STANDARD

Overview

1. All patients are consistently and correctly identified, and matched to their intended care, health records, investigation and procedure requests, prescriptions, results and all other documentation.
2. Consistent correct patient identification is vital to patient safety. Correct identification requires the use of at least three (3) approved patient identifiers.
3. Correct patient identification begins with the patient's first contact with the Bay of Plenty District Health Board (BOPDHB). It is the responsibility of all staff involved in the admission process, both clinical and administrative, to make sure that the correct patient identification details are gathered and recorded, and that any queries are highlighted and resolved.
4. All patients must be able to be identified at all times whilst being assessed or undergoing procedures or treatments within the DHB. All patients therefore wear a patient identification (ID) band except on the rare occasion where alternative forms of identification have been implemented.
5. Patient ID bands are an important tool however they do not remove individual clinicians' and other health care workers' responsibility to check patient identification prior to each interaction.
6. Patient sticky labels are also an important tool however they do not remove individual clinicians' and other health care workers' responsibility for checking that the patient label they are using matches the health record and patient for whom it is intended.

OBJECTIVE

The purpose of this protocol is to set out actions for correct patient identification. The protocol is based on national standards and specifications developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC); the United Kingdom's National Patient Safety Agency (NPSA), and the World Health organisation (WHO) in association with the Joint Commission (USA). These include the following four elements:

- **Correct identification of individual patients** – use at least three approved patient identifiers on registration or admission, when providing care, therapy, services or advice and/or information.
- **Transfer of care** - use at least three approved identifiers when transferring responsibility of care and whenever clinical handover, patient transfer or discharge documentation is generated
- **Match patients to their intended procedure, treatment or investigation** – apply explicit processes [Verification of patient information: Matching that information against the request form (or the consent form where appropriate): Time out immediately prior to the procedure: Sign out/Post-procedure confirmation and documentation checks]
- **Assess risk of mismatching** - report, investigate and review incidents of incorrect patient identification and procedural mismatching events

NOTE on the use of at least three (3) approved identifiers:
Several studies using both large and small databases of US medical records found that the risk of mismatching decreases from a 2-in-3 chance when last names only are used (e.g. Are you Mrs Jones?) to a 1-in-3,500 chance when first and last names and a third approved identifier are used (Hillestad et al 2008).

Approved identifiers are items of information that are unique to a patient and which can be used to identify him or her. They include the following, the first three of which make up the core items for a patient identification band:

- Patient name (family and given names)
- Date of birth
- National Health Index (NHI) number
- Gender
- Address

Other items of information such as bed or room number are not approved identifiers because they are not unique to an individual patient and can change.

1. Consistently and correctly identify individual patients

1.1. ALWAYS identify patients correctly before providing any health care services or interventions. Failure to consistently and correctly identify patients constitutes a serious risk to patient safety.

1.2. Use at least three (3) approved identifiers; wherever possible these are the core patient identifiers, namely:
   a) Patient name (family and given names)
   b) Date of birth
   c) National Health Index (NHI) number

1.3. The patient's bed or room number is an example of an identifier that is not approved.

2. Engage with patients and carers

2.1. Patients and carers can play an important role in maintaining patient safety.

2.2. Explain the need for repetitive identification: patients are more likely to accept repetitive questions about their identification if the reasons are explained to them.

2.3. Highlight their role in maintaining safety; to always wear their ID band; to check that paperwork given to them has the correct patient information and/or the correct sticky label attached.

2.4. Encourage patients and carers to raise concerns about misidentification with the health care team.

3. Correct identification

3.1. Correct identification is an integral part of providing patient care and takes place at the beginning of a care episode i.e. at registration or admission and with each intervention throughout:

a) **ASK the patient to state their full name and date of birth; NEVER ask the patient 'Are you Mr Jones?'** The patient may have misheard and mistakenly agree**.**

b) **NEVER use a patient's bed or room number or assume that the name tag above the bed is correct.** Bed and room numbers are not unique to the patient and can change.

c) **ALWAYS check the patient against the patient's identification (ID) band and against any associated documentation.** Human error may result in the wrong ID band being put on the patient or the wrong label being placed on documentation.

3.2. All staff acknowledge and accept that the management and monitoring of patient identification is an ongoing process and not something that only happens on admission.

3.3. All electronic and manual patient master indexes and health records must contain the three core identifiers (name, date of birth and NHI number). [A master patient index is an electronic database that holds the names, contact and medical information of patients registered at a care facility].

4. Where patients / clients have similar names and other demographic details

4.1. The potential for misidentification where patients have a similar name is acknowledged (Check 6.1.5 P1 Alerts – Medical (section 2.2 b.).

