Northern Lincolnshire and Goole Hospitals NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the “protected characteristics” as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.
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1.0 Policy Statement

1.1 All patients must be able to be correctly identified at all times whilst being assessed, or undergoing procedures/treatments within the organisation. Failure to correctly identify patients constitutes one of the most serious risks to patient safety.

1.2 The purpose of this Policy is to describe the steps which must be taken to ensure that the right patient receives the right care at the right time, and if applicable that an intended procedure is performed on the correct patient, at the correct site.

1.3 This Policy & Procedure has been developed to assist staff to positively and safely identify patients whilst taking account of key principles relating to privacy, dignity and confidentiality. It is also intended to reduce risk and increase patient safety.

2.0 Background

2.1 Analysis of incident data from the National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS) shows that patient safety incidents relating to identification of patients continue to occur.

2.2 The four main, interdependent themes to emerge related to:

- Mismatches between patients and the documentation on samples, records, blood transfusion samples and products, and medication. For example the documentation had the wrong patient details or insufficient identifiers to allow accurate matching to the appropriate patient
- Missing wristbands or wristbands with incorrect data on them
- Mismatches between patients and their medical records. For example where a patient’s records or results are filed in another patient’s medical records, or where the wrong medical records are with a patient
- Failures in the manual checking processes. For example where the data states that procedures for checking the identity of a patient were not used

2.3 Some of the common causes of patient identification incidents are:

- Administrative errors:
  - Incorrect labelling
  - Misfiling of results
  - Transposing digits in hospital numbers
  - Wrong addressograph labels
  - Incorrect, illegible or incomplete documentation
• Failure of verification:
  − Inadequate or non-existent verification protocols
  − Non-compliance with verification protocols

• Communication difficulties:
  − Due to patients illness, mental state or language barrier
  − Failure to read back

2.4 In November 2005, the National Patient Safety Agency (NPSA) issued Safer Practice Notice 11 “Wristbands for hospital inpatients improves patient safety” NPSA/2005/SPN11, which recommended that “all hospital inpatients in acute settings should wear wristbands with accurate details that correctly identify them and match them to their care”¹ and set out the actions required by NHS organisations in order to comply with the alert.

2.5 In November 2006 the National Patient Safety Agency (NPSA) Published Right Patient Right Blood: Advice for Blood Transfusions (NPSA/2008/SPN14) in November 2006 which sets out measures to improve the safety of blood transfusions, including photo identification cards for regular patients and electronic tracking systems for patients and blood. In 2008 the NPSA issued Right patient, right blood: Core competencies as part of the 2006 Safer Practice Notice.

2.6 In July 2007 the National Patient Safety Agency (NPSA) issued Safer Practice Notice 24 – Standardising Wristbands Improves Patient Safety NPSA/2007/SPN24. This outlines the Action for the NHS:

• 18 July 2008, all NHS organisation in England and Wales that use patient wristbands should:
  − Only use wristbands that meet the NPSA’s design requirements. (The wristband/identity band design requirements relate to Size, Comfort, Usability, Method for recording patient identifiers, Information presentation, Coloured wristbands and New technology)
  − Only include the following core patient identifiers on wristbands: Last Name, first name; date of birth, NHS Number (if the NHS number is not immediately available, a temporary number should be used until it is). If any additional identifiers are thought to be necessary, these should be formally risk assessed
  − Develop clear and consistent processes, set out in trust protocols, specifying which staff can produce, apply and check wristbands, how they should do it and what information sources they should use

¹ Safer Practice Notice 11, Wristbands for hospital inpatients improves safety. NPSA. 22nd November 2005.
– Only use a white wristband with black text. If you wish to have a system for identifying a known risk (for example an allergy or where a patient does not want to receive blood or blood products), the wristband should be red with patient identifiers in black text on a white panel on the wristband

• By July 2009 all patient Identity bands/wristbands must be generated from the hospital demographic system (for example the Patient Administration System; PAS) at the patient’s bedside, wherever possible

2.7 In June 2009, the NPSA issued a Safer Practice Notice Risk to patient safety of not using the NHS Number as the national identifier NPSA/2009/SPN002. This outlines the actions for the NHS, stating that all NHS organisations should:

• Use the NHS Number as the national patient identifier; OR the NHS Number as the national patient identifier in conjunction with a local hospital numbering system

• Use the NHS Number in/on all correspondence, notes, patient wristbands and patient care

• Put processes in place to ensure that patients can know their own NHS Number and are encouraged to make a note of it

• Primary care organisations should inform patients about their NHS Number in writing whenever they register as a new patient

2.8 These Safety Notices are part of a wider programme of NPSA work on safer patient identification and matching patients correctly with samples, specimens, records and treatment. To date the NPSA has:

• Published Right patient – right care in December 2004, which summarises research on manual checking and the use of technologies for patient identification

• Published a patient safety alert on “Correct Site Surgery” on ways to minimise the risk of surgery on the wrong part of the body

