PostScript

LETTER

Identifying patients in hospital: are more adverse events waiting to happen?

In November 2005, the National Patient Safety Agency (NPSA) published a directive concerning identity bracelets in hospitals, and set a deadline of May 2006 for trusts to comply.¹ It outlined that all inpatients should wear identification bracelets unless they do not consent, or there is good clinical reason and a formal risk assessment is undertaken to confirm this.

In June 2006, in a large UK university hospital, we conducted a prospective review of 54 emergency orthopaedic admissions to assess adherence to the recommendations. Data were recorded on the morning after admission.

The presence of an identification bracelet on each patient was recorded, as was the accuracy of identification details written on a white board above each patient's bed. The ability of each patient to identify himself or herself was recorded.

In all, 30 (55%) patients did not have an identification bracelet. None of the patients objected to a bracelet or were deemed clinically unsuitable. Four patients without bracelets were unable to identify themselves.

Also, 26 (48%) patients had no identification details written on the identification white board above their respective beds; 4 (7%) patients had incorrect details—those of the previous bed occupant. One of these patients had no identification bracelet and was unable to identify himself. One patient had a similar but incorrect name on the board.

Errors in patient identification clearly remain a cause for concern. The media take delight in sensationalising such errors.²⁻⁴

A recent study from a US source showed 3273 cases of wrong-treatment/wrong-procedure errors recorded over a 13-year period⁵—a proportion of which was owing to failures in identification. Between November 2003 and July 2005, the NPSA received 236 reports of safety incidents and near misses relating to missing or inaccurate identification bracelets.¹

Use of bracelets in the US has been improved by empowering phlebotomy staff to refuse to take blood from patients until the identification bracelet is present and accurate—the error rate was reduced from 7.4% to 3% over a 2-year period.⁶

No data exist relating to the use of patient identification boards. If accurate, they are useful in facilitating identification; but conversely, if inaccurate, they may cause confusion and magnify the risk of adverse events.

The NPSA has not yet been successful in ensuring that safe practice recommendations

for the use of identification bracelets are being adhered to. Inaccurate patient identity boards also pose risks to patient safety.

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ECHO

Curb on gastroscopy will have little impact on patient outcome

Please visit the *Quality and Safety in Health Care* website [www.qshc.com] for a link to the full text of this article.

Revised UK guidelines restricting open access gastroscopy will miss just a few cases of curable cancer in patients with uncomplicated dyspepsia, a retrospective survey of patient outcomes has confirmed.

Just five patients out of 14 (36%) with dyspepsia but no “alarm” symptoms in the four year survey had a malignant oesophageal or gastric tumour removed and were alive three to six years after the diagnosis. One patient was unfit for surgery, and the remaining patients had metastases. Three patients were aged under 55 years, only one of whom had a resection.

The survey identified 228 patients with upper gastrointestinal (GI) cancer from 11 145 gastroscopies performed during 1998–2002 in one hospital in South Wales. Most patients (214, 94%) presented with alarm signs/symptoms; 25 were aged under 55 years and two under 45. One caveat is the lack of potentially pertinent data, such as, pre-existing symptoms, *Helicobacter pylori* infection, and treatment with proton pump inhibitors from general practitioner records.

In 2004 the National Institute for Health and Clinical Excellence (NICE) recommended that any patients without alarm signs/symptoms should not have gastroscopy, unless they are aged over 55 with persistent symptoms of dyspepsia after *H pylori* treatment and acid suppression treatment.

Fear of possible cancer has driven the need for open access gastroscopy, even though the incidence of cancer in patients with no alarm symptoms is very low, about 2%. Most upper GI cancers are accompanied by alarm symptoms. Just under 10% of deaths from cancer in England and Wales are because of these cancers.

▲ Sundar N, et al. *Postgraduate Medical Journal* 2006;82:52–56.