CONTROLLED DOCUMENT

University Hospitals Birmingham
NHS Foundation Trust

Policy for Identification of Patients

CATEGORY:	Policy
CLASSIFICATION:	Clinical
PURPOSE	This policy sets out the framework by which the Trust ensures that all patients are correctly identified.
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Controlled Document Lead:	Lead Nurse for Quality and Clinical Assurance
Approved By:	Chief Executive
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Distribution: • **Essential Reading for:** • **Information for:**	All Staff involved with the registration or treatment of patients All Managers

Contents

1 Policy Statement

1.1 The National Patient Safety Agency (2005, 2007and 2018) has recognised that failure to correctly identify patients constitutes one of the most serious risks to patient safety. Correct identification, incorporating the core patient identifiers as directed by the NPSA (2008), will reduce and, where possible, eliminate the risk and consequences of misidentification and as a result improve patient safety.

1.2 University Hospitals Birmingham NHS Foundation Trust (the 'Trust') will ensure that the identity of all patients is effectively verified at every stage of the patient's pathway by ensuring that:

1.2.1 All staff must be aware of the importance of identifying the correct patient before providing treatment;

1.2.2 Patients receive the correct information, medication, treatment and care;

1.2.3 A clear and consistent approach is taken towards the identification of all patients and that best practice is applied at all times; and

1.2.4 When it is not possible to confirm a patient's identity safe mechanisms are in place to ensure the patient is receiving the correct care and treatment (NHSI, 2018). https://improvement.nhs.uk/news-alerts/safer-temporary-identification-criteria-for-unknown-or-unidentified-patients/

2 Scope

2.1 This policy applies to all Trust staff that work directly with patients or who use patient information in their role. This includes students, locum and bank/agency staff and all staff employed on temporary or honorary contracts.

2.2 This policy applies to all patients of the Trust.

3 Framework

3.1 The policy provides the broad framework of patient identification along with individual responsibilities. The procedural documents associated with this policy provide detailed instructions of how positive identification is achieved.

3.2 The Chief Nurse is the Controlled Document Sponsor and shall approve all procedural documents associated with this policy; they may delegate this role to a suitable deputy. All procedural documents must be compliant with this policy.

3.3 Identification Bands

3.3.1 To support the identification of patients, an identification band is to be produced for and worn by all inpatients and specific groups of outpatients as identified in paragraph 3.4.6. The information on the

identification band must be checked with the patient, where possible, and this must be documented in the medical records.

3.3.2 The information recorded on the identification band shall be as follows:

Last name first name e.g. SMITH John

Date of birth recorded as DD-MMM –YYYY E.G. 01-JUN-1945. All dates with value last than 10 must be preceded by zero.

Hospital Number

NHS Number.

3.3.3 A single red identification band (with printed black text on a white panel) must be used instead of the standard identification band to alert staff to situations or conditions, where the patient has shown characteristics which put them at risk. The reason for the red alert identification band must be documented in the notes or, in the case of an allergy, on the patient's prescription chart or electronic patient record. It is the responsibility of the member of staff who checks the identification band to check the alert status of the patient before carrying out any treatment on that patient or administering any medication. The healthcare worker must refer to the patient and their documentation for verification of the risk, as the nature of the alert will not be stated on the identification band.

3.4 Verification of patients

3.4.1 Prior to an identification band being given to the patient, three pieces of information must be obtained in order to verify the identity of the patient; full name, date of birth and patient's address must be used, but other information such as correct spelling of name and next of kin details, General Practitioner (GP) and telephone number may also provide added assurance that the patient has been correctly identified. Staff must not assume that previous departments have done this.

3.4.2 Subsequently, identity must be confirmed by asking the patient to provide the information which must then be checked against the records. The questions should be phrased openly, for example:

"Can you tell me your name?" and not "Is your name Mr Smith?"

3.4.3 The checking of a patient's identity must be carried out sensitively and the information treated as confidential; care must be taken to ensure that other patients and visitors to the area are unable to hear any verbal checks being made and that patient privacy is maintained

3.4.4 In addition to identifying the correct patient, it is essential to identify the correct healthcare records pertaining to the patient. This is the responsibility of the member of staff accessing the healthcare records.

Staff must check the correct spelling of a patient's name to prevent misidentification.

