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.
Controlled Document Number:	382
Version Number:	5.0
Controlled Document Sponsor:	Chief Nurse
Controlled Document Lead:	Lead Nurse for Quality and Clinical Assurance
Approved By:	Chief Executive
On:	12th February 2024
Review Date:	12th February 2027
Distribution: • **Essential Reading for:** • **Information for:**	 All Staff involved with the registration or treatment of patients All Managers

Contents

Version Control

Version	Title	Issue Date
1.0	Policy for Patient Identification	27/11/2008
2.0	Policy for Patient Identification	19/09/2011
3.0	Policy for Patient Identification	25/02/2016
3.1	Policy for Patient Identification	26/08/2016
4.0	Policy for Identification of Patients	30/08/2019
5.0	Policy for Identification of Patients	13/02/2024

1 Policy Statement

1.1 NHS England (2019) identified content and actions from previous patient safety alerts issued by NHS England and NHS Improvement (NHSI) (or its predecessor organisation, the National Patient Safety Agency (NPSA)) that are classified as ongoing enduring standards which remain valid beyond an alert's action complete date. One of these standards is in relation to identity bands. Correct identification, incorporating the core patient identifiers as directed by the NPSA in 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://www.england.nhs.uk/2018/12/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, volunteers 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 3.5.6. 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.

Patient Identification Number (PID)

NHS Number

3.3.3 A single, standard identification band shall be white with black text with only one exception.

3.3.4 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 could put the patient at risk. The reason for the red alert identification band must be documented in the patient's records 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 Non-Identification Bands

3.4.1 Within the Trust there are specialties/departments which use a colour wristband to denote a procedure/treatment/circumstance relevant to the patient.

3.4.2 Any colour wristbands in use **must not** be used to check the identity of the patient.

3.4.3 Where a colour wristband is being considered for use in practice, the rationale for and proposed use of the colour wristband must be presented to the Operational Care Quality Group for discussion. Final approval for the use of the colour wristband must be obtained at Trust Executive level.

3.5 Verification of patients

3.5.1 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 all 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.

3.5.2 Subsequently, identity must be confirmed by asking the patient to provide the 3 pieces of information (full name, date of birth and patient's address) 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?"

For patients under 16 years of age identity must be confirmed with the patient's parent/guardian/carer.

In circumstances where the patient is unable to confirm their identity please refer to section 3.5.7.

3.5.3 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.

3.5.4 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.

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

3.5.6 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. This includes all day case patients	Yes
Transfer of patient	The registered healthcare practitioner must check all documentation accompanying the patient.	Yes
Healthcare Practitioner 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.	No

Event	Additional Information	Identification Band Required
Requesting treatment or investigations	All request forms must accurately identify the patient and the Consultant responsible for the care. Check patient 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 Code (current version), 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	Identify the surgical procedure, the operation side and site. The World Health Organisation (WHO) Surgical checklist / Local Safety Standard for Invasive Procedure (LocSSIP) must be completed.	Yes
Patients undergoing interventional imaging procedures	LocSSIP to be completed. Identification must be undertaken in line with IRMER Procedure 1.	Yes
Obtaining of blood samples and other specimens – biopsies, body fluids, amniocentesis samples.	All specimens must be labelled immediately at the point of collection, without moving away from the patient. It is the responsibility of the person collecting the specimen to make sure it is labelled correctly.	Minimum dataset required: name, PID, DOB, Consultant, NHS Number.
Patients receiving blood component transfusions.	All patients regardless of if they are an inpatient or an outpatient must have an identification band on when receiving a blood component transfusion. Refer to Trust Procedures for Administration of Blood Components (current versions).	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 agitated 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

Event	Additional Information	Identification Band Required
Patients receiving intravenous therapy	All patients attending an outpatient setting, where they receive intravenous (IV) therapy or any invasive treatments must have an identification band on when receiving treatment.	Yes
New-borns and neonates	All new-borns and neonates must have two identification bands ideally one on each 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
Community Patients	For all patients visited in their own home or within the community clinic, patient identity must be confirmed by the healthcare practitioner with either the patient or family member. For all patients visited in residential homes, the healthcare practitioner must be accompanied by a member of the residential home staff to the patient's own room. The patient must only be seen in their own room for delivery of care/treatment. If the healthcare practitioner is visiting more than one resident patient, they must only take one patient's care plan in at a time. All safety checks must take place at the point of patient care. If the healthcare practitioner is not familiar with the patient, photographic ID should be checked.	Not required in community setting
Last Offices	When a patient dies, a second identification band must be placed on the patient, where possible on the opposite wrist to where the original identification band is located. 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.

