Clinical Imaging Board

Patient Identification: guidance and advice

Magnetic Resonance Imaging (MRI)

The Clinical Imaging Board (CIB) has previously issued a statement in recognition of the importance of correct patient identification when undertaking diagnostic imaging procedures utilising ionising radiation. [1] This statement has been adapted as follows to apply to magnetic resonance imaging (MRI) examinations. MRI uses a combination of a very strong static magnetic field, time-varying magnetic fields and radiofrequency pulses to create the patient images. These examinations do not involve the use of ionising radiation; however, there are very serious risks to the patient associated with MRI, particularly for those patients with implanted medical devices. Thus the principles of safe patient identification are the same.

The CIB is committed to promoting and improving the quality of care for patients and ensuring that patients are correctly diagnosed and treated. [2, 3, 4] 'Right test, right patient, right time' relies on accurate identification of any patient who undergoes MRI.

The CIB expects members of the MRI workforce to be competent within their individual scope of practice and to follow the policies, protocols and procedures issued by their employer with regard to the positive checking of patient identification.

For imaging procedures involving MRI, the Medicines and Healthcare products Regulatory Agency (MHRA) advises the following:

> *'there should be a policy to ensure that the patient is correctly identified. The policy should include provision to ensure correct identification of the unconscious and/or sedated patient, children, those patients who are deaf, those patients with learning difficulties, patients with mental health problems and those for whom English is not their first language'.* [5]

The patient identification procedure must specify how a patient is to be identified before an MRI examination is performed.

The procedure should be positive and active eg '*What is your name*?' The procedure should state by whom the patient should be identified eg by the MR operator carrying out the examination.[6] This should be consistent across an organisation and should be developed in line with national guidance from the Department of Health and the former National Patient Safety Agency, which have issued guidance recognising that '*reducing and where possible eliminating errors in matching patients with their care is one of the key ways to improve patient safety*'.[7]

Established good practice generally requires the patient to give their name, address and date of birth.[8] The Care Quality Commission (CQC) in its 2013 annual report cites an example where adding '*checks of clinical information, the site requested and checks of previous imaging have been shown to reduce incorrect examinations from failed patient identification processes making this a six point check*'.[9] Where available, the staff member may be required to match details to wrist bands or use bar code/electronic tagging verification. The source document or record against which details are checked must be specified and this should be linked to the patient's NHS number[10] or other unique identifier, wherever possible.

It is important that the staff member or radiographer performing the patient identification check can be identified at a later date. Note, in the case of MRI examinations, there is a requirement for the patient to complete a pre-examination safety questionnaire (sometimes called a screening form). This form must be signed by the patient and countersigned as checked by the MR operator.[11]

The employer should have clearly documented procedures in place for situations where patients are unable to actively respond to identifying questions. These may be patients with dementia or learning or sensory disabilities, those who are non-English speaking, those who are unconscious, children, or otherwise unidentified patients.

Employers, and colleagues in the imaging workforce, are recommended to review their practice and procedures in light of this guidance, and that contained in the CQC annual report, with a view to taking a risk-based approach to introducing checks additional to the patient ID procedure, for example pause and check.[12]

Recommendations

Local procedures should include the following:

1. confirming name, address, date of birth
2. confirming timing, modality, site/laterality
3. checking against original (or scanned-in) request forms
4. checking previous imaging, where possible (on receipt of referral AND/OR on date of examination)
5. screening the patient prior to arrival for their MRI appointment (to avoid booking an inappropriate examination) and completing an MRI safety questionnaire prior to actually starting the examination. This should be reviewed by an experienced MR Authorised Person. Arrangements for radiographers to check with referrer in cases of doubt or when the patient is unable to complete a safety questionnaire/has an unidentified medical history–on the request form itself, or arising from inconsistencies arising from checks carried out

6. checking there are no contraindications for those patients requiring the administration of a contrast agent
7. referrer checks of ID and previous imaging; referrer training on electronic requesting systems, including training in how to cancel requests made in error
8. arrangements for inpatients and admitted patients concerning fitting of a wrist-band [13] (some organisations adopt a 'no wrist-band – no examination' policy), and arrangements on the ward for patients with similar or identical names where there may be potential for confusion, and whether there are any circumstances when radiographers can rely solely on ward staff to direct them to the intended patient.

