

## Patient Safety Tip of the Week

### December 17, 2019 Tale of Two Tylers

Back in our days in Western New York, the Buffalo Sabres hockey team had a player named Tyler Ennis and the Syracuse University basketball team had a player named Tyler Ennis. They used to joke about getting mixed up. People would ask the basketball Tyler Ennis if he was a hockey player, and vice versa.

It was funny then. But not so funny recently, when x-rays from one Tyler Ennis were mistaken for those on the other Tyler Ennis ([Mendes 2019](#)). Hockey Tyler Ennis had suffered a broken bone in his ankle after taking a puck to the ankle while playing for the Toronto Maple Leafs in 2018. He anticipated having to miss 1-2 months of the hockey season. But he then received a call from the medical staff saying he had a severely displaced fracture, that would likely end his hockey season. Stunned by the bad news, Ennis said to the medical staff right away “But you said this wasn’t displaced,” as Ennis remembered them saying at the time of the injury. Confused, the medical staff went back and re-examined the image. It turns out they did have the X-ray image of a badly displaced ankle bone from Tyler Ennis. But it was the x-ray of Basketball Tyler Ennis. The latter had been playing basketball overseas on a team affiliated with the Toronto Raptors basketball team and had suffered a leg fracture around the same time. He had returned to Toronto to rehab the injury.

Of course, two factor patient identification verification should have prevented this mix up since the two players had different ages and different dates of birth. But one can easily understand how two individuals with a relatively uncommon name get misidentified.

Now, admittedly, we do not know the details of how the mix up occurred. We don’t know if a radiology staff person located actual films and gave them to the medical staff or whether the medical staff looked at digital films on the electronic medical record (EMR) or radiology PACS system. One can suspect what might have happened to lead to this mix up. Likely, a computer search for "Tyler Ennis" (in an electronic medical record or a radiology PACS system) may have truncated after the first Tyler Ennis was listed. Since sometimes there are many patients with the same name, it is inevitable that such truncation may occur, even if your system was programmed to not truncate after finding the first name. We have advocated **that electronic medical records should flag in some manner that there are additional patients with the same name**. Such a flag could be presenting the name in a special color or with an asterix in order to let the user know that there are additional patients with the same name. That would force the user to then go to a second identification factor (like a date of birth) in order to identify the correct patient.

But even that is not infallible. In our March 26, 2019 Patient Safety Tip of the Week “[Patient Misidentification](#)” we noted a near-miss when two patients had the same name and same date of birth ([Frost 2018](#)) and the fact that, in one hospital district in Texas, 2488 patients were named Maria Garcia, and 231 of these (9.3%) also shared the same date of birth! ([Lippi 2017](#)).

A national patient identifier (NPI) system has long been proposed as a means of preventing patient misidentifications. But the above incident begs the question, since the event(s) took place outside the US! It would take an international or global patient identifier system to have prevented this mix up. Both Tylers were born in Canada and both had their x-rays done in Canada. But Canada also does not have a national patient identification number program.

Many, including ourselves, have long advocated for a national patient identifier (NPI) system. But Congress had banned funding for an NPI system. Congress’ reason for not providing funding primarily stemmed from a privacy concern ([Jason 2019](#)). However, in June 2019 Congress voted to overturn that prior ban on funding for a national patient identifier system ([Monica 2019](#)). Healthcare industry stakeholders including AHIMA, AMIA, CHIME, eHealth Initiative, Intermountain Healthcare, and MMGA had issued a joint letter to Congress expressing their support for the bill.

The major benefit of an NPI system is that it improves interoperability of medical records. As we integrate medical information from many sources into one electronic medical record, an NPI would reduce the chance of entering data from a different patient into one patient’s record. That could also help avoid unnecessary duplication of tests.



In theory, an NPI system should also reduce the likelihood of patient misidentification. EMR’s and other electronic healthcare systems could be searched using the NPI rather than patient names. Of course, we doubt healthcare professionals are likely to search for records by primarily using an NPI unless their patient has an extremely common name that is likely to be shared by multiple patients. We are still always likely to search using the patients name.

But there is one tool we bet could have helped avoid this misidentification – use of **photographs**. We’ve long been advocates for **patient photographs** in the EMR. Digital photos are easy enough to obtain and most EMR’s have a field in which you can place a photo. See our April 30, 2013 Patient Safety Tip of the Week “[Photographic Identification to Prevent Errors](#)” for examples of how photos can help prevent identification errors. We have even done several columns on the utility of patient photographs in the electronic medical record, including several in which radiologists were helped by the presence of patient photographs.

A study just recently presented at the ACEP 2019 Research Forum ([Blanchfield 2019](#)) demonstrated that a passive display of patient photos in the EHR is associated with reduced rates of wrong patient orders and near misses in the Brigham and Women’s

Emergency Department. While the study looked at how having patient photos in the EHR helped physicians identify the correct patient when entering orders in the EHR, one can readily see how having the photo at the top of every screen (in the EHR or the radiology PACS system), along with their name and DOB and medical record number, would help whomever is searching for an image identify the correct patient.

In the case of the two Tyler Ennis's, photos in the EHR or radiology PACS system should have easily helped the medical staff correctly identify their patient:

	
Hockey Tyler Ennis	Basketball Tyler Ennis

If you are medical staff who have directly interacted with the player, you should have little difficulty identifying your patient by photo. If your search screen truncated at the first Tyler Ennis it found, you'd say to yourself "That doesn't look like my patient" and you'd scroll down to see if there was another Tyler Ennis.

