1 Introduction

The most essential step in any diagnostic testing or treatment process is to establish positively and beyond doubt, the correct patient identity. Failure to do so can lead to the patient being misdiagnosed, wrongly treated and potentially harmed. Over 80% of all patient diagnoses and subsequent management of treatment depends upon support service testing.

The vast majority of errors associated with patient testing are pre-analytical in nature and almost all of these are as a direct consequence of incorrect patient identification and inaccurate labelling. Poor patient identification means that subsequent testing is both expensive and meaningless and can present significant potential danger to the patient.

Individual staff member responsibilities for ensuring correct patient identification are described in more detail in the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) Patient Identification Policy. This was introduced to facilitate the highest level of patient safety and ensure that all patients are positively and correctly identified on every occasion. It is intended to ensure that all staff involved in patient identification processes, are fully aware of their responsibilities and understand the significance and importance of using wristbands for identification.

Patient identification e-record barcode labels can now be produced as a functionality of the system and these are widely used in a variety of diagnostic testing processes. This has, however, led to an increase in the number of diagnostic test incidents resulting from incorrect patient identification and/or information provided.

In the case of pathology specimens, a failure to label the samples in the presence of the patient and/or to carry out the checks as required by Trust policy is the root cause in nearly every incident of poor identification/ mislabelling. It is most likely this will apply to other diagnostic services e.g. Radiography. Similarly the pre-printing of labels in advance of sample taking produces issues with perceived sample age and subsequent viability upon arrival in the laboratories. In addition the lack of relevant information on requests can be an obstruction to the interpretation of diagnostic test results.
Labelling requirements are described in the NUTH Sample Acceptance and Rejection Policy.

2 Scope

The policy applies to Newcastle upon Tyne Hospitals NHS Foundation Trust (The Trust) and includes all people who use or work the Trust, including employees, honorary contract holders, researchers, trainees, clinical observers and other contractors or individuals involved in patient care.

This policy covers the requirements for ensuring that the identity of a patient is correctly established before any Laboratory Medicine diagnostic tests are ordered and subsequently performed. It is highly likely however, that this process will apply to all diagnostic testing and could have numerous areas of application, including all treatment processes involving other support specialities such as Radiography, Chiropody, Cardiology, Speech Therapy, Optometry, Pharmacy and all point of care testing processes. This list is not exhaustive and represents a limited number of examples of the much broader range of tests and treatment procedures carried out within the Trust. The principles however apply to all Trust areas that undertake diagnostic/treatment processes, where failure to positively identify the patient would have detrimental consequences.

3 Aims

3.1 To ensure that the correct patient is identified before any specimens are taken for diagnostic testing.

3.2 To ensure that full and correct patient labelling is applied to all specimens that are taken for diagnostic testing.

3.3 To ensure that the Trust labelling policy is completely followed on every occasion and that this is performed in at the patient’s side.

3.4 To ensure that the electronic ordering and subsequent processing steps involved in diagnostic testing, is done in strict adherence to the procedures described in the Trust e-record policies.

3.5 To remove the risk of incorrect patient identification when requesting diagnostic tests.

4 Duties (Roles and responsibilities)

4.1 The Trust’s overall responsibility is to ensure that patients are positively and correctly identified before any procedure, including support diagnostic testing, is performed.
4.2 Directorate Managers and Directorate Directors have the responsibility for ensuring that staff are aware of and fully comply with all relevant elements of this policy. They must raise awareness within their directorates with particular emphasis on staff responsibilities. They must ensure that full and complete training is fulfilled and that competence assessment is carried out and recorded.

4.3 All staff must adhere to the policy and are personally responsible for their own actions. They must not deviate from protocol and must undertake training as required and ensure that this is applied as reflective practice.

5 Definitions

- The Trust means The Newcastle upon Tyne Hospitals NHS Foundation Trust.
- MRN means the Medical Record Number.

6 Main body of the policy

**PROCESS**

The person taking any specimen is directly responsible for ensuring that the patient is positively and correctly identified and that patient details correspond to the information given on both the specimen/s and any accompanying request form.

6.1 If the patient is conscious and competent then labelling must be done by receiving verbal confirmation of details from ‘open’ questions. The patient should be asked to state their full name, address and date of birth. Their MRN and/or NHS number should be obtained from their wristband if present.

6.2 In the case of Cellular Pathology specimens, if the patient has no wristband or is not deemed to be competent to give reliable details then they should be provided by an accompanying parent/guardian/carer who has signed the consent form for the procedure.

