

Patient Identification Band Policy

Approved By:	Policy and Guideline Committee
Date Originally Approved:	10 th December 2007
Trust Reference:	B43/2007
Version:	V4
Supersedes:	V3 – June 2016
Author / Originator(s):	Becky O'Brien, Director of Quality Governance
Name of Responsible Committee/Individual:	Chief Nurse
Latest Approval Date	21 January 2022 – Policy and Guideline Committee
Next Review Date:	April 2025

CONTENTS

Section		Page
1	Introduction	3
2	Policy Aims	3
3	Policy Scope	3
4	Definitions	4
5	Roles and Responsibilities	4
6	Policy Statements 6.1 Who must wear patient ID bands 6.2 Responsibilities of staff when putting an ID band on a Patient 6.3 Printing the Patient ID Band 6.4 When a Patient ID Band has to be handwritten 6.5 Verifying a Patients Identity 6.6 Managing Possible Miss-identification of a Patient 6.7 Using patient ID bands for alert reasons 6.8 Considerations for Specialist areas / groups of patients <ul style="list-style-type: none"> • Babies in Maternity • Babies in Neonatal Unit • Babies, children and young people • Patients with an Unknown Identity admitted to the Emergency Department (ED) • Deceased Patients 6.9 Patients who are unable or refuse to wear an identity band	5
7	Education and Training	14
8	Process for Monitoring Compliance	15
9	Equality Impact Assessment	15
10	Supporting References, Evidence Base and Related Policies	15
11	Process for Version Control, Document Archiving and Review	16

Appendices		Page
One	Printing Patient ID Bands – links to information on INsite	14

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V4-Bullet points (3), (6.2), (6.8.1), (11.2) updated. Appendix 1-Deletion of expired links. Remaining link updated.

V3 – Review of V2 in April 2016, updated into latest Trust Template, additions to Roles and Responsibilities section, inclusion of printed ID bands for Neonates, new section 6.1 6.6 and 6.9

V2 – review of V1 in March 2008 – all references to writing or printing the ward / clinical area on the ID band removed.

V1 – approved by Policy and Guideline Committee on 10th December 2007

KEY WORDS

ID band, identification, wristband, allergy,

1 INTRODUCTION

- 1.1 It is essential that patients who are receiving care within the University Hospitals of Leicester (UHL) NHS Trust are correctly identified to ensure they receive the right treatment and care. Failure to correctly identify patients constitutes one of the most serious risks to patient safety
- 1.2 The identity bracelet provides security in patient identification as well as alerting practitioners to the possibility of allergies. Patient identification is relevant to all of the multi-disciplinary team. All staff, regardless of grade or staff group are responsible for checking the identity of a patient before performing any clinical, medical, nursing or midwifery procedure, intervention or care
- 1.3 This policy sets out the requirements for patient identification and the use of patient identification wristbands (hereafter referred to as Patient ID band or ID Band) as detailed in the National Patient Safety Agency (NPSA) Safer Practice Notice No 11 'Wristbands for Hospital patients improves safety' (2005) and No 24 'standardising wristbands improves patient safety' (2007)

2 POLICY AIMS

- 2.1 The aim of this policy is to ensure that patients are correctly identified for care and treatment by:
 - a) Setting the standards for the contents and application of patient ID Bands
 - b) Defining the key identifiers which must be used to ensure the correct patient receives the right treatment and care

