Trust Policy

Plymouth Hospitals NHS
NHS Trust

Identification of Patients Policy

Date	Version
July 2015	7

Purpose

To ensure that patients receive the correct treatment, in the correct place at the correct time and that the potential for error is reduced to a minimum in line with the National Patient Safety Agency (NPSA) Safer Practice Notices November 2005 and July 2007.

Who should read this document?

All Staff.
Permanent, locum, agency, and NHSP staff working at Plymouth Hospitals Trust have a responsibility to adhere to this policy

Key messages

This policy sets out the Plymouth Hospitals Trust process for positive patient identification.
Safe and reliable positive patient identification is an essential step in providing safe care for our patients
Failure to correctly identify patients is one of the most serious risks to patient safety

Accountabilities

Production	Patient Safety Manager
Review and approval	Clinical Effectiveness Group
Ratification	Executive Director of Nursing and Medical Director
Dissemination	Patient Safety Manager
Compliance	Quality Assurance Committee

Links to other policies and procedures

Blood Transfusion Policy
Clinical Handover of Care and Internal Transfer of Adults Standard Operating Procedure
Consent to Examination or Treatment Policy
Correct Patient, Correct Procedure and Correct Site Policy
Deceased Patients Policy
Incident Management Policy
PHNT Medicines Management Policy
Registration and Identification of Newborn Infants
Serious Incidents requiring Investigation Policy
Specimen Transport Procedure
Standard Operational Procedure for the Safe Treatment and Management and Treatment of Unidentified and Hospital Trauma Patients
Checking Patient Details and Reception of Patients-Administrative Procedure Note

Version History

1.1	July 2010	
2.1	July 2010	Removal of ward from wristband. Change to definition of day case patient.
3.1	July 2010	Clarification of use of NHS number Removal of need to record application in Health record.
3.2	July 2010	Ratified by CGSG
4.1	October 2010	Ratified by CGSG
5	June 2015 February 2016	Updated to include: Definition of outpatient/ward attender/positive patient identification. Wristband exceptions. Inclusion of sample labelling and request card/referrals Clarification of Positive Patient Identification
6	August 2019	Extended to January 2020
7	November 2019	Extended to March 2020

Last Approval	Due for Review

July 2015	Extended to March 2020

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available in Document Library. Larger text, Braille and Audio versions can be made available upon request.

1 Introduction

Plymouth Hospitals NHS Trust (PHNT) recognises that a fundamental factor in ensuring patient safety and reducing errors is a reliable method of identifying patients.

Staff will ensure that the following patients must be identified by the use of a **single** hospital wristband that conforms to the standard set out by the National Patient Safety Agency (NPSA).

- **All inpatients**
- **Patients admitted for day case/day care**
- **Patients undergoing significant interventional/invasive procedures**
- **Patients undergoing any procedure where consciousness or capacity might be impaired**
- **Patients in any setting where it is professionally judged that there may be a risk of injury or harm that would be reduced by the use of a wristband (eg. An elderly unaccompanied patient, with reduced capacity, attending as a ward attender)**

This is supported by Trust wide and locality/speciality led procedures for checking the patient's identity on admission, and prior to commencing any consultation, treatment, therapy or interventional/invasive procedure.

PHNT uses electronically generated wristbands and will routinely use the patients' NHS number as the primary means of identification. If this is not available, the Hospital Number will be the prime identifier

The following patients do not require wristbands (unless it is professionally judged to be necessary)

- Patients attending **outpatient** Haemodialysis
- Patients attending **outpatient** Vascular Access Clinic
- Outpatients attending for a **consultation** in the Outpatient Departments
- Ward Attender patients attending a ward to receive nursing care.

Positive patient identification must be carried out by reception staff and by the Healthcare Professional prior to consultation or treatment

2 Purpose, including legal or regulatory background

To accurately identify patients in all locations of Plymouth Hospitals Trust, to ensure that patients receive the correct treatment, in the correct place at the correct time.

The use of safe and reliable positive patient identification will reduce the potential for error to a minimum.

This is in line response to guidance from with the National Patient Safety Agency (NPSA 2007) Safer Practice Notices November 2005 and July 2007

3 Definitions

Positive Patient Identification for patients who are required to wear a wristband

All staff must positively check the identification of the patient prior to delivering care or treatment. Positive identification involves asking the patient to verbally confirm their identity to you by using open-ended questions

- What is your name? This must match the name on the patient's wristband
- What is your date of birth? This must match the date of birth on the patient's wristband

- Checking the hospital number/NHS number on the patient's wristband. This must be cross-referenced with the medical or nursing healthcare record

For the administration of medication, the prescription chart is the healthcare record.

