

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Patient Identification Policy

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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 not harm to serious and life threatening consequences.

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 includes appropriate practice for; identifying patients in person, the applying identification bands, the identification of patients using electronic systems and the labelling of specimens and samples and associated request forms.

2 Scope

- 2.1 This policy applies to all permanent, locum, agency, bank and voluntary staff of Newcastle Upon Tyne Hospitals NHS Trust who encounter in and outpatients, including patients visited in their own homes or clinic's during the course of their duties.
- 2.2 This policy is intended to:
- ensure the highest level of patient safety
 - ensure all staff involved in patient identification are fully aware of their responsibilities
 - ensure that staff recognize the significance / importance of appropriately identifying patients
 - ensure staff are aware of which patients should have a wristband applied and ensure patients requiring wristbands are positively and correctly identified BEFORE application of wristbands
 - ensure staff identify patients accurately when using electronic systems
 - ensure specimens and samples and associated request forms are labelled with the correct patient details.

3 Policy Aim

This policy aims to clarify and standardise the procedure for identifying patients requiring hospital admission and is in response to the guidance from the National Patient Safety Agency (NPSA 2007).

4 Duties

4.1 Trust Board

The Trust Board is responsible for implementing a robust system of risk management within the organisation. This includes having a system for the identification of patients.

4.2 Chief Executive

The Chief Executive has ultimate accountability for ensuring there are appropriate processes in place for the effective and reliable identification of patients but delegates this responsibility through the Director of Quality and Effectiveness .

4.3 Director of Quality and Effectiveness

The Director of Quality and Effectiveness has responsibility for monitoring the effectiveness of the processes and presentation of a bi-annual review of incidents relating to patient identification to the Clinical Governance and Quality Committee.

4.4 Clinical Directors, Directorate Manager, Heads of Department, Ward Managers

All Managers are responsible for:

- Adequately disseminating and implementing this policy within their areas of responsibility
- Adequately training/inducting staff, to ensure they are competent to undertake consistently accurate patient identification requirements
- Implementing any required action to address areas of non-compliance as identified through completion of the clinical assessment tool (CAT), adverse incidents and near misses

4.5 All Staff

All staff are responsible for:

- Complying with this policy and ensuring that when performing any procedure, investigation or providing care they assume responsibility for checking the identification of a patient, to prevent the occurrence of adverse incidents or near misses arising from misidentification.
- Completing an adverse incident reporting form in accordance with the Trust Policy for any instances of misidentification or refusal to wear, or loss of, an identification band.

5 Definitions

- **Verification**

Verification is the process of using identification information to determine the identity of a patient.

- **Inpatient**

An inpatient is a patient who is admitted to hospital ward for a procedure and is expected to remain in hospital for more than one day, e.g. for surgery, or for treatment of an acute period of illness.

- **Day case**

A day case patient is a patient who is admitted to a ward for a procedure and is expected to be discharged from hospital the same day.

- **Outpatient**

An outpatient is a patient who attends hospital for a clinic appointment under the care of a consultant or specialist nurse or who attends for a procedure or treatment to a department where it is unlikely they will need to be admitted to a ward.

- **Correct patient identification**

Correct patient identification is achieved when the healthcare worker is able to confirm that the identity markers given by the patient or the patient's guardian/representative, match those on the patient's identity band and documents.

- **Misidentification**

This occurs when the patient identity markers given by the patient, or his/her guardian/representative, do not match exactly, those on the patient's identity band and/or documents. It can also occur when a healthcare worker mistakes one patient for another by not following correct identification policy.

- **Mislabelling**

This occurs when patients are not identified appropriately and one or more incorrect patient marker is applied to patient notes, a specimen and/or a specimen request form.

- **DATIX**

Trust incident reporting system

6 Patient Identification Process

6.1 Positively identifying patients

Positive patient identification is a process which when followed will promote good patient identification practice and reduce the risk of misidentification from occurring. This process should be an integral part of patient care.

Checking the patient's identity should not only take place at the beginning of a care episode but continue at each patient intervention throughout the patient's entire episode of care to maintain the patient's safety.

Misidentification of the patient can result in wrong: diagnosis, treatment, procedure, medication, blood transfusion, etc., all of which can result in minor or major morbidity and even death.

6.1.1 Identifying the patient (4 steps)

There are FOUR steps to identifying patients. They should be undertaken in the following order of preference (if the first is not possible, undertake the second, etc.):

- a. By asking the patient to tell you their name, date of birth and/or address. Remember to ask an open question that needs more than a 'yes or 'no' answer, i.e. "What is your name?" rather than are you "Mrs Smith?" Check this is compatible with the patient identification wristband; where wearing an identification wristband is contraindicated or not applicable confirm patient's details against their record. For details on validation of patient records see the Trust [Clinical Record Keeping Policy](#).
- b. If the patient is unable to tell you their name, refer to the identification band and, if possible, verify the information by asking family, relatives or another member of the clinical staff who knows the patient or by using the services of an appropriate interpreter or other communication support.
- c. By asking that the patients relative to identify the patient by name, date of birth and/or address.
- d. By the A&E Department identification number*.

