Alder Hey Children's NHS
NHS Foundation Trust

RM25 – PATIENT IDENTIFICATION POLICY

Version:	9
Ratified by:	Clinical Quality Steering Group
Date ratified:	08/07/2014
Name of originator/author:	Margaret Chowdhury
Name of responsible committee:	Senior Nurses Forum
Name of Executive Sponsor:	Director of Nursing
Key search words:	ID, Identification, labelling, sample, misidentification, sampling, RM25
Date issued:	July 2014
Review date:	July 2017

Quick Reference Guide – Patient Identification Policy

Please refer to the full policy for further guidance.

This policy applies to all staff involved in patient identification and specimen labelling.

The objective of the policy is to ensure all patients are correctly identified and receive the correct treatment. Failure to correctly identify patients constitutes serious risk to patient safety,

On admission (or on arrival at an outpatient clinic / A&E / Ward) the patient will be checked onto the meditech system by the clerk / nurse. The clerk / nurse will check identity details with the patient / parent / legal guardian or transferring nurse (patient's name, date of birth and address). Details will be checked against the patient notes.

Wristband ID

Two wristbands will be produced on meditech by the admitting nurse and placed on the patient. Wristbands must be applied on two opposing limbs unless the clinical condition or treatment dictates otherwise.

Mepitac ID

When wristbands are not appropriate, patients must be identified with two strips of mepitac: The admitting nurse should cut two strips of mepitac and write patient details in black ink (name, date of birth, NHS number / AH number and known allergy).

Photograph ID

When mepitac is not appropriate, patients should be identified by a photograph. Photographs should be taken in the presence of a parent /carer who can identify the patient. The admitting nurse should write name, date of birth, NHS number / AH number on the photograph ID, along with the date when the photograph was taken. The name and signature of the person talking the photograph should be written on the photograph ID. A copy of the photograph ID should be attached to the medical record, prescription sheet and cot / bed.

Allergies

Red wristbands should be given to patients with known allergies. The admitting nurse should write patient details in black ink (name, date of birth, NHS number / AH number and known allergy). If the patient has multiple allergies the band should state 'multiple allergies please see casenotes'

Ongoing identity checks

Staff are responsible for continual checking to reduce the risk of misidentification or inaccurate information documented on the patient's wristbands.

Before any significant intervention or procedure is carried out in any area, it is the responsibility of the member of staff undertaking the intervention or procedure to check the patient's identity with the patient or their legal guardian. If any of the information is found to be incorrect, it is the responsibility of the member of staff discovering this to correct the situation, and report this as an incident on Ulysses.

Specific Patient Groups:

A&E

Patients do not require a wristband unless they are receiving high risk treatment. For those patient brought into A&E unaccompanied and / or in extreme emergency situations, clinical care may take priority over attaching identity bands.

Community patients

Out-patients will not be issued with wristbands. Identification will be sought verbally prior to administration of medicine or delivery of care by a health professional. The health professional must check the patient identity verbally with the patient / parent / carer, checking their full name, date of birth and the purpose of the proposed care delivery. These details must be checked against the patient's records.

Internal transfers

Receiving staff member must check the patient wristbands with patient / parent / legal guardian or transferring nurse, along with the medical notes for positive patient identification on arrival to the ward.

External transfers

Patients transferred from elsewhere should have their identity confirmed upon admission by the receiving nurse. Patients transferred direct to surgery (Park & Ride) should be admitted and their identity checked by the accepting theatre team.

PICU retrievals

Before carrying out any procedures / interventions the retrieval team must check the patient's identity by checking the wristbands and patient notes. Identity must also be confirmed with the referring hospital or parent / carer.

Neonatal patients

Identity bands should be attached to each ankle. If wristbands are inappropriate, mepitac should be positioned on two opposing limbs

Multiple siblings / children with same names

Twin / multiple birth infants must have their identity bands differentiated with their first names wherever possible. Alternatively labelled Twin 2, Triplet 3 etc. Caution stickers with 'Caution, there is another patient with the same name' must be used on notes and medication charts where it is known that there is another child with the same name.

Theatre patients

It is the responsibility of the member of staff who meets the patient prior to admission to theatres to check the patient's identity with the nurse transferring the patient to theatre, patient / parent / carer and patient's notes.

Deceased patients

For patient who have died within the Trust or outside and taken direct to the mortuary, please see section 5.10.

Requests for interventions

All requests for interventions such as x-rays, medications, blood tests or other specimens should be correctly labelled with the patient's full name, date of birth and NHS number / AH number. In the event that specimens are incompletely / incorrectly labelled, the requested tests will not be performed until the specimen is labelled correctly.

Incident Reporting

Any incidents (or near misses) that have occurred as a result of misidentification must be reported on Ulysses.

