Humber Teaching
NHS Foundation Trust

Patient Identification Policy and Procedure (N-055)

Version Number:	1.5
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Executive Lead (name & job title):	Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals
Name of approving body:	Quality and Patient Safety Group
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*01/12/23 - Quality and Patient Safety Group*
Date EMT as approving body notified for information:	*December 2023*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

Positive patient identification is a process which, when followed, will promote good practice and reduce the risk of misidentification from occurring. Checking a patient's identity should not only take place at the beginning of an episode of care but also at each patient intervention throughout the entire episode to maintain safety.

Failure to correctly identify patients constitutes one of the most serious risks to patient safety. Whilst incidents such as these are considered as unacceptable and eminently preventable, misidentification is not exclusive to the administration of medication. This process should be an integral part of patient care.

This policy and procedure sets out the principles and practices to be used to ensure the correct identity of the patient at all times before undertaking clinical procedures.

2. SCOPE

This policy and procedure support the appropriate identification of people receiving care within all inpatient and community settings including when care is delivered in a patient's home. All clinical staff are required to follow the procedures outlined in this policy and to ensure patient identification is prioritised. Patient identity must be verified on every occasion when staff:

- Admit patient/service user to an inpatient service.
- Make or receive referrals.
- Administer treatment, care intervention or medication.
- Collect a sample or specimen.
- Perform an investigation or examination.
- Undertake a clinical assessment.
- Provide a diagnosis or management plan.
- Provide results.
- Arrange an appointment.
- Transport or transfer patient between services
- Verify a patient death.

3. POLICY STATEMENT

The Trust is committed to maximising patient safety by minimising the potential for preventable harm. This policy is in line National Patient Safety Agency recommendations and NHS England's standards and has been developed to ensure that all patients are positively identified on admission and before any assessment, investigation, treatment or care whilst under the care of Humber Teaching NHS Foundation Trust.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
Responsible for ensuring that a policy for the correct identification of patients and service users is in place and that all staff working in the Trust are aware of this.

Executive Director of Nursing, Allied Health and Social Care Professionals/Caldicott Guardian
Responsible for ensuring mechanisms are in place to ensure nursing and allied health professionals within all services are aware of and comply with the requirements of the policy for the implementation and management of patient identification within all clinical environments.

Divisional Managers and Clinical Leads
Are responsible for ensuring that all staff are aware of and operate within the policy for the identification of ~~in~~patients and services users. They must also ensure staff can order the appropriate equipment to implement and maintain the policy requirements.

Charge Nurses/Unit Managers/Team leaders
Must ensure all staff are aware of and comply with the requirements of this policy.

Must ensure that equipment is available and in working order to support implementation of the policy and procedure. They must also ensure that appropriate systems are in place to monitor compliance with this policy.

The Nurse in Charge of the Ward
The nurse in charge must ensure that on admission the requirements of policy are met and every patient is supported to consider which means of identification they would accept. If the patient declines identification means, this must be documented in the clinical record.

Supplies Team
The supplies team will support the clinical teams to identify, procure and review all resources required to comply with this policy.

All Staff
Will positively identify patients/service users prior to carrying out any clinical procedure or care intervention as outlined in the scope of this policy.
The Trust expects all staff to contribute to its determination to provide safe care and, in doing so, to uphold the statutory Duty of Candour and to meet the responsibilities articulated in their professional standards and in NHS and Trust Values.

5. PROCEDURES

5.1 Establishing Method of Patient Identification

The method of patient identification may differ slightly according to care environment.

Community Wards

Within Humber Teaching NHS Foundation Trust's community in-patient wards, identity bands will be the primary choice of identification.

Mental Health, CAMHS, Forensic and Learning Disability Inpatient Ward/Unit

Guidance from the National Patient Safety Agency (NPSA) advocates the use of identity bands for the purpose of identification in acute inpatient settings but acknowledges that they may not be appropriate in mental health settings. Therefore, within our mental health, forensic, CAMHS and learning disability inpatient units, photographs/images of patients should be the primary choice of identification. Identity bands may provide a second option if the patient declines a photograph/image however this requires risk assessment. Where a photograph is to be used as identification the patient's full name and date of birth will be confirmed with the patient and cross referenced with the patient's records.

On admission a general description of the patient will be documented in the electronic patient record.

Community/Outpatient settings
In a community or outpatient settings (including a patient's home) photographs/images and/or identity bands may not be appropriate however any patient receiving services must be positively identified using as a minimum their full name, and date of birth at each care/clinical intervention. These must correspond with the details on the patient's health record or referral form.