3 POLICY SCOPE

- 3.1 This policy applies to all staff employed by UHL (including those on bank, agency or honorary contracts)
- 3.2 This policy applies to all patients in both an outpatient, daycase and inpatient setting.
- 3.4 Some patient groups have additional identification requirements and the following policies must be used in partnership with this one in these instances:
 - a) Using Electronic BloodTrack sample labelling for inpatient and outpatient transfusion samples. Patients will have a wrist band printed and applied to the wrist. Before actually taking the sample, the staff member will verify patient's ID by asking them to state their full name and date of birth, cross checking that information on wrist band, taking the blood sample and then scanning the wristband, whilst still at the patient's side, to print the label(s) for transfusion samples, as outlined in the UHL Blood Transfusion Policy (Trust reference B16/2003).
 - b) **Radiation:** please refer to the Ionising Radiation (Medical Exposure) Regulations 2000 Policy (Trust reference B26/2019)
 - c) **Safe Surgery:** Please refer to the Safer Surgery Policy (Trust reference B40/2010)
 - d) **Last Offices:** For Patient ID band requirements of deceased patients please refer to the Last Offices Policy (Trust Reference B28/2010)

4 DEFINITIONS

- 4.1 **Positive Patient Identification:** A means of identifying patients which involves the patient recounting their details and these being checked against relevant documentation (e.g. health records, request or treatment card or consent form).
- 4.2 **In Patient:** An inpatient is a patient who is admitted to a hospital ward for a procedure e.g. surgery, or for treatment of an acute episode or illness requiring hospitalisation. Any day case patient who is may subsequently require an overnight stay is considered an inpatient. (see 6.2 for further details regarding patients in the Emergency Department)
- 4.3 **Out- Patient:** An outpatient is a patient who attends hospital for a clinic appointment under the care of a consultant or specialist nurse, or attends for a procedure or treatment to a department where it is unlikely they will need to be admitted to a ward.
- 4.4 **Daycase:** A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled.
- 4.5 **Admission / Assessment Units:** are defined as either inpatient or daycase areas for the purpose of this policy

5 ROLES AND RESPONSIBILITIES

5.1 The Executive Lead for this Policy is the Chief Nurse

5.2 Clinical Directors and Heads of Nursing are responsible for:

- a) Adequately disseminating and implementing this policy within their areas of responsibility
- b) Implementing any required action to address areas of non-compliance as identified through incident reporting

5.3 Ward Sisters/Charge Nurses and Department Managers are responsible for:

- a) Adequately training / inducting staff, to ensure they are competent to undertake consistently accurate patient identification requirements and print a patient ID band
- b) Implementing any required action to address areas of non-compliance as identified through incident reporting
- c) Ensuring systems are in place in case a patient ID band cannot be printed and needs to be hand written.

5.4 All staff who have patient contact are responsible for:

- a) Ensuring that patients meeting the criteria identified within this policy are wearing patient ID bands
- b) Undertaking positive patient identification, checking the identification of a patient and verifying that they have the correct patient prior to performing any procedure, investigation or providing care
- c) Reporting any instances of misidentification or refusal to wear, or loss of a patient ID band via Datix and replace the patient ID band as soon as possible.

6.1 Who must wear patient ID bands

The following groups of patients are to have identification bands immediately on admission at the hospital. No procedure can take place without one

- a) All patients who attend the Emergency department (ED) via assessment bay or children's triage (majors departments) receive an electronic Patient ID band. Patients in Resuscitation have a hand written Patient ID band
- b) All in-patients, including those admitted directly to Assessment / Admission Units
- c) All daycase attendees
- d) Outpatients who will undergo treatments where there is a significant risk of an adverse reaction requiring resuscitation or admission.
- e) Other patients who do not fit into the above categories but for reason of care or treatment being provided or concerns about their cognitive ability to reliably identify themselves would require a patient ID band for safety reasons.

