POSITIVE PATIENT IDENTIFICATION POLICY (and procedures)

POLICY

Reference	CPG-TW-PPI		
Approving Body	• v8.0, Documentation Group) reporting to Nursing, Midwifery and Allied Health Committee) • v8.1, Maternity & Gynaecology CG Group		
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	YES	**NO**	**N/A**
	X		
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Summary of Changes from Previous Version	v8.1 • Following an incident in maternity, amends made to appendix 1 (identification of the newborn) and include recording information on Badgernet. v8.0 • 7.0 SDEC added to which patients are require to wear an identification band. • 8.5 If the patient is already registered on Careflow PAS with any know details and if there is any concern about the DOB or any other details being different and they can not be confirmed as the same person ie. Previous home address now changed due to house move, then the patient should be registered with the known details rather than change an existing registration. • Medway updated to Careflow PAS throughout the policy. • 9.1.1 When completing Positive Patient Identification checks for a patient requiring a blood transfusion, confirming the spelling is also required. • 9.4.6 In cases where an emergency transfusion may be requested/required, it is imperative to keep both wristbands (unknown and known ID) attached to enable completion of the pre-administration checks. Blood bank to be contacted prior to the removal of the unknown wristband once the identity of the patient has become known.		
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	- Mark Stone – Emergency Planning and Business - Continuity Officer. - Paediatric Governance - All Ward Leaders and Matrons - Jackie Lynam – Careflow PAS System Manager - Transfusion Team
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Author (Position & Name)	• v8.0, Jackie Simpson – Corporate Practice Development Matron • v8.1, amends by Ruth Nanthambwe – Saving Babies Lives Lead Midwife
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Position of Person able to provide Further Guidance/Information	Practice Development Team

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not applicable	Not applicable
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Positive patient identification is fundamental to patient safety. Failure to correctly identify patients can result in significant harm to patients including medication errors, transfusion errors, testing errors, wrong person procedures, and the discharge of infants to the wrong families (WHO, 2007).

The National Patient Safety Agency (NPSA) has recognised that failure to correctly identify patients constitutes one of the most serious risks to patient safety and cuts across all sectors of healthcare practice. Correct identification, incorporating the NHS number as directed by the NPSA, will reduce and, where possible, eliminate the risk and consequences of misidentification and as a result, improve patient safety.

This policy and associated procedures will assist all staff to positively and safely identify all patients while taking account of fundamental principles relating to privacy, dignity and confidentiality. This policy complies with NHS NPSA Safer Practice Notice No. 24 (July 2007).

All patients must be treated with respect for their right to privacy, dignity and confidentiality. Although confidentiality is paramount within clinical professions' code of ethics and conduct (NMC 2018), confidentiality issues must not hinder the provision of prompt and effective patient care.

2.0 POLICY STATEMENT

Aim:

- To ensure that all patients are positively identified on admission and before any assessment, investigation, treatment or care whilst under the care of Sherwood Forest Hospitals NHS Foundation Trust.

Objectives:

- To ensure all staff positively identify a patient before the delivery of care or treatment.
- Encourage the use of three identifiers (e.g. name, date of birth and NHS/ D number) to verify a patient's identity.
- To ensure all inpatients wear a Patient Identification Band.
- To ensure all outpatients who are undergoing invasive procedures under sedation and/or receiving intravenous medicines or receiving a transfusion of blood components or blood products wear a Patient Identification Band.

This clinical policy applies to:

Staff group(s)

- All staff

Clinical area(s)

- Trustwide

Patient group(s)

- All patients including adults, maternity services, neonates, newborns, infants children and young people

Exclusions

- None

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Care record(s):	Refers to and includes medical case notes and Emergency Department records. Documentation such as referral letters and requests for investigations are filed and kept during an episode of care and help to form the care record. However, documentation may be "hard copies" (written) or electronic.
Clinical Professionals	Clinical professionals, for the purpose of positive patient identification, are defined as those registered with a regulatory authority; i.e. doctors with GMC, nurses with NMC, Allied Health Professionals and Healthcare Scientists with HCPC and Pharmacists with the RPS.
Patients:	All patients of Sherwood Forest Hospitals NHS Foundation Trust including inpatients and outpatients.
Patient Identification band:	Are used as part of the process for the positive identification of a patient. They are usually issued and applied to a patient's wrist or ankle and must include the standard patient identifiable information defined within this policy.
SFH	Sherwood Forest Hospital
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust

4.0 ROLES AND RESPONSIBILITIES

Adherence to this policy is the duty of all staff employed by the Trust.

5.0 APPROVAL

Following appropriate consultation (outlined on page 1) this policy (v8.0) has been approved by the Trust's Documentation Group.

DOCUMENT REQUIREMENTS (POLICY NARRATIVE) – Sections 6 to 12

6.0 GENERAL PRINCIPLES

6.1 General Principles

6.1.1 Using positive patient identification, each and every time, ensures safe and effective care is delivered to the right patient at the right time and prevents mistakes in care delivery occurring.