4.2. For processes to follow when adding an alert refer to 6.1.5 protocol 0 Alerts - Standards

5. Identification (ID) bands

5.1. As a general rule all patients wear an ID band. This includes all patients who are; inpatients, same day or day surgery patients, having blood or blood product transfusion, any form of medication including non-admitted patients in the emergency department, any therapy where consent is required. Where a patient refuses to wear and ID band or it is not practical to do so refer to point 9 in this protocol.

5.2. ID bands are put on the patient as soon as practical.

5.3. Any staff member who notices a patient without an ID band or with an ID band that is incorrect, faded, damaged or unreadable, assumes responsibility for correctly identifying the patient and applying a ID band except where other forms of identification have been implemented. All staff have a responsibility to improve patient safety.

5.4. Patient ID bands are an important patient safety tool. It should be remembered however, that patient ID bands do not remove the individual responsibility of all health care workers to correctly confirm patient identification, with the patient wherever possible, prior to every intervention or procedure.

6. Specifications for a standard ID band

6.1. The layout and order of information is standardised across the organisation. Standardisation can help to reduce the risk of errors.

6.2. ID bands should be white with identifiers written in back, i.e. use black text on a white background. This is easier to read in reduced light (such as wards at night). International best practice does not recommend the use of coloured bands for alerts – where it is deemed necessary to use coloured bands for alerts use only red.

6.3. Maintain a full range of sizes from new born through to bariatric patients and patients with conditions such as lymphodema.

6.4. Comfort; no sharp edges or profiles that may irritate the skin; fastenings do not press in to the skin. Patients are more likely to keep ID bands in place if they are comfortable.

6.5. Material; durable, smooth, flexible, cleanable, waterproof, breathable, non-allergenic, and resistant to other fluids such as alcohol cleaning products. Must be secure and allow patients to wash; information does not wash or wear off.

6.6. Usability; intuitive, quick and easy for all staff to issue, use and remove. ID bands are issued/used by a variety of staff who may not have specific training about how to use ID bands.

6.7. Information and presentation; core patient identifiers are used (name, date of birth and NHI number).

7. Where a patient is not able to communicate for themselves

7.1 Patients may be too young, confused or unconscious, or they may not have English as their first language and ID bands are especially important in this context.

7.2 All reasonable attempts are made to correctly confirm patient identification with an accompanying adult, e.g. parent or relative.

7.3 Check other forms of identification e.g. driver's license.

7.4 Use an interpreter where appropriate.

8. Where no ID bands are used

8.1 Where a patient refuses to wear an ID band (after their importance has been explained), or it is not possible or practical for a patient to wear an ID band, formal risk-assessed alternatives are implemented and this is documented.

8.2 Consider attaching an identification label to patient's right shoulder and covering / affixing with a transparent, waterproof adhesive such as Opsite. Affixed identification label and other forms of patient identification contain the three core identifiers as for ID bands (name, date of birth and NHI number).

8.3 Other forms of patient ID may include a photograph or lanyards where these are authorised.

9. **Check patient identifiers against printed adhesive (sticky) patient labels.**

9.1. Health records containing labels with incorrect information and / or belonging to another patient pose a significant risk to patient safety; they may be used mistakenly by other health care workers for a variety of reasons – this can begin a chain of errors that can result in a range of unwanted outcomes ranging from reduced patient confidence in health care workers to serious adverse events.

9.2. Patient labels are checked for correctness
   a) Before and after printing
   b) Before being placed into a patient's health record
   c) Before being attached to forms and other documentation associated with the patient (for example clinical notes pages, request forms, consent forms).

10. Transfer of care

10.1. The 3 core identifiers are used in all handover, transfer and discharge documentation; where this involves the use of adhesive patient labels (sticky labels) clinicians and other health care workers must make sure that labels match the patient for whom they are intended every time they are used.

10.2. Correct patient identification management and monitoring is an ongoing process for which each staff interacting with the patient is responsible. Adhesive patient (sticky) labels can be inadvertently printed out wrongly and/or put into the wrong patient's health record. In an audit 5 different patient labels were found in one patient's health record (BOPDHB Quality & Patient Safety 2015).

10.3. When a transfer occurs between internal departments the receiving staff member checks the patient ID label with the patient where the patient has the capacity to do so, along with all relevant health records.

10.4. Where a transfer is from another DHB, patients will have a BOPDHB ID band applied and the previous DHB's ID band removed as soon as possible.

10.5. Where a transfer of care to another responsible consultant within this DHB, an updated label with the correct consultant's name must be printed. The previous "sticky" labels should be destroyed. This also includes a transfer from the Emergency Department to any other department within the hospital.

10.6. All yellow coloured "sticky" patient labels –specific to the Emergency Department - should be removed from the clinical notes prior to transfer to another ward or department. Regardless of whether new stickers are available at that time.

