Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patient Identification Policy

This procedural document supersedes: PAT/PS 7 v.4 – Patient Identification Policy

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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 5	2 January 2019	Reviewed throughout – clarification of practices involved.	Nicki Sherburn/ Fiona Dunn
Version 4	Amended 17 June 2014	Change to section **6.4.12 – Department-specific Standards – Maternity Services** - use the same identification criteria as Neonatal Unit for all babies' identity bands.	Richard Stott
Version 4	October 2012	Order communications requirements. Revised identification for merged records.	Richard Stott
Version 3	November 2009	Computer printed ID bands	Richard Stott and Victoria Bagshaw
-	-	Reviewed at Patient Identification Group on 24.06.08 - no changes. Review date extended to July 2009	
Version 2	August 2007	Modification from "Patient Identity Band policy". Creation of new sections in response to NPSA & NHSLA requirements. • Initial Identification / Admission process • Unidentified Patients • Patients admitted during a Major Incident. • Actions in the event of misidentification of a patient or identification of a previously 'unknown' individual.	Richard Stott (On behalf of the 'Patient Identity Group')

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1. INTRODUCTION

Research and anecdotal evidence shows that there is a significant risk of patients being incorrectly identified and given the wrong care (National Blood Service and Royal College of Physicians, 2003; Guthrie, 2003; Human Reliability Associates, 2004; Cambridge Consultants, 2004; Royal College of Nursing, 2004; all cited by National Patient Safety Agency [NPSA], 2005).

The Joint Commission on Accreditation of Healthcare Organizations reported that incorrect patient identification is involved in 13% of medical errors in surgery and 67% of transfusion errors (NPSA, 2005).

In 2014/15 NHS England reported 4 never events through misidentification of patients

Local audit and incident reporting support this evidence and show that there are regular examples of errors within the trust. These have the potential to seriously affect patient care and on occasion could have fatal outcome if not discovered.

Recommendations from National Patient Safety Agency alerts regarding patient identification through wristbands remain relevant to the Never Events list 2018.

2. PURPOSE

This policy sets out the standard required for the appropriate patient identification throughout the Trust and is to be implemented in all areas. It is designed to:

- Ensure that all aspects of the management of patient identification within the Trust comply with the latest recommendations from the NPSA and other agencies.
- Ensure the safety of all patients throughout their hospital stay through correct identification on admission and prior to any assessment, investigation or treatment whilst under the care of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.
- Provide clear standards and procedures for staff carrying out their duties involving patient identification using identity bands and other aids to positive patient identification

The policy supersedes the 'Patient Identity Band' policy but includes all the content of that document. The original policy was launched via the team communication and trust intranet. The importance of patient identity bands and the additional processes included here will be covered in the Trust induction programme.

3. DEFINITIONS

DBTH or DBH	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
ID	Identification
NPSA	National Patient Safety Agency
A&E	Accident and Emergency Department

CaMIS or PAS	Patient Administration System
HAS	Hospital Admission System
EDIS	A&E administration system
JAC	Medicines management system

4. DUTIES & RESPONSIBILITIES

Patients / Relatives and Carers:

All patients / Relatives and Carers are requested to help with implementing this policy which is intended to ensure the safety of patients while under the care of the Trust. This will require them to:

- Confirm the patient's identity whenever asked to do so.
- Ensure that no treatment is given without the patient's identity being confirmed first.
- Cooperate by wearing an Identity Band if requested to do so and check that the details are correct.
- Immediately report any identification problems to senior nursing staff.
- Use the 'Your opinion Counts' process to suggest possible improvements in the process of identification.

Patients lacking capacity:

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest .
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

Healthcare professionals:

- All healthcare practitioners and support staff are required to follow the detailed process contained within this policy when establishing or confirming a patient's identity.
- All healthcare practitioners and support staff are required to ensure that, in the absence of specific contraindications, all patients wear a computer printed identity band.

- Where there is a contraindication or the patient refuses to wear an identity band, the facts must be recorded in the patient's notes. In the event of refusal by an individual who has the capacity to make that decision, the record must be signed by the patient to confirm that they have been informed of and accept the risks associated with their actions. Suitable risk assessed alternative means of confirming patient identity must be provided.
- Except in an emergency, no diagnostic procedure or treatment should be performed without first identifying that it will be received by the correct patient.
- If a member of staff removes a patient's identity band, it is his/her responsibility to replace it or ensure that it is replaced with a new identity band as soon as possible.
- Report all patient identification issues (Including near miss events) using the Trust's Incident Reporting procedures.

Unit / Department managers:

Unit managers should ensure that –

- All patients on their unit have an ID band in place (exceptions only if bullet point 2 below performed)
- Any patient on their unit who is not wearing an ID band has the required risk assessment performed and documented.
- All incidents regarding patient identification are recorded using the Trust's incident reporting process and discussed by the appropriate Clinical Governance Group(s).
- Any identified actions resulting from incidents are implemented.
- The required audits are performed as detailed in the "Monitoring effectiveness" section of this document, identified issues are communicated to the Speciality Governance Lead and resulting action plans are implemented.
- Any department specific sections of this policy are reviewed at appropriate intervals and updated as required.
- Any local feedback regarding patient identification is formally recorded.
- All staff receive induction in the sections of this policy which relate to their work.

5. MONITORING EFFECTIVENESS OF THE POLICY

Incident reporting:

The policy requires all patient identity related incidents to be logged via DATIX and themes monitored through the Trust's governance process. Copies of any incident forms must be sent for action to the department manager, Matron or relevant speciality governance lead. The Trust's risk management process will ensure that the incident is reported to the National Reporting and Learning System (NRLS).

DATIX entries relating to patient identification are included in the Quarterly Report, which is distributed to via the Trust Clinical Governance and Risk management processes.

