



Standard 5

Patient Identification and Procedure Matching

Safety and Quality Improvement Guide



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Standard 5: Patient Identification and Procedure Matching

The National Safety and Quality Health Service Standards

The *National Safety and Quality Health Service (NSQHS) Standards*¹ were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients.

The primary aims of the *NSQHS Standards* are to protect the public from harm and to improve the quality of care provided by health service organisations. These Standards provide:

- a **quality assurance** mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met
- a **quality improvement** mechanism that allows health service organisations to realise developmental goals.

Safety and Quality Improvement Guides

The Commission has developed Safety and Quality Improvement Guides (the Guides) for each of the 10 *NSQHS Standards*. These Guides are designed to assist health service organisations to align their quality improvement programs using the framework of the *NSQHS Standards*.

The Guides are primarily intended for use by people who are responsible for a part or whole of a health service organisation. The structure of the Guides includes:

- introductory information about what is required to achieve each criterion of the Standard
- tables describing each action required and listing:
 - key tasks
 - implementation strategies
 - examples of the outputs of improvement processes
- additional supporting resources (with links to Australian and international resources and tools, where relevant).

Direct links to these and other useful resources are available on the Commission's web site:

www.safetyandquality.gov.au

The Guides present **suggestions** for meeting the criteria of the Standards, which should not be interpreted as being mandatory. The examples of suggested strategies and outputs of improvement processes are **examples only**. In other words, health service organisations can choose improvement actions that are specific to their local context in order to achieve the criteria. The extent to which improvement is required in your organisation will heavily influence the actions, processes and projects you undertake.

You may choose to demonstrate how you meet the criteria in the Standards using the example outputs of improvement processes, or alternative examples that are more relevant to your own quality improvement processes.

Additional resources

The Commission has developed a range of resources to assist health service organisations to implement the *NSQHS Standards*. These include:

- a list of available resources for each of the *NSQHS Standards*
- an *Accreditation Workbook for Hospitals* and an *Accreditation Workbook for Day Procedure Services*
- *A Guide for Dental Practices* (relevant only to Standards 1–6)
- a series of fact sheets on the *NSQHS Standards*
- frequently asked questions
- a list of approved accrediting agencies
- slide presentations on the *NSQHS Standards*.



Overarching NSQHS Standards

Standard 1: Governance for Safety and Quality in Health Service Organisations, and *Standard 2: Partnering with Consumers* set the overarching requirements for the effective application of the other eight *NSQHS Standards* which address specific clinical areas of patient care.

Standard 1 outlines the broad criteria to achieve the creation of an integrated governance system to maintain and improve the reliability and quality of patient care, and improve patient outcomes.

Standard 2 requires leaders of a health service organisation to implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce should use the systems for partnering with consumers.

Core and developmental actions

The *NSQHS Standards* apply to a wide variety of health service organisations. Due to the variable size, structure and complexity of health service delivery models, a degree of flexibility is required in the application of the standards.

To achieve this flexibility, each action within a Standard is designated as either:

CORE

- considered fundamental to safe practice

OR

DEVELOPMENTAL

- areas where health service organisations can focus activities or investments that improve patient safety and quality.

Information about which actions have been designated as core or developmental is available on the Commission's web site.

Quality improvement approaches in health care

Approaches to improving healthcare quality and safety are well documented and firmly established. Examples of common approaches include Clinical Practice Improvement or Continuous Quality Improvement. The Guides are designed for use in the context of an overall organisational approach to quality improvement, but are not aligned to any particular approach.

Further information on adopting an appropriate quality improvement methodology can be found in the:

[NSW Health Easy Guide to Clinical Practice Improvement²](#)

[CEC Enhancing Project Spread and Sustainability³](#)

[Institute for Healthcare Improvement \(US\)⁴](#)



The National Safety and Quality Health Service Standards (continued)

Roles for safety and quality in health care

A range of participants are involved in ensuring the safe and effective delivery of healthcare services. These include the following:

- **Patients and carers**, in partnership with health service organisations and their healthcare providers, are involved in:
 - making decisions for service planning
 - developing models of care
 - measuring service and evaluating systems of care.

They should participate in making decisions about their own health care. They need to know and exercise their healthcare rights, be engaged in their healthcare, and participate in treatment decisions.

- Patients and carers need to have access to information about options and agreed treatment plans. Health care can be improved when patients and carers share (with their healthcare provider) issues that may have an impact on their ability to comply with treatment plans.
- The role of **clinicians** is essential. Improvements to the system can be achieved when clinicians actively participate in organisational processes, safety systems, and improvement initiatives. Clinicians should be trained in the roles and services for which they are accountable. Clinicians make health systems safer and more effective if they:
 - have a broad understanding of their responsibility for safety and quality in healthcare
 - follow safety and quality procedures
 - supervise and educate other members of the workforce
 - participate in the review of performance procedures individually, or as part of a team.

When clinicians form partnerships with patients and carers, not only can a patient's experience of care be improved, but the design and planning of organisational processes, safety systems, quality initiatives and training can also be more effective.

- The role of the **non-clinical workforce** is important to the delivery of quality health care. This group may include administrative, clerical, cleaning, catering and other critical clinical support staff or volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – this group can help to identify and address the limitations of safety systems. A key role for the non-clinical workforce is to notify clinicians when they have concerns about a patient's condition.
- The role of **managers in health service organisations** is to implement and maintain systems, resources, education and training to ensure that clinicians deliver safe, effective and reliable health care. They should support the establishment of partnerships with patients and carers when designing, implementing and maintaining systems. Managing performance and facilitating compliance across the organisation is a key role. This includes oversight of individual areas with responsibility for the governance of safety and quality systems. Managers should be leaders who can model behaviours that optimise safe and high quality care. Safer systems can be achieved when managers in health service organisations consider safety and quality implications in their decision-making processes.
- The role of **health service senior executives and owners** is to plan and review integrated governance systems that promote patient safety and quality, and to clearly articulate organisational and individual safety and quality roles and responsibilities throughout the organisation. Explicit support for the principles of consumer centred care is key to ensuring the establishment of effective partnerships between consumer, managers, and clinicians. As organisational leaders, health service executives and owners should model the behaviours that are necessary to implement safe and high quality healthcare systems.