3.5.7 Where a patient lacks capacity (for example they are unconscious or confused) or have difficulties in communicating due to i.e. a language

barrier, Healthcare Practitioners must be extra vigilant 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. Where appropriate, the use of a photograph to identify the patient may be considered. The photograph must be taken within the Trust with either the consent of the patient (Appendix A) or following a Best Interests decision and be documented in the patient's records. The photograph must only be taken for the specific purpose of patient identification and treated as a medical record for its retention and secure disposal. If the patient's appearance changes a new photograph must be taken using a new consent form.

3.5.8 Preparation of patients undergoing surgery / invasive procedures must comply with the Trust WHO Surgical Safety Checklist and relevant LocSSIP.

3.5.9 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.

3.5.10 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 exactly match all details on the patient's identification band and/or that the patient states (where the patient does not have an identification band) Sheets of multi-labels must be bound into the clinical record and not loosely attached at all times.

3.5.11 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 Trust 'Procedures for Medical Imaging - Procedure 1' for patient identification in accordance with the legal requirements of IRMER (current version) and the Radiology LocSSIP.

3.5.12 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 misidentification. Wherever possible, patients with the same/similar name must not be nursed in the same bay

3.5.13 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/unconscious/unable to communicate and are unaccompanied.

3.5.14 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 (current version)).

3.5.15 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 (current version).

3.6 Removal and/or Disposal of Patient Identity Bands

3.6.1 If a member of staff needs to remove an identification band before a patient is discharged it is their responsibility to immediately replace it. Any member of staff who discovers a patient without an identification band must 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.

3.6.2 Upon discharge, identification bands should be removed and destroyed in accordance with the Standard Operational Procedure (SOP) Storage/Collection/Disposal of Used Plastic Patient Cash and Valuables Envelopes and ID wristbands (Appendix B).

3.6.3 If the patient has been treated for an infectious disease, the patient identification band must be disposed of within the clinical infected waste bags.

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

3.7 Patients without Identity Bands

3.7.1 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 at the minimum a check of the patient's full name, date of birth and address. (Please refer to section 3.3).

3.7.2 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.

3.7.3 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 refuses to wear an identification band, verbal identification must be made on each occasion prior to any treatment/procedure taking place.

3.7.4 For patients who cannot tolerate wearing an identification band i.e. paediatric patients, patients with learning disability and/or autism, without capacity, verbal identification must be made on each occasion prior to any treatment/procedure taking place.

3.8 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.

3.9 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.

3.10 Misidentification of patients

3.10.1 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 band, are amended where relevant.

3.10.2 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 (current version).

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 Senior Management Teams and their Deputies

Senior Management Teams and the Deputies are responsible for ensuring that the wards/departments and staff within the site are aware of and implement this policy, and where there are deficiencies or concerns in delivery, these are investigated and reported via the site Clinical Quality and Patient Safety 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 has been made 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 C provides details on how the policy will be monitored.

6 References and Bibliography

HSIB (2021) **Wrong Site Surgery – Wrong Patient: Invasive Procedures in Outpatient Settings.** Healthcare Safety Investigation Branch. [Accessed 26.10.22]
https://www.hsib.org.uk/investigations-and-reports/wrong-site-surgery-wrong-patient/

NHS Digital (2009) **ISB 0099: Patient Identifiers for Identity Bands.** [Accessed 26.10.22]
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NHS England (2019) **Enduring Standards and General Principles from previously issued safety alerts** [Accessed 26.10.22]
NHS England » Our National Patient Safety Alerts

NHSI (2018) **Safer temporary identification criteria for unknown or unidentified patients.** [Accessed 26.10.22]
https://www.england.nhs.uk/2018/12/safer-temporary-identification-criteria-for-unknown-or-unidentified-patients/

