Torbay and South Devon NHS
NHS Foundation Trust

Patient Identification Policy for Community Hospital Inpatients

Ref No: 1865 Version 3
Date: 3 November 2017

Document Ratification

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.
Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

Document title:	Patient Identification Policy For Community Hospital Inpatients.		
Purpose of document:	To ensure effective identification of patients maintaining safety for Community Hospital inpatient		
Date of issue:	3 November 2017	Next review date:	3 November 2020
Version:	3	Last review date:	18 September 2017
Author:	Associate Director if Nursing/Allied Health professional Community Services		
Directorate:	Community		
Committee(s) approving the document:	Care and Clinical Policies Group Meeting		
Date approved:	20 September 2017		
Links or overlaps with other policies:	Blood Transfusion Policy Ref No 0219 Version 9 Medicines Policy for Registered Professionals in Community Services Delivery Unit Ref No 1927 Version 3 Medicines Policy for Skilled Not Registered (SNR) Staff Ref No 1928 Version 2		

	Please select Yes	No
Does this document have training implications? If yes please state:	☐	✗
Does this document have financial implications? If yes please state:	☐	✗
Is this document a direct replacement for another? If yes please state which documents are being replaced:	☐	✗

Document Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Reviewed	1 October 2013	Reviewed	Sue Ball
2	Review date	2 March 2017	Review date extended	CCG
3	Ratified	3 November 2017	Revised	Care and Clinical Policies Group Meeting
3		19 February 2018	Review date extended from 2 years to 3 years	

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	X	Visitors / Relatives	☐
	General Public	☐	*Voluntary / Community Groups*	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	*X*	*Other Statutory Agencies*	☐
	Others (please state):			

Does this document require a service redesign, or substantial amendments to an existing process?	*No*
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	*Voluntary / Community Groups*	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	*x*	*Other Statutory Agencies*	☐
	Details (please state):			

Clinical Policy no. CL 122			
Title:	**Patient Identification Policy For Community Hospital Inpatients**		
Document Owner:	**Helen Ireland**		
Presented to:	**Care and Clinical Policies Group**	**Date:**	
Ratified by:		**Date:**	
Review date:	**December 2014**		
Links to other policies:	**Blood Transfusion Policy Ref No 0219 Version 9 Medicines Policy for Registered Professional in Community Services Delivery Unit Ref No 1927 Version 3 Medicines Policy for Skilled Not Registered (SNR) Staff Ref No 1928 Version 2**		

1. Purpose of this Document

This policy provides clear instructions for staff to enable them to deliver safe care and defines the practical aspects that will help minimise the risk for patients receiving treatment within all clinical settings. To safeguard practice, it is essential that correct patient identification procedures are maintained throughout the patient journey.

This policy sets out requirements for staff to recognise their own responsibility and involvement regarding the managerial and organisational arrangements for correct patient identification.

2. Scope of the Policy:

This policy applies to all Torbay and South Devon NHS Foundation Trust employed staff involved in the care and delivery of services to patients whilst inpatients or attending day case units. This applies to all staff who come into contact with patients and all staff who obtain samples from patients in in-patient units.

3. General Statement

3.1. Patient identity bracelets **do not** remove the healthcare professionals' responsibility for checking patient identity but acts only as a validation of identification.

3.2. Whenever possible the patient should be asked to state their full name and date of birth in order to check the details on the patient identity bracelet and confirm they are correct.

3.3 Patient adhesive labels must **not** be applied or substitute the writing or printing of patient details on the identification bracelet, which should be clearly written/printed.

3.4 Patient details are entered as described within this document

3.5 ***If the patient is known to have an allergy, he/she must be given a written red patient identity bracelet in addition to the standard white band***

3.6 All patients receiving treatment or undergoing diagnostics including those patients admitted to day treatment areas must wear a patient identity bracelet, unless this is contrary to the patients' wellbeing or the patient declines to wear one (In this case follow 6.1, box 2, page 6).

3.7 Where a patient identity bracelet attached to the patient's wrist will compromise patient safety, the patient identity bracelet should be applied to the patient's ankle by the healthcare professional.

3.8 For patients who are unable to identify themselves (unconscious, confused or language barrier) seek verification of identity from relative, parent or carer at the bedside. This must exactly match the information on the identity band. In emergency or operative situations where the identity bracelet is removed, patient identification must be fixed to the patients' skin using transparent adhesive film (after checking allergy status).

