POLICY TO IDENTIFY ALL PATIENTS

STANDARDISED IDENTITY BANDS

Department / Service:	Worcestershire Acute Hospitals Trust - County wide
Originator:	Allan Bailey – Associate Director of Clinical Governance, Patient Safety and Risk
Accountable Director:	Sarah Shingler - Chief Nursing Officer
Approved by:	Improving Safety Action Group
Date of Approval:	7th May 2024
Review Date: **This is the most current document and should be used until a revised version is in place**	7th May 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All patient areas
Target staff categories	All healthcare staff who have direct patient contact

Policy Overview:

This policy aims at reducing and where possible eliminating errors in matching patients with their care.

Patient identification is fundamental to patient safety. Misidentification of patients through the wrong details on patient identification bands, absent identification bands, selection of the incorrect patient on electronic systems or the incorrect labelling of specimens and associated forms can result in the mismatching of treatments or interventions. The consequence of these errors can range from no harm to serious and life threatening consequences.

The National Patient Safety Agency (NPSA) recognised that failure to correctly identify patients constitutes one of the most serious risks to patient safety and cuts across all sectors of healthcare practice. Correct identification, incorporating the NHS number as directed by the NPSA, will reduce and, where possible, eliminate the risk and consequences of misidentification and as a result improve patient safety.

The policy outlines safe practice in relation to;

- Production, checking and application of identity bands
- Procedures for patient identification
- Recommended procedures for patients unable to wear an identity band
- Recommended procedures for patients who are unconscious, confused or unable to confirm their identity on admission to hospital
- Procedure if a patient misidentification occurs

Date	Amendment	By:
20/10/08	Inclusion of all patients departments.	Michelle Norton
20/10/08	Use of interpreting	Michelle Norton
20/10/08	Enhance monitoring process	Michelle Norton
20/10/08	Updated Monitoring Tool	Chris Badger
22/01/10	Use of orange wristband as an alert for patients at high risk of falling	Rani Virk
07/05/10	Enhancing positive patient identification process	Rani Virk
08/07/11	Re-approved at PSQC	Sharon Ellson
8/5/13	Minor amendments made to references and policy to reflect NPSA requirements	Gill Godding
08/06/15	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2016	Further extension as per TMC 22nd July 2015	TMC
November 2017	Document extended whilst under Review	TLG
December 2017	Document extended for 3 months as per TLG recommendation	TLG
13/06/17	Minor amendments made to references and policy to reflect NPSA requirements. Changed to new policy template. Repetition removed and policy clarified	Gill Godding
09/10/2019	Amended to reflect the introduction of specific direct thermal ID bands printers to the trust. Amended with A&E guidance on unknown patient identification. Neonatal exception added to policy	Gill Godding
23/04/24	Inclusion of the #call me function and process	Allan Bailey

Contents page:

1. Introduction

2. Scope of this document

3. Definitions

4. Responsibility and Duties

5. Policy detail

- **5.1** Patient identification standards
- **5.2** The identity band
- **5.3** Procedure for patient identification
- **5.4** Recommended procedure for patients unable to wear an identity
- **5.5** Recommended procedure for patients who are unconscious or confused and unable to confirm their identity on admission to hospital
- **5.6** Procedure if patient misidentification occurs
- **5.7** #CallMe

6. Implementation of key document

- **6.1** Plan for implementation
- **6.2** Dissemination
- **6.3** Training and awareness

7. Monitoring and compliance

8. Policy review

9. References

10. Background

- **10.1** Equality requirements
- **10.2** Financial Risk Assessment
- **10.3** Consultation Process
- **10.4** Approval Process
- **10.5** Version Control

Supporting Documents

Supporting Document 1 Equality Impact Assessment
Supporting Document 2 Financial Risk Assessment

1. Introduction

Patient identification is fundamental to patient safety. Misidentification of patients through the wrong details on patient identification bands, absent identification bands, selection of the incorrect patient on electronic systems or the incorrect labelling of specimens and associated forms can result in the mismatching of treatments or interventions. The consequence of these errors can range from no harm to serious and life threatening consequences.

Reducing and where possible, eliminating errors in matching patients with their care are one of the key ways to improve patient safety.
(The National Patient Safety Agency [NPSA] - Safer practice notice 24- Standardising wristbands improves patient safety July 2007, these standards remain valid - NHS improvement: Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018)

Identification mismatching errors form a significant proportion of the errors that occur in the healthcare setting. There are many reasons for this including patients not wearing an identity band or wearing an identity band that does not provide reliable and unique identifiers. Standardisation of the design of patient wristbands has improved patient safety.

Identity bands must be put on patients immediately a decision to admit has been made and worn throughout their hospital stay.

