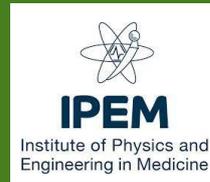




SCoR

THE SOCIETY & COLLEGE
OF RADIOGRAPHERS



Patient Identification: guidance and advice

April 2019

Review Date April 2021

Quartz House
207 Providence Square
Mill Street
London SE1 2EW

020 7740 7200
info@sor.org

www.sor.org

Contents

Summary	3
Recommendations	5
Notes for Editors	6
References	7

Summary

The Clinical Imaging Board (CIB) has revised this statement to reflect IR(ME)R 2017 and the importance of correct patient identification when undertaking diagnostic imaging procedures.

The Royal College of Radiologists, Society and College of Radiographers, and Institute of Physics and Engineering in Medicine, as the professional bodies for the radiology, radiography and medical physics workforce (hereafter referred to as the medical imaging workforce) are committed to promoting and improving the quality of care for patients and ensuring that patients are correctly diagnosed and treated^{1,2,3}. 'Right test, right patient, right time' relies on the accurate identification of any patient who requires diagnostic imaging.

The CIB expects members of the medical imaging workforce to be competent within their individual scope of practice and to follow the policies, protocols and procedures issued by their employer with regard to the positive checking of patient identification.

For imaging procedures involving ionising radiation, employers are required, under Schedule 2 of the Ionising Radiation (Medical Exposure) Regulations (IR(MER)R) 2017, to have in place 'procedures to identify correctly the individual to be exposed to ionising radiation'. The procedure must specify how an individual is to be identified before a medical exposure is made.

The procedure should be positive and active, for example, 'What is your name?'. The procedure should state by whom the individual should be identified, for example, by the operator carrying out the exposure⁴. This should be consistent across an organisation and should be developed in line with local governance systems, as required by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014⁵.

Established good practice generally requires the healthcare practitioner to ask the individual to confirm their name, address and date of birth⁶. The Care Quality Commission (CQC) have previously reported the 'wrong patient' being referred for imaging or improperly identified by staff working within the imaging department as the most commonly notified error⁷. They raise concerns that patient identification errors are still the highest category of notification, suggesting little year-on-year learning. Despite the College of Radiographers' 'pause and check' procedure being in place since 2015, the CQC still feel that errors are occurring because of a lack of adherence to this patient safety measure.

The National Patient Safety Agency recognised that reducing and, where possible, eliminating errors in matching patients with their care is one of the key ways to improve patient safety. NHS Improvement (NHSI)'s *Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018* include two safer practice notices calling for the use of standardised wristbands in all acute hospital in-patient settings⁸. The alerts highlight the importance of patient identification wristbands displaying information that accurately identifies the patient and matches them to their care and the requirement that the wristband demonstrates only four core identifiers:

- last name
- first name
- date of birth
- NHS number (if the NHS number is not immediately available, a temporary number should be used until it is)

NHSI go on to recommend that a local risk assessment is undertaken before any additional identifiers are included. Patient identification wristbands should be clearly distinguished by the use of black text on a white background. Similarly, where a wristband is used to alert risk, for example, red for allergy, the wristband should be red with patient identifiers in black text on a white panel.

Where identification cannot be confirmed verbally, it may be necessary to match referral details to wristbands or use bar code/electronic tagging verification. The source document or record against which details are checked must be specified and this should be linked to the individual's NHS number⁸ or other unique identifier, wherever possible. It is important that the staff member performing the identification check can be identified at a later date by a signature on the request form or, more commonly, from an electronic signature. If there are two individuals involved with the exposure, the person responsible for initiating the exposure and the person performing the ID check must be clearly identifiable and their responsibilities agreed in advance. This should be described in the employer's procedures.

The employer should have clearly documented procedures in place for situations where individuals are unable to actively respond to identifying questions. These may be patients living with dementia or learning or sensory disabilities, individuals who are non-English speaking, those who are unconscious (including in the operating theatre), children, and unidentified patients involved in major accidents. NHSI have issued a patient safety alert, *Safer temporary identification criteria for unknown or unidentified patients*⁹, and have developed resources to enable its implementation by providers of emergency care¹⁰.

Employers, and colleagues in the imaging workforce, are recommended to review their practice and procedures in light of this guidance and that contained in the CQC annual report, with a view to taking a risk-based approach to introducing checks additional to the patient ID procedure.

Recommendations

Local procedures should include the following.

