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**Literature search results**

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**Search details**

Patient identification and misidentification

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; CINAHL; EMBASE; MEDLINE; PsychINFO; Google Scholar; Google Advanced Search

**Database search terms:** misidentify* adj3 patient*; (ident* adj3 patient* adj3 (incorrect OR wrong); PATIENT IDENTIFICATION; misident* OR incorrect* OR wrong; misident* OR incorrect* OR wrong OR correct* OR right; ident*; (misident* OR incorrect* OR wrong OR correct* OR right) adj3 patient*).

**Evidence/ Google search string(s):** (patient OR patients) (identify OR identified OR identification OR misidentify OR misidentified OR misidentification) (correct OR correctly OR incorrect OR incorrectly OR wrong OR wrong OE wrongly OR right);

"patient identification" OR "patient misidentification"

**Summary**

There seems to be a lot of research into reducing patient identification errors, depending on the aspect you’re interested in for your policy. Not much on incidence, apart from some relatively old data from NHS Patient Safety, and slightly more recent data from NHS Wales’ 1000 Lives campaign.

**Guidelines and Policy**

**1000 Lives Campaign**

Reducing Patient Identification Errors
British Association of Dermatologists

Quality standards for teledermatology: using 'store and forward' images 2013

5.1.3.7 Patient identification of the image set

Each unique patient event sent through teledermatology should include an image that identifies the patient through the inclusion of some form of unique patient identifier, such as NHS number, a case record number or initials and date of birth. It is essential that the image set be tagged with some form of unique identifier before it is sent so that there can be no misunderstanding about identification of a series of images from the same patient.

Cancer Care Ontario


- The Working Group recommends that organizations should set up a process for patient identification such that patients are identified at entry in the system, and then at each step of the treatment process, by the different members of the healthcare team involved.

- This process should include the use of at least two identifiers, the first being the patient's full name and the second being the patient's date of birth, medical record number, or other patient-identifying information, and specifics about the methods for the proper identification of patients with language barriers or special needs.

- Patients should receive an identification wristband at entry to the organization, and this should be used during their stay in the organization while receiving treatment.

- If possible, a technology such as automated identification and data capture (e.g., barcoding, radiofrequency) should be used for patient identification. Institutions that use these technologies should have policies, procedures, and staff education in place so that workarounds that threaten patient safety using automated identification systems are avoided.

Evidence Updates

Electronic Health Record-Based Patient Identification and Individualized Mailed Outreach for Primary Cardiovascular Disease Prevention: A Cluster Randomized Trial 2013

In this effectiveness trial, individualized mailed CVD risk messages increased the frequency of new lipid-lowering drug prescriptions, but we observed no difference in proportions lowering LDL-cholesterol after 9 months. With longer follow-up, the intervention's effect on LDL-cholesterol levels was apparent.

NHS Connecting for Health

Automatic identification and data capture (AIDC)

Auto-Identification and Data Capture is the use of machine readable codes such as Barcodes and Radio Frequency ID tags using the GS1 Global standards.

NHS Patient Safety

Safer patient identification 2005

Patient identification errors from failure to use or check ID numbers correctly

Quarterly Data Summary Issue 10: Learning from reporting - patient identification 2008

Royal College of Nursing
**Evidence-based reviews**

**Archives of Disease in Childhood**
A systematic review of the effectiveness of double checking in preventing medication errors 2012

There is insufficient evidence to confirm that double checking of medication reduces the risk of medication errors. This does not mean that double checking is ineffective but simply that its effectiveness has not yet been proven. More research is required to examine the effectiveness of the double checking process.

**Database of Abstracts of Reviews of Effects**
Effectiveness of barcoding for reducing patient specimen and laboratory testing identification errors: a Laboratory Medicine Best Practices systematic review and meta-analysis 2013

Bar-coding systems for specimen labelling and point-of-care test bar-coding effectively reduced patient specimen and laboratory testing identification errors in diverse hospital settings.

