Patient Safety Update:

Patient Identification – Strategies for Improving Accuracy and Minimizing Vulnerabilities

Webinar Objectives

- Prevalence of patient identification errors
- Top-level mitigation strategies
  - Electronic health record
  - Wrong-Patient/Wrong-Procedure/Wrong-Site Surgery
- Prevention strategies
- Conclusion – Three Quick Things
Why focus on patient identification?

Patient Identification Errors

- A study involving 69 hospitals found identification defects in 2.9 percent of surgical specimen samples\(^1\)
- An analysis of more than 1 million medication orders found that 0.064 percent were associated with a misidentified patient\(^2\)

Patient Identification Errors

- Wrong-patient/wrong-procedure/wrong-site surgery has been the most frequently reported sentinel event over the 12-year period of 2005-2016³
- In the Harris County Hospital District database of 3,428,925 patients – 231 Maria Garcia’s that share the same DOB⁴


Frequency of Patient Identification Errors

- 7,613 events
- 181 healthcare organizations
- 32-month recording period
- 1.3 (self-reported) events per month per organization

Distribution of Patient Identification Errors

- Post Encounter and Other: 15%
- Intake Process: 13%
- Patient Encounters: 72%


Impact of Patient Identification Errors

- 19.2 percent of the patient identification errors analyzed were found to cause either:
  - temporary harm,
  - permanent harm, or
  - the requirement for monitoring of the patient to rule out the need for any intervention.

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Mitigation Strategies

Patient Involvement

• Good Practices
  – Educate patients on the process – help them to understand the safety check element – not an impersonal experience

• Watch-Outs
  – Patients may provide incorrect information
    o Confused, fail to understand (hear), overly helpful

“Where Everybody Knows Your Name”
Identification and Matching

- Use two or more identifiers
  - Name, DOB, MRN, bar code, photo
  - Biometrics, RFID
- Ensure that initial identification is accurate
- Continue rigorous identity confirmation throughout the patient’s stay

Key Processes

- Culture and Protocols – Primary responsibility of healthcare providers to check the identity of patients and match the correct patients with the correct care (e.g. laboratory results, specimens, procedures) before that care is administered.
- Point of Care Processes – Enforce the labeling of containers used for blood and other specimens in the presence of the patient.
- Unavailable Patients – Develop standardized approaches for identifying non-communicative patients.
The Electronic Health Record

Technology

- 14.8 percent of patient identification errors had technology contributing to the error
  - An analysis of 7,740 patient identification errors

SAFER Guides

- Safety Assurance Factors for EHR Resilience
  - 14-point checklist
  - Evaluates the innate protections resident in the EHR
  - Review the capabilities of the EHR to help prevent errors


SAFER Guides

- Does your system display patient photographs?
  - Item 3 – Phase 1 – Safe Health IT

Screen shot courtesy of Taylor Healthcare.
SAFER Guides

• Users are warned when they attempt to create a new record for a patient (or look up a patient) whose first and last name are the same as another patient.

SAFER Guides

• The EHR limits the number of patient records that can be displayed on the same computer at the same time to one, unless all subsequent patient records are opened as "Read Only" and are clearly differentiated to the user.
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Never Events

- Letter to staff: “…there have been four wrong site procedures over a 40 day period…”
Wrong-Patient / Wrong-Procedure / Wrong-Site Surgery

- An instance of wrong-patient/wrong-procedure/wrong-site surgery reaches a patient, on average, once per year in a 300-bed hospital

Wrong-Patient / Wrong-Procedure / Wrong-Site Surgery

- The most effective mechanism for avoiding wrong-patient / wrong-procedure / wrong-site surgery is verification of the consent form
- More effective than the formal Time-Out


Consider Boxing Patient, Procedure and Site

- Note that the example also lists the MRN
Preventing and Addressing Patient Identification Errors

Conduct an FMEA

<table>
<thead>
<tr>
<th>Failure</th>
<th>Mode</th>
<th>Effects</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The potential issue</td>
<td>Patient misidentification – wrong medication</td>
<td>Reliance on the room number</td>
<td>Employ two identifiers along with patient involvement</td>
</tr>
<tr>
<td>Patient misidentification – wrong medication</td>
<td>How can the failure occur?</td>
<td>Two patients affected – misidentified patient, intended patient</td>
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<tr>
<td>Reliance on the room number</td>
<td>What are the consequences?</td>
<td></td>
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<tr>
<td>Two patients affected – misidentified patient, intended patient</td>
<td>How to reduce the risk?</td>
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Develop a Culture of Safety

- Non-Punitive Culture
- Effective Reporting System
- Adverse Event Response Team

CUSS
- I am Concerned
- I am Uncomfortable
- This is for Safety
- Stand up and stand together

Resources
- IHI – Culture of Safety
  - http://www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx
- Joint Commission – High Reliability in Health Care


Conduct an RCA

Legend
- Event
- Mode
- Hypothesis
- Physical Root
- Human Root
- Latent Root
- Not True

- Root Cause Analysis
  - Patient misidentification at Registration

Why?
(Courtesy of the Reliability Center Inc. www.reliability.com)
Three Quick Things

1. Perform an RCA on your next “near miss”

Root-cause analysis might be shallow-cause analysis.

Three Quick Things

2. Conduct a SAFER assessment on your EHR (other systems)

Three Quick Things

3. Add a line for “Surgical Site” to your consent forms
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Questions
Timothy.Kelly@TaylorCommunications.com

Resources