| **Reference Number: UHB 101**<br>**Version Number: 4** | **Date of Next Review:** 1st March 2026<br>**Previous Trust/LHB Reference Number** |
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**Patient Identification Procedure**

**Introduction and Aim**

This document supports the Health Board's Patient Identification Policy and sets out the procedures which must be followed to ensure that patients are correctly identified at all stages of their interaction with the Health Board.

**Objectives**

- Provide instruction on the process of checking patient identification and when this should occur.
- Describe the systems used to identify patients, including wristbands.
- Explain the responsibilities of staff to confirm correct patient identification.

**Scope**

This procedure applies to all of our staff in all locations including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.

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| **Equality and Health Impact Assessment** | An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact. |
| **Documents to read alongside this Procedure** | • Blood Transfusion Policy<br>• Drug administration policy Procedure for the Safe Administration of medicines<br>• Equality and Human Rights Policy<br>• Labelling of Specimens submitted to Medical Laboratories Policy<br>• Latex Policy<br>• Major Incident Policy<br>• Massive Transfusion Policy<br>• Maternity Services Guidelines<br>• Medicines Management Policy<br>• Mental Health Service Guidelines<br>• Neonatal Services Guidelines<br>• Procedures for the Identification of Deceased Patients<br>• Safe Use of Ionising Radiation Policy<br>• Theatre Service Guidelines |
| **Approved by** | Quality, Safety and Experience Committee on 14 December 2021 |

| | Version 4 (Temporary amendment due to ePMA implementation) Approved by Medicines Safety Executive Group. |
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| **Accountable Executive or Clinical Board Director** | Executive Medical Director<br>Executive Nurse Director<br>Executive Director Therapies and Health Sciences |
| **Author(s)** | Patient Safety Team |

**Disclaimer**

**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**

| **Summary of reviews/amendments** | | | |
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| **Version Number** | **Date of Review Approved** | **Date Published** | **Summary of Amendments** |
| 3 | *14.12.21* | *16.01.23* | Updated / Revised Document |
| 4 | 21.03.25 | 21/03/2025 | Section 6 temporarily amended due to implementation of ePMA system |
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## 1. INTRODUCTION

Patient misidentification has been recognised as a widespread problem within healthcare organisations and has been recognised by the former National Patient Safety Agency (NPSA) as a significant risk within the National Health Service (NHS).

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 former NPSA 1 that highlighted the risks of incorrect patient identification and required all NHS organisations in England and Wales to standardise the design of patient wristbands (ID bands), the information on them and the processes used to produce and check them in order to improve patient safety. The UHB is now compliant with this notice and has introduced electronic printing of identity bands across the UHB.

## 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 RESPONSILITIES:

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 Clinical Boards and Directorates via the Clinical Board Directors and appropriate Senior Managers.

It is the responsibility of Clinical Boards 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 (known as a ‘patient ID check’) the following three pieces of information must be confirmed:

- Full name (first name and surname)
- Address
- Date of birth

The preferred method of confirming this information is by asking the patient themselves. The patient must be asked to confirm their details in a non-leading way, for example:

✓ “Please could you confirm your full name for me?”
✗ “Are you Mr Jones?”

✓ “Please could you tell me your address?”
✗ “Do you live at 1 North Street?”

- ✓ "What is your date of birth please?"
- ✗ "Is your date of birth 01/05/1950?"

The patient details must be checked against any documentation related to the task or treatment to be completed, such as test request forms, medical records or medication charts.

An interpreter or sign language interpreter should be used to assist with the patient identification check if necessary.

If a patient is unable to identify themselves due to their condition or other impairment and a relative or carer is not present, the patient's identification wristband should be checked.

In the following limited areas, patient ID wristbands are not used:

- Mental Health Clinical Board
- Day Hospital
- Outpatients
- Primary Community and Intermediate Care areas

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 Clinical Board Quality & Safety Meeting.

*The section highlighted in purple below is a temporary amendment to the Patient Identification Procedure and will be updated in line with developments to the ePMA system.*

**Temporary variation for ePMA**

**Using the desktop Nervecentre application**
When accessing the patient's ePMA record, the patient Identification process remains unchanged and the patient should be identified using the name, first line of address and date of birth.

**Using the mobile device Nervecentre application for patients with ID wristbands**

The mobile Nervecentre ePMA application does not show the patient's address, therefore the following approach is required:

Before administering medication using ePMA, the patient's details should be checked against the wristband. This check ensures that the wristband is correct.

The patient's name, date of birth and the hospital/NHS number (from the wristband) should be used to select the correct patient record within the ePMA

application. This is confirmed by scanning the 2D (square) barcode on the wristband using the mobile device.

A patient ID check is mandatory before any of the following:

- All investigations, including radiology, ECG, blood sampling and point of care tests.
- All interventions, treatments and surgical procedures.
- The administration of medicines or blood products.
- Transport of a patient to another ward, department or area. • Receiving a patient from another ward, department or area.