Terms and definitions

Approved patient identifiers: Items of information accepted for use in patient identification, including patient name (family and given names), date of birth, gender, address, medical record number and/or Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for patient identification. Identifiers such as room or bed number are not to be used.

Flexible standardisation: Flexible standardisation recognises the importance of standardisation of processes to improve patient safety. However, the standardisation of any process, and related data sets and participants, must be designed and integrated to fit the context of health service organisations, including varying patient and staffing profiles. These will vary widely as health service organisations will have differing functions, size and organisation with respect to service delivery mode, location and staffing. Tools, processes and protocols should be based on best available evidence and the requirements of jurisdictions, external policy and legislation.

Governance: The set of relationships and responsibilities established by a health service organisation between its executive, workforce, and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way an organisation is directed, administered, or controlled. Governance arrangements provide the structure through which the objectives (clinical, social, fiscal, legal, human resources) of the organisation are set, and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests, and actions of different participants in the organisation in order to achieve the organisation's objectives. The Commission's definition of governance includes both corporate and clinical governance and where possible promotes the integration of governance functions.

Individual Healthcare Identifier (IHI): a 16 digit unique number allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs (DVA) treatment card, and others who seek healthcare in Australia.

Organisation-wide patient identification system: A system of explicit policies, protocols and procedures that are in place to ensure the consistent and correct identification of a patient at any point and time during an admission or course of treatment, and to match their identity using at least three identifiers when providing care, therapy or services.

Outputs: The results of your safety and quality improvement actions and processes. Examples of outputs are provided in this guide. They are examples only and should not be read as being checklists of evidence required to demonstrate achievement of the criterion. Outputs will be specific to the actions, processes and projects undertaken in your context which will be influenced by your existing level of attainment against the criterion and extent to which improvement has been required.

Patient care mismatching events: Events where a patient receives the incorrect procedure, therapy, medication, implant/device or diagnostic test. This may be as a result of the wrong patient receiving the treatment (e.g. the wrong patient receiving an X-ray) or as a result of the correct patient receiving the wrong care (e.g. a surgical procedure performed on the wrong side).

Organisations may elect to include other forms of patient care mismatching in their reporting (e.g. provision of an incorrect meal resulting in an adverse event) however these should be recorded separately.

Patient/procedure matching protocols: Protocols that provide guidance regarding the steps that should be taken to correctly match patients to their intended care.

Transfer of care: Any instance where the responsibility for care of a patient passes from one individual or team to another. This includes nursing and medical change of shift, transfer of care to another medical officer or primary care practitioner and transfer of a patient to another health facility.



Standard 5: Patient Identification and Procedure Matching

Clinical leaders and senior managers of a health service organisation establish systems to ensure the correct identification of patients and correct matching of patients with their intended treatment. Clinicians and other members of the workforce use the patient identification and procedure matching systems.

The intention of this Standard is to:

Correctly identify all patients whenever care is provided and correctly match patients to their intended treatment.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Introduction

Patient identification and the matching of a patient to an intended care process is an activity that is performed routinely in all care settings. Risks to patient safety occur when there is a mismatch between a given patient and components of their care, whether those components are diagnostic, therapeutic or supportive.

Much of the information about the number of patient mismatching events comes from incident reporting systems. In 2009–10 there were 10 reported events in Australia with procedures involving the wrong patient or body part that resulted in death or major permanent loss of function.⁵ When less serious events from nonsurgical areas such as pathology and radiology are included in reporting systems, the number of reported events can rise considerably.⁶

Implementing systems to ensure correct patient identification and procedure matching

Since patient identification is an activity that is performed frequently, it can often be seen as a relatively unimportant task. It is important to take human factors into account when planning patient safety, to emphasise the design of systems that consider human capabilities, limitations and characteristics.⁷ The development of safety routines for common tasks (such as patient identification) provides a powerful defence against simple mistakes that may progress and cause harm. These routines allow the workforce to focus their attention on those activities that require more cognitive processing and judgement, such as the provision of clinical care.⁸ The use of tools such as the World Health Organization Surgical Safety Checklist⁹ and Ensuring Correct Patient, Correct Site, Correct Procedure protocols¹⁰ provide a basis for the development of such routines. Links to resources for patient identification and procedure matching are included in Appendix A.

Note: this Standard does not relate to establishing legally correct identity in those persons who may choose to use an alias, but rather to ensuring that a person's declared identity is able to be matched with any care, therapy or service that is provided within a health service organisation.



Criteria to achieve the Patient Identification and Procedure Matching Standard:

Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services.

Processes to transfer care

A patient's identity is confirmed using three approved identifiers when transferring responsibility for care.

Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care.

For the purposes of accreditation, please check the Commission's web site regarding actions within these criteria that have been designated as core or developmental.



Standard 5

Criterion: Identification of individual patients

At least three approved patient identifiers are used when providing care, therapy or services

This Standard requires the use of at least three approved patient identifiers each time identification occurs, to give both manual and electronic patient identification systems the best chance of correctly matching a patient with their record while not imposing impractical demands on information gathering. Studies using both large and small databases of medical records from the US have demonstrated that the risk of false positive matching decreases from a 2-in-3 chance using last name only to a 1-in-3500 chance when first and last names, postcode and date of birth are used.¹¹

Healthcare providers and health service organisations must specify the data items approved for patient identification for use in their organisation:

- at admission or registration
- when matching a patient's identity to care, therapy or services
- whenever clinical handover, patient transfer or discharge documentation is generated
- in specific service settings if they are different from those generally used across the organisation.