*NB. This number indicates the episode of patient stay/treatment. This is not linked to identification of a specific patient but to the identification of a specific episode of stay. The hospital number is the only number that can be used to identify a particular patient and should always be used in preference to the A&E number.

For a full list of "Dos and Don'ts" in relation to identifying patients see Appendix 1.

6.2 Patient Identification Bands who should wear them

All in-patients admitted for treatment to the Trust for treatment / care must have a standardised Trust wristband applied on admission. Three sizes are available adult, child and neonates. This includes;

6.2.1 All Hospital in-patients

6.2.2 All day case patients, excluding dialysis out-patients **except** when they are to receive blood transfusions or any other intravenous therapy or medication, when a patient identity band **must** be applied

- 6.2.3 All outpatients undergoing diagnostic or invasive procedures and/or treatment that impair their conscious levels during the appointment excluding dialysis outpatients as above
- 6.2.4 Any outpatient who is cognitively compromised and/or impaired
- 6.2.5 Patients undergoing a transfusion of blood or blood products. (As well as ensuring the correct identification of the patient, the wearing of an ID band for transfusion of blood or blood products is also required for compliance with the current European Union Directive on blood safety, which requires the tracking of all blood products to the point of patient transfusion. If an appropriately completed identification band is not attached the transfusion will not be permitted until the patient's identification is verified.)
- 6.2.6 All* infants at the time of birth must wear **2** identification bands at all times whilst an inpatient (*see section 6.7 for exceptions).
- 6.2.7 All patients in the Emergency Department (ED) meeting any of the following requirements:
 - All patients where a decision to admit has been made
 - With a Glasgow coma scale of less than 15
 - Who are placed within the resuscitation area of the ED
- 6.2.8 Infants who are miscarried in hospital
 - These infants do not receive their own MRN and should be labelled as 'infant of' with maternal details (including mothers MRN), and the infant date of birth.

The patient's NHS number may not be immediately available at the time of initial assessment. However, patients must still be fitted with an identification band containing other available information and a new one attached when the NHS number has been confirmed. The attachment of this new identification band must be recorded in the patient's records.

6.3 What information should wristbands contain

There are two types of identification band type 1 for babies and type 2 for adults and children. Please note that for type 1 identification bands the details may vary depending upon the location of the baby. Table 1 summarises what information patient identification bands **must** contain;

Table 1

Type	Areas of use	Patient group	Information required	Number of identification bands to be worn
Type 1	Delivery suite Maternity Wards	For newborn babies only	<i>TWIN/TRIPLET I/II/III if applicable</i> <ul style="list-style-type: none"> • <i>Mother's LAST NAME, baby or first name if known)</i> • <i>Date of birth</i> • <i>Baby's MRN Number (and/or NHS number when this is available)</i> • <i>For miscarriages add maternal details and 'infant of' as additional information as no MRN will be generated</i> 	2
Type 1	SCBU PICU All Children's Services Wards MSU (children's ward) ENT (children's ward)	For premature babies OR For babies moved from maternity	<i>TWIN/TRIPLET I/II/III if applicable</i> <ul style="list-style-type: none"> • <i>Baby (or forename if known)</i> • <i>SURNAME (Mother's name if baby born in the Trust and remained an in-patient since birth and birth is not yet registered. Babies admitted to the Trust who have had their birth registered under a surname different to that of the mother must use their registered surname)</i> • <i>Date of Birth</i> • <i>Baby's MRN Number (and/or NHS number when this is available)</i> 	2
Type 2	All adult wards All Children's Services Wards MSU (children's ward) ENT (children's ward)	Children & Adults	<ul style="list-style-type: none"> • <i>last name;</i> • <i>first name;</i> • <i>date of birth;</i> • <i>NHS Number (if the NHS Number is not immediately available, a temporary number should be used until it is);</i> • <i>MRN</i> 	1

6.4 Format of Identification bands for all patients

6.4.1 Only one type of patient identification band is allowed – a white patient identification wristband with clear black text.

6.4.2 The identification band must contain only the information listed in 6.3

6.4.3 Special circumstances or risks must not be written on the patient identification band, staff must refer to the E-record for identification of a risk or alert.

6.4.4 A single patient identification band only is allowed, the use of multiple patient identification bands increases the risk for the patient and is therefore not permitted. The only exception to this rule is new born babies or babies cared for on Special Care Baby Units (SCBU) or Paediatric Intensive Care Units (PICU) who must wear two identification bands, attached to two limbs. (see section 6.7 for details of specific exceptions) Comfy bands, which at present must be hand written, are

also to be used for babies to protect their skin and ensure a better fit.

