The Royal Wolverhampton NHS Trust

Policy Number
OP52
Title of Policy

Patient Identification Policy

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1.0 Policy Statement (Purpose / Objectives of the policy)

The safety of many treatments and activities within the Trust depends on ensuring that correct patient identity has been established. This policy has been developed to provide guidance for ensuring that staff can correctly identify patients prior to the delivery of any care episode or intervention

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

The correct identification of patients ensures that the intended care and/or intervention is delivered to the correct patient every time. The Executive Brief for the Top 10 Patient Safety Concerns for Healthcare Organisations 2016 have identified that patient identification errors have broad implications resulting in serious consequences.

3.0 Accountabilities

The healthcare professional primarily responsible for admitting the patient must ensure that an ID band is attached.

The policy will be available in all patient areas, implemented through Matrons and Clinical Directors, and monitored locally by central governance incident reporting mechanisms.

All staff must report incidents of patient misidentification in accordance with the Trust incident reporting system (OP10 Risk Management and Patient Safety Reporting Policy).

4.0 Policy Detail

Specific Areas	When to apply an identity band
In-patients/Day Cases/Day Units	At point of admission to the ward/department by nurse / midwife admitting the patient following confirmation of details. This includes patients receiving any kind of interventional treatment / medication.
Out-patients Community Areas	If able to confirm their identity the patient must be identified verbally using full name, date of birth and address. During verbal identification the patient must be asked to declare their details rather than be asked to agree that the details read out to them are correct. If the patient is unable to confirm these details, this must be checked and confirmed with the next of kin, carers or relative.
ED and AMU	As soon as it is established that the patient will be admitted. Patients who are confused / unconscious / have special needs must have an ID band applied immediately upon being received into ED/AMU/SAU/other portals/direct admission to department. Where possible confirm details with the patients NOK.

Unconscious Patient/Primary Cardiac Patient	If a patient is unconscious and unaccompanied, and there is no one who can verify their identification details, the patient will be given an "unknown patient number" whilst efforts to identify the patient continue.
Delivery Suite	Babies must be labelled with two identification bands on two separate limbs. On transfer to a ward two members of staff (Midwife or Support Worker) must re-check the baby's bands to ensure that they are correct; this information is checked against the cot card.
Neo-natal Unit	As above - with the exception of if the baby is nursed in an incubator. In these circumstances, the two identification bands are taped onto the incubator. When the babies are transferred into a cot, the Delivery Suite actions as above apply.
Deceased Person:	Bodies that are transferred to the Swan Suite must have an accurate ID band attached before leaving the ward / department. SafeHands badges must be removed before transfer to the Swan Suite.
Theatres	Theatre patients, including Day Case patients must have an ID band and associated paperwork completed before they can be admitted into the Operating Theatres.

4.1 In addition to the ID band, at the point of admission, the SafeHands badge must be assigned and attached to the patient securing it with the ID band. The tracking badge enhances the safety of the patient during their stay through real-time locating.
Note: SafeHands facilities do not exist at Cannock Chase Hospital or West Park. In maternity for mothers and babies the SafeHands system is not used. Instead, babies are electronically tagged, with the parents consent, on the X-tag Baby Tagging System. A serial number is allocated to each baby tag, the bed number and name of the baby is identified on the X- Tag baby system. This X tag is attached to the baby and can identify where the baby is located in the ward area / Maternity Unit. This system is in place to prevent / alert the team to potential baby abduction from the Maternity Unit.

4.2 The healthcare professional primarily responsible for admitting the patient must ensure that an ID band is attached.

4.3 The information on the ID band must be checked with the patient and the patient's health records before application. Information must be clearly printed in indelible black text.

4.4 The printed ID band must display the last name, first name, date of birth and verified NHS Number / Hospital Number (OP 52 Appendix 1 – Information Presentation of the Patient's Identity Band). In the first instance laser printer ID bands should be used.
If addressograph labels are used see section 4.8.1.

4.5 When attaching the ID band the patient/parent/carer must be given an explanation as to the importance of wearing the ID band and be requested to inform staff if it becomes lost, not replaced after removal, or illegible.

4.6 The ID band should be put on the patient's dominant arm (the side used for writing) unless that arm is the operative site. The NPSA recommends that patient's wear one wrist band only, if there is a circumstance where it is essential to use more than one band, all the bands should satisfy the standards within this policy (OP 52 Appendix 1 - Information Presentation of the Patient's Identity Band). The exception to this is babies wear two ID bands, not one.