3.4.5 If the patient's identity cannot be determined and treatment is time critical, treatment must not be delayed

3.4.6 A patient's identification must be verified on each of the following occasions: (this list is not exhaustive)

Event	**Additional Information**	**Identification Band Required**
Admission of patient	New admissions must have an identification band in place within 30 minutes of admission. Including all day case patients	Yes
Transfer of patient	The registered healthcare practitioner must check all documentation accompanying the patient.	Yes
Health professional meeting patient for the first time	Staff must introduce themselves to the patient. If the patient is not receiving any treatments/procedures verbal confirmation will suffice.	Not required in out-patient setting
Requesting treatment or investigations	All request forms must accurately identify the patient and the Consultant responsible for the care. Check name is spelt correctly.	Minimum dataset required name, PID, DOB, Consultant NHS Number.
Medicine Administration	All medication to be administered in line with Trust Medicine policy, including medication for discharge	All inpatients including patients for discharge and any patients in an outpatients setting receiving Intravenous, medication controlled drugs or chemotherapy,
Surgical Procedures	Need to identify, the surgical procedure, the operation site. The WHO Surgical checklist to be completed. Consent must be checked as outlined in the National Association of Theatre Nurses standards and recommendations.	Yes

Event	Additional Information	Identification Band Required
Obtaining of other specimen-biopsies, body fluids, amniocentesis samples.	All specimens must be labelled immediately at the point of collection, ideally at the patient location. It is the responsibility of the person collecting the specimen to make it is labelled correctly.	Minimum dataset required name, PID, DOB, Consultant NHS Number.
Patients receiving blood transfusions or blood related products.	All patients regardless if they are an in-patient or an outpatient must have an identification band on when receiving a blood transfusion blood or blood related products. Refer to UHB Blood Transfusion Policy	Yes
Patients receiving invasive treatment in outpatient setting	All patients attending an outpatient setting who are undergoing a treatment/procedure who are unable to confirm their identity verbally or are receiving sedation, are agitate or confused;	Yes
Patients receiving chemotherapy	All patients regardless if they are an inpatient or an outpatient must have an identification band on when receiving chemotherapy.	Yes
Patients receiving intravenous therapy	All patients attending an outpatient setting, where they receive intravenous (IV) therapy or any invasive treatments.	Yes
New-borns and neonates	All new-borns and neonates must have two identification bands ideally one on the wrist and one on the ankle. If the identification band cannot be placed on the limb (in neonates an additional band is placed on the inside of the incubator. New-borns without a name are recorded by the mother's surname. If multiple births occur e.g. Twins are born record as TWIN 1 and TWIN 2. It is the responsibility of the registered Midwife caring for the baby at delivery, to ensure the identification wristbands are correctly applied as soon as possible after delivery and always before the mother or baby are transferred from the delivery room	Yes Electronic security tags can also be used within maternity and neonates
Last Offices	When a patient dies, a second identification band is placed on the patient other wrist. The original identification band must not be removed as this is the only identifier placed on the patient when they were alive.	Two identification bands are required.

Event	Additional Information	Identification Band Required
Patients attending Nuclear Medicine	A yellow wristband will be issued to all in-patients who undergo procedures within nuclear medicine and maybe radioactive. This band should be removed once the radioactive period has ceased. This must recorded in the post procedure plan.	Yes an additional one

3.4.7 Where patients are unconscious, confused or cannot communicate, for example because they do not speak or understand English or because they have an impairment due to disability, Healthcare Practitioners must be extra vigilant with these patients, particularly when they have not met the patient previously. (Wherever possible try and use staff members who have been involved with the patient previously). In these circumstances, where feasible, staff should involve carers/relatives and, where appropriate, interpreters to assist in identification.

3.4.8 Preparation of patients undergoing surgery must comply with the Trust World Health Organisation (WHO) Surgical Safety Checklist.

3.4.9 All patients going to theatre for surgery must have a single identification band on a limb which, wherever possible, is not being operated on or which does not/will not have an intravenous/arterial device in place.

3.4.10 Patient specimen identity labels must not be used to directly identify a patient. When placing labels on samples or documentation staff must ensure that the labels they use are the correct labels for the patient; at all times the sheets of multi-labels must be bound into the clinical record and not loosely attached.

