YORK DIAGNOSTIC IMAGING

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Patient Identification Policy

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Author	Ross Devlin
Policy Owner	Registered Manager
Approval	Director York Neuroimaging Centre
Review Date	3 Years

Document Control

This document is **uncontrolled** when printed. Please ensure that you have the most current issue of this document. A current version is available at YNiC reception.

Document History

Version	Comments	Author	Date
1.0	Initial Release	Ross Devlin	April 2011
1.1	2013 Review	Ross Devlin	Sept 2013
1.2	Header update YDI	Ross Devlin	May 2014
1.3	Review and update	Ross Devlin	May 2017
1.4	Review and update	A Morland	November 2017

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1. Aim

1.1 To ensure the correct patient is examined and that the correct examination is performed, in line with the clinical information provided.

2. Scope

2.1 This policy is to be followed by all York Diagnostic Imaging staff involved in communication with patients attending York Diagnostic Imaging.

3. Roles and Responsibilities

3.1 The Director has ultimate responsibility for the service delivered.

3.2 The Registered Manager is responsible for ensuring that staff are aware of the policy and work within its framework

3.3 Employees are responsible for the correct implementation of this policy and notifying the registered manager of any areas of non compliance.

4. Policy

4.1 Identification Check

4.1.1 Patients will be identified upon arrival at reception by administration staff. The following will be checked against the referral form:

- Name
- Date of Birth
- Address/correct telephone contact details

Patient confidentiality will be considered at all times.

4.1.2 Patients will be called from the waiting area using their full name, by a member of the clinical team.

4.1.3 The responsible Healthcare Professional (HCP) e.g. Radiographer, Technologist, Assistant Practitioner will check the following details (against the referral card/letter) with the patient before proceeding with any examination:

- Full name including correct spelling
- Date of Birth
- Address
- Clinical history (including area to be examined and the reason for the examination).

4.2 Children

4.2.1 Where the child is unable to confirm ID details these must be sought from the responsible adult. This must be the parent or guardian where possible.

4.3 Non-verbal Patient Identification

4.2.1 If the patient is unable to confirm their identity verbally, then the responsible operator must take any necessary steps e.g. use of patient wristband, confirmation by relative or guardian, to be certain of the identity before proceeding with any examination. Such steps should be clearly documented on the patient referral card/letter.

4.2.3 If the York Diagnostic Imaging HCP and patient cannot communicate due to language difficulties, the scan will be deferred until translation services of an interpreter can be arranged.

4.3.1 If there is any doubt about the identification of the patient, the examination must not continue. Further advice must then be sought from the referring clinician or principal investigator to ensure the correct patient will be scanned.

4.3.2 An examination must not be started until identification is positively established beyond doubt. This is ultimately the responsibility of the system operator performing the examination.

4.4 Errors in Patient Identification

4.4.1 If at any stage of an examination it is realised that there has been an error in the identification of the patient the error must be recorded and investigated through the University of York Health and Safety Policy.

4.42 If the error has not been rectified before the images have been dispatched for reporting or to the referring clinician then all appropriate parties will be informed of the error.

4.4.2 If a patient has had the incorrect area scanned due to an identification error the patient must be recalled at the earliest opportunity to receive the correct examination. All images with the wrong identification on must be destroyed or deleted. Notification of regulatory bodies will be made where deemed appropriate.

4.4.3 Monitoring of the frequency of identification error will be undertaken at YDI's quarterly review meeting.

5. Review

5.1 It is the responsibility of the Director and Registered Manager to review this policy on a 3 yearly basis or as national updates to guidance are introduced that requires the policy to be updated.

6. Evaluation

6.1 Effectiveness of this policy will be evaluated by a review of incidents and complaints associated with patient identification.