Approved patient identifiers are items of information that can be used to identify a patient when care, therapy and services are provided. These may include:

- patient name (family and given names)
- date of birth
- gender
- address
- medical record number
- Individual Healthcare Identifier.

Identifiers such as room or bed number should not be used as they are frequently changed and are not unique to an individual patient.

These potential approved identifiers include the core items that should be recorded on a patient identification band, as described in the *Specifications for a Standard Patient Identification Band* (Appendix B). The core items for a patient identification band are name, date of birth and medical record number; these can also be used as approved patient identifiers. In some situations patients will not be wearing identification bands and other identifiers may be needed to identify them and correctly match them to their care.

Regardless of the type of care, therapy or service that is provided, all health service organisations need to ensure that a comprehensive, organisation-wide system is in place for the reliable identification of patients at each treatment episode. This means that resources and procedures are organised, integrated, regulated and administered to achieve the objective of correctly identifying patients at any point and time during an admission or course of treatment. Written policies, procedures and protocols are required to describe the process of consistently and correctly identifying a patient at any point and time during an admission or course of treatment. These must be documented and implemented so that all members of the workforce clearly understand their responsibilities and accountabilities.

Actions required	Implementation strategies
<p>5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:</p> <ul style="list-style-type: none"> • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated 	
<p>5.1.1 Use of an organisation-wide patient identification system is regularly monitored</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Develop or confirm an organisation-wide system for patient identification and describe the key requirements for monitoring its effectiveness • Agree on strategies for evaluating the organisation-wide patient identification and procedure matching system that includes both process and outcome measures • Identify a suitable individual, group or committee to take responsibility for monitoring the organisation-wide patient identification system <p>Suggested strategies:</p> <p><i>Organisation-wide system for patient identification and procedure matching</i></p> <p>An organisation-wide patient identification system is the set of written policies, procedures and protocols designed to ensure the consistent and correct identification of a patient at any point and time during an admission or course of treatment. This system is at the core of your efforts to ensure correct patient identification and procedure matching, and policies, procedures and protocols for specific activities (such as patient registration or generating and checking identification bands) should be included within, or linked to it.</p> <p>This system should describe what documentation is needed about the process of identification and patient and procedure matching. The requirements for documentation will vary depending on the situation. For example, it is not feasible or necessary to record that three identifiers have been used to check identity for each patient to whom medication is administered. However if the surgical safety checklist is used in operating theatres, there should be some confirmation that it has been used, or the completed checklist itself can be kept in the patient's record. This process is discussed in Action 5.5.1.</p> <p>There may be specialist areas within the health service organisation that have specific needs regarding patient identification and procedure matching. For example, in mental health units or dialysis units the use of patient identification bands may be inappropriate and other methods such as photographic identification may be required. Health service organisations need to determine what methods for patient identification and procedure matching will be used in each service or unit, and these should be included in, or linked to the organisation-wide patient identification system. You should consider privacy concerns when adopting a particular method of patient identification – for example, asking for verbal confirmation of a patient's address in an open waiting room may not be appropriate.</p> <p><i>Evaluating the patient identification and procedure matching system</i></p> <p>Monitoring the organisation-wide patient identification system includes review of compliance with the relevant policies, procedures and protocols, and reporting and analysis of any patient identification and mismatching errors that are identified. Reporting and analysis of errors is specifically discussed in Item 5.2.</p>



Actions required	Implementation strategies
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5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:

- define approved patient identifiers
- require at least three approved patient identifiers on registration or admission
- require at least three approved patient identifiers when care, therapy or other services are provided
- require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated (continued)

(continued)

5.1.1 Use of an organisation-wide patient identification system is regularly monitored

A number of measures can be used to identify compliance with the patient identification and procedure matching policy. It is not necessary to conduct continuous auditing of these measures. An evaluation plan should be developed that sets out the nature of the evaluation activities to be undertaken and their frequency. The frequency of audits will vary according to the specific measure, the risks faced by your health service organisation, and your progress with implementing these systems. For example, audits about the use of patient matching protocols may occur more frequently following introduction of a new policy. Observational audits may be done less frequently because of the resources required for them.

Process measures are designed to measure the implementation and operation of the system. For example, to assess compliance with the process of using three patient identifiers to establish or match identification, an observational audit of practice at the point of care might be required. You could collect data through observation of practice during activities such as medication rounds, surgical handover, registration or admission. You could design observational audits to collect data to enable simultaneous assessment of compliance with other Standards, such as *Standard 6: Clinical Handover*. Alternatively, you could review the patient clinical record to ensure treatment notes, test results and amendments to orders all use three agreed patient identifiers, and that there is appropriate documentation that identification and matching processes have occurred.

Outcome measures are used to give an indication of the organisation’s performance against a particular objective. An example of an outcome measure is conducting an audit to assess the proportion of inpatients who are wearing a patient identification band that meets the national specifications and correctly matches their identity. Outcome measures can also include numbers of mismatching events or near misses.

You can find examples of what might be audited for the specific criteria in this Standard in Actions 5.2.1, 5.4.1 and 5.5.2.

The Patient Safety and Quality Improvement Service in Queensland Health has developed audit tools that may be useful for evaluating the patient identification and procedure matching system. These tools are available from:

www.health.qld.gov.au/psq/safetyandquality/nsqhss-audit-tools.asp

You should make sure that data is fed back to individual services and units for action at the local level as well as up to the individual or committee responsible for governance. In small organisations this may be a straightforward process of including audit feedback on notice boards and listing it on the agenda for discussion at team meetings. In large health services communication pathways may be more complex and reporting lines and processes need to be clearly documented.

