NHS Tayside

Clinical

Establishing Patient Identity Policy

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Signed: **Executive Lead**
(Authorised Signatory)

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1. PURPOSE AND SCOPE

The purpose of this document is to set out the standards within NHS Tayside, which aim to ensure that all healthcare workers effectively establish patient identity before sharing of information, communication, consultation and/or the initiation of any procedure, care and/or treatment. This policy must be read in conjunction with the NHS Tayside Informed Consent Policy (2007). Consent and confidentiality must be considered prior to any communication and the sharing of information in accordance with NHS Tayside Care Together – A General Protocol for Sharing Information (2002) and NHS Code of Practice on Protecting Patient Confidentiality (2003).

1.1 This policy applies to all healthcare workers working within NHS Tayside. Establishing patient identity will be required to take place in various clinical and non-clinical environments throughout NHS Tayside.

1.2 For the purpose of this document the following definitions apply:

- "A patient" is defined as any individual receiving care and/or treatment from NHS Tayside;
- "An inpatient" is defined as any individual attending NHS Tayside where the intention is to fully admit the patient to hospital;
- "A healthcare worker" is defined as any person who is employed by NHS Tayside;
- "Establishing patient identity" is defined as the process of ensuring that the correct patient or their relatives/carers are confirmed before sharing of information, communication, consultation and/or before the initiation of any procedure, care and/or treatment occurs.

2. STATEMENT OF POLICY

2.1 To ensure that all NHS Tayside staff accurately establish patient identity prior to sharing of information, communication, consultation and the initiation of any procedure, care and/or treatment.

2.2 All NHS Tayside staff involved in establishing and confirming patient identity must be familiar with this policy.

2.3 A patient who requires transfusion of blood products or components must have their identity established and a patient identity band applied before this takes place (NHS QIS 2006 and NHS Tayside and East of Scotland Blood Transfusion Service 2007).

2.4 "*All hospital inpatients in acute settings must wear a patient identity band* "(NPSA Safer Practice Notice (11) 2005).

Within NHS Tayside patients in all wards/clinical areas and inpatient areas in Ninewells Hospital, Perth Royal Infirmary and Strathcathro Hospital must wear a patient identity band. In all other environments within NHS Tayside including community hospitals, mental health and learning disability units, patient identity bands must be used wherever possible or appropriate. When this is not possible or inappropriate the level of risk associated with not using the patient identity band must be assessed and documented in the medical and/or nursing records, this must include the rationale for not using the patient identity band. Each individual must be assessed locally and the alternate way to safely establish and confirm

identity of the individual patient must be clearly documented. This may include verbal identification checks and/or confirmed photographic identification, refer to 3.6. Emergency situations, special considerations and exemptions are detailed in 4.5 and 4.6.

2.5 The patient identity band will be white except where the patient has a known allergy or there is an alert, for example, to distinguish patients who do not wish to receive blood products or components. In these cases a red alert patient identity band must be used instead of a white identity band. Information relating to the patients allergies and/or alert information must be documented as a minimum in the dedicated section on the front or inside cover of the medical records. It must not be documented on the patient identity band. **The patient must only wear one patient identity band.**

2.6 It is the responsibility of the admitting nurse/midwife to establish patient identity and apply the patient identity band during the admission procedure. This will be given priority during the admission procedure.

2.7 The information on the patient identity band must only include forename, surname, date of birth and Community Health Index Number (CHI) (NPSA 2007), refer to section 4.8 regarding the use of additional identifiers. In situations where the CHI number is not immediately available this must be added at the earliest opportunity. It is the responsibility of the admitting nurse/midwife to communicate the absence of these details and initiate processes to ensure completion.

2.8 The information written on the identity band must be clear and legible and written with black indelible ink (NPSA, 2007).

2.9 Babies within maternity units must have two patient identity bands. Where possible one must be placed on the baby's wrist and the other on the baby's ankle. The identity band must include the following details:

- Baby of - surname of mother
- Current address of mother
- Date of birth of baby
- Time of birth of baby
- Sex of baby.

In the case of multiple births the baby order must be added after the surname of mother.

The mother or the birthing partner must check this information. Where this is not possible then this must be documented in the mother's maternity records.