6.2 Responsibilities of staff when putting an ID band on a Patient

- a) The ID band must never be printed in advance of first contact with the patient and only printed after positively establishing patient identity by asking the patient. The right patient is then selected from PAS/Patient Centre to print the ID band and the ID band is immediately placed onto the patient's wrist.
- b) The use of patient ID bands does not remove staff's responsibility for positive patient identification. Checking/verifying the patient's identity should not only take place at the beginning of a care episode but continue throughout their hospital stay.
- c) It is essential that the Patient ID band contains the correct information as this may be the only way of verifying the patient's identity.
- d) Responsibility for putting an ID band on a patient can be delegated to another member of staff, however ultimate accountability and responsibility remains with the Registered Professional in charge of that patients care at that time.
- e) A Patient ID band must be put on a patient as soon as they are admitted (as detailed in 6.1) and worn throughout their hospital stay.
- f) If a second ID band is required (required for some surgical procedures because of the possibility of not being able to access a wrist band under surgical drapes) the second ID band should be applied to the ankle but never be sent loose with the patient e.g. clipped to the notes.

There are some situations in theatres where arms and legs are both covered under drapes and neither wrist band is accessible. The correct procedure in this scenario is for the Anaesthetist to cut one of the ID labels either from the wrist or ankle and securely tape to the endotracheal tube so that it is accessible during surgery. The other wrist band must remain affixed to the patient so that when are taken out to recovery area, they still have a wrist band attached.

- g) The person applying the Patient ID band will advise the patient and or parent / guardian not to remove it and to inform a member of staff immediately, should the Patient ID band be lost, soiled, damaged or removed and not replaced.
- h) Patient ID band must only be removed in exceptional circumstances. If a member of

staff removes a patient ID band it is their responsibility to make sure it is replaced or make clear alternative arrangements for ensuring the patient can be identified if it cannot be replaced immediately.

- i) The Patient ID band should be put on the dominant arm as it is less likely to be removed, if this is not possible the non-dominant arm or ankle may be used.
- j) If a member of staff discovers that a patient does not have an ID band, or it is illegible or damaged then it is their responsibility to correctly identify them and put an accurate ID band on the patient.

6.3 If a patient ID band is removed either for discharge or to be replaced the original band must be destroyed by placing it in a yellow clinical waste bag for incinerating or shredding at local level.rinting the Patient ID Band

- a) UHL's printed patient ID Band application complies with NPSA guidelines; enabling staff to electronically print wristbands with legible information and bar-coded ID
- b) Access to the printed patient ID band web based application is via any UHL computer; the various options are listed in the user guide. A password is not required, but staff must accept terms and conditions on their first use. (please see appendix One for further information)
- c) **A wristband can only be printed once a patient is registered on Patient Centre.**
- d) Information is provided in two formats; eye readable (text) and two 2d bar-codes:



Figure 1: Adult standard white wristband

- I. **Patient ID** This number relates to the local hospital system 'S Number' and identifies a patient with their electronic healthcare record (e.g. S9876543). This number is automatically assigned when a patient is registered on Patient Centre.
 - II. **Name** The surname is printed in uppercase to differentiate it from the forename. The forename uses a capital first letter followed by the remaining letters in lowercase.
 - III. **DOB** The date of birth is recorded in short format 'DD-Mmm-YYYY', the day is recorded as a two digit number, the month is abbreviated to the first three letters and the year is a four digit year.
 - IV. **NHS No** The NHS Number identifies a patient (e.g. NHS123 456 7890) and is displayed in a 3-3-4 format. It is a national unique identifier and should be used alongside our local 'S Number'.
- e) If it is difficult to obtain accurate identification details of the patient (e.g. they are unconscious, confused, have no relatives) the S Number given on admission must be used until the patients identity can be correctly verified. (See section 6.7.4)

6.4 When a Patient ID Band has to be handwritten

- a) In circumstances when a Patient ID band cannot be printed (i.e equipment failure) patient information must be clearly hand written onto an ID band using black ink, addressographs or any other label must not be used.
- b) The patient ID band must be formatted as per NPSA guidance and contain the patients hospital number, full name and date of birth

Last Name SMITH	First Name John
Date of Birth 05-Jun-1946	NHS/Hospital Number 123-456-7890

