

**IDENTIFICATION OF PATIENTS
 FOR MEDICINE ADMINISTRATION AND CLINICAL THERAPY
 POLICY**

**This policy should be read conjunction with the Recording, Videoing and
 Photography Policy**

Version	4
Ratified by:	Senior Managers Operational Group
Date ratified:	May 2016
Title of originator/author:	Joint: Senior Nurse for Clinical Practice and the Information Governance and Records Manager
Title of responsible committee/group:	Caldicott and Information Governance Group
Date issued:	May 2016
Review date:	April 2019
Relevant Staff Group/s:	All Somerset Partnership staff who need to check patient identification as part of their role

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DOCUMENT CONTROL

Reference LP/Dec/11/PID P	Version 4	Status Final	Author Joint: Senior Nurse for Clinical Practice and the Information Governance and Records Manager
Amendments	Revised integrated policy for community and mental health and social care		
Document objectives: This document will inform Trust staff on the requirements for positively identifying patients. The intention is to reduce identification errors when administering medication and any clinical therapy.			
Intended recipients: All Somerset Partnership staff who need to check patient identification as part of their role			
Committee/Group Consulted: Caldicott and Information Governance Group;			
Monitoring arrangements and indicators: Monitoring will be by the Caldicott and Information Governance Group			
Training/resource implications: General awareness for all Trust staff. Specifically all in-patient staff to understand Data Protection implications of this policy.			
Approving body and date	Clinical Governance Group		Date: April 2016
Formal Impact Assessment	Impact Part 1		Date: TBC
Ratification Body and date	Senior Managers Operational Group		Date: May 2016
Date of issue	May 2016		
Review date	April 2019		
Contact for review	Information Governance and Records Manager		
Lead Director	Director of Governance and Corporate Development		

CONSULTATION LIST Key individuals involved in developing the document

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1. INTRODUCTION

- 1.1 This policy aims to ensure that all patients under the care of Somerset Partnership are correctly identified in order to receive the medication or treatment intended for them. Misidentification of patients is one cause of administration of medicines errors.
- Eliminating errors in the matching of patients with their care is central to improving patient safety. Three main types of errors can occur:
- a patient is given the wrong treatment as a result of a failure to match them correctly with samples, specimens or X-rays
 - a patient is given the wrong treatment as a result of a failure in communication between staff or staff not performing checking procedures correctly
 - a patient is given the wrong treatment as a result of a failure to identify him or her correctly

2. PURPOSE AND SCOPE

- 2.1 This policy applies to all patients under the care of Somerset Partnership
- 2.2 This policy covers:
- Positive identification of patients
 - The use of Wristbands
 - The use of Photographic ID
 - Situations where either of the above are indicated, but cannot be used

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has a duty to care for patients receiving care and treatment from the Trust.
- 3.2 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 Chief Nurse.
- 3.3 The **Director of Nursing, Therapies and Patient Safety** is responsible for this policy, but will delegate authority for the overall implementation and ongoing management of this policy to the Leads of Services this policy applies to.
- 3.4 The **Information Governance lead** is co-author of this policy and is responsible for the annual review and presentation of the updated policy to the Caldicott and Information Governance Group.
- 3.5 The **Caldicott and Information Governance Group** will monitor this policy.

3.6 **Ward, Clinical and Departmental 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
- Undertaking a bi-annual audit within their areas of responsibility, to monitor ongoing compliance with this policy
- Implementing any required actions or additional training to address any areas of non-compliance, as identified by the audit
- Implementing any required action as identified through adverse incidents and near misses

3.7 **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 online adverse incident reporting form in accordance with the Trust Policy for the Reporting of Adverse Incidents and Near Misses, for any instances of misidentification or refusal to wear, or loss of, an ID band

3.8 **Clinical Audit Department**

The Department is responsible for collating the results of the bi-annual audit and producing a report on that audit, to support onward reporting to the Trust Board, Caldicott & Information Governance Group and the Patient Safety Group

4. **PROCEDURES**

General Requirements

4.1 All inpatients regardless of the setting must have either a wristband or photo ID.

All patients receiving blood transfusions must have a wristband in situ

All patients receiving general anaesthetic must have a wristband in situ

Where it is known that the patient has an allergy or intolerance to any drug or other substance, the wristband must be RED or the Photo ID should be marked with a red pen line or stick-on red spot. The nature of the sensitivity must be recorded in the appropriate sections of the patient record and Medicines Administration Record, and brought to the attention of others involved in the patient's care.

