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Search details
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Evidence search string(s): patient* (identification OR identify OR misidentification OR verification)

Google search string(s): patient (identification OR identify OR misidentification OR verification)

Guidelines and Policy
Australian Commission on Safety and Quality in Healthcare
Patient Identification | Safety and Quality

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee
Handbook of Transfusion Medicine: 4.1: Patient identification, 2014

National Patient Safety Agency
Safer patient identification, 2005

NHS Wales
Reducing Patient Identification Errors, 2010
Published research – Databases

Patient identification errors: the detective in the laboratory.
Author(s) Salinas M, Lopez-Garrigos M, Lillo R, Gutierrez M, Lugo J, Leiva-Salinas C
Citation: Clinical Biochemistry, November 2013, vol./is. 46/16-17(1767-9), 0009-9120;1873-2933 (2013 Nov)
Publication Date: November 2013
Abstract: BACKGROUND: The eradication of errors regarding patients' identification is one of the main goals for safety improvement. As clinical laboratory intervenes in 70% of clinical decisions, laboratory safety is crucial in patient safety. We studied the number of Laboratory Information System (LIS) demographic data errors registered in our laboratory during one year.METHODS: The laboratory attends a variety of inpatients and outpatients. The demographic data of outpatients is registered in the LIS, when they present to the laboratory front desk. The requests from the primary care centers (PCC) are made electronically by the general practitioner. A manual step is always done at the PCC to conciliate the patient identification number in the electronic request with the one in the LIS. Manual registration is done through hospital information system demographic data capture when patient's medical record number is registered in LIS. Laboratory report is always sent out electronically to the patient's electronic medical record. Daily, every demographic data in LIS is manually compared to the request form to detect potential errors.RESULTS: Fewer errors were committed when electronic order was used. There was great error variability between PCC when using the electronic order.CONCLUSIONS: LIS demographic data manual registration errors depended on patient origin and test requesting method. Even when using the electronic approach, errors were detected. There was a great variability between PCC even when using this electronic modality; this suggests that the number of errors is still dependent on the personnel in charge of the technology. 2013.
Source: Medline

Decreasing patient identification band errors by standardizing processes.
Author(s) Walley SC, Berger S, Harris Y, Gallizzi G, Hayes L
Citation: Hospital Pediatrics, April 2013, vol./is. 3/2(108-17), 2154-1663;2154-1671 (2013 Apr)
Publication Date: April 2013
Abstract: OBJECTIVE: Patient identification (ID) bands are an essential component in patient ID. Quality improvement methodology has been applied as a model to reduce ID band errors although previous studies have not addressed standardization of ID bands. Our specific aim was to decrease ID band errors by 50% in a 12-month period.METHODS: The Six Sigma DMAIC (define, measure, analyze, improve, and control) quality improvement model was the framework for this study. ID bands at a tertiary care pediatric hospital were audited from January 2011 to January 2012 with continued audits to June 2012 to confirm the new process was in control. After analysis, the major improvement strategy
implemented was standardization of styles of ID bands and labels. Additional interventions included educational initiatives regarding the new ID band processes and disseminating institutional and nursing unit data. RESULTS: A total of 4556 ID bands were audited with a preimprovement ID band error average rate of 9.2%. Significant variation in the ID band process was observed, including styles of ID bands. Interventions were focused on standardization of the ID band and labels. The ID band error rate improved to 5.2% in 9 months (95% confidence interval: 2.5-5.5; P < .001) and was maintained for 8 months. CONCLUSIONS: Standardization of ID bands and labels in conjunction with other interventions resulted in a statistical decrease in ID band error rates. This decrease in ID band error rates was maintained over the subsequent 8 months.

Source: Medline

Standardized patient identification and specimen labeling: a retrospective analysis on improving patient safety.

Author(s) Kim JK, Dotson B, Thomas S, Nelson KC
Citation: Journal of the American Academy of Dermatology, January 2013, vol./is. 68/1(53-6), 0190-9622;1097-6787 (2013 Jan)
Publication Date: January 2013
Abstract: BACKGROUND: There is an increased risk of specimen labeling errors with the generation of a high volume of pathology specimens. Measuring specimen labeling accuracy has been suggested as a possible measure for patient safety. OBJECTIVE: We sought to identify operational areas for improvement around specimen handling with the institution of a standardized specimen labeling protocol in the Duke University Medical Center Department of Dermatology. The average rates of specimen labeling events before and after implementation of this protocol were analyzed to determine the efficacy of this systematic approach. METHODS: We collected the monthly aggregated rates of specimen labeling events occurring with skin specimens processed through the Duke University Medical Center Department of Pathology from December 2008 through June 2011. The average monthly rates of events per 1000 cases for the time periods from December 2008 through March 2010 and June 2010 through September 2011 were compared. RESULTS: The data collected showed a statistically significant decline in the average monthly rate of specimen labeling errors after institution of the protocol. Before implementation, specimen labeling events occurred at a rate of 5.79 events per 1000 with a decrease to 3.53 events per 1000 after integration of this system (P = .028). LIMITATIONS: Limitations of this study include possible sampling error and regression toward the mean. CONCLUSIONS: Low-cost, process-driven interventions are effective in the reduction of specimen handling errors. Copyright 2012 American Academy of Dermatology, Inc. Published by Mosby, Inc. All rights reserved.

Source: Medline

The impact of staff safety attitude on reduction in urine specimen identification error.

Author(s) Tomoyasu, Flora, Krages, Mary, Kalowes, Peggy, McKinzie, Janice
Citation: Communicating Nursing Research, 01 January 2013, vol./is. 46/(431-431), 01601652
Publication Date: 01 January 2013
Source: CINAHL

Accurate patient identification in the emergency department.

Author(s) Thompson V
Effectiveness of barcoding for reducing patient specimen and laboratory testing identification errors: a Laboratory Medicine Best Practices systematic review and meta-analysis.


Citation: Clinical Biochemistry, September 2012, vol./is. 45/13-14(988-98), 0009-9120;1873-2933 (2012 Sep)

Publication Date: September 2012

Abstract: OBJECTIVES: This is the first systematic review of the effectiveness of barcoding practices for reducing patient specimen and laboratory testing identification errors. DESIGN AND METHODS: The CDC-funded Laboratory Medicine Best Practices Initiative systematic review methods for quality improvement practices were used. RESULTS: A total of 17 observational studies reporting on barcoding systems are included in the body of evidence; 10 for patient specimens and 7 for point-of-care testing. All 17 studies favored barcoding, with meta-analysis mean odds ratios for barcoding systems of 4.39 (95% CI: 3.05-6.32) and for point-of-care testing of 5.93 (95% CI: 5.28-6.67). CONCLUSIONS: Barcoding is effective for reducing patient specimen and laboratory testing identification errors in diverse hospital settings and is recommended as an evidence-based "best practice." The overall strength of evidence rating is high and the effect size rating is substantial. Unpublished studies made an important contribution comprising almost half of the body of evidence. Copyright 2012 The Canadian Society of Clinical Chemists. All rights reserved.

Source: Medline

Positive patient identification begins at step one... Affordable, high-resolution, dedicated ID card image scanners allow medical practices to start positive patient identification at the point of registration.

Author(s) Cunningham, Ben

Citation: Health Management Technology, 01 August 2012, vol./is. 33/8(10-11), 10744770

Publication Date: 01 August 2012

Source: CINAHL

Available in fulltext at Health Management Technology; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Available in fulltext from Health Management Technology at EBSCOhost

Accurate Patient Identification in the Emergency Department: Meeting the Safety Challenges.

Author(s) Paparella, Susan F.

Citation: JEN: Journal of Emergency Nursing, 01 July 2012, vol./is. 38/4(364-367), 00991767

Publication Date: 01 July 2012

Source: CINAHL

Reducing specimen identification errors.
Reducing specimen identification errors.

Author(s) Rees S, Stevens L, Mikelsons D, Quam E, Darcy T
Citation: Journal of Nursing Care Quality, July 2012, vol./is. 27/3(253-7), 1057-3631;1550-5065 (2012 Jul-Sep)
Publication Date: July 2012
Abstract: In 2006, the University of Wisconsin Hospital and Clinics identified that the number of specimen identification errors each month was much greater than desired and represented a significant patient safety issue. A collaborative performance improvement approach between nursing and the laboratory was undertaken for the inpatient, ambulatory, and surgical services areas, with the focus on creation of a just culture. Between 2007 and 2011, interventions were successful in significantly reducing the number of errors by 85%.
Source: Medline

He thought the "lady in the door" was the "lady in the window": a qualitative study of patient identification practices.