Appropriate DATIX codes include –

IIP	Incorrect or incomplete identification of patient
IDWB	Incorrect or incomplete details on patient's wristband
MRN	Multiple registration numbers
NWB	No wristband attached
IPC	Incorrect patient information communicated (verbal or written)

Complaints feedback:

All patient feedback received is recorded and included in the unit audits and the DATIX Quarterly Report as appropriate.

Audit:

Local patient identity band audits are carried out annually by ward / department / unit managers, in line with the documentation and medicines management. These audits will include a review of:

- Feedback (Both formal & informal) from patients, relatives, carers and staff regarding patient identification procedures.
- The number and percentage of patients wearing identity bands;
- The accuracy, legibility and reliability of the information included on identity bands;
- Compliance with the process of recording application of the identity bands;
- The reasons why patients may not be wearing identity bands and the recording of this information in the notes;
- The efficacy of alternative arrangements;
- Safety incidents & near misses related to patient identification.

As part of the monthly Matron Survey, Matrons will ensure that the patients have identification bands in place.

Any issues identified are initially handled by the appropriate ward / department / unit managers. Actions and outcomes must be reported via the appropriate division / specialty Clinical Governance Group.

6. POLICY & PROCEDURES

6.1 Initial identification/Admission process

Initial identification of the individual is critical to performing the correct procedures and recording events in the correct records.

This policy requires that existing hospital numbers (and NHS numbers) are not used as primary identifiers at admission to ensure any replicated registrations are identified and merged and that all sets of notes are available.

- At the discretion of the admitting staff, formal documentary evidence of a patient's identity (e.g. Passport, driving licence, Hospital Photo-ID card etc) **may** be used providing there is a photograph which is a good visual match to the presenting patient.

- Patients transferred from other hospitals outside the Trust must be admitted as a new admission. Under no circumstances should hospital numbers from outside the Trust be used for care on the DBTH sites. NHS numbers should be checked as for a new admission and a new patient ID band will be required. Original band must be removed(to avoid use of inappropriate unit numbers). Primary or secondary identification confirmation must be gained whenever possible.

- Non-photo ID (including clinic letters, appointment cards etc) must not be used as evidence of identity but can be used as confirmation of verbally stated details (eg Address, hospital number, NHS number) or an accepted version of names where the spelling of the patient's name presents difficulty (eg their native language uses an alphabet which the computer systems do not handle).

If available a relative or carer must be included in the initial identification process for individuals who are not able to respond on their own behalf. This includes –

- Children
- Unconscious individuals
- Any patient presenting with either permanent or temporary reduced mental capacity.

Where confirmation of identity is not possible the 'Unidentified patient' procedure should be followed and the identity created should then be used until the patient can be formally identified and all computer systems updated.

6.2 Initial identification/Admission procedure

6.2.1 When initially identifying a patient there may be a language difficulty in communicating with the patient. In this situation a relative, carer or the language line service may be used to assist. This requirement should be recorded on the notes front sheet to ensure the continued availability of translation where necessary throughout the patient's care.

6.2.2 Explain to the patient (or their representative) that their initial identification and the use of ID bands (and/or other forms of non-verbal identification) are a central part of ensuring their continued safe identification throughout their care as an inpatient or day-patient and ensures the use of the correct patient records. This requires the active involvement of all patients who are sufficiently aware to understand and applies to all actions relating to their identification.

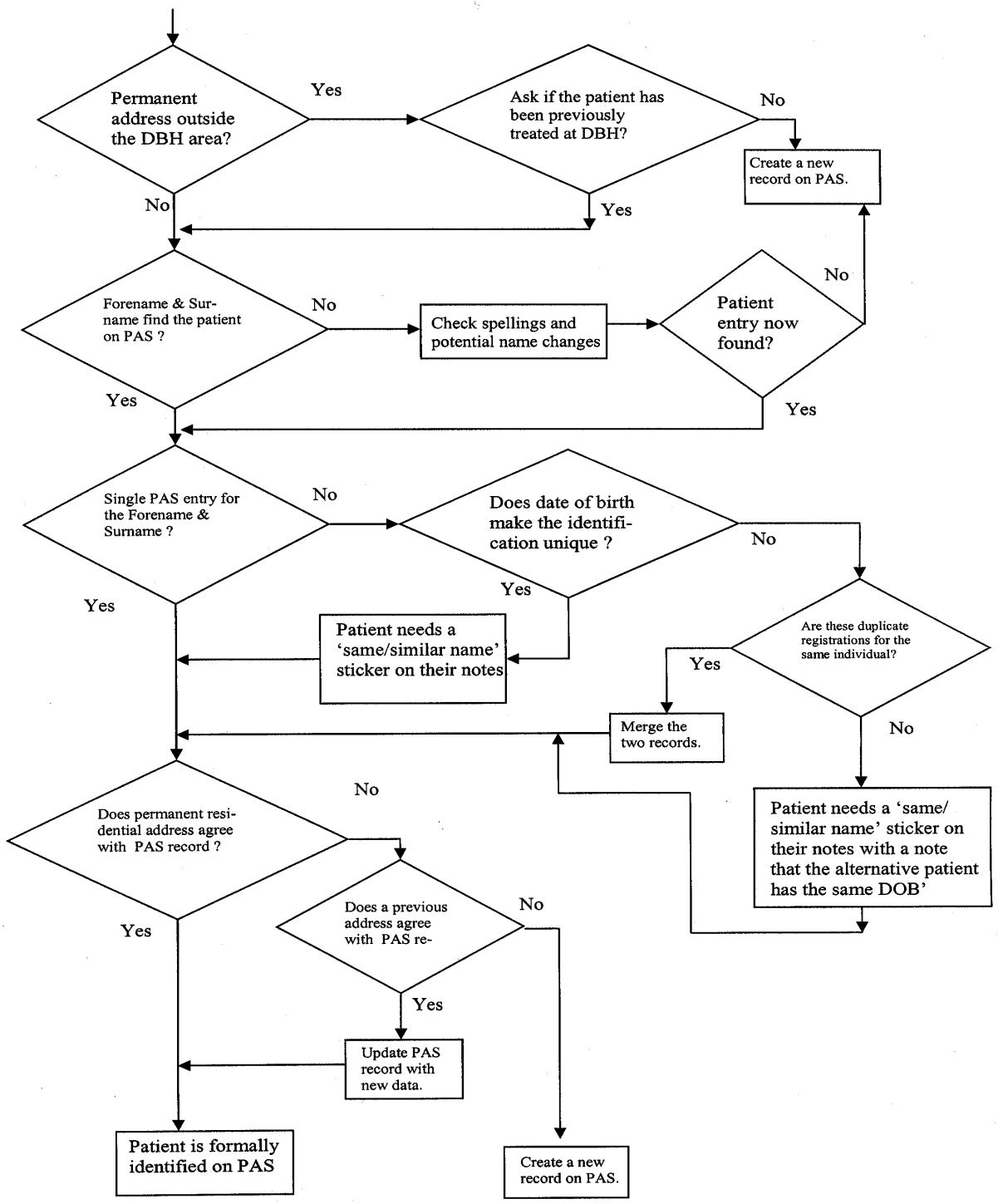
6.2.3 Patients are to be allowed to wear their own wristbands to designate clinically important preferences eg 'No blood transfusions' or serious allergies. Any preferences or allergies on the band must also be recorded in the appropriate area of the patient's notes. Any patient wearing their own band must be aware that this band may be removed as part of routine procedures and that any personal details on the band may confuse staff.