• Published in January 2009 NPSA/2009/PSA002 WHO Surgical Safety Checklist. Which outlined the actions which organisations are required to undertake:
  – Ensure an executive and a clinical lead are identified in order to implement the surgical safety checklist within the organisation
  – Ensure the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia)
  – Ensure that the use of the checklist is entered in the clinical notes or electronic record by a registered member of the team
In respect of specific actions relating to patient identification the actions and safety checks which must be consistently applied for every patient is the team will operate on the correct patient at the correct site, the WHO Surgical Safety Checklist has been adapted locally within this Trust to incorporate these requirements.  Please refer to the Surgical Safety Checklist Procedure

2.9 The NPSA is also promoting safer ways of identifying patients through:

- Working with Connecting for Health (CfH – formerly NPfIT) in England and Informing Health care in Wales, the NHS and the health care industry on appropriate technologies for identifying patients

- Exploring local NHS initiatives for reducing incidents of incompatible blood transfusions

- Assisting the Department of Health conduct a regulatory impact analysis on the proposed use of barcodes and/or radio frequency tags on medicines, samples and blood products in the UK

- Working with the British Medical Journal (BMJ) and the Institute of Healthcare Improvement to launch www.saferhealthcare.org.uk which contains evidence and examples of good practice

2.10 The NPSA has together with the British Medical Journal (BMJ) and the Institute of Healthcare Improvement (IHI) launched a website www.saferhealthcare.org which is free once registered. This contains a website are on patient identification which contains evidence and examples of good practice.

3.0 Area

3.1 This Policy applies to all patients under the care of Northern Lincolnshire & Goole Hospitals NHS Foundation Trust.

3.2 All employees are required to adhere to this policy and procedures, including contracted staff.

4.0 Duties

4.1 Chief Executive

4.1.1 Has overall accountability for ensuring that the Trust meets its statutory and non-statutory obligations in meeting the standards to manage the risk associated with the identification of patients.

4.2 Trust Governance Committee

4.2.1 Receives and reviews information relating to patient identification/patient safety. This committee is chaired by a non-executive director who represents this Group at the Trust Board.
4.2.2 Local Governance Groups and the Trust’s Governance Liaison Group report by exception/highlight to the Trust Governance Committee information relating to patient identification/patient safety.

4.3 **Head of Governance & Trust Secretary**

4.3.1 Has delegated overall responsibility for ensuring that the Trust has in place a Patient Identification Policy to manage the risk associated with the identification of patients.

4.4 **Directors & Clinical Directors**

4.4.1 Will ensure that all policies/procedures and documentation within their areas of responsibility meet the terms of this Patient Identification Policy.

4.5 **Trust Risk Manager**

4.5.1 Will have designated responsibility for developing a Patient Identification Policy to manage the organisational risks associated with the identification of patients.

4.5.2 Will have designated responsibility for ensuring organisational compliance with national guidance on Patient Identification (NPSA), in accordance with the Department of Health Central Alert System (CAS), and will escalate concerns/areas of non-compliance to the Trust Governance Committee.

4.6 **Customer Services Manager**

4.6.1 As part of their role as chair of the Trust Information For Patients Group, will ensure that relevant Patient Information Leaflets explain to patients the importance of correct patient identification and the importance of wearing an Identity band/wristband for their own safety at all times during their hospital stay.

4.7 **Lead Clinicians and Matrons**

4.7.1 Will ensure that this Policy is disseminated and effectively communicated, implemented operationally and monitored within their areas of responsibility.

4.7.2 Will ensure that all patients within their specialty and area of responsibility are managed in line with this policy.

4.8 **Dept/Ward Managers/Heads of Service/Team Leaders**

4.8.1 Will have nominated responsibility for ensuring that all staff within their areas of responsibility are aware of and have access to this policy.

4.8.2 Will ensure that all staff within their sphere of responsibility receive training on the Patient Identification Policy at Local Induction.

4.8.3 Will ensure that all staff receive training in the relevant information technology systems to allow them to access/update patient details and unique patient identifier number, and produce identity/wrist bands in the standardised format following positive identification.

4.8.4 Will ensure that failures to comply with this Policy are reported via the Incident Reporting Policy.
4.8.5 Will ensure that incidents relating to patient misidentification are reported and managed in line with the Trust’s Incident Reporting Policy and action plans developed where appropriate in order to learn lessons and prevent reoccurrence.

4.9 All staff dealing with patients and/or health records (Including Administration Staff)

4.9.1 Will use this Policy in conjunction with all other Trust Policies which relate to patient identification.

4.9.2 Will adhere to this policy, regardless of profession and grade, and accept the professional accountability for failure to comply.

4.9.3 Will report all incidents related to patient identification via the Trusts Incident Reporting Policy.

5.0 Process for Identification of Patients

5.0.1 Please also refer to the Appendix for the:

- Procedure for Positive Patient Identification (Appendix A)
- Procedure for Identity Band/Wristband (Appendix B)
- Procedure for Patient Identification on Documentation (Appendix C)

5.1 NHS Number

5.1.1 In line with the Governments strategy for patient identification, the unique identification number for patients is the NHS Number.

5.1.2 The NHS Number must be used as the national patient identifier in conjunction with a local hospital numbering system. For patients admitted to the Emergency Care Centre or Accident & Emergency Departments, or admitted as an emergency, where the NHS Number is not available, a temporary number should be used until the NHS number becomes available.