6.1.2 All Trust employees must positively identify patients every time before undertaking any consultation, intervention, investigation, procedure or treatment as part of the process of care delivery. Furthermore, all Trust employees must ascertain whether the patient has any known allergies.

6.1.3 Never read the patients details out to the patient and allow them to positively agree. Instead, ask the patient direct questions e.g. what is your date of birth and allow them to answer.

6.1.4 On admission to the hospital or transfer within clinical areas, it is the responsibility of the admitting clinical professional to positively identify the patient and ensure that an appropriate identification band is applied. See section 7 for further information on who must wear an identification band and section 8 for further information on the process for applying an identification band.

6.1.5 If any staff member finds any of the information to be illegible, the staff member must ensure the identification band is replaced in accordance with section 8.
Note: The use of alcohol hand gel may erase the writing on the patient's identification band.

6.1.6 If the identification band is removed at any time during the patient's stay, it is the responsibility of whoever has removed it to ensure a new one is issued and applied. Where the patient refuses to wear an ID band, it is the responsibility of the staff member caring for the patient to ensure that an explanation as to the importance of wearing the Identification band is given.

6.1.7 Whenever a patient is transported from a ward or department for investigations or treatment, positive identification must take place before transfer to ensure that the correct patient is being transferred. The receiving area must also confirm the identification of the patient.

6.1.8 If a patient is unable to support with the positive patient identification process (i.e. unable to answer appropriate questions) then the patient must be transferred with a staff member from the transferring department. The transferring staff member must confirm with the receiving department that the information on the identification band is

correct. The information on the identification band can then be utilised for positive patient identification within the receiving department.

6.1.9 Any communication difficulties should be addressed to ensure the patient understands what is being asked and that the information is accurate. The use of interpreter services should be utilised where necessary.

6.1.10 All patients who have been highlighted as being at risk of falls via a falls risk assessment should receive the appropriate Colour Me Safe Band (Yellow or Blue) in addition to their white/ red patient identification band. Please note Colour Me Safe Bands are not patient identification bands.

6.1.11 Upon discharge patient identification bands should be disposed of in a confidential waste bin.

7.0 WHO MUST WEAR AN IDENTIFICATION BAND

All of the following patients must wear a Patient Identification Band on the wrist or ankle for the duration of their stay:

- Inpatients.
- Outpatients: undergoing invasive procedures under sedation and/or receiving intravenous medication or receiving transfusion of blood components or blood products.
- Emergency Department (ED) including Urgent Care Centre (UCC):
    - All patients in 'Majors' and/or 'Resuscitation' areas of ED.
    - Ambulatory patients (i.e. Minors) where it is professionally judged to be - appropriate; i.e. patients with confusion and/or disorientation.
    - Paediatric patients in the Resuscitation area and/or where it is professionally judged to be appropriate.
    - UCC and SDEC patients for transfer to an acute care facility.

8.0 PROCESS FOR APPLYING AN APPROPRIATE IDENTIFICATION BAND

8.1 All patients will be issued with a white patient identification band. If the patient has a known allergy a red patient allergy identification band must also be worn.

8.2 The white patient identification band should preferably be a bar-coded electronically generated identification band via Careflow PAS. Where electronically generated bands are not available, all patient identification information must be handwritten in CAPITALS on water resistant identification bands using indelible black ink. **Note: a hospital addressograph sticker is not to be attached to a Patient Identification Band** as the ink is easily smudged, becoming illegible. Addressograph stickers may be uncomfortable; may catch on clothing/ skin, are oversized in relation to band with hard/ sharp edges and is an infection control and prevention risk (background adhesive).

8.3 The following details must be included on the patient identification band:

- Forename.
- Surname.
- Date of Birth.
- NHS unique patient identifier number.
- Hospital patient identifier number (also known as the D Number).

8.4 Patients with known allergies (medications, food and/or environment) will also be issued with a red, handwritten patient identification band which includes the words *Allergy Alert* and the information within 8.3. All staff are further responsible to ensure that the allergy status (including the associated reaction) of the patient is recorded in the medical and nursing notes, on the red alert divider (front of hospital notes) and on all prescription charts.

8.5 Before the patient identification band is applied to a patient all the details must be checked with the patient/ relative/ family member in accordance with section 9.2. This includes checking that the spelling of the patients name is correct. Once the information has been confirmed as correct, the patient identification band can be applied to the patient. If the patient is already registered on Careflow PAS with any know details and if there is any concern about the DOB or any other details being different and they can not be confirmed as the same person ie. Previous home address now changed due to house move, then the patient should be registered with the known details rather than change an existing registration.

8.6 If a Patient Identification Band is produced (printed/ written) by a non-regulated person (i.e. receptionist, healthcare worker) it must be counter-checked by a registered professional before being applied to the patient. If any information is incorrect, an up-to-date identification band must then be issued and applied to the patient's wrist or ankle.

8.7 For the application of a patient identification band to a new-born on the Sherwood Birthing Unit/ Maternity Unit, follow the guidance in Appendix 1.