Actions required	Implementation strategies
<p>5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:</p> <ul style="list-style-type: none"> • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated 	<p style="text-align: right;">(continued)</p>
<p>(continued)</p> <p>5.1.1 Use of an organisation-wide patient identification system is regularly monitored</p>	<p><i>Governance regarding the patient identification and procedure matching system</i></p> <p>Regardless of the size of the health service, you are required to have a system of organisation-wide governance to ensure that any issues are investigated and responsive action is taken across the organisation when required. Key requirements of those who are responsible for governance of the patient identification and procedure matching system may include:</p> <ul style="list-style-type: none"> • ensuring that the necessary policies, procedures and protocols are developed and that they are consistently and correctly applied across the organisation • developing feedback mechanisms that enable recommendations from the analysis of audit data to be actioned at an organisational level as well as at the local level • monitoring data received from the incident reporting system so that learning from any patient mismatching errors made in individual areas can be applied across the organisation (see Item 5.2) • fostering the spread of locally developed strategies for successfully improving compliance with the patient identification and procedure matching system across the organisation • reporting to the executive team. <p>You should map the key requirements for the governance of your patient identification system to the individuals or committees who currently hold clinical governance responsibilities. If no suitable individual or committee can be identified, new governance structures may need to be developed or existing roles and responsibilities redefined. Refer to <i>Standard 1: Governance for Safety and Quality in Health Service Organisations</i> when planning governance arrangements for the patient identification system.</p> <p>Outputs of improvement activities may include:</p> <ul style="list-style-type: none"> • an organisation-wide system for patient identification and expectations of the workforce made explicit through policies, procedures and protocols • a person or committee that takes responsibility for governance of the system • key accountabilities of the individual or committee with responsibility for the governance of organisation-wide patient identification system in position descriptions, policies or terms of reference • routine and systematic assessment of compliance with the identification matching system, and data reported for action at all levels of the organisation • monitoring and governance systems that enable the sharing of data and the development of local strategies for quality improvement across the organisation.



Actions required	Implementation strategies
<p>5.1 Developing, implementing and regularly reviewing the effectiveness of a patient identification system including the associated policies, procedures and/or protocols that:</p> <ul style="list-style-type: none"> • define approved patient identifiers • require at least three approved patient identifiers on registration or admission • require at least three approved patient identifiers when care, therapy or other services are provided • require at least three approved patient identifiers whenever clinical handover, patient transfer or discharge documentation is generated 	<p>(continued)</p>
<p>5.1.2 Action is taken to improve compliance with the patient identification matching system</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Use data from the monitoring system to develop or review strategies for improvement and action these at individual service or unit level as well as at an organisational level • Communicate to the workforce the results of monitoring activity and any resulting changes to policy, procedure or protocols <p>Suggested strategies:</p> <p>Each service or unit in an organisation should use data specific to their performance to develop local strategies to improve. You should also review the data to determine what changes need to be made across the whole health service organisation. Analysis of incidents, adverse events and near misses and compliance data may indicate the source of increased risk of mismatching events in the workflow which could be corrected with input from the clinicians involved.</p> <p>A range of strategies can be undertaken to improve compliance with the patient identification system. One of the strongest of these is the introduction of critical stops or forcing functions in policies, procedures and protocols. Such stops may include information technology systems that require documentation of the use of the surgical safety checklist before a procedure can commence or the requirement for inpatients to be wearing an identification band before venepuncture can occur. The introduction of strategies such as these requires considerable planning and consultation with all parties that may be affected by the change.</p> <p>Other strategies for improvement include the development of education and orientation programs for the workforce involved in patient identification and matching processes. You should map out which members of the workforce are involved in identification and matching processes – this may include doctors, nurses, pharmacists and other members of the multi-disciplinary team, as well as administrative and auxiliary staff. All of these people should receive orientation and education on the patient matching and identification processes and their importance in preventing avoidable errors in the delivery of care, therapy and other services. Records should be kept to indicate who has received training.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols that include requirements for patient identification and procedure matching • orientation and ongoing education programs for the workforce that include information about the patient identification matching process and the reporting system • a record of workforce education about patient identification and matching processes • a record of action taken in response to education and local data collection • recommendations from investigation of patient mismatching events or near misses.

Actions required	Implementation strategies
5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events	
<p>5.2.1 The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Establish or adapt an incident reporting system that captures data on patient mismatching events and near misses <p>Suggested strategies:</p> <p>Systems for reporting, investigation and analysis of patient identification mismatching events are one part of a broader incident management system. Item 1.14 of <i>Standard 1: Governance for Safety and Quality in Health Service Organisations</i> outlines the actions required to implement an incident management and investigation system. Implementation of systems to meet Item 1.14 enables the effective reporting, investigation and analysis of patient care mismatching events.</p> <p>You should review patient mismatching incidents, adverse events and near misses to enable identification of failures to comply with policies, procedures and protocols, failures of implementation of policies, or the need to revise policies.</p> <p>You should monitor the effectiveness of the system for reporting, investigating and analysing patient care mismatching events, including assessment of:</p> <ul style="list-style-type: none"> • reporting rates over time (note that reporting rates should not be interpreted as the rate of incidence – they may increase as a successful reporting culture becomes established) • uptake of recommendations stemming from any investigations into any patient care mismatching events. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • reports from incident reporting systems • documents from the investigation of serious mismatching events.



Actions required	Implementation strategies
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5.2 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any patient care mismatching events (continued)

5.2.2 Action is taken to reduce mismatching events

Key tasks:

- Use the data from the incident reporting system to recommend and prioritise quality improvement activities
- Review data and risks of mismatching events and near misses and develop strategies for reducing the likelihood of these events
- Communicate to the workforce the results of investigations into mismatching events and any resulting changes to policy, procedure or protocols

Suggested strategies:

Note: The strategies outlined in Actions 5.1.1 and 5.1.2 also apply to this action.