6.5 Production and application of the ID band

- 6.5.1 An identification band **MUST** be produced for the patient as soon as they are admitted or born and worn throughout their hospital stay. It is the responsibility of the person admitting the patient/attending midwife to provide an appropriately sized identification band. **Emergency admissions are no exception. The patient is already at risk in an emergency without the added problem of being misidentified.**
- 6.5.2 Patient identification wristbands will be produced and printed from the Cerner millennium (or E3 for babies in maternity only), In cases of emergency where pre-printed labels/wristbands are not available labels should be handwritten. Handwritten labels should be replaced as soon as printed labels become available, the exception being those on newborn babies or those in SCBU. For newborn infants the wrist band should be printed onto an adult band, and the **identical information only (i.e no additional information)** carefully transcribed onto the comfy band. The original band should be given to parents of a well baby, or to special care for an unwell baby.
- 6.5.3 Staff printing and issuing identification bands will have undergone training on the printing of the identification band and be deemed competent in issuing and verifying identification markers.
- 6.5.4 Where the patient does not have an NHS/MRN, a local or temporary number may be issued, e.g. A&E number. Once the permanent information is available the correctly written patient identification wristband should be applied.
- 6.5.5 The identification band must, where possible, be applied to the **dominant** arm, as the band is less likely to be removed when, for example, intravenous lines are inserted. The member of staff applying the wrist-band must have undertaken local induction training. To confirm the details are correct you must;
- verbally checking with the patient or accompanying adult
 - checking the patients notes / PAS system.
- 6.5.6 It is the responsibility of the admitting registered nurse to check the status of the wristband on admission.
- 6.5.7 For elective/booked admissions, patients and/or guardians will be given an explanation of the identification band and the details checked at the pre-operative assessment.
- 6.5.8 On admission, the patient and/or guardian/carer/partner will be advised by the registered nurse or midwife;
- The rationale for correct identification
 - Not to remove the identification band

- To inform a member of staff immediately, should the identification band be lost, soiled, damaged or removed and not replaced.

If the patient does not have the capacity to appreciate the need for wearing a name band, or the risks involved in not wearing one, this should be explained to the parent/ guardian/carer/ partner. The parent/ guardian/ carer/ partner shall be asked to inform a member of staff immediately if a name band is removed, damaged or unreadable and a new name band shall be applied immediately following re-verification of the patient's identity

6.6 Ongoing checks throughout the patient's episode of care

Correct identification of a patient is paramount throughout the course of their care, to ensure their safety and minimise occurrence of any misidentification. To support this;

- 6.6.1 Frontline staff must always verify that the patient they are attending to is the patient for whom the treatment is intended and match the treatment to that patient.
- 6.6.2 Should any alteration to the content of a wristband be required, the wristband should be replaced in its entirety by a newly provided band with the correct information. Written alterations to the content of the wristband are not permitted.
- 6.6.3 In the event of name bands being obscured or removed due to theatre restrictions, arrangements must be in place to safely identify the patient during the procedure. This may include other methods such as the marking on the skin of the patient's identity with an indelible marker.
- 6.6.4 If a wristband is removed by a member of staff, e.g. to gain venous access, then it is **their responsibility to ensure it is replaced correctly** as soon as is reasonably possible. Clear alternative arrangements for the patient's correct identification if the wristband cannot be applied immediately must be documented.
- 6.6.5 If a member of staff discovers a patient does not have a wristband, they must assume responsibility for correctly identifying the patient and replacing the wristband or inform an appropriate registered nurse who must assume the responsibility for replacing the wristband and for raising an adverse incident reporting form, in line with the [Management and Reporting of Accidents and Incidents Policy](#)
- 6.6.6 Each time a patient is transferred to another ward or department, e.g. ED to ward, ward to X-ray etc. the wristband must be checked for accuracy by both the transferring and the receiving registered nurse or a member of the clinical team.
- 6.6.7 Patients must not leave their base ward or department until a wristband

has been correctly applied.

6.6.8 Except in emergency situations, should the verification process fail at any stage, all activities for the patient must be halted until the patient's identity can be accurately determined. In these circumstances, an Adverse Incident Reporting form should be completed and actioned in accordance with the [Trust Policy](#) (see 6.6.5).

6.6.9 In normal circumstances, a patient's identification band must only be removed on discharge home. As many patients use the discharge lounge, the identification band must not be removed until the patient leaves the hospital premises. **Note:** Identification bands must **not** be removed if a patient is 'discharged' to another hospital, into social service or private nursing care.

6.6.10 **Note:** In the event of death, the identification band must **not** be removed from the patient's body.

