Health Information Compliance Alert

Adverse Events: EHR Is Often a Culprit in Patient-Identification Errors

A picture could be the key to preventing dangerous mistakes.

Patient-identification errors are common and sometimes deadly, says a recently published report from the **ECRI Institute**, a nonprofit research organization that studies patient safety. Sometimes, electronic health records snafus contribute to the errors, the report says.

ECRI researchers studied 7,600 wrong-patient events among 181 health care organizations that occurred over a 32-month period. In one instance an infant received breast milk intended for another infant. The mother who produced the breast milk was infected with the hepatitis B virus. As a result, the infant who mistakenly received the breast milk had to be treated with hepatitis B immune globulin. In another dramatic example, a patient was approved for surgery based on a different patient's records and was found dead in his hospital room the next day.

Worth noting: 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.

Patient-identification mix-ups, or "wrong-patient events," may be driven by increasing patient volume, frequent handoffs among providers, and increasing interoperability and data sharing among IT systems, ECRI researchers say.

The ECRI report says that 13 percent of wrong-patient errors they examined occurred during registration, when a duplicate record was created for the same patient, in part because some electronic medical record systems were unable to recognize minor spelling variations. "Mary Ellen Smith, Mary E. Smith and Mary-Ellen Smith might all appear to be different patients," ECRI director **William Marella** told The Wall Street Journal.

The report recommends steps that providers can take to reduce patient identification errors related to EHR, including:

1. Standardizing how patient names are displayed in EHRs, and
2. Including patient photos in the medical record.

Editor's Note: To read an executive summary of ECRI's report, go to https://www.ecri.org/Resources/Whitepapers_and_reports/PSO Deep Dives/Deep Dive_PT_ID_2016_exec summary.pdf.