6.3 Where the patient is anaesthetised, sedated or not competent to answer questions, specimen labelling should be checked against the wristband or photo identification badge and should include all of details described in point 1. above.

**E-Record Ordering Procedure**

The following General process flow must be strictly followed without exception:

6.4 Place the electronic order (described below).
6.5 Generate the appropriate labels for the sample/s.

6.6 Take the labels to the patient (do not place on the samples at this point).

6.7 Check the data with the patient wrist band/photo identification badge and identify the patient by asking them to state their name and date of birth (open ended questions).

6.8 Obtain the specimen/s from the patient.

6.9 Label the specimen/s in the presence of the patient.

6.10 When taking the specimen/s, do not present with any labels that refer to another patient.

**E-Record Ordering Process**

All personnel responsible for ordering Laboratory Medicine diagnostic tests using e-record must ensure that the following steps in the process are followed exactly (refer to e-record Standard Operating Procedures for complete process).

6.11 Place an order for the required appropriate tests in PowerChart. This is done depending on when the sample is to be collected, as follows:

i. For ‘Collected Immediately’ = ‘Yes’ with ‘Ward Staff Collect’ = ‘No’ the required number of sample labels are generated on the zebra printer and a ‘Collected’ status is generated in PowerChart. Samples must now be directly taken.

ii. For ‘Collected Immediately’ = ‘Yes’ with ‘Ward Staff Collect’ = ‘Yes’ the required number of sample labels are generated on the zebra printer and a ‘Collected’ status is generated in PowerChart. Samples must now be directly taken.

iii. For ‘Collected Immediately’ = ‘No’ with ‘Ward Staff Collect’ = ‘Yes’ for a future order the required number of sample labels are generated on the zebra printer and a ‘Dispatched’ status is generated in PowerChart. Samples must now be taken as soon as possible. The request should be marked as ‘Collected’ using the ‘task list’ in PowerChart once the sample is taken.

iv. For ‘Collected Immediately’ = ‘No’ with ‘Ward Staff Collect’ = ‘No’ on blood samples only for a scheduled future order to be collected by a Phlebotomist a ‘Scheduled’ status is generated in PowerChart. The status of the order will be automatically raised to ‘Dispatched’ when the order becomes due for collection as part of a pre-planned phlebotomy list and the required labels
print on the zebra printer. The person taking the sample now must raise the status to ‘Collected’.

6.12 If immediate collection samples or ward staff collect samples are not taken then the order should be cancelled in PowerChart (see appropriate eRecord SOP).

6.13 **N.B. IMMEDIATE COLLECTION MUST ONLY BE USED WHEN A SAMPLE IS TO BE TAKEN DIRECTLY AFTER PLACING THE ORDER IN POWERCHART.**

6.14 **It is extremely important that all samples are at ‘collected’ status before they are sent to the laboratory for analysis.**

6.15 **Non- e-Record request**

Specimens sent with an accompanying request form must conform to the full requirements stipulated in the NUTH ‘Sample Acceptance and Rejection Policy’.

6.16 **Blood Specimens**

A process flow diagram illustrating this process can be seen in section 12 of this document.

- Pre-printing of specimen labels from e-record will take place just as the sample is about to be taken.

**Pre-labelling of specimens with the eRecord specimen label prior to the sample being taken is unacceptable practice under any circumstances.**

Positive patient identification must be determined before any specimen is taken. This should be done by comparing the patient details from their wrist band or by answers to questions, with the details on the e-record label at the patient’s side.

Questions to the patient must be open and should not permit a simple yes or no response. The data required to determine positive identification is:

- **Full name.**
- **Date of birth.**

As much as possible of the following additional data should be obtained from the patient’s wristband or from their notes.

- **NHS Number and Medical Record Number (MRN) if known.**
- **Patient location and report destination.**
- **Patient’s Medical Consultant.**
- **Requesting Medical Officer/Practitioner.**
- **Investigations required.**
- **Date and time of request.**
- **Patient address (for Cytology specimens).**
Labelling should be carried out in the presence of the patient after their identification has been positively determined and the samples have been taken. **Samples should not be removed and labelled away from the patient.**

Clinical details must be provided as this is invaluable in result interpretation and medical advice offered by the laboratories.

The samples should be taken in compliance with the current NUTH Venepuncture guidance.

Specimens should be sent to the laboratories as soon as possible.

6.17 **Blood Transfusion Special Note:**

- **All Requests** must have the request form declaration signed by the person who took the specimen.