You should ensure that all members of the workforce who are involved in identification and matching processes receive training and updates about:

- their roles, responsibilities and accountabilities as participants in the patient identification and matching process
- the policies, procedures and protocols for matching a patient’s identity to their intended procedure, treatment or investigation
- relevant data from audit and reporting systems and the recommendations from any investigations into mismatching events
- the importance of, and process for, reporting mismatching events
- when and how to use the reporting system.

Specific actions required to reduce mismatching events may vary depending on the root cause of any errors or near misses that occur. You should develop local strategies for improvement in response to analysis of local data. Strategies may include:

- introduction of forcing functions or critical stops to ensure correct patient identification
- orientation, training and education
- changes to the policies, procedures and protocols for ensuring correct patient identification
- changes to the policy supporting correct patient identification
- investigation of mismatching events and near misses and implementation of subsequent recommendations.

Outputs of improvement processes may include:

- education and training programs and evidence of the application of the training
- documents describing the process and outcomes of relevant quality improvement activities
- workforce feedback and communication strategies that provide information about the patient identification matching process, the reporting system, and relevant audit data and recommendations from any investigations into mismatching events
- action taken at both a local and organisational level in response to recommendations stemming from the investigation of patient mismatching events or near misses.

Actions required	Implementation strategies
5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands	
<p>5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Introduce and/or confirm that the identification bands used in your organisation meet the national specifications for patient identification bands <p>Suggested strategies:</p> <p>The primary use of patient identification bands is to identify patients when care, therapy or services are provided. They are most commonly used in inpatient settings. The <i>Specifications for a Standard Patient Identification Band</i> (see Appendix B) and an accompanying fact sheet and Frequently Asked Questions can be downloaded from the Commission’s web site. You should use these to ensure that the patient identification bands used by your organisation are standardised and comply with the specifications. These resources are available from:</p> <p>www.safetyandquality.gov.au/our-work/patient-identification/a-national-standard-for-patient-identification-bands-in-australia/</p> <p>The specifications apply to bands that have the primary purpose of identifying the patient within the health service organisation. They do not apply to bands or bracelets that have other purposes (such as triggering an alarm when a patient leaves a certain area).</p> <p>Neither the <i>NSQHS Standards</i> nor the specifications require all people receiving care in a health service organisation to wear identification bands. The organisation-wide system for patient identification and procedure matching should identify when such bands need to be used, and what arrangements are in place for maintaining and checking identify for people who do not wear bands.</p> <p>The Commission does not recommend that identification bands vary from the specifications. If it considered absolutely necessary to use a band that is different from the specifications (for example, one that includes additional data items), these changes should be considered within a risk management framework. The specifications were developed to minimise adverse events associated with patient identification and procedure matching, and using identification bands that do not comply with them may increase the risk of such events occurring. You should assess the potential risks associated with any proposed changes, identify strategies to ameliorate these risks, and document this process.</p> <p>You should conduct regular audits to monitor the proportion of identification bands in use that meet the national specifications.</p>



Actions required	Implementation strategies
<p>5.3 Ensuring that when a patient identification band is used, it meets the national specifications for patient identification bands (continued)</p>	
<p>(continued)</p> <p>5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands</p>	<p>Note: The Commission does not recommend the use of coloured bands to alert clinicians to specific clinical information such as falls risk, allergies or resuscitation status. The use of colour-coded bands to indicate clinical risk is based on tradition rather than evidence of any patient safety benefit.¹²⁻¹³ Inconsistencies in the meaning attached to the various colours of band in different hospitals can lead to confusion and error, particularly when the workforce works across different health service organisations.¹⁴⁻¹⁶ In one Australian state it was found that over 60 different types of identification and alert bands were in use, and there was significant variation in the type of risk indicated by a particular colour of band.¹⁷</p> <p>Problems have also been identified with ensuring that the information conveyed by a coloured band accurately reflects the patient's clinical situation and is synchronised with the patient record.¹² Incorrect or out-of-date bands can have tragic consequences for patients, particularly when they are used to indicate resuscitation status.¹⁴</p> <p>You should use a multi-factorial approach for the management of clinical risk for patients with specific characteristics or conditions. The Commission recommends that if a risk alert band is deemed absolutely necessary, then only a red band be used with information regarding the specific nature of the risk documented in the patient record.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • a policy and system for ensuring that the organisation uses only inpatient bands that meet the <i>Specifications for a Standard Patient Identification Band</i> • evidence that inpatient bands are regularly checked for compliance with the national specifications for patient identification bands.



Standard 5

Criterion: Processes to transfer care

A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care

Transfer of responsibility for a patient's care occurs frequently in health care. This includes at changes of medical and nursing shifts, and when care is transferred to another health facility, primary care practitioner, or medical officer. Breakdowns in the transfer of information during transfer of care are a major preventable cause of patient harm.¹⁸ *Standard 6: Clinical Handover* requires organisations to implement systems for structured clinical handover – it is important that the requirements for confirming patient identification are considered when developing these systems.