Author(s) Phipps E, Turkel M, Mackenzie ER, Urrea C
Citation: Joint Commission Journal on Quality & Patient Safety, March 2012, vol./is. 38/3(127-34), 1553-7250;1553-7250 (2012 Mar)
Publication Date: March 2012
Abstract: BACKGROUND: Accurate patient identification (PT ID) is a key component in hospital patient safety practices and was addressed by one of the first six Joint Commission National Patient Safety Goals, which were introduced in 2003. Although the literature on patient safety practices is replete with discussion of strategies for improvement, less is known about frontline providers' subjective views. A qualitative study was conducted to examine the subjective views and experiences of nurses and residents regarding PT ID at an urban teaching hospital.METHODS: Some 15 registered nurses and 15 residents were interviewed between August 2009 and June 2010. Transcripts were analyzed using qualitative methodologies.FINDINGS: Although residents and nurses viewed PT ID as crucial to patient safety, they cited time pressures; confidence in their ability to informally identify patients; and a desire to deliver personal, humanistic care as reasons for not consistently verifying patient identification. Nurses expressed concern about annoying, offending, and/or alienating patients by repeatedly checking wristbands and asking date of birth, in the belief that excessive patient identification practices could undermine trust. Residents relied on nurses to check ID and preferred to greet the patient by name, a practice that they viewed as more consistent with their professional identity. Referring to patients by their room number and location was cited as a commonly used practice of PT ID and a contributor to errors in
identification.

CONCLUSIONS: Nurses and residents are aware of the importance and requirements to verify PT ID, but their adherence is mitigated by a variety of factors, including assessment of necessity or risk, impact on their relationship with the patient, and practices in place in the hospital environment that protect patient privacy.

Source: Medline

Oops, sorry, wrong patient! A patient verification process is needed everywhere, not just at the bedside.

Author(s) anonymous
Citation: Alberta RN, 2012, vol./is. 67/6(18-22), 1481-9988;1481-9988 (2012)
Publication Date: 2012
Source: Medline
Available in fulltext from Alberta RN at EBSCOhost

A review of automatic patient identification options for public health care centers with restricted budgets.

Author(s) Garcia-Betances RI, Huerta MK
Citation: Online Journal of Public Health Informatics, 2012, vol./is. 4/1, 1947-2579;1947-2579 (2012)
Publication Date: 2012
Abstract: A comparative review is presented of available technologies suitable for automatic reading of patient identification bracelet tags. Existing technologies’ backgrounds, characteristics, advantages and disadvantages, are described in relation to their possible use by public health care centers with budgetary limitations. A comparative assessment is presented of suitable automatic identification systems based on graphic codes, both one- (1D) and two-dimensional (2D), printed on labels, as well as those based on radio frequency identification (RFID) tags. The analysis looks at the tradeoffs of these technologies to provide guidance to hospital administrator looking to deploy patient identification technology. The results suggest that affordable automatic patient identification systems can be easily and inexpensively implemented using 2D code printed on low cost bracelet labels, which can then be read and automatically decoded by ordinary mobile smart phones. Because of mobile smart phones’ present versatility and ubiquity, the implantation and operation of 2D code, and especially Quick Response (QR) Code, technology emerges as a very attractive alternative to automate the patients’ identification processes in low-budget situations.
Source: Medline
Available in fulltext from Online Journal of Public Health Informatics at National Library of Medicine

"I meant that med for Baylee not Bailey!": a mixed method study to identify incidence and risk factors for CPOE patient misidentification.

Author(s) Levin HI, Levin JE, Docimo SG
Citation: AMIA ... Annual Symposium Proceedings/AMIA Symposium, 2012, vol./is. 2012/(1294-301), 1559-4076;1942-597X (2012)
Publication Date: 2012
Abstract: Computerized physician order entry (CPOE) systems can create unintended consequences. These include medication errors and adverse drug events. We look at a less understood error; patient misidentification. First, two email surveys were used to establish potential risk factors for this error. Next, an automated detection trigger was designed and validated with inpatient medication orders at a large pediatric hospital. The incidence was 0.064% per medication
ordered. Finally, a case-control study identified the following as significant risk factors on multivariate analysis: patient age, last name spelling, bed proximity, medical service, time/date of order, and ordering intensity. These results can be used to improve patient safety by increasing awareness of high risk situations and guiding future research.

**Source:** Medline

Available in fulltext from AMIA Annual Symposium Proceedings at National Library of Medicine

Nurses' behaviors and visual scanning patterns may reduce patient identification errors.

**Author(s)** Marquard JL, Henneman PL, He Z, Jo J, Fisher DL, Henneman EA

**Citation:** Journal of Experimental Psychology: Applied, September 2011, vol./is. 17/3(247-56), 1076-898X;1939-2192 (2011 Sep)

**Publication Date:** September 2011

**Abstract:** Patient identification (ID) errors occurring during the medication administration process can be fatal. The aim of this study is to determine whether differences in nurses’ behaviors and visual scanning patterns during the medication administration process influence their capacities to identify patient ID errors. Nurse participants (n = 20) administered medications to 3 patients in a simulated clinical setting, with 1 patient having an embedded ID error. Error-identifying nurses tended to complete more process steps in a similar amount of time than non-error-identifying nurses and tended to scan information across artifacts (e.g., ID band, patient chart, medication label) rather than fixating on several pieces of information on a single artifact before fixating on another artifact. Non-error-identifying nurses tended to increase their durations of off-topic conversations—a type of process interruption—over the course of the trials; the difference between groups was significant in the trial with the embedded ID error. Error-identifying nurses tended to have their most fixations in a row on the patient's chart, whereas non-error-identifying nurses did not tend to have a single artifact on which they consistently fixated. Finally, error-identifying nurses tended to have predictable eye fixation sequences across artifacts, whereas non-error-identifying nurses tended to have seemingly random eye fixation sequences. This finding has implications for nurse training and the design of tools and technologies that support nurses as they complete the medication administration process. (c) 2011 APA, all rights reserved.

**Source:** Medline

Patient identification data on medical images.

**Author(s)** Van Weyenberg SJ

**Citation:** European Journal of Radiology, September 2011, vol./is. 79/3(337), 0720-048X;1872-7727 (2011 Sep)

**Publication Date:** September 2011

**Source:** Medline

Is it possible to eliminate patient identification errors in medical imaging?

**Author(s)** Danaher LA, Howells J, Holmes P, Scally P

**Citation:** Journal of the American College of Radiology, August 2011, vol./is. 8/8(568-74), 1546-1440;1558-349X (2011 Aug)

**Publication Date:** August 2011

**Abstract:** PURPOSE: The aim of this article is to review a system that validates and documents the process of ensuring the correct patient, correct site and side, and correct procedure (commonly referred to as the 3 C's) within medical imaging. METHODS: A 4-step patient identification and procedure matching
The process was developed using health care and aviation models. The process was established in medical imaging departments after a successful interventional radiology pilot program. The success of the project was evaluated using compliance audit data, incident reporting data before and after the implementation of the process, and a staff satisfaction survey. RESULTS: There was 95% to 100% verification of site and side and 100% verification of correct patient, procedure, and consent. Correct patient data and side markers were present in 82% to 95% of cases. The number of incidents before and after the implementation of the 3 C's was difficult to assess because of a change in reporting systems and incident underreporting. More incidents are being reported, particularly "near misses." All near misses were related to incorrect patient identification stickers being placed on request forms. The majority of staff members surveyed found the process easy (55.8%), quick (47.7%), relevant (51.7%), and useful (60.9%). CONCLUSION: Although identification error is difficult to eliminate, practical initiatives can engender significant systems improvement in complex health care environments.
Reducing patient identification errors related to glucose point-of-care testing.

