

## **Examples of Patient Identification Mix-Ups**

**Here are some sample case histories from the ECRI institute:**

Scenario: A patient in cardiac arrest was mistakenly not resuscitated because the care team pulled the wrong patient's record and adhered to a do-not resuscitate order.

Scenario: A cardiac clearance for surgery meant for a different patient was given to a patient who previously had an abnormal electrocardiogram. The patient underwent surgery and was found unresponsive in his hospital room the next day.

Scenario: The wrong meal tray was given to a patient with a nasogastric tube who was not to receive any food or fluids orally. The patient attempted to eat the food and choked.

Scenario: The wrong patient was marked as deceased in the doctor's office EHR. All of her outstanding appointments were automatically cancelled.

Scenario: Two patients with the same first name were scheduled for cataract surgery. The wrong patient was brought into the operating room and received the lens implant intended for the other patient.

**Here are additional real-life examples from CHIME and AHIMA members:**

Scenario: Woman received routine mammogram. Returns to provider office for annual physical following year and mentions she never received her mammogram results from prior year, relieved that nothing was found. Unfortunately, her results were mis-filed in the chart of a deceased patient of the same name. When the woman received her results, they showed cancer and after the delay, the cancer had become terminal, beyond treatment.

Scenario: Grandmother calls hospital CIO requesting calls cease to her daughter, who had lost her daughter, the caller's granddaughter, to pediatric cancer. The caller's granddaughter shared a name with a child currently undergoing treatment for pediatric cancer. The caller's daughter was receiving appointment reminders and ongoing outreach for the patient currently undergoing cancer treatment. The persistent calls were causing emotional distress to the daughter of the caller as she was still grieving the tragic loss of her daughter, of the same name as the other patient.

Scenario: Patient presents for an emergency appendectomy. Insurance provider denies the claim citing prior removal of appendix. After further evaluation, patient's brother had used his insurance card years prior when he needed the procedure.

Scenario: The narrative below was provided by a hospital house supervisor. Correct and incorrect patients' names were the same with only the middle initial differing.

The first of my shift the ED had an unresponsive patient brought in via Life Flight (LF) from an accident scene. The patient was given a trauma name (Ex: ZZZDoe, John). When they arrived the LF provided/had only the patient's last name. The social worker (SW) called the Sheriff's department and spoke with the Deputy, seeking any available additional information on the patient. The Deputy read off the patient's full name, DOB, and address, with which the SW was able to look the patient up in our data base. This information was then given to medical staff and registration, and emergency contacts were then informed.

The information that was given to the SW by the Deputy was wrong.

It was soon after this information was given that the family arrived at the ED. The triage RN let the registrar know that the family was here, and she went out to speak with the family and to confirm the information she was given. She first took the family to the waiting room to be with the other family members that had arrived, only to find that those family members didn't know these family members. In fact, the first group of family included the patients' wife and the second group said that their nephew didn't

have a wife. The wife was asked for the patient's middle name and DOB. She said it was XXX. (she noted that it was different than what the fact sheet had). The registrar immediately realized that something was not right and reported the problem.

The house supervisor (HS) spoke with the wife and was able to obtain the patient's driver's license and get a few identifying markers of the patient such as a growth on his arm and scar on his left leg. HS went to the Cath Lab and confirmed that it was indeed her husband. Once verified, the registrar was able to find the correct patient in the hospital database under the correct name, dob, and social security number.

During this time the mother of the supposed patient had walked down to her son's house and found that he was indeed at home and not at the hospital. We talked with the family that had arrived at the hospital and let them know that the wrong information had been provided, and it was not their relative that was brought on Life Flight to the hospital. We assured them that no medical records had been compromised as it was still under a trauma name and we apologized profusely. They were understanding.

HS tried to call Deputy to get a clearer picture of the breakdown in information, but he was not available. They did speak with a Sergeant and let him know of the concerns we had, who stated that he would escalate to their Lieutenant.

We are so lucky that we had used a trauma name because if we had the **incorrect** name of the patient a few minutes earlier we would have seen that the patient was DNR/DNI and would have **stopped life saving measures such as compressions and intubation**. I tried to express the severity of being given the wrong name.