Any wristband from another healthcare provider must be removed as soon as a patient is transferred to a Somerset Partnership ward, and replaced with a Somerset Partnership wristband.

Wristbands or photo ID **do not** remove the clinician's responsibility for checking patient identity. They are an important way of validating identification, particularly when a patient is unable to provide their own details. Therefore it is the responsibility of any clinician caring for the patient to ensure that the patient is wearing an identification wristband or has a photo ID or, clear written evidence in the patient's notes why this does not occur.

Positive Identification

See Appendix A for the flowchart for this process.

- 4.2 All staff must positively identify a patient prior to delivery of care or treatment. Whenever a patient is transported from/to a ward or department for investigations or treatment, positive patient identification must take place and be confirmed by a member of staff responsible for the care of the patient. The receiving area should confirm the identification of the patient through measures outlined in this policy.
- 4.3 On admission to hospital/each attendance at a clinic or each visit to a patient's home, it is the responsibility of the admitting/visiting clinician to positively identify the patient. For patients who are unable to verbally confirm their own identity, confirmation may be gained from relatives, carers or clinical staff transferring the patient.
- 4.4 Patient information stored in the patient's records should be used in conjunction with other methods to positively identify patients including the checking of information on the wristband or photo ID.
- 4.5 Verbal measures may include asking the patient to state their full name and date of birth (this can then be checked against details in the notes). *NB: Under no circumstances should staff relate these details to the patient and then ask the patient to confirm them.*

Where a patient is not previously known to a practitioner and the patient is unable to communicate their identity and no relatives are available to do this, the identity details must be checked with another member of staff if possible. In a patient's home, other means of identification may be necessary such as checking details on the nursing record, or prescribed medication.

Wristbands

See Appendix B for the flowchart for this process.

It is the admitting clinician who is responsible for applying the identity wristband to the patient on admission. The admitting clinician will:

- ensure the identification wristband contains the minimum and correct information
- check the information is correct with the patient or relative
- place the identification wristband on the patient's writing or dominant arm (where practicable)

- Ensure the patient understands the importance of wearing the identity wristband and gain the patient's consent. This may necessitate the use of a professional interpreter to ensure they are able to give informed consent (in line with the Professional Interpreter and Translation Services Policy). Where the patient lacks capacity the principles of working in the patients' best interest must apply. Please see the Consent and Capacity to Consent Policy for more information. Any discussions about consent must be documented in the patient's record. Please refer to section 6 if a patient refuses or is unable to wear a wristband.
 - Document in the patient's record that a wristband has been applied.
- 4.6 All identity wristbands must be printed directly from the electronic patient record using printers provided for that purpose. The wristbands produced from the wristband printers must be legible, durable and display authentic patient information.
- 4.7 The minimum identification parameters required on an identification wristband are:
- unique patient hospital number
 - forename
 - surname
 - date of birth
 - NHS Number (if the NHS number is not immediately available, a temporary number should be used until it is)
- 4.8 Any change in minimum details (eg. change of patient date of birth) should be recorded onto the Electronic Patient Record, as soon as the change is known and a new wristband printed as required.
- 4.9 The patient must wear an identification wristband throughout their inpatient stay. Any member of staff that discovers an inpatient does not have a wristband must assume responsibility for correctly identifying them, and ensuring a wristband is applied.
- 4.10 If the identification wristband is removed at any time during the patient's stay, it is the responsibility of whoever has removed it to ensure it is replaced.
- 4.11 Should the Electronic Patient Record not be functional, a temporary written wristband should be used. This must include the minimum identification parameters outlined in section 5.10. It is the nurse or clinician responsible for caring for the patient to replace the written wristband with a printed one as soon as the Electronic Patient Record is functional

Wristbands can be removed by staff on the patient's discharge, or if preferred by the patient, left on for them to remove. If the patient is to receive ongoing care in their home from Somerset Partnership staff, the wristband may be left in place with the patient's consent.

Photographic Identification

Please see the Recording, Videoing and Photography Policy for more information. See Appendix C for the flowchart for this process.

All staff recording audio, video or taking photographs of patients must be registered to do so – see the Recording, Videoing and Photography Policy for more information on this process

- 4.12 In every case, photographs must only be taken after informed written consent has been obtained. The only exception to this would be if a patient was unconscious or unable to give consent. Please see the Recording, Videoing and Photography Policy, Appendix D, for the consent form.

