



## PATIENT IDENTIFICATION POLICY

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<b>Documents to read alongside this Policy</b>	<ul style="list-style-type: none"> <li>• Latex Policy</li> <li>• Blood Transfusion Policy</li> <li>• Major Incident Policy</li> <li>• Procedures for the Identification of Deceased Patients</li> <li>• Drug administration policy Procedure for the Safe Administration of medicines</li> <li>• Medicines Management Policy</li> <li>• Maternity Services Guidelines</li> <li>• Neonatal Services Guidelines</li> <li>• Mental Health Service Guidelines</li> <li>• Equality and Human Rights Policy</li> <li>• Safe Use of Ionising Radiation Policy</li> <li>• Labelling of Specimens submitted to Medical Laboratories Policy</li> </ul>
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**OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON**

<b>Version Number</b>	<b>Date of Review Approved</b>	<b>Date Published</b>	<b>Summary of Amendments</b>
1	21/02/2012	05/032012	This policy supersedes the policy of the former Trust.

## **PATIENT IDENTIFICATION POLICY**

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## **1. INTRODUCTION:**

Patient misidentification has been recognised as a widespread problem within healthcare organisations and has been recognised by the National Patient Safety Agency (NPSA) as a significant risk within the National Health Service (NHS). In the NHS in England patient misidentification errors are now listed as Never Events (NPSA and Department of Health). Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented

The extent to which patient misidentification happens is thought to be widely underestimated by clinical staff, as very often they are unaware that a misidentification has occurred.

Patient misidentification can lead to a range of detrimental outcomes for patients, such as:

- Administration of the wrong drug to the wrong patient
- Performance of the wrong procedure on a patient
- Patient is given the wrong diagnosis
- Patient receives inappropriate treatment
- Wrong patient is taken to theatre
- Serious delays in commencing treatment on the correct patient e.g. mislabelling of an abnormal blood sample or tissue sample. (An abnormal histology specimen, which has been wrongly labelled can lead to a delay in diagnosis of the correct patient, and potential misdiagnosis of another patient)
- Unnecessary exposure to radiation - IRMER reportable events. (IRMER is the Ionising Radiation (Medical Exposure) Regulations)
- Cancellation of operations due to the misfiling of results, GP letters and correspondence
- Patient identity related blood transfusion incidents

In July 2007 a “Safer Practice Notice” was issued by the NPSA <sup>1</sup> that highlighted the risks of incorrect patient identification and required all NHS organisations in England and Wales to standardise the design of patient wristbands, the information on them and the processes used to produce and check them in order to improve patient safety.

## **2. POLICY STATEMENT:**

Cardiff and Vale University Health Board (UHB) are committed to ensuring that all patients are correctly identified using standardised personal information and will achieve this through the implementation of this policy.

## **3. AIMS AND OBJECTIVES:**

This policy will provide a framework to enhance Patient Safety across the UHB, the policy aims to reduce incidents of misidentification that may cause harm to a patient.

The policy will:

- Provide instruction on the process of checking patient identity and when this should occur.
- Describe how to standardise wristbands
- Explain the responsibilities of staff when checking patient identification.

#### 4. SCOPE:

This policy applies to all UHB staff in all locations and sets out the processes to be followed to ensure correct identification for all UHB patients.

#### 5. ROLES AND RESPONSIBILITIES:

The **Medical Director, Executive Nurse Director and Executive Director of Therapies and Health Sciences** hold ultimate responsibility for ensuring effective clinical governance arrangements and the quality of patient care. This responsibility is discharged within the Divisions and Directorates via the **Divisional Directors, Clinical Directors** and appropriate **Senior Managers**.

It is the responsibility of **Divisional Teams** to implement this policy, ensuring that appropriate up to date guidance is available and implemented at Directorate level and that compliance is audited.

**All staff** - are responsible for ensuring that:

- Their practice is in line with this policy **and** any additional local and national guidelines.
- Staff must comply with the provision of this policy and where requested demonstrate compliance.
- Information regarding failure to comply with the policy is reported to their line manager **and** that the incident reporting system is used when appropriate.
- Incidents of failure to ensure positive patient identification will be reported and investigated as appropriate. Investigations may be concise or comprehensive investigations dependant on the incident and patient outcome. Advice on investigations can be sought from the Patient Safety Team.
- Evidence of continued failure to comply with the provision of this policy may be dealt with via UHB Disciplinary Procedures.
- Information regarding any changes in practice, organisational structure or legislation that would require a review of this policy is immediately reported to their line manager.