**London and South East Regional Medicines Information Service**
Use of bar codes for managing medications: an update 2009-2012

In relation to bar code medication administration (BCMA) systems, the papers are discussed in relation to the effects of the system on medication errors and patient safety and on the time taken to administer medicines, and barriers to and enablers of successful implementation are outlined.

**NICE Evidence QIPP**
Electronic blood transfusion: Improving safety and efficiency of transfusion systems 2013

**Published research – Databases**

1. **Physician identification and patient satisfaction in the emergency department: are they related?**.
   **Author(s)** Mercer MP, Hernandez-Boussard T, Mahadevan SV, Strehlow MC
   **Citation:** Journal of Emergency Medicine, May 2014, vol./is. 46/5(711-8), 0736-4679;0736-4679 (2014 May)
   **Publication Date:** May 2014
   **Source:** Medline

2. **Patient identification in blood sampling.**
   **Author(s)** Davidson, Anne, Bolton-Maggs, Paula
   **Citation:** Nursing Times, 12 March 2014, vol./is. 110/11(16-17), 09547762
   **Publication Date:** 12 March 2014
3. Use of safety strategies to identify children for drug administration.

Author(s) de Souza, Sabrina, Rocha, Patrícia Kuerten, de Almeida Cabral, Patrícia Fernanda, Kusahara, Denise Miyuki

Citation: Acta Paulista de Enfermagem, 01 January 2014, vol./is. 27/1(6-11), 01032100

Publication Date: 01 January 2014

Source: CINAHL

Available in fulltext at Acta Paulista de Enfermagem; 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 Acta Paulista de Enfermagem at Directory of Open Access Journals

Available in fulltext from Acta Paulista de Enfermagem at Free Access Content

4. Will the Real John Smith Please Stand Up?

Author(s) Wiedemann, Lou Ann

Citation: Journal of AHIMA, 01 January 2014, vol./is. 85/1(52-53), 10605487

Publication Date: 01 January 2014

Source: CINAHL

Available in fulltext at Journal of AHIMA; 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.

5. Patient Matching.

Author(s) Hagland, Mark

Citation: Healthcare Informatics, 01 November 2013, vol./is. 30/8(29-29), 10509135

Publication Date: 01 November 2013

Source: CINAHL

Available in fulltext at Healthcare Informatics; 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.

6. Automated patient identification and localization error detection using X-ray setup images

Author(s) Lamb J.M., Agazaryan N., Low D.A.

Citation: International Journal of Radiation Oncology Biology Physics, October 2013, vol./is. 87/2 SUPPL. 1(S584), 0360-3016 (01 Oct 2013)

Publication Date: October 2013
7. [Counter-measures against patient misidentification and specimen mismanagement with blood collection]

**Author(s)**: Ohgoe K.

**Citation**: Rinsho byori. The Japanese journal of clinical pathology, August 2013, vol./is. 61/8(739-744), 0047-1860 (Aug 2013)

**Publication Date**: August 2013

**Source**: EMBASE

8. Computerized bar code-based blood identification systems and near-miss transfusion episodes and transfusion errors.

**Author(s)**: Nuttall, Gregory A, Abenstein, John P, Stubbs, James R, Santrach, Paula, Ereth, Mark H, Johnson, Pamela M, Douglas, Emily, Oliver Jr, William C

**Citation**: Mayo Clinic Proceedings, 01 April 2013, vol./is. 88/4(354-359), 00256196

**Publication Date**: 01 April 2013

**Source**: CINAHL

Available in fulltext from Mayo Clinic Proceedings at Free Access Content

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Available in fulltext from Mayo Clinic Proceedings at National Library of Medicine

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9. Understanding and preventing wrong-patient electronic orders: a randomized controlled trial.