Positive Patient Identification for patients who do not require a wristband

The patient will have their details verified at the first point of contact between hospital staff and the patient, and by the Healthcare Professional prior to consultation or treatment

Positive Identification will include asking the patient to verbally confirm their identity to you

- What is your name?
- What is your date of birth?
- What is your address?

The responses must be cross-referenced with the medical or nursing healthcare record

For all patients, it is necessary to take into account any communication issues, gender, mental capacity, culture, disability and religious naming systems. Confirmation of identity may need to be gained from relatives or carers if patients are unable to verbally confirm their own identities

Inpatient

A patient who is admitted to a ward with the intention of staying for more than 24 hours

Ward Attender

A Patient who attends a ward to receive **nursing care**, but has not been admitted to hospital, and does not stay on the ward.

Day Case/Day Care patient

A patient who comes into Hospital to receive care, have a diagnostic examination, therapy or day case surgery and is discharged on the same calendar day.

Significant Interventional/Invasive procedure

For example

- Patients undergoing Surgery
- Endoscopy
- Liver/Renal Biopsy
- Angiography
- Blood Transfusion
- Chemotherapy
- Interventional Radiology
- Using a laser to treat eye problems

4 Duties

Chief Executive

Has overall responsibility for ensuring the safety of patients in PHNT

Medical Director and Executive Director of Nursing

Accountable to the Trust Board in ensuring compliance with this policy in all areas of PHNT

Deputy Director of Nursing

Responsible to the Executive Director of Nursing that this policy is implemented within all areas of PHNT.

Heads of Nursing

Responsible to the Deputy Director of Nursing for implementing and embedding this policy

In all areas of PHNT

Care Group Managers

Hold Service Lines to account for compliance with the policy

Ensure Service Lines comply with the annual audit. Audit results to be reported at Care Group Governance meeting

Service Lines

Ensure that all staff within the Service Lines comply with positive patient identification

Ensure that internal transfers are according to policy and that handovers of care include positive patient identification

Ensure that local procedures, eg identification of a renal fistula, do not contravene this policy.

Ensure an annual audit is completed within the Service Lines

Share learning from any patient identification incidents at Service Line meetings