- Blood Transfusion specimens must be hand written.

- **Printed labels are not permitted for the specimens** but can be applied to the request forms.

- Patient identification must not be taken from the printed label and must be done using the process described above.

- It is the professional responsibility of the admitting Registered Nurse to ensure that the details on the patient wrist band are correct and the responsibility of the person taking the specimen/s to ensure that the patient is correctly identified and specimen/s information is correctly transcribed.

6.18 **Tissue Specimens**

A process flow diagram illustrating this process can be seen in section 12 of this document.

Specimens from a patient must be formally checked and labelled by two members of staff, both of whom must be one of the following:

- Qualified Nurse.
- Qualified Midwife.
- Qualified Operating Department Assistant.
- Qualified Doctor.

Only the identified patient notes must be used in the clinical area and the patient must have an identity wristband if they are anaesthetised or sedated.
The specimen containers must not be pre-labelled.

Patient details must be checked by two members of staff who must then check the details with the operator/surgeon. The specimen must be labelled (handwritten or addressograph) using the patient notes.

The same two members of staff are responsible for ensuring that the specimen(s) has/have been fully labelled and packaged for transport. This is of particular importance where the sample has not been forwarded on to Pathology before the patient has left the clinical area and before the arrival of subsequent patients.

Where multiple specimens are obtained from a single patient, the request form and the specimens must clearly identify the different areas of origin of the tissues.

Slides submitted for cytological examination must have all of the above details written clearly on the labelling area of the slide itself.

6.19 Other Specimens

The labelling criteria should apply to all samples sent for pathological testing and this should include urine, tissues and swabs.

Samples collected from Operating Theatres or from post mortem patients should still conform to the criteria described in the exceptions section of the NUTH Patient Identification Policy.

6.20 SAMPLE ACCEPTANCE AND REJECTION

Samples that do not conform to the above criteria will most likely be rejected by the laboratory in accordance with NUTH policy.

Sample rejection will be done in order to protect the patient from processing error that may impact on the clinical management of the patient. This may in turn cause procedural delays.

6.21 LEGISLATION

All blood transfusion incidents that are attributable to incorrect patient identification have to be reported by law to the Serious Hazards Of transfusion (SHOT) in compliance with the Blood Safety and Quality Regulations 2005 which formulate United Kingdom law.

The Trust is inspected for compliance with this need by the Medical and Healthcare Regulatory Agency (MHRA) and has to declare continued compliance with the requirements annually.
7 Training

7.1 It is essential that all practitioners taking specimens are fully trained in procedure and deemed competent. They should be able to clearly demonstrate this to their manager or supervisor if requested to do so. All training should be subjected to periodic competence reassessment. Training should be provided by a practitioner that is documented as being fully competent in the procedure.

7.2 It is essential that all practitioners requesting diagnostic tests using the Trust electronic ordering system are fully trained in this process and are deemed competent. They should be able to clearly demonstrate this to their manager or supervisor if requested to do so. All training should be subjected to periodic competence reassessment. Training should be provided by a practitioner that is documented as being fully competent in the procedure.

7.3 Should a member of staff be unable to demonstrate competence, their ward/department manager must arrange re-training before the individual can operate the medical device in a clinical environment independently.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSLA standard 5.7</td>
<td>Laboratory Management will monitor compliance in conjunction with Trust Risk Management, by audit</td>
<td>Laboratory Medicine Quality Management in conjunction with Trust Risk Management</td>
<td>Clinical Standards and Practice</td>
<td>Quarterly audit</td>
</tr>
<tr>
<td>CPA standard E3 (specimen collection and handling)</td>
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</table>

10 Consultation and review

The policy was reviewed by the Laboratory Medicine Executive Committee prior to ratification. It was also presented at CGARD in 2012 with Diane Palmer, Jackie Moon and Elaine Coghill present; and twice at the Laboratory Clinical Audit and Governance meetings with Dr. Walls presiding (most recently in January 2013).
11 References


v. Laboratory Medicine NUTH Sample Acceptance and Rejection Policy Jan 2011.


The **PROCESS** for Labelling Specimens for the Laboratory

1. **eRecord**
   - Place electronic order for eRecord generated labels:
     - Labels to be used for ALL specimens (except Blood Transfusion)
   - Blood Transfusion Specimens:
     - Must be hand written
     - eRecord generated labels to be placed on the request form
     - Declaration on request form must be signed by the sample taker
     - Specimen labels must include the full name, MRN and D.O.B.

