Organisation name Site or unit		STANDARD OPERATING PROCEDURE **Patient Identification and Specimen Labelling**	
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Signature			

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Abbreviations

Abbreviation	Meaning
IPC	Infection prevention and control

Abbreviation	Meaning
SOP	Standard operating procedure
WHO	World Health Organization

Key points

- Identify every patient with two person-specific identifiers, such as full name, date of birth or medical record number, before every care task [1].
- A room number or bed location is never an identifier [1].
- Ask the patient to state their identifiers. Do not ask “Are you Mrs X?”, because the patient will often just agree.
- Label specimens with two identifiers at the bedside, in the patient’s presence, straight after collection. Never pre-label tubes [1].
- If identity is in doubt, stop. Do not continue until it is resolved.

1. Purpose

To make sure each patient receives the right care, and that every specimen, medicine, blood product and record is linked to the right patient. Most wrong-patient errors happen at the point of care, when a task is done for a patient whose identity has not been checked against the record. This SOP sets out how identity is confirmed before each task, how specimens and blood products are labelled, and what to do when identity cannot be confirmed. This SOP supports the identification requirements of the ASF hospital standard.

2. Scope

Element	Coverage
Who	Clinical staff who give care, collect specimens, dispense or give medicines, give blood products, or record patient information.
Where	Inpatient, outpatient, emergency, day-care, imaging and procedure areas, and the laboratory interface.
When	On admission or first contact; before each medicine, procedure, specimen or blood product; at each handover; at any transfer between areas.
Not covered	Identification of deceased persons, which follows the mortuary procedure.

3. Definitions

Term	Meaning
Person-specific identifier	An attribute unique to one patient: full name, date of birth, medical record number, or a telephone number. At least two are required [1].
Not an identifier	Room number, bed location, diagnosis, or the name of the clinical team. These can change or be shared [1].
Wristband	The identification band on the patient. It carries at least two identifiers and must stay on the patient at all times [1].
Temporary identifier	A unique name and number assigned when a patient cannot be identified. Used on every record until the real identity is confirmed [1].
Name alert	A visible flag on the record and the wristband where two patients on the same unit share a name, as set by the facility policy.

Term	Meaning
Mismatch	Any difference between the identifiers on the request, label, wristband or record and those confirmed with the patient.

4. Background

The Joint Commission requires two patient identifiers to be used, and states that a room number is not a unique identifier [1]. Identification is one of the nine WHO Patient Safety Solutions published in 2007 [2]. Wrong-patient errors are often caused by a task being done on the patient in the bed rather than on the patient named in the order. The check must therefore be made with the patient, against the order, every time.

5. Responsibilities

Role	Responsibility
Clinical director	Approves this SOP, the name-alert policy and the temporary-identifier process; receives the quarterly audit.
Ward or unit manager	Ensures wristband stock and label printers are available, and that staff are trained and observed.
Clinical staff	Confirm two identifiers before each task; label specimens at the bedside; stop and report any mismatch.
Laboratory and blood bank	Reject unlabelled or incorrectly labelled specimens and inform the requesting clinician at once.
Quality and risk team	Analyses mismatch incidents, looks for patterns, and advises on system changes.

6. Materials and equipment

Item	Requirement
Wristband	Printed with at least two identifiers and the record number; applied on admission; checked each shift.
Specimen labels	Printed at the bedside or point of care, with two identifiers, date and time of collection and collector’s initials.
Name-alert wristband or sign	Used where the facility policy requires it for patients sharing a name on the unit.

7. Safety and exceptions

- **Patients who cannot confirm identity** (unconscious, confused, sedated, or non-verbal): use the wristband and the record, check with a second member of staff where possible, and record how identity was confirmed.
- **Unidentified patients** on arrival (for example, an unresponsive patient in the emergency department): assign a temporary name and a unique number, use them on every order, label and record, and link to the real identity as soon as it is confirmed [1].
- **Pre-labelled items:** a label printed or applied before the patient is seen is never used. Unused labelled containers are discarded at once [1].
- **Language barrier:** use a qualified interpreter. A nod or “yes” from a patient who has not understood is not confirmation.

8. Procedure

Before you start

- Check the order, request or prescription: it names the patient and the task.
- Check that wristband stock and label supplies are available on the unit.
- Check for a name alert before you approach the bed.

