University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR PATIENT IDENTIFICATION

Reference Number POL-CL/3715/21	**Version:** V2		**Status** Final	**Author:** Lisa Lamb **Job Title:** Head of Patient Safety
Version / Amendment History	Version	Date	Author	Reason
	2	July 2024	Lisa Lamb	Policy review
Intended Recipients: This policy relates to all professional, relevant administrative and support staff employed by University Hospitals of Derby and Burton (UHDB) and to all locum, agency, temporary/bank, healthcare students and voluntary staff. The scope of this policy is Trust wide.				
Training and Dissemination: Dissemination via the Trust Intranet and via operational leads for outpatient, imaging and administrative staff Trust wide also included in local staff inductions				
To be read in conjunction with: Policy for the Management of Latex Allergy, Blood Transfusion Policy, Incident Reporting and Near Misses Policy, Identification and Labelling of the Newborn Standard Operating Procedure , Interpretation and Translation Services – Trust Policy and Procedure and Trust policies relating to Death, Dying and Bereavement Policy.				
In consultation with and Date: Patient Safety Group – 9th July 2024 Divisions via Clinical Governance Facilitators - May 2024				
EIRA Stage One Completed Yes EIA110 Stage Two Completed Yes / No				
Approving Body and Date Approved	Trust Delivery Group			

Date of Issue	29 July 2024
Review Date and Frequency	July 2027 then every 3 years
Contact for Review	Author: Lisa Lamb
Executive Lead Signature	Mark Hill -Director of Nursing on behalf of the Executive Chief Nurse

PATIENT IDENTIFICATION POLICY

1. Introduction

Positive patient identification is fundamental to patient safety. Failure to correctly identify patients can result in significant harm to patients including medication errors, transfusion errors, testing errors, wrong person procedures, and the discharge of infants to the wrong families (WHO, 2007).

The National Patient Safety Agency (NPSA) has 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.

This policy and associated procedures will assist all staff to positively and safely identify all patients while taking account of fundamental principles relating to privacy, dignity and confidentiality. This policy complies with NHS NPSA Safer Practice Notice No. 24 (July 2007).

All patients must be treated with respect for their right to privacy, dignity and confidentiality. Although confidentiality is paramount within clinical professions' code of ethics and conduct (NMC 2018), confidentiality issues must not hinder the provision of prompt and effective patient care.

2. Purpose and Outcomes

The aim of this policy is to ensure that all patients are positively identified on admission and before any assessment, investigation, treatment or care whilst under the care of University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).

Objectives:

- To ensure all staff positively identify a patient before the delivery of care or treatment.
- Encourage the use of five identifiers (e.g. name, date of birth and NHS/ Hospital number) to verify a patient's identity.
- To ensure all inpatients wear a Patient Identification Band.
- To ensure all outpatients who are undergoing invasive procedures under sedation and/or receiving intravenous medicines or receiving a transfusion of blood components or blood products wear a Patient Identification band.

3. Definitions Used

Trust:	University Hospitals of Derby and Burton NHS Foundation Trust.
Care record(s):	Refers to and includes medical case notes and Emergency Department records. Documentation such as referral letters and requests for investigations are filed and kept during an episode of care and help to form the care record. However, documentation may be "hard copies" (written) or electronic.
Clinical Professionals	Clinical professionals, for the purpose of positive patient identification, are defined as those registered with a regulatory authority, i.e. doctors with General Medical Council, nurses, midwives and nursing associates with NMC, Allied Health Professionals and Healthcare Scientists with Health Care Professionals Council (HCPC) and Pharmacists with the Royal Pharmaceutical Society.
Patients:	All patients of UHDB including inpatients and outpatients this is to include women and children
Patient Identification band:	Are used as part of the process for the positive identification of a patient. They are usually issued and applied to a patient's wrist or ankle and must include the standard patient identifiable information defined within this policy.
Staff:	All employees of the Trust including those managed by a third party on behalf of the Trust

4. Key Responsibilities/Duties

Adherence to this policy is the duty of all staff employed by the Trust.

