Standard 5: Patient Identification and Procedure Matching

Standard:
• 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 system.

Intent:
• To correctly identify all patients whenever care is provided and correctly match patients to their intended treatment

Context:
• To be applied in conjunction with Standard 1: Governance for Safety and Quality and Standard 2: Partnering with Consumers
Correctly identifying patients and matching them to their treatment is fundamental to safe care.

Risks occur when there is a mismatch between a given patient and components of their care – diagnostic, therapeutic, supportive.

Patient identification is such a routine process – can be seen as unimportant.

Putting systems in place to ensure patients are correctly matched to their care means that more attention can be paid to more complex tasks.
1. Identification of individual patients
   • At least three approved patients identifiers are used when providing care, therapy or services

2. Processes to transfer care
   • A patient’s identity is confirmed using three approved patient identifiers when transferring responsibility for care

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

Note: all actions in Standard 5 are core
Key concepts

- **Flexible standardisation:**
  - Standardisation of processes is an important way of improving safety and quality
  - Needs to reflect context of the health service
  - Contextual issues that will affect the systems that are put in place to meet Standard 5 include:
    - type and size of health service – small or large hospital, day procedure
    - nature of services provided – inpatients, outpatients, mental health
    - policy framework that exists – state or territory, private hospital group
    - existing systems and processes, including electronic health records

- **Streamlining:**
  - Don’t need to have separate processes and systems for each action in the Standard
  - Consider how activities fit together to coordinate evidence and outcomes
5.2.1, 5.2.2 Mismatching events

5.3.1 Patient identification bands

5.4.1 Handover, transfer and discharge

5.5.1, 5.5.2, 5.5.3 Matching patients to their intended care

5.1.1, 5.1.2 Organisation-wide patient identification system

Put the system in place

Audit / review performance of or compliance with the system

Make improvements based on the results of the audit
Organisation-wide patient identification system

What is an “organisation-wide patient identification system”?

• A system of explicit policies, procedures and protocols that apply across the organisation and cover:
  • consistent and correct identification of patients
  • matching identity using at least three identifiers
  • responsibility of members of the workforce regarding patient identification
  • what documentation is required that identification and matching processes have occurred

• Should include processes for patient identification and maintaining identity:
  • at admission or registration
  • when matching a patient’s identity to care, therapy or services
  • whenever responsibility for care is transferred – handover, transfer and discharge
  • in specific service settings if they are different from those generally used across the organisation
Organisation-wide patient identification system

- Approved patient identifiers could include:
  - Patient name (family and given names)
  - Date of birth
  - Gender
  - Address
  - Medical record number
  - Individual Healthcare Identifier

- Room and bed number should not be used as they are frequently changed and not intrinsically linked to an individual
Evaluation of patient identification system:

- Review of compliance with relevant policies, protocols and procedures
- Review of patient identification mismatching events and near misses
- Should include both process and outcome measures:
  - process measures – designed to measure implementation and operation of the system, eg observational audit of use of three patient identifiers when administering medication
  - outcomes measures – designed to measure performance against an objective, eg audit to assess proportion of inpatients wearing a patient identification band that meets the specifications
- Do not need continuous monitoring – develop evaluation plan relevant to organisational context
- Specific evaluation measures can be related to actions in the Standard (such as use of correct identification bands and matching patients to their care)
Organisation-wide patient identification system

Taking action for improvement:

- Information from evaluation, audit and monitoring processes should be:
  - fed back to local teams
  - reported to the executive
  - used to identify actions for improvement

- Examples of types of improvement actions include:
  - introduction of forcing functions or critical steps
  - development of new systems and protocols
  - training and education for the workforce
  - review of policies and procedures

- These strategies apply to other actions in the Standard:
  - activities only need to be undertaken once
  - can be used to demonstrate compliance with more than one action
Mismatching events

- Incident reporting system should be part of the larger system required as part of Standard 1: Governance for Safety and Quality (1.14)

- Systems for reporting mismatching events and taking action for improvement should be part of organisation-wide patient identification system (5.1.1)
Patient identification bands

- Specifications developed for identification bands worn by inpatients or other situations when bands are used.

- Specifications relate to:
  - Colour
  - Size
  - Comfort
  - Usability
  - Methods for recording patient identifiers
  - Information presentation
  - New technology

- Specifications do not specify who should wear bands:
  - Where bands are not used, need to consider other ways to maintain identify of the patient.

- Use of patient identification bands should be part of organisation-wide patient identification system.

- Documented risk management approach if any variation from Specifications.
Patient identification bands

Coloured bands:

• Common practice to use coloured bands to indicate alerts such as falls risks, allergies and resuscitation status
• Use of coloured bands based on tradition, not evidence
• Wide range of different colours and meanings – leads to patient safety risks
• Specifications recommend one white band only
• If considered necessary to indicate an alert – replace white band with red band
• Recommend multi-factorial approach to identify clinical risk
Handover, transfer and discharge

- Patient identification and use of three identifiers should be included in structured clinical handover system required under Standard 6: Clinical Handover

- Patient identification processes at handover, transfer and discharge should be included in organisation-wide patient identification system (5.1.1)
Matching patients to their intended care

- Processes for matching patients to their intended care should be included in organisation-wide patient identification system (5.1.1)

- These actions require documentation of process of checking identity, and matching identity to care

- Scope of these actions:
  - Procedures and investigations
  - Specific treatments – such as nuclear medicine
  - It is not intended that requirements of these actions would relate to treatments such as routine provision of medications
Matching patients to their intended care

- Protocols for matching patients to their intended care:
  - Ensuring Correct Patient Correct Site Correct Procedure:
    - originally released in 2004
    - state and territory / regional / hospital policies based on original protocol
    - additional protocols developed for specific areas outside surgery (2008) – radiology, nuclear medicine, radiation therapy, oral surgery
  - WHO Surgical Safety Checklist:
    - adapted by Royal Australasian College of Surgeons for use in Australia
    - includes patient identification
  - Key steps:
    - marking site (if necessary)
    - verification of identity
    - verification of procedure / site etc
    - time out
    - confirmation of all documentation post-procedure
Resources

- Australian Commission on Safety and Quality in Health Care:
  - Safety and Quality Improvement Guide for Standard 5
  - Specifications for standard patient identification bands – and FAQs and fact sheets
  - Ensuring Correct Patient Correct Site Correct Procedure protocols – and FAQs and fact sheets

- State and territory health department policies and protocols in areas such as:
  - Patient identification
  - Matching patients to their care
  - Clinical handover

- Royal Australasian College of Surgeons:
  - Surgical Safety Checklist

- World Health Organisation:
  - Implementation manual for the Surgical Safety Checklist
Summary

- Patient identification is a basic clinical process and needs to be done properly to ensure safety.
- Purpose of the Standard is to improve outcomes for patients by setting out basic requirements for patient identification processes.
- Standard based on a systems approach – rather than what is often ad hoc and fragmented.