Author(s) Alreja G, Setia N, Nichols J, Pantanowitz L
Citation: Journal of Pathology Informatics, 2011, vol./is. 2/(22), 2153-3539 (2011)
Publication Date: 2011
Abstract: BACKGROUND: Patient identification (ID) errors in point-of-care testing (POCT) can cause test results to be transferred to the wrong patient's chart or prevent results from being transmitted and reported. Despite the implementation of patient barcoding and ongoing operator training at our institution, patient ID errors still occur with glucose POCT. The aim of this study was to develop a solution to reduce identification errors with POCT.MATERIALS AND METHODS: Glucose POCT was performed by approximately 2,400 clinical operators throughout our health system. Patients are identified by scanning in wristband barcodes or by manual data entry using portable glucose meters. Meters are docked to upload data to a database server which then transmits data to any medical record matching the financial number of the test result. With a new model, meters connect to an interface manager where the patient ID (a nine-digit account number) is checked against patient registration data from admission, discharge, and transfer (ADT) feeds and only matched results are transferred to the patient's electronic medical record. With the new process, the patient ID is checked prior to testing, and testing is prevented until ID errors are resolved.RESULTS: When averaged over a period of a month, ID errors were reduced to 3 errors/month (0.015%) in comparison with 61.5 errors/month (0.319%) before implementing the new meters.CONCLUSION: Patient ID errors may occur with glucose POCT despite patient barcoding. The verification of patient identification should ideally take place at the bedside before testing occurs so that the errors can be addressed in real time. The introduction of an ADT feed directly to glucose meters reduced patient ID errors in POCT.
Source: Medline
Available in fulltext from Journal of Pathology Informatics at National Library of Medicine
Available in fulltext from Journal of Pathology Informatics at Directory of Open Access Journals

Patient identification in the laboratory: complying with NPSG.01.01.01.

Author(s)
Citation: Joint Commission Perspectives on Patient Safety, 01 January 2011, vol./is. 11/1(1-4), 15345181
Publication Date: 01 January 2011
Source: CINAHL

A pragmatics' view of patient identification.

Author(s) Lichtner V, Galliers JR, Wilson S
Citation: Quality & Safety in Health Care, October 2010, vol./is. 19 Suppl 3/(i13-9), 1475-3898:1475-3901 (2010 Oct)
Publication Date: October 2010
Abstract: BACKGROUND: Patient identification is a central safety critical aspect of healthcare work. Most healthcare activities require identification of patients by healthcare staff, often in connection with the use of patient records. Indeed, the
increasing reliance on electronic systems makes the correct matching of patients with their records a keystone for patient safety. Most research on patient identification has been carried out in hospital settings. The aim was to investigate the process of identification of patients and their records in the context of a primary healthcare clinic.

**METHOD:** A qualitative field study was carried out at a Walk-In Centre in London (UK).

**RESULTS:** The identification of patients and their records was found to be a context-dependent process, both when formalised in procedures and when relying on informal practices. The authors discovered a range of formal and informal patient identifiers were used in this setting, depending on the task at hand. The theoretical lens of Pragmatics was applied to offer an explanation of this identification process.

**CONCLUSIONS:** Context provides the cognitive scaffolding for a process of 'suitably constrained guesswork' about the identity of patients and their records. Implications for practice and for system design are discussed. Practitioners and technology designers should be aware of the risk for misidentifications inherent in this natural information processing activity.

**Source:** Medline
Available in fulltext from *Quality and Safety in Health Care* at National Library of Medicine
Available in fulltext from *Quality and Safety in Health Care* at Free Access Content
Available in fulltext from *Quality & Safety in Health Care* at EBSCOhost

**Blood sample collection and patient identification demand improvement: a questionnaire study of preanalytical practices in hospital wards and laboratories.**

**Author(s)** Wallin O, Soderberg J, Van Guelpen B, Stenlund H, Grankvist K, Brulin C

**Citation:** Scandinavian Journal of Caring Sciences, September 2010, vol./is. 24/3(581-91), 0283-9318;1471-6712 (2010 Sep)

**Publication Date:** September 2010

**Abstract:** Scand J Caring Sci; 2010; 24; 581-591 Blood sample collection and patient identification demand improvement: a questionnaire study of preanalytical practices in hospital wards and laboratories

Background: Most errors in venous blood testing result from human mistakes occurring before the sample reach the laboratory. Aims: To survey venous blood sampling (VBS) practices in hospital wards and to compare practices with hospital laboratories. Methods: Staff in two hospitals (all wards) and two hospital laboratories (314 respondents, response rate 94%), completed a questionnaire addressing issues relevant to the collection of venous blood samples for clinical chemistry testing. Results: The findings suggest that instructions for patient identification and the collection of venous blood samples were not always followed. For example, 79% of the respondents reported the undesirable practice (UDP) of not always using wristbands for patient identification. Similarly, 87% of the respondents noted the UDP of removing venous stasis after the sampling is finished. Compared with the ward staff, a significantly higher proportion of the laboratory staff reported desirable practices regarding the collection of venous blood samples. Neither education nor the existence of established sampling routines was clearly associated with VBS practices among the ward staff. Conclusions: The results of this study, the first of its kind, suggest that a clinically important risk of error is associated with VBS in the surveyed wards. Most important is the risk of misidentification of patients. Quality improvement of blood sample collection is clearly needed, particularly in hospital wards. 2009 The Authors. Journal compilation 2009 Nordic College of Caring Science.

**Source:** Medline
Available in fulltext from *Scandinavian Journal of Caring Sciences* at EBSCOhost
An intervention to decrease patient identification band errors in a children's hospital.

**Author(s)** Hain PD, Joers B, Rush M, Slayton J, Throop P, Hoagg S, Allen L, Grantham J, Deshpande JK

**Citation:** Quality & Safety in Health Care, June 2010, vol./is. 19/3(244-7), 1475-3898:1475-3901 (2010 Jun)

**Publication Date:** June 2010

**Abstract:** CONTEXT: Patient misidentification continues to be a quality and safety issue. There is a paucity of US data describing interventions to reduce identification band error rates. SETTING: Monroe Carell Jr Children's Hospital at Vanderbilt. KEY MEASURES: Percentage of patients with defective identification bands. STRATEGIES FOR CHANGE: Web-based surveys were sent, asking hospital personnel to anonymously identify perceived barriers to reaching zero defects with identification bands. Corrective action plans were created and implemented with ideas from leadership, front-line staff and the online survey. Data from unannounced audits of patient identification bands were plotted on statistical process control charts and shared monthly with staff. All hospital personnel were expected to "stop the line" if there were any patient identification questions. EFFECTS OF CHANGE: The first audit showed a defect rate of 20.4%. The original mean defect rate was 6.5%. After interventions and education, the new mean defect rate was 2.6%. LESSONS LEARNT: (a) The initial rate of patient identification band errors in the hospital was higher than expected. (b) The action resulting in most significant improvement was staff awareness of the problem, with clear expectations to immediately stop the line if a patient identification error was present. (c) Staff surveys are an excellent source of suggestions for combating patient identification issues. (d) Continued audit and data collection is necessary for sustainable staff focus and continued improvement. (e) Statistical process control charts are both an effective method to track results and an easily understood tool for sharing data with staff.

**Source:** Medline

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Available in fulltext from Quality & Safety in Health Care at EBSCOhost

Patient identification errors are common in a simulated setting.

**Author(s)** Henneman PL, Fisher DL, Henneman EA, Pham TA, Campbell MM, Nathanson BH

**Citation:** Annals of Emergency Medicine, June 2010, vol./is. 55/6(503-9), 0196-0644;1097-6760 (2010 Jun)

**Publication Date:** June 2010

**Abstract:** STUDY OBJECTIVE: We evaluate the frequency and accuracy of health care workers verifying patient identity before performing common tasks. METHODS: The study included prospective, simulated patient scenarios with an eye-tracking device that showed where the health care workers looked. Simulations involved nurses administering an intravenous medication, technicians labeling a blood specimen, and clerks applying an identity band. Participants were asked to perform their assigned task on 3 simulated patients, and the third patient had a different date of birth and medical record number than the identity information on the artifact label specific to the health care workers' task. Health care workers were unaware that the focus of the study was patient identity. RESULTS: Sixty-one emergency health care workers participated--28
nurses, 16 technicians, and 17 emergency service associates—in 183 patient scenarios. Sixty-one percent of health care workers (37/61) caught the identity error (61% nurses, 94% technicians, 29% emergency service associates). Thirty-nine percent of health care workers (24/61) performed their assigned task on the wrong patient (39% nurses, 6% technicians, 71% emergency service associates). Eye-tracking data were available for 73% of the patient scenarios (133/183). Seventy-four percent of health care workers (74/100) failed to match the patient to the identity band (87% nurses, 49% technicians). Twenty-seven percent of health care workers (36/133) failed to match the artifact to the patient or the identity band before performing their task (33% nurses, 9% technicians, 33% emergency service associates). Fifteen percent (5/33) of health care workers who completed the steps to verify patient identity on the patient with the identification error still failed to recognize the error.

CONCLUSION: Wide variation exists among health care workers verifying patient identity before performing everyday tasks. Education, process changes, and technology are needed to improve the frequency and accuracy of patient identification. Copyright (c) 2009. Published by Mosby, Inc.

Source: Medline
Available in fulltext from Annals of Emergency Medicine at the ULHT Library and Knowledge Services' eJournal collection

Reduction in specimen labeling errors after implementation of a positive patient identification system in phlebotomy.

Author(s) Morrison AP, Tanasijevic MJ, Goonan EM, Lobo MM, Bates MM, Lipsitz SR, Bates DW, Melanson SE

Citation: American Journal of Clinical Pathology, June 2010, vol./is. 133/6(870-7), 0002-9173;1943-7722 (2010 Jun)

Publication Date: June 2010

Abstract: Ensuring accurate patient identification is central to preventing medical errors, but it can be challenging. We implemented a bar code-based positive patient identification system for use in inpatient phlebotomy. A before-after design was used to evaluate the impact of the identification system on the frequency of mislabeled and unlabeled samples reported in our laboratory. Labeling errors fell from 5.45 in 10,000 before implementation to 3.2 in 10,000 afterward (P = .0013). An estimated 108 mislabeling events were prevented by the identification system in 1 year. Furthermore, a workflow step requiring manual preprinting of labels, which was accompanied by potential labeling errors in about one quarter of blood "draws," was removed as a result of the new system. After implementation, a higher percentage of patients reported having their wristband checked before phlebotomy. Bar code technology significantly reduced the rate of specimen identification errors.

Source: Medline
Available in fulltext from American Journal of Clinical Pathology at Free Access Content

Patient misidentification in laboratory medicine: a qualitative analysis of 227 root cause analysis reports in the Veterans Health Administration.

Author(s) Dunn EJ, Moga PJ

Citation: Archives of Pathology & Laboratory Medicine, February 2010, vol./is. 134/2(244-55), 0003-9985;1543-2165 (2010 Feb)

Publication Date: February 2010

Abstract: CONTEXT: Mislabeled laboratory specimens are a common source of harm to patients, such as repeat phlebotomy; repeat diagnostic procedure, including tissue biopsy; delay in a necessary surgical procedure; and the execution of an unnecessary surgical procedure. Mislabeling has been estimated to occur at a rate of
0.1% of all laboratory and anatomic pathology specimens submitted.

OBJECTIVE: To identify system vulnerabilities in specimen collection, processing, analysis, and reporting associated with patient misidentification involving the clinical laboratory, anatomic pathology, and blood transfusion services.

DESIGN: A qualitative analysis was performed on 227 root cause analysis reports from the Veterans Health Administration. Content analysis of case reports from March 9, 2000, to March 1, 2008, was facilitated by a Natural Language Processing program. Data were categorized by the 3 stages of the laboratory test cycle.

RESULTS: Patient misidentification accounted for 182 of 253 adverse events, which occurred in all 3 stages of the test cycle. Of 132 misidentification events occurring in the preanalytic phase, events included wrist bands labeled for the wrong patient were applied on admission (n = 8), and laboratory tests were ordered for the wrong patient by selecting the wrong electronic medical record from a menu of similar names and Social Security numbers (n = 31). Specimen mislabeling during collection was associated with "batching" of specimens and printed labels (n = 35), misinformation from manual entry on laboratory forms (n = 14), failure of 2-source patient identification for clinical laboratory specimens (n = 24), and failure of 2-person verification of patient identity for blood bank specimens (n = 20). Of 37 events in the analytic phase, relabeling all specimens with accession numbers was associated with mislabeled specimen containers, tissue cassettes, and microscopic slides (n = 27). Misidentified microscopic slides were associated with a failure of 2-pathologist verification for cancer diagnosis (n = 4), and wrong patient transfusions were associated with mislabeled blood products (n = 3) and a failure of 2-person verification for blood products before release by the blood bank (n = 3). There were 13 events in the postanalytic phase in which results were reported into the wrong patient medical record (n = 8), and incompatible blood transfusions were associated with failed 2-person verification of blood products (n = 5).

CONCLUSIONS: Patient misidentification in the clinical laboratory, anatomic pathology, and blood transfusion processes were due to a limited set of causal factors in all 3 phases of the test cycle. A focus on these factors will inform systemic mitigation and prevention strategies.

Source: Medline
Available in fulltext from Archives of Pathology & Laboratory Medicine at EBSCOhost
Available in fulltext at Archives of Pathology and Laboratory Medicine; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Medication safety improves after implementation of positive patient identification.

Author(s) T H, Heelon M, Siano B, Douglass L, Liebro P, Spath B, Kudler N, Kerr G

Citation: Applied Clinical Informatics, 2010, vol./is. 1/3(213-20), 1869-0327 (2010)

Publication Date: 2010

Abstract: OBJECTIVE: To report the incidence and severity of medication safety events before and after initiation of barcode scanning for positive patient identification (PPID) in a large teaching hospital. METHODS: Retrospective analysis of data from an existing safety reporting system with anonymous and non-punitive self-reporting. Medication safety events were categorized as "near-miss" (unsafe conditions or caught before reaching the patient) or reaching the patient, with requisite additional monitoring or treatment. Baseline and post-PPID implementation data on events per 1,000,000 drug administrations were compared
by chi-square with p<0.05 considered significant. RESULTS: An average of 510,541 doses were dispensed each month in 2008. Total self-reported medication errors initially increased from 20 per million doses dispensed pre-barcoding (first quarter 2008) to 38 per million doses dispensed immediately post-intervention (last quarter 2008), but errors reaching the patient decreased from 3.26 per million to 0.8 per million despite the increase in "near-misses". A number of process issues were identified and improved, including additional training and equipment, instituting ParX scanning when filling Pyxis machines, and lobbying for a manufacturing change in how bar codes were printed on bags of intravenous solutions to reduce scanning failures. CONCLUSION: Introduction of barcoding of medications and patient wristbands reduced serious medication dispensing errors reaching the patient, but temporarily increased the number of "near-miss" situations reported. Overall patient safety improved with the barcoding and positive patient identification initiative. These results have been sustained during the 18 months following full implementation.

Source: Medline
Available in fulltext from Applied Clinical Informatics at National Library of Medicine

Variable pre-transfusion patient identification practices exist in the perioperative setting.

Author(s) Burrows JM, Callum JL, Belo S, Etchells E, Leeksma A
Citation: Canadian Journal of Anaesthesia, December 2009, vol./is. 56/12(901-7), 0832-610X;1496-8975 (2009 Dec)
Publication Date: December 2009
Abstract: PURPOSE: The operating room (OR) has been identified by hemovigilance systems as a hospital area at high risk for transfusion errors. Where it was confirmed that transfusion products were being administered to the intended patient, we sought to determine the frequency that surgical patients' identification (ID) bands were inaccessible, the procedures used to identify patients when ID bands were inaccessible, and the effect on pre-transfusion bedside checks when ID bands were inaccessible.METHODS: We tracked the accuracy, location, and accessibility of patient ID bands in the operative phase over three months at a single Canadian Academic Health Sciences Centre. We also evaluated the surgical team's compliance with transfusion policy, focusing on bedside checks.RESULTS: Forty-four percent of the 426 patients who were tracked had accessible ID bands intraoperatively. The ID bands were removed from 6.3% of surgical patients, primarily for the placement of additional vascular lines. Cardiovascular procedures, which have a high frequency of transfusions, had the highest rate of ID band removals (26.9%) and the third-to-lowest ID band accessibility rate (19.2%). General surgery procedures had the lowest percentage of accessible ID bands (14.8%). Sixty-four of the 77 patients observed receiving transfusions in the OR had inaccessible ID bands due to positioning of the patient's arm, interference from equipment, or the surgeon. No patient ID bands were used at bedside checks, and addressograph cards and anesthetic records were used in place of the ID band in 97.4% and 2.6% of transfusions, respectively. CONCLUSION: Due to intraoperative inaccessibility, the system of patient ID banding has inherent limitations as a means for providing consistent pre-transfusion checks in surgical patients. A consistently accessible ID source that is continuously affixed to surgical patients should be introduced in the OR.

Source: Medline
Available in fulltext from Canadian Journal of Anaesthesia at EBSCOhost
Available in fulltext from Canadian Journal of Anesthesia at Free Access Content
Decreasing patient misidentification before chemotherapy administration.