N.B. Never assume a minor difference is not important. Patients can have very similar names and dates of birth

6.7 Exceptions to the application of patient identification wristbands

6.7.1 Patients being treated in the community (except those receiving blood transfusions and/or treatment which could impair their cognitive ability). The principles stated in section 6.1.1 must be followed if the patient is not well known to staff.

6.7.2 Outpatients (with the exception of patients who are cognitively impaired, receiving blood transfusions or are undergoing invasive procedures or investigations which could impair cognitive ability) The principles stated in section 6.1.1 must be followed in outpatients.

6.7.3 Neonates/babies in Specialist Care areas being nursed in an incubator. However, it is NOT a recognised clinical reason to exclude neonates just because they are small all attempts must be made to apply an appropriate identification band "comfy band" for this patient group if they are cared for in any other kind of cot or bed.

6.7.4 Examples of clinical reasons which could prevent an identification band being applied include;

- Patients with allergies or whose skin integrity is compromise by dermatological conditions at the site where an identification band would be applied.
- Patients without limbs or burns to their limbs, patients with multiple venous access at the site an identification band would be situated.

NB: Where possible every attempt should be made to find a method of applying an identification band to the patient. Where wrists are not

appropriate/accessible consideration should be given to attaching the identification band to the patients ankle.

Where wristbands cannot be worn for clinical reasons other strategies must be used to match the patient to the correct care. (Section 6.8.2 for risk management strategies).

6.7.5 Identification Cards may be used instead of identification band in the care of long term care patients, e.g. haematology / renal dialysis patients whilst on the day unit, this refers to the department and patient in that department not the patient going to other departments. If the patient leaves the Department for further treatment or investigation an identification band must be applied. If the patient does not have an identification card an identification band must be applied.

6.7.6 Patients, who are regularly transfused, i.e. more than every three months, are eligible for a photo identification card, which includes full patient details including a barcode and a recent photograph of the patient. These can be used in the outpatient setting and community. The cards are available through the transfusion laboratory.

6.8 High Risk Patient Groups

6.8.1 Patients who refuse to wear an identification band

The patient **MUST** be informed of the potential risks of not wearing an identification wristband however they do have the right to refuse. An appropriate alternative should be discussed. This discussion and the reason for the patient not wearing an identification wristband **MUST** be documented in the patient's health record.

6.8.2 Risk Management Strategies for patients who are unable to wear or refuse to wear an identification band

6.8.2.1 Newborn babies

Newborn babies must have type 1 identification bands applied as per policy. It is recognised that in emergency situations it is not always possible to generate a MRN number/NHS number immediately following birth. In these cases identification bands must be produced which include all other available identifiers. Every effort must be made to generate an MRN as soon as possible and any requests for invasive tests must be delayed until a MRN has been generated, unless the situation is an emergency. If invasive testing is urgently required eg radiology requests, hand written request forms should be used and in addition to the babies identifiers must stipulate baby of... mother name and mothers MRN. When staff from visiting departments attend babies without an MRN the babies identifier must be checked and their identity confirmed by a member of the midwifery/nursing team. In situations where a request has been generated using a babies MRN but the

babies MRN has not been added to their identifier the attending midwife/nurse must apply an identifier which includes the babies MRN prior to any invasive testing being undertaken.

6.8.2.2 Neonates/babies on the neonatal unit nurses in incubators/ variotherms

For neonates/babies cared for on the neonatal unit and nursed in incubator/variotherms who cannot wear an identification band due to a combination of the integrity of their skin and the humidity within the incubator, a single name band must be printed off and attached to the incubator. If however, the neonate needs to leave the specialist care unit to attend any other department, two identification bands must where possible be temporarily applied to the neonate/baby on two separate limbs as outlined in section 6.4.4, PRIOR to the neonate/baby leaving the department. Where this is not possible due to skin integrity/sickness the two identity bands must travel with the baby, attached to notes, and remain with the baby at all times. These may be removed on return to the specialist care unit providing a single name band identifier is attached to the incubator.

All Other Patients who cannot wear an identification band

For patients who cannot wear an identification band, because of their condition or treatment for example patient suffering severe burns, or major multiple trauma, have multiple intravenous lines etc, Consider placement of the identity band on a lower limb, if possible. Where it is not possible to apply an identification a risk assessment **must** be carried out by a registered nurse, and all measures taken to reduce the risk of patient misidentification. Following initial identification by the patient one or more of the following measures must be taken:

- Confirmation of patient's identification with the patient or their relative (see 6.1.1)
- Confirmation of patient identity using identification card (if available)

The following measures may be used to support the above interventions:

- Correct patient identity details displayed on the vital signs monitor correlating to the patient's bed-space but be cautious **NEVER** assume the patient is in the right bed as the name above it suggests. The patient may have sat by the wrong bed or have just been admitted without the board being changed.