3.4.11 Where individual departments such as Theatres, Radiology, and Emergency Department have additional checking procedures, these must be followed by all appropriate clinical staff. Radiology staff , for example, are required to follow the 'UHB Procedures for Medical Imaging - Procedure 1' for patient identification in accordance with the legal requirements of IRMER 2017

3.4.12 Where there are patients with the same or similar names who are in the same clinical area, additional checks need to be made to prevent miss-identification. (ask the patient to confirm their date of birth and address if possible) Wherever possible, patients with the same/similar name must not be nursed in the same bay

3.4.13 Patients in the Emergency Department (ED) must wear an identification band in the following circumstances:

- All patients requiring blood transfusion or intravenous/controlled drugs
- All patients who are confused and are unaccompanied.

3.4.14 When the identification of a patient is unknown and emergency lifesaving treatment is required this must always take precedence (refer to Procedural Guide for Unidentified patients in the Emergency Department).

3.4.15 The identification of neonates and children who are unable to communicate verbally and who do not possess a stage of cognitive development allowing identification themselves, the identification must be confirmed with their parent or guardian. For new-borns please refer to the Operational Procedure for Electronic Tagging and security of new-borns.
http://sharepoint/policies/Guidelines/Baby%20Tagging%20Operational%20procedure.pdf

3.5 Removal and/or Disposal of Patient Identity Bands

3.5.1 If a member of staff needs to remove an identification band before a patient is discharged it is their responsibility to replace it. Any member of staff who discovers a patient without an identification band has to assume responsibility for correctly identifying the patient and placing an identification band on the patient. If the information has become illegible the band must be replaced as soon as this is discovered.

3.5.2 Upon discharge, identification bands should be removed and either destroyed via shredding or placed in confidential waste bags.

3.5.3 At QEHB only, used patient identification bands are to be stored locally at ward/department level until collection by Trust logistics controllers who will transfer the patient identification bands to a secure/lockable container that will be provided by the commercial waste contractor.

3.5.4 At all sites, if the patient has been treated for an infectious disease, the patient identification band must be disposed of within the clinical infected waste bags.

3.5.5 Some patients or parents of new-borns may wish to keep their identification band upon discharge, particularly within paediatrics. Patients are permitted to keep their identification band, so long as they have not been treated for an infectious disease.

3.6 Patients without Identity Bands

3.6.1 All staff working in an Outpatient Department including all areas where patients attend for treatment as an outpatient, for example renal

dialysis units and those caring for patients in their own homes, must ensure that systematic verbal and note checking occurs to confirm the identity of the patient before any consultation and/or treatment takes place. This must include a check of the patient's full name, date of birth and address. (Please refer to section 3.3).

3.6.2 When patients cannot wear an identification band due to their clinical condition; for example patients with no or swollen limbs, certain dermatology conditions and those patients with multiple intravenous/arterial lines staff may need to consider attaching the identification band to the patient's clothing. This decision and rationale must be documented in the patient's records. Staff must be vigilant in these circumstances due to the inherent risk of the identification band being removed by the patient or when the patient's clothes are changed. It is the responsibility of the staff member caring for the patient to ensure that the identification band is transferred when clothing is changed. When it is not possible to attach a means of identification to the patient's clothing, staff must ensure that systematic verbal and record checking occurs.

3.6.3 For patients who refuse to wear an identification band, a clear explanation of the risks associated of not wearing an identification band must be made clear to the patient with a witness present and the conversation recorded in the patient medical records. Wherever possible this should also be signed by the patient. If the patient continues to refuse to wear an identification band, verbal identification must be made on each occasion prior to any treatment/procedure taking place.

3.7 Bar-coding and Identification

Where barcoded identification bands or other barcoding identification procedures are in place, it is important to recognise that the barcode does not provide sufficient assurance of patient identity when administering treatment or changing patient location. Identification must still be confirmed by other visual, verbal and documented cues as identified above.

3.8 Patient Identification and Electronic Systems

Where a patient is being identified on an electronic system, particular care must be taken to ensure that the patient name is spelt correctly and details on the system match the specific patient being identified. See section 3.3.2 for details of the type of information that must be used to verify a patients' identity. Staff must be vigilant for patients with the same or similar name and details to prevent the wrong patient being selected on the electronic system.

3.9 Mis-identification of patients

3.9.1 Any member of staff who discovers that a patient has been wrongly identified must immediately ensure that the patient is safe and, where relevant, that all records/documents relating to the patient, including the patient identification wristband, are amended where relevant.