6.2.4 Obtain the following primary identification details from the patient or their representative

- Family name
- Fore name
- Any second initial
- Date of birth
- Permanent residential address.
- Current address (if different from above)

6.2.5 Use the flow chart to confirm the patient's identity.

Initial Patient Identification Process



6.2.6 Produce a current front sheet for the patient notes and sign to confirm the patient identification details are correct.

6.2.7 Where there is another patient with similar or identical names and date of birth, the patient (and/or their carer / Relative) must be informed of the increased potential for incorrect identification. This communication must be recorded on the notes front sheet and the appropriate warning sticker used to alert all staff of the potential for identity confusion.

6.2.8 In the absence of a patient representative who knows them well, the identity bands of patients who cannot confirm their own identity (e.g. those who cannot communicate, young children, the critically ill, unconscious, or confused) must be checked by two members of staff of whom at least one MUST be a registered practitioner, prior to the identity band being placed on the patient.

6.2.9 Produce a patient ID band according to the policy and procedures in the "Patient Identity Band" section of this document. Check that all details agree with the Notes front sheet and attach it to the patient's dominant wrist. Refer to 6.5

6.2.10 Any discrepancy between the information the patient gives and the details in the corresponding case-notes must be investigated immediately. Once the correct information has been confirmed the case-notes must be amended accordingly. The discrepancy must also be reported to the registered practitioner in charge so that s/he may notify the medical records department to correct the information on the central electronic record and all affected departments. This action may be delegated to the receptionist or the ward clerk. (See section 6.6 "Actions in the event of misidentification of a patient".)

6.2.11 If the patient has an ID band from another hospital and will be remaining as a patient of DBTH the external hospital's band should be removed.

6.2.12 It is essential to request all sets of notes at each admission to ensure all record front sheets are appropriately updated.

6.2.13 If the patient's notes are already available, check that the patient's notes folder has both the District number and NHS number on the cover and the front sheet. If not then the notes must be labelled with these items to ensure the full unique patient identity can be checked between the notes and the identity band.

6.2.14 Check that all addressograph labels present agree with the front sheet and that the label includes the District number and the NHS number if available. If not, destroy all of the labels and produce a replacement sheet with the correct details.

6.3 Unidentified patients' policy

Patients admitted without formal identification will be registered on CaMIS and therefore issued with identification tags and records which give their forename and Surname as 'Unknown'. The only available identification details for these individuals will be their District number and Gender and no other personal data will be available on CaMIS.

Following identification of the individual, full patient identity can be commenced immediately by applying a second ID band. The "unidentified patient" ID band must remain in place until all of the following actions are complete –

- Any blood products or medicines which were allocated under the original number have been administered, re-labelled or re-allocated to another patient.
- The two separate CaMIS identities have been merged (This also resolves any split record issues on the laboratory system and medical imaging systems)
- The two sets of paper records have been combined.
- Any manually updated record systems have been corrected. This may need to be delayed until all affected departments which need to make manual corrections to their computer systems or records have done so. For details, see section 6.6 "Actions in the event of misidentification of a patient".

NB . The identity band of unknown patients must state:

- 'Unknown' as both the surname and first name.
- Patient identity number
- Dummy date of birth being used (NB must be less than 110 years old to avoid issues with reference ranges on the pathology system).

6.4 Policy on identification of patients admitted during a Major incident

Patients attending A&E from a Major Incident should arrive with identity information hung around their necks, attached at the scene of the incident.

A&E staff will apply a Major Incident identity band, with a pre-assigned Major Incident casualty number, to each casualty **immediately** as he/she enters the department. As soon as the casualty's identification markers of name and date of birth have been verified.

Depending on the nature of the incident and the numbers of individuals attending the appropriate A&E department(s) these numbers may also be used for individuals who were not directly involved in the incident.

As for 'unidentified patients', these identities will contain no patient related details and will not be fully entered on CaMIS. Full patient identity will be added to the CaMIS system and appropriate individual's records merged after the immediate incident is over. For details, see section 6.3 "Unidentified patients policy".

6.5 Patient Identity Band Policy

6.5.1 Introduction

Correct patient identity is fundamental to the health and safety of patients in hospital. Shorter stays in hospital can make it more likely that inpatients will not be recognised (NPSA, 2005). Therefore, all hospital inpatients in acute settings should wear a securely fastened identity band, with accurate details, that correctly identify them and match them to their care and treatment (NPSA, 2005).

The content and format of patient Identification bands must be computer printed and comply with the current approved Trust format and produced 'with the active involvement of the patient'.

