# Policy for Patient Identification

<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>Policy document</th>
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<tr>
<td>CLASSIFICATION:</td>
<td>Clinical Governance</td>
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<tr>
<td>PURPOSE</td>
<td>This policy sets out the framework by which the Trust ensures that all patients are correctly identified.</td>
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- **Essential Reading for:**
- **Information for:**
1 Policy Statement

1.1 The National Patient Safety Agency (2005, 2007) 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 NHS England’s List of Never Events 2013/14 includes patient misidentification stating that “death or severe harm as a result of administration of the wrong treatment following inpatient misidentification due to failure to use a standard wristband (or identity band) identification processes” is an event which should never occur.

1.3 The Trust will ensure that the identity of all patients is effectively verified at every stage of the patient’s pathway by ensuring that:

1.3.1 all staff are aware of the need to identify the correct patient before providing treatment
1.3.2 patients receive the correct information, medication, treatment and care; and
1.3.3 a clear and consistent approach is taken towards the identification of all patients and that best practice is applied at all times.

2 Scope

2.1 This policy applies to all Trust staff involved in contact with or delivering care to patients and includes students, locum and agency staff and all staff employed on honorary contracts.

2.2 This Policy applies to all patients who are in-patients, day case patients, patients attending Trust premises as out-patients and patients for whom care is delivered in the community.

3 Framework

3.1 This section describes the broad framework for the verification of patient identification. Detailed instructions on the application of an identification wristband are provided in the associated procedural documents.
3.2 The Chief Nurse shall approve all procedural documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy.

3.3 Verification of Identification

3.3.1 When an identification wristband is fitted, the information on the band must be checked with the patient, whenever possible, and this must be documented in the medical records.

3.3.2 In all circumstances, prior to fitting the identification wristband, three pieces of information must be obtained in order to verify the identity of the patient in the first instance; full name, date of birth and patient’s address must be used but other information such as Next of Kin details, General Practitioner and telephone number may all provide added assurance that the patient has been correctly identified. Staff must not assume that previous departments have done this.

3.3.3 It is not sufficient to ask patients to confirm the details given to them. Confirmation of identity must be sought by asking the patient to provide the information which must then be checked against the records. E.g. the question should be phrased:

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

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

3.3.5 Where patients are unconscious, confused or cannot communicate, for example because they do not speak or understand English or because they have impairment due to a physical or mental disability, clinicians must take extra vigilance with these patients, particularly when they have not dealt with the patient previously, possibly involving other staff in the checking procedure. In these circumstances, wherever possible, staff should involve carers/relatives and where appropriate interpreters to assist in identification; however care and treatment must not be delayed if the patient can be identified without such assistance.
3.3.6 A patient’s identification must be verified on each of the following occasions:

3.3.6.1 Before applying the identification wristband.

3.3.6.2 When a patient arrives at the clinical area.

3.3.6.3 Before carrying out all consultations, treatments and procedures.

3.3.6.4 Before taking patients from a ward or department to another location.

3.3.6.5 In all circumstances before providing information.

3.3.7 Where more than one healthcare professional is participating in a clinical procedure, each is responsible for correctly identifying the patient.

3.3.8 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.

3.3.9 The preparation of patients undergoing surgery must comply with the Trust World Health Organisation (WHO) Surgical Safety Checklist.

3.3.10 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.

3.3.11 Where individual departments such as Theatres, Radiology and Emergency Departments 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 2000.

3.4 Application of Identity Bands

3.4.6 All identification wristbands must contain the patients first and last name, date of birth, Hospital Unit number, NHS Number, and barcode. Identification wristbands must be printed from the Patient Administration System viewer applications; directions for this are available in the associated procedural document.
3.4.7 All inpatients/day cases must have a Trust approved identification wristband fitted as soon as they arrive at the ward/day case area. Only one patient identification wristband must be applied to each patient at any one time. Barcoded identification wrist bands are not utilised in the Emergency Department, therefore handwritten identification wristbands must be applied until the patient is transferred to the ward.

3.4.8 A single red identification wristband (with printed black text on a white panel) must be used instead of the standard identification wristband 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 wristband must be documented in the notes or, in the case of an allergy, on the Prescribing and Information Communication System (PICS). It is the responsibility of the member of staff who checks the identification wristband 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 wristband.

3.4.9 All patients going to theatre for surgery, must have a single identification wristband on a limb which, wherever possible, is not being operated on or which does not/will not have an intravenous/arterial device in place. An additional identification wristband must be part of the documentation that accompanies the patient to theatre; so that in the case of the identification wristband being removed, it can be replaced immediately.

3.4.10 Unconscious patients of unknown identity must have an identification wristband attached with the allotted Emergency Department number in full on it and checks with the notes made prior to any treatment. In extreme emergency situations clinical care may take priority over attaching an identification wristband to the patient. Where this has occurred the accountable health professional responsible for the patient’s care must take appropriate steps to confirm the patient’s details and attach an identification wristband as soon possible after the immediate emergency situation is over.

3.4.11 A yellow wristband may be issued by Nuclear Medicine to identify that an individual patient is radioactive. These wrist bands MUST NOT be used for ascertaining patient identification and must be removed as soon as possible once radioactivity is no longer an issue.
3.4.12 Wristbands will be issued by medical and ambulance staff to identify that an individual patient has received a blood transfusion as part of their prehospital care. These wrist bands **MUST NOT** be used for ascertaining patient identification.