5.2 Consent and the Right to Refuse

Guidance around consent is provided by the Trust in a separate Consent Policy.

Full explanation of the reasons for the use of photographs/images and identity band must be given to the patient and a record made of the discussion in the patient's electronic patient record.

The patient **must** be informed of the potential risks of not agreeing to have their photograph taken or wearing an identification band. However they do have the right to refuse. This discussion and the reason for the patient not having their photograph/image taken or wearing an identification wristband **must** be documented in the patient's clinical record.

The clinical team should identify a plan to address the patient's refusal. This could include for example, liaison with the patient's carer or approaching the patient when appropriate to repeat the request. Treatment must not be withheld if the patient declines to participate in the safe identification procedure; however, the **Safety Pause** must be implemented on all occasions to ensure correct identification.

5.3 Capacity and Refusal

If there is any doubt regarding a patient's capacity regarding making a decision about having a photograph taken or wearing an identity band, an assessment should be completed according to the Mental Capacity Act 2005. This should be documented on the Trust Mental Capacity form and appropriate steps taken in accordance with best interests process if capacity is found to be lacking. Staff should refer to the MCA 2005 & DoLS Policy M-002 for further information. Refer to the Consent Policy.

5.4 The Safety Pause

Prior to the administration of medication or any other treatment that is person specific, staff must undertake the following:

1. Ask the person to confirm their name and date of birth

Where possible:

2. Confirm their identity with the patient photograph/image or identity band or other identifying source

There may be situations due to a patient's mental health or cognitive functioning where the patient misidentifies themselves i.e. provides incorrect details regarding their name and/or date of birth. Where a patient declines, or is unable to correctly confirm their identity, it is essential that a witness who is familiar with the patient is able to correctly identify the person prior to treatment commencing. This may be a family member or carer. A secondary method of identification can be used to confirm a patient's identity where available for example photo identification (i.e., passport/driving license).

Before any procedure is undertaken use the

'Safety pause principal'

Pause; ask the patient or carer their name and date of birth
AND if unsure or unable to provide, find a secondary method of identification

Resources
Each inpatient area should consider any additional equipment necessary to take and print photographs/images and supply identity bands. For users of electronic patient records, the equipment will be computer compatible to allow the image to be taken and uploaded at the same time.

Only the specified equipment for patient identification purposes can be utilised to fulfil the requirements of this policy. The equipment must be held in a locked drawer/cabinet. No personal cameras or phones may be utilised by staff to fulfil Trust procedural requirements.

Supplies will order the agreed Trust camera to meet the requirements of this policy. Supplies will also advise on the identity band specification.

5.5 The Photograph/Image

The photographs/images will be in electronic patient record and available for identification for care planning, medication management and other identification purposes that are compatible with the safe provision of care and the protection and wellbeing of the patient. This does however negate the need to positively identify a patient prior to carrying out care interventions including administration of medication. This should be done by asking the patient to confirm their name and date of birth.

The taking of photographs/images **must not** take place in a public area or compromise patients' privacy and dignity.

The Trust may share these photographs/images with other agencies with the patient's consent, or when it is deemed to be in the public interest for example with the Police in the case of a Missing Person and we cannot gain the patient's consent.

Guidance should be sought from the Information Governance Team/Caldicott Guardian for requests for access to photographs by outside agencies under Section 29 of Date Protection Act.

A head and shoulders photograph/image is sufficient for the use of identification (i.e. passport style). A plain wall as a background is preferable.

The photograph/image should be uploaded immediately to the electronic patient record as described in the Help Guides and deleted from the device desktop.

Patients details (including patient name, date of birth, NHS number), i.e. an addressograph must be attached to the photo to enable patient identification.

Photographs/images should be kept up to date and retaken:

- When someone's appearance changes (e.g. hairstyle/colour, weight change/dental work/facial hair)
- If the patient (reasonably) requests it

A copy of the photograph/image should be given to the patient if they wish to have one. A note should be made in the clinical record that the photograph/image has been taken.

If a patient declines a photo being added to their electronic patient record in inpatient settings the ward-based Pharmacy Technician (or delegated other) will activate the patient photo capture mode by clicking on the camera icon in the top righthand corner of the electronic patient record banner. A photo will then be taken holding up a poster in front of the screen stating "Patient declined photo" which also includes the date of decline. This is to ensure the process of capturing a photo for patient ID purposes can be revisited at a later date if declined at this point.

5.6 Storage and Transport of Photograph/Image

Photographs/images must be kept securely with the person's medicine administration record (MAR) chart, if they have one, and/or clinical record. During transit (e.g. from one clinical area to another) photographs should be hidden from public view to protect privacy and confidentiality and the Trust's Safe Haven Procedure followed. The charge nurse is responsible for developing and monitoring effective systems that assure the security of photographs taken in their area(s).