**Author(s)**: Adelman JS, Kalkut GE, Schechter CB, Weiss JM, Berger MA, Reissman SH, Cohen HW, Lorenzen SJ, Burack DA, Southern WN

**Citation**: Journal of the American Medical Informatics Association, 01 March 2013, vol./is. 20/2(305-310), 10675027

**Publication Date**: 01 March 2013

**Source**: CINAHL

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Available in fulltext from Journal of the American Medical Informatics Association : JAMIA at National Library of Medicine

Available in fulltext from Journal of the American Medical Informatics Association : JAMIA at National Library of Medicine

Available in fulltext from Journal of the American Medical Informatics Association (JAMIA) (älter als 12 Monate) at Free Access Content

Available in fulltext from Journal of the American Medical Informatics Association at EBSCOhost

Available in fulltext from Journal of the American Medical Informatics Association : JAMIA at National Library of Medicine
10. Oops, sorry, wrong patient! A patient verification process is needed everywhere, not just at the bedside

Author(s)

Citation: Alberta RN / Alberta Association of Registered Nurses, December 2012, vol./is. 67/6(18-22), 1481-9988 (2012 Winter)

Publication Date: December 2012

Source: EMBASE

Available in fulltext from Alberta RN at EBSCOhost

11. Patient identification and checklists

Author(s) Mandel C.

Citation: Journal of Medical Imaging and Radiation Oncology, August 2012, vol./is. 56/(36), 1754-9477 (August 2012)

Publication Date: August 2012

Source: EMBASE

Available in fulltext from Journal of Medical Imaging & Radiation Oncology at EBSCOhost

12. Reduction in pediatric identification band errors: A quality collaborative

Author(s) Phillips S.C., Saysana M., Worley S., Hain P.D.

Citation: Pediatrics, June 2012, vol./is. 129/6(e1587-e1593), 0031-4005;1098-4275 (June 2012)

Publication Date: June 2012

Source: EMBASE

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13. Identifying the right patient supports all HIT initiatives.

Author(s)

Citation: Health Management Technology, 01 June 2012, vol./is. 33/6(26-26), 10744770

Publication Date: 01 June 2012

Source: CINAHL

Available in fulltext from Health Management Technology at EBSCOhost
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Available in fulltext from Health Management Technology at EBSCOhost
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14. Patient identification band error rates at a children's hospital
15. Identifying the 'right patient': Nurse and consumer perspectives on verifying patient identity during medication administration.

**Author(s):** Kelly, Teresa, Roper, Cath, Elsom, Stephen, Gaskin, Cadeyrn

**Citation:** International Journal of Mental Health Nursing, 01 October 2011, vol./is. 20/5(371-379), 14458330

**Publication Date:** 01 October 2011

**Source:** CINAHL

Available in fulltext from International Journal of Mental Health Nursing at EBSCOhost

16. Wristbands as aids to reduce misidentification: An ethnographically guided task analysis

**Author(s):** Smith A.F., Casey K., Wilson J., Fischbacher-Smith D.

**Citation:** International Journal for Quality in Health Care, October 2011, vol./is. 23/5(590-599), 1353-4505;1464-3677 (October 2011)

**Publication Date:** October 2011

**Source:** EMBASE

Available in fulltext from International Journal for Quality in Health Care at EBSCOhost

Available in fulltext from International Journal for Quality in Health Care at Highwire Press

Available in fulltext from International Journal for Quality in Health Care at Oxford University Press

Available in fulltext from International Journal for Quality in Health Care at Free Access Content

17. Effect of staff training for correct patient identification

**Author(s):** Kerr P., Sansom V., Davies J.

**Citation:** Transfusion Medicine, October 2011, vol./is. 21/(39), 0958-7578 (October 2011)

**Publication Date:** October 2011

**Source:** EMBASE

Available in fulltext from Transfusion Medicine at EBSCOhost

18. Accuracy of patient identification in blood product administration: The role of barcodes

**Author(s):** Scamman F.L., Kemp J.

**Citation:** Anesthesia and Analgesia, August 2011, vol./is. 113/2 SUPPL. 1(64), 0003-2999 (August 2011)

**Publication Date:** August 2011

**Source:** EMBASE
19. Is it possible to eliminate patient identification errors in medical imaging?

**Author(s)** Danaher L.A., Howells J., Holmes P., Scally P.

**Citation:** JACR Journal of the American College of Radiology, August 2011, vol./is. 8/8(568-574), 1546-1440;1558-349X (August 2011)