Actions required	Implementation strategies
5.4 Developing, implementing and regularly reviewing the effectiveness of the patient identification and matching system at patient handover, transfer and discharge	
5.4.1 A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	<p>Key task:</p> <ul style="list-style-type: none">• Introduce or confirm the use of structured handover, transfer and discharge processes that include the use of three patient identifiers for each patient <p>Suggested strategies:</p> <p>You should incorporate patient identification and matching processes into structured handover systems that are in place as part of the requirements of <i>Standard 6: Clinical Handover</i>. The documentation required for patient identification at handover, transfer and discharge should be determined by these policies, procedures and protocols, and reflected in your organisation-wide patient identification and procedure matching system.</p> <p>You should incorporate the review of patient identification and matching processes during handover, transfer and discharge into the monitoring and evaluation processes that are required for Standard 6.</p> <p>When designing paper-based or electronic systems for handover, transfer and discharge, these should require the workforce to use at least three patient identifiers. The Individual Healthcare Identifier is a unique identifier that has been developed to facilitate electronic transfer of information, and can be used as a patient identifier when this occurs.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• policies, procedures and protocols that require the use of three patient identifiers at patient handover, transfer and discharge embedded into structured handover systems and the evaluation of those systems• documents, templates and electronic systems for the transfer of care, including handover, transfer and discharge• audit of transfer and/or discharge documentation• documentation from the review of policies, procedures and protocols.



Standard 5

Criterion: Processes to match patients and their care

Health service organisations have explicit processes to correctly match patients with their intended care

Processes for matching patients to their intended procedure, treatment or investigation are essential for ensuring that the right patient receives the right care. Most health service organisations have processes in place for patient identification and procedure matching but these may not be formally documented.

The specific type of patient and procedure matching process in use will be dependent on the type of procedure, the design of the workflow in a particular work area or organisation, and the risks for the patient. Clearly documenting the process for how patient identification and procedure matching is performed in each specialist area will help to ensure that particular

requirements are not overlooked. For example, in most procedural areas 'time outs' are required with the whole team before the procedure can commence. In other situations, such as radiology where there may only be a single operator, this could be done as a stop to verify that all requirements are correct.

This criterion is particularly focused on clinical situations where there may be greater risks to the patient; including procedural areas such as surgery, investigations such as radiology and specific treatments such as nuclear medicine. The focus for action is particularly on the use of protocols for matching patients to their intended care.



Actions required	Implementation strategies
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5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols

5.5.1 A documented process to match patients and their intended treatment is in use

Key task:

- **Develop explicit, documented protocols to outline the process of matching a patient to their intended treatment**

Suggested strategies:

You should incorporate structured patient/procedure matching protocols into your organisation-wide patient identification system and use these protocols to ensure that the right patients receive the right care. The original focus for efforts to correctly match patients to the correct procedure was in surgery; however there is now a wider range of protocols available that address the specific needs of other speciality areas.

The Commission has developed a set of patient matching protocols for specific therapeutic and diagnostic areas such as surgery, nuclear medicine and radiation therapy. The protocols are available for download from:

www.safetyandquality.gov.au/our-work/patient-identification/enhancing-ensuring-correct-patient-correct-site-correct-procedure-protocol/

www.safetyandquality.gov.au/our-work/patient-identification/expanding-the-3cs-into-other-therapeutic-areas/

The WHO surgical safety checklist has been demonstrated to improve patient safety¹⁹ and is now widely used in Australia. This checklist includes elements relating to patient identification and procedure matching and if it is in place in your health service organisation it can be used as the patient/procedure matching protocol.

The surgical safety checklist and implementation manual can be downloaded from:

www.who.int/patientsafety/safesurgery/ss_checklist/en/

The Australia and New Zealand edition of the surgical safety checklist can be downloaded from:

www.surgeons.org/media/12661/LST_2009_Surgical_Safety_Check_List_%28Australia_and_New_Zealand%29.pdf

The key steps that underlie all of these protocols of care are:

- if necessary, mark the site of the procedure
- verify the identity of the patient
- verify the details of the procedure being undertaken, including the site of the procedure
- take a time out or similar stop with all members of the team to do a final check before the procedure commences
- confirm all documentation, samples and other information and materials following completion of the procedure.

To develop protocols for other clinical situations, involve those with local knowledge of the process to adapt the patient identification and procedure matching protocols for their specific requirements. When deciding what clinical areas should have their own specific patient/procedure matching protocol, you should focus on areas of higher risk for patients and your health service organisation.

Outputs of improvement processes may include:

- protocols for patient identification and procedure matching for different clinical situations
- communication material for the workforce on procedure matching requirements.

Actions required	Implementation strategies
<p>5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols (continued)</p>	
<p>5.5.2 The process to match patients to any intended procedure, treatment or investigation is regularly monitored</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Incorporate process measures that will identify if the patient identification matching system is in use and working effectively into your monitoring system for the organisation-wide patient identification system (see Action 5.1.2) <p>Suggested strategies:</p> <p>You should include audit of compliance with the patient/procedure matching protocols in the evaluation plan developed as part of your organisation-wide patient identification system.</p> <p>Process measures that will assist in identifying whether the patient identification and matching system is being used effectively may include:</p> <ul style="list-style-type: none"> • observational audit of particular practice episodes, e.g. admission or registration procedures; medication rounds; radiology matching procedures; surgical procedures • audit of documentation that is used as part of patient matching procedures, for example, checklists or clinical pathways. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • data from the audit of patient identification and procedure matching processes.



Actions required	Implementation strategies
<p>5.5 Developing and implementing a documented process to match patients to their intended procedure, treatment or investigation and implementing the consistent national guidelines for patient procedure matching protocol or other relevant protocols (continued)</p>	

5.5.3 Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation

Key tasks:

- **Introduce or confirm the use of specific, localised strategies for improvement based on the results of audit of local practices**
- **Communicate to the workforce the results of audit into the patient matching process and any resulting changes to policy, procedure or protocols**

Suggested strategies:

Note: the strategies outlined in Actions 5.1.1, 5.1.2 and 5.2.2 are also applicable to this action.

Specific actions required to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation may vary depending on the areas for improvement that are identified through audit data. You should develop local strategies for improvement in response to analysis of local data. These strategies may include:

- introduction of forcing functions or critical stops to patient/procedure matching protocols
- orientation, training and education about using the protocols for matching patients to their intended care
- changes to policies, procedures and protocols
- investigation of mismatching events and implementation of subsequent recommendations
- reporting of incidents and cases where mismatches were averted through positive checking procedures.

