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Summary

Local integrated investigation pilot 2: Incorrect patient details on handover

Independent report by the
Healthcare Safety Investigation Branch NI-003716
for the local integrated investigation pilot

January 2022

Providing feedback and comment on HSIB reports

At the Healthcare Safety Investigation Branch (HSIB) we welcome feedback on our investigation reports. The best way to share your views and comments is to email us at **enquiries@hsib.org.uk** or complete our online feedback form at **www.hsib.org.uk/tell-us-what-you-think**.

We aim to provide a response to all correspondence within five working days.

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About HSIB

We conduct independent investigations of patient safety concerns in NHS-funded care across England. Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or the potential for harm to patients. The safety recommendations we make aim to improve healthcare systems and processes, to reduce risk and improve safety.

We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability.

Considerations in light of coronavirus (COVID-19)

A number of HSIB national investigation reports were in progress when the COVID-19 pandemic significantly affected the UK in 2020. Much of the work associated with developing the reports necessarily ceased as HSIB's response was redirected.

For this national report, the investigation continued as the pandemic progressed due to its association with COVID-19.

A note of acknowledgement

We would like to thank the family of Mrs E, whose experience is documented in this report. We would also like to thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

Local integrated investigation pilot

This investigation has been published as part of HSIB's local integrated investigation pilot (local pilot). The local pilot was launched to evaluate HSIB's ability to carry out effective local investigations with actions aimed at specific trusts or hospitals, while still identifying and sharing relevant national learning. After evaluation, consideration will be given as to whether this model can be implemented more widely by HSIB.

This investigation report presents the findings of one of four investigations within the local pilot. It provides the investigation's findings and makes safety recommendations and safety observations to support local improvements in patient safety. The report also identifies safety risks that HSIB might address through a potential future national investigation.

This report is intended for healthcare organisations and the public to help improve patient safety. For readers less familiar with this area of healthcare, medical terms are explained throughout.

Our investigations

Our investigators and analysts have diverse experience of healthcare and other safety-critical industries and are trained in human factors and safety science. We consult widely in England and internationally to ensure that our work is informed by appropriate clinical and other relevant expertise.

We undertake patient safety investigations through two programmes:

National investigations

Concerns about patient safety in any area of NHS-funded healthcare in England can be referred to us by any person, group or organisation. We review these concerns against our investigation criteria to decide whether to conduct a national investigation. National investigation reports are published on our website and include safety recommendations for specific organisations. These organisations are requested to respond to our safety recommendations within 90 days, and we publish their responses on our **website**.

Maternity investigations

We investigate incidents in NHS maternity services that meet criteria set out within one of the following national maternity healthcare programmes:

- Royal College of Obstetricians and Gynaecologists' 'Each Baby Counts' report
- MBRRACE-UK 'Saving Lives, Improving Mothers' Care' report.

Incidents are referred to us by the NHS trust where the incident took place, and, where an incident meets the criteria, our investigation replaces the trust's own local investigation. Our investigation report is shared with the family and trust, and the trust is responsible for carrying out any safety recommendations made in the report.

In addition, we identify and examine recurring themes that arise from trust-level investigations in order to make safety recommendations to local and national organisations for system-level improvements in maternity services.

For full information on our national and maternity investigations please **visit our website**.

Executive Summary

The safety event

This investigation focuses on the systems and procedures that are in place to help health and care staff to correctly identify patients. It explores how the incorrect identification of a patient can have an impact on their treatment. To do this it uses a real patient safety event involving a patient who was cared for by a nursing home, an Ambulance Trust and an Acute Trust (that is, a local hospital with an emergency department).

The safety event involved Mrs E, a woman aged 93 with dementia. Mrs E was taken by ambulance to her local emergency department (ED) after a fall in her nursing home, accompanied by an escort from the nursing home. Incorrect patient details (date of birth and spelling of surname) were used to try to book Mrs E into the ED. The ED staff were unable to find Mrs E's details on the digital patient management systems available. A new patient record was created with the incorrect patient details. After having an X-ray in the radiology department, which confirmed that Mrs E did not have a fracture, she was discharged the same day.

The next day, after another fall in the nursing home, Mrs E was taken to the same ED by ambulance. She was booked in under the new patient record created the previous day, with the incorrect patient details. Mrs E had an X-ray which confirmed a fractured neck of femur (broken hip) and she was admitted to the hospital for surgery.

Mrs E had surgery the next day, during which the pathology department identified a problem with the accuracy of her personal identification information. Following surgery, Mrs E's correct identification details were confirmed, and her past hospital notes were gathered. The two sets of patient records were merged.

The investigation focused on the key communication points in Mrs E's care pathway at which her identification details were handed over. The systems and procedures in place within each care provider, including their local practice and guidance, were reviewed.