3.9 The nurse or healthcare professional responsible for providing the patients' care will ensure that each patient has a patient identity bracelet throughout their stay in hospital. If this is removed outside the ward or department the responsibility for prompt replacement lies with the person who removed the patient identity bracelet. A check should be made with the patient using full name and DOB to confirm identity.

3.10 If the patient identity bracelet is noted as missing it is the responsibility of the healthcare professional that first notices that the patient identity bracelet is missing to promptly replace.

3.11 Health care professionals will not undertake any procedure or administer medication until the patients' identity is confirmed.

3.12 Patients who are transferred from one hospital to another must be given a new patient identity bracelet, and the old patient bracelet removed. **Do not write over the old patient identity bracelet.**

3.13 Bracelets that become faded must be replaced to enable clear identity and use of labelling systems for phlebotomy and transfusion

3.14 This policy is in line with the recommendations from the National Patient Safety Agency NPSA Safer Patient Practice Notice, July 2007, No.24

4. Duties and Responsibilities

It is the duty of all staff, who have responsibility for the admission of patients, administration of treatment and care including clinical investigations and assessments to ensure that patients have a patient identity wristband in place. If such placement would be contrary to the patient's wellbeing or the patient declines to wear one, it is also the responsibility of staff to document this.

It is the responsibility of all ward and department leaders to be fully aware of the policy principles and to disseminate this policy to members of their staff. Each lead is to be fully aware of the legislative requirements outlined in the policy, and to monitor adherence within their area of responsibility.

5. Process

5.1 Identifying the patient / applying the patient identity bracelet

Details below explain the steps to be taken to ensure patients are identified correctly. The steps should be taken in the following order (and if the first is not possible, undertake the second etc.)

5.1.1 Ask the patient to tell you their name, date of birth and/or address. Check this is compatible with the patient's case notes. Enter the details from the case notes onto the wristband. Apply the wristband at that point.

5.1.2 If the patient is unable to tell you their name, confirmation should be obtained by asking the patients' relatives / carers to identify the patient by name, date of birth and/or address. Enter the details from the case notes onto the wristband. Apply the wristband at that point. Ensuring details exactly match information held.

5.1.3 Those patients who are unable to tell you their name, and are brought into the Community Hospital settings by South West Ambulance Service Trust (SWAST), may be identified by the accompanying documentation (e.g. accompanying medical notes), ***once*** the healthcare professional has established the source of information as being appropriate.

5.1.4 Where patient identification cannot be established, the **Typenex** system must be used as detailed within the policy.

5.2 What information must be written on a patient identity wristband?

5.2.1 The Trust requires that only the core patient identifiers are written or printed on wristbands; full name, date of birth and NHS number.

5.2.2 Name

Priority should be given to the patient name that includes

- last name.
- first name.

First and last name should be clearly differentiated by using lower case letters for first name (with upper case first letter) and UPPER CASE for last name, and should be presented in the order: LAST NAME, First name e.g. SMITH, John
Where a patient is known by another first name e.g. John Albert Smith known as Albert, both first names and surname must be written on the identity band .

5.2.3 Date of birth

Date of birth should be recorded in the short format, in the style recommended by the NHS Connecting for Health Common User Interface Design Guide as follows DD-Mm- YYYY e.g. 07-Jun-2005
Where DD is the two-digit day Mm is the abbreviated month name (e.g. Feb) YYYY is the four-digit year
Day values less than 10 should appear with a zero in the first position e.g. 08
Month names should abbreviate to the first three letters. Day, month and year separators should be hyphens.

5.2.4 NHS Number

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

Wherever possible the NHS number must be used. Where the NHS number is not available the hospital number or a temporary number should be used until it is.

5.2.5 Text

Black text on a white background should be used to ensure the wristband is clearly legible in reduced lighting conditions (such as wards at night) and by those with visual impairments.

5.2.6 Layout

The order of information and information style should be used on all wristbands across the organisation to encourage standardisation. This helps make wristbands easier to read and avoid errors.

Figure 1: Recommended layout for patient identifiers

Last Name	First name
Date of Birth	NHS number

N.B. PATIENT DETAILS MUST BE WRITTEN IN BLACK INK PATIENT ADHESIVE LABELS MUST NOT USED AS A SUBSTITUTE

6. Coloured Wristbands

6.1 Where a red wristband is used it indicates a patient is undergoing chemotherapy. Red wristband will be used in addition to a white printed I.D. wristband.

