Patient Safety Advisory

Veterans Health Administration Warning System
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Item: **Misidentification of patient resulting in delay of surgery**

Specific Incident: A patient had incorrect information (incorrect middle initial and incorrect day of birth) in their Veteran's Health Information Systems and Technology Architecture (VistA) record that was not detected until the time out before the patient's surgery. The patient's full name and full date of birth (DOB) were used as identifiers at the time out and this information did not match the printed consent form. The planned surgery was canceled due to lack of verification of patient identifiers, resulting in a delay in care.

The incorrect information was not detected earlier due to the absence of local facility-standard criteria for patient identification. There were multiple patient encounters over several months prior to the scheduled surgery where the errors in the patient's identity data could have been detected and corrected; however, only partial name and social security number (SSN) were used in those encounters. Use of partial name and SSN is inadequate and is not an acceptable identification practice.

Contributing to this event was a sequence of activities involving the patient's demographic data in the patient's VistA record (e.g. name, SSN, DOB, address, etc.). The patient had been treated in multiple VA Medical Facilities over a span of many years with a unique VistA record at each facility. Several facilities had linked their local demographic record to the VA's Master Patient Index (MPI) national record. However, a different VistA record containing non-verified demographic data was recently linked to the patient's national MPI record. The MPI system's current logic records the demographic data from the most recent link interaction (even if this information is years old) and subsequently overwrote more recent correct information at the other VA medical centers involved, including the VA facility for which surgery was scheduled.

General Information: Within the VA, patient name and social security number are the most universally used patient identifiers when accessing electronic records. In certain situations it is preferable to use the additional patient identifier of date of birth.

The current logic in the MPI software that saves the most recently uploaded identity data as correct is undesirable and is being addressed through a New Service Request (NSR). We will notify the field when that correction is complete.

Recommendations: Facility staff should complete the following recommendations or implement other measures to achieve an equivalent or increased level of safety.

1. Patient identification procedures should be reviewed to verify that there is consistent use of minimally two complete identifiers (i.e. FULL name and FULL social security number, FULL name and FULL date of birth) throughout the continuum of care, for inpatients and outpatients.

2. All clinical AND administrative staff involved with patient identification should ask the patient to verbally state (not confirm):

   (a) their FULL legal name, including their middle name (if one exists), and

   (b) their FULL social security number (SSN) and/or their FULL date of birth (DOB).

Whenever possible, in cases where patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a close family member, should be asked to state the FULL name of the patient and their FULL social security number or FULL date of birth.

   Note: *Asking the patient or family member to state rather than confirm the patient's name and other information is vital to help prevent miscommunication and wrong-patient procedures.*

3. Training and competencies should be verified for all pertinent staff on the importance of correct patient identification and the consequences when identification errors occur.

4. The Patient Safety Manager is requested to document implementation of this Patient Safety Advisory on the VHA Hazardous Recalls/Alerts website within 30 days of the issue date.

References:

1) **Directive 2004-028 Ensuring Correct Surgery and Invasive Procedures**
2) **Directive 2005-029 Transfusion Verification and Identification Requirements for all Sites**
3) **Directive 2007-037 Identity Authentication for Health Care Services**
4) VHA Healthcare Identity Management (HC IdM) Program http://vaww.vhaco.va.gov/dataquality/identitymgmt.htm
5) The Joint Commission http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
6) TIPS June/July 2003 issue, "NCPS Patient Misidentification Study: A Summary of Root Cause Analyses", http://www.patientsafety.gov/TIPS/Docs/TIPS_Jul03.pdf
7) Neily J, Mills PD, Eldridge N, et al. Incorrect surgical procedures within and outside of the operating room. *Arch Surg*. 2009; 144(11):1028-1034

Source: VA Medical Centers

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