Photo Identification (photo ID's) will only be held and used for the current care episode. The photo ID will form part of the patient's record, and is subject to the Data Protection act and can be disclosed as part of the record if such a situation arises. On discharge from the service the patient will be given the option of retaining the photograph themselves, otherwise it will be confidentially destroyed in a safe and secure manner. The handing-over or destruction of the photograph will be recorded in the electronic health record of the service user.

- 4.13 Staff must ensure that the photographs are not:

- Taken when the service user objects to the photo being taken,
- To be used for any other purpose excepting the circumstances set out in the section above.

- 4.14 The nursing staff on duty at the time of admission/first visit will take the patient's photograph using appropriate photographic equipment supplied for the purpose. (Please refer to the Recording, Videoing and Photography Policy for more details). If using a digital camera the digital image should be erased immediately following the printing of a single hard copy of the photo. The patient should be informed of this and it should be noted within the patient's record.

- 4.15 If the camera used stores a negative this should be destroyed or handed to the patient once a single hard copy of the photograph has been made for identification purposes. Again this should be explained to the patient and a note made within the patient's record.

- 4.16 The photograph will be updated if the patient's features change significantly during admission, e.g., grow beard or change hair style (long to short etc.), so that the image held is accurate.

- 4.17 For inpatients the photograph will be attached to the front of individual's prescription or a copy of the case record screen from the patients EPR (if electronic prescribing is in place). These would then be held in a folder in the clinic room. In people's homes, the photograph will be kept with the patient's hand-held record.

The security of photo ID's is the responsibility of the nurse-in-charge of the area where the service user and photos are held.

Where the patient objects to the photo being taken or the patient withdraws consent, the nurse-in-charge is responsible for ensuring a note is made within the electronic health record to that effect.

5 PROCEDURES FOR IDENTIFICATION OF INPATIENTS REFUSING OR UNABLE TO WEAR WRISTBANDS OR AGREEING TO BEING PHOTOGRAPHED

- 5.1 A local risk assessment must be undertaken to formally assess the risks associated with identifying inpatients:
- who cannot wear a wristband because of their clinical condition or treatment (eg. multiple intravenous access lines, dermatology conditions and treatment)
 - who refuse to wear a wristband despite clear explanation of the risks of not doing so
 - who may or may not be wearing a wristband but who are critically ill, unconscious, confused or cannot communicate
 - who refuse to have a photograph taken
- 5.2 Measures to safeguard identification of patients in the absence of the wristband/photo ID should be recorded in a risk management plan, and documented in their record. Where necessary, the identification wristband may be placed around an ankle.
- 5.3 If the patient has any objections to the wearing of an identification wristband or have a photograph taken, the nurse must ensure, wherever possible, the patient is informed of the risks. Any communication issues should be addressed to ensure the patient, parent or guardian fully understands, e.g., an interpreter may be necessary. An alternative method of identification should be discussed if more appropriate. The patient's preference should be documented in the patient's record. The patient's Doctor should be informed.
- 5.4 Where a patient is not previously known to a practitioner and the patient is unable to communicate their identity and no relatives are available to do this, the identity details must be checked with another member of staff.
- 5.5 Non-verbal measures may include using a photograph or other picture, or through identification and recording of two or more different types of distinguishing features. Alternatively two completed wristbands could be attached to different sites on the bed or garment the patient is wearing.

6. PATIENT IDENTIFICATION INCIDENTS

- 6.1 If misidentification of a patient occurs, the safety of the patient is paramount. If any treatment has been given, where necessary action should be taken to make the patient safe and minimise harm. The appropriate medical practitioner must be informed immediately. A DATIX must be completed. The patient should be made aware of the error as soon as possible after the event.
- 6.2 In all cases of a patient receiving incorrect treatment, a root cause analysis must be undertaken.

6.3 It is the responsibility of any member of staff who discovers an issue with a patient's identification, such as incorrect information on a wristband, or no appropriate patient identification in place, to report the incident or near miss by completing a DATIX. It is the responsibility of the member of staff discovering the problem to ensure appropriate identification methods are put into place or to ensure they have communicated this to the nurse in charge.