6.5.2 Patient awareness

All patients or parents/carers must be informed of the importance of identity bands for correct patient identification.

The importance of wearing an identity band for their own safety at all times during their hospital stay should be explained to patients in the Accident and Emergency Department and at pre-admission clinic. This should be re-iterated at pre-admission assessment clinics and at the time of putting the band on. It should also be included in any relevant leaflets, posters, website information and bedside patient information folders.

Where there is another patient with similar or identical names and date of birth, the patient must be informed of the increased potential for incorrect identification. This communication must be recorded on the notes front sheet.

NPSA guidance recommended that patients be allowed to wear their own wristbands to designate clinically important preferences eg 'No blood transfusions' or serious allergies. Any patient doing so must be aware that this band may be removed as part of routine procedures and that any personal details on the band may confuse staff.

6.5.3 Who may prepare and attach an identity band to a patient?

Registered practitioners may prepare and attach an identity band to a patient, e.g:

- Registered Nurse/Midwife
- Doctor
- Operating Department Practitioner

Clinical support workers and health care students may prepare and attach an identity band (providing they have undertaken the necessary theory and practise) under the supervision of a registered practitioner.

6.5.4 Who must wear identification bands

The following groups of patients are to have identification bands immediately on admission at the hospital. No procedure can take place without one

All patients to the accident and emergency department (A&E) where a decision has been made to admit or they may need to be admitted.
All in-patients
All day ward attendees
Outpatients who will undergo treatments where there is a significant risk of an adverse reaction requiring resuscitation or admission.

6.5.5 Preparation and application of identity bands

Identity bands must normally be produced using the appropriate option on CaMIS. See Appendix 1 for detailed procedure of printing bands. See Appendix 2 for detailed procedure of loading new bands to wristband printer.

In the event of computer printing being unavailable, the identity band may be hand written using a black marker pen using details taken from the patient's notes, or from CaMIS) to ensure consistency across the trust, the information on the identify band must be arranged in the same format as currently used.

NHS No.	Name
Address	
D.O.B.	Hospital Number

Bands produced in this way must be replaced with computer printed band at the earliest opportunity.

NB: Samples will not be taken by the pathology based phlebotomy team if there is no barcode available to scan into the ICE system. These tests will need to be drawn by ward staff to ensure that the patient identity can be checked effectively.

The information must be checked for accuracy with the patient where possible. On each admission, the front sheet must be re-checked, re-printed and placed in the front of the medical records, ensuring disposal of the previous front sheet and any out of date patient identity labels. The process in sections 6.2.6, 6.2.8 and 6.5.5 should be followed.

Any discrepancy between the information the patient gives and the details in the case-notes must be investigated immediately. Once the correct information has been confirmed the case-notes must be amended accordingly. The discrepancy must also be reported to the registered practitioner in charge so that s/he may notify the medical records department to correct the information on the central electronic record and all affected departments. (See section 6.6 "Actions in the event of misidentification of a patient".)

Whenever possible, the identity band should be put on the wrist of the dominant arm, i.e. the side that is used for writing; it is then less likely to be removed when intravenous access lines etc. are inserted. If neither wrist is suitable for use, either ankle may be used.

N.B. The identity band must not be put onto a limb, which is going to be operated on, nor should it be applied to the operative side in patients undergoing breast surgery. Alternative secure methods of identification should be implemented for example pin the details to clothing.

The identity band must be tight enough to remain on the limb but loose enough to avoid irritation. Patients should be asked if the identity band is comfortable to reduce the risk of removal.

6.5.6 Information to be included on the identity band

The information provided on the identity band must achieve a unique identification of each patient. As names and dates of birth are not unique to individuals, further information is required. Therefore all patient identity bands must have the following information:

- Surname (in UPPER CASE) and Full, birth-registered first name (in lower case) in the order: LAST NAME, First name e.g. SMITH, John
- Date of birth in the format DD-Mmm-YYYY e.g. 07-Jun-2005
- NHS number in the format nnn nnn nnnn eg 123 456 7891
- District number including the letter prefix. Refer to CORP/REC 5- Clinical Records Policy
- Linear barcode containing the patient's District number.
- 2 dimensional barcode containing the patient's District number, Surname, forename, DOB, Gender.

NB No other data should be included without formal approval and only as a result of a formal risk assessment.

The identity band of unknown patients must state:

- 'Unknown' as both the surname and first name.
- Patient identity number

- Dummy date of birth being used (NB must be less than 110 years old to avoid issues with reference ranges on the pathology system).

As more information becomes available, the patient identity must be updated according to the process detailed in Section 6.6 “Actions in the event of misidentification of a patient or identification of a previously ‘unknown’ individual.” and the ID band replaced.

6.5.7 Safe identification of patients

No clinical procedure (e.g. blood test, investigation, operation) should be performed on or drug administered to a patient until the patient’s identity band has been checked to confirm his/her identity.

All patients must be identified in the following way (if the first method can not be used, move to the second and so on):

a) In the event that automated patient documentation is available (eg the ICE phlebotomy process) a scan of the barcoded identification number will provide full patient details as recorded on CaMIS at the time the ID band was applied and signed for.

b) Ask the patient to tell you his/her name and date of birth. Check that these details are confirmed by the patient identity band.

c) If the patient is unable to tell you his/her name and date of birth, refer to the identity band and if possible verify the information by asking a relative (if there is one in attendance) to tell you the patient’s name and date of birth.

d) If the patient is not wearing an identity band, ask the patient’s relative or another healthcare professional to identify the patient by name, date of birth and address. Confirm these details using the case-notes and, if there are no contra-indications, apply an identity band as soon as possible.

An interpreter or sign language interpreter may be required for the safe identification of patients with language/hearing difficulties.

Caution stickers with ‘Caution, there is another patient with the same name’ must be used on notes and medication charts when patients have the same/similar names.