5. Identifying The Patient

All of the following patients must wear a Patient Identification Band on the wrist or ankle for the duration of their stay:

- Inpatients.
- Outpatients: undergoing invasive procedures under sedation and/or receiving intravenous medication or receiving transfusion of blood components or blood products.
- Emergency Department (ED) including Urgent Care Centre (UCC):
    - All patients in 'Majors' and/or 'Resuscitation' areas of ED.
    - Ambulatory patients (i.e. Minors) where it is professionally judged to be - appropriate, i.e. patients with confusion and/or disorientation.
    - Paediatric patients in the Resuscitation area and/or where it is professionally judged to be appropriate.
    - UCC patients for transfer to an acute care facility

All patients will be issued with a printed white patient identification band, if the patient has a known allergy a printed red patient allergy identification band will be provided and must also be worn at all times.

The following details must be included on the patient identification band:

- Forename.
- Surname.
- Date of Birth.
- NHS unique patient identifier number.
- Hospital patient identifier number

During system 'downtime' staff should resort back to handwritten identification bands which are to be replaced with printed identification bands at the earliest opportunity.

Note Gender may be omitted for newborn babies in the maternity unit.

5.1 Patients Who Have an Allergy

- **ALL** patients ***MUST*** be asked if they are allergic to ***anything*** when they are admitted/treated. If a patient is unable to respond to this request, then the case notes are to be used to assist in clarifying whether all.
- If a patient is known to have an allergy, they MUST wear a single RED identification band which alerts staff to the risk of allergy and should prompt them to ask/seek further details.
- If the patient refuses, this should be clearly documented in the nursing, medical and medical notes and the risks explained to the patient.
- It is essential that their allergy status is communicated between staff at all stages of their stay in hospital.
- An incident form must also be completed if the patient declines the second identification band.

NOTE: that 'allergy' can include foods, latex and other material components as well as medicines it is important that all allergies are identified as, for example, food proteins may be present in medicines.

5.2 Process for identifying patients

It is the responsibility of every member of staff admitting patients, to check and ensure that:

- The identification band must, whenever possible, be placed on the patient's dominant wrist (routine procedures requiring removal of an identification band, e.g. cannulation, are usually undertaken on the non-dominant arm).
- An identification band with the minimum data requirements as detailed above is attached to an appropriate limb. If not printed, all details must be clearly legible and in black pen.
- The patient should be asked to read and confirm the details on the identification band. Where the patient lacks capacity or has difficulties

communicating this should be checked with an appropriate adult if present.

- The staff member responsible for providing the patient's care will ensure that each patient has an identification band throughout their stay in hospital.
- If the identification band is removed the responsibility for ensuring prompt replacement lies with the person who removed it or the staff member who first noticed that the identification band was missing.
- In cases when the identification band cannot be attached to the patient's wrist, or if doing so will compromise patient safety (e.g. frequent checking of identification during surgery, condition of skin at wrists etc.), the identification band should be applied to the patient's ankle by a registered professional known to the patient and prior to transfer to other areas.
- If a limb is not available, the identification band must be securely attached to the patient's clothing, on an area of the body that is clearly visible. The identification band must be re-attached as clothing is changed and must accompany the patient at all times. In emergency or operative situations, where clothing is removed, identification must be attached to the patient's skin, using a see- through adhesive film dressing.
- Identification bands should **not** be attached to patient beds.
- Identification bands do not remove healthcare staff's responsibility for checking patient identity. They are an important way of validating identification particularly when a patient is unable to provide their own details.
- Please refer to Identification and Labelling of the Newborn Standard Operating Procedure Appendix 1, for newborn guidance.
- For detailed guidance on specific departmental patient identification arrangements, please consult their local Standard Operating Procedures

5.3 Patients Who Lack Capacity (Including confusion and Dementia)

If there is concern that a patient lacks capacity, this should be assessed and documented following the Trusts Mental Capacity Act (MCA) Policy.

If the patient is proven to lack capacity following the completion of the appropriate paperwork and is unable to confirm key identifiers, then this information should be confirmed with an appropriate adult or care provider (for example an appropriate care giver from a care home).

Once the identity of the patient is appropriately confirmed, an identification band should be applied following the information above. Once the identification band is in place, this should be utilised to verify the patient's identification during their stay within UHDB.

