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PATIENT SAFETY NETWORK

Patient misidentification events in the Veterans Health Administration: a comprehensive review in the context of high-reliability health care.

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Kulju S, Morrish W, King LA, et al. Patient misidentification events in the Veterans Health Administration: a comprehensive review in the context of high-reliability health care. J Patient Saf. 2022;18(1):e290-e296. doi:10.1097/pts.0000000000000767.
https://psnet.ahrq.gov/issue/patient-misidentification-events-veterans-health-administration-comprehensive-review-context

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Patient misidentification can lead to serious patient safety risks. Researchers used patient safety reports and root cause analyses (RCA) to characterize patient misidentification events in the Veterans Health Administration (VHA). The incidence of patient misidentification in inpatient and outpatient settings was similar and most commonly attributed to the absence of two unique patient identifiers. The authors identified three strategies to mitigate misidentification based on high-reliability principles: (1) develop policies for patient identification throughout the continuum of care, (2) develop policies to report and monitor patient misidentification measures, and (3) apply quality and process improvement tools to patient identification emphasizing use by front line staff.