**Publication Date:** August 2011

**Source:** EMBASE

20. Effective strategies of unequivocal identification of the patient and their biological samples

**Author(s)** Cuadrado M.A., Alvarez C., Ortega I., Arroyo M.

**Citation:** Biochemia Medica, June 2011, vol./is. 21/2(A6), 1330-0962 (June 2011)

**Publication Date:** June 2011

**Source:** EMBASE

21. Patient identification errors in an emergency department using computerized provider order entry

**Author(s)** Nguyen T., Husk G., Avram A., Gupta A., Woo K.-M., Heller M.

**Citation:** Academic Emergency Medicine, May 2011, vol./is. 18/5 SUPPL. 1(S238-S239), 1069-6563 (May 2011)

**Publication Date:** May 2011

**Source:** EMBASE


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

**Citation:** Quality & Safety in Health Care, 02 October 2010, vol./is. 19/(0-), 14753898

**Publication Date:** 02 October 2010

**Source:** CINAHL
23. Patient misidentifications caused by errors in standard bar code technology

**Author(s)** Snyder M.L., Carter A., Jenkins K., Fantz C.R.

**Citation:** Clinical Chemistry, October 2010, vol./is. 56/10(1554-1560), 0009-9147;1530-8561 (October 2010)

**Publication Date:** October 2010

**Source:** EMBASE

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Available in print at Grantham Hospital Staff Library

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24. Wrong phone numbers threaten patient safety.

**Author(s)**

**Citation:** Healthcare Risk Management, 01 July 2010, vol./is. 32/7(77-79), 10816534

**Publication Date:** 01 July 2010

**Source:** CINAHL

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25. 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, 01 June 2010, vol./is. 55/6(503-509), 01960644

**Publication Date:** 01 June 2010

**Source:** CINAHL

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


**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, 01 June 2010, vol./is. 19/3(244-247), 14753898

**Publication Date:** 01 June 2010

**Source:** CINAHL

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<td>Risk management: correct patient and specimen identification in a surgical pathology laboratory. The experience of Infermi Hospital, Rimini, Italy.</td>
<td>Fabbretti G</td>
<td>Pathologica, June 2010, vol./is. 102/3(96-101), 0031-2983;0031-2983 (2010 Jun)</td>
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<td>Patient misidentification in laboratory medicine: a qualitative analysis of 227 root cause analysis reports in the Veterans Health Administration.</td>
<td>Dunn EJ, Moga PJ</td>
<td>Archives of Pathology &amp; Laboratory Medicine, 01 February 2010, vol./is. 134/2(244-255), 00039985</td>
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<td>Right time, right surname, right procedure. Wrong patient.</td>
<td>Halstead J</td>
<td>Nursing Standard, 02 December 2009, vol./is. 24/13(28-28), 00296570</td>
<td>02 December 2009</td>
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31. Decreasing patient misidentification before chemotherapy administration.

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

**Citation:** Clinical Journal of Oncology Nursing, 01 December 2009, vol./is. 13/6(716-717), 10921095

**Publication Date:** 01 December 2009

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**Author(s)** Cohen MR

**Citation:** Nursing, 01 November 2009, vol./is. 39/11(15-15), 03604039

**Publication Date:** 01 November 2009

**Source:** CINAHL

33. Patients' positive identification systems.

**Author(s)** Pagliaro P, Turdo R, Capuzzo E

**Citation:** Blood Transfusion, October 2009, vol./is. 7/4(313-8), 1723-2007;1723-2007 (2009 Oct)

**Publication Date:** October 2009

**Source:** Medline

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34. The 3 Cs: Getting it right in Queensland health medical imaging facilities

**Author(s)** Scally P., Howells J., Velkovic J., Coulthard A.

**Citation:** Journal of Medical Imaging and Radiation Oncology, October 2009, vol./is. 53/(A76), 1754-9477 (October 2009)

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35. Perioperative patient identification: The patient identification band does not meet the needs of patients in the operating room

**Author(s)** Burrows J., Callum J., Belo S., Etchells E., Leeksma A.

**Citation:** Transfusion Medicine, October 2009, vol./is. 19/5(278), 0958-7578 (October
36. Identifying the "right patient": Mind to Care about verifying patient identity during medication administration [research note]... Mind to Care -- 35th International Mental Health Nursing Conference of the Australian College of Mental Health Nurses, 29 September - 2 October, Sheraton on the Park, Sydney, NSW, Australia.