If the patient is unable to support with the patient identification process (i.e. unable to answer appropriate questions) then the patient must be transferred with a staff member from the transferring department. The transferring staff

member must confirm with the receiving department that the information on the identification band is correct. The information on the identification band can then be utilised for positive patient identification within the receiving department.

5.4 Identification of the Deceased Patient

All deceased patients MUST be properly identified with two identification bands, one on each wrist. On rare occasion that the deceased patient has an upper limb amputation, one identity bracelet should be applied to one wrist and the other to an ankle. If the deceased patient's limbs are excessively swollen two identification bracelets can be attached to make a large one. In the event of the patient's name not being known, the identity identification band must state UNKNOWN MALE/FEMALE.

Notification of Death: the white (or top) copy of the notification of death form must be taped securely to the outer sheet.

NOTE Please refer to the Clinical Guidelines and policies for deceased patients.

5.5 Extreme Emergencies

In extreme emergencies and possible life-threatening situations (such as in the Emergency Department), clinical care may take priority over attaching an identification band to the patient. Where this occurs the responsible clinician for the patient's care **MUST** take appropriate steps to identify the patient using the hospital number or unknown patient number or major accident number.

Once the surname, forename, date of birth, hospital and NHS numbers are confirmed, a new identity identification band **MUST** be attached to the patient IMMEDIATELY.

5.6 Temporary Identification of the Unknown Patient

In 2018 NHS Improvement released a patient safety alert, NHS/PSA/RE/2018/008: Safer temporary identification criteria for unknown or unidentified patients. This highlighted the issues relating to misidentification of patients who are not initially identified on their arrival at the Trust due to similarities in name or hospital number created by simple systematic approaches.

This section provides an agreed UHDB approach to management of these patient groups in line with this alert.

Once the patient has been identified, the Admissions Department should be contacted to ensure any existing case notes are obtained for the patient.

The now known demographics (i.e. key identifiers) should be updated by either ED administration or admissions staff and a new identification band should be applied to the patient.

The pre-registered hospital number should continue to be used throughout the patient's stay otherwise this can affect the processing of pathology and radiology requests. The merging of the patient's pre-registered number and their unique identifier number will take place by NHIS Data Quality after the patient's episode

of care is complete.

5.7 Transferring patients

When collecting an inpatient from a ward, transferring staff must identify the patient. Details of the patient to be collected are then checked against the patient's identification band. Patients without identification bands MUST NOT be moved from the ward until an identification band has been supplied and fitted.

5.8 Outpatient and Imaging Departments

a. Imaging Departments

The need for correct positive identification of patients also applies to patients attending radiology departments for either diagnostic or interventional procedures; specific ionising Radiation and Medical Exposure Regulations should be followed. These are accessed locally within the radiology department by staff as required.

b. Outpatient Departments

Outpatients that can identify themselves will not require an identification band to complete their journey within the hospital. Outpatients who transfer from department to department for a procedure or investigation and who can't identify themselves and do not have a carer with them should have an identification band created and put on by the first department within their journey.

In line with the UHDB 'Interpretation and Translation Services – Trust Policy and Procedure', a family member is not the ideal person to speak on behalf of the service user. Informal interpretation can lead to incomplete information and misunderstandings.

Please note.
The reason for imaging or investigation procedures should be discussed with the patient by the responsible clinician prior to attending the imaging or investigation department. Pay special attention to those investigations with sensitive or life changing implications – the imaging or investigation department may not be able to provide the delicate care and attention required to support the patient with difficult news or uncertainty.

5.9 Identification of the Unconscious, Anaesthetised or Sedated Patient

Patients who have a planned intervention where they will receive sedation or general anaesthesia should be positively identified prior to the administration of any medication.

If a patient is unconscious but has an identification band in place this should be utilised to confirm the patient's identity. If the patient does not have an identification band, a relative should confirm the patient's identity, an appropriate identification band should then be put in place and should be utilised to identify the patient going forwards.

5.10 Procedure in the event of a patient's misidentification incident

In the event of a patient misidentification incident, the staff member must take the following action:

5.10.1 Stop the intervention/treatment/procedure as soon as it is safe to do so.

5.10.2 Undertake the positive identification procedure to confirm the identity of the patient.

5.10.3 Inform the responsible clinician for the care of the patient (or designated deputy).

5.10.4 Inform their line manager.

5.10.5 A responsible clinician must inform the patient of the incident and provide them with the advice and support required as a result of the misidentification incident (Duty of Candour).