Outputs of improvement processes may include:

- orientation, training and education programs and evidence of the application of the training
- documents describing the process and outcomes of relevant quality improvement activities
- material for the workforce that provides information about the patient identification matching process, the reporting system, and relevant audit data and recommendations from any investigations into mismatching events.



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Appendix A: Links to resources

Specifications for a standard identification band

The following information is about the specifications is available from the Commission's web site:

- Specifications for a standard patient identification band
- Fact Sheet – Specifications for a standard patient identification band
- FAQ – Specifications for a standard patient identification band

www.safetyandquality.gov.au/our-work/patient-identification/a-national-standard-for-patient-identification-bands-in-australia/

Surgical procedure identification matching

It should be noted that **for surgery** organisations should use the World Health Organisation Surgical Safety Checklist as the basis for patient identification and procedure matching processes. The checklist can be downloaded from:

www.who.int/patientsafety/safesurgery/ss_checklist/en/

The Australia and New Zealand edition of the surgical safety checklist can be downloaded from:

[www.surgeons.org/media/12661/LST_2009_Surgical_Safety_Check_List_\(Australia_and_New_Zealand\).pdf](http://www.surgeons.org/media/12661/LST_2009_Surgical_Safety_Check_List_(Australia_and_New_Zealand).pdf)

An earlier protocol developed by the Australian Council for Safety and Quality in Health Care (the Council) in consultation with the Royal Australasian College of Surgeons (RACS) and the States and Territories was based on principles and processes that could be applied in a range of clinical areas. These principles form the basis of the specific protocols developed by the Commission for nuclear medicine, radiology, radiation oncology and oral surgery. Because these principles still apply in general, the protocol and associated resources are still provided here.

The Ensuring Correct Patient, Correct Site, Correct Procedure Protocol kit contains two workplace posters, two patient brochures and a fact sheet:

- If time is money
- Ensuring Correct Patient, Correct Site, Correct Procedure
- Ensuring Correct Patient, Correct Site, Correct Procedure Fact Sheet
- Patient Brochure – Understanding your procedures
- Patient Brochure – Understanding your surgery

This material can be downloaded from:

www.safetyandquality.gov.au/our-work/patient-identification/enhancinensuring-correct-patient-correct-site-correct-procedure-protocol/



Protocols to support correct matching of patients and their care in the specific areas of radiology, nuclear medicine, radiation therapy and oral surgery

These protocols and supporting materials can be downloaded from:

www.safetyandquality.gov.au/our-work/patient-identification/expanding-the-3cs-into-other-therapeutic-areas/

Fact Sheet:

- Ensuring Correct Patient, Correct Site, Correct Procedure in Radiology, Nuclear Medicine, Radiation Therapy and Oral Surgery

Protocols:

- Ensuring Correct Patient, Correct Site, Correct Procedure in CT and MRI
- Ensuring Correct Patient, Correct Site, Correct Procedure in General Radiology and Ultrasound
- Ensuring Correct Patient, Correct Site, Correct Procedure in Interventional Radiology
- Ensuring Correct Patient, Correct Site, Correct Procedure in Nuclear Medicine
- Ensuring Correct Patient, Correct Site, Correct Procedure in Radiation Therapy Simulation
- Ensuring Correct Patient, Correct Site, Correct Procedure in Radiation Therapy Treatment
- Ensuring Correct Patient, Correct Site, Correct Procedure in Oral Surgery

Frequently Asked Questions:

- Ensuring correct patient, correct site, correct procedure in Radiation Therapy
- Ensuring correct patient, correct site, correct procedure in Radiology
- Ensuring correct patient, correct site, correct procedure in Oral Surgery
- Ensuring correct patient, correct site, correct procedure in Nuclear Medicine

Audit tools for the organisation-wide patient identification and procedure matching system

The Patient Safety and Quality Improvement Service in Queensland Health has developed audit tools that may be useful for evaluating the patient identification and procedure matching system. These tools can be downloaded from:

www.health.qld.gov.au/psq/safetyandquality/nsqhss-audit-tools.asp

Appendix B: Specifications for a standard patient identification band

SPECIFICATIONS

Specifications for a standard patient identification band

The purpose of these specifications is to set out standards for the useability, content and colour of patient identification bands in Australia.

The draft specifications are based on design requirements for patient wristbands developed by the United Kingdom National Patient Safety Agency.

There are a number of principles that have guided the development of the draft specifications. These are as follows:

- Wherever possible inpatients should wear some form of patient identification, and healthcare providers should have a policy in place that guides this identification process.
- The primary purpose of an identification band or other identification mechanism is to identify the patient wearing the band. The use of identification bands to signify clinical alerts is secondary.
- It is up to States, Territories and other health service providers to determine how they meet the specifications for identification bands. The focus is on what patient identification bands should look like and how they should be used, not how they should be created.

The specifications

These specifications describe the standard features patient identification bands should have. The specifications do not prescribe how these features should be achieved. The application of the specifications to specific patient identification bands needs to be done in a way that is relevant to the particular circumstances of patients and facilities.

The patient identification specifications relate to:

1. Colour
2. Size
3. Comfort
4. Usability
5. Method for recording patient identifiers
6. Information presentation
7. New technology

1. Colour

- 1.1. A single white band should be used for patient identification.
- 1.2. It is recommended that no coloured alert bands be used.¹ However if it is considered necessary to have a system for identifying a known allergy or other known risk the patient identification band should be red only. No other colours should be used to indicate alerts.
- 1.3. Only one band should be used. When an alert condition exists the white identification band is replaced by a red band.

1.4. Where red bands are used they should comply with all requirements of these specifications. The red patient identification band will have patient identifiers in black text on a white background.