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
9	July 2014	Margaret Chowdhury	Current	
8	December 2011	Head of Nursing – Medical	Archived	Changed to CBUs
7	August 2010	Head of Nursing – Medical	Archived	Policy updated following NHSLA audit. Changes include nurses clerking in patients when a clerk is not present, changes made to bodies brought into the Trust, inclusion of park and ride patients and the use of caution stickers with multiple siblings
6	January 2010	Head of Nursing – Medical	Archived	Patients now required to have 2 wristbands at all times. Amendments to Section 5 Patient Identification Process, Section 7 Process for the ongoing checks throughout the patient care episode, Section 9 Patient Misidentification. Appendix A Procedure and Appendix B Flow Chart for Process of Patient Identification
5	July 2008	Head of Nursing - Medical	Archived	
4	July 2006	Risk Manager	Archived	
3	December 2005	Risk Manager	Archived	
2	May 2005	Risk Manager	Archived	
1	May 1997	Unknown	Archived	

Record of changes made to Patient Identification Policy – Version 9			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Converted to new Policy Template.	New Template introduced
5.2	10	Clarification of requirements for wristbands in A&E	Unclear in previous policy
Appendix A 2.4	21	Update to information about taking photographs for patient ID	Digital camera has replaced polaroid camera.

Contents

1 Introduction

1.1 Patient misidentification is increasingly being recognised as a widespread problem within healthcare organisations. Failure to correctly identify patients constitutes a serious risk to patient safety. The National Patient Safety Agency (NPSA) [1] has recognised patient identification as a significant risk within the NHS.

1.2 The Trust recognises that the accurate identification of patients is a vital component in the management of patient safety. The consequences of not doing so can be disastrous for patients and have serious repercussions for the Trust. Therefore correct patient identification and application of patient wristbands is an essential part of the care process.

1.3 The Trust will ensure, so far as is reasonably practicable, that all patients are adequately and correctly identified and matched to their records, requests, prescriptions, results and all other documentation.

1.4 To ensure that the correct patient receives their planned treatment, patients will be positively identified by either wearing a personal identification wristband, wearing Mepitac or the positioning of photograph ID, which must be checked prior to undertaking any procedure.

1.5 Objectives

i. To ensure that all patients are correctly identified
ii. To ensure all patients receive the correct treatment

2 Purpose

2.1 To inform staff of the policy and procedure involved in patient identification and specimen labelling.

2.2 Policy Statement

It is the policy of Alder Hey Children's NHS Foundation Trust that patients can be identified correctly at all times in the absence of their parent/carer.

3 Definitions

3.1 Mepitac

This is a silicone based tape that can be applied to any area of the body.

3.2 **Patient Groups**

i. **Inpatients**

Patients who have been admitted onto a ward within the Trust.

ii. **Outpatients**

Patients who do not reside within the Trust but are treated here usually through an outpatient clinic.

iii. **Neonatal Patients**

Patients who are 4 weeks old or younger.

iv. **Internal Transfer Patients**

Patients who have been transferred internally between wards/departments.

v. **External Transfer Patients**

Patients who have been transferred into Alder Hey Children's NHS Foundation Trust from another hospital or a patient who is being transferred from Alder Hey Children's NHS Foundation Trust to another hospital.

vi. **Community Patients**

Those who receive care in a variety of settings including clinics, health centres, own home and residential home.

vii. **Theatre Patients**

Patients who attend theatre whilst in our care.

viii. **Multiple siblings**

These patients represent twins, triplets etc.

ix. **Deceased Patients**

Patients who have died both within the Trust and outside of the Trust.

3.3 **PICU**

Paediatric Intensive Care Unit at Alder Hey Children's NHS Foundation Trust.

4 Duties

4.1 **Trust Board**

i. Is ultimately responsible for ensuring that all patients are correctly identified.

4.2 **Service Managers / CBU Lead Nurses / CBU Clinical Directors**

i. Ensure that all staff are aware of and adhere to this policy and that the resources required to implement this policy are available.

ii. To undertake an audit adherent to this policy on a regular basis.

4.3 **Senior Nurse in Charge**

i. Ensure all inpatients on their ward are wearing approved forms of identification at each shift.

ii. Ensuring that staff in their areas are aware of and understand the policy and that it is implemented into practice locally.

iii. Ensuring that failures to comply with the policy are reported via the Trust Incident Reporting System (Ulysses), and the appropriate action is taken to prevent a recurrence.

iv. Investigate failures to comply with the policy and ensure corrective action is taken to prevent a recurrence.