5.1.3 The NHS Number must be used in/on all correspondence, notes, patient wristbands and patient care.

5.2 Identifying the patient

5.2.1 Frontline health care staff must always verify that the person they are attending to is the one for whom the treatment is intended, and match the treatment to that person. (In this context ‘treatment’ includes all care, investigations, procedures and reports). All staff must positively identify the correct patient prior to assessment and delivery of care or treatment.

5.2.2 If filing documentation in a patient health record, it is the responsibility of the person to ensure that the correct information is being filed in the correct patient health record. Please refer to the Trust Single Health Record Filing Procedures (SDR007).
5.2.3 The identity of the patient must be confirmed at each and every handover or transfer of care and in the case of children should be confirmed with the parent, guardian, relative or person with parental responsibility.

5.2.4 If referring a patient to another specialty/department it is the responsibility of the referrer to ensure he/she is contacting the correct team, and that the correct patient is referred, e.g. the correct Patient ID label has been attached to the correct referral form. All patient identifiers must be given to the receiver of the referral to ensure the correct patient will be identified.

5.2.5 For In Patients/Day Case Patients it is important to ensure that on discharge any information relating to the discharged patient is removed from the bedside.

5.2.6 Correct patient identification is everybody’s responsibility, and is an ongoing process throughout episodes of care. It is essential that staff acknowledge their individual role within the process of patient identification. Assumptions must not be made by word of mouth from colleagues regarding patient identity as each individual must check the patient details and be sure the patient is the intended subject of the intervention they are performing.

5.3 Identity Band/Wristband

5.3.1 All hospital in-patients must wear an identification bracelet/wristband throughout their stay in hospital, and this should be used to positively identify the correct patient (see Appendix B). In the case of children, identification should be confirmed with the parent, guardian, relative or person with parental responsibility see also Appendix B.

5.4 Risk Factors

5.4.1 It is important to ensure that Allergy & Alert information is included in the correct patient’s health record. Please refer to the Health Records management Policy and Strategy (SDP010).

5.4.2 If there are problems with identification due to language or disability an appropriate interpreter/translator/sensory impairment communicator should be sought. The PALS office hold contact details of interpreters. Out of office hours Switch Board hold contact details of interpreters.

5.5 Information for Patients

5.5.1 All patients who are to be admitted to hospital must receive information, either in a pre-admission letter or patient information leaflet on the importance of positive patient identification and on why they should wear an identity band/wristband when staying in hospital.

6.0 Patient Misidentification

6.1 Anyone who discovers a patient identification issue should report it immediately to the person in charge. This includes ‘near miss’ situations where the error has been detected before an incident has taken place.
6.1.1 Examples may include:

- Wrong addressograph labels in health records
- Wrong information on ID wrist band
- Wrong information on theatre list
- Wrong information on referral forms
- No Identity band/Wristband
- Misidentification of documentation within the health record
- Misidentification of x-rays
- Misidentification of investigation reports
- Misidentification related to appointments

6.2 The safety and care of the patient is the priority, all necessary action should be immediately implemented to minimise the harm to the patient, and any actions should be taken to reduce the risk of further risk, for example replacement of the Identity band/Wristband. The manager of the unit/ward/department should also be informed of the incident.

6.3 An Incident Report Form should be completed for all incidents and ‘near miss’ events, it is the responsibility of the person who discovers or witnesses the incident to report it, using the Trust Incident Report Form. Please refer to the Trust Incident Reporting Policy & Procedures.

6.4 It is crucial that weaknesses in systems involved in patient identification are identified so that the organisation can eliminate or reduce the risk, and by reporting incidents staff will be contributing to this.

6.5 Incident Analysis Reports of Incidents are routinely provided by Risk Management. These reports will be used to develop action plans and inform the audit programme for patient identification. The analysis reports, audit findings and action plans will routinely be reviewed by the Trust Governance Co-ordinators Group, with escalation to the Trust Governance Committee where appropriate.

7.0 Monitoring Compliance and Effectiveness

7.1 The implementation of this policy and procedures will be subject to regular audit. The audit programme is developed and maintained by the Clinical Effectiveness and Audit Department.

7.2 There are a number of clinical audits which incorporate elements of patient identification, these include Health Record Documentation Audit and the Treatment Sheet Audit. The results of these will be used to form part of the overall audit of compliance with this Policy.
7.3 Patient Identity band/wristband audits will be carried out annually. These audits will include:

- the number and percentage of in-patients wearing correct/approved Identity Bands
- the accuracy and reliability of information on them
- the reasons why the patient may not be wearing an Identity band
- the efficacy of alternative arrangements, including any Risk Assessments

7.4 Audit finding reports are presented to the Governance Liaison Group for review and development of Action Plans. Where relevant, the Trust Governance Committee will receive highlight reports of areas requiring escalation.

7.5 Analysis of patient identification incidents will be included in the Quarterly Incident Analysis reports provided to Trust Board and Trust Governance Committee. These will include:

- the number of patient safety incidents related to patient identification
- the number of incidents related to misidentification and documentation

7.6 An annual aggregate review of Incidents, complaints and claims will also include analysis of data on patient identification.

8.0 Policy Review

8.1 This policy will be reviewed in line with Trust Document Control Policy, every three years or sooner if further guidance becomes available, this will include review following the issue of any national safety guidance received via the DoH CAS process.