Author(s) Spruill A, Eron B, Coghill A, Talbert G

Citation: Clinical Journal of Oncology Nursing, December 2009, vol./is. 13/6(716-7), 1092-1095;1538-067X (2009 Dec)

Publication Date: December 2009

Abstract: More accurate patient identification is a Joint Commission National Patient Safety Goal. To decrease the possibility of patient misidentification during chemotherapy administration, nurses on the Bone Marrow Transplant Unit at the University of North Carolina-Chapel Hill instituted a bedside check and measured compliance.

Source: Medline

Available in fulltext from Clinical Journal of Oncology Nursing at EBSCOhost

Observation and measurement of hand hygiene and patient identification improve compliance with patient safety practices.

Author(s) Rosenthal T, Erbeznik M, Padilla T, Zaroda T, Nguyen DH, Rodriguez M

Citation: Academic Medicine, December 2009, vol./is. 84/12(1705-12), 1040-2446;1938-808X (2009 Dec)

Publication Date: December 2009

Abstract: Measurement, a crucial step in any quality improvement activity, is difficult in two important patient safety processes: hand hygiene and patient identification. This study describes a program at the UCLA Medical Center, called Measure to Achieve Patient Safety (MAPS), which uses undergraduate student volunteers to carry out observations in the hospital. This program has been an important part of UCLA's efforts for quality improvement in patient safety efforts. Since 2004, approximately 20 students per year plus two student leaders have been selected to participate in the MAPS program. They were trained in techniques of measuring and observation and in professional behavior. They participated in weekly and monthly meetings with program leadership, received continuing education from the UCLA patient safety staff, and were trained in observational measurement. The students' observational results have been systematically reported to clinicians and departmental and hospital leadership. Handwashing increased from 50% to 93%, and nurses' checking of two identifiers at the time of medication administration increased from 50% to 95%. Compliance with proper patient identification at the time of nurse-to-transporter handoffs of patients for procedures increased to >90%. This unique program has made a significant contribution to UCLA's quality, safety, and service programs. MAPS has been widely accepted by the clinical staff and has also been valuable to the student volunteers. Such an approach is easily adaptable to other academic medical centers.

Source: Medline

Available in fulltext from Academic Medicine at Free Access Content

AAGP psychiatry rounds. Prescribing error in a geriatric outpatient due to patient
misidentification.

Author(s) Mendoza T, Meyers BS

Citation: Clinical Geriatrics, 01 December 2009, vol./is. 17/12(9-12), 10701389

Publication Date: 01 December 2009

Abstract: The prescription or administration of an incorrect medication is a common form of medication error that is associated with a high risk of serious untoward health consequences. The risk for medication errors increases at points of transition between different levels of healthcare. The authors of this AAGP Psychiatry Rounds column discuss a case of medication error due to patient misidentification in a 75-year-old female at a multispecialty teaching clinic.

Source: CINAHL

Identification of patient information corruption in the intensive care unit: Using a scoring tool to direct quality improvements in handover.

Author(s) Pickering BW, Hurley K, Marsh B

Citation: Critical Care Medicine, 01 November 2009, vol./is. 37/11(2905-2912), 00903493

Publication Date: 01 November 2009

Abstract: OBJECTIVE:: To use a handover assessment tool for identifying patient information corruption and objectively evaluating interventions designed to reduce handover errors and improve medical decision making. The continuous monitoring, intervention, and evaluation of the patient in modern intensive care unit practice generates large quantities of information, the platform on which medical decisions are made. Information corruption, defined as errors of distortion/omission compared with the medical record, may result in medical judgment errors. Identifying these errors may lead to quality improvements in intensive care unit care delivery and safety. DESIGN:: Handover assessment instrument development study divided into two phases by the introduction of a handover intervention. SETTING:: Closed, 17-bed, university-affiliated mixed surgical/medical intensive care unit. SUBJECTS:: Senior and junior medical members of the intensive care unit team. INTERVENTIONS:: Electronic handover page. MEASUREMENTS AND MAIN RESULTS:: Study subjects were asked to recall clinical information commonly discussed at handover on individual patients. The handover score measured the percentage of information correctly retained for each individual doctor-patient interaction. The clinical intention score, a subjective measure of medical judgment, was graded (1-5) by three blinded intensive care unit experts. A total of 137 interactions were scored. Median (interquartile range) handover scores for phases 1 and 2 were 79.07% (67.44-84.50) and 83.72% (76.16-88.37), respectively. Score variance was reduced by the handover intervention (p < .05). Increasing median handover scores, 68.60 to 83.72, were associated with increases in clinical intention scores from 1 to 5 (chi-square = 23.59, df = 4, p < .0001). CONCLUSIONS:: When asked to recall clinical information discussed at handover, medical members of the intensive care unit team provide data that are significantly corrupted compared with the medical record. Low subjective clinical judgment scores are significant associated with low handover scores. The handover/clinical intention scores may, therefore, be useful screening tools for intensive care unit system vulnerability to medical error. Additionally, handover instruments can identify interventions that reduce system vulnerability to error and may be used to guide quality improvements in handover practice.

Source: CINAHL

Available in fulltext from Critical Care Medicine at the ULHT Library and Knowledge Services' eJournal collection
Patient misidentification in Papanicolaou tests: a systems-based approach to reducing errors.

Author(s) Meyer E, Underwood RS, Padmanabhan V

Citation: Archives of Pathology & Laboratory Medicine, August 2009, vol./is. 133/8(1297-300), 0003-9985;1543-2165 (2009 Aug)

Publication Date: August 2009

Abstract: CONTEXT: Patient safety is of prime concern in every laboratory. Double labeling of glass slides is performed in many cytology laboratories where handwritten patient information on the frosted portion of the glass is overlaid with paper labels (sometimes containing bar codes). The cytotechnologists match this information by turning slides over. We use SurePath liquid-based cytology for Papanicolaou tests in our laboratory and noticed patient misidentification because of slide labeling errors, a problem that has not been addressed in the literature. OBJECTIVE: To reduce slide labeling errors without increasing costs, using a systems-based approach. DESIGN: All errors from mislabeled slides during November 2006 were documented, and an informal root-cause analysis was performed. Slides were labeled on opposite ends and monitored for errors. RESULTS: Labeling on different ends of the glass slide reduced our error rate from 0.59% to 0%, made visual matching easy, and did not alter costs. CONCLUSIONS: The practice of overlaying handwritten information with printed labels for liquid-based Papanicolaou tests should be strongly discouraged and replaced with placing patient information in separate portions of the glass slide so that crucial patient identification is not hidden and visual matching is easy.

Source: Medline

Available in fulltext from Archives of Pathology & Laboratory Medicine at EBSCOhost

Available in fulltext at Archives of Pathology and Laboratory Medicine; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Developing education to examine best practice and identify potential practice drift related to patient identification.

Author(s) Conyers A, Watson P, Hillson J, Williams C, Allen DH

Citation: Oncology Nursing Forum, 01 May 2009, vol./is. 36/3(61-61), 0190535X

Publication Date: 01 May 2009

Source: CINAHL

Available in fulltext from Oncology Nursing Forum at EBSCOhost

Available in fulltext at Oncology Nursing Forum; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Improving patient safety outcomes through increased compliance with patient identification.

Author(s) Knowlson SA, Roberson A

Citation: Critical Care Nurse, 01 April 2009, vol./is. 29/2(0-), 02795442

Publication Date: 01 April 2009

Source: CINAHL

Available in fulltext from Critical Care Nurse at Free Access Content

Available in fulltext from Critical Care Nurse at EBSCOhost

Available in fulltext from Critical Care Nurse at Highwire Press
The effectiveness of inking needle core prostate biopsies for preventing patient specimen identification errors: a technique to address Joint Commission patient safety goals in specialty laboratories.