4.4 **Medical, Nursing and Allied Health Professionals**

i. All staff involved with the clinical care of patients are responsible for ensuring that all patients can be correctly identified.

ii. Nursing staff are responsible for checking patient details onto the Meditech system on arrival to the ward, in the absence of a clerk; this would also include ensuring the information is correct and up to date.

iii. All staff involved with the clinical care of patients are responsible for ensuring that they are aware of and adhere to this policy.

iv. All staff involved in the clinical care of patients need to ensure that children with known allergies are clearly identified, by the application of two red name bands, or clearly written in red on the approved alternative form of identification (photographic or mepitac).

v. All staff involved in obtaining specimens need to ensure that the specimen is labelled against the correct patient.

vi. Ensuring that all patient details entered by them onto electronic or hard copy records or wristbands are valid and accurate.

vii. Ensuring that any wristband removed by them (or where more appropriate, another member of staff) is replaced immediately

and that that the information on the replacement wristband is valid and accurate. If immediate replacement is not possible then it is the responsibility of the member of staff to make clear alternative arrangements for the patient's correct identification.

viii. Any member of staff discovering a patient who does not have two wristbands has to assume responsibility for correctly identifying them.

ix. In general it will be nursing staff who will be responsible for the generation and application of the patient wristbands. However it is the responsibility of all staff to check the validity and accuracy of patient identification before carrying out any actions relating to patient care.

4.5 **Ward Clerks/Clinic Clerks/A&E Reception Clerks**

i. Ensure patients are checked onto the Meditech system on arrival.

ii. Ensure all information on the system is correct and up to date.

4.6 **All staff**

i. Reporting all failures to comply with the policy via the Trust Incident Reporting System (Ulysses).

5 Process for Identifying all Patients

5.1 Patient Identification Process

i. Accurate patient identification starts with the patient's first contact with the service and it is the responsibility of all staff involved in the admission, clinical and administrative processes to ensure correct details are obtained and recorded and that any inaccuracies or queries are highlighted and dealt with.

ii. On admission (or arrival at an outpatient clinic/A&E/Ward) the patient will be checked onto the Meditech system by the clerk/nurse. As a minimum the clerk/nurse will check with the patient/parent/legal guardian or transferring nurse, the:

- patient's name
- patient's date of birth
- patient's address

In the absence of the parent or legal guardian the details must be checked with the transferring nurse immediately on arrival to the ward. Details must be checked again once parent(s) or legal guardian arrive to ensure validity.

iii. If the patient already exists within the system the clerk/nurse will check these details with the information already held on Meditech and update if necessary.

iv. For new patients these details will be entered onto Meditech and a new Alder Hey number will be created for the patient.

v. These details will be checked with the patient/parent/carer by the admitting nurse and against the patient notes. Two wristbands will be produced (A&E and outpatients **will not** receive wristbands – see section 5.2) and placed on the patient. See appendix B for the procedure for creating and applying wristbands. For exceptions on wearing a wristband please see section 6.

vi. **Before any significant intervention or procedure is carried out in any area, it is the responsibility of the member of staff undertaking the intervention or procedure to check the patient's identity with either the patient or their legal guardian.**

5.2 **A&E Patients**

i. The Health Care Professional (HCP) caring for the patient will confirm patient identification by asking the patient/carer/legal guardian for the patient's name, date of birth, address and checking these details against those in the patient's notes.

ii. **A&E patients do not require a wristband unless they are receiving high risk treatment** i.e. ketamine, opiates or intravenous drugs. If the patient is receiving such treatment two wristbands will be produced and applied to the patient. The wristbands will be checked by the HCP carrying out the procedure prior to any intervention.

iii. For those patients who are brought into A&E unaccompanied and/or in extreme emergency situations, clinical care may take priority over attaching identity bands to the patient. Where this has occurred, the nurse responsible for the patient's care must take appropriate steps to confirm the patient details and attach two wristbands as soon as the immediate emergency situation is over.

5.3 **Internal Transfer Patients**

i. When an internal transfer occurs, the receiving staff member must check the patient wristbands with the patient/parent/legal guardian, or transferring nurse, along with the medical notes for positive patient identification on arrival to the ward.

ii. If it is found that the information on the wristbands is incorrect, the wristbands are missing or not readable then it is the responsibility of the member of staff discovering this to remedy the situation, reapply the amended wristbands and report this on the Trust's Incident Reporting System (Ulysses).

5.4 External Transfer Patients

i. Patients who have been transferred to Alder Hey Children's NHS Foundation Trust should have their identity confirmed upon admission by the receiving nurse. Children who are transferred direct to surgery as in a "Park and Ride" patient should be admitted and their identity checked by the accepting theatre team.

ii. The admitting nurse must remove any existing wristbands and carry out the patient identification process as described in section 5.1 above – this will also include "Park and Ride" patients whose wristbands should be printed as part of the admission process, prior to surgery.

iii. For any patient who is being transferred out of the Trust to another Trust the nurse caring for that patient must ensure that the patient is wearing two Alder Hey Children's NHS Foundation Trust wristbands on transfer. These wristbands must be checked against the patient's records.