3.9.2 The member of staff must complete an online incident report in accordance with the Trust Policy for the Reporting and Management of Incidents Including Serious Incidents and Near Misses Requiring Investigation.

4 Duties

4.1 Chief Nurse

The Chief Nurse is responsible for ensuring that the Trust has the appropriate mechanisms and systems in place in order to effectively verify the identity of all patients who are to receive care and treatment within the Trust.

4.2 Divisional Directors / Divisional Directors of Operations and Associate Directors of Nursing and their deputies

Divisional Directors/Divisional Directors of Operations and Associate Directors of Nursing are responsible for ensuring that the wards/departments and staff within the Division are aware of and implement this policy, and where there are deficiencies or concerns in delivery, these are investigated and reported via the Divisional Clinical Quality Groups.

4.3 Anyone who has responsibility for staff

Anyone who has responsibility for staff involved in the process of effectively verifying the identities of patients who are to receive care and treatment must ensure that:

4.3.1 All staff have access to this policy and associated procedural documents;

4.3.2 All staff will have access to information and resources to ensure they can comply with the requirements of the policy and all associated procedural documents; and

4.3.3 All staff have sufficient knowledge and resources available to adhere to and implement this policy and its associated procedural documents.

4.4 **All staff involved in the process of verifying the identity of patients who are to receive care and treatment**

All staff involved in the process of verifying the identity of all patients who are to receive care and treatment must:

4.4.1 Comply with the policy and all related procedures;

4.4.2 Ensure that the identification band is replaced if they remove the identification band or they discover that a patient does not have an identification band in place; and

4.4.3 Complete an incident report form, should they discover an error with the identification process.

5 Implementation and Monitoring

5.1 Implementation

This policy and its associated procedures are available on the Trust Intranet and disseminated to staff through the divisional management and internal team structures within the Trust.

5.2 Monitoring

Appendix A provides details on how the policy will be monitored.

6 References

National Patient Safety Agency (2005) **Safer Practice notice 11 – Safer Patient Identification** [Accessed 05.02.18]

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60032

National Patient Safety Agency (2007) **Your guide to implementing standard wristbands** [Accessed 05.02.18]

http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824

National Patient Safety Agency (2007) Standardising wristbands improves **patient safety** [Accessed 05.02.18]

http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824

National Patient Safety Agency (2018**) Safer temporary identification criteria for unknown or unidentified patients.** [Accessed 04/01/2019]

https://improvement.nhs.uk/news-alerts/safer-temporary-identification-criteria-for-unknown-or-unidentified-patients/

NHS England (2013) **The Never Events List 2018** [Accessed 05.02.18]

https://improvement.nhs.uk/uploads/documents/Never_Events_list_2018_FINAL_v5.pdf

World Health Organisation (2007) Patient Identification [Accessed 05.02.18]

http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf

7 Associated Policy and Procedural Documentation

WHO Safer Surgery Checklist

Bereavement Care Procedures

Procedures for Medical Imaging - Procedure 1- Patient Identification

Policy for the Reporting and Management of Incidents (including Serious Incidents Requiring Investigation)

Medicines Policy and associated procedural documents

Blood Transfusion procedure obtaining samples for pre transfusion testing HGS

Blood Transfusion Procedure Administration of blood components/products HGS

Procedure for the management of unknown /unidentified patients within the Emergency Department.

Appendix A **Monitoring Matrix**

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
At Queen Elizabeth Hospital Birmingham:				
Incidents are reported monthly as part of the contract review meeting Clinical Quality Performance Report	Senior Sister/Senior Charge Nurse	Matron/ Associate Divisional Director of Nursing	Review of incidents	Bi -Annual to Divisional Operational Quality Assurance Meeting
Audit of compliance with patients wearing correct patient identification wrist bands.	Lead Nurse Quality and Clinical Assurance	Associate Divisional Director of Nursing	Audit of compliance with patients wearing correct patient identification wrist bands	-Annual to Operational Quality Assurance Meeting
At Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital:				
Incidents and an audit of compliance with patients wearing correct patient identification bands	Lead Nurse Quality and Clinical Assurance	Associate Divisional Director of Nursing	Monitored as part of the monthly Nursing and Midwifery Care Indicators	Monthly to Operational Quality Assurance Meeting