8.2 Any amendment to this Policy will be communicated throughout the organisation by the Directorate of Nursing via Matrons & Ward/Unit Managers, and via the department of the Head of Governance & Trust Secretary.

8.3 The review of this Policy and Procedures will also be informed by adverse incident data collected by the Trust.

9.0 Related Documents

9.1 In addition to this policy, locally agreed policies and guidelines which complement this policy should be adhered to. Specific policies/guidelines exist for:

- **Policy for the Administration of Blood and Blood Components and Clinical Guidelines for the Management of Transfusion Reactions.** Available at: [http://nww.nlq.nhs.uk/documentmanagement/display_search_results.asp?keyword=csp002](http://nww.nlq.nhs.uk/documentmanagement/display_search_results.asp?keyword=csp002)

- **Latex Policy (MDP018).** Available at: [http://nww.nlq.nhs.uk/documentmanagement/display_search_results.asp?keyword=mdp018](http://nww.nlq.nhs.uk/documentmanagement/display_search_results.asp?keyword=mdp018)
• Pre-Operative Marking Verification Policy (MDP002)  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=mdp002

• Identification & Security of the Newborn (FSG108) Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=fsg108

• Medicines Code (CSP003) Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=csp003

• Pathology Samples and Request Form Labelling Expected Standards of Practice. Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=pathology%20samples

• Health Records Management Strategy (SDP010). Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=sdp010

• Single Health Record Filing Procedures (SDR007). Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=sdr007

• The Ionising Radiation (Medical Exposures) Regulations 2000. Available at:  
  http://nww.nlg.nhs.uk/Radiology/IR(ME)R%20procedures%202009/index.htm

• Major Incident Policy. Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=major%20incident

• Trust Incident Reporting Policy (GQP019). Available at:  
  http://nww.nlg.nhs.uk/documentmanagement/display_search_results.asp?keyword=GQP019


10.0 Useful Contacts

10.1 For further information and guidance please contact Risk Management.

• Contact Numbers:
  – Trust Risk Manager – SGH Ext 2237, DPoWH Ext 1250
11.0 **References**


11.8 NHS Connecting for Health Common User Interface Design Guide Entry – Patient Name 5 December 2006 Version 0.0.0.2 Draft (www.cui.nhs.uk)

11.9 The NHS Number – a key to greater patient safety. Patient Safety Alert issued jointly by the NPSA, NHS Connecting for Health and Informing Healthcare.

11.10 British Committee for Standards in Haematology.

12.0 **Dissemination and Implementation**

12.1 This Policy will be placed on the Trust's intranet to enable availability to all staff.

12.2 This Policy will be sent via e-mail and hard copy to all individual Clinical Directors, Branch Managers, Directors, Assistant Directors, Associate Directors, Matrons, Directorate of Nursing staff, Governance Leads, Governance Co-ordinators and Ward/Unit/Departmental Managers.

12.3 The policy will be launched via team communication through Ward and Departmental Managers, Sisters, Matrons, Governance Co-ordinators.

12.4 Patient Identification is a fundamental part of safe patient care and will be included in many aspects of training and development. All staff will receive training at Local Induction of the Trust's Patient Identification Policy. It will be the designated responsibility of all line managers to ensure that this training is delivered to all new staff.
12.5 The Policy will also be included in annual update training/awareness sessions to all staff throughout the Trust and following each Policy review. It will be the designated responsibility of all line managers to ensure that this training is delivered to all staff.

The electronic master copy of this document is held by Document Control, Office of the Medical Director, NL&G NHS Foundation Trust.
PROCEDURE FOR CORRECT PATIENT IDENTIFICATION

1. IDENTIFYING THE PATIENT

1.1 All staff must positively check the identification of the patient at every contact point.

1.2 There are THREE steps to correctly identifying a patient. They should be undertaken in the following order (if the first is not possible, undertake the second then third)

   1.2.1 Ask the patient to tell you their name and date of birth and address (rather than asking the patient to confirm). These details must be cross-referenced with the patient Identity band/wristband (if worn by the patient), and the health record or request form of the patient you wish to identify. In the case of positively identifying children, this must be carried out and confirmed with the parent, guardian, relative or person with parental responsibility who must be asked to state unprompted the patient’s full name and date of birth.

   1.2.2 If the patient is unable to tell you their name and date of birth, due to their condition or lack of capacity, if possible verify the information by asking family, relatives or another member of clinical staff who know the patient, also refer to the Identity band/wristband (if worn by the patient)

   1.2.3 Confirm these details using the health record/Request Form/ CaMIS PAS record and if these match and there are no contraindications continue with the assessment/care/treatment.

1.3 in the following events there are additional procedures to follow:

   - Pathology Samples – All pathology samples should have the following core identifiers clearly marked: NHS No, Surname, Forename, D.O.B, Address/Post Code. Please refer to Pathology Samples and Request Form Labelling Expected Standards of Practice.