7. DECISION-MAKING IN MENTAL HEALTH INPATIENT SETTINGS

7.1 Where it is necessary to make decisions under this policy that might:

- breach patient confidentiality (including release of the photograph in the limited circumstances according to law which are described above),
- involve decisions about the use of photo ID in the best interests of an incapacitated patient.

7.2 Such decisions should be made through multi-disciplinary team discussion, where possible. These discussions should consider:

- balancing the clinical risks, including hidden risks such as the patient disengaging from treatment through a perceived lack of trust in clinicians
- the broader interests of the safety of the public
- any less restrictive alternatives available

7.3 Team discussions should be fully documented within the electronic patient record and should include the consideration of alternative courses of action and the views of team members who did not agree with the overall eventual decision.

7.4 Where a patient lacks capacity and the team cannot come to a unanimous decision regarding identification a Datix incident form should be completed, detailing the incident and the circumstances that led to the decision. A Datix incident form should also be completed where a photo has been disclosed in one of the limited circumstances permitted within this policy (see 2.5).

7.5 Where the decision is made to:

- (i) release a photograph within one of the limited circumstances permitted under paragraph 2.5; or
- (ii) the patient lacks capacity and the team are unable to come to a unanimous decision regarding identification. These decisions should be communicated to the Medical Director in his role as Caldicott Guardian as soon as possible. He will ensure that the matter is reviewed and discussed at the next Caldicott and Information Governance Group as an "Information Governance Incident".

7.6 Where there is a dispute as to further action between multi-disciplinary team members that cannot be resolved then the matter should be escalated to the Medical Director in his role as Caldicott Guardian, or in his absence to either:

- The Director of Mental Health and Social Care Services, or
- The Director of Nursing and Patient Safety, or
- The Director of Finance and Business Development.

- Out of hours this role will be taken by the Senior Manager on-call who will escalate the matter to the Director on-call.

7.7 Where it is deemed clinically necessary to look at alternatives to photo ID, wristbands should be considered as the next alternative. The facility to print these is available on Older Peoples' inpatient wards, and other inpatient wards may seek assistance from these clinical areas with the production of wristbands where it is necessary.

8. TRAINING REQUIREMENTS

8.1 Processes, including this policy, are included in the Corporate Induction Programmes and local induction for all clinical and non-clinical staff

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

8.3 Ward, clinical and departmental managers will ensure that any additional training highlighted as required by the bi-annual audit is implemented

8.4 General awareness of the Data Protection Act is available through the SOMPAR Information Governance eLearning.

9. EQUALITY IMPACT ASSESSMENT

9.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 This policy will be monitored by the Caldicott and Information Governance Group. All audits, complaints, feedback and DATIX incidents related to this policy will be monitored by this group. Any shortfalls, action points, lessons learnt, and feedback will be shared with the relevant Best Practice Groups and disseminated through the Trust newsletter – 'What's on @ Sompar'.

Key Performance Indicator	Lead Responsible for Audit	Evidence	Reviewed by / Frequency	Lead Responsible for any Required Actions
100% compliance with the requirements of patient identification	Ward, clinical, departmental managers	Report of audit of 10 patients in each area	Patient Safety Working Group annually	Heads of Nursing coordinated by Head of Patient Safety

11 COUNTER FRAUD

- 11.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

12. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 12.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 20:	Duty of candour

- 12.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 11:	General
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- 12.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

Relevant National Requirements

National Patient Safety Agency (2005) – Safer Practice Notice 11: Wristbands for hospital inpatients improves safety, London.

National Patient Safety Agency (2007) – Safer Practice Notice 24: Standardising wristbands improves patient safety, London.

National Patient Safety Agency (2004) - Right patient - right care

National Patient Safety Agency (2006) - Safer Practice Notice 14: Right patient, right blood

National Patient Safety Agency (2009) Guidance on Safer Patient Identifiers

13. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

13.1 References

Data Protection Act 1998

Department of Health (2003) – Building a safer NHS for patients, improving medication safety

Department of Health (2001) – Building a safer NHS for patients, Implementing an organisation with a memory

Department of Health, National Audit Office (2005) – A safer place for patients: Learning to improve patient safety

Health Service Circular 2001/023 Model Consent Policy.

The Human Rights Act 1998, Article 8

NMC (2015) Code of Conduct, Nursing & Midwifery Council, London.

NHSE (1999) The Caldicott Committee: Report on the review of patient identifiable information – December 1997. NHSE, Leeds.