- c) The surname must be written in capital letters / upper case to differentiate it from the first name
- d) The first name must have a capital / upper case first letter and then the rest written in lower case
- e) The date of birth must be recorded in short format DD-Mmm-YYYY, where the day is recorded as a two digit number, the Month is abbreviated to the first three letters and the year is the four digit year
- f) When the NHS number is used it must be written in a 3-3-4 format (e.g. 123-456-7890)

6.5 Verifying a Patients Identity

- a) Any clinical procedure / intervention must not be done until the patients ID is verified, unless the patient is requiring life saving treatment. Procedures / interventions may include (examples not a definitive list)
 - First contact with the patient
 - Administration of medicines including chemotherapy
 - Attachment of identification band.
 - Blood transfusion.
 - Specimen collection.
 - Interventional procedures whether in an inpatient or outpatient setting.
 - Prior to consultation
 - Transfer of patients between departments
 - Invasive procedures.
 - Radiological Interventions
 - Imaging procedures
 - Any treatment which could result in the patient being unable to identify themselves

- b) To confirm the patient identity the details on the Patient ID band should be verified by the patient by asking them to confirm their full name and date of birth. Gender can also be used if the name is unisex or ambiguous. Never read the patients details out and allowing them to passively agree.
- c) Staff must observe confidentiality, privacy and dignity issues when asking patients to confirm this information.
- d) If the patient is not able to verify their details and they do not have a Patient ID band, it is illegible or damaged and the member of staff is not sure of the patient's identity an accompanying relative or member of staff previously involved in caring for the patient can verify the patients' identity. An accurate ID band must be attached to the patient as soon as possible after their identity has been verified.
- e) Please see the Safer Surgery Policy (Trust Reference B40/2010) for details relating specifically to identifying patients who require surgery e.g. all cardiac surgery patients must have two ID bands

6.6 Managing possible miss-identification of a patient

- a) A query may be raised regarding the correct identification of a patient e.g. a relative notices that wristband information is incorrect, or provide other conflicting information
- b) If an incident of Patient Misidentification occurs staff must follow the Incident and Accident Reporting Policy (Trust reference A10/2002) and take immediate action to ensure patient safety and a correct ID band is applied.
- c) The ward must also immediately notify the Data Quality team, providing the System Number that is currently in use and the details of the actual patient.

Data.quality@uhl-tr.nhs.uk Tel: 16263

- d) The Data Quality team will validate the information via external sources and internal record change logs.
- e) *If out-of-date information is found to be cause:* The Data Quality team will update the patient record and liaise with the ward. A new patient ID band and identification labels may need to be created.
- f) *If the wrong patient record is in use:* The Data Quality team will create an admission on the correct System Number and liaise with the ward to ensure all activity is transferred to the correct number. All service requests (test requests, imaging, ePMA charts etc) will need to be transferred to the correct record. This will be led by the Data Quality team using information provided by the ward. The overlap in the use of 2 different patient records will be minimised to limit further possible confusion. In these cases a new patient ID band and identification labels must be printed.

6.7 Using patient ID bands for alert reasons

- a) Patient ID bands can be used to alert staff to special considerations that may need to be taken into account when they are caring for that patient. However it is not acceptable or practical for patients to be expected to wear many different coloured ID bands to identify each individual risk factor.
- b) The only acceptable use of a coloured Patient ID band within UHL is red wristband for drug allergies or severe life threatening allergies such as latex.
- c) Patients who have a drug or life threatening allergy must wear a red Patient ID band instead of the white one. The allergy can be written on the non coated area of the wristband (See Figure 2 and 3)



Figure 2: Adult red 'allergy' wristband



Figure 3: Childrens red 'allergy' wristband

d) The patient's drug allergy details must also be recorded on the patients prescription chart and in the patients casenotes using the alert sticker and must be clearly recorded on the front inside cover of the casenote folder or on Alert Notification sheet as per the following policies:

- Policy for Documenting in Patients' Health records (Trust refB30/2006)
- Policy for the identification and management of allergy or suspected allergy to latex in patients and staff (B29/2005)

6.8 Considerations for Specialist areas / groups of patients

6.8.1 Babies in Maternity:

a) All babies in the Maternity Unit will be labelled with two ID bands containing the following information

I. Baby's S Number

II. Twin/Triplet 1/11/111 if applicable – this will be written on the ID band until the babies are entered on Patient Centre/HISS.