   - Blood transfusion -Please refer to the Trust’s Policy for the Administration of Blood and Blood Components and Clinical Guidelines for the Management of Transfusion Reactions

   - Drug administration -Please refer to the Trust’s Medicines Code

   - Radiological examinations – Imaging It is the specific responsibility of the Operator to ensure that the correct patient is being examined according to the request that has been made. The details on the request form must be checked with the patient personally, prior to any examination / imaging. The details on the request form must be checked and matched specifically with the patient presenting for imaging, and cross checked with the persons imaging history available on the system. If the patient details stated on the request form are incomplete or have not been completed correctly further information must be obtained before an exposure is performed. The exposure must not be performed until the patient’s correct identification can be confirmed. Radiology Staff must specifically refer to the Ionising Radiation (Medical Exposure) Regulations 2000 “Procedure A – Procedure to identify correctly the individual to be exposed to ionising radiation”.

Appendix A

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• **Deceased Patients** - Please refer to the Trust ‘**Last Offices (Adults) Policy**’ for the procedures relating to identification of deceased patients.

• **Out Patients** It is the responsibility of the nurse, clinician or healthcare professional delivering care to ensure that the right patient is in the room with the right health records prior to commencing the consultation or treatment AND when there is face-to-face contact with the patient, that any identification label (addressograph) is affixed to any investigation request / prescription / booking form, at that these are personally checked for accuracy with the patient prior to the patient leaving the consultation room. Please refer to the **Outpatients Operational Procedure: Checking Patient Identification, August 2010**. Available on the Trust Intranet.

• **Operating Theatres**

It is the responsibility of any Operating Surgeon to check the patient’s identity and consent form before commencing surgery. This is just as pertinent if a surgeon was not involved from the beginning of the operation, but called on to assist during surgery. The **Procedure for Correct Site Surgery** should be followed.

It is also the responsibility of all members of the theatre team to participate in the use of the **Surgical Safety Checklist** (INSERT DOC NO), to ensure that the correct patient receives the correct treatment / procedure. Please refer to the **Surgical Safety Checklist Procedure included in the Pre-Operative Marking Verification Policy (MDP002)**.

1.4 The identity of the patient must be confirmed at each and every handover or transfer of care and documented in the patient’s health record.

1.5 The identity of the patient must be confirmed at each and every transfer/move of a patient from one department to another. E.g. Ward to theatre, ward to x-ray etc.

1.6 It is important that records of bed identity/ allocation and information on the patient’s bed is accurate and kept up-to-date.

1.7 It is important to ensure that on discharge any information relating to the discharged patient is removed from the bedside.

1.8 It is important that the ward/department white board which contains information regarding the location of patients, is updated following each admission, transfer and discharge. There should be a routine check of the board to maintain accuracy, as a minimum before each staff shift changeover. In addition, in order to further reduce risk of misidentification avoid placing patients with the same or similar sounding last names in the same room/area.

1.9 All documentation kept at the bedside (care plans, vital signs charts, Integrated Care Pathways, and prescription charts) must be checked before recording any information to ensure it belongs to the intended patient.

1.10 **Health records** should always be checked through to ensure all documentation stored within them relate to the correct patient.

1.11 **Addressograph labels** represent a risk to the patient because they are prepared in advance of the patient being present and may have been inadvertently filed in the
wrong healthcare record. It is essential that before using any addressograph labels, the details contained on the label must be confirmed with the patient.

1.12 *Investigation/test requests* should be completed accurately with all essential patient identity information, and should also be re-verified by the person carrying out the test before any investigation test is undertaken.

1.13 *Investigation results* should always be stored in the patient’s health record, and verified to ensure they have been actioned in accordance with Trust Policy/procedures.

1.14 All patients who are to be admitted to hospital must receive information, either in a pre-admission letter or a patient information leaflet on the importance of positive patient identification and on why they should wear an Identity band/wristband when staying in hospital.

1.15 All *inpatients* must wear an Identity band/wristband. The nurse who is primarily responsible for admitting/meeting the patient is responsible for administering the Identity band/wristband. This should be applied as a priority during the initial admission process. A written record must be made in the patient’s health record, each and every time the patient’s identity is checked and confirmed.

1.16 *Identity bands/wristbands* do not remove responsibility for checking patients’ identity. They are an important way of validating identification particularly when a patient is unable to provide confirmation of their identity.
Procedure for correct patient identification

(large printed versions of this flowchart for display in ward/patient areas are available from Risk Management)

1. Is it necessary to check the identity of the patient? YES NO
2. Is the patient a child? YES NO
3. Is the patient competent to answer your questions? YES NO
4. Are there problems with identification due to language or disability? YES NO
5. Verify patient identity by asking family, relative or another member of clinical staff who knows the patient.

Identity must be confirmed with the parent, guardian, relative or person with parental responsibility who must be asked to state, unprompted, the patients full name and date of birth.

Ask the patient to tell you their date of birth and address (rather than asking the patient to confirm).

Seek assistance from an appropriate interpreter/translator/ sensory impairment communicator. Contact PALS Office for details of interpreters.

Refer to the identification bracelet/wristband (if worn by patient).

Cross reference the verbal information and identification bracelet details with the health record/request form.

Are all details correct? YES NO

Procedure may be undertaken.