Author(s) Kelly T

Citation: International Journal of Mental Health Nursing, 02 September 2009, vol./is. 18/(0-0), 14458330

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37. 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, 01 August 2009, vol./is. 133/8(1297-1300), 00039985

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38. Pre-analytical workstations: a tool for reducing laboratory errors.

Author(s) Da Rin G

Citation: Clinica Chimica Acta, June 2009, vol./is. 404/1(68-74), 0009-8981;1873-3492 (2009 Jun)

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39. Is this the right patient? An educational initiative to improve compliance with two patient identifiers.

Author(s) Mollon DL, Fields WL

Citation: Journal of Continuing Education in Nursing, 01 May 2009, vol./is. 40/5(221-227), 00220124

Publication Date: 01 May 2009

Source: CINAHL
40. Identify yourself. Using palm vein scanning to ID patients fits right in with the innovative culture at BayCare.

Author(s) Lawrence D

Citation: Healthcare Informatics, 01 April 2009, vol./is. 26/4(42-45), 10509135

Publication Date: 01 April 2009

Source: CINAHL

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41. Who are you? Plucked from science fiction, palm-vein patient authentication is a cutting-edge technology that can yield major cost avoidance

Author(s) Lawrence D.

Citation: Healthcare Informatics: the business magazine for information and communication systems, March 2009, vol./is. 26/3(32, 34-35), 1050-9135 (Mar 2009)

Publication Date: March 2009

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42. Fingerprint recognition to assist daily identification of radiotherapy patients

Author(s) Palmgren J.-E., Lahtinen T.

Citation: Journal of Radiotherapy in Practice, March 2009, vol./is. 8/1(17-22), 1460-3969;1467-1131 (March 2009)

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43. 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 A.J., Mattiuzzi C., Plebani M.

Citation: Clinical Chemistry and Laboratory Medicine, February 2009, vol./is. 47/2(143-153), 1434-6621;1437-4331 (01 Feb 2009)

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44. Verifying patient identity and site of surgery: improving compliance with protocol by audit and feedback.

Author(s) Garnerin P, Arès M, Huchet A, Clergue F

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45. 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

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Source: CINAHL

Available in print at Pilgrim Hospital Staff Library

46. 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

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47. Providers Do Not Verify Patient Identity during Computer Order Entry.

Author(s) Henneman PL, Fisher DL, Henneman EA, Pham TA, Mei YY, Talati R, Nathanson BH, Roche J

Citation: Academic Emergency Medicine, 01 July 2008, vol./is. 15/7(641-648), 10696563

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Author(s) Schulmeister L

Citation: Clinical Journal of Oncology Nursing, 01 June 2008, vol./is. 12/3(495-498), 10921095

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

Citation: Health Informatics Journal, 01 June 2008, vol./is. 14/2(141-150), 14604582

50. Commentary. 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, 01 February 2008, vol./is. 26/2(140-140), 0884741X

51. Prevention of bedside errors in transfusion medicine (PROBE-TM) study: a cluster-randomized, matched-paired clinical areas trial of a simple intervention to reduce errors in the pretransfusion bedside check.