**Author(s)**: Raff LJ, Engel G, Beck KR, O'Brien AS, Bauer ME  
**Citation**: Archives of Pathology & Laboratory Medicine, February 2009, vol./is. 133/2(295-7), 0003-9985;1543-2165 (2009 Feb)  
**Publication Date**: February 2009  
**Abstract**: CONTEXT: The elimination or reduction of medical errors has been a main focus of health care enterprises in the United States since the year 2000. Elimination of errors in patient and specimen identification is a key component of this focus and is the number one goal in the Joint Commission's 2008 National Patient Safety Goals Laboratory Services Program. OBJECTIVE: To evaluate the effectiveness of using permanent inks to maintain specimen identity in sequentially submitted prostate needle biopsies. DESIGN: For a 12-month period, a grossing technician stained each prostate core with permanent ink developed for inking of pathology specimens. A different color was used for each patient, with all the prostate cores from all vials for a particular patient inked with the same color. Five colors were used sequentially: green, blue, yellow, orange, and black. The ink was diluted with distilled water to a consistency that allowed application of a thin, uniform coating of ink along the edges of the prostate core. The time required to ink patient specimens comprising different numbers of vials and prostate biopsies was timed. The number and type of inked specimen discrepancies were evaluated. RESULTS: The identified discrepancy rate for prostate biopsy patients was 0.13%. The discrepancy rate in terms of total number of prostate blocks was 0.014%. Diluted inks adhered to biopsy contours throughout tissue processing. The tissue showed no untoward reactions to the inks. Inking did not affect staining (histochemical or immunohistochemical) or pathologic evaluation. On average, inking prostate needle biopsies increases grossing time by 20%. CONCLUSIONS: Inking of all prostate core biopsies with colored inks, in sequential order, is an aid in maintaining specimen identity. It is a simple and effective method of addressing Joint Commission patient safety goals by maintaining specimen identity during processing of similar types of gross specimens. This technique may be applicable in other specialty laboratories and high-volume laboratories, where many similar tissue specimens are processed.

**Source**: Medline  
Available in fulltext from Archives of Pathology & Laboratory Medicine at EBSCOhost  
Available in fulltext at Archives of Pathology and Laboratory Medicine; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Causes, consequences, detection, and prevention of identification errors in laboratory diagnostics.

**Author(s)**: Lippi G, Blanckaert N, Bonini P, Green S, Kitchen S, Palicka V, Vassault AJ, Mattiuzzi C, Plebani M  
**Citation**: Clinical Chemistry & Laboratory Medicine, 2009, vol./is. 47/2(143-53), 1434-6621;1434-6621 (2009)  
**Publication Date**: 2009  
**Abstract**: Laboratory diagnostics, a pivotal part of clinical decision making, is no safer than other areas of healthcare, with most errors occurring in the manually intensive preanalytical process. Patient misidentification errors are potentially associated with the worst clinical outcome due to the potential for misdiagnosis and
inappropriate therapy. While it is misleadingly assumed that identification errors occur at a low frequency in clinical laboratories, misidentification of general laboratory specimens is around 1% and can produce serious harm to patients, when not promptly detected. This article focuses on this challenging issue, providing an overview on the prevalence and leading causes of identification errors, analyzing the potential adverse consequences, and providing tentative guidelines for detection and prevention based on direct-positive identification, the use of information technology for data entry, automated systems for patient identification and specimen labeling, two or more identifiers during sample collection and delta check technology to identify significant variance of results from historical values. Once misidentification is detected, rejection and recollection is the most suitable approach to manage the specimen.

**Source:** Medline

Available in fulltext from *Clinical Chemistry & Laboratory Medicine* at EBSCOhost

**Patient misidentification in the NHS is recognised as a significant risk to all groups of patient's, however certain groups of patients are more vulnerable, this include neonates [sic].**

**Author(s)**

**Citation:** Journal of Neonatal Nursing, 01 October 2008, vol./is. 14/5(170-171), 13551841

**Publication Date:** 01 October 2008

**Source:** CINAHL

Available in print at Pilgrim Hospital Staff Library

**Eliminating transfusion errors related to patient misidentification: complying with NPSG.01.03.01.**

**Author(s)**

**Citation:** Joint Commission Perspectives on Patient Safety, 01 September 2008, vol./is. 8/9(1-3), 15345181

**Publication Date:** 01 September 2008

**Source:** CINAHL

**Maximizing patient safety utilizing effective patient identification and image labeling practices.**

**Author(s) Aloisio JJ**

**Citation:** Radiology Management, September 2008, vol./is. 30/5(54-9), 0198-7097;0198-7097 (2008 Sep-Oct)

**Publication Date:** September 2008

**Abstract:** Proper patient identification in the radiology setting is increasingly being recognized as a widespread safety issue. This article discusses the corrective action taken when a mislabeled portable image contributed to a patient's demise. Annual bedside portable exams at North Shore University Hospital exceed 60,000 procedures. Managing workload of this volume is extremely difficult and requires effective patient identification policies and procedures to ensure patient safety. Developing a safety culture across the radiology department is a critical component of patient safety. Staff education and ongoing re-enforcement of safety principles are fundamental elements to a successful program.

**Source:** Medline

**Picture this... putting a face to positive patient identification.**

**Author(s) Sanchez S, Weeres A**
Patient misidentification in oncology care.

Author(s): Schulmeister L

Citation: Clinical Journal of Oncology Nursing, June 2008, vol./is. 12/3(495-8), 1092-1095:1092-1095 (2008 Jun)

Abstract: Patients with cancer are at risk for patient misidentification, or "wrong patient" incidents. Patient misidentification can result in medication and transfusion errors, unnecessary testing or procedures, and, in some cases, death. Patients may be misidentified when nurses mispronounce their names, refer to them by their first or last names only, are complacent and fail to check armbands, or encounter language or communication barriers. Errors caused by patient misidentification can be prevented when healthcare providers consistently use two unique patient identifiers (other than the patient's room, examination, or chair number) to verify identities.

Source: Medline

Available in fulltext from Clinical Journal of Oncology Nursing at EBSCOhost


Author(s): Lichtner V, Wilson S, Galliers JR

Citation: Health Informatics Journal, June 2008, vol./is. 14/2(141-50), 1460-4582;1460-4582 (2008 Jun)

Abstract: The correct identification of a patient's health record is the foundation of any safe patient record system. There is no building of a 'patient history', no sharing or integration of a patient's data without the retrieval and matching of existing records. Yet there can often be errors in this process and these may remain invisible until a safety incident occurs. This article presents the findings of an ethnographic study of patient identification at a walk-in centre in the UK. We offer a view of patient identifiers as used in practice and show how seemingly simple data, such as a person's name or date of birth, are more complex than they may at first appear and how they potentially pose problems for the use of integrated health records. We further report and discuss a dichotomy between the identifiers needed to access health records and the identifiers used by practitioners in their everyday work.

Source: Medline

Patient identification in three acts.

Author(s): Fernandes L, O'Connor M

Citation: Journal of Ahima, April 2008, vol./is. 79/4(46-9; quiz 51-2), 1060-5487;1060-5487 (2008 Apr)

Publication Date: April 2008
DNA time-out procedure may help reduce patient identification error among prostate needle core biopsy specimens.

**Author(s)**

**Citation:** AHRQ Research Activities, 01 April 2008, vol./is. /332(9-9), 15370224

**Publication Date:** 01 April 2008

**Source:** CINAHL

Available in fulltext from AHRQ research activities / Agency for Healthcare Research and Quality at Free Access Content

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**Improving patient safety--everyone's job. Patient identification: an example of how the wrong man got a bath!**

**Author(s)** Reed AS

**Citation:** Home Healthcare Nurse, February 2008, vol./is. 26/2(140), 0884-741X;0884-741X (2008 Feb)

**Publication Date:** February 2008

**Source:** Medline

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**Computer-assisted bar-coding system significantly reduces clinical laboratory specimen identification errors in a pediatric oncology hospital.**

**Author(s)** Hayden RT, Patterson DJ, Jay DW, Cross C, Dotson P, Possel RE, Srivastava DK, Mirro J, Shenep JL

**Citation:** Journal of Pediatrics, February 2008, vol./is. 152/2(219-24), 0022-3476;1097-6833 (2008 Feb)

**Publication Date:** February 2008

**Abstract:** OBJECTIVE: To assess the ability of a bar code-based electronic positive patient and specimen identification (EPPID) system to reduce identification errors in a pediatric hospital's clinical laboratory. STUDY DESIGN: An EPPID system was implemented at a pediatric oncology hospital to reduce errors in patient and laboratory specimen identification. The EPPID system included bar-code identifiers and handheld personal digital assistants supporting real-time order verification. System efficacy was measured in 3 consecutive 12-month time frames, corresponding to periods before, during, and immediately after full EPPID implementation. RESULTS: A significant reduction in the median percentage of mislabeled specimens was observed in the 3-year study period. A decline from 0.03% to 0.005% (P < .001) was observed in the 12 months after full system implementation. On the basis of the pre-intervention detected error rate, it was estimated that EPPID prevented at least 62 mislabeling events during its first year of operation. CONCLUSIONS: EPPID decreased the rate of misidentification of clinical laboratory samples. The diminution of errors observed in this study provides support for the development of national guidelines for the use of bar coding for laboratory specimens, paralleling recent recommendations for medication administration.