Findings

The investigation found the following:

- The nursing home care records available to staff had varying levels of risk of incorrect personal identification data (PID) associated with them.
- Although the Red Bag policy (a method of transferring a patient's medical records, medication and personal belongings when they go into hospital) could not be followed in full due to the COVID-19 pandemic, the nursing home continued to provide the same patient documentation.
- When it was not possible to retrieve Mrs E's NHS number from NHS Spine (the IT system through which patient information is shared across NHS organisations), this indicated an increased risk that the PID captured may not have been reliable.
- The Ambulance Trust did not consider the NHS number as a primary patient identifier.
- There was an increased risk of incorrect patient PID being recorded by the emergency operations centre (EOC) because it was using 'emergency rules apply' procedures. This risk, which had been assessed and accepted by the EOC, was transferred to the Acute Trust without its knowledge when Mrs E was booked in at the ED.
- Incorrect PID on the Ambulance Trust electronic patient record form was not corrected through cross-checking with provided nursing home documentation.
- The functionality and sensitivity of the Personal Demographic Service search (a search of the database of users of health services in England) meant potential matches were not offered when any inaccurate patient PID was entered.
- There was no evidence of a standardised and consistent patient 'booking-in' procedure in the ED. This was influenced by:
  - there being no formal Acute Trust 'booking-in' procedure
  - the individual practices of Acute Trust and Ambulance Trust staff
  - staff capacity
  - inconsistent use of available patient documentation provided
  - inconsistent use of additional PID sources such as nursing home escorts and external healthcare organisations.

- The Acute Trust (except pathology) did not consider the NHS number to be a primary patient identifier in reducing the safety risk of incorrect patient identification. Mrs E's NHS number was missing; this did not prompt further action to verify her PID either during the booking-in procedure or when her care was transferred between internal departments.

- The combination of the sensitivity of the Acute Trust digital systems, and the reliance on staff to understand how their search functions worked, did not support positive patient identification when provided with aspects of incorrect PID.

- The Acute Trust does not currently have a system to help staff visually identify patients with dementia. Such a system may help staff to adapt their patient identification procedure accordingly.

- By promoting the use of information on the patient identification band when a verbal 'ask, check, confirm' process cannot be carried out, the Acute Trust's positive patient identification policy enables the internal transfer of patients with incorrect PID.

- Ensuring that a patient identification band with accurate PID is placed on a patient with dementia on admission to the Acute Trust was identified by the investigation as the single safeguard to prevent the risk of incorrect PID 'following' patients, specifically those with dementia, when they are transferred between Acute Trust departments.

- The pathology information management system had an inherent safety control; it identified a PID issue due to Mrs E not having an NHS number.

The investigation also identified the following learning points that could potentially offer benefits at a national level:

- The correct identification of patients relies on staff checking patient details and therefore will not always occur effectively. There may be opportunities for further engineered or technological barriers to help mitigate the risk of incorrect identification.

- The investigation recognises that a single hospital trust may receive patients from multiple ambulance trusts, and ambulances from a single ambulance trust may attend several hospital trusts. Pathways and procedures potentially vary across different trusts and a consistently agreed approach may not exist.

- There may be variation across the country in how NHS numbers are used by trusts for identification of patients. The investigation found that the NHS number may not be being used as per national expectations.

Safety recommendations, safety observations and safety risk

Safety recommendations are directed to a specific organisation for action. They are based on information derived from the investigation and are made with the intention of preventing future, similar events.

HSIB makes the following local safety recommendations

Safety recommendation R/2022/170:
HSIB recommends that the nursing home implements a mechanism to use care records with the lowest risk of having incorrect personal identification data during interactions with the wider healthcare system.

Safety recommendation R/2022/171:
HSIB recommends that the Ambulance Trust carries out additional personal identification data verification when a successful Patient Demographic Service search via NHS Spine has not been achieved.

Safety recommendation R/2022/172:
HSIB recommends that the Acute Trust, in collaboration with the Ambulance Trust, develops and implements a formal emergency department booking-in policy.

Safety recommendation R/2022/173:
HSIB recommends that the Acute Trust carries out additional personal identification data verification when an NHS number is not available.

Safety recommendation R/2022/174:
HSIB recommends that the Acute Trust tests its positive patient identification procedure for patients with dementia in order to identify risks and support the development of effective mitigating controls.

HSIB makes the following local safety observations

Safety observation O/2022/143:
It may be beneficial if the Acute Trust reviews the infrastructure and layout of the emergency department majors area in order to support the flow co-ordinator to reliably carry out their full responsibilities.

Safety observation O/2022/144:
It may be beneficial if the Acute Trust considers the results of current research to understand whether a way of visually identifying patients with dementia would be appropriate to help positive patient identification.

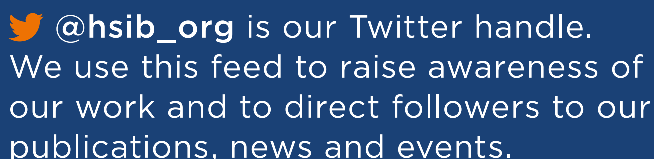
HSIB notes the following specific national safety risk

The NHS number is a unique identifier for people living in England (and Wales). There is a risk to the accurate identification of patients when the NHS number is not used as the primary patient identifier.

Further information

More information about HSIB – including its team, investigations and history – is available at **www.hsib.org.uk**

If you would like to request an investigation then please read our **guidance** before contacting us.



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