5.5 PICU Retrieval Patients

i. Before carrying out any procedures/interventions the retrieval team must check the patients' identity by checking the wristbands and patients notes. Identity must also be confirmed with the referring hospital or parent/carer.

ii. On arrival to PICU the admitting nurse must remove any existing wristbands and carry out the patient ID process as described in section 5.1 above.

5.6 Neonatal patients

i. Neonates must be identified as any other patient would be. Two wristbands should be produced (see appendix B) and attached one to each ankle.

ii. If wristbands are inappropriate, neonates should be identified using two strips of mepitac (see appendix B) positioned on two opposing limbs.

5.7 **Multiple Siblings/children with same names**

i. Twin/multiple birth infants must have their identity bands differentiated by being completed with their first names whenever possible (the use of names should be encouraged). Alternatively, they are labelled 'Twin 2', 'Triplet 3' etc.

ii. Caution stickers with 'Caution, there is another patient with the same name' must be used on notes and medication charts where it is known that there is another child(related/unrelated) with the same name.

5.8 **Community Patients**

i. Due to the variety of community settings, and in order to ensure patient safety, it is paramount that the identity of the patient is confirmed prior to administration of medicine or delivery of care by the health professional.

ii. Within this setting identification will be sought verbally. Community patients will not be issued with patient wristbands

iii. The HCP must check the patient identity verbally with the patient/parent/carer checking their full name, their date of birth and the purpose of the proposed care delivery. These details must be checked against the patient's records prior to administration of medication or care.

5.9 **Theatre Patients**

i. When a patient is to be admitted to Theatres it is the responsibility of the member of staff who meets the patient prior to admission to Theatres to check the patient's identity with the:

- Nurse transferring the patient to theatre
- Patient/parent/carer
- Patient's notes

ii. **If a patient is found to have only one name band in place, it is the responsibility of the person in charge of the patient at that time to replace the second name band.**

iii. If wristbands are to be removed in theatre, then Mepitac should be used as an alternative form of identification until such a time that the wristbands can be replaced.

5.10 **Deceased Patients**

Died Within the Trust

i. The patient's identity should be confirmed with the health records and identity bands as part of the verification of death process.

ii. All deceased patients must be properly identified with two identity bands, on opposing limbs i.e. (one on the right wrist and one on the left ankle where possible).

iii. In the event of the patient's name not being known, the identity band must state unknown male / female.

iv. A Mortuary card, which is kept in the Bereavement Care Pathway folder, should be placed on the torso area prior to the child being wrapped in a sheet and transferred to the mortuary.

v. In the mortuary, when identification is confirmed, a small white card is marked with patient name/location and placed on the door of the "cold store" by the Mortuary Staff.

Died outside of this Trust and taken direct to the Mortuary

i. On direct arrival to the mortuary i.e. brought in dead, the body must be identified by the accompanying person e.g. undertaker or police. The mortuary register or body acceptance form must be completed and two wristbands, produced and applied by that person.

ii. If the patient is unknown they are identified as 'unknown 'on the wristbands until a relative or next of kin can make positive patient identification. A mortuary technician shall then apply new replacement wristbands.

iii. Once identification is confirmed a small white card is marked with patient name/location and placed on the door of the "cold store" by the Mortuary Staff.

6 Exceptions to the Application and Removal of patient wristbands

6.1 A&E patients, community patients and outpatients are exempt from wearing wristbands (see Section 5.2 & 5.8).

6.2 There are some rare and exceptional situations where a patient cannot wear a wristband, or the wristband needs to be removed, for example:

- A clinical condition or treatment e.g. burns patients, intravenous lines or dermatology conditions and treatment
- Refusal to wear a wristband despite clear explanation of the risks of not doing so to patient/parent/carer
- Allergy to the wristband
- Long term/respite care patients (these include Transitional Care Unit and Dewi Jones patients)

6.3 These patients should be identified by mepitac strips or photographs. Please see appendix A and B for the procedure.

7 Process for the ongoing checks throughout the patient care episode

7.1 In order to minimise the risk of patient misidentification, checks of the patient's details against those contained on the wristbands must be continuously made throughout the patient episode.

7.2 **Before any significant intervention or procedure is carried out it is the responsibility of the member of staff undertaking the intervention or procedure to check the patient's identity with either the patient or their legal guardian.**

7.3 If it is found that the information on any of the wristbands is incorrect and there is a need to amend any of the details, then it is the responsibility of the member of staff discovering this to remedy the situation, reapply the amended wristbands, and report this on the Trust's Incident Reporting System (Ulysses).