5.10.6 When a misidentification incident has occurred, it is the responsibility of the identifier of this incident to report using Datix (Trust's Incident Reporting Procedure).

5.11 Clinical Investigation and collection of specimens

The need for the correct identification of patients also applies to requesting clinical investigations and the collection of specimens. This is undertaken in line with the UHDB local policy.

6 Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

Monitoring Requirement:	Patient safety incidents associated with the identification of patients
Monitoring Method:	Review of patient safety incident reports on non-adherence to policy via the incident reporting procedure (Datix).
Report Prepared by:	Head of Patient Safety
Monitoring Report presented to:	Patient Safety Group
Frequency of Report	Quarterly

7 **References**:

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National Patient Safety Alert (NPSA) (NHSI) (2018) Safer Temporary Identification criteria for Unknown Patients. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient_Safety_Alert_-_unknown_or_unidentified_patients_FINAL.pdf

Nation Patient Safety Alert (NPSA) (2007). Standardising wristbands improves patient safety – Safer Practice Notice 3rd July 2007 No 24.

Nursing and Midwifery Council (NMC) (2015) The Code: standards of conduct, performance and ethics for nurses and midwives. Available at: https://www.nmc.org.uk/standards/code/

Consent & The Mental Capacity Act (Lawful Authority for providing examination, care or treatment) POL-CL/1903/02

The Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER) Regulations - IRMER 3-64, Version 3.0

NHS/PSA/RE/2018/008 Safer temporary identification criteria for unknown or unidentified patients

NPSA (2004) Right Patient Right Care, Framework for Action, https://improvement.nhs.uk/documents/2267/Recommendations_from_NPSA_alerts_that_remain_relevant_to_NEs_FINAL.pdf

NPSA (2005) Safer Practice Notice 11: Wristbands for Hospital Inpatients, https://improvement.nhs.uk/documents/2267/Recommendations_from_NPSA_alerts_that_remain_relevant_to_NEs_FINAL.pdf

NPSA (2007) Safer Practice Notice 24: Standardising Wristbands Improves PatientSafety.https://improvement.nhs.uk/documents/2267/Recommendations_from_NPSA_alerts_that_remain_relevant_to_NEs_FINAL.pdf

NHSLA Risk Management Standards for Community Trusts

Trust Processes and Procedures for Interpreting and Translation Services, POL-CL/2233/18

Trust Policy and Procedure for Duty of Candour - Being Open, POL-RKM/1791/15

Trust Policy - Incident Reporting, Management and Learning, POL-RKM/1448/07

Trust Policy and Procedure - Medicines Management (Medicines Code) – POL-CL/2898-062/2018 | SOP-CLIN/2898/24

Identification and Labelling of the Newborn
Standard Operating Procedure

Reference No: UHDB/Operational/02:24/O24

Contents

1. Identification of the Baby

It is the responsibility of the attending Midwife to undertake identification and labelling of the baby at birth. The baby must remain in the presence of the Midwife until this process is completed, and preferably not removed from the presence of the parents.
Wherever possible, the identification process should not interfere with the parents' wishes for skin-to-skin and feeding after birth. A newborn examination should be undertaken by the Midwife with consent from and in the presence of the parents, during which two hand-written identity labels should be attached to the baby - most commonly, these are placed around each ankle.
The identity bands should contain the following information:

- Baby girl/ boy of (mother's surname)
- Baby's date of birth
- Baby's time of birth
- Mother's hospital number

On completion, the identity bands should be shown to the parents to confirm the information is correct, before attaching them to the baby.
If the identity bands are completed by a non-registered person who attended the birth e.g. Maternity Support Worker (MSW) or Student Midwife, they must also be checked by a registered professional before being attached to the baby.
The procedure must be documented in the labour notes, and the placement of the identity bands recorded e.g. "2X identity bands to ankles".

