Reporting
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Safe Care Bulletin

Starship Child Health

May 2021

Positively identifying your patient may be the safest thing you do today

I.D. ME

In busy clinical settings, it is possible for staff to make patient identification errors which can result in patient harm.

Fortunately, the strategy of positive patient identification can significantly reduce the risk of patient misidentification.

Positive Patient Identification

Ask	**What is your (your child's) first & last name?** **What is your (your child's) date of birth?**
Check	**Check the patient's full name and date of birth corresponds to the details on the Patient Identification Band being worn.**
Confirm	**Confirm the patient's name, date of birth, & NHI number by cross-referencing with the patient's clinical record (e.g. national medication chart, investigation or procedure request, treatment consent)**

Communication barriers such as staff and whānau/family language, accents, and hearing ability can present identification challenges.

Whānau may feel unable to question staff

- Always ask the child and whānau what language they prefer to use and arrange interpreters as required.

Explain to the child and whānau why we need to check their identity before every test or treatment.

- *"I know it can seem like you are being asked the same things many times, but we do it deliberately for safety, to make sure we have the right person"*

The following are excerpts from Child Health Datix reports.

Incorrect use of bed space to identify patient:
Patient asked me what medication she had been given as it tasted different. I realised that it was meant for the other patient in the room. The patients' bed spaces had been changed and the whiteboard had not been updated.

Incorrect patient identity for procedure:
Infant Y received a skull x-ray. There was no clinical indication or plan in the medical record for this investigation. The clinical information on the x-ray request was inconsistent with patient Y but had patient Y label. The clinical information was consistent with patient Z who was expected to have a skull x-ray. Both infants had similar names.

Use of incorrect patient identifier
RN inadvertently gave an antibiotic to patient A which was meant for Patient B. Patient did not have an ID band and the child's parent answered YES when asked if this was patient A.

For further information refer to the ADHB Policy : Identification of Patients (including Newborns)

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