



Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI & ISMP under contract to the Pennsylvania Patient Safety Authority

PATIENT IDENTIFICATION

Ensuring positive identification of patients is a challenge in all healthcare settings. Sometimes patient misidentification can be a causative factor in many events involving medication administration, invasive procedures, transfusions, injections of contrast media, phlebotomy, pathology specimen preparation, and provision of emergency medical services. The potential for errors of patient identification may be greatest in acute care hospitals, where a wide range of interventions are delivered in various locations by numerous staff who work in shifts.

The true extent of harm to patients caused by misidentification is unknown. The Joint Commission on the Accreditation of Healthcare Organization's (JCAHO) national sentinel event database contains 30 reports over an eight-year period of invasive procedures performed on the wrong patient.¹ New York State's mandatory reporting system has reports of 27 patients who underwent invasive procedures intended for another patient.² U.S. Pharmacopeia's MedMARxSM system received reports of 8,196 medication errors involving the wrong patient in 2002, 1.4% of which involved harm.³

Preliminary reports from the 22 healthcare facilities participating in the test phase of PA-PSRS indicate that Pennsylvania facilities are not immune from the risks of patient misidentification. Between November 2003 and April 2004, PA-PSRS received a number of reports in which patient identification was or may have been a contributing factor (see Table 1). While nearly all of these reports were Incidents as defined in Act 13, in which no harm came to the patient, the volume of reports demonstrates that patient identification can be a significant issue.

Wrist bands are not a panacea for the risk of misidentification.

An analysis of major blood transfusion errors reported to the Food and Drug Administration (FDA) over a ten-year period from 1976 to 1985 revealed that 10 patient deaths occurred in situations in which the actual and intended recipients

bore the same last name and that five deaths occurred involving patients who shared the same room.⁴ These contributing factors have also been

cited in patient misidentification reports submitted to PA-PSRS.

In one case reported to PA-PSRS, a patient received medications intended for another patient with the same first name. The report indicated that medications were administered in part based on patient first names. While the patients' charts were marked with "same name alert" stickers, the practitioner administering the drugs may not have checked the charts, and the report indicates they may also have failed to check the patient's wrist band. In an effort to prevent this type of error, many facilities use two unique patient identifiers (e.g., name, telephone number, birth date, social security number), particularly before high-risk interventions such as administering medications or blood products or before performing surgery.

Wrist bands are a common medium for unique identifiers, and Pennsylvania regulation requires the use of a patient identification band or other visible means of identification on individuals at the time of admission to a hospital (PA Code 28, Section 105.15). Wrist bands are not a panacea for the risk of misidentification, however. The College of American Pathologists (CAP) reported⁵ on several studies it conducted between 1991 and 2000 to identify wrist band errors. In these studies (which focused on the hospital setting), mean error rates ranged from approximately 2.4% to 8.4%.

Practices to enhance patient identification reported by the best and most improved performers in recent CAP studies include:

- Placing new wrist bands on patients immediately following removal of a band during a procedure.

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Patient Identification (Continued)

Table 1. Levels of Harm Associated with Reports Potentially Involving Patient Identification Problems (November 2003-April 2004)

Level of Harm	Percentage of Total
Incident: Unsafe Conditions (PA-PSRS Harm Score A)	7%
Incident: No Harm (PA-PSRS Harm Scores B1-D)	90%
Serious Event: Temporary Harm (PA-PSRS Harm Scores E-F)	1%
Serious Event: Significant Harm (PA-PSRS Harm Scores G-I)	1%

- Having a written protocol for identifying patients at the time of phlebotomy.
- Forbidding phlebotomists from drawing blood from patients with wrist band errors.
- Educating staff members who use wrist bands and defining a process to immediately fix a wrist band error.

Healthcare facilities use a variety of system elements to correctly identify patients and to catch identification errors when they occur, and clinicians play a crucial role in that system. Each interaction with a patient is an opportunity to verify correct identification and to serve as a system safeguard when identification errors are present.

Notes

1. Croteau R. (Executive Director, Strategic Initiatives. Joint Commission on the Accreditation of Healthcare Organizations). Personal communication with ECRI 2003 Mar 17.
2. Chassin M, Becher EC. The wrong patient. *Ann Intern Med* 2002 Jun 4;136(11):826-33.
3. Hicks RW, Cousins DD, Williams RL. Summary of information submitted to MedMARxSM in the year 2002. *The Quest for Quality*. Rockville (MD): USP Center for the Advancement of Patient Safety; 2003.
4. Sazama K. Reports of 355 transfusion-associated deaths: 1976 through 1985. *Transfusion* 1990 Sep;30(7):583-90.
5. Howanitz PJ, Renner SW, Walsh MK. Continuous wristband monitoring over 2 years decreases identification errors: a College of American Pathologists Q-Tracks study. *Arch Pathol Lab Med* 2002 Jul;126(7):809-15.



An Independent Agency of the Commonwealth of Pennsylvania

The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error (“Mcare”) Act. Consistent with Act 13, ECRI, as contractor for the PA-PSRS program, is issuing this newsletter to advise medical facilities of immediate changes that can be instituted to reduce serious events and incidents. For more information about the PA-PSRS program or the Patient Safety Authority, see the Authority’s website at www.psa.state.pa.us.



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The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP’s efforts are built on a non-punitive approach and systems-based solutions.