10.7. Where the transfer of care is between an ambulance service and the DHB and none of the patient identifiers are available, as much other detail is recorded. This may include the time and location that the person was picked up from; the ambulance case number, the physical description of the patient.

11. Matching patients with their care; explicit processes

11.1. Prior to any interventional procedure the entire team has a shared responsibility to ensure that the patient is correctly identified and correctly matched to the intended procedure. All staff are responsible for patient safety, including correct patient identification.

11.2. Two (2) team members verbally confirm the following with the patient (or their representative if the patient is unable)
   a) Patient identity
   b) What they are having done
   c) That informed consent has been given and documented with correct ID

11.3. Wherever possible, include the patient in the verification of their ID and marking of the procedural site.

11.4. Use approved forms and processes, for example
   a) Informed Consent
   b) Surgical Checklist [SIGN IN, TIME OUT, SIGN OUT]

11.5. All explicit processes to confirm ID undertaken by staff are documented in the patient's health record; associated forms and checklists are fully completed and form part of the health record.

11.6. Full and complete documentation is an important requirement and reference for transfer of patient and ongoing care. Health records are also used by others such as students, clinical auditors, certification auditors and Quality and Patient Safety staff. Such documentation is relied upon where investigations such as Root Cause Analyses are needed.

12. Additional explicit process for general radiology, ultrasound, CT and / or MRI and / or for single-operators

12.1. Verification using the 4Ws:
   a) What is your name?
   b) What is your date of birth?
   c) What is your address or What is your NHI?
   d) What are you here for?

12.2. The 4Ws should then be matched to the patient's ID band (if present), the request form and the consent form (if applicable).

12.3. If a mismatch is discovered, then the procedure must not start until the mismatch is resolved.

12.4. Ask yourself "Is there any clinical reason I should not perform this procedure now?" including patient allergies and other clinical conditions.

12.5. Post-procedure confirmation reduces the risk of the images and/or information being attributed to the wrong patient. Prior to the release of any images to either a clinician or any networked device used for display or interpretation the operator must confirm that;
   a) The attached patient details are correct, displaying the current consultant's name.
   b) The laterality markers are correct.

12.6. The patient ID process of verification, matching, time out and post procedural confirmation is documented in the patient's notes.

12.7. Single operator error is reduced when they perform verification and an internal TIME OUT immediately prior to commencing the procedure.

13. Assess risk of mismatching

13.1. Report, investigate and review incidents of incorrect patient identification and procedural mismatching events. Report all incidents that involve incorrect patient identification or procedure-matching:
   a) Report to the Charge Nurse Manager and attending medical officer

b) Document in the patient's health record
c) Report the incident using the Incident Management Form
d) Inform patients and/or carer.

13.2. Information is used for potential improvements to the patient identification process (protocol and practice).

13.3. It is often useful to report incidents of near misses.

REFERENCES

- Australian Commission on Safety and Quality in Health Care (2012) *Safety and Quality Improvement Guide Standard 5: Patient Identification and Procedure Matching.* Sydney. ACSQHC.
- BOPDHB Q&PS (2015) *Accurate Patient Identification: review and analysis*. Unpublished.
- Hillestad R, Bigelow J, Chaudry B, Dreyer P, Greenberg M, Meili R, et al *Identity Crisis: an examination of the costs and benefits of a unique patient identifier for the US health care system.* RAND Health 2008
- National Patient Safety Agency (2005) Safer Practice Notice 11 *Wristbands for hospitals inpatients improves safety.* London. NPSA
- South Australia Health (2014) *Policy Guideline Patient Identification Guideline*. Adelaide. SA Health Quality & Safety Unit. Western Australia Department of Health (2014) *WA Health Patient Identification Policy.* Perth. WA Department of Health.
- World Health Organization & Joint Commission International (2007) *Patient Identification. Patient Safety Solutions* vol1:2 May. Geneva. WHO Press.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.1.1 Patient Identification
- Bay of Plenty District Health Board Emergency Department protocol ED.I1.1 Identification of Patients in ED
- Bay of Plenty District Health Board Maternity protocol MAT.I1.1 Identification of Mothers and Babies
- Bay of Plenty District Health Board Dental protocol DENT.C1.12 Formal Identification of Patients in a Dental Facility
- Bay of Plenty District Health Board policy 6.1.5 protocol 0 Alerts – Standards
- Bay of Plenty District Health Board policy 6.1.5 protocol 1 Alerts – Medical (Allergic Responses, Adverse Reactions and High Risk Issues)
- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.22 Admission to Acute Inpatient Unit
- Bay of Plenty District Health Board Incident Management Form