III. Mother's surname is printed in uppercase, followed by the baby's forename. If baby has not yet been named 'Baby' is written.

IV. Mother's Maternity/Hospital Number

V. DOB Using the short format 'DD-Mmm-YYYY'

VI. Sex (if known) (M/F)

b) A baby must be registered on Patient Centre/HISS before a wrist band can be printed. Registration and completion of E3 will generate an NHS Number.

- c) If the baby loses an ID label, requires prolonged stay for treatment and medications then replace the written bands with the printed ones.



- d) Until a band is able to be printed, this information is to be hand written in black ink by the midwife caring for the baby.
- e) The ID bands must be checked by a parent before application and should be applied within the first half hour after birth to both ankles, before the Midwife leaves the delivery room after the birth of the baby. Application of ID bands must be documented in the case notes
- f) The presence of the ID bands must be checked every day that the baby remains an in-patient by the Midwife or delegated other, and recorded in the case notes
- g) If a baby is found with one or both ID bands missing the Midwife must quickly replace the missing ID bands following the principles outlined above.
- h) Parents should be advised not to remove the ID bands until they (and / or the baby) have been discharged and arrive home.

6.8.2 Babies in Neonatal Units

- a) All babies in the Neonatal Unit will be labelled with labelled with two printed ID bands containing the following information:



Figure 5: Neonate standard white wristband

I. Baby's S Number

- II. **Twin/Triplet 1/11/111** if applicable – this will print on the ID band until baby name entered on Patient Centre/HISS
 - III. **Mother's surname** is printed in uppercase, followed by the baby's forename. If baby has not yet been named 'Baby' is printed.
 - IV. **DOB** Using the short format 'DD-Mmm-YYYY'
 - V. **Sex** (M/F)
 - VI. **Baby's NHS Number** All babies are registered with an NHS Number at birth.
- b) A baby must be registered on Patient Centre/HISS before a wrist band can be handwritten or printed**
- c) Until a band is able to be printed, this information is to be hand written in black ink by the neonatal nurse caring for the baby.
 - d) The presence of the ID bands must be checked every day that the baby remains an in-patient by the Neonatal Nurse, or delegated other, and recorded in the case notes
 - e) Should it be necessary to remove ID bands (e.g. very premature baby requiring intensive care) one should remain attached to the baby (e.g. on the baby's hat) and one must be taped securely onto the side of the cot / incubator, and should be replaced as soon as possible.
 - f) If a baby is found with one or both ID bands missing the Neonatal Nurse must quickly replace the missing bands following the principles outlined above.
 - g) Parents must be advised not to remove the ID bands until they (and / or the baby) have been discharged and arrive home.
 - h) ID band is to be printed from E3 (Euroking 3) if this system is down then staff must handwrite a name band and apply a new one as soon as possible
 - i) For babies where a name band cannot be applied e.g. very premature babies requiring Intensive care a name band must be securely taped to the side of the cot / incubator. If the baby is removed from the incubator then an ID band must be attached to the baby, on their hat if they are unable to tolerate wearing a band at this time

6.8.3 Babies, Children and Young Children

- a) All babies, children and young people nursed in the Trust will be labelled with an ID band applied to their non-dominant hand or limb. (in babies under the age of one year ID bands must be applied to lower limbs only)
- b) When undertaking a clinical procedure / intervention or needing to confirm the patient identity the details on the ID band should be verified by the child, parent or carer by asking them to confirm their full name and date of birth.
- c) Should it be necessary to remove the ID band (e.g. premature baby or older child requiring intensive care) they must be taped securely onto the side of the cot/bed, and should be replaced as soon as possible.
- d) If a baby, child or young person is found without an ID band the Nurse must quickly replace the missing bracelet checking the details with a parent/carers or a member of staff previously involved in caring for the child.

