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Sources:

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ECRI Patient Safety Organization, "Deep Dive Patient Identification," August 2016

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Northwell Health (formerly North Shore LIJ), Sherman Award nomination, March 2015, www.engagingpatients.org

Simple Steps to Ensure Positive Patient Identification

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Positive patient identification is the cornerstone of patient safety. Identifying patients correctly at each point on their healthcare journey helps reduce potentially fatal treatment and medication errors. The process of positively identifying a patient also offers an opportunity to build relationships and improve communication with patients and families.

The Issue

"…wrong-patient errors can occur at multiple points during a patient's healthcare encounter and can involve nearly anyone on the patient's healthcare team. Safe patient identification requires multi-pronged solutions to engage team members and patients."

-ECRI Institute Patient Safety Organization Deep Dive about Patient Identification, 2016

Positive patient identification is so critical that the Joint Commission has included it as a National Patient Safety Goal since 2003. The National Quality Forum also lists wrong-patient mistakes as serious reportable events and also considers patient identification as a high-priority area for measuring health information (IT) safety.

Joint Commission recommendations include:

- Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- Make sure that the correct patient gets the correct blood when they get a blood transfusion.

ECRI *Deep Dive Patient Identification* at a Glance:

- Analyzed **7,613** events from **181** healthcare organizations between January 2013-August 2015
- More than **72%** of the failures happened during patient encounters; almost **13 percent** happened during the intake process
- **More than half** of the failures involved diagnostic procedures (lab, pathology, imaging) or treatment (medications, procedures, transfusions)
- **Two wrong-patient** events associated with deaths involved documentation failures
- Wrong patient events involving physical identification of patients constituted about **15 percent** of all of the failures. Most fell into three categories: Missing wristbands, patient ID not verified or wristband identifiers incorrect.

Dangerous Consequences

From the ECRI Institute Patient Safety Organization Database:

- A patient in cardiac arrest was mistakenly not resuscitated because the care team pulled up the wrong patient's record and followed a do-not-resuscitate order.
- Cardiac clearance meant for a different patient was given to a patient with a previous abnormal electrocardiogram. The patient was found unresponsive the day after having surgery.
- The wrong patient was taken to get an MRI with general anesthesia. The patient was intubated and sedated before the error was caught.
- An infant received breastmilk intended for a different infant. The mother who produced the breastmilk had the hepatitis B virus so the infant who received her milk had to be treated with hepatitis B immune globulin.
- 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.

Use patient photos to help correctly identify patients: Only about 20% of hospitals use patient photos.

-"Medical Record Mix-Ups a Common Problem, Study Finds," Wall Street Journal

What Can You Do?

- Use at least two ways to identify patients. Do not use patient room number as an identifier.
- Ask patients to identify themselves before receiving medication or treatment. Ask patients or family members to verify identifying information to ensure its accuracy.
- Listen to patients and families who may have questions about patient identification.
- Use specific language to ask a patient to identify themselves. Do not ask them to confirm their name. Instead say, "Tell me your name."
- Standardize the approach to patient identification among different facilities within a healthcare system.
- Provide clear protocols for identifying patients who lack identification and for distinguishing the identity of patients with the same name. Audit policies and processes to discover system-wide problems.
- Standardize protocols to verify patient's identity including how names are displayed in electronic records and include patient photos.
- Encourage patients to participate in all stages of the process.
- Label blood and other specimens in the presence of the patient.
- Establish clear protocols for questioning test results or findings when they are not consistent with the patient's clinical history.
- Provide for checks and reviews in orders to prevent automated multiplication of a computer entry order.
- Help registration staff get it right at the beginning of care: Establish clearly defined policies and procedures for the registration process. Otherwise, incorrect patient registration information can affect care throughout the patient visit. Provide support for registration staff so they don't feel rushed—which can lead to the introduction of errors.
- Consider implementation of automated systems (EHRs, computerized provider order entry, bar coding, RFID, physiologic monitors, e-prescribing) to decrease the potential for patient identification errors.
- Discuss errors openly to learn from them.

"It doesn't take a lot of mental energy to notice out of the corner of your eye that this record shows a young white woman and you're treating an elderly African-American."

-Jason Adelman, chief patient safety officer at Columbia University Medical Center in New York, Wall Street Journal

Best Practices

Northwell Health (formerly North Shore LIJ) won the 2015 Sherman Award for Excellence in Patient Engagement from EngagingPatients.org for their positive patient identification program.

Key elements:

- Leadership and patient and family support and engagement. The Northwell team included leadership, clinical and non-clinical frontline staff and patients and families.
- Eight Critical Elements created: Use full name and DOB; Request patient/family state and spell full name and DOB; compare patient/family statement to source document(s); Include family if the patient is unable to participate; Label all specimens in the presence of the patient; Do not use location; Clarify all discrepancies.
- Eight Patient Rights created: Right patient; Right test/treatment/procedure/medication; Right time; Right location and place; Right reason; Right to participate; Right to understand; Right to consent or refuse treatment.

Results (as of March 2015):

- Significant positive movement in Press Ganey surveys at the time of program implementation/measurement
- 35,000+ staff completed an online Patient ID learning module
- 13% improvement in staff knowledge of the critical elements for patient identification
- 86% decrease in medication errors related to patient identification in four participating facilities
- 83% of staff surveyed agreed or strongly agreed that the culture of safety improved in their unit