There are also genuine cases of patients with identical names and date of birth within DBTH. These patients should be identifiable via an additional statement on their notes (See initial identification procedure, section 6.2). In this case the first line of their address must also be confirmed.

6.5.8	Patients who cannot confirm their own identity

The identity bands of patients who cannot confirm their own identity (e.g. those who cannot communicate, young children, the critically ill, unconscious, or confused) must be checked by two Registered Nurses/Midwives prior to the identity band being placed on the patient.

6.5.9	Confused patients

Patients who are confused and at risk of removing their identity band must have two bands put on, usually one on the wrist and one on the ankle.

6.5.10	Patients who are unable or refuse to wear an identity band

If a patient cannot/will not wear an identity band, a local risk-assessed checking procedure to confirm the patient's identity should be put in place.

Patients who cannot wear an identity band because of their clinical condition or treatment, e.g. multiple intravenous lines, dermatological conditions/ treatments. Consider placement of the identity band on a lower limb if possible. Alternatively, it is possible to attach two or three bands together to enable attachment above IV lines on a limb.

Patients who refuse to wear an identity band, despite clear explanation of the risks of not doing so, will be asked to give their full name, date of birth and address, and their wishes must be documented in the case-notes and an incident form completed.

The absence of an identification label should be explained during handovers.

6.5.11	Removal / replacement of an Identity band

In normal circumstances, a patient's identity band should be removed only on his/her discharge from hospital to home. This is the responsibility of the nurse caring for the patient.

If the identity band is removed because it interferes with treatment, the responsible member of staff must make clear alternative arrangements for the patient's correct identification until the identity band can be replaced at the earliest opportunity. For the transfusion of blood products, the identity band must be replaced immediately. Alternative areas for the placement of the identity band, such as the ankle, should be considered.

An identity band removed for any other reason, for example, due to illegibility, **must be replaced immediately by the staff member responsible for its removal**. The replacement band must be new and the identification

details confirmed with the patient / guardian / relative and the records front sheet signed.

Where an identity band is found to be missing, the attending clinical staff are responsible for its **immediate replacement.** The event must be recorded using an Adverse Incident report using code - NWB No wristband attached

Identity bands should not be removed from patients prior to or during transfer to another hospital or into social service or private nursing care.

In the event of death, the identity band should **not** be removed from the patient's body. A second ID band bearing additional details must be attached prior to transporting the deceased to the hospital mortuary (For full information see section 6.5.14 Mortuary transfers). The additional details can be hand written on the standard printed band.

It is the responsibility of any clinician who removes an ID band to replace it

6.5.12	Department-specific standards

1. Routine admissions

Identity bands must be put on patients as soon as they are admitted and worn throughout their hospital stay.

2. Emergency Care Centre/Accident and Emergency Department

- Any patient presenting with a complex or acute condition or injury must wear an identity band.
- Any patient who has been or is planned to be given drugs which impair their mental capacity must wear an identity band.
- Any patient with reduced mental capacity must wear an identity band if they will require transfer to other departments (eg Medical Imaging).

Uncomplicated cases attending a 'Minor Injuries / Illness Unit' do not need to wear an identity band. Patients attending Mexborough Minor Injuries Unit will not wear an identify band unless it is deemed that they require admitting ward at time of admission.

3. Maternity services

All women requiring admission to Maternity Services will have a patient identify band placed on in line with this policy.

Placing identity bands on infants has been discussed at Family Services Governance Meeting, changes to NPSA guidance has been discussed and agreed.

All infants must have two handwritten identity bands placed on their ankles before leaving the labour ward/theatre.

The information on their identity bands must be checked with the infant's parent(s) and/or birth partner and then placed on the infant in the presence of the parent(s) and/or birth partner. Prior to birth registration the information will be limited to:

- Baby of (Mother's full name)
-
- Birth order for multiple births. See below.
- Date of birth
- Time of birth
- Sex

The information on the Identity band must be arranged as shown here.

Baby of (Mothers Name)	Sex
Birth Order	
Date of Birth	Time of Birth

All infants must have two identity bands as well as a cot card in situ.

On transfer of the mother and infant to the post natal ward, the midwife transferring the infant must check the identity details of the infant with the midwife receiving the infant.

All infants' cots must have a pink (girl) or blue (boy) 'cot card' according to the infant's gender. The information on the cot card must include:

• Mother's full name
• Baby's full name (if known) – Including birth order for multiple births. See below
• Date of birth
• Time of Birth
• Head circumference (if available)
• Birth weight

Once birth registration is completed, two new infant labels must be printed which will include baby's NHS number and hospital number in the standard trust format for baby labels.

For well infants the identity band change will occur on the post natal ward.

Identity band change will occur following admission to the Neonatal Unit.

All changes in infant names must be handled as a formal change of identity. CaMIS must be updated and new identity bands prepared as described in section 6.6 -"Actions in the event of misidentification of a patient or identification of a previously 'unknown' individual". An incident form is not required unless there has been confusion over the child's identity.

4. Neonatal unit

All infants must have one identity band as well as cot card in situ and the information on the band must
include:

- SurnameFirst name (if known)
- Mother's name
- Birth order for multiple births
- NHS number
- Date of birth
- The baby's District number

The information on the Identity band must be arranged as shown here.

Surname and first name if known
Mother's name
Birth order for multiple births
NHS number
Date of birth
District number

All identity bands must be checked on every shift and this must be documented in the care plan as part of patient safety checks. Any missing or inaccurate bands must be recorded using an Adverse Incident report.

For infants in incubators, or cots, whose skin maturity does not allow the application of a name band, the band will be attached to the incubator.

All infants must have a pink (girl) or blue (boy) cot card according to the infant's gender.

The information on the cot card must include:

- Surname
- First name (if known) – Including birth order for multiple births. See above.
- The baby's District number
- Date of birth
- Birth weight

- Type of delivery
- Head circumference (if available)
- Consultant's name

All identity bands and cot cards must be completed and checked by a Registered Midwife/Nurse and the mother (Preferable) or two Registered Midwives/Nurses. The front sheet of the baby's records (or other suitable notes) must be signed to confirm the identity check has been performed. The same standard applies to replacement identity bands/cards.