Identity bands should also be applied to patients undergoing invasive procedures as an outpatient to aid identification in the event of escalation of care.

#CallMe is a locally introduced programme to recognise and encourage staff to address patients in the chosen name of the patient. This recognises that a significant number of patients prefer to be addressed by a name that is not their first formal forename.

2. Scope of this document

This policy is relevant for all patients and staff caring for patients in Worcestershire Acute Hospitals NHS Trust

3. Definitions

An identity band is defined as that which meets the NPSA requirements.

“A means of identification put on patients as soon as the decision to admit has been made and worn throughout their hospital stay.”

Identity bands should only include the core patient identifiers; last name; first name; date of birth and NHS number. For neonatal band requirements, see section: 5.2.
As part of the transition to meeting this standard the hospital number is currently also present on the ID band within Worcestershire Acute Hospitals Trust.

4. Responsibility and Duties

The overall responsibility for health and safety in the Trust rests with the Chief Executive.
It is the responsibility of the Directors and Management team to ensure that they are familiar with the contents of this policy and that identified persons within the directorates have lead responsibility for ensuring the policy is available and adhered to.

5. Policy detail

5.1 Patient identification standards

- Patients should only have **ONE** identity band except in the case of new-born babies who require TWO bands.
- Only use a **WHITE** identity band with black text.
- To identify a known **allergy**, the identity band should be **RED** with patient identifiers in black text on a white panel. Known drug allergies should be recorded on the patient prescription.
- **No** additional information should be added onto the ID band. (e.g. the type of allergy, the allergy status is documented on the prescription chart)
- Identity bands do not remove clinicians' responsibility for checking patients' identity. They are an important way of validating identification particularly when a patient is unable to provide their own details.
- Any member of staff that discovers a patient without an identity band must assume responsibility for correctly identifying them and take steps to arrange for an identity band to be applied.
- If for any reason the identity band has to be removed, it is the responsibility of the person removing it to ensure that it is replaced immediately.
- The NPSA standards state that the identity band should ideally be placed on the **dominant arm** i.e. the arm used for writing (unless surgery / procedure planned for dominant arm). The NPSA rationale for this is that it is less likely to be removed when for example, intravenous access lines are inserted.
- In the event that the patient has no arms then the ID band can be placed on the ankle if this is not possible, see section 5.4 for patient identification.
- It is imperative to correctly demonstrate positive patient identification at each step in the care process.
- Best practice for patient identification is to ask the patient (where possible or relative) to state their first name, last name and date of birth, and checking these details against the identity band and the relevant clinical records by all disciplines. For example, checking and supplying medication, transferring patients to other departments, theatre checking and shift handover.

- Verbal consent must be obtained, when possible, from the patient before application of the identity band.

- In the event of IT system failure, the ID band can be handwritten in indelible black ink but must contain the core identifying factors explained in section 5.2. The temporary band should be replaced by the health care professional accountable for the patient as soon as systems are re-established.

- In the event that a patient is wearing a white ID band and it is subsequently discovered that the patient has an allergy it is the responsibility of the health care professional accountable for the patient to ensure that it is changed to a red band as soon as practicable.

It is the responsibility of the health care professional accountable for the patient to ensure these standards are implemented.

5.2 The Identity band

The identity band is printed directly from Oasis PAS.
Each identity band includes the following core patient identifiers.

For children and neonates, the core identifiers should always be confirmed with the patient/parent or guardian

Adults, Children and Young People
NHS Number
Last name
First name
Date of birth
Hospital number
#CallMe

All neonate and new born babies require **two** identification bands with the following information on both babies' ankles:

Identification of neonates/new born
Baby's NHS number
Twin/triplet 1/11/111 if applicable
Baby of - Mothers surname
Date of birth
Sex
Hospital number

Exception: With some neonates it is impossible to apply 2 ID bands to the ankles due to peripheral lines. In these cases, it is acceptable to have 1 ID band on the ankle and one other form of identifier on the nasogastric tube. Maintaining 2 points of Identification at all times.

Outpatient Identification

Patients attending A&E or Outpatients awaiting assessment may not have an identity band; therefore, the three methods of identification, using core patient identifiers, must apply to all these patients. The procedure for patient identification in an outpatient's clinic is described in section 5.4. "Recommended procedure for patients unable to wear an identity band".

If the procedure is **INVASIVE***, an ID band should be applied by the healthcare professional prior to the procedure taking place to aid identification in the event of escalation of care. The process for identification for these patients is described in section 5.3.