7.4 If a wristband has been removed for a clinical procedure or for some other purpose, then it is the responsibility of the person who removed the wristband to reapply one.

7.5 If it is found that the patient does not have two wristbands or if one or both of the wristbands has fallen off, then it is the responsibility of the member of staff discovering this to correctly identify the patient, remedy the situation and report this using the Trust's Incident Reporting System (Ulysses). The same process is to be followed as when identifying a patient upon admission.

8 Requests for Interventions

8.1 Correct identification of patients undergoing interventions relies on accurate patient information. Positive identification of patients is necessary (but not exclusive to) in the following situations:

- Any clinical assessment (history taking or examination)

- Blood letting/blood sampling.
- Blood transfusion.
- Collecting of patient bodily fluid samples.
- Confirmation of death.
- Administration of all medicines.
- Surgical intervention and/or any invasive (diagnostic or therapeutic) procedure.
- Therapeutic interventions.
- Transport/transfer of the patient.
- X-Rays and imaging procedures.
- Diagnostic interventions in Neurophysiology.

8.2 All requests for interventions such as x-ray, medications, blood tests and other specimens should have the following patient identification markers:

- Name (first and family)
- Date of birth
- NHS Number(when no NHS number is available the Alder Hey Number will remain the default number)

8.3 In the event that specimens are incompletely/ incorrectly labelled, the requested tests will not be performed until the specimen is labelled correctly by the person who obtained the specimen. This is in accordance with the standard operating procedures for laboratories. Any incomplete or incorrect labelling incidents should be reported via the Trust Incident Reporting System (Ulysses).

9 Patient Misidentification

9.1 Any incidents that have occurred as a result of misidentification and also ‘near miss’ situations where the error has been detected before an incident has taken place must be reported via the Trust Incident Reporting System (Ulysses).

9.2 If an error occurs, for example, a patient receives the wrong medication, the wrong investigation or procedure are carried out, an incorrect result reported; all appropriate actions must be initiated to remedy the error.

9.3 Any actual error must be explained to the patient/parent/legal guardian. The patient/parent/legal guardian should be kept fully informed of the action the staff have taken and any necessary future action. (Please refer to the Trust’s Being Open Policy).

9.4 If an error occurs the person in charge of the area such as the ward manager will be responsible for managing the error. The incident must be investigated, and consideration given as to whether more senior action needs to be taken. This will depend on the nature of the error

and seriousness of the outcome. The manager will discuss necessary action with their line manager.

10 Training

10.1 Patient identification is a fundamental part of patient care and, as such, must be included in many aspects of staff training and development throughout the organisation. This policy will be incorporated into local training programmes, along with Induction for all clinical staff.

10.2 If specific training needs are identified then the ward manager should ensure this is provided at a clinical level using this policy as training material.

11 Consultation, Approval and Ratification Process

11.1 This policy was circulated to ward managers, staff nurses, service managers, lead nurses and theatre managers during development.

11.2 The policy was approved by the Senior Nurses Forum in July 2014 prior to ratification by the Clinical Quality Steering Group on 08/07/2014.

12 Equality and Diversity

12.1 The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. The policy should be implemented with due regard to this commitment

No potential for differential impact has been identified for any specific equality group in relation to this policy. If evidence of adverse impact is identified, actions will be taken, where possible, to address any inequality. This will be done in collaboration with the Trust Equality Leads.

13 Review and Revision Arrangements including Version Control

13.1 This policy will be reviewed by the Patient Flow Manager as required, and no later than July 2017.

14 Dissemination and Implementation

14.1 Dissemination and implementation will take place through the CBU Management Teams, and appropriate executive lead.

14.2 The Policy Administrator will update the intranet and internet, and arrange for new and revised policies to be advertised.

15 Monitoring Compliance with the Effectiveness of Policy

15.1 Compliance with this policy will be monitored against key performance indicators as shown in the schedule below:

Key performance indicators	Schedule of monitoring	Monitoring conducted by whom	Form of monitoring	Findings of monitoring reported to
Process for identifying all patients (section 5)	Bi-yearly from issue of the policy	Clinical Audit Department	Audit	Clinical Quality Steering Group
Process for ongoing checks throughout the patient care episodes (section 7)	Bi-yearly from issue of the policy	Clinical Audit Department	Audit	Clinical Quality Steering Group
Procedure to be followed in cases where patient misidentification occurs (section 9)	Bi-yearly from issue of the policy	Clinical Audit Department	Audit	Clinical Quality Steering Group

15.2 The findings from this monitoring programme will be reported to the Clinical Quality Steering Group. An action plan will accompany the report, should any deficiencies in the compliance of this policy be identified. Implementation of any action plans will be monitored by the Clinical Quality Steering Group.