*All babies born in England and Wales are given a ten digit NHS Number at birth; other patients get an NHS number when they join the NHS by registering with an NHS GP. The NHS number is vital if the Trust is to be paid for treatments/services provided, and should therefore be used on all correspondence and requests for investigations/tests etc.

All changes in infant names must be handled as a formal change of identity. CaMIS must be updated and new identity bands prepared as described in section 6.6 -"Actions in the event of misidentification of a patient or identification of a previously 'unknown' individual". An incident form is not required unless there has been confusion over the child's identity.

5. Twins/multiple births

Twin/multiple birth infants must have their identity bands and cot cards differentiated by being completed with their first names whenever possible (the use of names should be encouraged). Alternatively, they are labelled 'Twin two', 'Triplet three' etc. Caution stickers with 'Caution, there is another patient with the same name' must be used on notes, cot cards and medication charts. It is essential that this naming strategy is compatible with all trust systems to avoid creation of identical entries for each member of the multiple birth family. District number must never be the only way of distinguishing between multiple births.

All changes in infant names must be handled as a formal change of identity. CaMIS must be updated and new identity bands prepared as described in "Actions in the event of misidentification of a patient or identification of a previously 'unknown' individual". An incident form is not required unless there has been confusion over the child's identity.

6. Blood Transfusion Collection

All staff collecting blood products should have had prior training. The Blood Hound system will ensure that blood units are not accessible to other staff.

The collection, transport, delivery and handover of the blood and blood products are the responsibility of the member of staff collecting the blood and blood products.

Staff collecting blood and blood products must be supplied with authorised documentation containing the patient's core identifiers and bar coded NHS number e.g. an addressograph label. This must be done even if Teletrack is used to organise collection.

Take particular care where there has been a previous "unknown" identity as there may be units allocated under the original or corrected district numbers. Information from both ID bands should be provided in this situation and the units allocated to the "unknown" identity should preferably be used first.

7. Administering a Blood Transfusion

Any person involved in the administration of blood or blood products must have full comprehension of the Blood Transfusion Policy (PAT/T 2).

All patient core identifiers on the patient' identification wristband must match the details on the blood component label.
Final check must be conducted next to the patient by the same trained and competent licensed healthcare professional who administers the component.

Although two members of staff may be involved in the checking procedure it is recommended that one member of staff should be responsible for carrying out the identity check on the patient and the unit of blood at the patient's bedside.

Where possible also check verbally with the patient by ASKING them to state their surname, first nameand DOB prior to transfusion. Checking this information against the wristband is mandatory.

When unable to check verbally two qualified members of staff must check with the patient ID band.

If you are in any doubt regarding patient identity and the blood or blood products matching – **DO NOT** give the blood or blood products. Contact blood bank staff urgently to resolve the issues.

8. Medical Imaging

It is the ultimate responsibility of the Operator to ensure that the correct patient is being examined according to the request that has been made.

If the patient details stated on the request form are inaccurate or incomplete, further information must be obtained before an exposure is performed. An examination will not be commenced until identification is established beyond doubt.

Outpatients – The operator must correctly identify the patient prior to performing any exposure: ask the patient to state their full name, address and date of birth. Do not ask them to confirm the details against those expected according the request form. Check these details against those given on the request form. If the details match, proceed with the exposure. If there is more than one patient on the radiology information system with the same name double check identity against address.

Inpatients – When collecting an inpatient from a Ward, portering staff must confirm the identity of the patient beyond doubt. If a patient is unable to confirm their identity, the Ward Staff will be asked to identify the patient. Details of the patient to be collected are then checked against the patient's identification bracelet. In the imaging department, the operator must correctly identify the patient prior to performing any exposure: ask the patient to state their full name, address and date of birth and check this against those details on the request. If the patient details stated on the request form are inaccurate or incomplete, further information must be obtained before an exposure is performed. An examination will not be commenced until identification is established beyond doubt. For patients unable to identify themselves, the patient identity on the form must be checked, by the operator, against the identification bracelet prior to any exposure. Patients without bracelets MUST NOT be moved from the Ward until a bracelet has been supplied and fitted. If an inpatient arrives for a radiographic/radiological examination without a bracelet, an accompanying Ward nurse may confirm the patient's identity. A record must be made on the patient's request form including the nurse's name if this procedure is followed. If an appropriate Ward nurse is not available, the patient must be returned to the Ward and the nurse-in-charge informed of the situation, requesting that a Ward nurse who is familiar with the patient fits a bracelet.

If a patient's condition is such that imaging is required on the ward, check the details on the request form against those on the identification bracelet. If no bracelet is present, request that a Ward nurse who is familiar with the patient fits a bracelet, and check the details against those on the request form before imaging takes place.

9. Specific Situations in Medical Imaging

The procedures outlined below will be followed in all other situations. A record must be made on the patient's request form if these additional procedures are followed.

Uncomprehending patients – An accompanying capable adult must answer on behalf of patients who are incapable of confirming their own identity (too young, unconscious, incoherent, language difficulties). An interpreter must be used if there is a language problem. This must be documented on the request.

Unknown patients – For unknown and unconscious patients (such as trauma patients), identification is made by Resuscitation or ED staff until a unique identification has been made by means of a number on a bracelet, or until the patient's true identity is established. This must be documented on the request.

Theatre/Sedated patients – Patient identification is confirmed by Theatre staff prior to being anaesthetised according to operating theatre procedures. A member of this team identifies the patient prior to the medical exposure. This must be documented on the request.

6.5.13 Exemptions

Patients are exempt from wearing an identity band if they are attending:
- a pre-admission assessment clinic;
- an out-patient clinic/department;
- a phlebotomy department as an out-patient.
- a minor injuries unit

If there are any concerns for the safety of a patient in these situations an identity band should be put on.