UNABLE TO POSITIVELY CONFIRM PATIENT IDENTITY. DO NOT UNDERTAKE PROCEDURE. SEEK FURTHER ADVICE.
PROCEDURE FOR IDENTITY BANDS / WRIST BANDS

1. STANDARD FOR IDENTITY BANDS/WRISTBANDS

1.1 In July 2007 the National Patient Safety Agency (NPSA) issued Safer Practice Notice 24 – Standardising Wristbands Improves Patient Safety, which sets out the action to be taken by the NHS to ensure wristbands are standardised. This procedure for Identity bands/wristbands has been developed in line with the NPSA Safer Practice Notice 24.

1.2 The organisation requires that all areas use the approved wristband for all in-patients, which meets the requirements of the NPSA Safer Practice Notice 24, (available on the NPSA website www.npsa.nhs.uk/alerts).

1.3 Details of the approved wristband for Northern Lincolnshire & Goole Hospitals NHS Foundation Trust can be obtained from the Purchasing Department.

2. PATIENTS REQUIRED TO WEAR AN IDENTITY BAND / WRISTBAND

2.1 All Inpatients must wear an Identity band/Wristband.

2.2 The following patients are also required to wear an Identity band/wristband:

- All patients who have impaired conscious levels
- Any patient who has blood taken from them that may be used at any time to cross match against
- Patients to whom medicines are administered
- Patients who receive blood or blood products
- Patients having surgical or invasive procedures
- Patients being transferred or transported
- Patients attending as an out patient where safety concerns are raised, for example confused patients
- A patient who is in the Accident & Emergency Department, when it has been decided to admit him/her to a ward

2.2 Patient’s attending Out Patients do not need to wear an Identity band. However, robust formally risk assessed alternatives must be in place.

3. PATIENTS WHO REFUSE TO WEAR AN IDENTITY BAND / WRISTBAND

3.1 Patients must be informed of the importance of wearing an Identity band/wristband and the potential risks involved if they do not comply, so that they can make an informed decision. If a patient refuses to wear an Identity band/wristband, the discussion and the reason for the patient not wearing an Identity band/wristband must be documented in the patient’s health record.
4. **PATIENTS WHO ARE UNABLE TO WEAR AN IDENTITY BAND / WRISTBAND**

4.1 Alternative arrangements should be made for patients who cannot wear an Identity band/wristband because of their clinical condition or treatment. These include:

- those who refuse to wear an Identity band/wristband despite explanation of the risks of not doing so – See 3.1 of this appendix/procedure
- pre-term babies – See 6.21 of this appendix/procedure
- multiple intravenous access lines – See 6.10 of this appendix/procedure
- patients with some dermatology conditions – See 6.9 of this appendix/procedure
- or those who may or may not be wearing a Identity band/wristband, but who are critically ill, unconscious, confused or cannot communicate – See 6.1 of this appendix/procedure
- bilateral upper limb surgical procedures See 6.12 of this appendix/procedure.

5. **ALERT IDENTITY BANDS / WRISTBANDS**

5.1 The National Patient Safety Agency has undertaken comprehensive research into the risks of using coloured “Alert” Identity bands/wristbands. Evidence suggests that using different colour bands can introduce risk, as organisations use different colours for different Alerts, for example one Trust may use yellow as an “At Risk Of Fall” Alert bracelet, whilst another will use Green etc.

5.2 The National Patient Safety Agency Safer Practice Notice 24 Standardising Wristbands Improves Patient Safety in July 2007, which requires that all NHS organisations should only use white wristbands with black text. It also allows for Trusts to use a RED wristband for patients with a known risk (for example an Allergy or where a patient does not want to receive blood or blood products).

5.3 Where an Alert wristband is used to indicate a known patient risk (E.g. Allergies, At Risk of Falls, No Blood or Blood products) no other wristband will be used, it should allow the patient identifiers to be presented in black text on a white panel on the wristband.

5.4 Therefore with immediate effect **ALL** Alert Identity bands for an identified risk must be RED.

5.5 **Please also note:** Where an Alert is identified / known this must also be written inside the patient’s health record on the inside cover Alert Section. Please also refer to the Trusts Health Records Management Policy & Strategy (SDP010).

6. **PROCEDURES FOR WRISTBANDS**

6.1 All patients and/or guardians must be informed of the importance of positive patient identification and the use of Identity bands/wristbands either in their pre admission letter, or in a patient information leaflet, and again on admission. They should be asked not to remove it and to inform a member of staff immediately should the band be lost, removed, soiled or illegible.

6.2 It is the responsibility of the health care professional admitting or treating the patient to ensure that an Identity band/wristband is correctly completed and secured to the
patient. If this task is delegated to another person, it remains the responsibility of the admitting health care professional to check and ensure the wristband is accurately completed and applied to the patient.

6.3 The Trust is moving towards electronically producing wristbands from computer information systems which hold the patient identifiers. Where this has been implemented staff must produce the wristband electronically from the hospital Patient Administration System.

6.4 Where wristbands cannot yet be produced electronically, identity bands/wristbands must be hand written clearly using a ball point pen, not a fountain or fibre tip pen, as these are not durable. It should resist all types of gels, rubs and sprays.

6.4 Identity bands/wristbands must ONLY INCLUDE THE FOLLOWING CORE PATIENT IDENTIFIERS: Single capital letters should be used to aid legibility.

- **Patient Name** - The First name and Last name should be clearly differentiated by using lower case letters for the first name (with upper case first letter) and UPPER CASE for last name, and should be presented in the order: LAST NAME, First name e.g. SMITH John.