#### 6. GENERAL PRINCIPLES OF PATIENT IDENTIFICATION

- When identifying a patient always ask the patient (or a relative / carer if the patient is unable) to:

1. State their name
2. Address and
3. Date of birth.

This information must then be checked against relevant documentation and the armband, and must include a check of the hospital/NHS number.

If the patient cannot verify their identification and a relative or carer is not present patient identification must be checked with relevant documentation and the Medical Notes.

**Do not** read the details out and ask them to confirm, as this may lead to misidentification. Always ensure that you check name, address, date of birth, and hospital/NHS number, checking a Patient's name is not enough to ensure safe practice. Patient's details must be checked against relevant documents e.g. drug chart, medical record etc. as appropriate to situation.

The UHB will provide an interpreter or sign language interpreter if the patient is unable to identify themselves.

- Correct patient identification involves **all UHB staff** and is essential before:
  - All investigations
  - All interventions, treatments and surgical procedures
  - The administration of all medicines and blood components
  - Provision of all aspects of patient care Moving patients to another clinical area (TRANSFER OF PATIENTS).
  - ID must also always be checked by the person receiving the patient in the new area
- **Do not** proceed with any procedure or intervention without checking the patients' Identification (ID). With the exception of Mental Health Division, Day Hospital, Outpatients and Primary Community and Intermediate Care areas this is done using a patient ID band. Areas that do not use ID bands **must** locally define how they will comply with this policy. The local policy **must** be agreed at the Divisional Quality & Safety Meeting.
- Always check that any forms (e.g. request forms or sample forms) have the correct patient ID information on them and wherever possible complete them while you are with the patient before proceeding with the investigation.
- Label samples taken from patients straight away. The safest way is to label bottles **after** the sample has been taken and **before** leaving the patients bedside.
- Pre labelling sample tubes is not recommended best practice
- National guidance from the Transfusion Community advises against the use of addressograph labels on cross match samples; and promotes handwriting on the sample. This should be done at the patient's bedside as stated above (See Transfusion Policy).

- Other specimens and or samples can be labelled with a Patient's addressograph (see Labelling of Specimens Policy).
- Always check that you are using the correct addressograph for all medical records and forms. Do not assume that the addressographs in patients' notes are the right ones (Loose addressograph sheets can easily be filed in the wrong patients' notes). Ensure that patient's addressographs are filed as securely as possible in the correct set of notes.
- Ensure that patients' full birth-registered or married/ legally changed name is captured on admission. Many patients are known by other names (e.g. Mary Jones may be known to family and friends as Molly Jones). The full birth-registered name must be used for all identification purposes. If patients have a preferred name this should be clearly recorded in their notes.

## 7. PATIENTS WITH THE SAME OR SIMILAR NAMES

If there are patients with the same or very similar names (e.g. William Thomas and Thomas Williams) in a clinical area, all staff in the area must be alerted.

Evidence suggests that putting patients with the same name next to each other in clinical areas reduces the risk of miss identification as staff remain more alert to checking ID than if they are kept apart at different ends of the ward.

Reducing the risk of miss identification of patients with the same or similar name can be also be done by highlighting the patients:

- During handovers
- During safety briefings
- By applying alert stickers (available from medical records) to notes / drug charts etc
- By marking it on the patient name board at the desk and above the patients' bed.
- By informing the patients and their relatives / carers that there is someone with the same or a similar name so that they can remind staff and can question any interventions that may take place.
- Completing full ID checks on all patients, as outlined in this policy, will avoid misidentification – even if there are two or more patients with the same name.

## 8. PATIENT IDENTITY BANDS:

### 8.1 When to apply an identity band

An identity band must be applied to all patients on admission to hospital or, patients who are receiving intervention that requires positive patient identification such as; blood transfusion, medicines etc. (exceptions identified in 8.7). This **includes** patients in the Emergency Unit and outpatient areas

who are undergoing investigations prior to admission and those who are undergoing any invasive procedures e.g. Angiogram, ERCP and Endoscopy.