When I finally did speak with the Deputy he explained that when he got to the scene the "wife" (which was actually the daughter) who found him unresponsive was so upset that they could barely get a name out of her and she didn't even know his birthdate and could only give an age. With the name and age, the Deputy looked the person up in the database and only found one match and thought it was correct. When SW called, he read from the database what he had found. I explained to him what could have gone wrong due to it not being correct and to maybe let us know how he got the name and the situation around the name, that it could be wrong. If we had any inclination it could be wrong the SW could have investigated it further.

Scenario: A biopsy was done in OB. When the provider entered the room, she brought the previous patient's information in with her. The Medical Assistant came in to chaperone and help collect the biopsy. The Medical Assistant put the label on the specimen from the previous patient because that was the only chart the provider had in the room. The specimen was sent to the lab with the wrong name on it. The lab questioned the sample after they went through their process to identify the sample because there was no Patient X name and order for that patient. They called the clinic and luckily, the OB provider went down to the lab to verify that the sample was indeed from the other patient and she re-labeled it with the correct name so the lab did the pathology on the biopsy.

Scenario: A lab test where the patient had a pap smear done but had a male gender name so the lab cancelled the order thinking it was a mis-labeling when in fact the female patient who had a pap smear did have a typically male gender name.

Scenario: Patient X was brought into the ER by law enforcement, provided a first, last name, and SSN. Six weeks later, a bill was sent to the father of alleged Patient X. After further investigation, it turned out the person that presented at the ER was falsely using Patient X's identity. Over 100 or more hours of manpower were spent by the records department, provider, and legal team to resolve the issue.

Scenario: Patient presented unresponsive from an outside hospital as a transfer to our organization. Demographic details were provided, but we could not locate any identifying data in our EHR so we created a new medical record. Days later the patient is responsive and alerts staff that they have been treated at our facility previously (used middle name as first name). Older medical record identified and

combined with the newer record. This is a near miss as patient's current treatment could have led to drug interactions as this data was on the older record and had not yet been obtained on the latest encounter.

Scenario: Two patients with the same first and last name, and the same dates of birth. Their records were combined (overlaid) several times over the course of years. Patient safety was jeopardized as the two distinct patients could have had been harmed due to the combining of their records.

Scenario: Parents with multiples (i.e. twins, triplets, etc.) named their children either the same name with a variation in spelling, similar names, a nickname of an actual name, or naming after a parent and incorrectly using suffixes (i.e. one child is classified as Jr. while the other is classified as II).

Scenario: Parents with non-multiples using the same name for children of differing ages. This led to the children's records being combined and overlaid, placing the patients at risk.

Scenario: At Hospital Registration training, the trainer explained the importance of correctly identifying patients. She explained that there are 5 other people in the metropolitan area around the hospital with her first/last name and one that shares her same:

- DOB (month/day the same; years are different),
- spouse's name,
- wedding date (exact same!),
- physical characteristics (height, weight, hair, eyes, etc)

and they actually ended up talking TO EACH OTHER because their medical bills were being sent to each other.

Scenario: A Medical Assistant called a patient's first name and a man stood up and went to the exam room with her. Once in the room she did the intake and poked his finger for an A1C. Meanwhile, a different MA called the same name and a patient stood up and went to the exam room with her. She did vitals and the check in process and at the end of her intake, she asked for 2 identifiers and realized she had the wrong patient. She had documented in the wrong chart and found her correct patient was the one who had his finger poked, who did not need to have that done.

Scenario: Two siblings had appointments but came back to the exam room separately. The Medical Assistant failed to check multiple patient identifiers and documented on the wrong chart. The provider then went in and did her note in the wrong chart.

Scenario: Patient was scheduled with the wrong DOB and address. When the patient registered, the DOB was not verified.

Scenario: A Medical Assistant received a call from the patient, she asked the name and pulled the patient up on the computer. There was only one patient with that name. She then asked for the date of birth but only heard the month. Put note in the computer for the MD. MA realized that she had not gotten the day of the birthday and called the patient back. She realized she had the wrong patient's chart.

Scenario: Annie B Smith and Ann B Smith have same DOB and same zip code. Records were overlaid. Annie B Smith gives birth to baby boy on July 23, 2006—family is celebrating, baby is health and then...Child Protective Services removes the child from the mother. The reason? The day before, on July 22<sup>nd</sup>, 2006, Ann B Smith was seen in the ER for a cocaine overdose. Annie B Smith did not get her baby back for three weeks and the facility suffered a multi-million-dollar lawsuit.