

Patient Safety Tip of the Week

August 1, 2017 Progress on Wrong Patient Orders

As early as 2008 we were concerned that wrong-patient errors might be more frequent as we began implementing CPOE systems (see our Patient Safety Tip of the Week for May 20, 2008 "[CPOE Unintended Consequences – Are Wrong Patient Errors More Common?](#)") and we've done multiple subsequent columns on errors in patient identification. We outlined the many factors contributing to wrong-patient orders in that column and in our Patient Safety Tips of the Week for July 17, 2012 "[More on Wrong-Patient CPOE](#)" and January 19, 2016 "[Patient Identification in the Spotlight](#)".

In the latter columns we noted some of the tools developed by Adelman and colleagues to minimize the chances of such occurring ([Adelman 2013](#)). The intervention tools they developed were simple yet elegant. The "**ID-verify alert**" was triggered by opening an order entry screen and prompted the physician with the patient name, gender and age and the physician was required to acknowledge that was the correct patient before being allowed to proceed with order entry. The "**ID-reentry function**" prevents the provider from accessing the order entry screen until he/she re-enters the patient's initials, gender and age. These interventions were piloted in a randomized fashion. While the "ID-verify alert" reduced errors by 16%, the "ID-reentry function" reduced them by 41%.

And, of course, not all solutions are high tech. In our August 2015 What's New in the Patient Safety World column "[Newborn Name Confusion](#)" we discussed another study by Adelman and colleagues in which they applied their "retract and reorder" (RAR) tool to assess the impact of a **change in naming conventions for newborns** ([Adelman 2015](#)). Hospitals need to create a name for each newborn promptly on delivery because the families often have not yet decided on a name for their baby. Most hospitals have used the nonspecific convention "Baby Boy" Jones or "Baby Girl" Jones. A suggested alternative uses a more specific naming convention. It uses the first name of the mother. For example, it might be "Wendysgirl Jones". Montefiore Medical Center switched to this new naming convention in its 2 NICU's in July 2013 and the RAR tool was used to measure the impact on wrong patient errors. **Wrong patient error rates** measured in the one year after implementation of the new more specific naming protocol were **36% fewer** than in the year prior to implementation.

Now a new study in NICU patients has demonstrated that these interventions, applied serially, have indeed had a positive impact on reducing wrong-patient errors ([Adelman 2017a](#)). At baseline, wrong-patient orders were more frequent in NICU than in non-NICU pediatric units (117.2 vs 74.9 per 100,000 orders, respectively). Over a 7-year study period there was a substantial reduction in the error rate. After implementation of the ID reentry intervention, errors in the NICU were reduced to 60.2 per 100,000. The combined

ID reentry and distinct naming interventions yielded an additional decrease to 45.6 per 100,000 (a 61.1% reduction from baseline).

The study confirms this combination of hi-tech and low-tech interventions has had a dramatic impact on wrong-patient errors. Congratulations to Adelman and colleagues, who have been pioneers in the charge to reduce such errors.

We should also mention here yet another recent contribution by Adelman and colleagues regarding wrong-patient errors. We've always contended that one of the biggest risk factors for wrong-patient orders is having medical records of more than one patient open at a time. Adelman and colleagues ([Adelman 2017b](#)) recently found in a survey of 167 inpatient and outpatient facilities using EHR systems designed to open multiple records at once, 44.3% were configured to allow ≥ 3 records open at once (unrestricted), 38.3% allowed only 1 record open (restricted), and 17.4% allowed 2 records open (hedged). Hence, there is yet no consensus on how to best address this issue.

Some CPOE systems might be able to prevent you from having two patient records open at the same time but some CPOE systems still have limited integration with other systems, such as a radiology PACS system. It is not uncommon for a physician to look at information on that other system while trying to input orders into the CPOE system. Since they are two different systems, it is possible to be looking at two different patients in the two systems. You therefore need to ensure that when the physician moves between these two systems the same patient must be visible on each system. That means you need to develop a way to launch the other application and port the patient identification information to the other application. We concur with Adelman and colleagues that this is an issue demanding consensus and there is a need for more clearcut guidelines.

Some of our prior columns related to identification issues in newborns:

November 17, 2009 “[Switched Babies](#)”,
December 20, 2011 “[Infant Abduction](#)”
September 4, 2012 “[More Infant Abductions](#)”.
December 11, 2012 “[Breastfeeding Mixup Again](#)”.
April 8, 2014 “[FMEA to Avoid Breastmilk Mixups](#)”
August 2015 “[Newborn Name Confusion](#)”
January 19, 2016 “[Patient Identification in the Spotlight](#)”
July 19, 2016 “[Infants and Wrong Site Surgery](#)”

Some of our prior columns related to patient identification issues:

May 20, 2008 “[CPOE Unintended Consequences – Are Wrong Patient Errors More Common?](#)”
July 17, 2012 “[More on Wrong-Patient CPOE](#)”
June 26, 2012 “[Using Patient Photos to Reduce CPOE Errors](#)”
April 30, 2013 “[Photographic Identification to Prevent Errors](#)”
August 2015 “[Newborn Name Confusion](#)”

January 12, 2016
January 19, 2016

[“New Resources on Improving Safety of Healthcare IT”](#)
[“Patient Identification in the Spotlight”](#)

References:

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