Nurses and Midwifery Council: Standards for Medicine Management February 2008

World Health Organisation (2007) – Patient Identification, Patient Safety Solutions Vol. 1

13.2 Cross reference to other procedural documents

Being Open and Duty of Candour Policy

Admissions, Transfer and Discharge Policy

Confidentiality and Data Protection Policy

Consent and Capacity to Consent to Examination and/or Treatment Policy.

Development & Management of Organisation-wide Procedural Documents Policy and Guidance

Learning Development and Mandatory Training Policy

Medicines Policy

Privacy, Dignity and Respect Policy

Record Keeping and Records Management Policy

Integrated Care Planning Approach (ICPA) Policy

Risk Management Policy and Procedure

Staff Mandatory Training Matrix (Training Needs Analysis)

Untoward Event Reporting Policy and procedure

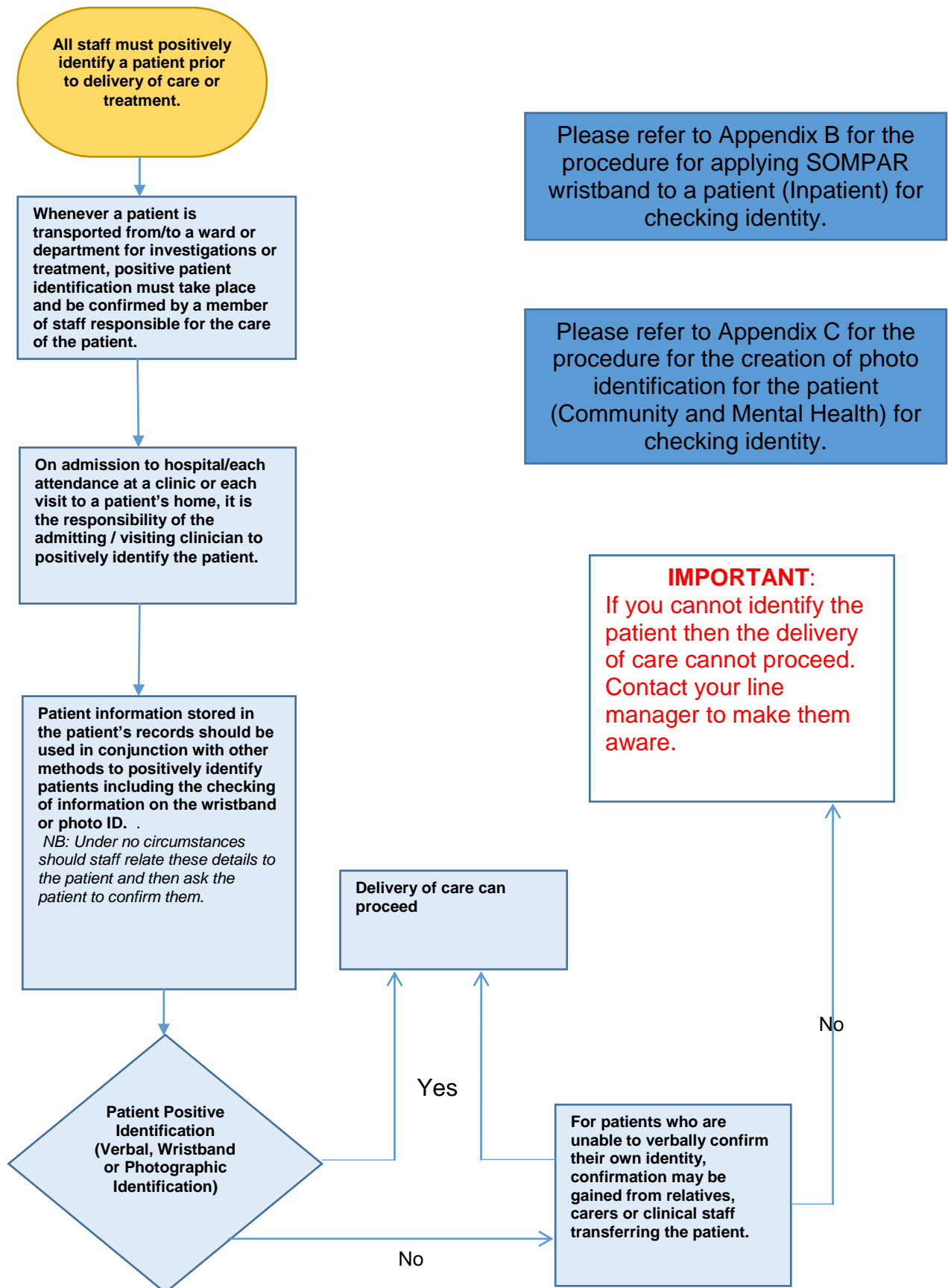
All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