If patients do not fall into this category, for example attendees of outpatient clinics, and there is concern about the safety of the patient, an identity band must be applied while they are in the department and removed when the patient is leaving.

## **8.2 Information to be included on an identity band:**

The UHB is working hard to achieve compliance with NPSA Safer Practice Notice No.24. The NPSA Safer Practice Notice No.24 – ‘Identifying patients’, states that a standard white identity band should be used to identify patients. Wristbands must be electronically printed where possible or handwritten until electric printing systems are available. The following information must be included on the wristband:

- Forename
- Surname
- Date of birth
- First line of address
- Hospital number
- NHS number

\*Note, it is no longer deemed safe practice for coloured wrist bands to be used. (this includes the use of red armbands – allergy status)

Whenever possible the patient must be asked to provide their name, DOB and first line of address to be written on the identity band prior to application so that the details can be verified and confirmed as correct.

On transfer of a patient to a new location, the identity band must be checked by the person taking over responsibility of the patient. This includes porters / staff who transport patients to other departments, who must check the identity band before transporting the patient and on arrival in the department.

## **8.3 Unknown Patients:**

Where the patients’ details are not known on admission (e.g. if they arrive at the Emergency Unit without ID or are unable to verify their ID) a temporary emergency hospital number will be issued and an ID band with this number will be applied to the patient until their identity is known. As soon as the patient’s identity is known a new ID band containing all the required fields must be applied.

For unknown patients attending theatre, local guidelines **must** be adhered to.

For unknown patients who require a blood transfusion, their request form must contain the following details:

- Gender
- Emergency Number



- Location (e.g. ward)
  - Name, signature and bleep of requesting doctor
- (see UHB Transfusion Policy).

#### **8.4 Printing of the identity band:**

The ID band should be generated as close to the patient as possible. There must be **no** delay between printing and applying the ID band.

If electronic generation is not available identity bands must be hand written, the use of addressographs is not viewed as best practice as patient details can become obscured.

##### **8.4.1 Application of the identity band:**

Wherever possible the identity band must be applied to the patient's wrist. Where this is not possible the band must be applied to the patient's ankle. Ensure when applying the band that the band can freely move and does not constrict the patient's limb. For patients attending theatre two identity bands should be applied in accordance with the "Patient Identification Procedure in Theatres Policy".

If a limb is not available, the band must be firmly attached to the patient's clothing in an area of the body which is clearly visible, using a suitable adhesive tape. The band must be reattached as clothing is changed and must accompany the patient at all times. In emergency or operative situations where the clothing has to be removed, the identification part of the band must be applied to the skin using see-through adhesive film.

Before a wristband is finally applied, the patient / relative or carer must confirm the patients' details again and you must check that these correspond to the details on the ID band.

##### **8.4.2 Replacement of Wristband**

If the band is removed it is the responsibility of the person who removed it to replace it promptly. Any staff member who notices that a band is missing must take prompt action to either replace it or inform the nurse looking after the patient. If a wristband becomes illegible, damaged or contaminated it must be replaced at the earliest opportunity.

#### **8.5 Babies born in the UHB**

8.5.1 For babies in the Maternity Departments the "Guideline for the Identification of Babies in the Consultant Led Unit and Midwifery Led Unit" (September, 2010) should be followed.

- The mother must have a standard information ID band applied as soon as she is admitted (as above).
- After delivery 2 bands must be applied to the baby's ankles with:
  - Mothers surname and forename

- Mother's unit number
- Date and time of birth of baby
- Sex of the baby (boy or girl)

- One band to also be applied to the mother's wrist with the same identifying number as the baby's bands

A baby's wristband must be renewed when:

1. Baby is allocated a name
2. NHS number is allocated
3. Baby's name is changed

#### 8.5.2 For babies in the neonatal unit

- If mother is still an inpatient on maternity, baby has 2 name bands with mother's details as per 8.5.1 **plus** 1 ID band with patient details as 8.2
- If mother is discharged, the baby has 2 of its own ID bands only.