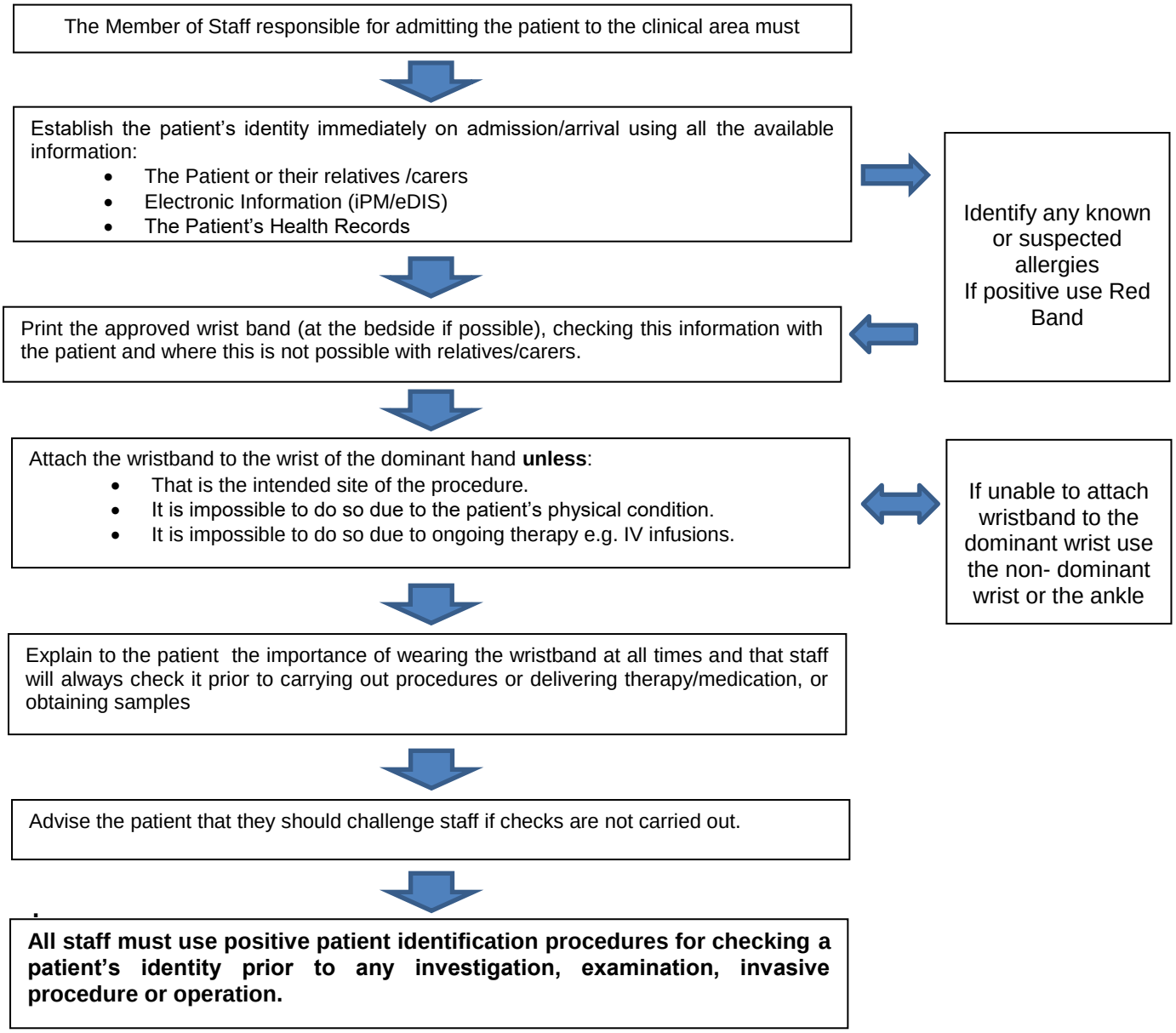
All Staff

Responsible for compliance with the contents of this policy

All staff must report any incidents relating to patient identification so as to identify issues and share learning in order to keep our patients as safe as possible

5 Key elements

Process Flow Chart for establishing the patient's identity and applying wrist bands



Process for establishing the patient's identity and applying wrist bands

The Member of staff responsible for admitting the patient to the clinical area must:

- **Be competent to do so**.
- Have the appropriate training in order to access the relevant Information Technology (IT) Systems
- Establish the patients identity immediately upon admission/arrival using all the available information including:
    - The Patient or their relatives /carers
    - Electronic Information (iPMS)
    - The Patient's Health Records

  Ref. Administrative Procedure Note :Checking Patient Details and Reception of Patients

- Print the approved wrist band (at the bedside if possible), checking this information with the patient and where this is not possible, with relatives/carers
- Hand written labels must only be used in exceptional circumstances and this must be done in black permanent/indelible ink with the following information only
    - Patients first and last name
    - Last name in upper case
    - First name in lower case with first letter in upper case eg**. SMITH Patricia**
    - Date of Birth in DD-MMM-YYYY format eg**. 08-Dec-1996**
    - NHS Number - this should be the primary means of identification
    - Local Hospital Number is also printed. (There are occasions when the NHS Number is not available)

No other information should be included on the wristband.

- Attach the wristband to the wrist of the dominant hand unless:
    - That is the intended site of the procedure.
    - It is impossible to do so due to the patient's physical condition.
    - It is impossible to do so due to ongoing therapy e.g. IV infusions.

Where it is impossible to fit the wristband on to the patients wrist, use the ankle. If no limb can be utilised, the wristband must be secured to the patient's clothing. In all instances, the wristband must be accessible and visible

- Check that the wristband is of a suitable size and fit for the patient and that it will remain in situ and is comfortable. For patients with larger limbs, it may be necessary to join two wristbands together
- Ensure that the barcode is able to be scanned, and not obscured by clothing or jewellery
- Explain to the patient of the importance of wearing the wristband at all times to enable correct identification. Explain that staff will always check it prior to carrying out procedures, obtaining samples, or delivering therapy/medication in line with the documented Trust policies and local procedures.

Patients must be advised they should challenge staff if checks are not carried out.