6.5.14 Mortuary Transfers

All deceased patients must be sent to the mortuary wearing their inpatient identity bands. An additional identification band MUST be added by the healthcare professional completing last offices and MUST bear the **full name and address** of the deceased, **age and date of admission.**

If full details of the body are not known at the time of receipt of the body - temporary tags bearing the terms unidentified male /female /adult /child are used. These tags should also include the date and time of admission to the mortuary. Verbal patient details can be accepted from the funeral director or police handling the body.

Bodies from within the hospital are accompanied by the death notification form, completed by the ward staff completing last offices and signed by the nurse in charge and countersigned by the service assistants/porters transferring the body. Particular attention must be made to any valuable items remaining on the deceased and must be accurately recorded on the notification of death form.

For hospital deaths, the yellow form must be checked with the deceased patient identification wrist or ankle band before the body is placed in the fridge.

Mortuary staff must ensure that the appropriate identification of the patient has occurred. At least three patient identifiers (including a unique identifier) must be checked.

For deaths outside the hospital primary identification must be checked via personal identification bands/tags and verified with person delivering the body At least three patient identifiers (including a unique identifier) must be checked

If a deceased patient arrives at the mortuary without an identity band during routine hours, the mortuary staff will notify the relevant ward/department/unit manager. It is the responsibility of the manager to arrange for a Registered Nurse/Midwife, who knows the patient, to attend the mortuary as soon as possible to identify the deceased patient and attach an appropriate identity band. **All such events must be recorded on a trust incident form and investigated as a "Interventional Near Miss" severity incident.**

6.5.15	Monitoring

The registered practitioner is accountable for ensuring that each patient in his/her care is wearing an identity band (or two if appropriate) during his/her span of duty. However all health care workers are responsible for ensuring that the identity band policy is adhered to. Therefore any health care worker who discovers that an identity band is illegible, missing or incorrect has to assume responsibility for correctly identifying the patient and correcting the situation or reporting it, so that it may be replaced.

If a member of staff removes a patient's identity band, it is his/her responsibility to replace it or ensure that it is replaced with a new identity band. If it cannot be replaced immediately, alternative methods for identifying the patient must be used, e.g. the patient will be asked to give their full name, date of birth and address. The identity band must be replaced as soon as possible.

6.6 Actions in the event of misidentification of a patient or identification of a previously 'unknown' individual

Correction of the consequences of misidentified patients can be complex because there are several computer systems involved in recording sections of the patient record. In all cases these systems record patient care beyond the current admission and errors may therefore mean previous information is not available to guide treatment decisions and may also impact on future care of the current patient and any individual as which they have been incorrectly identified. Even in the absence of a full computerised patient record, changes made on paper versions of notes are not sufficient and it is essential that all systems are corrected as soon as is practically possible.

In some cases the interface between CaMIS and these systems does not directly handle changes in CaMIS details and individual departments will need to make the changes / corrections on their own systems. Usually this requires actions by a system manager or other senior staff therefore patient merges and other detail changes should only be performed during normal working hours (9:00 – 5:00 Monday to Friday excluding public holidays).

System	**Function & potential issues**	**Contact details**
CaMIS	Provides the primary identification database, manages multiple local unit numbers for the same individual & tracks multiple sets of patient records.	Medical records
Symphony (A&E)	This system uses the District number as primary reference. Does not automatically receive details of changes made on CaMIS. Full records may not be incorporated into patient's main notes.	System administrator
Pathology	Provides laboratory test results for all patients regardless of the care location (including GP requests). This system uses the district number as a primary reference but also handles local unit numbers as subordinate identification. Automatically receives details of changes made on CaMIS. In addition to inpatient records, this system may have multiple 'temporary number' records for a patient due to issues with external patient identification (eg use of alternative names, spelling errors, DOB errors etc). Also may retain records for non-current registration numbers which were used as long ago as the 1990's.	Via enquiries at DRI
JAC	Provides access to prescription records. This system uses district number as a primary reference, but multiple records exist for patients due to historic episodes using local unit numbers. Automatically receives details of changes made on CaMIS.	DRI
Evolution	Receives patient ID data from CaMIS at each event – All changes are made on CaMIS.	DRI
PACS	Provides access to medical images. This system uses the district number as primary reference. Automatically receives details of changes made on CaMIS via the Radiology Information System. In addition to inpatient issues, this system may have multiple records for a patient due to issues with external patient identification eg use of alternative names, spelling errors, DOB errors etc).	Clinical Governance Lead – Medical Imaging, who will inform relevant manager.

ICE order communication system	This system receives patient identification information from CaMIS and also from GP systems via incoming requests. For some patients this may be more up-to-date than the information contained on CaMIS. Any changes made on CaMIS will be automatically updated. System administrator manages CaMIS updates with information from primary care and resolves any identification issues.	ICE system administrator. DRI

6.6.1 Providing the difference in patient identity is because a previously 'unknown patient' has been identified there is no requirement for further investigation and recording of an incident. The changes should be made as described from section 6.6.4 onwards.

6.6.2 All incidents involving **incorrect** identification of patients must be recorded using a trust incident form by the health care professional who discovers the problem (This may affect a single request form or an entire treatment period and all 'identities' involved must be included on the incident form). Appropriate DATIX codes include –

IIP	Incorrect or incomplete identification of patient
IDWB	Incorrect or incomplete details on patient's wristband
MRN	Multiple registration numbers
NWB	No wristband attached
IPC	Incorrect patient information communicated (verbal or written)

Typically the reporting will be performed in the routine timescale (48 hours) alongside the correction of the problem, however, where there is a 'serious' or 'dangerous' incident (eg inappropriate surgical procedures, blood transfusion or medication) arising from the incorrect identification this must be reported to senior staff for immediate investigation– For further details see the trust Risk Identification, Assessment and Management (CORP/RISK 30). The existence of a 'serious' or 'dangerous' incident may mean that detailed investigation of all computer systems involved is required prior to rectifying the error. In this case the resolution will be coordinated and recorded by the group which investigates the incident.