- Reconfirmation of the patient's identity with staff at each shift change: this must be recorded in the patient's records
- Cross-referencing of all identifying information
- When in theatre, if a limb is not accessible to enable an identification band to be applied; then the band may be fixed temporarily to the patient's forehead. The identification band must be re-applied correctly to a limb before leaving the theatre to go to recovery, after being checked by two members of staff.

6.8.3 The unknown patient

- 6.8.3.1 There will be occasions when a patient is admitted to hospital unconscious and without any means of identification. Patients can be unconscious for a number of reasons. Sometimes it is the treatment they are having, e.g. anaesthetic/sedation, but it may be due to the influence of drugs or alcohol. These patients are incapable of identifying themselves and maintaining their own safety. It is the responsibility of the staff looking after the patient to ensure they can be identified properly. (see section 6.8.4 the unconscious patient)
- 6.8.3.2 An identification band must be applied as soon as an ED number has been allocated and must include the patient's identity status (unknown), gender, approximate age and the ED number. These details should be used to generate a printed identification wristband for the patient. For patients who cannot supply the relevant information, the name and date of birth can be verified by the patient's family, carer, guardian or other representative.
- 6.8.3.3 As soon as more details are available and only if the patient is stable, i.e. NOT in the middle of treatment, e.g. surgery, procedure, transfusion, etc., a new identification wristband including the surname, forename, date of birth, gender and NHS/hospital record number, should be produced and the laboratories informed so results can be matched to the right patient. Blood samples may also need to be repeated.

CAUTION: If an unknown patient is having active treatment, i.e. surgery, blood or blood component transfusion, changing the patient details could lead to confusion and put the patient at risk, see [Administration of Blood Products Procedure](#).

6.8.4 The unconscious patient

- 6.8.4.1 These patients are incapable of identifying themselves and maintaining their own safety. It is the responsibility of the staff

looking after the patient to ensure they can be identified properly. All unconscious patients **must** wear an ID wristband for identification purposes.

Two healthcare professionals should verify identification prior to the application of an identification band or prior to any invasive treatment.

6.8.5 Anaesthetised and sedated patients

6.8.4.1 Theatre Reception

Wherever possible the patient must be positively identified by reception staff, by asking for a full name and date of birth which must be checked against their identification wristband. Patients arriving in theatre reception without an identification band should have an identification band applied unless they have a clinical condition which prevents the application of an identification band in which case a [Check List Alert Sign](#) should be attached to the front of the patient's notes. All patient details must be checked against the theatre list, patient notes, X rays etc before proceeding Refer to [Safeguards for Invasive Procedures Policy](#).

6.8.4.2 Prior to Induction of Anaesthesia/Sedation

It is the responsibility of the Anaesthetist to positively identify the patient, by asking for a full name and date of birth, prior to induction. **This must be checked against their ID wristband.** All details must be checked against the theatre list, patient notes, X rays, etc., before proceeding (refer to policy).

6.8.4.3 Patients in Theatre

Prior to commencement of surgery one final patient identification check is undertaken as part of the "time-out" check. For further details see [WHO theatre checklist](#).

6.8.5 Patients with communication difficulties

6.8.5.1 If the patient has communication needs for example, as they are too young, confused, Deaf or have hearing loss, learning difficulties which impact on their ability to communicate or English is a second language, etc. It is especially important these patients wear an identification wristband to assist identification.

6.8.5.2 An accompanying reliable adult, e.g. parent or relative, may be asked to confirm the patient's details.

6.8.5.3 Where spoken language support is needed an interpreter MUST be used refer to [Interpreter Services](#).

6.8.5.4 Other relevant support services may also need to be utilised to support effective communication e.g. Learning Disability Nurse Specialist, Dementia Nurse Specialist

6.8.6 Patient's receiving Blood Products

All patients receiving blood products must be wearing an identification wristband. For full details see [Administration of Blood Products Procedure](#).

6.8.7 Patients receiving medication

Prior to the administration of any drug staff must verify the patients identification. Any medication given to the incorrect patient can have a detrimental effect on the patient and staff should remain vigilant. Drugs frequently associated with serious events included potassium, insulin, chemotherapy drugs, opioids and sedatives. For further information see the [Medicines Policy](#), [Strong Potassium Solutions](#) and [Intravenous Potassium Administration](#) Policies and [DoH Never Events List 2015/16](#)

6.8.8 The deceased patient

It is vitally important that the deceased patient is identified properly to prevent a mix up later on in the mortuary. Mix ups will cause a great deal of upset for the family and can also lead to litigation. All deceased patients **MUST** be properly identified with an identification wristband.

A patient identification bracelet must be attached around one wrist, and if this is not possible around the patient's ankle. This must be legible and contain details of name, date of birth, and hospital number (or maternal details and infant date of birth/name for a pre-registerable loss).

6.8.9 Major incident patients

In the event of a major incident, all involved patients will be identified as per the ED Major Incident Plan, until such time as their identity is confirmed. At which time the involved patients will be identified as per this policy.