4.6.1 If an ID band needs to be changed, e.g. change of ward or printing becomes illegible, the original band must remain in place until the new band is attached, and then the incorrect band removed and discarded.

4.6.2 If an ID band needs to be removed in theatre for reasons of access, it should be secured to the patient or their IV line. A new band should be attached as soon as possible to the patient, before they leave theatre. This will be the responsibility of the recovery practitioner.

4.6.3 If a member of staff discovers a patient does not have an ID band it is essential that it is brought to the attention of the person in charge to assume responsibility for correctly identifying them and arranging for an ID band to be applied.

4.6.4 If a patient refuses to wear an ID band a risk assessment must be undertaken (OP10 Risk Management and Patient Safety Reporting Policy) and precautionary action must be shared with all staff concerned, the patient must be clearly told the risks associated with not wearing an ID band. The discussion and reason will be clearly documented in the patient's health records. If a patient is unable to wear an ID band e.g. due to their clinical condition, an alternative method of identification must be sought, e.g. label affixed to the patient's gown.

4.7 Use of Allergy Bands

Red Allergy ID Bands must be used to alert all practitioners and clinicians of known or suspected allergies (OP 52 Appendix 2 - The Use of Red Allergy Wristbands). The allergy band is a **replacement for**, **not in addition to**, the normal ID band. It should be treated in the same manner as a normal ID band.

4.8 Documentation – use of printer labels.

4.8.1 In all instances, 'laser printer' ID bands will be used. These specific printers are available at all elective and emergency portals and are the usual mode of printing of identification labels for patients. If printed ID labels are unavailable, e.g. the printer is not working, this must be reported as a risk to that department and an alternative method for providing ID labels must be used. In this instance addressograph labels can be used, however, the label must conform to the standards identified in (OP 52 Appendix 1 - Information Presentation of the Patient's Identity Band).

4.8.2 In an emergency in the absence of preprinted ID bands, when addressograph labels are used:

- Addressograph labels must be checked with the patient's details on the health records to ensure they are the correct labels before using them. The labels must be inserted into the 'LaserBand' identity band.
- When used to refer patients for x-rays, the labels must be checked with the responses from the patient or their ID band. It is the responsibility of the doctor, or other registered healthcare professional making the request to ensure the correct label is attached to the form. This must not be delegated or undertaken by another member of staff.
- When requesting medical exposure to x-rays [or any form of radiation], full size addressograph labels must be used. The small labels designed for attaching to specimens must not be used.
- New labels must be printed if any information changes and all old labels must be removed from the health records and destroyed in a shredder bag as they contain confidential information. This practice is the responsibility of the member of staff making the change.
- If changes need to be made to the ID labels the new labels must be reapplied to all documentation including any at the bedside. This practice is the responsibility of the member of staff making the change.

4.9 Transferring Patients:
Before transferring a patient (CP05 - Transfer of patients between wards, departments, Specialist Units and Other Hospitals Policy) to another unit or hospital all relevant documentation must be gathered (Skinny File) and the patient identification checked before sending with the patient. The patient's ID band must be in place to allow other units to confirm identity of the patient.

4.10 Discharging Patients:
The ID band and SafeHands Badge must not be removed until the patient is leaving the hospital site. At discharge, all paperwork must be placed into the patient's health record (CP 04 - Discharge Policy and OP 07 Loose Filing - Health Records Policy).

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	- No
2	Does the implementation of this policy require additional revenue resources	- No
3	Does the implementation of this policy require additional manpower	- No
4	Does the implementation of this policy release any manpower costs through a change in practice	- No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	- No
	Other comments	

6.0 Equality Impact Assessment

The completion of the initial equality impact assessment screening tool has identified the potential for some low level risk or adverse effect for the following equality groups: age, disability or religion and belief.

7.0 Maintenance

The policy will be kept up to date through the central governance monitoring process and any changes or recommendations will be via the Trust Management Team.

8.0 Communication and Training

Trust wide notification of the availability of this amended policy will be communicated from the central governance team and cascaded via the Divisional Governance Managers and Departmental Heads not covered by the Divisional Structures and Senior Managers Briefing. Awareness of the policy will be introduced at local induction. Training of new clinical personnel will be undertaken through Trust and Local Induction. Training of existing personnel will be undertaken by Ward and Departmental Managers.

