Open Book
Learning from close calls and adverse events

Accurate patient identification

This report aims to alert providers to the key findings of a recent adverse event review. The emphasis is on the changes implemented by the provider involved to stop the event happening again. We advise providers to consider this report, and whether the changes made are relevant to their own systems.

This report is for:

- staff on wards and units providing direct care to patients
- staff on units where patients receive therapy or investigations
- training and education programme planners
- staff who collect patients and transport them between departments.

Incident

The wrong patient was taken for a chest X-ray.

Chronology

- Two patients with the same forename (Bill Adams and Bill Smith)[1] shared a two-bedded room.
- A chest X-ray was booked for Bill Adams, and an orderly was arranged (by phone) to take the patient to radiology. The orderly was directed to the correct room.
- One patient was in the room – Bill Smith – and the orderly identified the patient using his forename 'Bill'. The patient agreed to accompany the orderly to radiology.
- In radiology, the radiographer identified the patient using just his forename.
- The error was noticed three days later when a CT scan was performed on Bill Adams and compared with the chest X-ray taken erroneously of Bill Smith.

Key issue – patient identification

- Requests for patients to be transported to radiology were verbal rather than documented, leading to potential for misidentification.
- The patient was not correctly identified by (a) the orderly or (b) the radiographer in accordance with the organisation's patient identification policy. This policy requires two of the following unique identifiers to be used to identify the patient: full name, date of birth, NHI number.

Action subsequently taken

- A formal patient identification system was developed between radiology, the orderly room and the wards, to support the patient identification policy.

Commission comment

- Similar cases have been reported to the Health Quality & Safety Commission as serious adverse events.
- Policies should require staff to ask patients to identify themselves using full name and/or date of birth.
- The World Health Organization's guidance on correct patient identification[2] recommends that training on verifying a patient's identity be incorporated into orientation and continuing professional development for health and disability care workers.

[1] Not real names.
[2] www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa
open FOR BETTER CARE Hāpai ake te taiora
newzealand.govt.nz