1.5. The band should not contain details of the meaning of the alert. This should be recorded in the patient notes. The notes will need to be reviewed to determine the meaning of the alert.

2. Size

Patient identification bands must fit the range of sizes of patients, from the smallest newborn babies through to the largest adults. Patient identification bands should therefore be:

- 2.1. Long enough to accommodate:
 - Obese patients
 - Patients with lymphodema
 - Patients with IV lines and bandages.
- 2.2. Small enough to be comfortable and secure for newborns, babies and children.

Accommodating the range of patients that are needed could be achieved by increasing the maximum length available for the identification band. However, if excess length has to be cut from the identification band staff should be able to do this safely, preferably without the use of scissors. Cut ends should not be sharp. Alternatively, identification bands could be made in a variety of sizes.

3. Comfort

Patients complain about identification bands being scratchy, itchy, sweaty and hot, and this can contribute to the removal of bands. In particular, identification bands can cause skin damage to newborn babies and to people with delicate or vulnerable skin. In addition, patients can be concerned that identification bands may be a potential source of infection, so they should be easy to clean.

Aspects of the comfort of patient identification bands that need to be addressed include:

- 3.1. Shape - There should be no sharp corners, profiling or edges that can irritate or rub the skin.
- 3.2. Edges - The edges of the band material must be soft and smooth to ensure comfort over prolonged use. This includes any edges that are produced when cutting the band to size.
- 3.3. Fastenings - Fastenings should not press into the skin.
- 3.4. Material - Identification band material should be flexible, smooth, waterproof, cleanable, breathable and non-allergenic.

4. Usability

Patient identification bands can be issued and applied by a wide variety of nursing and administration staff, who may or may not have received training in how to do so. Therefore the use of identification bands should be intuitive, including where and how to fill in patient identifiers, checking of information, fastening and removal.

Patient identification bands should be:

- 4.1. Easy to clean.
- 4.2. Waterproof and resistant to other fluids (soap, detergents, gels, sprays, rubs, alcohol cleaning products, blood and other bodily fluids).
- 4.3. Secure and not fall off.
- 4.4. Designed to allow patients to wash.
- 4.5. Quick and easy for all staff to use who may have responsibility for issuing, applying and checking identification bands. Consideration of ease of use should include:
 - Storage
 - Access from storage
 - Filling in patient identifiers
 - Changing or updating information
 - Reading and checking information
 - Putting on patients (including selecting the correct size or adjusting to correct length)
 - Fastening
 - Removal.
- 4.6. The identification band should not catch on clothing, equipment or devices including IV lines. Special attention should be paid to fastenings and free ends.

5. Method for recording patient identifiers

Different jurisdictions and health services in Australia will use different methods to generate the patient identifiers to be included on the identification band. In some cases they may be printed directly from the hospital computer, in others they may be hand written. Regardless of the method used to generate the identifiers, the information should be:

- 5.1. Easy to read.
- 5.2. Durable and not wear off throughout the patient's stay.
- 5.3. Easy to read if exposed to water, soap and detergents, gels, sprays, rubs, alcohol cleaning products, blood and other bodily fluids and any other fluids or preparations that the identification band may come into contact with.

Suggestions for achieving these requirements include:

- 5.4. Ensure pre-printed labels fit the available space on the identification band – if labels are too big they may wrap over the band and information will be hidden.
- 5.5. Inserts should be sealed to ensure they are durable, waterproof, secure and tamperproof.

5.6. Write-on identification bands should be durable so that information cannot wear off.

5.7. Write-on identification bands should not require special pens.

6. Information presentation (patient identifiers)

- 6.1. The space available for patient data should be adequate for the patient identifiers to be recorded clearly and unambiguously.
- 6.2. The same layout, order of information and information style should be used on all patient identification bands across the organisation to ensure standardisation. This helps make identification bands easier to read and avoid errors.
- 6.3. Pre-defined spaces for each identifier or a pre-printed format can help encourage standardisation e.g. consider using a title or box for each identifier, but without reducing the space available for the patient identifiers.
- 6.4. If pre-defined spaces are not used, pre-printed lines can be used to help make information easy to read. This is particularly useful for write-on identification bands.
- 6.5. The core patient identifiers on bands should be limited to:
 - Name²
 - Date of birth
 - Medical record number.
- 6.6. Date of birth should be recorded in the short format as DD/MM/YYYY (e.g. 07/06/2005).
- 6.7. Family and given names should be clearly differentiated. Family name should appear first using UPPER case letters followed by given names in TITLE case: FAMILY NAME, Given names, e.g. SMITH, John Paul.
- 6.8. There should be enough space to include long names, multiple names and hyphenated.
- 6.9. Identifiers should be in a font size and style that is easy to read. Avoid italic, simulated handwriting and ornate typefaces. Use a common sans-serif typeface like Arial or Helvetica. Use a minimum font size of between 12 and 14 point (equivalent to a height of 2-2.3mm).
- 6.10. Black text on a white background should be used to ensure that the patient identification band is clearly legible in reduced lighting conditions (such as wards at night) and by those with visual impairment.

7. New technology

- 7.1. Patient identification bands should allow for the incorporation of new technologies that may be used to assist patient identification such as radiofrequency identification tags, barcode technologies or digital photos, whilst still fulfilling all of the above requirements.

¹ Despite the frequency of their use, there is evidence to suggest that coloured wristbands do not ensure that correct information is available about alert conditions, or assist with reducing the occurrence of incidents or risks indicated by the coloured band. In fact, it appears that the use of coloured wristbands can actually increase the risk of misidentification.

² The decision about what name should be recorded on the patient identification band will need to be made at a local policy level. Issues that will need to be considered regarding the use of names to identify patients include: cultural naming conventions, use of preferred names rather than correct names, use of names for neonates.

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