Report any incidents, including near misses, arising from the misidentification of patients, through the Trust's incident reporting process. (See Trust policy for Serious Incident Requiring Investigation (SIRI) procedure and the Management of Incidents)

Patients must only ever wear one wristband unless

- The patient is a newborn infant
  Refer to the Registration and Identification of Newborn Infants
- The patient has been previously unidentified. When identity is realised, **both** wristbands remain in situ until the patient is discharged from hospital.
  Refer to the Standard Operational Procedure for the Safe Management and Treatment of Unidentified and Hospital Trauma Patients

Transfer of Patients from another Hospital

Patients must have the Derriford Hospital (PHNT) wristband attached on arrival. The original wristband must be removed to avoid any confusion of identifying details

Internal transfer of patients

When admitting a patient from another ward or department the admitting person must

check the details on the wristband and with the patient in line with the above process.

Take the necessary corrective action if there is any doubt as to the patients' identity or a wristband is not in situ.

When transferring patients refer to the:

Clinical Handover of Care and Internal Transfer of Adults (excluding Maternity) Standard Operating Procedure

Removal and Replacement of wristbands

a) Never remove a wristband unless it is essential for clinical care, there is an error in the detail or it becomes illegible. Wristbands should be checked and replaced immediately if damaged.

b) Where the wristband has to be removed it is the responsibility of the person who removes it to replace it.

c) If you discover a patient who is not wearing a wristband you are responsible for confirming the correct identity of the patient and affixing a wristband as per the above process.

Patients who refuse to wear wristbands

Patients who refuse to wear a wristband should have the risks associated with non-compliance explained.

Non-compliance must be documented and verification of name /address/date of birth must occur before any consultation, treatment or intervention in order to positively identify the patient

Verification should also be documented. These patients must be highlighted on the ward safety brief, and all members of the multidisciplinary team should be made aware

The use of wristbands to identify patients with allergies

When admitting patients to wards/clinics/departments, it is the responsibility of the healthcare practitioner admitting the patient to establish if the patient has any known allergies.

Once it is established that a patient has a known allergy it is the responsibility of the healthcare practitioner admitting the patient to attach an approved wristband with a red strap which will alert staff that the patient has an allergy or sensitivity to a product(s), drug(s) or substance(s), and to record this in the Health Record and on the Medication Prescription Chart.

In addition to the bedside handover, the importance of knowing the allergy status of patients should be highlighted at the ward safety brief

Staff must refer to the Health Record for details of allergies.

A green 'ALERT' sticker on the Health Record is a visual aid to checking the inside cover where the allergy should be documented, and the written medical notes for allergy details.

Staff must ensure a Clinical Alert is added/ updated as necessary on iPM

Ref: Administrative Procedure Note-Recording Alerts

This wristband becomes the patient identifier and must be the only wristband worn.

N.B. The absence of a wristband with a red strap does not guarantee the patient does not have an allergy and all staff must make an appropriate risk assessment prior to any intervention.

SALUS Patient Care Manager – Real time patient bed management

The electronic boards are used by all staff to admit, transfer and discharge patients and to display attributes relevant to that patients care.

Patients with the Same or Similar Name

Wherever possible, patients with the same or similar name should be cared for in different bays or areas in the ward/department.

All patients with the same or similar name should be highlighted at the ward safety briefs and on SALUS Patient Care Manager using the attribute below

For those areas, not yet using SALUS,

If using magnetic whiteboards, please use the yellow magnets which state ''Same Name on Ward''

For those areas using non-magnetic boards, use the yellow circular warning labels stating: "Caution patient with same name on ward"

These should also be used on key documents, taking care not to obscure any patient information.

Managers must ensure all new and temporary staff understand how to identify patients with the same/similar name.

Managers must ensure that the labels are available for staff to use

Completion of Request Cards/Referrals etc

The person signing the request should complete all fields on the request themselves, including the application of the correct patient identification label.

Sample labelling

All patient samples must be labelled at the bedside with the details obtained from the patient's wristband. Samples with less than 3 points of patient identification are likely to be rejected.

Inaccurate labelling causes delays, misdiagnosis, and inappropriate treatment..

For further details on specimen labelling and completion of test requests, whether paper, ICM or ICE, see the Pathology Handbook at

http://www.plymouthhospitals.nhs.uk/ourservices/clinicaldepartments/plymouthpathology/Pages/GeneralInformationPathology.aspx

Misidentification of patients

Where a patient is misidentified this should be managed as an incident and the member of staff should:

Take all steps to mitigate any harm caused

Take all steps to prevent any future harm

Any member of staff who discovers a patient without an identification wristband, or with incorrect details displayed has to assume responsibility for ensuring the patient is correctly identified

Ensure the patient can be identified by following identification process described above.