3.4.13 Where a patient is confused or unable to communicate and there are concerns that they may leave the ward unsupervised an additional wrist band can be applied identifying the ward details. It is the responsibility of the member of staff who admits/receives the patient onto the ward to apply this additional band and to change the ward details if the patient is transferred from another area.

3.4.14 Patients within renal dialysis and Continuous Ambulatory Peritoneal Dialysis (CAPD) clinics must have identification wristbands when receiving a blood transfusion or intraperitoneal antibiotics.

3.4.15 Deceased patients must have 2 identification wristbands; one on each wrist. Please refer to the Trust Bereavement Care Procedures (current version).

3.5 **Removal of Patient Identity Bands**

3.5.1 If a member of staff finds it necessary to remove an identification wristband before a patient’s discharge, then it is their responsibility to replace it. Any member of staff who discovers a patient without an identification wristband has to assume responsibility for correctly identifying the patient and placing an identification wristband on the patient.

3.5.2 When a patient is transferred to a different ward – the receiving ward is responsible for re-confirming the correct patient details are on the patient identification wristband when accepting the patient.

3.6 **Patients without Identity Bands**

3.6.1 All staff working in outpatient departments including all areas where patients attend for treatment as an outpatient, for example renal dialysis, 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 Where patients cannot wear an identification wristband due to their clinical condition; these conditions may include patients with
swollen limbs, certain dermatology patients and those with multiple intravenous/arterial lines, the member of staff may need to consider attaching the identification wristband to 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 wristband being removed by the patient or when the patient’s clothes are removed or changed. It is the responsibility of the staff member caring for the patient to ensure that the identification wristband is transferred when clothing is removed or 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 wristband, a clear explanation of the risks of not wearing an identification wristband must be made to a patient with a witness present and the conversation recorded in the patient notes. Wherever possible this should also be signed by the patient. In the event that the patient continues to refuse to wear an identification wristband, verbal identification must be made on each occasion prior to any treatment/procedure.

3.6.4 An additional identification wristband must be part of the documentation that accompanies the patient to theatre; so that in the case of the identification wristband being removed, it can be replaced immediately. Printed identification wristbands are the Trust standard for all patients and must not be replaced by any other means of identification; the only exceptions to this are described in 3.4 above.

3.6.5 Patients attending the ED from a Major Incident will arrive with identity (if known) information attached, having had that put in place at the scene of the Incident. Immediately on arrival, ED staff must apply a Major Incident identity label containing a pre-written Major Incident casualty number. As soon as the identification markers of the casualty (name and date of birth) have been verified, a second Trust printed identification wristband detailing this information must be attached to the casualty. To ensure that the patient’s involvement in the incident can be identified, for any required follow-up purposes, the Major Incident identification label must not be removed until the casualty is discharged from hospital. This is an exception to the policy of single ID bands.

3.7 Bar-coding and Identification

3.7.1 Where bar-coded identification wristbands or other bar-coding 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**

3.8.1 Where a patient’s name is being identified on an electronic system particular care must be taken to ensure that the patient name and details on the system match the specific patient being identified see 3.3 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 **In the event of Misidentification**

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 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 hospital.

4.2 **Divisional Directors / Divisional Directors of Operations and Associate and Deputy Associate Directors of Nursing**

Divisional Directors/Divisional Directors of Operations and Associate and Deputy 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 are adequately trained/inducted, to ensure they are competent to undertake consistently accurate patient identification requirements.

4.3.3 All staff adhere to and implement this policy and associated procedural documents.

4.3.4 The appropriate staff, equipment and stationary are available to enable this policy to be followed.

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

All staff involved in the process of effectively 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 wristband is replaced if they remove the identification wristband or they discover that a patient does not have an identification wristband in place.

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 1 provides details on how the policy will be monitored.

6 References


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

[Accessed 20.5.15]
National Patient Safety Agency (2007) **Your guide to implementing standard wristbands**
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824
[Accessed 20.5.15]

National Patient Safety Agency (2007) **Standardising wristbands improves patient safety**
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824
[Accessed 20.5.15]

[Accessed 20.5.15]

World Health Organisation (2007) **Patient Identification**
[Accessed 20.5.15]

7 **Associated Policy and Procedural Documentation**

7.1 Trust Procedure for the Application of Patient Identification Wrist Bands

7.2 Trust WHO Safer Surgery Checklist

7.3 Trust Bereavement Care Procedures

7.4 Trust Procedures for Medical Imaging - Procedure 1- Patient Identification

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

7.6 Trust Medicines Policy and associated procedural documents

### Appendix 1: Monitoring Matrix.

<table>
<thead>
<tr>
<th>MONITORING OF IMPLEMENTATION</th>
<th>MONITORING LEAD</th>
<th>REPORTED TO PERSON/GROUP</th>
<th>MONITORING PROCESS</th>
<th>MONITORING FREQUENCY</th>
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<tr>
<td>Incidents are reported monthly as part of the contract review meeting Clinical Quality Performance Report</td>
<td>Head of Clinical Risk and Compliance</td>
<td>Contract review meeting</td>
<td>Review of incidents</td>
<td>Monthly</td>
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<td>Audit of compliance with patients wearing correct patient identification wrist bands.</td>
<td>Lead Nurse Standards</td>
<td>Chief Nursing Team</td>
<td>Audit of compliance with patients wearing correct patient identification wrist bands</td>
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