Southern Health and Social Care Trust

Quality Care - for you, with you

Policy on Patient/Client Identification

Lead Policy Author & Job Title:	Grace Hamilton Assistant Director Nursing, Patient Safety ,Quality and Experience
Directorate responsible for document:	Nursing, Midwifery and Allied Health Professionals
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Policy Checklist

Policy name:	**Policy on Patient/Client Identification**
Lead Policy Author & Job Title:	Grace Hamilton Assistant Director Nursing, Patient Safety, Quality and Experience
Director responsible for Policy:	Heather Trouton
Directorate responsible for Policy:	Nursing, Midwifery and Allied Health Professionals
Equality Screened by:	Lisa Houlihan September 2022
Trade Union consultation?	Yes ☐ No ☒
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	
Date approved by SMT:	
Policy circulated to:	Chief Executive, Directors, Assistant Directors, Heads of Service for onward distribution to Lead Nurses and Line Managers, Global Email, Staff Newsletter.
Policy uploaded to:	SharePoint , Trust Website and flyer on all Trust devices

Version Control

Version:	**Version 2**		
Supersedes:	Policy on Patient/Client Identification May 2009		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
Version 1	Original Policy subject to review	March 2009	Fiona Wright, Assistant Director Nursing Service Governance Christine Armstrong, Practice Development Facilitator
Version 2	Objectives and additional policy statements with changes in terminology and responsibilities added. **Appendix 1**- Good Practice in Hospital Settings- HSC record and electronic records. Administration of Blood and Blood Products. The correct ID of neonates and children; Neonatal and Children ID bands. **Appendix 2_**"Good Practice in Community Settings" Photographic ID in learning disability	2022	

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as the "Trust") has a responsibility to act in the best interests and maintain the safety of all patients and clients accessing health and social care and services within its area.

1.2 A key component of maintaining safety and reducing the risks to patients is the ability for staff who are delivering care and treatment to correctly identify each patient or client. Failure to do so correctly constitutes a serious risk to their health and safety which could result in minor or major injury to the patient or client.

2.0 Purpose and Aim

The purpose and aims of this policy are to:

2.1 Ensure that the Trust has in place suitable and robust governance arrangements to support the positive identification of patients / clients prior to treatment and care.

2.2 Support the development of standardised systems and processes to ensure consistency of approach for positive patient / client identification across the Trust where possible.

2.3 Adopt a risk based approach to ensure that the most appropriate methods of patient / client identification are applied to each area proportionate to the relevant risks.

2.4 Ensure that where a major incident has been declared staff should adhere to the guidance set out in the Trusts major incident on the identification of patients and clients.

2.5 Ensure that appropriate levels of monitoring and audit are undertaken.

2.6 Ensure there is clear guidance for staff at different levels in the organisation regarding their responsibilities in relation to the implementation of this policy.

3.0 Objectives

The objectives of this policy are to ensure that:

3.1 Where possible, patients/ clients will be encouraged to wear identification band(s) containing standardised information in order for staff to confirm the unique identity of the wearer (see Appendices 1 & 2).

3.2 If a patient / client is unable to wear an identification band for any reason Trust guidance should be followed (see Appendices 1 & 2).

3.3 Where a major incident has been declared staff should adhere to the guidance set out in the Trust's major incident plan on the identification of patients and clients.

3.4 Inform staff at different levels in the organisation of their responsibilities in relation to implementation of this policy.

4.0 Policy Statements

4.1 The Trust has in place suitable and robust governance arrangements to ensure the correct identification of patients and clients accessing care and services within its area.

4.2 All staff will adhere to a process of positive patient/client identification prior to initiation of each examination, treatment or care.

4.3 Where a major incident has been declared staff will adhere to guidance set out in the Trust's Major Incident Plan on the identification of patient and clients.

4.4 Staff at all levels will be aware of their responsibilities in relation to the implementation of this policy.

5.0 Scope of the Policy

5.1 This policy is applicable to all Trust staff providing care and services to patients and clients within the Trust area.

6.0 Responsibilities

6.1 Chief Executive

The Trust's Chief Executive, as "Accountable Officer" has oversight responsibility for ensuring the aims of this policy are met.

6.2 Senior Management

All Trust Directors and Assistant Directors are responsible for the effective implementation of this Policy and must ensure that suitable arrangements are in place to audit adherence to the Policy.

6.3 Assistant Directors and Heads of Service

Assistant Directors and Heads of Service are responsible for:

- Ensuring the effective implementation of the policy for patients/clients across their respective areas of responsibilities.

- Ensuring that there are suitable arrangements in place to audit adherence to this policy.

- Ensuring that there is a “lessons learned effective system”, to disseminate any learning from untoward events.

6.4 Lead Nurses

All Lead Nurses are responsible for ensuring compliance with this policy across their respective areas.

- Ensuring that all untoward incidents are recorded and reviewed using the Trust Datix system to identify and disseminate any learning.

- Ensuring that there are suitable arrangements in place to audit adherence to this policy.

- Ensuring that there is a “lessons learned effective system”, to disseminate any learning from untoward events.