Ensure that each patient's full birth-registered or married/legally changed name is captured on admission. Many patients are known by other names, for example Mary Jones may be known to friends and family as Molly Jones. It is also common for patients to choose to be referred to by a middle name. The full legal name must be used for all identification purposes. If patient's have an alternative preferred name, this should be clearly recorded in their notes.

**7. SAMPLE AND DOCUMENT LABELLING:**

Always check that any forms or documentation have the correct patient ID and wherever possible complete them while you are with the patient.

Label any samples taken from a patient straight away. The safest way is to label any bottles or sample pots after the sample has been taken and before leaving the patient's bedside.

Pre-labelling sample tubes is not recommended practice.

National guidance advises against the use of addressograph labels on cross match blood samples; and promotes handwriting on the sample. This should be done at the patient's bedside (see transfusion policy).

Other specimens and/or samples can be labelled with an addressograph (see labelling of specimens policy).

Always check the details on any addressograph before use. You must not assume that addressographs stored within a patient's notes are correct.

**8. PATIENTS WITH THE SAME OR SIMILAR NAMES:**

If there are patients with the same or very similar names in a clinical area, all staff within the area must be alerted. This must also be passed over to any incoming staff at each shift handover.

Evidence suggests that putting patients with the same name next to each other in clinical areas reduces the risk of misidentification and is safer than locating them on separate parts of the clinical area.

The risk of misidentification of patients with the same or similar names can also be reduced by:

- Reminding staff during safety briefings.
- Applying alert stickers (available from medical records) to patient notes and other documentation such as drug or observation charts.
- Marking it on the patient name boards at the nurse's station and above the relevant beds.
- Informing the patients and their relatives/carers that there is someone else with a similar name in the clinical area. This encourages patients to challenge any treatments or investigations that they are not expecting and may be intended for another patient.
- Ensuring full ID checks are carried out at all times (see section 6).

## 9. PATIENT IDENTITY WRISTBANDS:

Other than in the exception areas listed in **section 9.8**, printed patient ID wristbands are the primary method of identifying patients who are, or become unable to confirm their own details.

### 9.1 When to apply an Identity band:

ID wristbands must be applied to all patients on admission to hospital. Wristbands must also be applied to any non-admitted patients who are receiving interventions that require positive patient identification such as:

- Blood transfusion
- Medications
- Invasive treatments or procedures

If patients do not fall into any of the categories above, but there is concern about their safety or the risk of misidentification, an ID wristband must be applied while they are in the department and removed when the patient leaves.
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.

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.

### 9.2 Unknown Patients:

Where the patient's 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 identity 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 identity band containing all the required fields must be applied.

For unknown patients attending theatre, local Theatre Service Guidelines must be adhered to.

For unknown patients who require a blood transfusion the UHB Transfusion Policy must be followed.

**9.3 Printing of the identity band:**

The UHB has rolled out a system which prints patient ID wristbands that are compliant with former National Patient Safety Agency (NPSA) Safer Practice Notice 24.

Patient identity bands must be electronically printed using the printers situated in clinical areas.

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

If electronic generation is not available (e.g. during a power cut) an addressograph can be applied to an identity band as an interim measure however an identity band should be printed as soon as possible. If an addressograph is not available, a blank addressograph should be placed on the Identity bands and must be hand written. Full guidance and troubleshooting guide can be found on the Intranet Wristband page.

**9.4 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 "The procedure for patient identification in theatres".

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 an identity band 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 identity band.

**9.5 Replacement of Wristband:**

If the identity 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 an identity band becomes illegible, damaged or contaminated it must be replaced at the earliest opportunity.

**9.6 Babies born in the UHB:**

9.6.1 For babies in the Maternity Departments the "Guideline for the Identification of Babies in the Consultant Led Unit and Midwifery Led Unit (2020) should be followed.

The mother must have a standard information ID band applied as soon as she is admitted (as above).

As soon as possible after the birth two bands should be attached to the baby 1 around wrist and 1 around ankle, giving the following information:-

- Mother's surname and forenames.
- Mother's Unit Number, if allocated.
- Date and time of birth of baby
- Sex of the baby, recorded as boy or girl (not male or female since these terms are more likely to be misread).

The band placed on the mother's wrist only has the band number on it. The information on the three bands must be checked by:-

- the midwife and another responsible person who is usually one of the parents verifying the details or
- the delivering midwife and another member of staff in the presence of the mother

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

9.6.2 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 9.6.1 **plus** 1 ID band with patient details as section 6
- 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)

**9.7 Deceased Patients:**

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

**9.8 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.

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

9.8.2 Prior to any intervention the patient's ID must be checked against the Drug Chart, Notes and verbal checks be performed to ensure a positive identification.

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

9.8.3 The majority of patients within Mental Health Settings and in some Primary Community and Intermediate Care areas do not wear identity 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, identity 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.

**10. TRAINING:**

It is the responsibility of Directorate Teams to identify any training needs and action appropriately.
Training and information on the use of the printed wristband system can be found on the UHB intranet. Select ‘Wristbands’ from the A-Z index. Patient identification during drug administration is covered during Medicines Management Study Day.

## 11. IMPLEMENTATION:

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