***An invasive procedure is described as a surgical or exploratory activity in which the body is pierced by a device, instrument, or by manual digitation.**

See the Worcestershire acute intranet homepage for the "Local Safety standards for invasive procedures." http://nww.worcsacute.nhs.uk/locssips/. The list of procedures described are not exhaustive and the healthcare professional undertaking the procedure should ensure that positive patient identification is always obtained.

5.3 Procedure for POSITIVE PATIENT IDENTIFICATION:

It is imperative to correctly identify the patient at each step in the care process. Best practice identification is to check the following elements:

- **Ask the patient to tell you their name and date of birth**
- **Compare what they say against the identification band**
- **Cross reference the NHS number on the ID band with the relevant clinical records, prescription or request forms**

In the case of a pre-verbal paediatric patient, the above information must be checked with the patients' parent/guardian. All other paediatric patients will be identified in the same way as adult patients'.

If a patient's first language is not English, or sign language is required, interpreting services should be used available via the trust intranet A-Z "Interpreting and translation services".

5.4 Recommended procedure for patients unable to wear an identity band

The patient may not be able to wear an identity band because of their clinical condition or treatment, for example multiple intravenous access lines or dermatological conditions.

The patient may also have declined to wear an identity band; in these cases, the patient should be given a clear explanation of the risks of not doing so. The patient's refusal to wear an ID band should be documented in the patient notes.

In these cases, it is imperative to correctly identify the patient at each step in the care process. When a patient is not wearing an identity band, best practice identification is to use several elements:

- **Ask the patient to tell you their name and date of birth**
- **Compare what they say against the clinical records**
- **Confirm the patient the first line of their address**

- **Cross reference the NHS number against the relevant clinical records, prescription or request form**
- **Ask the patient if they have any allergies – cross reference against the prescription chart**

  In the case of a pre-verbal paediatric patient, all above information must be checked with the patients' parent/guardian. All other paediatric patients will be identified in the same way as adult patients.

5.5 Recommended procedure for patients who are unconscious or confused and unable to confirm their identity on admission to hospital:

- Identification of a patient can be checked with relatives, cross checking paperwork on patient e.g. driving licence, I.D. card, bank cards, and letter with home address.
- If unknown or in the event of multiple unknown patients being admitted, the A&E departments will issue the patient with a unique phonetic alphabet name, an approximate date of birth and a temporary hospital number. These details are pre setup and directly generated from Oasis PAS.
  - For example: *Zulu Golf, 01/01/1980, unique A&E Hospital number*

  These identifiers will be used for all patient identification prior to treatment until the patient can be correctly identified.
- Any unidentified patient in A&E must be treated on a clinical need basis. Emergency treatment will always be provided if waiting for a full identification constitutes a risk to the patient's clinical well-being.
- Identification of an unknown patient can usually be verified by contacting the police
- It is the responsibility of the accountable health care professional to ensure that any temporary ID number which has been issued to an unknown patient is replaced with the correct patient identifiers as soon as the identity of the patient has been established.
- If the patient is unconscious the identity band should be checked by **two** members of staff prior to any intervention

5.6 Procedure if patient misidentification occurs

In the event of the patient's identity band showing incorrect patient details the following action must be taken:

- Remove incorrect wristband and retain for investigation.
- Identify the patient following the steps described in section 5.3 and apply a correct and verified patient identity band.
- Check patient has not received incorrect drug/treatment.
- Complete an incident report (DATIX) each patient misidentification must be investigated to determine the cause and reasonable action taken to reduce the likelihood of reoccurrence.

5.7 #CallMe

#CallMe is a local initiative to ensure that patients are addressed by their preferred name for every interaction whist in our Trust. Approximately 30% of patients prefer to be addressed by a name that is not their first formal forename. Getting this right is a fundamental of both 'putting patients first' and personalised care.

CallMe data is to be checked and entered into PAS on presentation to the Trust. This may be Outpatients, Elective or Emergency care. Once entered this will be kept for future presentations. When entered into PAS this is transferred onto the #CallMe field for both name bands and stickers allowing for increased visibility for staff to utilise this information. Updates into EPR and other digital systems are underway to further enhance visibility across digital systems

Further information is available, including information on how to record #CallMe, is at http://nww.worcsacute.nhs.uk/departments-a-to-z/callme/

www.worcsacute.nhs.uk/CallMe

www.callmebecausenamesmatter.org

6. Implementation

6.1 Plan for implementation

The policy will be circulated to the divisional directors of nursing, once ratified it will be forwarded to all of the clinical areas via the divisional leadership teams.

6.2 Training and awareness

It is the responsibility of the individual professional to ensure that they are aware of the contents of this policy. It is the responsibility of managers to identify any training needs. Training to identify a patient is also included in the mandatory Blood transfusion training.