6.6.3 Detailed investigation of the problem may be necessary to determine which patient identities are involved and the time period. It is essential that clinical staff involved in the patient's care cooperate fully with the affected departments to ensure all diagnostic data is recorded against the individual from whom it originated. Where there is confusion between two patients who are simultaneously being treated this will require identification of individual events which are affected (eg specific surgical events, laboratory specimens, medical imaging investigations, prescribed medications & individual medication doses).

6.6.4 As soon as an identification problem is identified, the patient's true identity should be established as described for initial admission, the correct notes obtained and a replacement patient ID band prepared and applied.

6.6.5 Providing the patient's previous care has all been performed using a new record (eg an 'unknown patient' ID or a newly created duplicate record number) then the medical records department can merge the appropriate records. This will usually involve retention of the earliest number as a 'master' number and all other record numbers will be recorded on CaMIS as subordinates. In this situation medical records only require the two patient identities involved. Once the merge has been confirmed, ward clerical staff can merge the two sets of paper records and prepare replacement front pages for all affected record sets.

NB Once a number has been used it cannot be re-assigned to another patient as it may already exist on other systems.

6.6.6 Identification problems which involve aspects of one individual's care being recorded within an existing record belonging to another patient may require more complex resolution and more detail will be required by medical records as described in section 6.6.3 above. Clinical staff will need to transfer (and duplicate as necessary) the appropriate pages between the affected sets of paper records altering the identification on all transferred pages as appropriate. Each transferred page must include a short note indicating the reason for transfer, date of transfer and correction of the identity on the sheet and a reference to the incident form number. Clerical staff may prepare replacement front pages for all affected record sets.

6.6.7 Where there is potential for other computer systems to be involved it is essential that the appropriate individuals are informed to ensure any issues are resolved. Each affected department will require the details of all identities involved, the direction of any changes (eg which district number is being used as the master on CaMIS), the timescale and where appropriate the individual patient events affected.

6.6.8 Individual departments will record their corrective actions and may issue replacement reports for inclusion in the appropriate sets of patient notes (eg cumulative pathology reports without the presence of results, which originated on other individuals). For legal reasons all report copies produced for this purpose must replace the original sheets as the patient's active record – Evidence of the original content and or the replaced copies must be retained by the specialty which originally issued the reports for at least the period which is currently appropriate for patient notes (This may be as a paper record or in electronic form).

7. TRAINING/SUPPORT

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

8. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4)

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Risk Identification, Assessment and Management Policy – CORP/RISK 30
Care after Death and Bereavement Policy – Operational policy for staff to follow in the event of a patient death – PAT/T 60
Blood Transfusion Policy – PAT/T 2
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/EMP 27
Legal Retention and Destruction of Hospital Patient Health Records – CORP/REC 8
Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
Clinical Records Policy – CORP/REC 5

10. REFERENCES

Department of Constitutional Affairs
Mental Capacity Act (2005): Code of Practice, 2007
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

National Patient Safety Agency (2005) Wristbands for hospital inpatients improves safety. Safer Practice Notice Ref: NPSA/2005/11. Available from http://www.npsa.nhs.uk/health/display?contentId=4401 (accessed October 2007).

National Patient Safety Agency (2007) Standardising wristbands improves safety. Safer Practice Notice Ref: NPSA/2007/24. Notice, General guidance, design specification etc available from http://www.npsa.nhs.uk/health/display?contentId=6073 (accessed October 2007)

National Patient Safety Agency (2005) Why you should wear a wristband when you are staying in hospital. Patient briefing 11. Available from http://www.npsa.nhs.uk/health/display?contentId=6073 (accessed October 2007)

National Patient Safety Agency (Updated 2009) Risk to patient safety of not using the NHS Number as the national identifier for all patients. NPSA/2009/SPN002. Available from http://www.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=19183&type=full&servicetype=Attachment (accessed June 2009)

NHS England (2015) Never Events reported as occurring between 1 April 2014 and 31 March 2015 – final update. Available from https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/01/provsnl-ne-data-2014-15.pdf

NHS Improvement (2018) Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018

Mayday Healthcare NHS Trust case study on the connecting for health website. http://www.connectingforhealth.nhs.uk/systemsandservices/bloodpilot/lessons/wristbands (accessed June 2009)

APPENDIX 1 - PROCEDURE FOR PRINTING IDENTITY BANDS

1. Ensure the wristband printer is connected at the power socket and switched on. The button on top should now be green.
2. Log on to CaMIS Wristband Printing session.
3. Enter the username ____ and password ____ (Important: when the password changes **you must ensure you inform your colleagues).**
4. Find the required patient.
5. From the patient **Main Index Details** screen select **option 5 – Print labels.**
6. Next screen select option **2 – Patient Wristbands (Zebra).**
7. Next screen select option **1 – Adult** then select **1 – Print immediate.**
8. Next screen select option **3 – Choose another printer,** select **1 – SLAVE** finally select **1 – Start Printing.**
9. Label will print, remove from the printer and attach to patient.
10. **Log of** the CaMIS Wristband Printing session.

APPENDIX 2 - PROCEDURE FOR LOADING IDENTITY BANDS TO WRISTBAND PRINTER

The roll of wristbands must be inserted between the two blue guiders, the wristband must have the matt surface facing upwards as the patient information is printed on the matt side. If the labels are inserted the wrong way they will not print.

APPENDIX 3 - EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/PS 7 Patient Identification Policy	Clinical Specialities Division	Fiona Dunn	Existing	October 2018

1) Who is responsible for this policy? Executive team

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes?
Policy, intended to reduce the risk of patient identifications, protecting patients from harm and staff from error.

3) Are there any associated objectives? Legislation, targets national expectation, standards - Yes

4) What factors contribute or detract from achieving intended outcomes? Compliance in individuals.

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: October 2021

Checked by: N.Sherburn **Date:** 11 October 2018