2.10 The patient identity band must not be removed until immediately prior to discharge.

3 RESPONSIBLITIES AND ORGANISATIONAL ARRANGEMENTS

3.1 Prior to any sharing of information, communication, consultation and the initiation of any procedure, care and/or treatment, it is the individual healthcare worker's responsibility to establish or confirm patient identity.

3.2 If a healthcare worker removes the patient identity band it is their responsibility to ensure it is replaced. Similarly if a patient identity band is missing, has incomplete details or becomes contaminated/illegible, it is the responsibility of the healthcare worker who first notices this to ensure it is replaced, having first established the patient's identity.

3.3 When a patient is admitted to hospital or transferred to another area within NHS Tayside it is the responsibility of the nurse in the admitting/receiving ward or unit to confirm identity and check the allergy/alert status of the patient, ensuring the patient is wearing an appropriate patient identity band.

3.4 In Accident and Emergency (A & E) when patient identification cannot be easily established and the need for urgent blood transfusion is required, a Typanex Blood Recipient Identification Band will be used. The Typanex Blood Recipient Identification Band is used for this sole purpose. It holds a unique number required for the emergency blood transfusion or blood sampling for blood transfusion. As soon as patient identification is established, the required patient identity band must be used and on the completion of the initial transfusion prescription of blood products/components the Typanex band must be removed.

3.5 In Accident and Emergency (A & E) when patient identification cannot be established the individual's Accident and Emergency registration number will be written on the patient identity band until patient identity is established.

3.6 All Community Health Partnership (CHP) General Managers, Service Managers and Clinical Group Managers must ensure local implementation and monitor compliance with this policy. Relevant agreed local arrangements, guidelines and/or protocols must be in place to establish and enable a way to safely identify individual patients. Any evidence and/or associated level of risk that gives cause for concern must be acted on at local level. Any evidence gathered that impacts on the content of this document or the risk management process must be communicated to the relevant department, refer to section 6.

4. PROCEDURAL GUIDELINES AND MANAGEMENT OF RISK

4.1 Establishing patient identity will be required to take place in various clinical and non-clinical environments throughout NHS Tayside.

4.2 Patient identification must be established by all healthcare workers prior to:

- Any sharing of information, communication or consultation. For example between a patient and health worker and/or relatives/carers and healthcare worker
- Any procedure, care and/or treatment being initiated.

Consent and confidentiality must be considered prior to any communication and the sharing of information in accordance with NHS Tayside Care Together – A General Protocol for Sharing Information (2002) and NHS Code of Practice on Protecting Patient Confidentiality (2003).

4.3 Guidance for establishing patient identity:

- Ask the patient to state their full name, address and date of birth. When the patient is too young or unable to give full identification details, confirmation should be sought from a relative/carer or other reliable source who is in attendance, for example police, social worker. The Language Line 'interpretating over the phone' Service or the Clinical Governance Team can be employed if necessary to arrange interpretating services. These details must be cross-referenced with at least one of the following: The medical or nursing records; the request/referral form. When another has confirmed patient identity this process must be documented in the patient's records, including the source.

- All patients must be asked to confirm the information written on their identity band prior to it being put in place. The information on the patient identity band must only include forename, surname, date of birth and Community Health Index Number (CHI) (NPSA 2007), refer to section 4.8 regarding the use of additional identifiers. Where the patient cannot confirm their identity, confirmation should be sought from a relative/carer or another reliable source, for example police or social worker.

4.4 The patients' wrist will be used to position the patient identity band unless the patients' wrist is considered an inappropriate site. The patients' ankle will be the next site to be considered. Thereafter professional judgement should be used to determine the most appropriate position of the patient identity band or the most appropriate way of establishing patient identity of the individual considering the level of risk.

4.5 Once patient identification has been established it is acceptable to confirm subsequent patient identity using the patient identity band worn by the patient, cross-referenced with either the medical or nursing records or the request/referral form, for example, Phlebotomy/X-ray /specimen.

4.6 **Special considerations and exemptions will occur.** It is recognised that, for example, in outpatient departments, day patient areas, mental health, learning disability, continuing care settings or non-clinical environments the use of the patient identity band may be considered inappropriate or not possible. In these cases the level of risk associated with not using the patient identity band must be assessed and documented in the medical and/or nursing records. In areas where the use of the patient identity band is frequently considered inappropriate then locally agreed policy, guidelines and/or protocols must be developed, implemented and compliance monitored. Where the use of the patient identity band is refused or considered inappropriate the reason for this must be clearly documented in the nursing records, together with the expected way that patient identity will be established.

