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Event Reporting & Analysis - News

ECRI Institute Deep Dive: Patient Identification—Executive Summary

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For its fifth Deep Dive analysis of a patient safety topic, ECRI Institute PSO selected patient identification. Safe patient care starts with delivering the intended interventions to the right person. Yet, the risk of wrong-patient errors is ever-present for the multitude of patient encounters occurring daily in healthcare settings.

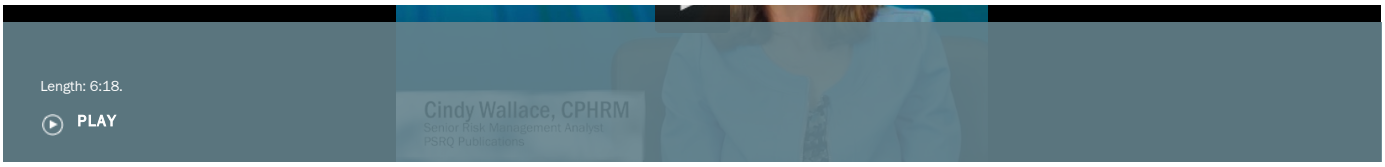
DEEP DIVE PATIENT IDENTIFICATION - FINDINGS

Many patient identification mistakes are caught before care is provided, but reports submitted to ECRI Institute PSO illustrate that others do reach the patient, sometimes with potentially fatal consequences.

In addition to their potential to cause serious harm, patient identification errors are particularly troublesome for a number of other reasons, including:

- Most, if not all, wrong-patient errors are preventable.
- Incorrect patient identification can occur during multiple procedures and processes, including but not limited to patient registration, electronic data entry and transfer, medication administration, medical and surgical interventions, blood transfusions, diagnostic testing, patient monitoring, and emergency care.
- Patient identification mistakes can occur in every healthcare setting, from hospitals and nursing homes to physician offices and pharmacies.
- No one on the patient's healthcare team is immune from making a wrong-patient error. Mistakes have been made by physicians, nurses, lab technicians, pharmacists, transporters, and others.
- Many patient identification errors affect at least two people. For example, when a patient receives a medication intended for another patient, both patients—the one who received the wrong medication and the one whose medication was omitted—can be harmed.

DEEP DIVE PATIENT IDENTIFICATION - RECOMMENDATIONS



Given that correct patient identification is fundamental to safe care, the Joint Commission has made accurate patient identification one of its National Patient Safety Goals since 2003 when the first set of goals went into effect. The Joint Commission is not alone in advocating for safe practices to ensure correct patient identification. The National Quality Forum lists wrong-patient mistakes as serious reportable events and also considers patient identification as a high-priority area for measuring health information technology (IT) safety. Even the media has called attention to the issue. Of the 25 "shocking medical mistakes" listed by cable news network CNN in 2015, at least 6 involved wrong-patient errors.

Despite the attention given to correct patient identification, mistakes continue to occur. This report summarizes ECRI Institute PSO's analysis of more than 7,600 wrong-patient events reported to the event report database.

Based on the findings, risk mitigation strategies are provided. Although the events occurred primarily in hospital settings, many of the circumstances contributing to the events and the prevention strategies suggested are applicable to all healthcare settings.

TOPICS AND METADATA

Topics

Transitions of Care; Quality Assurance/Risk Management; Health Information Technology; Interprofessional Communication

Caresetting

Hospital Inpatient; Hospital Outpatient; Emergency Department; Physician Practice; Skilled-nursing Facility; Ambulatory Surgery Center

Clinical Specialty

Nursing

Roles

Risk Manager; Patient Safety Officer; Quality Assurance Manager; Allied Health Personnel; Nurse; Clinical Practitioner

Information Type

News

Publication History

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RELATED RESOURCES

- Executive summary
- Deep Dive: Patient Identification
- Deep Dive: Patient Identification - online version
- Shared Practices for Patient Identification