6.9 Patient Identification and Electronic Systems

Where a patient's name is being identified on an electronic system particular care must be taken to ensure that the patient name and details on the system match the specific patient being identified. Staff must be particularly vigilant for patients with same or similar name and details to prevent the wrong patient being selected on the electronic system.

Failure to correctly identify patients on electronic systems can precipitate patients undergoing the incorrect tests or investigations and can also lead to breached in patient confidentiality.

6.10 Ordering tests/examinations via e-record

6.10.1 All staff ordering tests or examinations using e-record must ensure that they follow the appropriate steps as outlined in the relevant e-record Standard Operational Procedure (SOP).

6.11 Non e-record requests

6.11.1 Specimens sent with an accompanying request form must conform to the full requirements as stipulated within

6.12 Obtaining specimens and samples

6.12.1 The person taking any specimen is directly responsible for ensuring that the patient is positively identified and that the patient details correspond to the information given on both the specimen and any accompanying request form.

6.12.2 Verification of the patient's identity must be done as outlined in section 6.1.1 of this policy.

6.12.3 In the case of cellular pathology, if the patient has no identification band and is unable to verify their own identification an accompanying parent/guardian/carer who has signed the consent form for the intended procedure should be asked to verify the patient's identity.

6.12.4 In some circumstances typically Emergency Department patient's full patient details may not be known. In these cases the local policy for labelling of unknown patients and their samples must be followed.

6.12.5 When obtaining specimen/s generate the appropriate labels immediately prior to attending the patient to obtain the required specimen/s.

6.12.6 Take the labels to the person you need to acquire any sample/s or specimen/s from only. Never take labels or notes for multiple patients when obtaining specimens and never pre-label specimens.

6.12.7 Once the specimen has been obtained label the specimen in the presence of the patient.

6.12.8 All laboratory specimens may be labelled with an e-record generated label. EXCEPT blood transfusion specimens which MUST be handwritten and legible. Blood transfusion specimens must contain the patient's fore and surname, date of birth and a minimum of one unique identifier such as a MRN number, an NHS number or Accident Emergency number.

6.12.9 All blood transfusion request forms must have the request form declaration section signed by the person who took the specimen.

6.12.10 Tissue specimens must be formally checked and labelled by two members of staff, both of whom should be from one of the following groups.

- Qualified nurse
- Qualified midwife
- Qualified operating department assistant
- Qualified doctor

The patient's details must be checked by the two members of staff and verified with the operator/surgeon. The specimen must be labelled (hand written or addressograph) using the patient notes. Only one set of patient notes should be taken to the patient area. The same two members of staff are responsible for ensuring specimen(s) are packaged for transport. This is of particular importance where the sample has not been forwarded onto Pathology before the patient has left the clinical area and before the arrival of subsequent patients.

Where multiple specimens are obtained from a single patient the request form and the specimens must clearly identify the different areas of origin of the tissues.

Slides for cytology must have all details clearly written on the labelling area of the slide.

6.12.11 It is important the requesting clinician is identified on request forms and it is strongly recommended that a contact number for the requesting clinician is provided, in case there is a problem with the sample or request form or there are critically abnormal results.

6.13 Sample Acceptance and Rejection

6.13.1 Specimens or request forms which are mislabeled, have no label or have insufficient patient information/clinical details will most likely be rejected by the laboratory in accordance with the Sample Acceptance and Rejection Policy.

6.14 Legislation

6.14.1 All blood transfusion incidents that are attributable to incorrect patient identification have to be reported by law to the Serious Hazards Of Transfusion (SHOT) in compliance with the Blood Safety and Quality Regulations 2005.

The Trust is inspected for compliance with this requirement by the Medical and Healthcare Regulatory Agency (MHRA) and has to declare continued compliance with the requirement annually.

6.15 Imaging

6.15.1 Outpatients

6.15.1.1 The operator must correctly identify the patient prior to performing any exposure:

- Ask the patient to state their full name and date of birth. Do not ask them to confirm the details against those expected according to the request form.
- Check these details against those given on the request form. If the details match, proceed with the exposure. If there is more than one patient on the radiology information system with the same name double check identity against address.

6.15.2 Inpatients

6.15.2.1 When collecting an inpatient from a ward, portering staff must ask the ward staff to 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.

6.15.2.2 If an inpatient arrives for a radiographic/radiological examination without an identification band must be applied by a member of the transferring department in line with section 6.5 of this policy prior to any radiological intervention being undertaken.

6.15.2.3 If an appropriate ward nurse is not available, the patient must be returned to the ward and the nurse-in-charge informed of the situation.

6.15.2.4 Do not examine any inpatient on the ward that is not wearing an ID band. Request that a ward nurse who is familiar with the patient fits an ID band.