14. APPENDICES

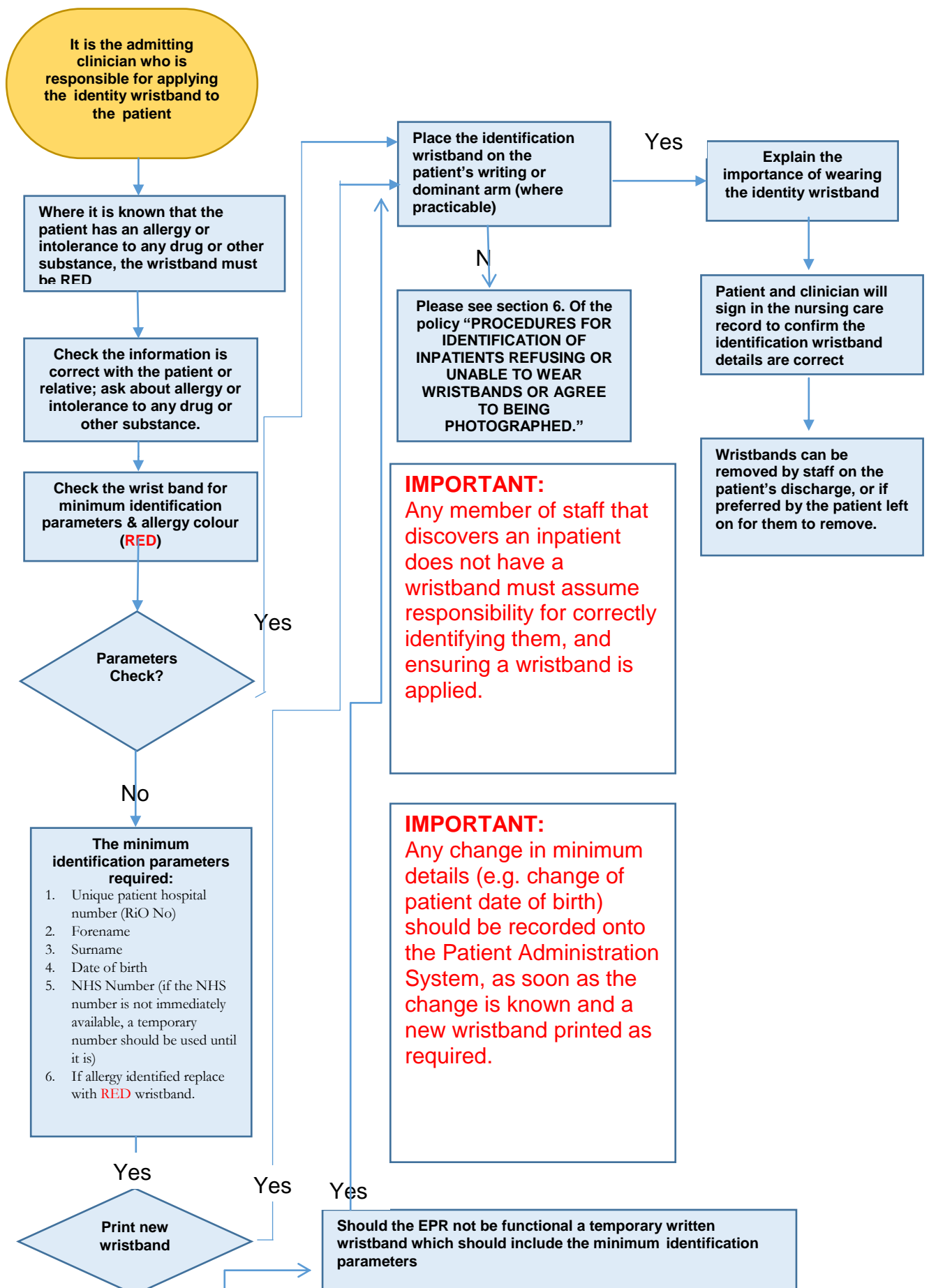
14.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

