Data Snapshot: Patient Identification Still Requires Focus

Background

Delays in care, misdiagnosis, and inappropriate treatments can be results of patient misidentification. This issue exists in both the inpatient and ambulatory settings despite its prominence as an ongoing patient safety goal (Joint Commission, 2019). Organizational policies and procedures as well as processes that seek to assure the “five rights” (e.g., for drug administration—the right patient, the right drug, the right dose, at the right time, and with the right method of administration) guide clinicians towards correctly identifying patients as a result of adhering to an ingrained protocol. As patients receive care throughout multiple health systems and multiple providers, correctly identifying the patient and their record(s) remains a high priority concern (U.S. GAO, 2019). Health information technology (IT) can augment such identification efforts through various technologies such as barcode scanning, biometrics, algorithmic matching, and other tools. However, for this to occur the appropriate information must be gathered and available so that accurate and timely care can be provided. Here we present de-identified patient misidentification safety events submitted to ECRI Institute PSO and reviewed by patient safety analysts for shared learning.

Case Study Events

Case Study 1: Prior to a computed tomography (CT) scan it is necessary to review laboratory results assessing kidney function if an IV contrast dye is to be injected (to enhance the quality of a CT scan) to ensure that the patient’s kidneys are able to clear the dye from the body following the scan. In a particular event, the provider reviewed the wrong patient’s lab results, which revealed normal kidney function, and consequently IV contrast dye was used to enhance the scan. Upon realization that the incorrect labs were reviewed, appropriate personnel were notified and the patient was monitored for ill effects. The patient who received the IV contrast dye had decreased kidney function as indicated by laboratory results, and should not have received IV contrast dye.

Case Study 2: At the start of a shift a nurse noticed an empty IV antibiotic bag hanging in an assigned patient’s room, the contents fully administered through the still-attached IV line, but labeled with the incorrect patient name. The attending physician was notified immediately that the patient had received an antibiotic intended for another patient. The patient was monitored for an adverse drug reaction.

Case Study 3: Two patients were to receive portable x-rays. The x-ray technician performed the first x-ray but assigned it to the wrong patient name in the system. The other patient did not receive an x-ray immediately because it appeared one had already been performed. Recognition of the incorrect assignment was eventually made by the care team. However, there was a delay in care for both patients.

Contributing Factors

The above events point to a variety of underlying issues. Those involve misuse of appropriate identifiers, possible workarounds, poor communication, distraction, and noncompliance with policies and procedures to name a few. Good patient identification, matching, and record management are first steps in assuring appropriate delivery of healthcare to the right patient and in a timely manner. Communication, information gathering, procedures, and documentation all play a key role in patient identification.
In order to mitigate diagnostic errors, delays in care, and increased costs it is important that the correct patient and patient records are available at every encounter. In order for safe, quality, effective care to be provided it is essential that the correct individual is identified. Technology has helped to improve patient identification with the use of barcode scanning, biometrics, matching algorithms, and other tools. However, accurate patient identification within and across health systems remains an ongoing concern. Safe practice recommendations provide a basis to address patient identification (Partnership, 2017) by making certain that the information is collected and collected in standard formats. The recommendations additionally provide some foundational elements for proper identification. They can be found at www.ecri.org/safepractices. It is important to review and implement these safe practices.

Moreover, it is important to assess the culture of proper identification. Failure to address contributing factors (which can include not effectively using available technologies, forgetting to scan items, scanning incorrect items, using workarounds, and issues with functionality, interoperability, and usability) continue to hamper accurate patient identification. Issues with patient identification are not new. It is important to ascertain how to best use the available technologies to improve upon identification challenges and to make care safer.

Conclusion

While technology can provide tools for identification, it is not the sole answer to this complex issue. It is important to build the foundation so that the use of technology can be maximized for safety. Moreover, it is important to continue to evaluate this issue within the sociotechnical model (Sittig and Singh, 2010) and to enlist all stakeholders who can impact safety moving forward.

References


Also available: doi: 10.1136/qshc.2010.042085.