Author(s) Murphy MF, Casbard AC, Ballard S, Shulman IA, Heddle N, Aubuchon JP, Wendel S, Thomson A, Hervig T, Downes K, Carey PM, Dzik WH

Citation: Transfusion, 01 May 2007, vol./is. 47/5(771-780), 00411132

52. Using a fingerprint recognition system in a vaccine trial to avoid misclassification.

Author(s)

Citation: Bulletin of the World Health Organization, 01 January 2007, vol./is. 85/1(64-67), 00429686

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

**Citation:** Joint Commission Journal on Quality & Patient Safety, 01 January 2007, vol./is. 33/1(25-33), 15537250

**Publication Date:** 01 January 2007

**Source:** CINAHL

54. Transfusion recipient identification.

**Author(s)** Pagliaro P, Rebulla P

**Citation:** Vox Sanguinis, August 2006, vol./is. 91/2(97-101), 0042-9007;0042-9007 (2006 Aug)

**Publication Date:** August 2006

**Source:** Medline

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55. Using biometrics for participant identification in a research study: a case report.

**Author(s)** Corby PM, Schleyer T, Spallek H, Hart TC, Weyant RJ, Corby AL, Bretz WA

**Citation:** Journal of the American Medical Informatics Association, 01 March 2006, vol./is. 13/2(233-235), 10675027

**Publication Date:** 01 March 2006

**Source:** CINAHL

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Author(s) Courtney T
Citation: Nursing Times, 31 January 2006, vol./is. 102/5(23-24), 09547762
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Source: CINAHL
Available in print at Lincoln County Hospital Professional Library
Available in print at Grantham Hospital Staff Library
Available in print at Pilgrim Hospital Staff Library
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57. Patient misidentification in the neonatal intensive care unit: quantification of risk.
Citation: Pediatrics, 02 January 2006, vol./is. 117/1(0-), 00314005
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Author(s) Santell JP, Camp S
Citation: RN, 01 June 2005, vol./is. 68/6(81-81), 00337021
Publication Date: 01 June 2005
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Published Research - Google Scholar
From 1st fifty results:
Errors in the administration of intravenous medications in hospital and the role of correct procedures and nurse experience BMJ Quality and Safety 2014
Checking patient identification reduced error risk by 56%

The use of patient pictures and verification screens to reduce computerized provider order
The incorporation of patient pictures within a computerized order entry verification process is an effective strategy for reducing the risk that erroneous placement of orders in a patient’s EMR will result in unintended care being provided to an incorrect patient.

Minimizing human error in radiopharmaceutical preparation and administration via a bar code-enhanced nuclear pharmacy management system Journal of Nuclear Medicine Technology 2012

The bar code–enhanced process linking the patient dose with the electronic information reduces the number of crucial points for human error and provides a framework to ensure that the prepared dose reaches the correct patient. Although the proposed flowchart is designed for a site with an in-house central nuclear pharmacy, much of the framework could be applied by nuclear medicine facilities using unit doses.


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).

Understanding and preventing wrong-patient electronic orders: a randomized controlled trial JAMA 2013

Wrong-patient electronic orders occur frequently with computerized provider order entry systems, and electronic interventions can reduce the risk of these errors occurring.

Positive Patient Identification using RFID and Wireless Networks

A Aguilar, W van der Putten, G Maguire - Citeseer

ABSTRACT The increased focus on patient safety in hospitals has yielded a flood of new technologies and tools seeking to improve the quality of patient care at the point-of-care. Hospitals are complex institutions by nature, and are constantly challenged

Setting safety standards by designing a low-budget and compatible patient identification system based on passive RFID technology

C Thuemmler, W Buchanan, V Kumar - International journal of …, 2007 - Inderscience

This paper outlines a large-scale audit for the enhancement of quality of care and staff and patient safety using passive RFID (Radio Frequency ID) wrist bands, which link to a patient’s database, in order to reduce errors in patient care. It has been developed with a ...

Minimization of patient misidentification through proximity-based medical record retrieval


Abstract—Patient misidentification in point-of-care environments can cause serious errors in medication dispersal, blood transfusions, and procedures, leading to patient injury or death. Pre-and post-operative care locations are especially susceptible to these types of errors ...

Performance Improvement: Registration-Associated Patient Misidentification in an Academic Medical Center: Causes and Corrections

MJ Bittle, P Charache… - … Commission Journal on ..., 2007 - ingentaconnect.com

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 ...