This changes if baby goes to theatre:

- The baby is required to have 2 of their own ID bands
- Local guidelines must be adhered to when a baby is attending theatre.

For incidents when a baby requires / is going to receive a blood transfusion please see transfusion policy re: identity requirements.

This also changes if the baby dies:

- For the mortuary the baby has to have a set (x2) of name bands with mother's surname and father's surname (if they are different)

### 8.6 Deceased Patients

All deceased patients must be clearly identified before leaving the clinical area where they died. Identification will consist of 2 identification bands (preferably one on the wrist and one on the ankle). Always cross check the patient details on the ID band with the mortuary form.

### 8.7 Patients who do not wear identity bands

There may be some situations where a patient may not wear an identity band but the general principles of identification still apply before any procedure or interventions can take place.

- 8.7.1 If the patient refuses to wear it – the patient must be informed of the potential risks on not wearing an ID band and if the patient does not have the capacity to understand the risks, application to other limbs or to clothes must be considered.

- 8.7.2 Prior to any intervention the Patient's ID must be checked against the Drug Chart, Notes and verbal checks be preformed to ensure a positive identification.
- 8.7.3 If the band causes skin irritation – other means of applying the band must be considered (applied to or over clothing – as discussed above). It is advisable that checks for alternate products such as foam protecting are sought.

The reason and any explanations given to the patient must be documented in the patients' notes in either of the situations above.

- 8.7.4 The majority of patients within Mental Health Settings and in some Primary Community and Intermediate Care areas do not wear ID bands as they may be perceived as being at odds with the principles of normalisation, promotion of independence and reduction of stigma that are fundamental to their treatment / recovery. However, ID bands must be worn when attending specific treatments such as Electro Convulsive Therapy. If patients from these areas are admitted to other secondary care areas then a wristband must be applied.
- 87.5 ID bands are used for some inpatients within Mental Health Services for older People (MHSOP) and ID cards are used for patients attending MHSOP day hospitals in accordance with the "Procedure for the use of ID Cards (MHSOP)".

## **9. RESOURCES**

The principles of this Policy are not associated with any financial risk.

## **10. TRAINING:**

It is the responsibility of Directorate Teams to identify any training needs and action appropriately.

Resources for training needs will be on available on the intranet. Patient identification during drug administration is covered during Medicines Management Study Day.

## **11. IMPLEMENTATION:**

It will be the responsibility of the Directorates and Divisions to ensure the implementation of this policy in their clinical areas.

## **12. OTHER RELAVENT POLICIES / PROCEDURES / GUIDELINES:**

- Latex Policy
- Blood Transfusion Policy
- Massive Transfusion Policy
- Major Incident Policy

- Procedures for the Identification of Deceased Patients
- Drug administration policy Procedure for the safe administration of medicines.
- Medicines Management Policy
- Maternity Services Guidelines
- Neonatal Services Guidelines
- Mental Health Service Guidelines
- Theatre service Guidelines
- Equality and Human Rights Policy
- Safe Use of Ionising Radiation Policy
- Labelling of Specimens submitted to Medical Laboratories Policy

### **13. FURTHER INFORMATION:**

1. National Patient Safety Agency (2007). Safer Practice Notice No. 24 – Standardising wristbands improves patient safety. [Available URL]  
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824>
2. Anselm C.W. Lee, Mona Leung, K.T. So, (2005) “Managing patients with identical names in the same ward”, International Journal of Health Care Quality Assurance, Vol. 18 Issue: 1, pp.15 – 23
3. IRMER - Ionising Radiation (Medical Exposure) Regulations (2000, amended 2006). Department of Health.
4. Never Events:
  - Department of Health: <http://neverevents.dh.gov.uk/>
  - NPSA: <http://www.nrls.npsa.nhs.uk/resources/collections/never-events/>

### **14. EQUALITY:**

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Single Equality Scheme- FAIR CARE. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate

we have taken or will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

**15. AUDIT:**

Divisions are requested to build Audits monitoring Patient Identification into their annual audit work plans. An Audit Proforma is available from Clinical Audit.

**16. DISTRIBUTION**

This policy will be made available on the UHB intranet, clinical portal and internet sites.

**17. REVIEW:**

Every 3 years or as new information becomes available