Step 1. Apply and check the wristband on admission or first contact

1. Confirm the patient's full name and date of birth with the patient, and check them against the registration or referral.
2. Apply the wristband with at least two identifiers and the record number, and check the details aloud with the patient before you leave.
3. The wristband must stay on the patient at all times. Do not leave it on the bedside table or tape it to the bed [1].
4. If the wristband is missing, cut or illegible, confirm identity with the patient and the record, then apply a new band and record the event.

Step 2. Confirm identity before each task

1. Ask an open question, for example: "Can you tell me your full name and date of birth?" Do not offer the answer. Do not ask a question that can be answered "yes" or "no".
2. Compare the patient's answer with the wristband, then with the order or request, reading each identifier aloud.
3. Where the patient cannot answer, use the wristband and the record, and confirm with a second member of staff.
4. Do not start the task until the identifiers match.

Step 3. Label specimens at the bedside

1. Confirm identity (Step 2) before you collect the specimen.
2. Label the container in front of the patient, straight after collection, with two identifiers, the date and time, and your initials [1].
3. Urine containers may be labelled before collection, but only after identity is confirmed, and the label must be applied in the patient's presence. Discard any unused labelled container at once [1].
4. Send the specimen with the matching request. Do not send a specimen whose label was written before the patient was seen.

Step 4. Give blood products and high-risk medicines

1. Follow the transfusion policy. Check the blood product label, the request and the wristband together, at the bedside, against the patient's identifiers.
2. Where the policy requires two staff to check, both check the identifiers aloud before the transfusion starts.
3. Record the check on the transfusion chart, with both names or initials.

9. Worked examples

Situation	What to do
Example A. Two patients named Maria Silva on the same ward. You are about to take a blood sample from the patient in bed 4.	Ask her to state her full name and date of birth. Check both against her wristband and the request, which should show the date of birth. Read the record number on the label. If the date of birth on the request is different, stop: the request may belong to the other Maria Silva. Confirm with the team, and do not collect until resolved. Use the name alert if one is in place.
Example B. An unresponsive patient arrives in the emergency department with no identification.	Assign a temporary name and a unique number, for example “Unknown male, Resus 2, 29 Oct 2026, number 0047”. Use this on all orders, specimen labels and the record. When the patient’s identity is confirmed (family, documents or a registration), link the temporary and real identities in the record, and tell the laboratory and the pharmacy.
Example C. The patient’s wristband has come off in the shower.	Do not give medicines or take specimens until identity is confirmed. Confirm the patient’s name and date of birth with the patient and the record, apply a new band, and record the event. If the patient is not able to confirm identity, use a second member of staff and the family.
Example D. A specimen arrives at the laboratory labelled before the patient was seen.	The laboratory rejects the specimen and informs the requesting clinician. Recollect the specimen, labelling it at the bedside in the patient’s presence, and record the rejection as an incident.

