

Lessons Learned, 2005 #03
“The Wrong Patient”

Case 1 –

Albert A. Raxton was seen by Dr. Smith in Ambulatory Clinic 9 for a groin nodule. Albert B. Raxton was also seen in Clinic 9 for an upper respiratory infection – he has a history of lymphoma.

Albert B. finished his appointment and was directed to the clinic scheduler for a chest MRI appointment while Dr. Jefferson was still completing the notes on his chart. While Albert B. was sitting there, Dr. Smith came out and gave the scheduler Albert A.'s chart that contained an order for a biopsy of the groin nodule. The scheduler made the appointment for Albert A. and handed an appointment card to Mr. Raxton (Albert B.) sitting in front of her. He was relieved to hear he is having a biopsy, even though he and Dr. Jones did not specifically talk about it - he knows that a new lump may be a bad sign of lymphoma recurrence.

One week later, Albert B. appears for his biopsy. He is registered by the registration staff and sent back for his procedure. Susan Talley brings the patient back to the room for the biopsy. She verifies the patient is “Albert Raxton” and that he is having a biopsy. Just after completing the procedure, Dr. Williams realizes that the patient who had the biopsy is not the same patient as the name on the paperwork.

Commentary:

- Although the case described above is fictional, it is representative of what can and has occurred in health care organizations throughout the nation.
- “Wrong patient” events are among the most disturbing adverse events that occur in healthcare.
- Particularly in a large complex health system such as ours, inadequate communication is a frequent contributor to such occurrences.
 - Communication between clinical areas and among individuals within the same area (registration clerk to technologist, physician to registration clerk) is often incomplete.
- **A standard process to verify patient identity, using two unique identifiers, protects patients from such occurrences.**
 - Patients with similar names challenge our systems – reliance on the patient’s name alone (or on a 2nd identifier such as patient room number or age) leaves our patients at risk for receiving treatments, tests and medications they do not need or want.
 - Assumptions about patient identity should never be made – if you encounter information that does not match, always consider whether this is the WRONG PATIENT.

Discussion Points:

1. All healthcare team members will use **two unique patient-specific identifiers** to assist in correct identification of the patient. *This is one of JCAHO’s National Patient Safety Goals.*
 - **Unique identifiers** include Patient name, Medical Record Number (MRN), Date of Birth (DOB), Social Security Number (SSN), Photo ID.
 - **Ask the patient** (or family) to state the patient's name whenever possible.
 - Armbands, as well as drivers licenses, passports/visas, birth certificates and social security cards, may be used as a source against which to verify patient name, SSN or DOB.
 - Please note: age, sex and room number are NOT unique identifiers.
2. **Patient identification will be verified prior to care**, treatment or service in the treatment cycle (for example, giving medications, collecting specimens, transportation, registration, etc.).
3. All staff who interact with patients, as well as those who interact with patient specimens or patient records should review VCUHS Policy No. 4500.02 “Patient Identification” and begin following these procedures immediately. Consult your supervisor with any questions.
4. Department Chairs and organizational leaders shall **communicate the above messages to all staff** and engage staff in discussions regarding such patient safety issues. This includes faculty, nurses, housestaff, technicians, therapists, patient service representatives, transportation staff and others.

Prior to any treatment, confirm the patient's identification using two unique identifiers.

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Additional Vignettes

Case #2 – “Check the Wristband” (adapted from AHRQ Web M&M, Jul03, www.webmm.ahrq.gov)

Ms. Yeardley, a 28-year-old female awaiting ambulatory surgery, was very anxious about her impending surgery. [She spoke English and appeared to be of average intelligence.]

The circulating nurse went to the peri-surgical unit to meet her next patient. She picked up the chart next to this patient - it was the correct chart for her next patient. The nurse then verbally stated the patient's name and this woman confirmed. She also confirmed other information, including the type of surgery.

The nurse then walked the patient to the operating room (OR) suite and positioned her on the table. The certified nurse anesthetist checked the patient's wristband and alerted the nurse to the error – the chart the RN had picked up was not that of Ms. Yeardley - it had inadvertently been left next to her. The shocked nurse apologized to the patient and escorted her back to the peri-surgical unit.

Commentary:

- As occurs with many “near miss” and actual events, the incident involved several errors:
 - (1) the wrong patient chart was placed by the patient's bedside;
 - (2) the RN did not question that the chart could be incorrect;
 - (3) the RN failed to check the patient's wristband; and
 - (4) the RN failed to ask patient identification questions in an appropriate way.
- As is often the case, these errors appear to have been made by conscientious professionals.
- The nurse had supplied much of the information for patient identification, rather than asking the patient open-ended questions and insisting that the patient provide correct identifying information, such as “What is your date of birth?” rather than, “Your birth date is May 1, 1976?”
- Why would the patient answer all the nurse's questions correctly? Many patients and families are quite anxious.

Case #3 – “Results posted to the Wrong Medical Record”

Mario B. Lopez, an 88 year old male with a known history of meningioma, was referred for MRI to evaluate progression of the size of the tumor. Mario A. Lopez, a 40 year old male, was also referred to MRI around the same date, for evaluation of neck and shoulder pain.

When Mario B. Lopez presented, he was registered as Mario A. Lopez due to an inadvertent selection of the wrong patient in the computer system. Thus, the cranial MRI report and films for Mario B. Lopez were generated with Mario A. Lopez's name and medical record number and posted to Mario A. Lopez's electronic record.

Mario A. Lopez, who had been referred for neck and shoulder discomfort, returned to the neurosurgeon for review of his films. The neurosurgeon reviewed the film and informed Mr. Lopez (erroneously) that he had a meningioma; surgery was recommended. After waiting 3 months, Mario A. Lopez was admitted for surgery. During a pre-op angiogram, it was discovered that Mario A. Lopez did not have a meningioma.

Commentary:

- Staff members involved in this case were all well-trained and well-intentioned.
 - While it might be easy to blame the individual who registered the patient for MRI, there are actually a series of factors that, if different, could have prevented this event.
- A simple slip of the hand can result in selection of the wrong patient from among a patient list in the computer. Such human errors are common, but can be easily detected through use of a standard process for patient identification, including:
 - Use of two unique patient-specific identifiers (such as full name, DOB, SSN) and
 - Active patient participation (have the patient state his/her name and second identifier).