The member of staff taking the photograph/image is responsible for ensuring that it is fixed to the correct patient's electronic clinical record.

Healthcare records take many forms, including photographs/images. All photographs/images form part of the clinical record when in use. If a person is discharged or transferred, then the photograph/image must be filed in line with the Health and Social Care Records Policy and the principles of good record keeping applied.

5.7 Identity bands

Note the term 'identity bands' has replaced the term wristbands used in the original safety alert (2005), as other types of wristbands have come into use in clinical settings and because identity bands may be worn on other limbs.

ISB 0099: Patient Identifiers for Identity Bands - NHS Digital. "This information standard specifies both the four identifiers that must be included on NHS patient identity bands and the format for presenting them, so that identity information is clear and unambiguous to all healthcare staff. A well-designed identity band based on the standard reduces the risk of misidentification, helping ensure a patient is not given the wrong care and treatment"

As outlined by NHSE Recommendations-from-NPSA-alerts NHSE identity bands should be white with black text and should include the following four core patient identifiers:

- Patient's name (Last name followed by first name)
- Date of Birth
- NHS number.

Details should be checked with the patient by asking them to confirm their full name, date of birth and if known, their NHS number and this will be cross-referenced with the patient's records.

Where identity bands are used, only core patient information should be included as identifiers: surname, first name, date of birth and NHS number.

If the NHS number is not immediately available a temporary number should be used until it is sourced (Safer Practice Notice, 2007).

The information on the identity band should be verified by the patient, their carer or a member of the healthcare team and a note made in the clinical record.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8. IMPLEMENTATION

This policy will be disseminated by the method agreed through the care group clinical networks.

This policy may require additional financial resources to purchase webcams, advice will be included in roll out through each division and replacement equipment advice will be available via procurement.

9. MONITORING AND AUDIT

Compliance with this policy will be monitored locally by ward managers/team leaders and their delegated deputy who will ensure the minimum standard is met.

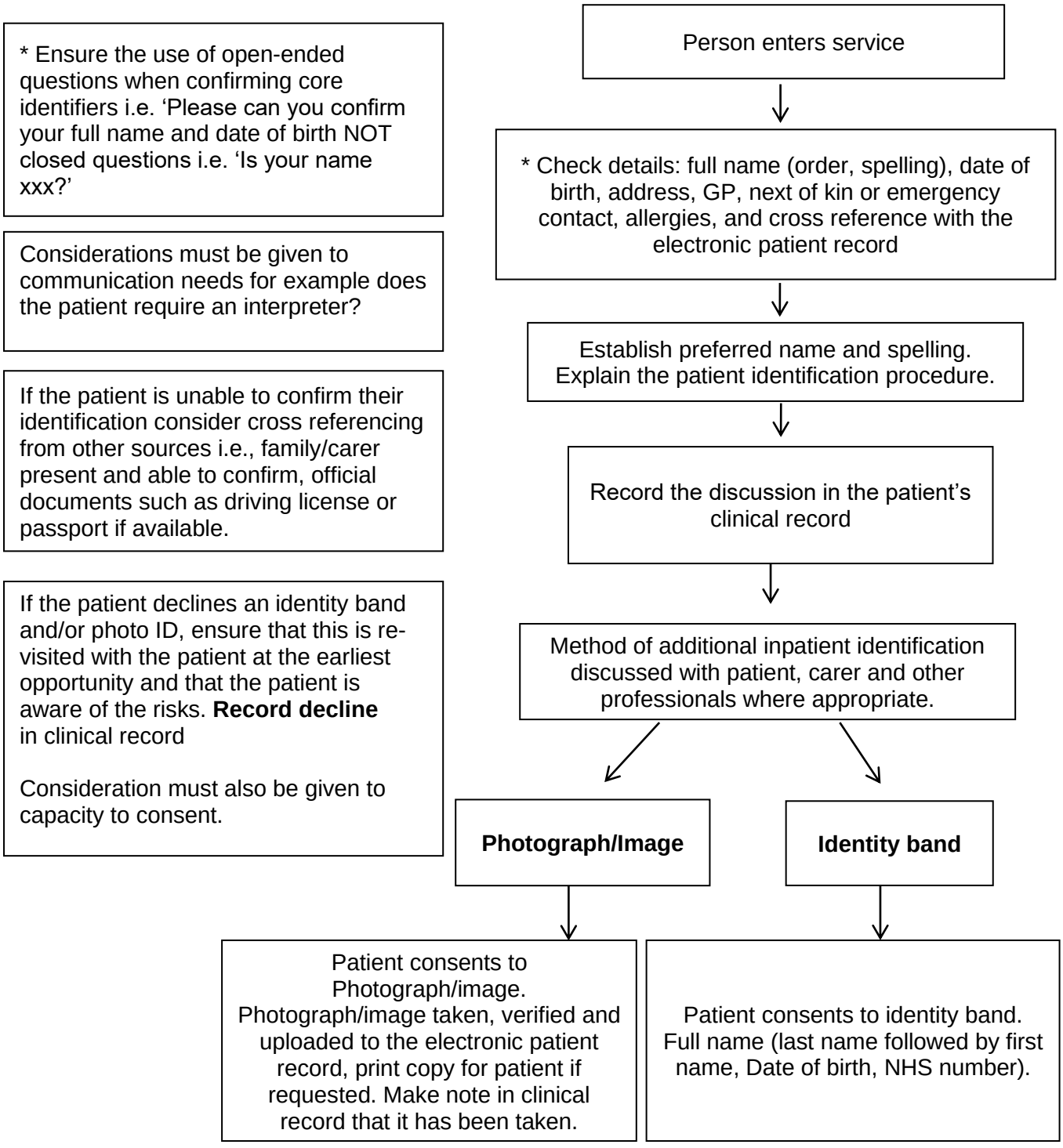
Within inpatient settings monthly audits are undertaken by the pharmacy technicians in respect of photo identification (Safe and Secure Handling of Medicines Procedures Audit). The audit results are automatically sent to the unit managers/leads. Audit results are reviewed by the Medicines Safety Officer to ensure the Trust is complying with legislation/policy and to identify any areas that require improvement.