7. Monitoring and compliance

To monitor this policy, an ID band audit will take place every two years. The standard for audit purposes will be 100% compliance with this policy.

It is the responsibility of the ward/department manager to ensure that all staff within the clinical area knows how to access this policy. In addition, the ward manager will monitor the safe correct use of identity bands within their clinical area.

Monitoring and review
The ID band audit of procedures should include checking:

- The number and percentage of patients wearing wristbands;
- The accuracy and reliability of the information included on them;
- The reasons why patients may not be wearing wristbands;
- The efficacy of alternative arrangements;
- Safety incidents related to wristbands.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to:	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
All	ID band Audit	ID band audit	2 yearly.	Transfusion practitioners	Senior nurse forum	2 yearly

8. Policy Review

This policy will be reviewed after 3 years.

9. References

NPSA Safer Practice Notice No.11 – Wristband for hospital inpatients improves safety – 22 November 2005 www.npsa.nhs.uk	
NPSA Safer Practice Notice No.24 – Standardising wristbands improves patient safety – 3 July 2007 www.npsa.nhs.uk	
NPSA Safer Practice Notice No:14 Right Patient, Right Blood November 2006	
NPSA Identification of Neonates: Antenatal October 2008	
NPSA Identification of Neonates: postnatal October 2008	
NPSA Standardising wristbands improves patient safety: guidance on implementing the Safer Practice Notice (SPN 24 July 2007) and the related information standard on core patient identifiers approved by the Information Standards Board for Health and Social Care in March 2009. April 2009	
Laboratory SOP for the Acceptance and Rejection of Specimens Feb 2016	
National Safety Standards for Invasive Procedures (NatSSIPs) NHS England patient Safety Domain, Sept 2015 https://improvement.nhs.uk/uploads/documents/natssips-safety-standards.pdf Accessed 02/01/2018	
NHS Improvement: Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018 January 2018	

10. Background

10.1 Equality requirements
The content of this policy has no adverse effect on equality and diversity.

10.2 Financial risk assessment
The content of this policy has no adverse effect on finance.

10.3 Consultation
Circulated to the following for comments for this revision

Contribution List
This key document has been circulated to the following individuals for consultation;

Designation
Divisional Director of nursing – surgery
Divisional Director of nursing – medicine
Divisional Director of Nursing Women's and Children's
Divisional Director of Nursing SCSD
Outpatients matrons
Lead Pharmacist
Radiology lead

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Improving Safety Action Group

10.4 Approval Process
This policy has been reviewed at the Clinical Governance Group.

10.5 Version Control
Key amendments made to this document:

Date	Amendment	By:
20/10/08	Inclusion of all patients departments.	Michelle Norton
20/10/08	Use of interpreting	Michelle Norton
20/10/08	Enhance monitoring process	Michelle Norton
20/10/08	Updated Monitoring Tool	Chris Badger
22/01/10	Use of orange wristband as an alert for patients at high risk of falling	Rani Virk
07/05/10	Enhancing positive patient identification process	Rani Virk
08/07/11	Re-approved at PSQC	Sharon Ellson
8/5/13	Minor amendments made to references and policy to reflect NPSA requirements	Gill Godding
13/06/17	Minor amendments made to references and policy to reflect NPSA requirements Changed to new policy template. Repetition removed and policy clarified	Gill Godding

02/01/18	Addition of National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPS)	Gill Godding
09/10/19	Amended to reflect the introduction of specific direct thermal ID bands printers to the trust. Amended with A&E guidance on unknown patient identification Neonatal exception added to policy	Gill Godding
23/04/24	Inclusion of #call me system and process	Allan Bailey

Supporting Document 1 - Equality Impact Assessment Tool

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council			
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire ICS	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Allan Bailey	**Associate Director of Clinical Governance and Risk**	**Allan.bailey6@nhs.net**
Date assessment completed	**23/04/24**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Policy to Identify all patients**			
What is the aim, purpose and/or intended outcomes of this Activity?	To ensure that the policy is relevant and fair to all stakeholders.			
Who will be affected by the development & implementation of this activity?	✓ ✓ ❑ ❑	Service User Patient Carers Visitors	✓ ❑ ❑ ❑	Staff Communities Other ______________________
Is this:	✓Review of an existing activity			

	❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	NPSA guidelines
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation not required as this policy has already gone through full review when it was first written. This version has minor amendments only.
Summary of relevant findings	None

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	None identified	.		
How will you monitor these actions?	N/A			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	March 2025			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc., and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Allan Bailey
Date signed	23/04/24
Comments:	
Signature of person the Leader Person for this activity	Allan Bailey
Date signed	23/04/24
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

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