ECRI Institute's

PSO Monthly Brief

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Deep Dive: “Most Wrong-Patient Errors Are Preventable”

Safe patient care starts with delivering the intended interventions to the right person. Yet, the risk of wrong-patient errors is present in all patient encounters that occur daily. Therefore, ECRI Institute PSO’s fifth annual Deep Dive addresses the topic of patient identification. Most patient identification mistakes are caught before care is provided, but others do reach the patient. About 9% of the events led to temporary or permanent harm or even death.

"Although many healthcare workers doubt they will actually make a mistake in identifying their patients, ECRI Institute PSO and our partner PSOs have collected thousands of reports that show this isn't the case," says William M. Marella, MBA, MMI, ECRI Institute executive director of PSO Operations and Analytics. "We've seen that anyone on the patient's healthcare team can make an identification error, including physicians, nurses, lab technicians, pharmacists, and transporters."

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, such as 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.

What ECRI Institute PSO found

ECRI Institute PSO analyzed 7,613 events submitted by 181 healthcare organizations. The vast majority of failures occurred during patient encounters, while a small percentage occurred during intake. More than half of all failures involved diagnostic procedures or treatment.

What ECRI Institute PSO recommends

ECRI Institute PSO offers recommendations for leadership, for policies and procedures, for patient and family engagement, for patient registration, for standardization and simplification, for technology use, and for event reporting and response. Some key recommendations include:

- Leaders should ask questions about the organization's patient identification practices and experiences to identify strengths and opportunities for improvement.
- The organization should adopt a standardized protocol to verify a patient's identity and ensure that the policies and procedures spell out which identifiers to use and when.

Learn more

The executive summary of the ECRI Institute PSO Deep Dive on patient identification is available for free download. Contact us for a demonstration of how we can help you review and improve your patient identification practices.

Assess Where Patient Identification Risks are Lurking In Your Facility

ECRI Institute's NEW web-based risk assessment for Patient Identification provides perspectives from the front-line to leadership to help you face these risks. Use our assessment services to identify which areas of your organization need more of your effort and pinpoint gaps that could leave your organization vulnerable.

- Learn more about our assessments

Patient Safety Center

World-class research, guidance, and tools made available to the public.
ECRI Institute is committed to patient safety, as it is the key element of our mission. The Patient Safety Center contains publicly available free resources to help all healthcare providers improve the quality and safety of the care they provide.

ECRI Institute is Hiring!

Are you seeking employment with an organization that focuses on improving healthcare and values and respects its staff? We are actively looking for patient safety and risk management experts for several positions. Learn more.

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