The Clinical Quality Steering Group reports to the Clinical Quality Assurance Committee, therefore providing board assurance.

15.3 Additional monitoring required

i. Monthly compliance with patient identification audits is submitted via ward managers to the CBU Lead Nurses through ward quality indicators.

ii. Observations of care of inpatients, outpatients, x-ray and haematology to establish that positive identification, in accordance with this policy, is undertaken. This will be part of the annual Trust wide audit of inpatients.

iii. Annual Trust audit to identify compliance with this policy will be undertaken by Lead Nurse and the clinical audit department. The audit will comprise of observations of care for outpatient areas in conjunction with a Trust wide inpatient review.

iv. Review of incident reports relating to patient identification and sample mislabelling is reported annually and forms part of the quarterly report to the Clinical Quality Steering Group.

v. Deficiencies identified from annual audit/report will be reported immediately to the ward managers for action by the CBU Lead Nurses.

vi. Where monitoring has identified deficiencies, an action plan will be drawn up, implemented and reported to the Clinical Quality Steering Group.

vii. Quarterly compliance reports will be fed back at CBU Ward Managers meetings to discuss outstanding deficiencies at local level, this is to be owned by Ward Managers.

16 References

National Patient Safety Agency

17 Associated Documentation

The Management of Incidents, including the Management of Serious Critical Incidents Policy – RM2

Being Open (When things go wrong) Policy – RM47

Blood and Blood Transfusion Policy – C1

Medicines Management Policy – C37

Alder Hey Children's NHS Foundation Trust Mortuary Standard Operating Procedure HP SOP-0042 - Specimen reception and release of deceased children (including high risk cases) and body parts.

Appendix A **Procedure**

1 Identification Methods

1.1 Patients should be issued with the following:

- 2 printed wristbands (there are 2 sizes; white bands are small and yellow wristbands are larger). Please select appropriate size.
- 2 red written wristbands for any patient with a known allergy

1.2 When wristbands are not appropriate patients must be identified with two strips of mepitac.

1.3 When mepitac is not appropriate patients should be identified by a photograph.

2 Producing Identification

2.1 Printed Wristbands

i. All yellow and white wristbands should be produced on Meditech by the admitting nurse following the procedure below:

How to print Meditech Wristbands

1. Log into Meditech and select the option on your menu called **Patient ID Tools Menu**.

   (If you cannot see this on your menu then please call the ServiceDesk on #6444)

2. At the **Patient** prompt identify the patient using one of the methods shown.

3. Once you have selected a patient you will be prompted to confirm your selection with a pop up box as shown here.

4. At the **Print On** prompt type the name of the required wristband printer. The printer should have a sticker on the front with its name. Please ensure you select the correct printer for the size of wristband you are printing.

NOTE: The printers are named in the format: **<location>WA** for adult size
<location>WP for paediatric size
where **<location>** is the name of the ward or department.

An F9 lookup is also available at the **Print On** prompt.

ii. The details on both wristbands must be checked against the patients' notes by the admitting nurse. The patient/parent/legal

guardian should confirm the full name and date of birth of the patient.

iii. The wristbands must be applied to the child on two opposing, limbs unless the clinical condition or treatment dictates otherwise (i.e. cannula in both arms, burns to the skin (please see section 6.2 of the policy) When placing wristbands they must be visible and accessible at all times. For children under twelve months: position bands on left arm and right leg. For children over twelve months: place on left and right wrists.

iv. The wristbands must not be removed until the discharge procedure is completed. The discharging nurse should cut the wristbands off and dispose of them in the confidential waste bin.

v. If either/both of the patient wristbands are removed, faded, damaged or unreadable, replacement wristbands MUST be applied immediately, by the nurse caring for the patient.

2.2 **Hand Written Wristbands**

i. Red wristbands given to patients with known allergies are the only wristbands that should be handwritten. Each patient must have two red wristbands (these patients do not need to have the white wristbands). They should be handwritten in black ink by the admitting Nurse and should contain the patients':

- First / given name
- Surname/family name
- Date of birth
- NHS number
- Known Allergy (if the patient has multiple allergies the band should state "multiple allergies please see case notes".)

ii. All known allergies **MUST** be documented in the patients' notes.

iii. The details on both wristbands must be checked against the patients' notes by the admitting nurse. The patient/parent/legal guardian should confirm the full name and date of birth of the patient.

iv. The wristbands must be applied to the child on two opposing, limbs unless the clinical condition or treatment dictates otherwise (i.e. cannula in both arms, burns to the skin (please see section 6.2 of the policy)).

v. The wristbands must not be removed until the discharge procedure is completed. The discharging nurse should cut the wristbands off and dispose of them in the confidential waste bin.

vi. If either/both of the patient wristbands are removed, faded damaged or unreadable, a replacement wristbands MUST be applied immediately, by the nurse caring for the patient.

