The Newcastle upon Tyne Hospitals NHS Foundation Trust

Patient Identification Policy

Effective: September 2010 Review: June 2012

1. Policy Aim

This policy aims to clarify and standardise the procedure for identifying patients requiring hospital admission and is in response to the recent guidance from the National Patient Safety Agency (NPSA 2007).

2. Introduction

2.1 Failure to correctly identify patients continues to result in medication errors, transfusion errors, testing errors, wrong person procedures and the discharge of infants to the wrong families (WHO 2007).

2.2 The current trend towards limiting working hours of members of the clinical team caring for patients increases the likelihood of handover and other communication problems with patient misidentification indicated as the root cause for many errors. Shorter patient hospital stays can also make it more likely that inpatients will not be recognised (WHO 2007).

2.3 There is increasing evidence that standardising patient care and how it is delivered contributes to greater patient safety. Standardising wristband design, the information they carry and the processes used to produce and check them can significantly improve patient safety. This will also support the introduction of new auto identification technologies as these will be located in the wristband (NPSA 2005, NPSA 2007).

2.4 Standardised printed labels have clear advantages over current systems – legibility, durability and elimination of transcription errors. The patient's wearing of a wristband does not remove responsibility of staff for checking the patient's identity by other means.

3. Scope

3.1 This policy is intended to:

- ensure the highest level of patient safety
- ensure all staff involved in patient identification are fully aware of their responsibilities
- ensure that staff recognize the significance / importance of using wristbands as an aid to patient identification
- ensure patients are positively and correctly identified BEFORE applying a wristband.

4. Training

4.1 Patient identification must be included in both Corporate and local induction programmes indicating the responsibility of the HCA/receptionist in confirming the patient details and applying the wristband and the responsibility of Registered staff in matching patients to their care.

4.2 Any changes to the policy will be cascaded to staff through the Trusts communication facilities i.e. Intranet, bulletins and by line managers.

5. Wristbands

5.1 All patients admitted to the Trust for treatment / care must have a standardised Trust wristband applied on admission.

5.2 Only one type of wristband is allowed – a white wristband with clear black text

5.3 Special circumstances or risks must not be written on the wristband, staff must refer to the E-record for identification of a risk or alert.

5.4 A single wristband only is allowed, the use of multiple wristbands increases the risk for the patient and is therefore not permitted.

5.6 Wristbands will contain the following patient data:
- patient name
- date of birth
- NHS hospital number also known as MRN (medical record number)

5.7 Wristbands will be produced and printed from the Cerner millennium, where this is not possible the small identification labels from the patient's records should be used. Handwritten wristbands should only be used in cases of emergency where pre-printed labels/wristbands are not available.

5.8 Where the patient does not have an NHS/MRN, a local or temporary number may be issued e.g. A&E number. Once the permanent information is available the correctly written wristband should be applied.

5.9 Wristbands must be applied to the patient as soon as they are admitted and worn throughout their hospital stay.

5.10 The wristband should be placed on the dominant arm (the side used for writing) wherever possible as it is less likely to be removed.

5.11 Should any alteration to the content of a wristband be required, the wristband should be replaced in its entirety by a newly provided band with the correct information. Written alterations to the content of wristband are not permitted.

6. Exceptions

6.1 It is recognised that for clinical reasons it is not always possible to use patient identification wristbands. Where this is not possible other strategies must be used to match the patient to the correct care.

6.2 Where the patient is likely to undergo any procedure that involves sedation the use of The Protocol for the Use of Check List Alert Signs should be considered.

6.3 Where wristbands cannot be worn, e.g. Dermatology, identification should be confirmed by checking the patient's name and date of birth verbally. If the patient lacks capacity it is appropriate to use next of kin if they are present.

6.4 Where the patient is new born and cannot wear a wristband the identification details should be attached to the inner surface of the cot by transparent adhesive tape. Parents must also, always be involved in patient identification when medications are given. An appropriate

wristband must be applied as soon as the infant is able to wear one.

6.6 In the event of name bands being obscured or removed due to theatre restrictions, arrangements must be in place to safely identify the patient during the procedure. This may include other methods such as the marking on the skin of the patient's identity with an indelible marker.

6.7 Identification Cards may be used in the care of long term care patients e.g. haematology / renal dialysis patients whilst on the day unit, this refers to the department and patient in that department not the patient going to other departments. Where these are used wristbands need not be applied however personal details must be confirmed verbally by the patient or by the person accompanying them.

7. Responsibility

7.1 Wristbands should only be applied by staff who have undertaken corporate or local induction training.

7.2 It is the responsibility of the person applying the wristband to ensure that the information is correct by:
- verbally checking with the patient or accompanying adult
- checking the patients notes / PAS system.

7.3 **It is the responsibility of the admitting Registered nurse to check the status of the wristband on admission.**

7.4 If a wristband is removed by a member of staff e.g. to gain venous access, then it is **their responsibility to ensure it is replaced correctly** as soon as is reasonably possible. Clear alternative arrangements for the patient's correct identification if the wristband cannot be applied immediately must be documented.

7.5 If a member of staff discovers a patient does not have a wristband, they must assume responsibility for correctly identifying the patient and replacing the wristband or inform an appropriate Registered nurse who must assume the responsibility for replacing the wristband.

7.6 Each time a patient is transferred to another ward or department e.g. A&E to ward, ward to x-ray etc. the wristband must be checked for accuracy by the receiving Registered nurse or a member of the clinical team.

7.7 Patients must not leave their base ward or department until a wristband has been correctly applied.

8. Incident Reporting

For any incident where a patient does not have a wristband, has been misidentified or injury has occurred due to the absence of a wristband- employees should report this to the person in charge, supervisor or senior manager straight away and complete an incident form as soon as possible. Managers should investigate the incident and ensure that where necessary actions are completed following investigation. This may include a full review of tests, treatment and medications and informing ward and clinical staff. Where an action is outstanding the manager should ensure that where appropriate, this is reported on the risk register with risk reduction measures identified.

9. Monitoring and Review

Compliance with this policy will be monitored by the Nurse Specialist Patient Safety on a quarterly basis, who from analysis of incident reports relating to patient identification will follow up any identified deficiency and action plans. Processes indicated in this policy will also be monitored by annual audits of wristband compliance and incidents of patient misidentification in inpatient wards.

Both the quarterly incident analysis and the annual audit reports will be presented to the Clinical Governance and Quality Committee which will identify any areas for improvement in the form of actions and these will be monitored by the Committee until all actions are completed.

References

- *NPSA (2005) Wristband for hospital inpatients improves safety. Safer Practice Notice No.1, November.*
- *NPSA (2007) Standardising Wristbands Improves Patient Safety. Safer Practice Notice No.24, July.*
- *World Health Organisation (2007) Patient Identification. Patient Safety Solutions, Volume 1, Solution 2, May WHO Press, Geneva.*

Author: Nurse Specialist Patient Safety

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Patient Identification Policy	Policy Author:	Nurse Specialist Patient Safety
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against any individual on the basis of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?		
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? *(If "yes", please answer sections 4(b) to 4(d)).*	NA	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

Comments:	**Action Plan due (or Not Applicable):**
	NA

Name and Designation of Person responsible for completion of this form: Jo Coward Nurse Specialist Patient Safety Date: 30/07/2009

Names & Designations of those involved in the impact assessment screening process: Clinical Governance and Quality Committee

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)