6.15.2.5 The patient's details on the request form must where possible, be verified with the patient and always checked against those on the patient's band before the exposure.

6.16 Incident Reporting

6.16.1 Misidentification of the patient or mislabelling of specimens can result in wrong: diagnosis, treatment, procedure, medication, blood transfusion, etc., all of which can result in minor to major, even death. For any incident where a patient does not have a wristband, has been misidentified or injury has occurred due to the absence of a wristband, employees should report this to the person in charge, supervisor or senior manager straight away and complete an incident form as soon as possible. Managers should investigate the incident and ensure that where necessary actions are completed following investigation. This may include a full review of tests, treatment and medications and informing ward and clinical staff.

6.16.2 In addition to reporting incidents of misidentification other actions may be necessary for example;

- If the patient's details are wrong on e-record it is essential that this is updated immediately and identification produced using the correct information.
- If a patient has an investigation using the wrong patient details, as soon as the error is discovered the Laboratory/X-ray/Medical physics, etc., must be informed of the incident and the investigation repeated wherever possible, or the record updated with the correct information. An apology must be made to the patient and/or the relative/carer where appropriate. An investigation, possibly involving a root cause analysis, must take place to find out how the error occurred. Where applicable the incident must be reported to any appropriate regulatory body.
- Where the patient receives the wrong treatment, drugs, blood, etc., the treatment/drugs/blood must be stopped immediately and the patient must receive any treatment appropriate to that specific situation. In addition to the clinician responsible for the patient being informed and in the case of blood transfusion, the lab and the transfusion nurse must be informed as soon as possible. An apology must be made to the patient and/or relative/carer where appropriate. A full investigation must be carried out, possibly involving a full root cause analysis, to establish exactly what happened and an action plan be implemented to prevent the same thing occurring again.

7 Training

7.1 Patient identification is included in both corporate and local induction programmes indicating staff responsibility.

7.2 All staff responsible for printing and issuing identification bands must undergo training and be deemed competent by their line manager prior to issuing and verifying identification markers.

7.3 Any changes to the policy will be cascaded to staff through the Trust's communication facilities, i.e. Intranet, bulletins and by line managers.

7.4 It is essential that all practitioners taking specimens are fully trained in procedure and deemed competent. They should be able to clearly demonstrate this to their manager or supervisor if requested to do so. All training should be subjected to periodic competence reassessment. Training should be provided by a practitioner that is documented as being fully competent in the procedure.

7.5 It is essential that all practitioners requesting diagnostic tests using the trust electronic ordering system are fully trained in this process and are deemed competent. They should be able to clearly demonstrate this to their manager or supervisor if requested to do so. All training should be subject to periodic competency re-assessment. Training should be provided by a practitioner that is documented as being competent in the procedure.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring compliance

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Monitoring of application of identification bands within Childrens Services in accordance with the requirement of Trust policy	Clinical Assurance Tool	Matron	Trust Board	Monthly
Monitoring of reporting of incidents related to; <ul style="list-style-type: none"> • patient identification • mislabelling of specimens 	Patient Identification incidents Report	Nurse Specialist – Patient Safety	Clinical Risk Group	Bi-annually

Audit of patient identification	Audit	Nurse Specialist – Patient Safety	Clinical Risk Group	Annual
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10 Consultation and Review

This policy will be reviewed by the Nurse Specialist – Patient Safety on a three yearly basis or more frequently if changes in practice warrant updates to the policy.

The contents of this policy has been discussed with the relevant stakeholders and agreed by the Clinical Governance and Quality Committee.

11 Implementation

All staff should be made aware of this policy as part of local induction.

12 References

- *NPSA (2005) Wristband for hospital inpatients improves safety. Safer Practice Notice No.1, November.*
- *NPSA (2007) Standardising Wristbands Improves Patient Safety. Safer Practice Notice No.24, July.*
- *NPSA (2012) The Never Events list 2012-13, January 2012*

13 Associated documentation

- [Administration of Blood Products Procedure](#)
- [Check List Alert Sign](#)
- [Clinical Record Keeping](#)
- [Interpreter and Translation Services Policy](#)
- [Intravenous Potassium Administration – General Adult Wards](#)
- [Reporting and Management of Incidents and Accidents Policy](#)
- [Reporting and Management of Serious and Untoward Incidents Policy](#)
- [Safeguards for Invasive Procedures](#)
- [Sample Acceptance and Rejection Policy](#)
- [Strong Potassium Solutions - Safe Storage and Handling](#)
- [The Management of Babies at Delivery and on Postnatal Wards, also called Post Natal Ward Guide Neonatal](#)
- The Ordering, Storage and Administration of all Medicinal Substances in the Newcastle Upon Tyne Hospitals NHS Foundation Trust
- [WHO theatre checklist](#)

Author: Nurse Specialist Patient Safety

How do we prevent patient misidentification?

