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# Joint Commission Advisory Addresses Ensuring Accurate Patient Identification

## Technology can help, but it is not a silver bullet

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Mistakes in patient identification can lead to wrong-patient errors, delays in treatment, and serious problems. In October, The Joint Commission issued an advisory on how healthcare providers can ensure accurate patient identification. Technology can help reduce patient identification mistakes, but healthcare organizations should not rely solely on these tools. (*Editor's Note: Learn more about the advisory online at: <https://bit.ly/2yS9ntg> (<https://bit.ly/2yS9ntg>).*)

"Despite advanced technology, patient misidentifications leading to wrong patient procedures still occur, suggesting that we cannot rely on technology alone," says **Gerard Castro**, PhD, MPH, project director, office of patient safety, The Joint Commission.

For instance, a common human factor that contributes to patient misidentification is a distraction. This can occur despite or even because of technology aides, Castro explains. These distractions include interruptions, too many people in the area, noise, and time constraints.

"Take, for example, a clinician who is completing documentation on a patient. Then, a colleague asks a question about a medication on another patient," Castro offers. "The clinician opens the record on the other patient, finds the information, and answers the question." Perhaps the clinician receives a phone call, answers another question, and then continues documenting on the record that is open, but it is on the incorrect patient. "Engagement of clinicians is essential to this process, but I'm unaware of any health systems that are working on this issue," Castro adds. "That is not to say, however, that they are not."

Other potential problems that can lead to patient misidentification include mistakenly creating duplicate charts, assigning a test to the wrong patient, and separating commingled patient information. The Joint Commission's recommended safety actions include:

- using an active confirmation process to help match the patient and documentation;
- standardizing the process for patient identification and capturing patient information (wherever registration occurs);
- implementing monitoring systems to readily detect identification errors, such as regular inspection for patient identification errors and possibly duplicate patient records;
- creating high-specificity alerts and notifications to ensure proper identification, including warning users when they attempt to create a record for a new patient whose first and last names are the same as of another patient.

These suggestions, such as implementing monitoring systems, include tactics that clinician researchers are employing, but possibly not many surgery centers or other healthcare providers, Castro notes.

"The vendor community is aware of this work because many vendors participate in the ECRI Partnership for Health IT Patient Safety, where much of the work is shared," he says.

The advisory suggests healthcare organizations use an identifier like a color photo in conjunction with other distinguishing identifiers.

“The idea is to add a visual cue to help corroborate the patient’s identity with more standard attributes, such as name and date of birth,” Castro says. “Currently, it is a recommended [tactic] that has been tested by some hospitals, but I am unsure of how widely the strategy is being used.”

The Joint Commission’s National Patient Safety Goal (NPSG.01.01.01) says organizations must use at least two identifiers when providing care, treatment, and services.

“It’s up to each organization to determine which strategy helps meet this goal,” Castro adds.

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