2. **Positively Identify the Patient**
   - **Do Not Use the Label to ID the Patient**
   - **Ask an open question**: Patient to state name and D.O.B.
   - **Inpatients**: Check the wristband to obtain MRN and NHS number and ensure that the details match accurately
   - **Check the notes for additional information**

3. **Outpatients**
   - Confirm stated name and D.O.B. with patient notes or with outpatient appointment card
   - If the patient is anaesthetised, sedated or unable to communicate, check the wristband or photo ID card to confirm information

4. **Taking the specimen**
   - Take the blood/nasal swabs and/or other specimen types in line with the current Trust policy

5. **Label specimen**
   - Label the specimen in the presence of the patient

6. **Final Check**
   - Recheck the details before placing the specimen in the bag and sealing
   - Send to Laboratory as soon as possible

**PROCESS: Key Points**

- Positively identify the patient
- Remember to add the label to the specimen in the presence of the patient
- Observe Trust policy when taking the sample
- Confirm verbally the details with the patient
- Ensure details are correct
- Seal/package the specimen in front of patient
- Send to the laboratory promptly

Produced with the support of Roche
The PROCESS* for Labelling Tissue Specimens for the Histopathology Lab

1. **Histopathology request form**
   - Use patient identification labels MUST include full name, MRN & D.O.B.
   - Please ensure all sections are completed accurately and legibly
   - Please refer to Trust policy for minimum acceptance criteria
   - Incomplete request forms will result in delay
   - Our aim is to report 95% of requests in 7 days
   - We can only do this with your help

2. **Positively Identify the Patient**
   - Ask an open question e.g. Name & Date of Birth
   - Inpatients - Check the wristband to obtain MRN & NHS Number & ensure a match
   - Check the notes for additional information

   **Outpatients**
   - Confirm stated name & D.O.B. with patient notes or outpatients appointment card
   - If the patient is anaesthetised/relaxed or unable to communicate, check the wristband, phone ID card, or verbally via a guardian to confirm information.

3. **Taking the specimen**
   - Take the specimen in line with current Trust policy and place in an appropriately sized container. Check it is sealed.

4. **Label specimen**
   - Label the specimen in the presence of the patient

**Final Check**
- Recheck the details on the pot and request form before packaging as per Trust policy - this indicates that the request form should be kept separate to avoid contamination. Send to the laboratory promptly.

*PROCESS: Key Points*

- Positively identify the patient
- Remember to add the label to the specimen in the presence of the patient
- Observe Trust policy when taking the sample
- Confirm (if appropriate) the details with the patient
- Ensure the pot and request form details are correct and match!
- Seal/package the specimen in front of patient
- Send to the laboratory promptly: **DO NOT BATCH – DISPATCH!**

Produced with the support of Roche
This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Patient Identification - Establishment and Confirmation Prior to Investigative Testing and Treatment</th>
<th>Policy Author:</th>
<th>Ian Mellors, Quality Manager Blood Sciences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)</td>
<td>Yes/No?</td>
<td>You must provide evidence to support your response:</td>
</tr>
<tr>
<td></td>
<td>• Race *</td>
<td>No</td>
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<td></td>
<td>• Ethnic origins (including gypsies and travellers)</td>
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<td>• Nationality</td>
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<td>• Gender *</td>
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<td></td>
<td>• Culture</td>
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<td></td>
<td>• Religion or belief *</td>
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<td></td>
<td>• Sexual orientation including lesbian, gay and bisexual people *</td>
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<td></td>
<td>• Age *</td>
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<td></td>
<td>• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *</td>
<td>No</td>
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<td></td>
<td>• Gender reassignment *</td>
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<td></td>
<td>• Marriage and civil partnership *</td>
<td>No</td>
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<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
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<tr>
<td>3.</td>
<td>If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(a).</td>
<td>Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(b).</td>
<td>If so can the impact be avoided?</td>
<td>No</td>
<td></td>
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<tr>
<td>4(c).</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(d).</td>
<td>Can we reduce the impact by taking different action?</td>
<td>No</td>
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</tr>
</tbody>
</table>

Comments: |

Action Plan due (or Not Applicable): N/A

Name and Designation of Person responsible for completion of this form: Ian Mellors, Quality Manager Blood Sciences

Date: 14.11.2012

Names & Designations of those involved in the impact assessment screening process: Ian Mellors Quality Manager Blood Sciences, Yvonne Scott Blood Bank Manager

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.

IMPACT ASSESSMENT FORM A

October 2010