4.7 In extreme emergency and possibly life-threatening situations clinical care may take priority over establishing patient identification. When emergency treatment has been undertaken it is the responsibility of the administering clinician to initiate processes to establish patient identification thereafter as a matter of urgency.

4.8 Section 2.7 of this policy identifies the only information that must be included on the patient identity band.

"*If any additional identifiers are thought to be necessary, these should be formally risk assessed"* (NPSA Safer Practice Notice (24) 2007).

All information written on the identity band must be clear and legible and written with black indelible ink.

5 MONITORING AND REVIEW

5.1 Compliance with this policy must be monitored. CHP General Managers, Service Managers and Clinical Group Managers will have responsibility for ensuring monitoring takes place. Mechanisms to measure positive compliance must be explored and agreed locally and appropriate improvement actions taken. Further guidance/advice on the monitoring process can be sought from the Safety, Governance and Risk Department. Sharing of experiential learning is encouraged throughout the organisation. Clinical Governance Teams can support this process.

5.2 This policy will be formally reviewed one year following implementation and alternate years thereafter unless risks identified prompt an early review.

6 **KEY ROLES AND DEPARTMENTS** who can be contacted via switchboard:

- Director of Nursing Single Delivery Unit, Directorate of Nursing and Patient Services Level 10 Ninewells Hospital;
- Medical Director Single Delivery Unit, Level 10 Ninewells Hospital;
- Senior Nurse Education Leaning and Development, Directorate of Nursing and Patient Services Admin Offices, Perth Royal Infirmary;
- Practice Development Team, Directorate of Nursing and Patient Services, Ninewells Hospital;
- Safety, Governance and Risk Co-ordinator, Kings Cross Hospital;
- Local Clinical Governance Co-ordinators

REFERENCES

National Patient Safety Agency (2005). Safer Practice Notice 11 – Wristbands for Hospital Inpatients Improves Safety. National Patient Safety Agency

National Patient Safety Agency (2007). Safer Practice Notice 24 - Standardising Wristbands Improves Patient Safety. National Patient Safety Agency

NHS Quality Improvement Scotland (2006), Clinical Standards: Blood Transfusion. NHS QIS, Edinburgh.

NHS Scotland (2003). NHS Code of Practice on Protecting Patient Confidentiality, Scottish Executive, Edinburgh

NHS Tayside and East of Scotland Blood Transfusion Service (2007). Policy on the use of Blood and Blood Components, NHS Tayside

NHS Tayside (2007). Informed Consent Policy, NHS Tayside

NHS Tayside (2002). Care Together - A General Protocol for Sharing Information, NHS Tayside

1. Rapid Impact Checklist (RIC)

Each policy must include a completed and signed template of assessment

Which groups of the population do you think will be affected by this proposal? • minority ethnic people (incl. gypsy/travellers, refugees & asylum seekers) • women and men • people in religious/faith groups • disabled people • older people, children and young people • lesbian, gay, bisexual and transgender people • people of low income Other Groups**:** • people with mental health problems • homeless people • people involved in criminal justice system • staff	
N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.	What positive and negative impacts do you think there may be? None Which groups will be affected by these impacts? All of the above
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition? • Exercise and physical activity? • Substance use: tobacco, alcohol or drugs? • Risk taking behaviour? • Education and learning, or skills?	None
Will the proposal have any impact on the social environment? Things that might be affected include • Social status • Employment (paid or unpaid) • Social/family support • Stress • Income	None
Will the proposal have any impact on • Discrimination? • Equality of opportunity? • Relations between groups?	None
Will the proposal have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Accidental injuries or public safety? • Transmission of infectious disease?	None
Will the proposal affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services • Education	Yes, positively. It will communicate NHS Tayside standards for establishing patient identity

Rapid Impact Checklist (RIC): Summary Sheet Each policy must include a completed and signed template of assessment	
1. Positive Impacts (Note the groups affected) That there will be clear processes for all NHS Tayside staff in relation to establishing patient identity prior to sharing information, communication, consultations and before the initiation of procedure(s), care and/or treatment.	**2. Negative Impacts (Note the groups affected)** None
3. Additional Information and Evidence Required None	
4. Recommendations None	
5. From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?	

