification Workgroup began meeting on November 20, and the quarterly meeting will include an update on the workgroup's progress to date. This is an important meeting as we launch into the new year. We look forward to your input and participation. This year looks to be a very busy one. We would like to extend our wishes for a healthy and safe 2016!

- Quarterly meeting, January 19, 2016, 3:00-4:00 p.m. eastern time
- Patient Identification Workgroup—next monthly meeting January 15, 2:00-3:00 p.m. eastern time
- Coming Soon: Meet the *Partnership* at HIMSS

Data Snapshot: What Role Can Technology Play in Patient Identification?

Data Snapshots provide lessons learned from patient safety reports submitted to the Partnership. In this edition we will look at the events submitted and ask: Can technology be used more effectively to prevent or limit events with prevalent human components? In particular, can technology be better utilized to

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Collaborating Organizations
Association for the Advancement of Medical Instrumentation (AAMI) • American Association for Physician Leadership (AAPL, formerly ACPE) • American Health Information Management Association (AHIMA) • American Medical Association (AMA) • Association of Medical Directors of Information Systems (AMDIS) • American Medical Informatics Association (AMIA) • American Organization of Nurse Executives (AONE) • American Society of Anesthesiologists (ASA) • Association for Healthcare Documentation Integrity (AHDI) • California Hospital PSO • College of Healthcare Information Management Executives (CHIME) • Council of Medical Specialty Societies (CMSS) • Health Care Improvement Foundation (HCIF) • Healthcare Information and

prevent improper identification, treatment, and reporting?

Background
In these events we find the common theme of misidentification. Patients were not appropriately identified, treatments were not appropriately matched to the correct patient, or results were not reported correctly. In these events, patients received medications intended for others, others had incorrect testing performed, or sometimes delays occurred in the intended care. In other examples, patients using their patient portal could not view their own information, but rather saw incorrect information belonging to another individual.

While many of these occurrences did not result in harm, they have the potential to severely and negatively impact patient safety. What becomes immediately clear is that correct, proper, and consistent patient identification is a key component of safe quality care. Proper identification needs to occur at every stage and location of a patient's contact with the healthcare system, including intake (registration and/or admission), evaluation, treatment, reporting of results and outcomes, portals, and information exchanges. The following are case examples that illustrate problems involving misidentification or improper matching at various points in the healthcare continuum. These examples lead us to ask what technology can do to address these issues.

Events Reviewed
In this first group of events, medications were dispensed to incorrect patients. These medications included eye drops, statins, antibiotics, insulin, and pain medications. In some of these occurrences, the medications were intended for the patient in the same room, but in the other bed; in others, they were intended for patients in the same bed (e.g., bed "B"), but in a different room. In still other instances, intravenous (IV) medications or fluids were administered, but it was not until later in the process of care that it became evident that the medications were intended for different patients. This error was discovered when a staff member or a patient noticed that a

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The *Partnership for Health IT Patient Safety* is sponsored in part through a grant from the Jayne Koskinas Ted Giovanis Foundation (JKTG) for Health and Policy.

Upcoming *Partnership* Events:

Quarterly Meeting: January 19, 2016, 3:00-4:00 p.m. eastern

Patient Identification Workgroup: Meets monthly, with the next scheduled call on January 15, 2016, from 2:00-3:00 p.m. eastern time.

Partnership meeting at HIMSS: Watch for an update regarding the date and time of the Partnership meeting at HIMSS.

different name was on the label, or in some instances the problem was discovered when the medication was unavailable for the intended recipient. In one reported instance, a patient received IV antibiotics, but there was no order for antibiotics for that patient. Here, only after infusion of the antibiotic was it discovered that the name on the IV medication did not match the patient receiving the infusion.

Technology, such as the use of bar coding, is intended to facilitate patient matching. In one example of errors in this category, the nurse was unable to scan a patient's armband bar code. Because this was not the first time scanning had failed for this particular patient, the nurse replaced the armband. However, the replacement armband was incorrect and information was not properly recorded.