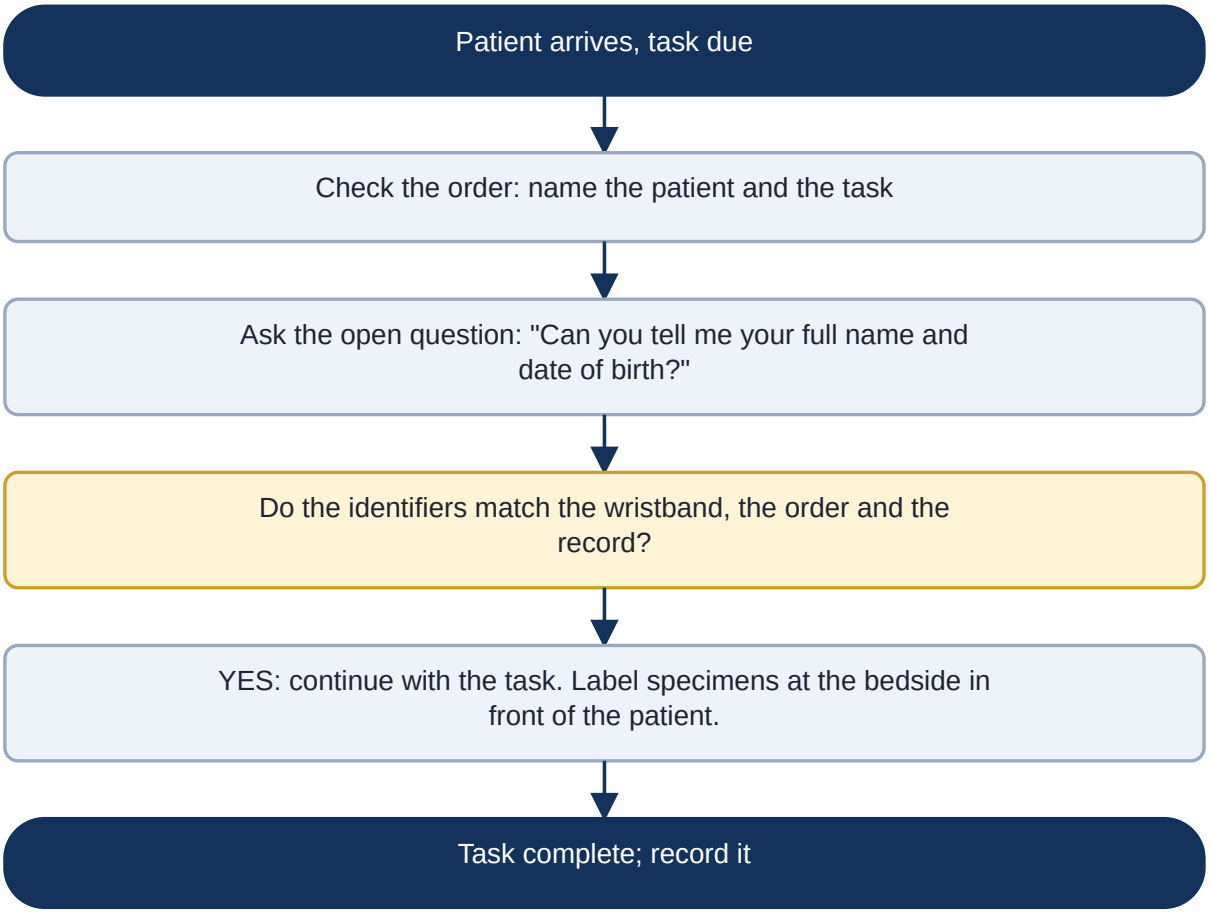


Figure 1. Process

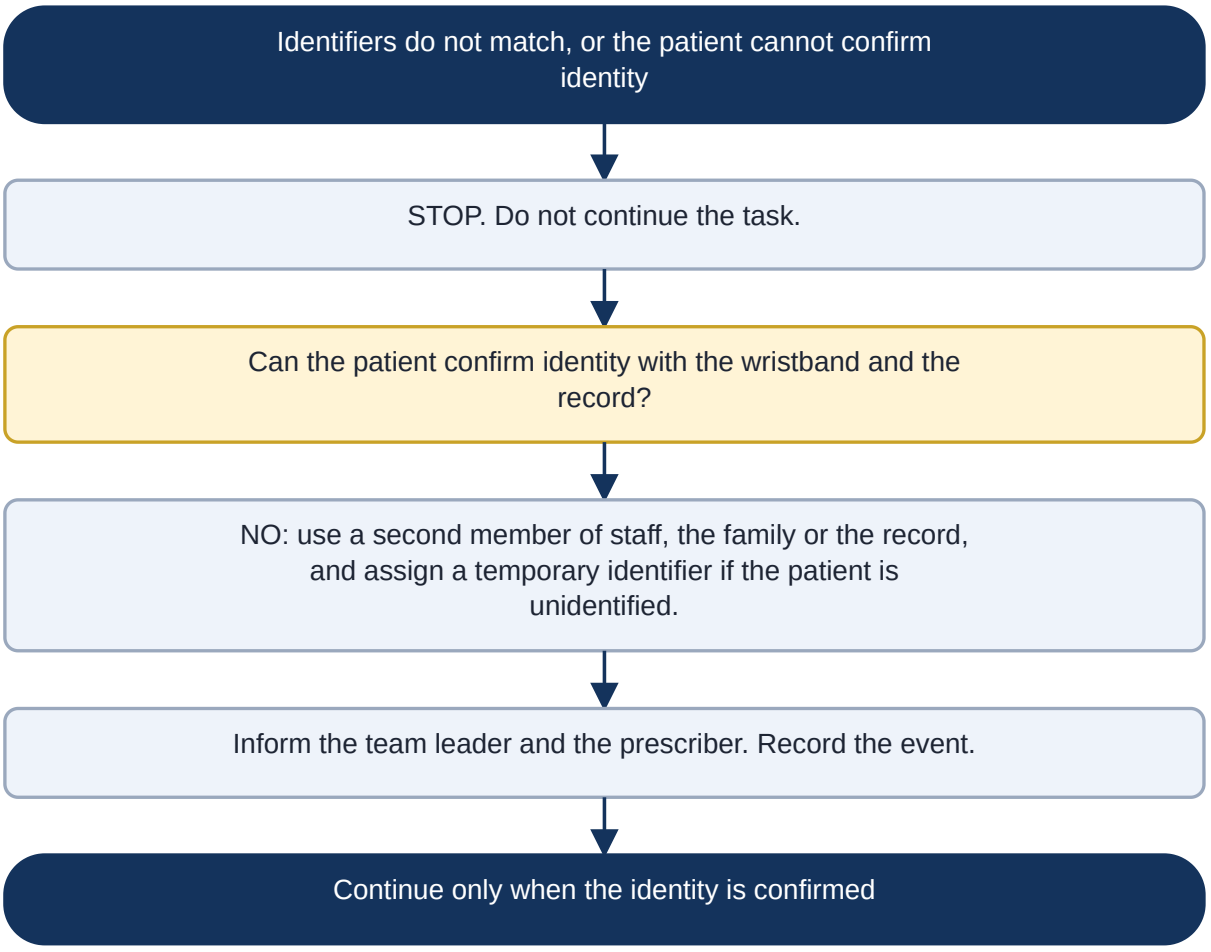


Figure 2. Decision rules

10. Decision points

If	Then
Identifiers match the wristband, the order and the record	Continue the task.
Any identifier does not match	Stop. Do not continue until the team leader or prescriber has resolved the mismatch.
Patient cannot confirm identity	Use the wristband, the record and a second member of staff. Record the method used.
Wristband missing or illegible	Confirm identity, apply a new band, record the event.
Specimen unlabelled, or labelled before collection	Do not send it. Recollect and label at the bedside.

11. Escalation

Event	Inform	Timescale
Mismatch found before any harm	Team leader and the clinician in charge	Immediately

Event	Inform	Timescale
Wrong patient treated or sampled	Clinician in charge, risk team, and the patient or family under the duty of candour policy	Immediately; incident report within 24 hours
Repeated mismatch on one unit	Unit manager and quality team	Within one week

12. Monitoring and compliance

Indicator	Target	Method	Frequency	Owner
Identity confirmed before each task (observed)	100% of observed tasks	Direct observation of 20 tasks per unit, including two blood transfusions where they occur	Monthly	Ward manager
Specimens labelled at the bedside with two identifiers	100% of sampled specimens	Review of 20 specimens per unit	Monthly	Laboratory liaison
Wristband on the patient and correct	100% of patients checked	Ward round check	Each shift	Nurse in charge
Mismatch incidents	Reported and analysed within one week	Incident system	Quarterly	Quality team

13. Records

Record	Kept in	Retention
Wristband application and replacement	Patient record	As set by the institutional retention policy