- **Date of Birth** - Should be recorded in the short format 03-Mar-1948, where DD is the two digit day, Mmm is the abbreviated month name (e.g. Mar), and YYYY is the four-digit year.

- **NHS Number** (Or Hospital Number until the NHS Number is available) The NHS number consists of 10 digits – the first nine digits constitute the identifier and the tenth is a check digit that ensures its validity. The format of the NHS number in NHS systems must be 3-3-4, because this format aids accurate reading and reduces the risk of transposing digits when information is taken from a screen.

NOTE: If Any additional identifiers are thought to be necessary, these should be formally risk assessed, and approval sought from the Director of Nursing.

6.5 **For unknown patients** – If a patient is unconscious and/or unable to provide or confirm any information about identification then they should have an Identity band/wristband attached with the following information included:

- **Patient Identity Number (A&E No)**

- **Name of Ward/Location**

As more information becomes available the Identity band/wristband must be replaced with the updated information.

6.6 The identity band/wristband must be applied immediately on admission.

6.7 Wherever possible, the Identity band/wristband should be applied to the ‘dominant wrist’ (the one the patient uses for writing) it is then less likely to be removed, when

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2 This is to conform with the NHS Connecting for Health Common User Interface Design Guide Entry – Patient Name 5 December 2006 Version 0.0.0.2 Draft (www.cui.nhs.uk)

3 The NHS Number – a key to greater patient safety. Patient Safety Alert issued jointly by the NPSA, NHS Connecting for Health and Informing Healthcare.
for example, intravenous access lines are inserted. If it is not possible/appropriate to apply the Identity band/wristband to the wrist, then it should be applied to the ankle.

6.8 The Identity band/wristband should be attached comfortably but securely, to ensure it cannot be slipped off. Patients should be asked if the Identity band/wristband is comfortable to reduce the risk of removal.

6.9 If a limb is not available, or a patient is unable to wear an Identity band/wristband due to their clinical condition or treatment, an Identity band/wristband should be attached to the patient’s clothing, in an area of the body, which is clearly visible. The band must be re-attached as clothing is changed. In emergency or operative situations where clothing is removed, identification must be attached to the patient’s skin using see through plastic adhesive film.

6.10 Patients going to theatre must wear two Identity band/wristbands, as one may need to be removed to enable access when cannulating the patient, these should be attached to each wrist or wrist and ankle. **NB** The Identity band/wristband must not be put on a limb which is going to be operated on.

6.11 If a patient is unable to state their name, then the Identity band/wristband must be checked by two members of staff, one of who must be a registered professional. The patient’s identity must be checked with the health records available to ensure all details match.

6.12 If surgery to the upper extremity is planned, the patient’s Identity band/wristband should be placed on the patient’s ankle. If the patient’s condition does not allow placing the Identity band on the wrist or ankle it should be attached to a visible part of the patient’s body using tape appropriate to the patient’s condition/allergies.

6.13 The person performing any treatment/procedure or administering any prescribed medicines is responsible for checking the Identity band/wristband and confirming the patient’s identification beforehand to ensure the correct patient.

6.14 No alterations will be made to the Identity band/wristband after attachment. If an alteration is required, a new identity band / wristband must be completed and attached.

  **NB** – The use of alcohol hand gel can erase the writing on a patient Identity band/wristband, if this happens ensure the Identity band/wristband is replaced immediately.

6.15 Any member of staff who removes an Identity band/wristband (perhaps to perform a procedure) has to assume responsibility for ensuring another is applied immediately, or make clear alternative arrangements for the patient’s correct identification if it cannot be replaced immediately; (a supply of Identity bands/wristbands must be kept in theatres, for example).

6.16 Any member of staff that discovers a patient does not have an Identity band/wristband, has to assume responsibility for correctly identifying the patient and replacing the Identity band/wristband and **must** report the misidentification incident on an Incident Report Form as per the Trust’s Incident Reporting Policy.

6.17 Each time a patient is transferred the Identity band/wristband should be checked with the patient and health records for accuracy and completeness by the admitting nurse, and replaced if needed.
6.18 The Identity band/wristband must not be removed until the discharge procedure is completed. It is the responsibility of the nurse discharging the patient to remove the Identity band/wristband.

6.19 The possession of an Identity band/bracelet should not be the only confirmation of identity. To reduce further the risk of misidentification, additional confirmation of identity should be sought from the patient, relative and/or health care professional prior to instigating examination, investigation or treatment or administering any prescribed medicines.

6.20 For long stay patients who require minimal interventions, their Identity band/wristband should be checked at least weekly and changed if required.

6.21 Children / Neonates

6.21.1 Neonates and children under one years of age should be given two Identity bands/wristbands, as a safety precaution should one of the bracelets be removed, or falls off.

6.21.2 Sometimes in cases of neonates that are very premature it is not possible to put on an Identity band/wristband because their skin is too fragile. If this is the case, the Identity band/wristband should be placed at the bottom of the incubator.

