



Using electronic patient identification systems

Implementation support

Published: 26 February 2026

www.nice.org.uk

See [recommendation 1.14.1](#).

Human error is the main cause of adverse events related to transfusion. The most serious of these are the wrong patient being given a transfusion or the incorrect blood product being given. These errors are caused by misidentification during pre-transfusion sampling or when giving a transfusion.

Electronic patient identification systems prompt staff to carry out key steps in the correct order, and ensure that transfusions are given to the right patients through scanning of compatible wristbands and blood component containers. These systems include bedside handheld computers that prompt staff through each step and verify that the correct transfusions are given.

If hospitals do not have such a system in place hospital managers could:

- Use published data (such as the [Transfusion Safety Standards' Serious Hazards of Transfusion](#) data) to demonstrate the patient safety benefits of implementing such a system and provide examples of where the system would have prevented errors, in particular where a potential [NHS England Never Event](#) would be avoided.
- Gain high-level support from influential patient safety representatives and the Hospital Transfusion Committee.
- Use examples from practice in other NHS hospitals to learn about how such a system has been implemented.