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Observation and measurement of hand hygiene and patient identification improve compliance with patient safety practices
T Rosenthal, M Erbeznik, T Padilla, T Zaroda… - Academic …, 2009 - journals.lww.com
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 ...
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Reduction in specimen labeling errors after implementation of a positive patient identification system in phlebotomy
AP Morrison, MJ Tanasijevic… - American journal of …, 2010 - ajcp.ascpjournals.org
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 ...
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An RFID and multi-agent based system for improving efficiency in patient identification and monitoring
C Turcu, T Cerlinca, C Turcu, M Cerlinca… - … on Information Science …, 2009 - nutsmumbai.co.in
Abstract: Hospital today are under increasing pressure to increase the quality and efficiency of patient identification and monitoring procedures. Most patient health records are stored in separate systems and there are still huge paper trails of records that healthcare providers ...
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The Development of a patient-identification-oriented nursing shift exchange support system using wireless RFID PDA techniques
PJ Huang, CC She, P Chang - AMIA Annual Symposium …, 2005 - ncbi.nlm.nih.gov
Abstract The objectives of this study were to technically testing the feasibility of combining RFID and PDA technologies in nursing care and to develop a support system for the nursing shift exchange, which featured with “Positive Patient Identification” and “Point of Care” for ...
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An RFID application model for surgery patient identification
BH Jeong, CY Cheng, V Prabhu… - … of Information for …, 2008 - ieeexplore.ieee.org
Abstract We suggested a workflow model to apply RFID technology to healthcare. The model is designed to improve patients’ safety during surgery, ensuring that both the correct site and patient are engaged in the surgical process. Certain types of mistakes may be ...
Cited by 6 Related articles All 2 versions Cite Save

Helping hippocrates: a cross-functional approach to patient identification
MA Greenly - Joint Commission Journal on Quality and Patient …, 2006 - ingentaconnect.com
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 ...
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Reduction of patient identification errors using technology
DR Colard - Point of Care, 2005 - journals.lww.com
Abstract Manual entry of patient information resulted in identification errors as high as 12.4% and 400-500 unidentified blood glucose results per month for the point-of-care glucose testing in St. Luke's Hospital, Kansas City, MO, prior to December 2002. These ...
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**Patient identification: hybrids and doppelgängers**
D Cummins - Annals of clinical biochemistry, 2007 - acb.sagepub.com
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 'doppelgänger'), is doubly registered (a 'duplicate registration'), or when registration...
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**He Thought the Lady in the Door Was the Lady in the Window: A Qualitative Study of Patient Identification Practices**
E Phipps, M Turkel, ER Mackenzie… - … Commission Journal on …, 2012 - ingentaconnect.com
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...
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**A pragmatics’ view of patient identification**
V Lichtner, JR Galliers, S Wilson - Quality and safety in health …, 2010 - qualitysafety.bmj.com
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...
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**Nurses’ behaviors and visual scanning patterns may reduce patient identification errors.**
JL Marquard, PL Henneman, Z He, J Jo… - Journal of …, 2011 - psycnet.apa.org
Abstract 1. 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...
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**Improving efficiency in patient identification and monitoring using RFID and multi-agent technologies**
C Turcu, T Cerlinca, C Turcu, M Cerlinca… - Proceedings of the 2nd …, 2009 - wseas.us
Abstract: Hospital today are under increasing pressure to increase the quality and efficiency of patient identification and monitoring procedures. Most patient health records are stored in separate systems and there are still huge paper trails of records that healthcare providers...
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**Positive patient identification: more than a double check**
R Aller - CAP Today October, 2005 - cap.org
First ever installation of positive patient ID system/product Most recent installation of positive patient ID system/product No. of contracts for US sites where system/product is installed, operational No. of contracts for foreign sites where system/product is installed, operational...
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**Maximizing patient safety utilizing effective patient identification and image labeling practices.**
JJ Aloisio - Radiology management, 2007 - europepmc.org
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...
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