**Source:** Medline

Available in print at Lincoln County Hospital Professional Library

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**Watermarking medical images with anonymous patient identification to verify authenticity.**

**Author(s)** Coatrieux G, Quantin C, Montagner J, Fassa M, Allaert FA, Roux C

**Publication Date:** 2008

**Abstract:** When dealing with medical image management, there is a need to ensure information authenticity and dependability. Being able to verify the information belongs to the correct patient and is issued from the right source is a major concern. Verification can help to reduce the risk of errors when identifying documents in daily practice or when sending a patient's Electronic Health Record. At the same time, patient privacy issues may appear during the verification process when the verifier accesses patient data without appropriate authorization. In this paper we discuss the combination of watermarking with different identifiers ranging from DICOM standard UID to an Anonymous European Patient Identifier in order to improve medical image protection in terms of authenticity and maintainability.

**Source:** Medline
Available in fulltext from Studies in Health Technology & Informatics at EBSCOhost

**Patient identification error among prostate needle core biopsy specimens--are we ready for a DNA time-out?**

**Author(s)** Suba EJ, Pfeifer JD, Raab SS

**Citation:** Journal of Urology, October 2007, vol./is. 178/4 Pt 1(1245-8), 0022-5347;0022-5347 (2007 Oct)

**Publication Date:** October 2007

**Abstract:** PURPOSE: Patient identification errors in surgical pathology often involve switches of prostate or breast needle core biopsy specimens among patients. We assessed strategies for decreasing the occurrence of these uncommon and yet potentially catastrophic events.MATERIALS AND METHODS: Root cause analyses were performed following 3 cases of patient identification error involving prostate needle core biopsy specimens.RESULTS: Patient identification errors in surgical pathology result from slips and lapses of automatic human action that may occur at numerous steps during pre-laboratory, laboratory and post-laboratory work flow processes.CONCLUSIONS: Patient identification errors among prostate needle biopsies may be difficult to entirely prevent through the optimization of work flow processes. A DNA time-out, whereby DNA polymorphic microsatellite analysis is used to confirm patient identification before radiation therapy or radical surgery, may eliminate patient identification errors among needle biopsies.

**Source:** Medline
Available in fulltext from Journal of Urology at the ULHT Library and Knowledge Services' eJournal collection

**Focus on five. Reducing the risk of errors involving digital imaging: reducing mislabeling and patient identification errors.**

**Author(s)**

**Citation:** Joint Commission Perspectives on Patient Safety, 01 July 2007, vol./is. 7/7(11-11), 15345181

**Publication Date:** 01 July 2007

**Source:** CINAHL

**Applying strategies that focus on laboratory specimen labeling errors can significantly reduce specimen identification errors.**

**Author(s)**

**Citation:** AHRQ Research Activities, 01 May 2007, vol./is. /321(10-10), 15370224

**Publication Date:** 01 May 2007
Patient identification: hybrids and doppelgangers.

Author(s): Cummins D

Citation: Annals of Clinical Biochemistry, March 2007, vol./is. 44/Pt 2(106-10), 0004-5632;0004-5632 (2007 Mar)

Publication Date: March 2007

Abstract: Safe laboratory practice requires accurate patient identification. Adverse events may occur when a patient has identifiers similar or identical to those of another patient (a 'doppelganger'), is doubly registered (a 'duplicate registration'), or when registration details are derived from two or more separate sources (a 'hybrid registration'). Distinguishing doppelgangers from duplicate registrations is not always easy. A search of the Harefield Hospital Patient Administration System (PAS) database revealed 39 registrations that shared a forename, surname and date of birth with at least one other registration. Thirty-seven of these cases involved a duplicate registration, one involved a hybrid registration, and one involved a doppelganger. The National Strategic Tracing Service can help with resolution of difficult cases. Many serious patient identification errors involve what the Serious Hazards of Transfusion (SHOT) Report refers to as 'extraordinary' coincidences of patients with similar names. Such coincidences are, in fact, not extraordinary, but ordinary. A major challenge will be to establish how adverse events involving coincidence can be described in a way that does not create the impression of extraordinary bad luck.

Source: Medline

Available in fulltext from Annals of Clinical Biochemistry at EBSCOhost

Registration-associated patient misidentification in an academic medical center: causes and corrections.

Author(s): Bittle MJ, Charache P, Wassilchalk DM

Citation: Joint Commission Journal on Quality & Patient Safety, January 2007, vol./is. 33/1(25-33), 1553-7250;1553-7250 (2007 Jan)

Publication Date: January 2007

Abstract: BACKGROUND: Proper patient identification is a major factor affecting patient safety in any health care organization.METHODS: An interdisciplinary team, using three Plan-Do-Study-Act (PDSA) cycles, reviewed the incidence of patient misidentifications resulting from registration process errors. Retrospective and prospective data were collected to determine the incidence among inpatients and outpatients.RESULTS: Registration-associated patient misidentification errors occurred 7 to 15 times per month. Information systems deficiencies, inadequate training, and the lack of a single master patient index were among the root causes identified. After three PDSA cycles, the incidence rate for registration-associated patient misidentification errors declined for inpatients (80.5%) but increased for outpatients (30.2%).DISCUSSION: Through an iterative process as implied in the PDSA cycle, registration-associated patient misidentification errors for established Johns Hopkins Hospital patients were dramatically reduced. A checklist is provided for other organizations to assess their vulnerability to registration-associated patient misidentification errors. The checklist suggests, for example, that organizations strive to develop a single master patient index and limit access to registration systems to staff with proper training and performance expectations.

Source: Medline
Patient safety in the clinical laboratory: a longitudinal analysis of specimen identification errors.

Author(s) Wagar EA, Tamashiro L, Yasin B, Hilborne L, Bruckner DA

Citation: Archives of Pathology & Laboratory Medicine, November 2006, vol./is. 130/11(1662-8), 0003-9985;1543-2165 (2006 Nov)

Publication Date: November 2006

Abstract: CONTEXT: Patient safety is an increasingly visible and important mission for clinical laboratories. Attention to improving processes related to patient identification and specimen labeling is being paid by accreditation and regulatory organizations because errors in these areas that jeopardize patient safety are common and avoidable through improvement in the total testing process.OBJECTIVE: To assess patient identification and specimen labeling improvement after multiple implementation projects using longitudinal statistical tools.DESIGN: Specimen errors were categorized by a multidisciplinary health care team. Patient identification errors were grouped into 3 categories: (1) specimen/requisition mismatch, (2) unlabeled specimens, and (3) mislabeled specimens. Specimens with these types of identification errors were compared preimplementation and postimplementation for 3 patient safety projects: (1) reorganization of phlebotomy (4 months); (2) introduction of an electronic event reporting system (10 months); and (3) activation of an automated processing system (14 months) for a 24-month period, using trend analysis and Student t test statistics.RESULTS: Of 16,632 total specimen errors, mislabeled specimens, requisition mismatches, and unlabeled specimens represented 1.0%, 6.3%, and 4.6% of errors, respectively. Student t test showed a significant decrease in the most serious error, mislabeled specimens (P < .001) when compared to before implementation of the 3 patient safety projects. Trend analysis demonstrated decreases in all 3 error types for 26 months.CONCLUSIONS: Applying performance-improvement strategies that focus longitudinally on specimen labeling errors can significantly reduce errors, therefore improving patient safety. This is an important area in which laboratory professionals, working in interdisciplinary teams, can improve safety and outcomes of care.

Source: Medline
Available in fulltext from Archives of Pathology & Laboratory Medicine at EBSCOhost
Available in fulltext at Archives of Pathology and Laboratory Medicine; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

No place to hide--reverse identification of patients from published maps.