6.21.3 The bands must be put in place as soon as possible following birth / admission. If the ward nurse hands over the child’s care to another midwife/ward nurse and the bands are not in place then this must be documented in the child’s nursing record.
Procedure for identification bracelets / wristbands

1. Admission as inpatient, or transfer to new ward?
   - Yes: Proceed further.
   - No: Proceed further.

2. Is the patient able to wear an identification bracelet / wristband?
   - Yes: Proceed further.
   - No: Proceed further.

3. If a patient refuses to wear an identification bracelet / wristband, the patient and the reason for the refusal must be documented in the patient’s health record.

4. Is the identification bracelet / wristband put on at the bottom of the incubator?
   - Yes: Proceed further.
   - No: Proceed further.

5. If the patient is unable to state their name, then any any identification bracelet / wristband generated must be checked by two members of staff one of whom must be a Registered Professional.

6. The identification bracelet / wristband should be removed, or falls off?
   - Yes: Proceed further.
   - No: Proceed further.

7. Sometimes in the cases of neonates that are very premature, it is not possible to put on an identification bracelet / wristband because their skin is too fragile.

8. If this is the case, the identification bracelet / wristband should be placed at the bottom of the incubator.

9. The band(s) must be put in place as soon as possible. If the ward nurse hands over the child’s care to another ward nurse and the band(s) are not in place, then this must be documented.

10. Prior to instigating examination, investigation, treatment or prescribing medication, the patient’s identity must be checked with the health records available to ensure all details match.

11. Patients and/or guarantors must be informed of the importance of identification bracelets (in a pre-admission letter and on admission).

12. They should be asked not to remove it and to inform a member of staff immediately should the band be lost, removed, soiled or illegible.

13. If a limb is not available, an identification bracelet / wristband should be attached to the patient’s clothing in an area of the body which is clearly visible.

14. In emergency or operative situations where clothing is removed, identification must be attached to the patient’s skin using see-through plastic adhesive film.

15. The band(s) must be re-attached as clothing is changed.

16. Additional confirmation of identity should be sought from the patient, relative and/or health care professional prior to instigating examination, investigation, treatment or administering any prescribed medicines.

(large printed versions of this flowchart for display in ward/patient areas are available from Risk Management)
Appendix C

PROCEDURES FOR PATIENT IDENTIFICATION ON DOCUMENTATION

1. TEST/INVESTIGATION REQUEST FORMS

1.1 The need for correct identification of patients also applies to request forms for clinical investigations/tests. The person signing the request should complete all the sections of the form themselves. The person completing and signing the form is responsible for ensuring that the patient identification information on the form is correct.

1.2 The practice of bulk pre-signing of request forms is dangerous and unacceptable.

1.3 All request forms must have the following details (all details must be spelt correctly and abbreviations MUST NOT be used).

- Forename
- Surname
- Gender
- NHS Number (preferred Unique Identifier) or hospital number
- Date of Birth
- Ward
- Consultants Full Name (N.B for maternity patients seen in the community, this information is not available)

2. HEALTH RECORDS

2.1 It is the responsibility of every member of staff dealing with a patient’s health record to check that it is maintained in a state consistent with that outlined in the Healthcare Records Management Policy and Strategy (SDP010).

2.2 Any discrepancy between the verbal information given and any written information should be dealt with appropriately i.e. inform appropriate staff if the notes are wrongly labelled so the problem can be rectified, before any treatment or intervention is carried out.

3. PATIENT IDENTIFICATION LABELS (ADDRESSOGRAPH LABELS)

3.1 Health records should always be checked through to ensure all Patient ID (addressograph) labels are for the patient identified and match the patient’s health record, and contain up to date accurate information. If they do not then the labels should be removed immediately and destroyed and a new set of accurate labels prepared and secured inside the patients health record. Please refer to the Trust Health Records Strategy for guidance on Health Record Keeping Standards.

3.2 When new “addressograph” labels have been printed they must be checked to ensure that they correspond with the patient identification information in the health
record/PAS record before being filed securely in the appropriate place in the health records.

3.3 Addressograph labels must be checked with the patient’s details on the inside cover of health record to ensure they are the correct labels before using them.

3.4 New labels must be printed if any information changes and all old labels must be removed from the health record and destroyed in accordance with the procedures for disposal of confidential waste, as they contain confidential information.

3.5 Re-apply new labels to all current documentation including any at the bedside.

4. PATHOLOGY SAMPLES / SPECIMEN LABELLING

Specimen containers should not be labelled in advance of receiving the specimen. For labelling of request forms and specimens for Pathology samples and details of the Procedures for dealing with specimen containers please refer to the Trust Policy “Pathology Samples and Request Form Labelling Expected Standards of Practice”.

5. RADIOLOGICAL EXAMINATIONS

For Patient Identification procedures to follow relating to radiological examinations please refer to the Radiology “Ionising Radiation (Medical Exposure) Regulations 2000” which can be found on the Trust’s Radiology Intranet Site.

6. BLOOD TRANSFUSION

Blood Transfusion requests will only be processed if they contain the patient’s NHS Number. Please refer to the Trust’s Policy for the Administration of Blood and Blood Components and Clinical Guidelines for the Management of Transfusion Reactions.

7. OUT-PATIENTS

For patient identification procedures to follow relating to checking patient identification in Out Patients please refer to the Trust’s Out Patients Operational Procedure” which can be found on the Trust Intranet.