9.0 Audit Process

Criterion	Lead	Monitoring	Frequency	Committee/ Group
• Process for identifying all patients	Senior Sister/ Charge Nurse	Safehands	Monthly	Directorate Governance/ /QSAG
• Process for ongoing checks throughout the patient's care episode	Senior Sister/ Charge Nurse	Safehands	Monthly	Directorate Governance/ /QSAG

The Patient Identification Policy will be audited using Safehands. Non-compliance identified by completion of this audit will be reported through the Trust's Governance processes. The author will request a 6 monthly report from Datix/PALS to monitor and review any specific concerns regarding breaches of patient identification and non-compliance with red allergy wristbands.

The policy will be reviewed on a regular basis in accordance with Trust Policy OP 01.

10.0 References

- National Patient Safety Agency, Identification Bands for Hospital Inpatients Improves Safety. November 2005.
- National Patient Safety Agency, Safer Practice Notice July 2007.
- Information Standards Board for Health and Social Care, Patient Identifiers for Identity Bands (DSC Notice: 04/2009) March 2009.
- National Patient Safety Agency, The 'Never Events' list 2014/15.
- National Patient Safety Agency, The 'Never Events' list 2015/16.
- Executive Brief - Top 10 Patient Safety Concerns for Healthcare Organisations 2016 - ECRI Institute.

- NHS England Patient Safety Alert: Safer temporary identification criteria for unknown or unidentified patients December 2015
- NHS England Patient online primary care services: Good Practice Guidance on Identity verification 2015
- NMC 2015 The Code: standards of conduct, performance and ethics for nurses and midwives

Practices as indicated:

THCP1 Checking the Patient into Theatre, 2012.

CP05 Transfer of Patients between Wards, Departments, Specialist Units and Other Hospitals Policy 2015.

CP 04 Discharge Policy, 2015.

OP 07 Loose Filing, Health Records Policy, 2013.

OP 20 Management of the Deceased Patient, 2004.

OP 10 Risk Management and Patient Safety Reporting Policy, 2016.

SOP Standard Operating Procedure for patient badging, assigning, attaching, removing and cleaning of SafeHands badges (inpatients), 2018.

Part A - Document Control

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and Policy version: **OP 52**	**Policy Title** **Patient Identification Policy**	**Status:** **Final**		**Author: Senior Matron – Adult Community Services Group** **Chief Officer Sponsor: Chief Nursing Officer**
Version / Amendment History	Version	Date	Author	Reason
	1	May 2006	Patient Safety Manager	Review
	2	Nov 2008	Patient Safety Manager	Review
	3	May 2012	Patient Safety Manager	Review
	4	July 2016	Senior Matron, Adult Community Services Group	Review
	4.1	August 2018	Senior Matron, Adult Community Services Group	Amendment
	5	July 2021	Senior Matron, Adult Community Services Group	Full review with amendments
Intended Recipients: All Trust staff				
Consultation Group / Role Titles and Date: Matrons across Division 1 and 2, Programme Manager – Safehands, Hospital Transfusion Practitioner, Health Records Manager - May 2016. Clinical Facilitator Productivity Programme – Sep 2018				
Name and date of Trust level group where reviewed	Trust Policy Group September 2021			
Name and date of final approval committee	TMC September 2021			

Date of Policy issue	October 2021
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	3 yearly (September 2024)
Training and Dissemination: Trust Intranet	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes / ~~No~~**	
To be read in conjunction with: OP 10 Risk Management Policy and Patient Safety Reporting Policy	
Initial Equality Impact Assessment (all policies): **Completed Yes** **Impact assessment (as required):** **Completed NA**	
Monitoring arrangements and Committee	Trust Policy Group. Patient Safety Improvement Group. Quality Standards Action Group. Clinical Audit Group.

Document summary/key issues covered.

- To provide clear instructions to ensure staff correctly identify patients prior to the delivery of any care episode or intervention.
- Staff members key responsibilities and actions to be taken in adhering to this policy.
- Reference to the use of SafeHands badges.
- Information presentation of the patient's identity band.
- The use of red allergy wristbands.