In yet another example, the patient was correct, but the intervention was incorrect. Here, the patient had an order for 5 mg of oxycodone. Instead the patient received 5 mg Norco (acetaminophen and hydrocodone). The patient had no known allergies. The Norco was obtained from the automatic dispensing cabinet (ADC); however, it was obtained by accessing the wrong patient. Apparently the staff member chose the wrong patient medication profile when obtaining the drug. When the medication would not scan into the patient's medication administration record (MAR), the medication was manually entered into that patient's MAR. The error went unrecognized until another staff member, intending to administer Norco to her patient, received a notice from the ADC that the medication had already been administered.

Contributing Factors
In many of the reported events, a human component to the identification error became clear. Those human components included the following types of error: not scanning bar codes, not checking armbands, and not checking identifiers. However, in other instances errors occurred despite active efforts to follow the correct procedures. Examples of this type include situations such as the one above in which the patient was identified correctly but the task (pulling the medication)

was performed incorrectly. Interoperability issues—such as the inability to scan a bar code; information that does not transfer between systems; or improper matching in large databases—also create identification mismatches. Finally, issues can also occur when patients have sound-alike names, junior/senior or male/female versions of a name, or when misidentification begins at the very onset of an encounter.

Health IT–Related Risk Factors
Patient identification issues happened before the technologies we use today were introduced, but those technologies have created new aspects to these issues and removed certain prompts that previously might have alerted staff to misidentifications. Pick lists where a wrong patient is selected ("retract and reorder" may indicate self-identified misidentifications); the lack of visual clues (the thickness of the chart and where someone last wrote on the page are cues not associated with electronic records); and information availability are just a few of the concerns present in the electronic environment. The use of redundant processes (reentering attributes such as date of birth and initials), checks occurring in the background (e.g., matching medication orders to a patient's problem list, or labs to a diagnosis), standard naming conventions (e.g., for newborns), and alerts (tied to particularized information) have decreased some identification errors. But mistakes are still occurring—so how do we best use the technology to further decrease these misidentifications?

Technological solutions offer the promise of decreasing identification errors and promoting safe quality care. However, these solutions must include methods that incorporate unique and stable identifiers and standards in matching that are consistent but tailored to the setting in which they are needed.

Lessons Learned
Minimizing the risk for human error is an important part of proper identification, and technology can facilitate that process. Proper identification must occur in multiple settings, multiple times (before, during, and after

information entry), and across many organizations or locations, and it must still occur when the technology is unavailable. The need for accurate and consistent methods in identification and matching will only increase with the continued addition of health information exchanges. It is important to identify strong and unique patient identifiers that are readily accessible and inexpensive and that can be validated at multiple times throughout the care continuum. The next step is to appropriately match those identifiers at multiple points and on multiple occasions in that same continuum. Understanding how and when technology can best be used to improve patient identification will ultimately have the greatest impact in providing safe quality patient care.

The Patient Identification Workgroup is examining these issues and others in an effort to identify safe practice recommendations for patient identification and to develop tools to facilitate implementation of those safe practices.

We invite you to send your events, suggestions, and strategies for safe patient identification so that these can be shared with others in the Partnership. Please send your comments and suggestions to hit@ecri.org. Remember, if you are submitting events, please use your secure communication portal.

Meet Us At HIMSS: HIMSS is early again in 2016: February 29 through March 4. The Partnership will be meeting at HIMSS. Watch for an update on dates and times.

HIT Safety Advisories: Health IT Safety Advisories are coming soon. In these updates you will find information about HIT-related issues that have come to the forefront for their ability to negatively impact patient safety. Submit your ideas for these advisories to hit@ecri.org.

Your Submissions Are Always Welcome

The Partnership welcomes all of your continued contributions, including items for this publication. Please submit any items for the Update using the subject line "Partnership Update" to hit@ecri.org and continue to submit data, RCAs, and help desk logs through the Partnership web portal.

Need Help Logging In?
Have a question that we can answer? Please contact Lorraine Possanza at 610-825-6000 ext. 5634 or at lpossanza@ecri.org.

Get in Touch with the *Partnership*
Do you have questions about any of these articles? Get in touch with us today by e-mailing hit@ecri.org!

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