Incident reports for mismatch	Incident management system	As set by the institutional retention policy
Observation and specimen audit records	Unit file	Three years

14. Training and competence

- **Induction:** the two-identifier check, the open question, bedside labelling, temporary identifiers and the mismatch rule, with a supervised session on a ward.
- **Annual competency:** direct observation of identification at three tasks, including one specimen and one medicine.

15. Related documents

ID	Title	Relationship
IPC-POL-001	Infection prevention and control programme	Sets the wider programme
WST-SOP-001-EN	Sharps and Clinical Waste Management	Sharps and specimen waste

16. References

1. The Joint Commission. Standards FAQ: National Patient Safety Goals, patient identifiers, specimen labelling, temporary names and armbands. Available from: https://www.jointcommission.org/standards/standard-faqs/home-

care/national-patient-safety-goals-npsg/000001545/
2. World Health Organization. WHO Patient Safety Solutions, launched 2 May 2007 (patient identification is one of the nine solutions). Available from: https://www.who.int/news/item/02-05-2007-who-launches-nine-patient-safety-solutions

17. Change history

Version	Date	Summary of change	Approved by
1.0		First approved version.	ASF Expert Committee
1.2		Substantive revision: step-by-step identity check, temporary identifiers, name alerts, transfusion and worked examples; references checked against the Joint Commission FAQ and the WHO solutions.	

Annex A. Identification audit record

Use this record for each audit session. Record one line per task observed. Enter Y, N or NA as shown in the column heading.

Date	Unit	Observer (initials)	Task observed	Two identifiers confirmed (Y / N)	Specimen labelled at bedside (Y / N / NA)	Mismatch found (Y / N)	Comment