



Patient Safety Notification

Service User Identification – Getting It Right



126

The number of incidents relating to service user identification reported on NIMS in a three-month period in 2019



Failure to correctly identify service users and missing / incorrect wristbands continues to result in:

- Medication errors
- Transfusion errors
- Diagnostic errors
- Wrong person or wrong site procedures

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Advice for enhancing correct service user identification

It is the primary responsibility of every health and social care professional to check the identity of service users and match the correct person with the correct care, before care is administered. Misidentification can result in errors in medical records, clinical time lost, and has the potential to result in harm. A standardised approach to service user identification practices across the organisation will reduce the frequency of these incidents. The [Clinical Risk Unit](#) in the [State Claims Agency](#) has noted a significant number of service user identification errors and has prepared the following advice.

Risk Considerations

A number of risk factors have been identified which may contribute to the occurrence of service user identification issues:

- Two service users with similar names or illnesses
- In an outpatient setting, where ID bands may not be used as an information source
- Service user who is non-communicative, unresponsive or confused
- Two records existing for the same service user, e.g. two records with different order of a double-barrel name
- Inadequate procedures and policies for the correct identification of service users.

Advice for Safe Practice

- Identification wristbands should include these **four core identifiers**: last name, first name, date of birth, hospital / MRN number
- On admission, use at least **two identifiers** to verify a service user's identity
- At **each encounter**, ensure the details are **correct and up to date**
- Ask the service user to **identify themselves** before receiving any **medication** and prior to any **diagnostic** or **therapeutic intervention**
- Even if the service user is familiar to the health and social care professional, **check the individual's details** to ensure the right person receives the **right care**
- Ensure **wristbands are legible** and replace those that are difficult to read
- **Encourage service users** to play an **active role** in the identification process – empower service users to **speak up** when they **identify errors** relating to their identification, procedure or care plan
- Where service users **cannot communicate**, e.g. intraoperatively, in the ICU, **alternative patient identification methods** should be employed

References:

1. The Joint Commission – Quick Safety 45: People, processes, health IT and accurate patient identification, 2018
2. The key elements organisers need to understand regarding the use of two patient identifiers – The Joint Commission 2020

Related Resources:

- [Diagnostic Imaging Patient Safety Notification](#)
- [Specimen Labelling Patient Safety Notification](#)