- e) Parents/carers must be advised not to remove the ID band until the baby, child or young person have been discharged home from the ward/unit.

6.8.4 Patients with an Unknown Identity admitted to the Emergency Department (ED)

- a) Patients with an unknown identity admitted to ED will be given a unique S Number which must be written onto their ID band along with 'Unknown'. This number must be used on all charts and test / investigation requests.
- b) The registered professional responsible for the patient's care within ED will liaise with the Police and Ambulance service to make every effort to obtain the patients identity.
- c) As soon as the patient's identity is confirmed all records must be updated with the correct details and ID band applied to the patient.
- d) In the event of a major incident where several patients of an unknown identity may be admitted to ED then the procedures for identifying patients set out in the Major Incident plan must be followed (available on INsite)

6.8.5 Deceased Patients

- a) Deceased patients require two ID bands, one placed on the deceased's right wrist, and one on their right ankle. It is acceptable for one of these to be their current ID band. If the right limbs are missing, place ID band on the left limbs.
- b) Patient ID bands are not printed specifically for deceased patients e.g. Date/Time of death not included on the printed band, therefore these details must be hand written using black ink on ID Band
- c) See Last Offices Policy for further information (Trust Reference B28/2010)

6.9 Patients who are unable or refuse to wear an identity band

- a) For patients who cannot wear an identity band because of their clinical condition or treatment, e.g. multiple intravenous lines, dermatological conditions/ treatments consider placement of the identity band on a lower limb if possible.
- b) Alternatively, it is possible to attach two or three bands together to enable attachment above IV lines on a limb.
- c) If a patient can not / will not wear an identity band, a local risk assessed checking procedure to confirm the patient's identity must be put in place.
- d) Patients who refuse to wear an identity band, despite clear explanation of the risks of not doing so, will be asked to give their full name, date of birth and address, and their wishes must be documented in the case-notes and an incident form completed.

7 EDUCATION AND TRAINING REQUIREMENTS

- 7.1 There are no specific training requirements for the implementation of this policy. All staff must be informed of their roles and responsibilities in relation to patient ID bands as part of their local induction.
- 7.2 Staff Information is available on INsite (staff intranet):
 - Patient Wristbands web page (user guide, frequently asked questions, how to order stock) <http://insite.xuhl-tr.nhs.uk/patientwristbands>

- Use the S Number web page (guidance, resources and materials)
<http://insite.xuhl-tr.nhs.uk/snumber>

8 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Method	Frequency	Reporting arrangements
Datix Incidents of Misidentification due to no ID band	Sisters / Managers of all Clinical Departments	Incident Reports	As reported	Escalated to Matron or Head of Nursing as per Incident reporting procedures

9 EQUALITY IMPACT ASSESSMENT

- 9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
- 9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

10.1 References

National Patient Safety Agency (2005) **Safer Practice Notice 11 Wristbands for Hospital inpatients improve Safety**, NPSA

National Patient Safety Agency (2007) **Safer Practice Notice 24 Standardising Wristbands improves Patient Safety**, NPSA

Health and Social Care Information Centre (HSCIC website for definitions of inpatient, outpatient and daycase) <http://www.hscic.gov.uk/>

10.2 Policies

Blood Transfusion Policy (Trust reference B16/2003)

Incident And Accident Reporting Policy (Trust reference A10/2002)

Ionising Radiation (Medical Exposure) Regulations 2000 Policy (Trust reference B26/2019)

Last Offices Policy (Trust Reference B28/2010)

Policy for Documenting in Patients' Health records (Trust ref B30/2006)

