HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

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Summary

Local integrated investigation pilot 1: Incorrect patient identification

Independent report by the
Healthcare Safety Investigation Branch NI-003718
for the local integrated investigation pilot

November 2021

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.

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

The investigation would like to thank the Patient whose experience is documented in this report, and her family. The investigation 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 the Healthcare Safety Investigation Branch (HSIB)'s local integrated investigation pilot (local pilot). The local pilot was launched to evaluate HSIB's ability to carry out effective locality-based investigations (that is, investigations occurring between specific hospitals or trusts). After an evaluation, it will be decided whether this model can be implemented more widely by HSIB.

This report presents the findings of one of the investigations that comprise the local pilot. It provides an overview of 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 might be addressed by a potential future national investigation by HSIB.

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

The Patient (Patient 1), a woman aged 75 years, was taken to an emergency department (ED) by ambulance in April 2021. This followed a 999 call from Patient 1's Granddaughter to the emergency operations centre.

The emergency operations centre used the wrong NHS number for Patient 1. They used the NHS number of another individual (Patient 2), who had the same date of birth as Patient 1 and a similar name.

On arrival in the ED, Patient 1 was booked in under Patient 2's NHS number. This NHS number continued to be used during Patient 1's time in hospital.

Initially, Patient 1 received medication prescribed by an ED doctor, based on her own supply brought in by her family. Following a pharmacy review on day 7 of admission, the medications were changed to those taken by Patient 2.

The Patient declined to take the incorrect medication; it was unclear why. The error was identified by a pharmacist the following day as an incidental observation of an unfamiliar medication.

The investigation focused on the key communication points in Patient 1's care pathway where details of the Patient's identification were handed over. The systems and processes in place with each provider (that is, the Ambulance Trust and the Acute Trust), including their local practices and guidance, were reviewed.

Findings

The investigation found the following:

- The first names and surnames of people from South Asian communities are often used interchangeably, and not all names are necessarily used in all situations (as occurred in this case).

- When the exact date of a person's birth is not known, some ethnic communities have a standard approach of recording the date of birth as 1 January, followed by the year. The Patient in the investigation was from a South Asian community, where this practice is common.

- There were no formal written procedures in the emergency operations centre for call assessors to follow in relation to patient identification.

- Patient identification was not included as a topic in the formal, standardised training for call assessors during their induction period (or subsequently).

- The NHS number was rarely used as a key identifier by call assessors answering 999 calls.

- The emergency operations centre regularly audited its calls, but the audit did not include specific questions on patient identification. It was therefore difficult to determine how frequently identification errors occur.

- Induction training for ambulance crews focused mainly on the clinical assessment of patients. Patient identification was not formally taught.

- In practice, ambulance crews varied in the way they learned and applied patient identification.

- There was no formal process between the Ambulance Trust and the Acute Trust to verify a patient's identity.

- ED reception staff had different practices for entering patients into the patient-tracking software, and there was no formal process.

- There were several different digital systems within the ED and the wider Acute Trust, with varying interoperability (that is, the ability of different IT systems to communicate and share information).

- Staff at the Acute Trust were unaware of the requirement to obtain three pieces of information to verify a patient's identity, as detailed in the Trust's patient identification policy, before giving the patient a wristband.

- The Trust's patient identification policy did not include use of the patient's NHS number.

- There was no formal identification process for patients being transferred from the ED to the medical assessment unit, or from the medical assessment unit to the ward.

- Once the Patient's misidentification was discovered, her records were promptly amended and relevant staff and the Patient's family were informed.

The investigation identified the following learning points for potential national benefit:

- 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 decrease the chance of incorrect identification.

- The design of the digital systems considered in this investigation did not always account for variations in how people identify themselves (for example, by different names). Those systems also did not make it clear to staff where patient demographics (that is, details such as the patient's name, date of birth, address and NHS number) might be incorrect.

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

- The use of NHS numbers to identify patients may vary across the country. The investigation found that the NHS number may not be being used according to national expectations.

Safety recommendations, safety observations, safety actions and safety risks

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/2021/161:
HSIB recommends that the Ambulance Trust develops and implements a standardised approach to patient identification in the emergency operations centre.

Safety recommendation R/2021/162:
HSIB recommends that the Acute Trust develops and implements a standardised approach to patient identification in the emergency department.

Safety recommendation R/2021/163:
HSIB recommends that the Acute Trust explores the barriers to checking three identifiers when confirming a patient's identification for their wristband, and takes appropriate action.

HSIB makes the following regional safety recommendation

Safety recommendation R/2021/164:
HSIB recommends the Acute Trust work with the Ambulance Trust to develop and implement a standardised approach to verifying and confirming a patient's identification during the handover process.

HSIB makes the following safety observations

Safety observation O/2021/133:
It may be beneficial if the Ambulance Trust develops mechanisms to capture the NHS number at the point of initial contact.

Safety observation O/2021/134:
It may be beneficial if further national work is undertaken on the use of the NHS number as a unique identifier, specifically in identifying patients.

Safety observation O/2021/135:
It may be beneficial if the Acute Trust considers the interoperability of its IT systems (that is, the ability of different IT systems to communicate and share information) as part of its digital strategy and in future procurement.

Safety observation O/2021/136:
It may be beneficial if the Ambulance Trust adjusts its call audit tool to assess whether patient identification is correctly confirmed.

HSIB notes the following safety actions

Safety action A/2021/049:
The Ambulance Trust training department has implemented training on patient demographics within its test system. Emergency operations centre staff receive this training during their formal induction.

Safety action A/2021/050:
The Ambulance Trust is designing a confirmation checkpoint, which will be included in the electronic patient record for ambulance crews to confirm the correct identification.

Safety action A/2021/051:
The Ambulance Trust now includes the importance of patient identification, including using the NHS number to verify a patient's identification, in its mandatory training.

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 chance that a patient may be incorrectly identified when the NHS number is not used.

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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.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

Contact us

If you would like a response to a query or concern please contact us via email using **enquiries@hsib.org.uk**

We monitor this inbox during normal office hours - Monday to Friday from 09:00 hours to 17:00 hours. We aim to respond to enquiries within five working days.

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