2.3 **Mepitac**

i. When wristbands are not appropriate Mepitac can be used as a form of identification. The admitting nurse should cut two strips of mepitac. The mepitac strips should be written on in black ink by the admitting Nurse and should contain the patients':

- First / given name
- Surname/family name
- Date of birth
- NHS number (or Alderhey number if NHS number is not appropriate)
- Known allergy (only if the patient has an allergy and cannot wear the red wristbands. If the patient has multiple allergies the band should state "multiple allergies please see case notes".)

ii. If the patient has any allergies these MUST be documented in the patients' notes by the admitting nurse.

iii. The details on both strips of mepitac must be checked against the patients' notes by the admitting nurse. The patient/parent/legal guardian should confirm the full name and date of birth of the patient.

iv. The mepitac strips must be applied to the child on two opposing, limbs unless the clinical condition or treatment dictates otherwise (i.e. cannula in both arms, burns to the skin (please see section 6.2 of the policy).

v. The mepitac must not be removed until the discharge procedure is completed. The discharging nurse should remove the mepitac strips and dispose of them in the confidential waste bin.

vi. If either/both mepitac strips are removed, faded damaged or unreadable, a replacement strip will be applied immediately, by the nurse caring for the patient.

2.4 **Photographs**

i. The admitting nurse should arrange for a photograph of the patient to be taken in the presence of the parent/carer who can identify the patient. If the department has a digital camera, the photograph can be taken by the nurse, or the Medical Photography Department should be contacted to take the photograph.

ii. Photographs can be printed by the Medical Photography Department with patient identification details pre-printed on the bottom of the photograph.

iii. All digital images should be deleted from the camera after they are printed, and should not be saved electronically.

iv. The admitting nurse should include the first name and surname of the patient, date of birth and NHS number (when no NHS number is available the Alder Hey Number will remain the default number) on the photograph, along with the date when the photograph was taken. The name and signature of the person taking the photograph should also be written on the back of the photograph. Where photographic ID sheets are used (eg Dewi Jones at Alder Park), the photograph should be glued to the Photographic ID sheet and the patient details recorded on the sheet, rather than the photograph itself.

v. The admitting nurse should attach a copy of the photograph ID to the patient's medical record, prescription sheet and the cot/bed.

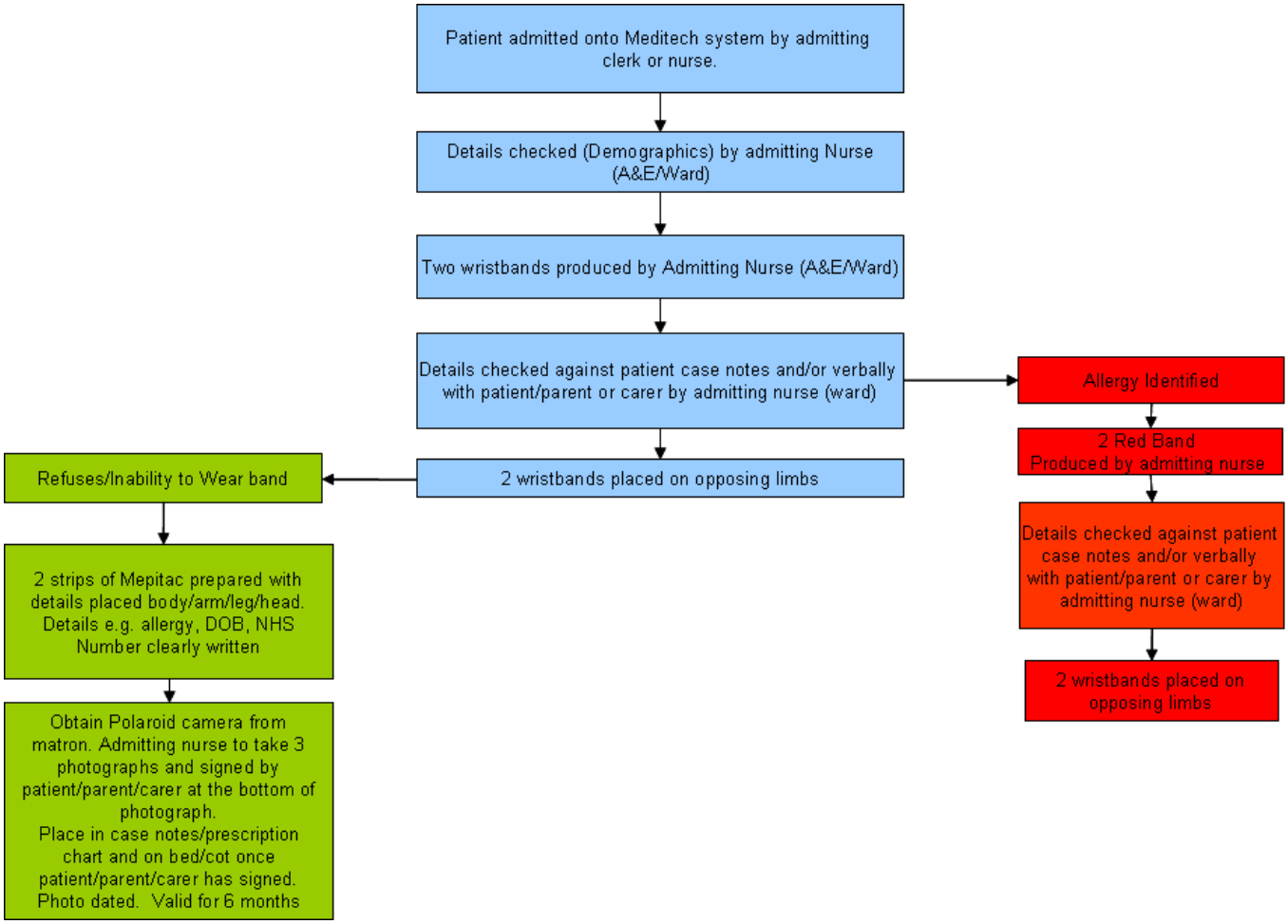
vi. Photographs are valid for 6 months only. If the photograph has expired (was taken over 6 months ago) the admitting nurse should issue a new photograph following this procedure and dispose of the outdated photograph in the confidential waste.