1.1 Multiple births

At the immediate birth of the babies before the formal identity process and attachment of identity bands can be performed; each baby should have cord clamps applied as below, as

a means of identification:

- Twin/triplet 1 - 1 cord clamp
- Twin/triplet 2 - 2 cord clamps
- Triplet 3 - 3 cord clamps

Identity bands for twins and triplets should contain the following information:

- Twin 1 or Twin 2 *or* triplet 1, 2 or 3
- Baby girl/ boy of (mother's surname)
- Baby's date of birth
- Baby's time of birth
- Mother's hospital number

The same procedure of checking these with the parents' and documenting should be undertaken.

1.2 Baby's requiring immediate transfer to Neonatal Unit (NNU)

Before the baby is removed from the delivery room or theatre, the above process should be undertaken by the Midwife attending the birth.

At the earliest convenience, the baby must be admitted to the hospital so that a hospital number/NHS number can be created. An electronic identity band must then be created by the admitting nurse, to replace one of the hand-written bands.

1.3 Baby's born at home requiring transfer to hospital

If this is a home- birth attended by Midwives, the baby should be identified and labelled as per the procedure in section 1.0 before the baby leaves the place of birth.

For a baby born before arrival, with no registered professional in attendance or a Paramedic in attendance, the Midwife accepting care of the baby upon arrival at the hospital, should identify and label the baby at the earliest opportunity, once the welfare of mother and baby has been established.

If the baby has been transferred to delivery suite and then requires transfer to NNU, the process as per section 1.2 should be followed.

1.4 Parents who do not wish identity bands to be attached to their baby

If parents object to identity labels being attached to their baby:

- Listen to their reasoning as to why they wish their baby not to wear identity bands, and address their concerns.
- Explain the rationale behind babies wearing identity bands.
- If they do not consent, try to establish what they would be happy for e.g. identity band being attached to the cord.
- If an agreement cannot be reached, escalate to the Senior Midwife for the area, or the Manager-on-call out-of-hours.
- If a baby is un-labelled - ensure all staff working in the area are aware.
- Document how many and where, if any, identity bands have been attached to the baby in their handheld notes.

If there are safeguarding concerns in relation to consent being withheld for attaching identity bands to a baby, seek advice from the Lead Midwife for Safeguarding and inform the named social worker if applicable.

If it is believed that the baby is at risk of abduction, do not leave the parents un-attended with the baby.

2. <u>Checking Identity Bands</u>

2.1 Transfer between departments

When a baby is transferred between departments e.g. from Labour Ward to the Postnatal Ward, the Midwife receiving care of the patient must check the identity bands

and confirm the details with the parents. It must be documented in the baby's hand-held records that both identity bands are in place and correct.

2.2 Daily check

During the daily newborn examination, the Midwife must check and document the baby's identity bands as in section 2.1.

Parents/guardians should be asked by Midwives in the Hospital setting to keep the identity bands attached to the baby until the first visit at home by the Community Midwife.

2.3 One identity band missing

Confirm the remaining identity band is correct with the parents. Produce a replacement identity band as per section 1.0.

2.4 Both identity bands are missing

- Ask the parents to confirm the identity of the baby, and ask them to remain with the baby until the issue has been resolved.
- Do not move any babies around the department or transfer to another area, unless in an emergency.
- Alert the Midwife in Charge of the department, and if in normal working hours - the Senior Midwife for the area.
- Check the identity bands of all the other babies within the department - once the identity of all other babies has been confirmed, create and attach new identity labels to the baby, as per section 1.0.
- Ascertain if the parents/carers removed the labels - if so, follow section 1.4
- Complete Datix for the incident

Documentation Control

Reference Number: UHDB/Operational/O24	**Version: 1**		**Status: DRAFT**	
Version / Amendment	Version	Date	Author	Reason
	1	Feb 2024	Lauren Wilkinson - Risk Support Midwife	New
Intended Recipients: All staff with responsibility for caring for women in the Postnatal period				
Training and Dissemination: Cascaded through lead midwives/doctors / Published on Intranet NHS mail circulation / Article in BU newsletter				
To be read in conjunction with:				
Consultation with:	Obstetricians, Maternity Staff			
Business Unit Sign off:	02/02/2024: Maternity Guidelines Group: Miss A Joshi – Chair 15/02/2024: Maternity Governance Group - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/02/2024				
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Review Date:	February 2027			
Key Contact:	Joanna Harrison-Engwell			

Suitable for printing to guide individual patient management but not for storage Review Due: February 2027