But you also need to be wary that circumstances may make use of photos unhelpful. For example, they may not be useful in patients with facial trauma. And you have to have a system to ensure your photos are not outdated. Butler ([Butler 2018](#)), in an article on best practices for accurate patient identification, also strongly endorses use of patient photographs. She also points out that requiring a photo ID, such as a driver's license or state identification card, is a preferred practice but isn't always available for populations such as children and seniors and others who don't drive.

People's appearances change as they age and their appearance may also change for other reasons. So that raises the issue of when and how patient photographs should be taken.

Our November 12, 2019 Patient Safety Tip of the Week "[Patient Photographs Again Help Radiologists](#)" showed how **real-time photographs**, taken at the same time a radiology study was being done, were of great value not only in identifying the correct patient but also improving the clinical information available to the radiologist. And, in the Blanchfield study ([Blanchfield 2019](#)) the patient photographs were taken when the patient presented to the ED. The ease with which we can today take a digital photograph today and upload it to the EHR enables the use of up-to-date patient photos. In the Blanchfield study, they created a new standard of care and implemented a new workflow

for ED registration staff. Using iPod touch devices, ED registration staff took photos of consenting patients either at the front desk when patients check-in, or at the end of the registration process.

In other venues, such as ambulatory care, we could have policies and protocols for updating photos at specified intervals, akin to what happens with driver's licenses.

So, the time has come to use patient photographs more extensively in healthcare. They now have been shown to reduce radiology errors and medication errors and today's example shows how they could also reduce other misidentification errors.

**Some of our prior columns on use of patient photographs in patient safety:**

December 2008	<a href="#">“Patient Photographs Improve Radiologists’ Performance”</a>
January 12, 2010	<a href="#">“Patient Photos in Patient Safety”</a>
June 26, 2012	<a href="#">“Using Patient Photos to Reduce CPOE Errors”</a>
April 30, 2013	<a href="#">“Photographic Identification to Prevent Errors”</a>
January 19, 2016	<a href="#">“Patient Identification in the Spotlight”</a>
March 26, 2019	<a href="#">“Patient Misidentification”</a>
November 12, 2019	<a href="#">“Patient Photographs Again Help Radiologists”</a>

**Some of our prior columns related to patient identification issues:**

May 20, 2008	<a href="#">“CPOE Unintended Consequences – Are Wrong Patient Errors More Common?”</a>
November 17, 2009	<a href="#">“Switched Babies”</a>
July 17, 2012	<a href="#">“More on Wrong-Patient CPOE”</a>
June 26, 2012	<a href="#">“Using Patient Photos to Reduce CPOE Errors”</a>
April 30, 2013	<a href="#">“Photographic Identification to Prevent Errors”</a>
August 2015	<a href="#">“Newborn Name Confusion”</a>
January 12, 2016	<a href="#">“New Resources on Improving Safety of Healthcare IT”</a>
January 19, 2016	<a href="#">“Patient Identification in the Spotlight”</a>
August 1, 2017	<a href="#">“Progress on Wrong Patient Orders”</a>
June 19, 2018	<a href="#">“More EHR-Related Problems”</a>
November 2018	<a href="#">“More on Hearing Loss”</a>
March 26, 2019	<a href="#">“Patient Misidentification”</a>
September 10, 2019	<a href="#">“Joint Commission Naming Standard Leaves a Gap”</a>

**References:**

Mendes I. The case of two Tyler Ennises and a near mistaken diagnosis. TSN 2019; December 2, 2019  
<https://www.tsn.ca/the-case-of-two-tyler-ennises-and-a-near-mistaken-diagnosis-1.1406936>

Frost S. Patient 'lucky' to avoid disaster after hospital's identity mistake. Mercury (UK) 2019; 07 April 2018  
<http://www.thewestonmercury.co.uk/news/weston-general-hospital-treats-patient-using-medical-records-of-another-man-1-5464234>

Lippi G, Chiozza L, Mattiuzzi C, Plebani M. Patient and Sample Identification. Out of the Maze? J Med Biochem 2017; 36(2): 107-112. Published online 2017 Apr 22  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5471642/>

Jason C. The Pros and Cons of a National Patient Identifier (NPI) System. Ehrintelligence.com 2019; December 4, 2019  
<https://ehrintelligence.com/news/the-pros-and-cons-of-a-national-patient-identifier-npi-system>

Monica K. House Overturns Ban on Funding for National Patient Identifier. Ehrintelligence.com 2019; June 14, 2019  
<https://ehrintelligence.com/news/house-overturns-ban-on-funding-for-national-patient-identifier>

Blanchfield BB, Salmaisian H, Landman A. Abstract #56. Adding Patient Photos to the Electronic Health Record to Improve Patient Identification and Reduce Wrong Patient Order Errors. Ann Emerg Med 2019; 74(4s): S22-23 :October 2019  
[https://www.annemergmed.com/article/S0196-0644\(19\)30733-4/fulltext](https://www.annemergmed.com/article/S0196-0644(19)30733-4/fulltext)

Butler, Mary. Show Me Some ID: Tips for Trusting Identity in the Era of Cybercrime and Fraud. Journal of AHIMA 2018; 89(6): 24-27  
<http://bok.ahima.org/doc?oid=302514#.W3sfy7gnZPZ>



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