Key words for intranet searching purposes	
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**Yes / No (delete as appropriate)** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

The Royal Wolverhampton NHS Trust

Part B **Ratification Assurance Statement**

Name of document: **Patient Identification Policy – OP_52**

Name of author: **Leigh Dillon** Job Title: **Senior Matron**

I, the above named author confirm that:

- The Policy presented for ratification meet all RWT Trust legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author:

Date: 16/07/2021

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version	Patient Identification Policy – OP_52	
Reviewing Group	Patient Safety Improvement Group. Quality Standards Action Group. Clinical Audit Group.	**Date reviewed:** 16/07/2021
Implementation lead: Leigh Dillon, Senior Matron (Interim) leighdillon@nhs.net		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	N/A	
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	N/A	
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	N/A	
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	Just usual policy update via the usual routes of Governance	
Financial cost implementation Consider Business case development	N/A	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation	Nil.	

Appendix 1

Information Presentation on the Patient's Identity Band

1.0 Information presentation

The same layout, order of information and information style must be used across the organisation to ensure standardisation.

1.1 Core Identifiers

The four core identifiers that uniquely identify a patient when used in combination and which must be present on the identity band are: Last Name, First Name, Date of Birth and a verified NHS Number / Hospital Number.

1.2 Names

First and last name must be clearly differentiated by using lower case letters for first name (with upper case first letter) and UPPER CASE for last name, and must be presented in the order: LAST NAME First name e.g. SMITH John. Ideally using a printed sticker once details confirmed as correct

1.3 Date of Birth

Date of birth must be recorded in the short format: DD-MM-YYYY e.g. 07-Jun-2016.

Where:
DD is the two-digit day
MMM is the abbreviated month name (e.g. Feb)
YYYY is the four-digit year
Day values less than 10 must appear with a zero in the first position e.g. 08
Month names must be abbreviated to the first three letters
Day, month and year separators must be hyphens.

1.4 NHS Number / Hospital Number

Systems must only display and print the NHS Number / Hospital Number in 3 3 4 format (e.g. 123 456 7890).

Guidance on all other aspects of identity band production and management including layout, font size, how to manage missing information etc. is available at http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/wristbands/

If any additional identifiers are thought to be necessary, these must be formally risk assessed in terms of why they are necessary, how they are distinguishable from the four specified identifiers and how they are located on the identity band so that the four identifiers remain clear and unambiguous.

In the case of newborns the bands must have:

- Infant of - mother's full name (surname followed by Christian name)
- Sex - boy / girl
- Mother's NHS and hospital number
- Baby's date and time of birth

Appendix 2

The Use of Red Allergy Wristbands

1.0 Introduction

1.1 Allergy wristbands have been in use in various areas of the Trust for a number of years. They, for example, indicate to a practitioner that the patient has some sort of sensitivity that should be checked prior to prescribing or administering drugs.

1.2 The use of a red allergy wristband **DOES NOT REPLACE** the completion of the allergy box in the patient's documentation. The absence of an allergy band should not lead to the assumption that there are no allergies. It does not replace the need to ask the relevant questions and to ensure that the appropriate documentation is completed correctly.

2.0 Aim

2.1 Allergy wristbands are to be used to alert all practitioners that the patient has stated, or is known to have a drug [e.g. Penicillin] or associated food allergy such as:

- Egg allergies can be related to Propofol
- Avocados and bananas are associated with latex allergies (HS01, Attachment 13)
- Peanut allergy can be related to some anaesthetic drugs

[This is not an exhaustive list]

Or any other substance known to have caused a previous significant or anaphylactic reaction.

3.0 Detail

The process for the use of red allergy alert wristbands is as follows. On admission:

3.1 Ask the patient if they have an allergy.

3.2 Check the patient's previous health records for evidence of allergies.

3.3 Check the patient's prescription chart and drug history.

3.4 Identify need for red allergy alert wristband.

3.5 Explain rationale to patient.

3.6 The red allergy wristband should be worn on the dominant hand to reduce the risk of it being removed for the siting of intravenous infusions etc.

3.7 Only one wristband should be worn – the allergy wristband. The allergy wristband is a replacement for, not in addition to, the normal wristband.

3.8 Document in the patient's notes the reason for the red allergy wristband. It is important that the nature and **severity** of the allergy is documented in the appropriate section of the patient's health records e.g. mild stomach upset, severe rash.

3.9 Remove if circumstances change and document in patient's notes.