Misidentification

In this article...

- Applying and checking wristbands to identify patients
- Verification protocols to check them

Wristbands are used to identify hospital patients. Serious harm can occur if a patient receives treatment or a procedure intended for someone else, or if treatment is delayed because it has been given to the wrong patient. This can be catastrophic if the procedure is surgical or involves medication (Sevdalis, 2007).

The National Patient Safety Agency (NPSA) has advised standardising the design and use of patient wristbands and verification processes to check them (NPSA, 2007).

Case study

Jenny, the staff nurse in charge of a general medical ward, is sorting out medication for Mr Wells, a new older patient admitted from accident and emergency with a suspected venous thromboembolism. A healthcare assistant is further down the ward finishing a discussion with another patient and the patients’ relatives, who are crying.

A porter arrives and shouts out “John Wells?” The new patient says “That’s me,” and the porter waves at the healthcare assistant to help transfer Mr Wells into the wheelchair. Distracted, she helps the porter, who glances at his sheet, checks the wristband and says: “Off to endoscopy, mate.” They disappear down the corridor.

Jenny gets up to give Mr Wells his medication. He is not in his bed. She asks where he is and is told he has gone to endoscopy. Jenny realises there has been some confusion. A young patient, also called Mr Wells, with possible haemoptysis is waiting for an urgent endoscopy in another bay. She calls endoscopy to cancel the procedure.

The nurse in endoscopy had checked the wristband and said that the date of birth did not match that of the patient expected. After 20 minutes, the correct Mr Wells is taken to endoscopy, and this delay causes no harm.

Recognising a nearly never event

This is a nearly never event. It was rescued before an invasive procedure was performed on the wrong patient, and before the correct patient was harmed through delay.

The trust is clear about what should be on the wristband; this was all present but verification protocols were not adhered to.

Prevention

Jenny talks to the healthcare assistant, who did not check all the details on the porter’s sheet against the wristband. Nor did they ask the patient to confirm his date of birth, or ask Jenny to clarify any confusion. Jenny goes through the correct procedures.

Jenny later speaks to the two patients, explaining the circumstances and what would be done to prevent this from happening again during their admission.

Jenny raises the issue of the two patients having the same name at handover, and with another staff who come to the ward, such as doctors. She writes on the ward whiteboard and on the patients’ notes that two patients have the same name.

She also talks this through with her manager, filling in an incident form. Consideration will be given to reporting to the commissioner because it was a nearly never event (NPSA, 2009). Jenny and her manager agree to circulate the policy on wristband checking and to share this example with staff, for example in their induction training.

BOX 1. NEVER EVENT: MISIDENTIFICATION OF PATIENTS

1. Death or severe harm as a result of administration of the wrong treatment following inpatient misidentification due to a failure to use standard wristband (or identity band) identification processes.
2. Failure to use standard wristband identification processes includes:
   a. Failure to use patient wristbands that meet the NPSA’s design requirements.
   b. Failure to include the four core patient identifiers on wristbands: last name; first name; date of birth; and NHS number.
   c. Failure to follow clear and consistent processes for producing, applying and checking patient wristbands.
   d. Printing several labels with different patients’ details at one time.
3. This event excludes where patients refuse to wear wristbands despite a clear explanation of the risks of not doing so.
4. The event also excludes where it has been documented that patients cannot wear wristbands due to their clinical condition or treatment, or in emergency care where patient turnover is high.
5. Identity information is insufficient or rapid treatment is needed.

Setting: All healthcare premises

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References