DO's

- DO read all related policies
- DO identify the patient as soon as they are admitted by asking for a full name and date of birth as well as confirming all other demographic details
- DO place a wristband on the patient's wrist as soon as you have established their identity
- DO ensure the identification wristband is worn throughout the whole admission whether that be a day or weeks
- DO explain the need to wear a wristband to the patient
- DO access communication support services as outlined in policy
- Do ensure if you are relying on friends and family members to verify a patients identity they fully understand you and do not have communication barriers of their own
- DO ask the patient for their full name and date of birth at every intervention
- DO remember that no one should take specimens from patients who are not wearing a correctly completed identification wristband
- DO check the details against the wristband before carrying out any procedure or administration of medicines or blood
- DO make sure the details on prescriptions and request cards are exactly the same as those on the wristband
- DO label any specimens after they have been taken before leaving the bedside, with the details from the identification wristband
- DO regularly check the wristband details are legible. If not, replace it
- DO take care in clinics as patients may admit to being someone else to jump the queue. Always ask the patient to give you their details and not just confirm what you say to them

DON'TS

- DON'T read the patient details and ask them to confirm them
- DON'T accept a patient pointing to a name above the bed
- DON'T forget that friend and family members could have communication needs
- DON'T take specimens without identifying the patient first
- DON'T label sample tubes and bottles before taking the specimen
- DON'T take samples from more than one person at a time. Concentrate on one patient, one sample, one request
- DON'T label samples of check medication or blood away from the bedside. Remember the patient's identity is the most important part of the checking procedure, as any treatment is no good for the wrong patient
- DON'T print off more addressographs labels or use them for patient identification as they can be misfiled and have been proven to lead to wrong blood transfusions
- DON'T label samples for someone else
- DON'T expect phlebotomists to take samples when there is no wristband on the patient

The Newcastle upon Tyne Hospitals NHS Foundation Trust
Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 21/08/2018

2. **Name of policy / guidance/ strategy / service development / Investment plan/Board Paper:**

Patient Identification Policy

3. **Name and designation of author:**

Karen Collingwood, Nurse Specialist – Patient Safety

4. **Names & Designations of those involved in the impact analysis screening process:**

Clinical Risk Group

5. **Is this a:** Policy Strategy Service Board Paper

Is this: New Revised

Who is affected: Employees Service Users Wider Community

6. **What are the main aims, objectives of the document you are reviewing and what are the intended outcomes?**
(These can be cut and pasted from your policy)

This policy is intended to:

- ensure the highest level of patient safety
- ensure all staff involved in patient identification are fully aware of their responsibilities
- ensure that staff recognize the significance / importance of appropriately identifying patients
- ensure staff are aware of which patients should have a wristband applied and ensure patients requiring wristbands are positively and correctly identified BEFORE application of wristbands.

7. Does this policy, strategy, or service have any equality implications? Yes No

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence What evidence do you have that the Trust is meeting the needs of people in all protected Groups related to the document you are reviewing– please refer to the Equality Evidence within the resources section at the link below: http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights.aspx	Does evidence/engagement highlight areas of direct or indirect discrimination? For example differences in access or outcomes for people with protected characteristics	Are there any opportunities to advance equality of opportunity or foster good relations? If yes what steps will be taken? (by whom, completion date and review date)
Race / Ethnic origin (including gypsies and travellers)	Provision of interpreter Mandatory EDHR Training The policy specifically mentions the need for interpreters where patients are unable to communicate in English t	Patients with little spoken English are at more risk of misidentification. This is acknowledged in the policy.	No
Sex (male/ female)	Mandatory EDHR Training	No	No .
Religion and Belief	Mandatory EDHR Training	No	No .
Sexual orientation including lesbian, gay and bisexual people	Mandatory EDHR Training	No	No.
Age	Needs of patients addressed	Very young patients and those	No.

	Mandatory EDHR Training The policy specifically mentions the need for additional care with patients who are too young to understand and those who are confused	who are confused are at more risk of misidentification. This is acknowledged in the policy	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Communication needs considered in the policy Mandatory EDHR Support available from the Learning Disability Specialist Nurse incorporated into the policy	Disabled Patients may be more at risk of misidentification. This is acknowledged within the policy	Amend the paragraph 6.8.5 to incorporate changes in terminology
Gender Re-assignment	Mandatory EDHR Training	Some transgender patients particularly young patients may not have been changed on the NHS records and calling them by what they consider their “Dead name” can be very distressing for them.	This issue is being reviewed and any additional guidance will be forwarded to the policy author.
Marriage and Civil Partnership	Mandatory EDHR Training	No	No
Maternity / Pregnancy	Mandatory EDHR Training	No	No

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

Do you require further engagement Yes No

11. **Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)**

PART 2

Name of author:

Date of completion

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)