All patient safety incidents are reviewed by the daily corporate safety huddle.

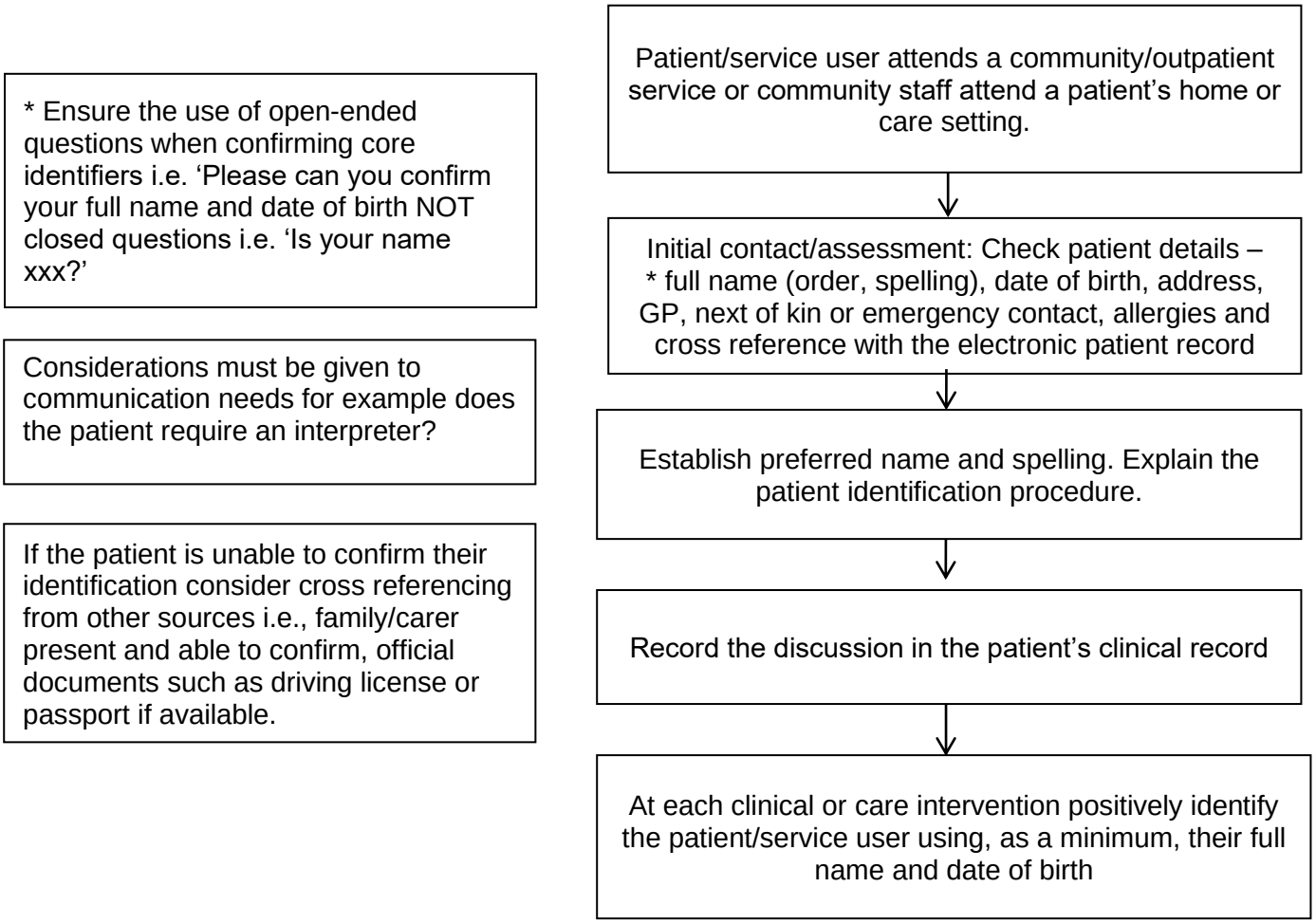
10. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Patient Identifiers for Identity Bands - NHS Data Standards Directory - patient-identifiers-for-identity-bands
ISB 0099: Patient Identifiers for Identity Bands - NHS Digital.
Recommendations-from-NPSA-alerts NHSE
http://www.cqc.org.uk/content/regulation-12-safe-care-and-treatment#guidance