6.5 Line Managers, Team Leaders, Ward Sisters/Charge Nurses

All staff with line management responsibilities are responsible for:

- Ensuring the induction and awareness of this policy with all new staff within their teams.

- The implementation, monitoring and adherence to the policy at ward/unit/team level.

- Ensuring that there are suitable arrangements in place to audit adherence to this policy.

- Ensuring that all untoward incidents are recorded and reviewed using the Trust Datix system to identify and disseminate any learning.

6.6 All Trust Staff, Bank, and Agency and Locum staff

All Trust staff Bank, Agency and Locum staff employed within the Trust have a responsibility to:

- Adhere to the aims of this policy, the good practice guidance as set out in Appendices 1 and 2 and to comply with any direction necessary to ensure compliance with this policy.

- Challenge non adherence to best practice.

- Complete a Datix form for an untoward or near miss event.

6.7 Responsibility of Patients/Clients and their Carers

- Patients / clients and their relatives/carers have a responsibility to ensure that the correct information is provided on the identification of all patients and clients accessing care and services.

- The Trust cannot be held liable for the actions of its staff in providing care to patients or clients who they believe are clearly identified. Where deliberate actions have been taken by patients/clients, or their carers to provide false information, further action may be taken by the Trust.

7.0 Legislative Compliance, Relevant Policies, Procedures / Guidance

Nursing and Midwifery Council (2015), The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates.

The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

Southern Health & Social Care Trust Acute Hospitals Major Incident Plan (Mass Casualties) (2022)

http://sharepoint/med/epbc/Plans/CORPORATE/Acute%20Hospitals%20Major%20Incident%20Plan/Acute%20Hospitals%20Major%20Incident%20Plan.pdf#search=MAJOR%20INCIDENT%20PLAN

SHSCT Medicine's Management Code (2015)

Southern HSC Trust

SHSCT Blood Transfusion Policy (2018)

http://vsrwebapps02/QPulseDocumentService/Documents.svc/documents/active/attachment?number=INTRANET-10

SHSCT Right Patient, Right Blood Guidance (2022)

http://vsrwebapps02/QPulseDocumentService/Documents.svc/documents/active/attachment?number=INTRANET-51

SHSCT Policy for the Safeguarding, movement & Transportation of patient/Client/Staff/Trust Records, Files and other media between facilities (2021)

20210302_SafeguardingMovementTransportationofPatientClientStaffTrustRecords_2.4_IG.pdf

SHSCT Policy on Gaining Consent (2022)
Southern HSCT Photography of Service Users in Care settings Policy

8.0 References

None

9.0 Equality Considerations

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any

adverse impact on the nine equality categories. The policy has been 'screened out' without mitigation or an alternative policy proposed to be adopted.

10.0 Human Rights Considerations

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed compatible with the European Convention of Human Rights contained in that Act. This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

11.0 Sources of Advice & Further Information

Further advice and information regarding this policy can be obtained from:

- Operational and Professional Managers
- The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

Appendix 1

Good practice guidance for the correct identification of patients and clients

(In hospital settings, including patients attending for day treatment)

1.0 All staff should adhere to standards and guidelines from their professional regulating body and to specific procedures within their area of practice for patient/ client identification.

2.0 First contact

Ensuring that the Trust secures the correct patient and client identification information begins at first contact. It is the responsibility of all staff, i.e clinical and administrative, at the first contact to elicit by enquiry the correct information from the patient/client and to detail the information on an appropriate health or social care record. Any anomalies or identification queries highlighted in relation to patient/client details should be clearly reconciled and clearly recorded within the health and or social care record.

All staff should also review existing electronic care/information systems as appropriate to their role to confirm/ second check the information that was obtained verbally. These systems include-

(Non-Exhaustive List)

- Northern Ireland Electronic Record (NIECR)
- PARIS
- SOSCARE

3.0 Subsequent contacts

At subsequent contacts, e.g., at in-patient or out-patient facility or unit, it is the responsibility of the admitting staff to ensure the patient/client information recorded at first contact remains correct. If there are changes to the patient/client's biographical details these should be clearly and unambiguously recorded in the health and or social care record.

Where a patient or client requires to be admitted to an in-patient facility or unit the admitting health care professional is responsible for ensuring that a patient/client identification wristband is applied.

The patient/client / parent / guardian must be advised as to the safety importance of wearing an identification band during an in-patient stay. The identification band must include the following information and must be a clearly printed label or written in black ballpoint pen: -

- Patient/Client Name
- Date of birth
- Health and Social Care Number

- Gender (if applicable)
- Ward/Department

4.0 Patients with the same or similar name

Where two patients or clients with the same or similar name are admitted to a facility or unit at the same time an alert sticker should be applied to both the patient/client's health care notes and highlighted in all other relevant documentation including drug Kardexes and prescriptions.

4.1 Removal of Identification Wristband for any reason

If an identification wristband needs to be removed for any reason it is the responsibility of the health care professional to replace the identification wristband immediately or as soon as it is appropriate to do so.