Ensure the misidentification is reported through the Trust's incident reporting system (Datix). See Trust policies for Incident Management and the Serious Incident Requiring Investigation.

For unidentified patients refer to the:

Standard Operational Procedure for the Safe Treatment and Management and Treatment of Unidentified and Hospital Trauma Patients

6 Overall Responsibility for the Document

The Patient Safety Manager has delegated authority for reviewing this policy.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Clinical Effectiveness Committee and ratified by the Executive Director of Nursing and Medical Director.

Non-significant amendments to this document may be made, under delegated authority from the Executive Director of Nursing and the Medical Director, by the nominated author. These must be ratified by the Executive Director of Nursing and the Medical Director and should be reported, retrospectively, to the approving Clinical Effectiveness Committee

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Executive Director of Nursing and the Medical Director , and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

- Incidents are monitored and themes reported to the Quality Governance and Learning Group.
- A Patient Identification project group has been established as part of the Quality Improvement Committee. An audit proforma will be developed as part of this project and will be disseminated by the Clinical Audit Team as a corporate audit priority.

10 References and Associated Documentation

NPSA/SPN/2009/002 Risk to patient safety of not using the NHS number as the national identifier for all patients

NPSA/2007/PSA/24 Standardising Wristbands improves patient safety

NPSA/2009/PSA002/U1 WHO Safer Surgery Checklist

NHS/PSA/RE/2015/008 Supporting the introduction of the National Safety Standards for Invasive Procedures

Dissemination Plan | Appendix 1

Core Information	
Document Title	Identification of Patients Policy
Date Finalised	July 2015
Dissemination Lead	Information Governance Team
Previous Documents	
Previous document in use?	Yes
Action to retrieve old copies.	Remove from Staff Net

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff		Email/Vital Signs	Document Control	

Review		
Title	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
Rationale	Are reasons for development of the document stated?	
Development Process	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
Content	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
Evidence Base	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
Approval	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
Document Control	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
Review Date	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

Core Information	
Manager	Cathryn McWhinnie
Directorate	Quality Governance
Date	20/07/2015
Title	Patient Identification Policy
What are the aims, objectives & projected outcomes?	To ensure that patients receive the correct treatment, in the correct place at the correct time and that the potential for error is reduced to a minimum in line with the National Patient Safety Agency (NPSA) Safer Practice Notices November 2005 and July 2007.

Scope of the assessment
This assessment considers all patient who would be required to wear a wristband

Collecting data	
Race	Consideration will be made for patients whose first language isn't English. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Religion	There is no evidence to suggest that there is a disproportionate impact on religion or belief and non-belief regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Disability	Consideration must be made for patients who have communication difficulties. Consideration must be made for patients with learning disabilities who will be referred to the learning disability liaison team. Consideration will be made for patients with other disabilities as required. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Sex	There is no evidence to suggest that there is a disproportionate impact on sex regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Gender Identity	Data for this protected characteristic is not currently collected. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Sexual Orientation	There is no evidence to suggest that there is a disproportionate impact on sexual orientation regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Age	There is no evidence to suggest that there is a disproportionate impact on age regarding this policy. Data collected from Datix incident reporting and complaints will ensure this is monitored.

Socio-Economic	Data for this protected characteristic is not currently collected.
Human Rights	Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
What are the overall trends/patterns in the above data?	Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Specific issues and data gaps that may need to be addressed through consultation or further research	No gaps have been identified at this stage but this will be monitored via Internal audit processes, datix incident reporting and complaints.
Involving and consulting stakeholders	
Internal involvement and consultation	Internal consultation via email with staff groups including Executive Governance Team Ward /Clinic/Theatre Managers Matrons Heads of Departments Clinical Service Line leads Anaesthetic Consultants Clinical Directors Quality Managers Head of Patient Access
External involvement and consultation	Not applicable
Impact Assessment	
Overall assessment and analysis of the evidence	Considerations will be made for patients where English is not their first language, who have communication difficulties, and patients with a disability.

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Collect and monitor data collected from Datix	Patient Safety Manager		Ongoing	This action will be addressed as required

Core Information	
Manager	Steve Mumford – Head of Quality Governance
Directorate	Quality Governance
Date	August 2015
Title	Identification of Patients Policy
What are the aims, objectives & projected	This policy will enable the Trust to meet its obligations with regard to the correct identification of patients

outcomes?	

Scope of the assessment

This assessment will highlight any areas of inequality with regard to the implementation of this policy