Appendix 1: Flow chart of procedure for inpatient settings



Appendix 2: Flow chart of procedure for community setting including outpatient settings, primary care services, and patient's own home.



Appendix 3: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Patient Identification Policy and Procedure**
2. EIA Reviewer (name, job title, base and contact details): **Sadie Milner**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service:		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	All ages admitted to inpatient units	Low	Will be explained to all people in accessible way and option for opt out will be given along with risk information
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	As above Will be assessed under MCA to support decision making
Sex	Men/Male Women/Female	Low	As above, is not gender specific
Marriage/Civil Partnership		Low	No issues identified,
Pregnancy/ Maternity		Low	No issues identified
Race	Colour Nationality Ethnic/national origins	Low	Recognition of potential barriers to communication and the need to consider interpreter
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	No issues identified, where issues arise with implementation, can be referred back to policy writer, person has option to refuse
Sexual Orientation	Lesbian Gay Men Bisexual	Low	As above
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	As above, person will be treated in line with Trust policy

Summary

This is a universal policy that applies to all clinical settings. In the event that any characteristic requires an alternative response this can be reviewed however options for non-participation are available. This is a patient safety policy and the risks will be explained, it can also be reviewed in light of mental capacity.	
EIA Reviewer: ***Sadie Milner, Patient Safety and Practice Development Lead***	
Date completed: ***October 2023***	Signature: ***S Milner***

Appendix 4: Document Control Sheet:

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Policy – Patient Identification Policy & Procedure		
Document Purpose	This policy sets out the principles and practices to be used to ensure the correct identity of the patient at all times before undertaking clinical procedures		
Consultation/ Peer Review:	Date:	Group / Individual	
List in right hand columns consultation groups and dates	June-22	LD Matron / CAMHS Matron Safeguarding Team	
Approving Committee:	QPaS	Date of Approval:	1st Dec 2023 (minor)
Ratified at:	Trust Board	Date of Ratification:	August 2022
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:	Compliance with this policy will be monitored locally by charge nurses and their delegated deputy who will ensure the minimum standard is met		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New Policy*	*July 2017*	*New policy and procedure* *Approved at Quality and Patient Safety Committee 14 July 2017*
1.1	*Review*	*Jan 2018*	*Minor amends following QPaS – approved January 18 (QPaS)*
1.2	*Review*	*October 2018*	*Minor amend to add infromation regarding adding the patient's name to the back of photographs.* *Approved QPaS October 2018*
1.3	*Review*	*July 2019*	*Minor amendment – added "Refer to Consent Policy" to the end of section 5.3* *Approved QPaS July 21019*
1.4	*Review*	*June-22*	*Reviewed with minor amendments* *Section 4 – update of job role in line with current structure. Amendment to some wording to give clarity* *Approved QPaS Group 13 July 2022*
1.5	*Full review*	*November 2023*	*Full review following action from Serious Incident investigation SI 2023-266 and SEA 2023-03 to remove risk of systematic error. Additional section relating to when and how to add 'patient declined 'to EPR – action from internal audit recommendation. Addition of identification of patient in community and non-inpatient settings. Minor amendments. Approved by QPaS 1st Dec 2023.*