Where a yellow wristband is used to indicate a patient who has been exposed to radioisotopes the yellow wristband will be used in addition to a white printed I.D. wristband.

Known allergies - Allergies can include latex and any other material components as well as medicines	
• Patients and or carers must be asked about known allergies upon admission and prior to treatment. • Allergies (suspected or confirmed) to be documented as such on all relevant documents e.g. prescription chart, patient case notes. • Suspected allergies to be confirmed by the admitting team through discussion with the patient, other relevant medical personnel and / or family, and documented within the patients' case notes. • A red patient identity bracelet should be applied (see Section 6).	• To establish patient allergy status and ensure patient safety at all times. • To prevent inadvertent administration or application of allergen. • To establish the true allergy status, of the patient. • To promote the patients' / family understanding of allergy status. • To alert all healthcare personnel of their responsibility to check all relevant documentation for identified allergy/allergies e.g. prescription chart, medical notes
Identifying the patient before administering medication / undertaking other procedures/ obtaining specimens	
• Where possible, ask the patient to tell you their name, date of birth and / or address. Check this correlates with details on the wristband. • If the patient is unable to tell you their name, refer to the patient identity bracelet and if possible, verify the information by asking family, relatives or a member of the clinical staff who knows the patient. • Label the specimen containers after the collection of the specimen and whilst with the patient.	• To ensure correct patient identification. • To confirm identity of patient and avoid mix-up of specimens.

When a patient declines to wear a patient identity bracelet	
• Establish why the patient declines to wear an identity bracelet. • Inform the patient of the potential risks in not wearing an identity bracelet • Document the discussion and the reason for the patient not wearing an identity bracelet in the patients' case notes	· To ensure patient is aware of the risks associated with not wearing an identity bracelet, and takes responsibility for his or her actions. · Establish an alternative method of identification with patient.
Patient transfer	
• In-patients who are transferred from one hospital to another must be given a new identity bracelet, and the old identity bracelet must be removed.	• To maintain correct patient identification at all times.
Uncomprehending patients / reduced capacity	
• When possible, ask an accompanying adult to confirm the identity of the patient, providing name, date of birth and/or address • Use an interpreter where necessary	• To maintain correct patient identification at all times.
Unknown patients	
• Use the unique red **Typenex** identity bracelet. • Record the patients' gender and approximate age. • The unique number remains with the patient until identification is established, when a routine identity bracelet can be applied to the same limb • The Typenex identification label should remain in place until all outstanding investigative results are received, where then it may be removed and filed in the patients' record.	• To compile an interim central record of all care and intervention for the unidentified patient, until confirmation is obtained.

Deceased patients	
• All deceased patients must be properly identified with two identity bracelets, one on the wrist and one on the ankle. These bands need to include three identifiable pieces of information: full name, date of birth, NHS number or hospital number (both can be included)	• To maintain correct patient identification at all times.

Staff should report all incidents, including near misses relating to patients who have no wristband or one with incorrect information, also incorrect specimen identification, using the incident reporting system i.e. DATIX.

7. Training and Implementation

This policy will be reinforced at staff induction or professional awareness sessions undertaken within the ward or department. All new staff involved in caring for patients and the delivery of services will receive this information at local induction.

8. Monitoring Tool

It is the responsibility of ward managers / senior staff to ensure compliance of this policy at each drug round.

Local checks of the above procedures should identify:

- The number and percentage of patients wearing identity bracelet.
- The accuracy and reliability of the information on the patient identity bracelet.
- The reasons why patients may not be wearing an identity bracelet.
- The efficacy of alternative arrangements (if identified)
- Safety incidences related to patient identification.

9. Standards:

Item	%	Exceptions
• The number and percentage of patients wearing identity bracelet. • The accuracy and reliability of the information on the patient identity bracelet. • The reasons why patients may not be wearing an identity bracelet. • The efficacy of alternative arrangements (if identified)	100%	· Patients who declare

• Safety incidences related to patient identification.		
How will monitoring be carried out?	By routine checks at medicine rounds.	
When will monitoring be carried out?		
Who will monitor compliance with the guideline?	Ward managers and senior nurses.	

11. Distribution

This policy will be distributed to staff providing care to community hospital inpatients via Managers responsible for the areas.

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Reviewed	1 October 2013	Reviewed	Sue Ball
2	Review date	2 March 2017	Review date extended	CCG
3	Ratified	3 November 2017	Revised	Care and Clinical Policies Group Meeting

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Torbay and South Devon NHS
NHS Foundation Trust

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy