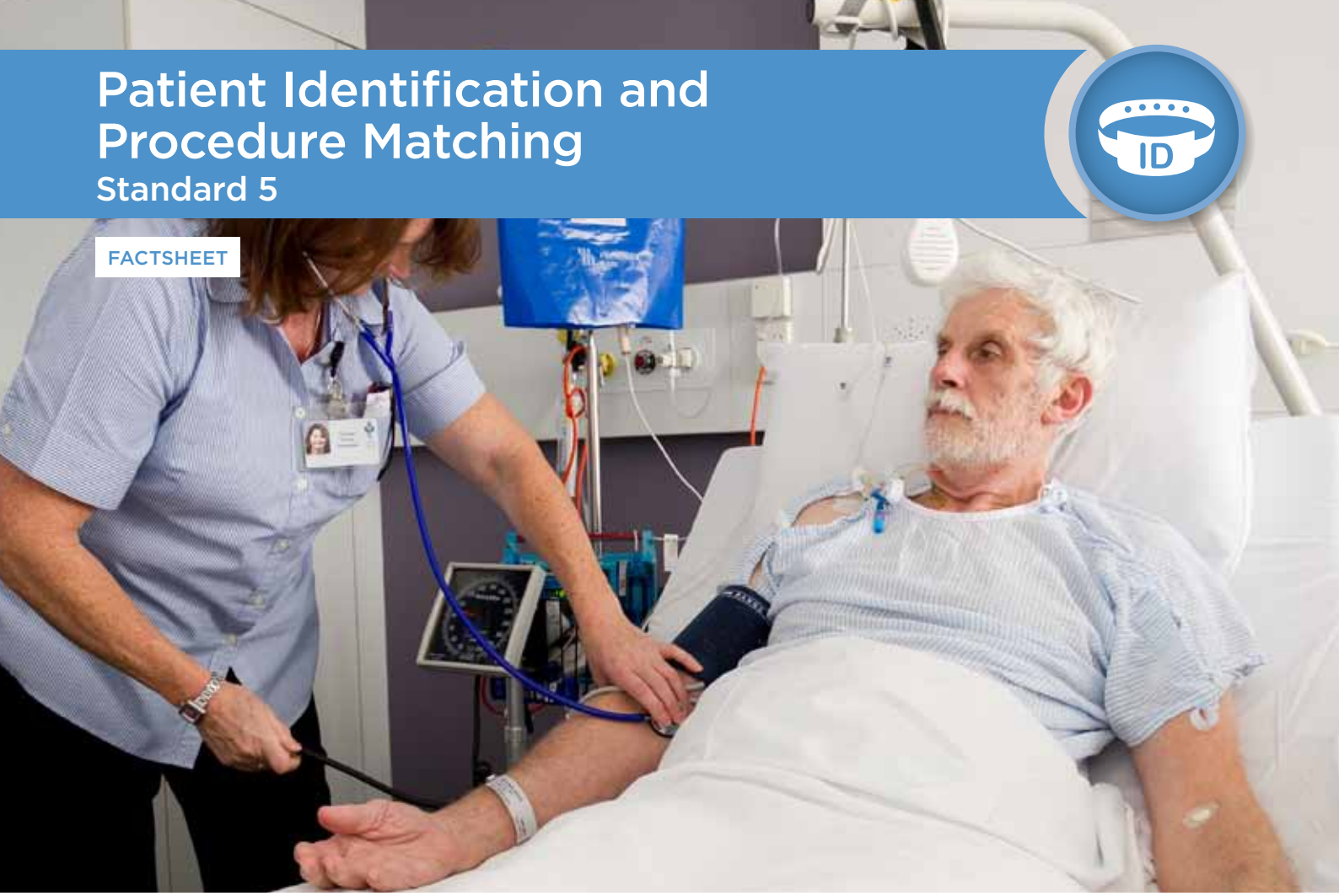
Patient Identification and Procedure Matching

Standard 5

FACTSHEET



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.

Ensuring the right care is provided to the right patient is an essential part of providing and receiving safe care. Unfortunately, this does not always happen. The failure to correctly identify patients and match that information to an intended treatment or intervention continues to result in procedures being performed on the wrong person, wrong side or wrong site; medication errors; blood transfusion errors; and errors in diagnostic testing.

Patient identification and the matching of a patient to an intended treatment is an activity that is performed routinely in all care settings, and can often be seen as a relatively unimportant task. The use of tools such as World Health Organisation's Surgical Safety Checklist[1] and the Ensuring Correct Patient, Correct Site, Correct Procedure Protocols[2] provide a basis for the development of safety routines for common tasks, such as patient identification, and provide a powerful defence against simple mistakes that may progress and cause harm to patients.

The aim of this Standard is to ensure that the health workforce correctly identifies all patients whenever care is provided and correctly matches patients to their intended treatment.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Patient Identification and Procedure Matching

Standard 5

Facts and Figures

Mismatches between patients and their care do not often result in harm, but they can have significant consequences. In 2008–09 there were eleven events in Australia with procedures involving the wrong patient or body part resulting in a death or major permanent loss of function.[3] When less serious events from non-surgical areas such as pathology and radiology are included in reporting systems the number of reported events can rise considerably.[4]

In brief, this Standard requires that:

- At least three approved patient identifiers are used when providing care, therapy or services.
- A patient's identity is confirmed using three approved patient identifiers when transferring responsibility for care.
- Health service organisations have explicit processes to correctly match patients with their intended care.

Why an identification band should be worn in hospital

An identification band, such as a wristband, with accurate details assists health care staff in identifying patients and providing the right care.

Resources and Tools

The Commission has the following tools and resources to assist with the implementation of this Standard:

- Specifications for a standard patient identification band
- Ensuring Correct Patient, Correct Site, Correct Procedure protocols for radiology, radiation oncology, nuclear medicine and oral surgery.

Further Information

A full copy of the Patient Identification and Procedure Matching Standard is contained in the *National Safety and Quality Health Service Standards.* It includes the criteria, items and actions required for health services to meet this Standard and is available on the Commission's website at **www.safetyandquality.gov.au**.

Examples of patient identifiers

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

References

1. Surgical Safety Checklist. Royal Australasian College of Surgeons, 2009. (Accessed 19 April 2011, at http://www.surgeons.org/racs/fellows/resources-for-surgeons#WHO).
2. Australian Commission on Safety and Quality in Health Care. *Ensuring Correct Patient, Correct Site, Correct Procedure Protocols Australian Commission on Safety and Quality in Health Care, 2008*. (Accessed 19 April 2011, at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PatientID-Resources-Exp_Correct-Pat-Site-Proc.)
3. Australian Commission on Safety and Quality in Health Care. *Windows into Safety and Quality in Health Care 2010*. Sydney: Australian Commission on Safety and Quality in Health Care, 2010.
4. Australian Commission on Safety and Quality in Health Care. *Windows into safety and quality in health care 2008*. Sydney: Australian Commission on Safety and Quality in Health Care, 2008.

Australian Commission on Safety and Quality in Health Care
Level 7, 1 Oxford Street, Darlinghurst NSW 2010
GPO Box 5480, Sydney NSW 2001
Phone: (02) 9126 3600
Fax: (02) 9126 3613
Email: mail@safetyandquality.gov.au
www.safetyandquality.gov.au