Patient Identification is a Top Patient Safety Concern

Correct patient identification is fundamental to safe care. Yet, the risk of wrong-patient errors is ever-present for the multitude of patient encounters occurring daily in healthcare settings. Some reach the patient, sometimes with potentially fatal consequences.

To understand this issue, ECRI Institute conducted a study of its patient safety reporting database, examined the literature, and convened an expert working group through its Partnership for Health IT Patient Safety.

In its analysis of 7,613 events from 181 healthcare organizations, ECRI Institute found:

- 9% led to temporary or permanent harm, and 2 deaths
- >50% involved diagnostic procedures or treatment
- 72% occurred during patient encounters; another 12% occurred during intake
- 36.5% involved diagnostic procedures (lab, pathology, x-rays)
- 22% involved treatment (medications, procedures, transfusions)

Key take-aways:

- Incorrect patient identification occurs during multiple procedures and processes
- Patient identification mistakes occur in every healthcare setting, from hospitals and nursing homes to physician offices and pharmacies
- No one on the healthcare team is immune from making a wrong-patient error

Why do patient identification errors occur?

Errors occur due to time constraints, distractions, fatigue, software, communications issues, device defects, patient characteristics, and other reasons. Despite the attention given to correct patient care, mistakes continue to occur. We need better solutions.

What is needed to improve patient identification?

We need to develop national standards that require consistent use of standard identifier conventions, including:

1) Use standard attributes and formats
2) Implement standards for all transactions between patients and the healthcare system
3) Adhere to a standard display across all health IT systems

Sample Case Histories

Medical-surgical unit: A patient in cardiac arrest was mistakenly not resuscitated because the care team pulled up the wrong patient’s record and adhered to a do-not-resuscitate order.

Surgery: A cardiac clearance meant for a different patient was given to a patient who previously had an abnormal electrocardiogram. The patient underwent surgery and was found unresponsive in his hospital room the next day.

Dietary: The wrong meal tray was given to a patient with a nasogastric tube who was not to receive any food or fluids orally. The patient attempted to eat the food and choked.

Physician’s Office: The wrong patient was marked as deceased in the doctor’s office’s electronic health record. All of her outstanding appointments were automatically canceled.

Eye Clinic: Two patients with the same first name were scheduled for cataract surgery. The wrong patient was brought into the operating room and received the lens implant intended for the other patient.

Empowering Organizations to Improve Patient Care

ECRI Institute is a 50-year-old independent, 501(C)(3) nonprofit organization that investigates, analyzes, evaluates, consults, advises, benchmarks, and educates—all to advance effective, evidence-based healthcare.

Our interdisciplinary staff of nearly 450 provides healthcare professionals the knowledge and assurance they need to make patient safety a top priority across all care settings.

Serving the Private and Public Sectors

ECRI Institute’s mission as an impartial and independent advocate for patient safety has meant that we work with many public and private sector organizations. For example, our Partnership for Health IT Patient Safety brings together providers, IT developers, researchers, and policymakers to advance patient safety in health IT, and eliminate unintended consequences that can contribute to patient harm. Many other federal and state agencies rely on ECRI Institute’s safety and clinical risk management programs to accelerate improvements and keep patients safe.

Integrity and Assurance

ECRI’s integrity is built on evidence-based research, strict conflict-of-interest policies, and transparent reporting of our findings. We give healthcare professionals the knowledge and assurance they need to make patient safety a top priority in healthcare settings around the world.

- Assurance on which technologies are safe, reliable, clinically effective, and cost effective
- Assurance that clinical guidelines are readily accessible and evidenced-based
- Assurance that patient safety challenges are assessed and improvements are provided for all care settings

To learn more about how ECRI Institute advances effective evidence-based healthcare globally, visit www.ecri.org.

About ECRI Institute

ECRI Institute, a nonprofit organization, is an independent, trusted authority on the medical practices and products that provide the safest, most cost-effective care. For more than half a century, ECRI Institute has built its reputation on rigorous evidence-based research, with an unwavering dedication to strict conflict-of-interest policies and transparent reporting of its findings. ECRI Institute is designated an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality. ECRI Institute PSO is listed as a federally certified Patient Safety Organization by the U.S. Department of Health and Human Services. Visit ecri.org and follow @ECRI_Institute.