4.2 Absence of Identification Wristband

If a patient/client is found not to have an identification wristband in place at any time during his/her stay it is the responsibility of health care professionals to ensure it is replaced, or to request that it is replaced, immediately.

5.0 Checks required prior to procedures

Before carrying out any procedure health care staff should always check that verbal information given to them by the patient/client corresponds with the information on the identification wristband. Staff should ask open questions such as, What is your registered first name and surname and how do you spell it, rather than 'Are you Mrs. Smith?'

6.0 The correct identification of neonates and children

Any anomalies or identification queries highlighted in relation to the neonate/child details should be reconciled and clearly recorded within the clinical records. (In the case of a new born, staff can obtain this information from the maternity record rather than the parent)

6.1 During all subsequent contacts, it is the responsibility of the staff present to ensure the neonate/child information recorded at first contact remains correct. If there are changes to the neonate/child biographical details, these should be clearly and unambiguously recorded in the clinical records. (In the case of a neonate this can occur if the parents register the infant under a different surname after the infants birth- which is a regular occurrence in neonatal, the Identification bands are then to be changed to reflect the surname change) Identification is always to be checked by two members of staff.

6.2 Within Neonatal care and the Special Care Baby Unit two identification limb bands are to be worn. In Neonates the identity band, should have the name, gender, date of birth, time of birth, health and care or NIMATS number until the Health and Care number is available, all of which should be legible.

If there are two neonates with the same or similar names in the same unit or ward alert stickers must be used.

6.3 In Paediatrics two identification limb bands are to be worn up to and inclusive of 1 year of age.

7.0 In Emergency situations

In emergency situations the need for immediate clinical intervention/care may take priority over attaching an identification wristband to the patient/client. When this occurs the healthcare professional in charge must take appropriate steps to identify the patient/client and maintain safety until full identification is verified.

8.0 Administration of Blood and Blood Products

Where the administration of blood, blood components or blood products is required, identity checks on the patient/client must be undertaken by two staff both of whom must be either a registered nurse or midwife or a registered doctor. The checks must be completed independently i.e., both staff must check the identity of the patient/client and the unit of blood / blood product separately and agree the result and this must take place at the patient/client's bedside, with the final check of the patient's identification wristband. Only in an emergency situation, where two staff members are not available, is one registered nurse/midwife/doctor permitted to check the identity of the patient/client and the unit of blood / blood product.

All staff must adhere to the Southern Health and Social Care Blood Transfusion Policy (2018).

9.0 Major Incident

Should a major incident be declared all staff must adhere to the guidance set out in the Southern Trust's Major Incident Plan on the identification of patients and clients?

10.0 Transfer of a Patient/Client to another hospital or facility

Where a patient/client is to be transferred to another hospital or facility, the registered nurse co-ordinating the transfer is responsible for ensuring that all details recorded on the identification wristband correspond with those on the patient/client's health care record and other supporting documentation being transferred with the patient/client.

11.0 Patients/clients unable to wear an identification wristband

In situations where patients/clients are unable to wear identification bands or in areas where it is considered inappropriate for patients/clients to wear an identification band appropriate risk assessments must be carried out to ensure the safety of patients/clients. In learning disability, in addition to individual risk assessments updated photographs should be used for identification.

Appendix 2

SHSCT Policy on Patient/Client Identification

Good practice guidance for the correct identification of patients and clients

(In community settings)

1.0 All staff should adhere to standards and guidelines from their professional regulating body and to specific procedures within their area of practice for patient/client identification.

2.0 First contact

2.1 Ensuring that the Trust secures the correct patient and client identification information begins at first contact. It is the responsibility of all staff, i.e., clinical and administrative, at the first contact to elicit the correct information from the patient/client and to detail the information on an appropriate health or social care record. Any anomalies or identification queries highlighted in relation patient/client details should be reconciled and clearly recorded.

2.2 Staff must adhere to a process of positive patient/client identification prior to initiation of each examination, treatment or care. This includes verifying the patient's name, date of birth, address and general practitioner. If there is any doubt as to the patient's identity, the health care professional should contact the referrer or the next of kin.

3.0 Subsequent contacts

Biographical details

At subsequent contacts, e.g., within the patient's/client's home it is the responsibility of all healthcare staff to ensure the patient/client information recorded at first contact remains correct. If there are changes to the patient/client's biographical details these should be clearly and unambiguously recorded in the health or social care record.

Episodes of examination, treatment or care.

3.1 Staff must always continue to adhere to a process of positive patient/client identification prior to initiation of each examination, treatment or care throughout subsequent contacts with the patient/client.

3.2 Where two patients or clients with the same name are receiving treatment an alert sticker should be applied to both patient/client health care notes where applicable and highlighted in all other relevant records, including electronic notes. District nurses will notify all staff within their team of patients with the same name who are receiving similar treatments. Staff should always be alert if two patients with the same or similar names are living at the same address.

3.3 In learning disability, in addition to individual risk assessments updated photographs should be used for identification. Staff must continue to adhere to a

process of positive patient/client identification prior to initiation of each examination, treatment or care.