Manager's Signature: Date:

NHS TAYSIDE - POLICY/STRATEGY APPROVAL CHECKLIST

This checklist must be completed and forwarded with policy to the appropriate forum/committee for approval.

POLICY/STRATEGY AREA: (See Intranet Framework) Clinical _____

POLICY/STRATEGY TITLE: Establishing Patient Identity _____

LEAD OFFICERS: Margaret Simpson and Professor Stewart Forsyth _____

Why has this policy/strategy been developed?	There is no existing policy. This policy will ensure that NHS Tayside staff are aware of NHS Tayside standards in relation to establishing patient identity
Has the policy/strategy been developed in accordance with or related to legislation? – Please give details of applicable legislation.	Recommendations of the National Patient Safety Agency. The Ionising Radiation (Medical Exposure) Regulations 2000.
Has a risk control plan been developed? Who is the owner of the risk?	No
Who has been involved/consulted in the development of the policy/strategy?	• Director of Nursing SDU NHST • Assistant Director of Nursing SDU • Medical Director SDU NHST • Medical Directors NHST • All Clinical Governace Leads NHST • CHP Managers NHST • Clinical Group Managers NHST • Lead Nurses NHST • AHP Lead NHST • Allyson Angus (PPG) NHST • Head of Safety Governance and Risk NHST • Senior Nurse Acute Liaison Learning Disabilities NHST • Practice Development Nurse NHST • Shared Governance Council NHST • Employee Director NHST
Has the policy/strategy been assessed for Equality and Diversity in relation to:-	**Has the policy/strategy been assessed For Equality and Diversity not to disadvantage the following groups:-**

Race/Ethnicity **Gender** **Age** **Religion/Faith** **Disability** **Sexual Orientation**	**Please indicate Yes/No for the following:** Yes Yes Yes Yes Yes Yes	**Minority Ethnic Communities (includes Gypsy/Travellers, Refugees & Asylum Seekers)** **Women and Men** **Religious & Faith Groups** **Disabled People** **Children and Young People** **Lesbian, Gay, Bisexual & Transgender Community**	**Please indicate Yes/No for the following:** Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes
Does the policy/strategy contain evidence of the Equality & Diversity Impact Assessment Process?		Yes	
Is there an implementation plan?		Yes	
Which officers are responsible for implementation?		The medical Director is ultimately responsible but delegated responsibility lies with Clinical Group Managers, CHP General Managers, Clinical Group Directors and Clinical Leads.	
When will the policy/strategy take effect?		December 2007 following ratification by the Improvement and Quality Subcommittee	
Who must comply with the policy/strategy?		All staff within NHS Tayside before any sharing of information, communication, consultation and the initiation of any procedure, care and/or treatment	
How will they be informed of their responsibilities?		The policy will be widely disseminated and discussed within clinical governance, shared governance and professional nurse forums and management meetings. The policy will also be available on the intranet	
Is any training required?		No	
If yes, has any been arranged?			
Are there any cost implications?		No additional costs, neutral to current system.	
If yes, please detail costs and note source of funding			
Who is responsible for auditing the implementation of the policy/strategy?		Clinical Group managers and CHP managers	
What is the audit interval?		Local compliance monitoring	
Who will receive the audit reports?		Medical Director	
When will the policy/strategy be reviewed and by whom? (please give designation)		One year post implementation then two years thereafter	

Name: Date:

APPENDIX 1

PROCEDURES/PROTOCOLS/GUIDELINES

LOCAL GUIDANCE

1. Each department must have evidence of a formalised system for the development of procedures, protocols and guidelines which has been communicated to all staff. In the absence of a formalised system the department will be required to develop such an arrangement.

2. There must be a formalised review system which ensures that all such documents are reviewed, as a minimum, on an annual basis, by a named group/committee.

3. There will be an implementation plan (including training) for all procedures, protocols and guidelines which follows the same criteria outlined on the policy approval checklist.

4. An audit system will be established to reflect the effectiveness of implementation of such documents.

5. All such documents must be accessible for all relevant staff, and information regarding access must be conveyed accordingly.

6. A master index / register must be held for all such documentation.

7. The local system for managing and developing procedures, protocols and guidelines must be reviewed annually to ensure compliance with all the above.