7 Associated Policy and Procedural Documentation

Bereavement Care Procedures

Blood Transfusion Policy and associated procedural documents

Development of Sequential LocSSIPs

Medicines Policy and associated procedural documents

Operational Procedure for electronic tagging and security of new-borns

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

Procedure for Phlebotomy and Blood Sampling from a Venous Access Device

Procedure for the Handling of Patient's Cash, Valuables and Property

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

Procedures for Medical Imaging - Procedure 1- Patient Identification

WHO Safer Surgery Checklist

Appendix A

Consent Form for Taking and Storing Photographic Image for Purpose of Patient Identification

University Hospitals Birmingham NHS
NHS Foundation Trust

Consent to Identification Photography

Patient identification bands are used by the Trust to help identify patients. Prior to the application of the band and subsequently, a patient's identity is checked by verifying 3 pieces of information with the patient.
In circumstances where it is not possible to confirm a patient's identity, a photograph may be used to help identify a patient. Such photographs will only be used for the purpose of patient identification and will be stored and accessed securely by clinical staff involved in your care. The copyright of all photographs remains the property of University Hospitals Birmingham NHS Trust.

Consent Type B (Restricted Internal Usage Only)

I hereby give consent for the photographs revealing my face or identity to be used by the Trust in relation to my treatment. I understand that the photographs will not be used for any other purpose.

Name: ..... **Signature: .....**

Address: .....

Date of Birth: …/…/…

Date Consent Signed: …/…/…

This section to be completed when the above is signed by a parent or guardian etc.

Name of person in the photograph: ……

Relationship to above: (parent/guardian/spouse etc.): ……

Date: …/…/…

Photographic Details – to be completed by the photographer

Intended use: Patient Identification
Patient Identification Number: …….. **Patient Date of Birth:** …/…/…
Name of person taking the photograph: ……
Details/Notes:
.....
…….....

Appendix B
Standard Operational Procedure (SOP) Storage/Collection/Disposal of Used Plastic Patient Cash and Valuables Envelopes and ID wristbands

Remember: this is confidential waste

Introduction

This SOP details the procedure to be followed by wards and departments in relation to the storage, collection and disposal of used plastic patient valuables bags. Used plastic patient valuables bags contain confidential patient information but must not be disposed of in the paper confidential waste bins.

Procedure

On the QEHB site, patient cash and valuables envelopes/ID wristbands must be stored locally at ward/department level prior to collection by Trust logistics ward/department controllers who will in turn transfer the bags to an identified secure/lockable container. For clinical areas, this will be part of the routine regular visits to the clinical area. Cashiers and bereavement care will contact Logistics Management to request collection (X13390 / X13391).

On SH, GHH and BHH sites and at Norman Power, patient cash and valuables envelopes/ID wristbands must be transferred by ward staff to the identified secure/lockable container.

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Ward staff/ Ward department controller "posts" patient valuables enveloped/ ID wristbands into the secure lockable container in the site location detailed below.

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When the container is full, Facilities/Logistics Managers (or at Norman Power the ward housekeeper) must contact the commercial waste contractor to arrange collection/consignment.

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Commercial waste contractor collects and ensures secure disposal.

Location of secure lockable storage containers:

QEHB:	Logistics Linen Room
GHH:	Facilities Post Room
SH:	Facilities Portering / Security Office
BHH:	Facilities Porters Help Desk
Norman Power:	Facilities First Floor Management Offices

Appendix C **Monitoring Matrix**

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
Datix incidents relating to poor patient identification compliance	Clinical Governance and Patient Safety Team	Clinical Quality Monitoring Group (CQMG) Trust Board	The top 5 increasing incidents are identified routinely by the Risk and Patient Safety Teams. If a potential issue with patient identification is identified, this will be incorporated into the Integrated Quality Report which is reported to CQMG.	Quarterly reporting to CQMG and then to Trust Board
Audit of compliance with patients wearing correct patient identification bands.	Lead Nurse Quality and Clinical Assurance	Operational Care Quality Group	Audit of compliance with patients wearing correct patient identification bands / Monitored as part of the Clinical Dashboard	Annual to Operational Care Quality Group