

The Joint Commission cuts key patient-safety measure

In establishing its 2010 National Patient Safety Goals (NPSGs), The Joint Commission — the agency that accredits approximately 17,000 healthcare organizations in the United States — eliminated the requirement to ensure positive patient identification prior to drawing a blood sample, despite its stated mission of “... evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.” The following evidence seems to indicate that The Joint Commission has placed the needs of the facilities it inspects above those of their patients.

Exhibit A: The 2009 NPSGs. Obtaining two identifiers prior to performing a procedure is an established patient-safety measure, but The Joint Commission still permits both identifiers to be obtained from a patient’s identification bracelet.

It has been reported, however, that up to 16% of patients can have ID bands with erroneous information.¹ Studies indicate 7% of wristbands are either missing or contain incorrect information.² A recent online survey revealed 74% of respondents have found identification bracelets attached to the wrong patient.³ What if a patient is wearing a bracelet with inaccurate information? Misidentified patients can be subjected to treatments, tests, medications, and transfusions intended for someone else.

“That’s a problem,” said Margaret Peck, former director of laboratory accreditation for the agency, when urged by the Center for Phlebotomy Education to beef up requirements in 2006. This problem seemed to be resolved with the release of the 2009 NPSGs, which required active patient involvement (or confirmation from a family member or caregiver) as a patient identification Element of Performance (EP). For the first time in the agency’s 100-year history, an ID bracelet alone could not be considered reliable. With this landmark provision, the agency’s requirement finally reflected the higher voluntary standard promulgated

by the Clinical and Laboratory Standards Institute, or CLSI, since at least 1998.

Exhibit B: The 2010 NPSGs. The Joint Commission stripped the active patient involvement EP from its 2010 goals. Effective in 2010, active patient identification is no longer required.

Why the deletion of this seemingly simple patient-safety measure?

Exhibit C: Correspondence between the Center for Phlebotomy Education and The Joint Commission — which the Center was given permission to share with its colleagues. “... The deletion of EP 1 is not intended to discourage use of active patient involvement or minimize its value. However, the requirement as written lacks enforceability and does not adequately address managing patients who are not able to participate in the identification process. ... When this requirement is understood by our clients, most find this to be burdensome and unnecessary.”

Burdensome and unnecessary? Tell that to the family of Blake Oliver who died in 2007 from a transfusion reaction after his hospital roommate was drawn for the crossmatch by mistake. Hospital officials stated, “The error was not a result of the hospital’s failure to reasonably comply with all applicable statutory and rule requirements.”⁴ The error occurred at a time when The Joint Commission did not require active patient involvement prior to blood sample collection.

More than 160,000 adverse patient events occur each year in the United States because of patient or specimen-identification errors involving the laboratory.⁵ Studies show that 11% of transfusion deaths occur as a result of the phlebotomist not properly identifying the patient or mislabeling the tube of blood.⁶ One hospital’s audit found that 0.5% of its transfusion specimens were mislabeled.⁷

The Joint Commission’s correspondence continues, “... it was determined that the EP was rendered not surveyable or enforceable through the accreditation process. This is the reason behind the

deletion. We continue to support active patient involvement in the identification process as a best practice and will encourage organizations to use such an approach when it is reasonable to do so.”

Not surveyable? If the The Joint Commission finds it surveyable to require a patient to be matched to a unit of blood before transfusion — which it does — why would it not be surveyable to require a patient to be matched to his ID bracelet before a venipuncture?

Only when The Joint Commission puts the needs of the patient ahead of the perceived inconveniences of its clients will patients be protected from mistakes caused by misidentification.

As the industry that provides physicians with 70% of the objective information on patients’ health, the laboratory community depends on The Joint Commission to make patient safety a top priority.

Visit www.jointcommission.org to register comments on this topic.

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