Important Announcements

Reminder: 2019 Dates for Upcoming Meetings

The Partnership for Health IT Patient Safety gathers stakeholders quarterly. Three of these meetings occur via web conferencing and the fourth is the annual in-person meeting. We look forward to having you with us on the dates and times below. Before each meeting, you will receive emails that will include registration and web conference access information.

The remaining 2019 meeting dates are:

Web-based quarterly meetings:

- April 23, 2019, 3 to 4 p.m. ET
- July 23, 2019, time to be determined

Annual, in-person meeting:
- September 12, 2019

Expert Advisory Panel

David W. Bates, MD, MSc
Kathleen Blake, MD, MPH
Pascale Carayon, PhD
Tejal Gandhi, MD, MPH
Chris Lehmann, MD
Peter J. Pronovost, MD, PhD
Daniel J. Ross, MD, DDS
Jeanie Scott, MS, CPHIMS
Patricia P. Sengstack, DNP, RN-BC, CPHIMS
Hardeep Singh, MD, MPH
Dean Sittig, PhD
Paul Tang, MD, MS
The presentation and recording of the January quarterly meeting are available on the membership website.

**Partnership News**

**Annual Report**

2018 was a productive year for the Partnership. The annual report contains information about the important events that occurred last year including learnings from the October in-person meeting - Collaboration: Building a Path to Sustaining Health IT Safety. Watch your mailbox for the announcement.

**Podcasts**

Our latest podcast, "Integrating a Health IT Safety Program," is available on the Partnership website. This podcast discusses how one organization used the toolkit to develop their health IT safety programing. Learn more about their initiatives, steps taken and tools that facilitated their planning by listening to the podcast. You can find access to the safe practices and tools for Developing, Implementing and Integrating a Health IT Safety Program [here](#).

**Would You Like to Improve Your Test Result Tracking?**

The Partnership is now looking for participants to take part in an implementation workgroup that will run over the upcoming spring and summer months. The workgroup will serve to help participants implement recommendations from the Health IT Safe Practices for Closing the Loop toolkit through various web-based meetings and outside work. The focus is test result tracking in the ambulatory setting, but others are not excluded. Participation will include identifying changes that can be made to your current practices, identifying particular implementations to undertake, identifying a measure of success to track, carrying out implementations, collaborating with other participants, and sharing learnings. Please contact [hit@ecri.org](mailto:hit@ecri.org) to indicate your interest in participating.

**There is Still Time To Get Involved in the Prototype Project**

The Partnership is moving towards a national collaborative and is launching a prototype project to be completed in 2019. The purpose of this project is to determine the best way to gather information for prioritizing safety events and shared learning. The project will use a measure endorsed by the National Quality Forum (NQF), the retract-and-reorder measure developed by Dr. Jason Adelman and his team of researchers. If you would like to participate, please contact us at [hit@ecri.org](mailto:hit@ecri.org) for more information.

If you would like to participate, please contact us at [hit@ecri.org](mailto:hit@ecri.org) for more information.

**Workgroup Updates**

2018 workgroup resources, including the EHRA/ECRI Safe Practice
Recommendations for Safer Opioid Prescribing white paper, evidence-based literature review, and quick implementation guide; and the Drug-Allergy Interactions Safe Practice Recommendations toolkit, also with an evidence-based literature review, will be released soon. Watch your mailbox for announcements.

**We Want to Hear from You**

Not only is it important to develop safe practices, it is important to implement them. To assess and measure their effectiveness we need your help in learning how these practices have enhanced safety within your organization. If your organization has implemented any of the Partnership's health IT safe practice recommendations, we would like to hear from you.

What has your experience been? Have you been successful? Did you have difficulty implementing these practices? How did you measure the outcomes? Start the conversation by emailing your responses and questions to hit@ecri.org.

**Collaborating Organizations**
Need to Submit an Event?
Partnership participants can submit events through your membership portal.

If you need assistance, please contact us at hit@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. If you wish to submit information for this publication, please submit items for the Update using the subject line "Partnership Update" to hit@ecri.org.

The Partnership for Health IT Patient Safety is sponsored through funding from the Gordon and Betty Moore Foundation.

How to Unsubscribe: If you wish to stop receiving the Partnership for Health IT Patient Safety Monthly Update, please send an e-mail to hit@ecri.org and we will accommodate your request.