- Appendix A Positive identification before delivery of care
- Appendix B Procedure for applying wristband to patient (Inpatient)
- Appendix C Procedure for photographic identification
- Appendix D Audit Standards

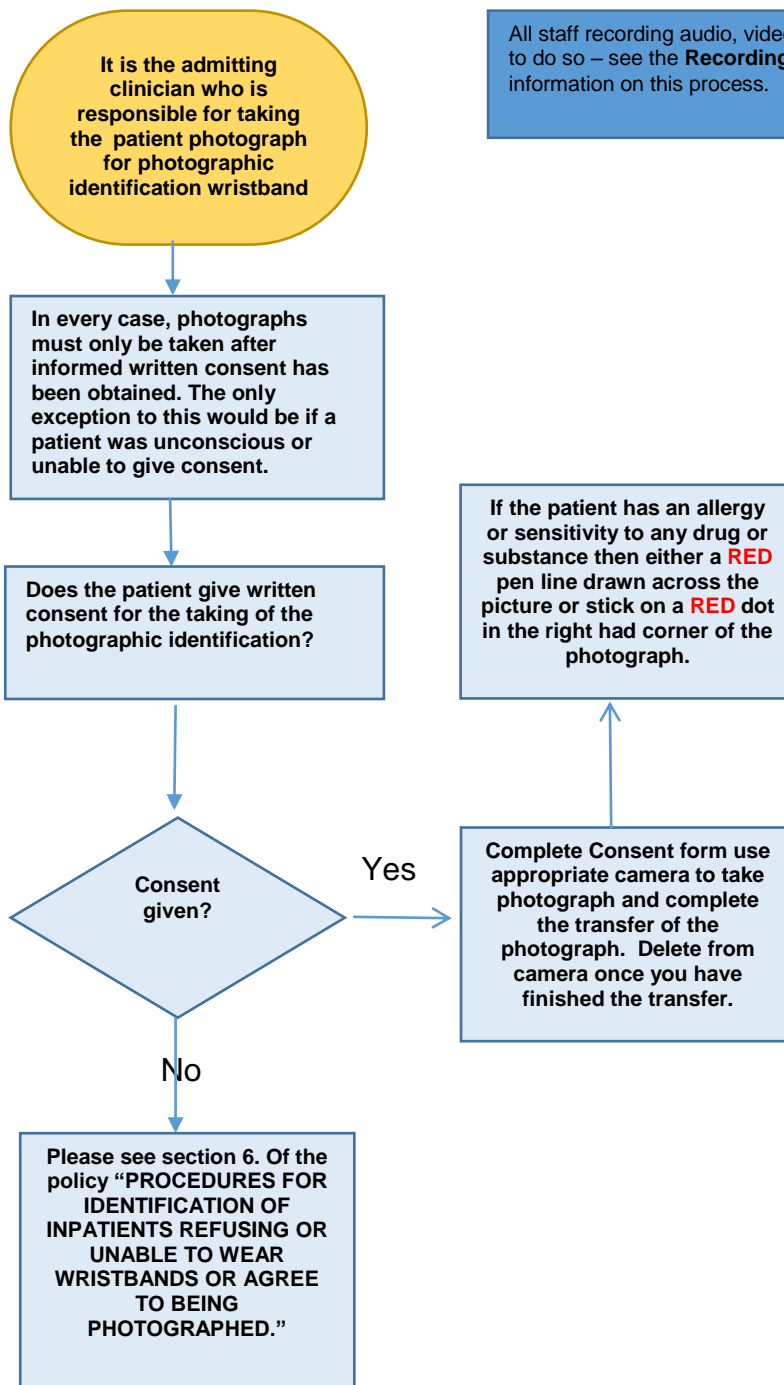
Positive Identification before Delivery of Care.



Procedure for applying wristband to patient (Inpatient)



Procedure for Photographic Identification.



All staff recording audio, video or taking photographs of patients must be registered to do so – see the **Recording, Videoing and Photography Policy** for more information on this process.

IMPORTANT: Photo Identification (photo ID's) will only be held and used for the current care episode. On discharge from the service the patient will be given the option of retaining the photograph themselves, otherwise it will be confidentially destroyed in a safe and secure manner. The handing- over or destruction of the photograph **will** be recorded in the electronic health record of the patient.