Author(s) Brownstein JS, Cassa CA, Mandl KD

Citation: New England Journal of Medicine, October 2006, vol./is. 355/16(1741-2), 0028-4793;1533-4406 (2006 Oct 19)

Publication Date: October 2006

Source: Medline
Available in fulltext from New England Journal of Medicine at Free Access Content
Available in print at Lincoln County Hospital Professional Library
Available in fulltext from New England Journal of Medicine at the ULHT Library and Knowledge Services' eJournal collection


Author(s) Greenly MA

Citation: Joint Commission Journal on Quality & Patient Safety, August 2006,
Abstract: BACKGROUND: The Joint Commission on Accreditation of Healthcare Organizations National Patient Safety Goal 1, which requires the use of at least two patient identifiers, is the foundation for other patient safety goals. St. Francis Hospital involved staff and patients in the "Helping Hippocrates" Project, which used a "game" with staff and patients to ensure the accuracy of information on patients' identification (ID) bands. THE PROJECT: Members of all hospital departments assigned to a specific day were to compare the ID band with the patient census report and identify patients who had no ID band on their wrist and patients who had a band with inaccuracies. They were to also ask patients if the staff had checked the ID band before treatments or procedures. Also, the nurse manager was to select a patient to add to his or her own ID band a special band bearing the name Hippocrates. The department conducting the survey had to find Hippocrates. FINDINGS: Internal data showed that patient identification errors declined from 8.2% to a sustained zero. Patient satisfaction data showed that since the inception of Helping Hippocrates, patients' perceptions of staffs compliance with ID verification showed steady improvement. CONCLUSION: Helping Hippocrates demonstrates the value of using an innovative problem-solving strategy that engages the entire organization.

Source: Medline

Identification errors involving clinical laboratories: a College of American Pathologists Q-Probes study of patient and specimen identification errors at 120 institutions.

Author(s) College of American Pathologists, Valenstein PN, Raab SS, Walsh MK

Citation: Archives of Pathology & Laboratory Medicine, August 2006, vol./is. 130/8(1106-13), 0003-9985;1543-2165 (2006 Aug)

Abstract: CONTEXT: Misidentified laboratory specimens may cause patient injury, but their frequency in general laboratory practice is unknown. OBJECTIVES: To determine (1) the frequency of identification errors detected before and after result verification, (2) the frequency of adverse patient events due to specimen misidentification, and (3) factors associated with lower error rates and better detection of errors. DESIGN: One hundred twenty clinical laboratories provided information about identification errors during 5 weeks. RESULTS: In aggregate, 85% of errors were detected before results were released; one quarter of laboratories identified more than 95% of errors before result verification. The overall rate of patient identification errors involving released results was 55 errors per 1,000,000 billable tests. A total of 345 adverse events were reported. Most of the adverse events caused material inconvenience to the patients but did not result in any permanent harm. On average, adverse events resulted from 1 of every 18 identification errors. Extrapolating the adverse event rate observed in this study to all United States hospital-based laboratories suggests that more than 160,000 adverse events per year result from misidentification of patients' laboratory specimens. CONCLUSIONS: Identification errors are common in laboratory medicine, but most are detected before results are released, and only a fraction are associated with adverse patient events. Even when taking into consideration the design of this study, which used imperfect case finding, institutions that did a better job of detecting errors within the laboratory released a smaller proportion of results that involved specimen misidentification.

Source: Medline

Available in fulltext at Archives of Pathology and Laboratory Medicine; Collection
The patient identification debate. The history of the national patient identifier and alternatives for accurate patient authentication.

Author(s): Wheatley V
Citation: Journal of Ahima, May 2006, vol./is. 77/5(62-3, 70), 1060-5487;1060-5487 (2006 May)
Publication Date: May 2006
Source: Medline

Management consultation. Improving the accuracy of patient identification in the medication-use process.

Author(s): Trapskin PJ, White L, Armistead JA
Citation: American Journal of Health-System Pharmacy, 01 February 2006, vol./is. 63/3(218-221), 10792082
Publication Date: 01 February 2006
Source: CINAHL
Available in fulltext from American Journal of Health-System Pharmacy at EBSCOhost

NT clinical. Increasing the awareness of patient misidentification.

Author(s): Courtney T
Citation: Nursing Times, 31 January 2006, vol./is. 102/5(23-24), 09547762
Publication Date: 31 January 2006
Abstract: The scale of misidentification of patients in the health service is significant and can lead to incorrect treatment and even death. The National Patient Safety Agency has recently issues advice on how to prevent misidentification in hospitals. Within the health service as a whole, there is still potential for improved practice.
Source: CINAHL
Available in print at Lincoln County Hospital Professional Library
Available in fulltext from Nursing Times at the ULHT Library and Knowledge Services' eJournal collection

The future of patient identification.

Author(s): Fernandes L, O’Connor M
Citation: Journal of Ahima, January 2006, vol./is. 77/1(36-8, 40), 1060-5487;1060-5487 (2006 Jan)
Publication Date: January 2006
Source: Medline

Early experiences with positive patient identification.

Author(s): Halamka J
Citation: Journal of Healthcare Information Management, 2006, vol./is. 20/1(25-7), 1099-811X;1099-811X (2006)
Publication Date: 2006
Source: Medline

Patient misidentification in the neonatal intensive care unit: quantification of risk.
OBJECTIVE: To quantify the potential for misidentification among NICU patients resulting from similarities in patient names or hospital medical record numbers (MRNs).

METHODS: A listing of all patients who received care in 1 NICU during 1 calendar year was obtained from the unit's electronic medical record system. A patient day was considered at risk for misidentification when the index patient shared a surname, similar-sounding surname, or similar MRN with another patient who was cared for in the NICU on that day.

RESULTS: During the 1-year study period, 12186 days of patient care were provided to 1260 patients. The unit's average daily census was 33.4; the maximum census was 48. Not a single day was free of risk for patient misidentification. The mean number of patients who were at risk on any given day was 17 (range: 5-35), representing just over 50% of the average daily census. During the entire calendar year, the risk ranged from 20.6% to a high of 72.9% of the average daily census. The most common causes of misidentification risk were similar-appearing MRNs (44% of patient days). Identical surnames were present in 34% of patient days, and similar-sounding names were present in 9.7% of days. Twins and triplets contributed one third of patient days in the NICU. After these multiple births were excluded from analysis, 26.3% of patient days remained at risk for misidentification. Among singletons, the contribution to misidentification risk of similar-sounding surnames was relatively unchanged (9.1% of patient days), whereas that of similar MRNs and identical surnames decreased (17.6% and 1.0%, respectively).

CONCLUSIONS: NICU patients are frequently at risk for misidentification errors as a result of similarities in standard identifiers. This risk persists even after exclusion of multiple births and is substantially higher than has been reported in other hospitalized populations.

Source: Medline
Available in fulltext from Pediatrics at Free Access Content
Available in fulltext from Pediatrics at Highwire Press
Available in print at Lincoln County Hospital Professional Library

Managers forum. Patient verification before medication administration.

Author(s) O'Shields ME, Zahradnik N
Citation: JEN: Journal of Emergency Nursing, 01 October 2005, vol./is. 31/5(477-477), 00991767
Publication Date: 01 October 2005
Source: CINAHL

Identification of patients with diabetes from the text of physician notes in the electronic medical record.

Author(s) Turchin A, Kohane IS, Pendergrass ML
Citation: Diabetes Care, 01 July 2005, vol./is. 28/7(1794-1795), 01495992
Publication Date: 01 July 2005
Source: CINAHL
Available in fulltext from Diabetes Care at Free Access Content
Available in fulltext at Diabetes Care; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

Eight steps to safer care: hospital performs FMEA on patient identification.
Technology in patient safety: using identification bands to reduce patient identification errors.

**Author(s)**
Citation: Joint Commission Perspectives on Patient Safety, 01 April 2005, vol./is. 5/4(1-3), 15345181
Publication Date: 01 April 2005
Source: CINAHL

**Abstract:** As a result of human error, an estimated 1 in 12,000 blood transfusions is given to the wrong patient. The cause of nearly all of these errors is failure of hospital personnel to identify positively intended transfusion recipients, their blood samples for cross-matching, or their correct blood components. We describe our experience using a point-of-care bar code transfusion safety system that links patients' bar-coded wristbands, with bar-coded labels on blood sample tubes, blood component bags, and nurses' identification badges. The result was 100% accuracy of matching patients, their blood samples, and components for transfusions. For verifying information before starting blood transfusions, nurses preferred bar code "double checks" to conventional visual "double checks" by a second nurse. Methods are needed to reinforce nurses' proficiency with technological approaches to transfusion safety, such as software-driven bar code scanning, in situations where transfusions are administered infrequently.

Source: Medline

**Increasing the awareness of patient misidentification.**

**Author(s)** Courtney T
Citation: Nursing Times, January 0001, vol./is. 102/5(23-4), 0954-7762;0954-7762 (2006 Jan 31-Feb 6)
Publication Date: January 0001
Abstract: The scale of misidentification of patients in the health service is significant and can lead to incorrect treatment and even death. The National Patient Safety Agency has recently issued advice on how to prevent misidentification in hospitals. Within the health service as a whole, there is still potential for improved practice.
Source: Medline

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