NB It should be noted that the MR Safety status of the wrist band should be ascertained before the patient enters the MR environment as there has been a reported case of a patient receiving a serious burn in MRI due to the paramagnetic ink in a wristband. [14]

9. specific guidance for radiographers training in MRI and assistant practitioners. [15]

The MHRA have published guidelines relating to the safe use of magnetic resonance imaging equipment in clinical use.[5]

References

1. **Clinical Imaging Board.** August 2015. Patient Identification: guidance and advice http://www.ipem.ac.uk/Portals/0/Documents/Partners/Clinical%20Imaging%20Board/Patient%20ID%20guidance.pdf

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3. **Society and College of Radiographers**. Imaging and Radiotherapy Professionals at the Heart of a Healthier Nation The 2015-17 Strategy of the Society and College of Radiographers. London: SCoR, 2015 https://www.sor.org/system/files/article/201510/sor_strategy_document_a4.pdf

4. **Institute of Physics and Engineering in Medicine.** About IPEM. http://www.ipem.ac.uk/?AboutIPEM.aspx

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6. **Department of Health.** The Ionising Radiation {Medical Exposure} Regulations 2000 (IRMER) London: DH, 2012 https://www.gov.uk/government/publications/the-ionising-radiation-medical-exposure-regulations-2000

7. **National Patient Safety Agency. 2005.** Safer patient identification. http://www.nrls.npsa.nhs.uk/resources/healthcare-setting/acute hospital/?entryid45=59799&q=0%C2%ACpatient+identification%C2%AC.0236

8. **The Society and College of Radiographers, British Institute of Radiology and Royal College of Radiologists.** A guide to understanding the implications of the Ionising Radiation {Medical Exposure} Regulations in diagnostic and interventional radiology. London: RCR, 2015 https://www.rcr.ac.uk/publication/guide-understanding-implications-ionising-radiation-medical-exposure-regulations

9. **Care Quality Commission. 2014.** IR(ME)R annual report 2013. http://www.cqc.org.uk/sites/default/files/20140721_irmer_annual_report_final.PDF

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11. **The Society and College of Radiographers** and the **British Association of MR Radiographers.** Safety in Magnetic Resonance Imaging. London: SCoR, 2013 https://www.sor.org/learning/document-library/safety-magnetic-resonance-imaging-0

12. **The Society and College of Radiographers.** Have you paused and checked? MRI London: SCoR, 2016. https://www.sor.org/learning/document-library/have-you-paused-and-checked-mri

13. **National Patient Safety Agency. 2007.** Standardising wristbands improves patient safety. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824

14. **Jacob ZC, Tito MF, Dagum AB**. MR imaging–related electrical thermal injury complicated by acute carpal tunnel and compartment syndrome: case report. Radiology 2010**;** 254(3): 846–850 http://pubs.rsna.org/doi/pdf/10.1148/radiol.09090637

15. **Society and College of Radiographers .** Student radiographers and trainee assistant practitioners: verifying patient identification and seeking consent. London: SCoR, 2010. http://www.sor.org/learning/document-library/student-radiographers-and-trainee-assistant-practitioners-verifying-patient-identification-and

(All websites accessed 3/7/16)

Glossary

Care Quality Commission (CQC)
The independent regulator of health and social care in England. http://www.cqc.org.uk/

Clinical Imaging Board (CIB)
This was established in 2013 by the Royal College of Radiologists, Society and College of Radiographers and the Institute of Physics in Engineering and Medicine to provide leadership on issues related to medical imaging.
https://www.rcr.ac.uk/clinical-radiology/faculty-structure/clinical-imaging-board

Royal College of Radiologists (RCR)
The Royal College of Radiologists leads, educates and supports doctors who are training and working in the specialties of clinical oncology and clinical radiology. https://www.rcr.ac.uk/

Society and College of Radiographers (SCoR)

The Society and College of Radiographers is the trade union and professional body for radiographers and all non-medical members of the workforce in diagnostic imaging and therapy in the UK. www.sor.org

Institute of Physics in Engineering and Medicine (IPEM)
IPEM is the learned society and professional organisation for physicists, clinical and biomedical engineers and technologists working in medicine and biology. http://www.ipem.ac.uk/

The Medicines and Healthcare products Regulatory Agency (MHRA)
The MHRA is the government agency responsible for ensuring that medicines and medical devices work, and are acceptably safe.
https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

National Patient Safety Agency (NPSA)
A former arms-length body of the Department of Health. The NPSA led and contributed to improved, safe, patient care by informing, supporting and influencing organisations and people working in the health sector. From June 2012, key functions were transferred to the NHS Commissioning Board Special Health Authority.