Policy for the identification and management of allergy or suspected allergy to latex in patients and staff (B29/2005)

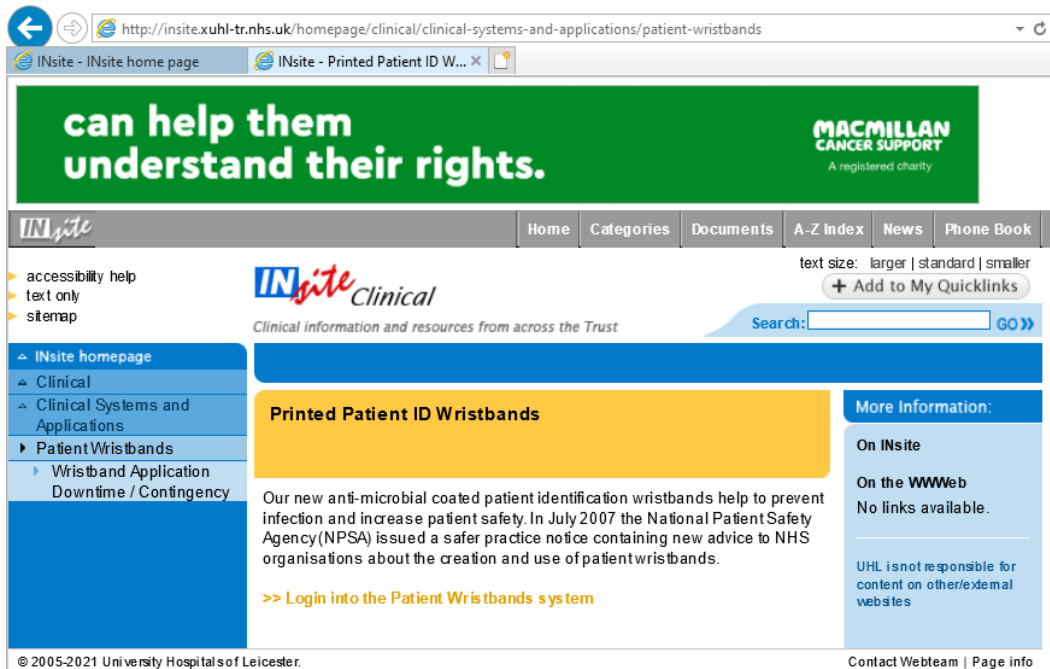
Safer Surgery Policy (Trust reference B40/2010)

11 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

- 11.1 This document will be uploaded onto the Trust's Policy & Guideline Library (PAGL) and will be available for access by staff. The policy is also accessible via the Trust's Freedom of Information publication scheme on the external website.
- 11.2 This document will be reviewed every three years, or sooner in response to reported risks or incidences

INsite pages:

<http://insite.xuhl-tr.nhs.uk/homepage/clinical/clinical-systems-and-applications/patient-wristbands>



The screenshot shows a web browser window with the URL <http://insite.xuhl-tr.nhs.uk/homepage/clinical/clinical-systems-and-applications/patient-wristbands>. The page features a green banner at the top with the text "can help them understand their rights." and the Macmillan Cancer Support logo. Below the banner is a navigation menu with links for Home, Categories, Documents, A-Z Index, News, and Phone Book. The main content area is titled "Printed Patient ID Wristbands" and contains the following text: "Our new anti-microbial coated patient identification wristbands help to prevent infection and increase patient safety. In July 2007 the National Patient Safety Agency (NPSA) issued a safer practice notice containing new advice to NHS organisations about the creation and use of patient wristbands." A link is provided: ">> Login into the Patient Wristbands system". A sidebar on the left contains a navigation menu with links for accessibility help, text only, and sitemap. A search bar is located at the top right of the main content area. The footer of the page includes the copyright notice "© 2005-2021 University Hospitals of Leicester." and the contact information "Contact Webteam | Page info".