vii. The details on the photograph ID must be checked against the patients' notes by the admitting nurse. The patient/parent/legal guardian should confirm the full name and date of birth of the patient.

viii. The photographs must not be removed until the discharge procedure is completed. The discharging nurse should remove the photographs from the cot/bed, prescription charts and the patients' notes and dispose of them in the confidential waste. **For long term patients' photographs within the medical records and prescription sheets should not be removed.**

ix. If any of the photographs are removed, faded damaged or the text is unreadable, replacement photographs must be applied immediately, by the nurse caring for the patient.

Appendix B Flow Chart for Process of Patient Identification



Appendix C User Feedback Form

Please use this form to provide any feedback on policies, guidelines, SOPs or Care Pathways. This feedback will be used to improve the Procedural Documents used by Alder Hey Children's NHS Foundation Trust.

In particular we need to know if:

- **There are any sections you did not understand**
- **There are sections that are unclear in relation to process or roles and responsibilities**
- **Sections you would like to be added**
- **There are any practical issues in relation to implementing a procedural document**

Document Name: _____

Comments:

Your Name: _____

Department: _____

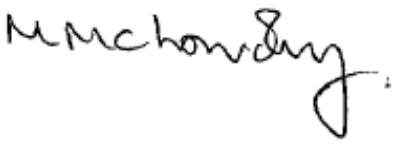
Contact Number: _____ **Date:** _____

Please return this feedback form to Elvina White, Care Pathways, Policy and Guidelines Manager, Clinical Governance Department, 1st Floor Mulberry House.

Appendix D - Checklist for the Review and Approval of Policy

	Patient Identification Policy	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Has the potential for differential impact on specific equality groups been considered (and appropriate action taken to mitigate any adverse impact, where required?)	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	

	Patient Identification Policy	Yes/No/ Unsure	Comments
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Margaret Chowdhury	**Date**	July 2014
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Gill core	**Date**	July 2014
Signature			

Appendix E - Plan for Dissemination of Policy

Title of document:	**Patient Identification Policy**		
Date finalised:	**July 2014**	**Dissemination lead:** *(Print name and contact details)*	**Margaret Chowdhury**
Previous document already being used?	**Yes**		
If yes, in what format and where?	**Electronic on intranet**		
Proposed action to retrieve out of date copies of the document:	**Replace on intranet**		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Format** *(i.e. paper or electronic)*	**Comments:**
All staff	**Via intranet**		

Dissemination Record - to be used once document is approved

Date put on register / library of procedural documents:	**July 2014**	**Date due to be reviewed:**	**July 2017**

Disseminated to: (either directly or via meetings, etc.)	**Format (i.e. paper or electronic)**	**Date Disseminated:**	**No. of Copies Sent:**	**Contact Details / Comments:**