1. Confirming name, address, date of birth (as is current established practice under IR(ME)R).
2. Confirming timing, modality, site/laterality.
3. Checking against original (or scanned-in) request forms.
4. Checking previous imaging, where possible (at 'justification and authorisation' AND/OR on date of examination).
5. Checking the possibility of pregnancy.
6. Enquiries of patients/individuals themselves (it may be necessary to explain why the same questions are repeated at different stages through the patient pathway).
7. Arrangements for practitioners and operators to check with the referrer where there is any doubt on the request form itself or following checks with the patient/individual.
8. Selection of the correct protocol/radiographic factors/geometry/automatic exposure control (AEC) settings.
9. Referrer checks of ID and previous imaging; referrer training on electronic requesting systems, including training in how to cancel requests made in error.
10. Arrangements for inpatients and admitted patients concerning fitting of a wristband⁸ (some organisations adopt a 'no wristband – no x-ray' policy), and arrangements on the ward for patients with similar or identical names where there may be potential for confusion, and whether there are any circumstances in which radiographers can rely solely on ward staff to direct them to the intended patient.
11. Specific guidance for student radiographers and trainee assistant practitioners¹¹.
12. The use of wristbands and bar codes where available.

This statement has been prepared on behalf of the CIB with contributions from Public Health England and the CQC.

Dr Nicola Strickland
President of The Royal College of Radiologists

Mrs Sue Webb
President of the Society and College of Radiographers

Professor Mark Tooley
President of the Institute of Physics and Engineering in Medicine

Notes for Editors

The Clinical Imaging Board (CIB) is a collaboration between the Royal College of Radiologists (RCR), the Institute of Physics and Engineering in Medicine (IPEM) and the Society and College of Radiographers (SCoR). It was set up in 2013 to provide leadership on issues related to medical imaging. The CIB's *Vision for Clinical Imaging in the UK* can be [downloaded here](#).

The current Chair of the CIB is Mr Steve Herring.

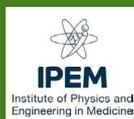
The Royal College of Radiologists (charity no: 211540) has over 10,600 Fellows and Members worldwide, representing the specialties of clinical oncology and clinical radiology. The College sets and maintains the standards for entry to, and practice in, the specialties of clinical radiology and clinical oncology, in addition to leading and supporting practitioners throughout their careers. See www.rcr.ac.uk

The Institute of Physics and Engineering in Medicine (charity no: 1047999) is the professional organisation for physicists, clinical and biomedical engineers and technologists working in medicine and biology. Its aim is to advance physics and engineering applied to medicine and biology for the public good. See www.ipem.ac.uk

The Society and College of Radiographers (charity no: 272505) represents the professional interests of 29,000 health practitioners who work in diagnostic imaging and radiotherapy. See <https://www.sor.org>

References

1. Royal College of Radiologists, Strategy 2017-20. Available at: https://www.rcr.ac.uk/sites/default/files/rcr171_strategy_2017-20.pdf [Accessed 17 October 2018].
2. Society and College of Radiographers, The 2018-2020 Strategy of the Society and College of Radiographers. Available at <https://www.sor.org/about-us/council/strategy> [Accessed 17 October 2018].
3. Institute of Physics and Engineering in Medicine, About IPEM. IPEM. [Online] [Cited: 17 07 2014]. Available at: <http://www.ipem.ac.uk/AboutIPEM.aspx> [Accessed 17th October 2018]
4. Department of Health and Social Care, Guidance to the Ionising Radiation (Medical Exposure) Regulations 2017. Available at: <https://www.gov.uk/government/publications/ionising-radiation-medical-exposure-regulations-2017-guidance> [Accessed 17 October 2018].
5. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No.2936 (2014). (Queen's Printer of Acts of Parliament). Available at: <https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents> [Accessed 12 December 2018].
6. Society and College of Radiographers, British Institute of Radiology and Royal College of Radiologists, A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology. Available at: <http://www.sor.org/learning/document-library/guide-understanding-implications-ionising-radiation-medical-exposure-regulations-diagnostic-and> [Accessed 17 October 2018] – revision in progress 2019.
7. Care Quality Commission, IR(ME)R annual report 2016. Available at: <https://www.cqc.org.uk/files/irmer-annual-report-2016> [Accessed 20 February 2019] .
8. NHS Improvement (2018). Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018. Available at: https://improvement.nhs.uk/documents/2267/Recommendations_from_NPSA_alerts_that_remain_relevant_to_NEs_FINAL.pdf [Accessed 20 December 2018].
9. NHS Improvement (2018). Patient Safety Alert. Safer temporary identification criteria for unknown or unidentified patients. Available at: https://improvement.nhs.uk/documents/3535/Patient_Safety_Alert_-_unknown_or_unidentified_patients_FINAL.pdf [Accessed 20 December 2018].
10. NHS Improvement (2018). Resources to support safer temporary identification criteria for unknown or unidentified patients. Available at: <https://improvement.nhs.uk/resources/resources-to-support-safer-temporary-identification-criteria/> [Accessed 20 December 2018].
11. Society and College of Radiographers (2010). Student radiographers and trainee assistant practitioners: verifying patient identification and seeking consent. Available at: <https://www.sor.org/learning/document-library> [Accessed 20 December 2018].



Material may only be reproduced from this publication
with clear acknowledgement that it is the original source.