8.8 On admission to the neonatal unit, all infants must initially be positively identified using ID Band Two (see Appendix 1 for further information on ID Band Two). Once an NHS number has been generated by maternity services (must be within 2hrs of admission to the neonatal unit), the infant will be given their own ID band with their name, DOB and NHS number. The information on the individual ID band must be checked by two registered nurses prior to applying the identification band to the patient. Once the patient has their own ID band applied, the mothers name band should be removed from baby.

8.9 On admission to Children and Young Peoples Services, the patient identification band must be confirmed by a responsible adult who has parental responsibility by two registered nurses. Once the information has been confirmed as correct by the two registered nurses, the identification band can be applied to the patient.

9.0 PROCESS FOR POSITIVELY IDENTIFYING PATIENTS: Ask, Check, Confirm

9.1 Patients with Identification Bands

9.1.1 Always **ASK** the patient (or responsible parent/ relative if the patient is a child or has communication difficulties, learning disabilities **and** lacks capacity) to tell you their full name and date of birth. The full name for positive patient identification is defined as their legally registered first and last name; noting some patients may use a preferred name(s) rather than their legally registered names. When completing Positive Patient Identification checks for a patient requiring a blood transfusion, confirming the spelling is also required. Consider alternatives if the patient is unable to verbalise answers to the questions/ see section 8.6 if the patient is not a child but does not have the capacity.

9.1.2 **CHECK** this information against the Patient's Identification Band.

9.1.3 Also check the unique identifier on the wristband (NHS or District number) and **CONFIRM** this against the relevant paper or electronic health record (i.e. medical case notes, consent form, prescription chart, investigation request slip, Careflow PAS, ORION).

Ask the patient/ parent:	• "What is your/ their full name?" • "What is your/ their date of birth?" • "Do you/ they have any allergies?
Check:	Check the patient's full name and date of birth corresponds to those on the Patient's Identification Band.
Confirm:	Confirm the patient's name, date of birth, NHS number/District number is correct on the patient identification band(s) by cross-referencing with the patient's care record (i.e. hospital notes, consent form, prescription chart).

9.2 Patients without identification bands

Ask, check and **confirm** the following information. Once confirmed with the patient/ parent/ relative ensure an appropriate identification band is applied following section 8.0:

Ask the patient/ parent:	• "What is your/ their full name?" • "What is your/ their date of birth?" • "What is the first line of your address?"
Check:	Check the patient's full name and date of birth corresponds on a SFH health record (i.e. outpatient reconciliation (appointment) form and case notes, x-ray request form, Careflow PAS etc)

Confirm:	Confirm the patient's name (ensuring name is spelt correctly), date of birth, NHS number /District number is correct by cross-referencing with the patient's paper care record (i.e. hospital notes, consent form, prescription chart) or patient's electronic care record (Careflow PAS, ORION, ICE).

9.3 Identification of the new-born

See Appendix 1 within this policy: Standard Operating Procedure for the Identification of the new-born.

9.4 Identification of the Unknown or Unidentified Patient

9.4.1 For patients that are unknown (i.e. unidentified) when presenting to the Emergency Department (ED), these patients will be allocated a 'Pre-registered District (D) number' and associated demographics from the 'reserved district number list' held in ED reception.

9.4.2 The 'reserved district number list' has forenames and surnames in a format using the phonetic alphabet used in combination with the NHS location code for Sherwood Forest Hospital – RK5 (NHSI, 2018).

9.4.3 The unknown patient's date of birth should be documented as today's date, with an estimated year of birth. For example, 07/01/1980 (if today is the 7th Jan and the patient is estimated to be approximately 40yrs old). An individuals estimated age is safer than a standard age for all unknown patients to ensure females of potential child-bearing age are given Rh D and K-negative red cells and that age-related needs are met for certain blood products (NHSI, 2018).

EXAMPLE:

- Dummy District Number: **D3059459**
- Surname = **TANGORK5BC1**
- Forename = **DELTA**
- DOB = **07/01/1980**

9.4.4 If the patient's sex cannot be identified due to severe injury, temporary identification should default to female sex to ensure females of potential child-bearing age are given Rh D and K-negative red cells (NHSI, 2018).

9.4.5 Once an ID band has been applied to the patient with the above information follow section 9.1 to positively identify the patient going forwards.

9.4.6 Once the patient has been identified, the Admissions Department should be contacted to ensure any existing casenotes are obtained for the patient. The now known demographics (ie. Name and DOB) should be updated on Careflow PAS by either ED admin or admissions staff and a new identification band should be applied to the

patient following section 8. In cases where an emergency transfusion may be requested/required, it is imperative to keep both wristbands (unknown and known ID) attached to enable completion of the pre-administration checks. Blood bank to be contacted prior to the removal of the unknown wristband once the identity of the patient has become known. The pre-registered hospital number should continue to be used throughout the patients stay otherwise this can affect the processing of pathology and radiology requests. The merging of the patient's pre-registered District (D) number and their unique identifier number (D number) on Careflow PAS will take place by NHIS Data Quality after the patients episode of care is complete. Ideally ED admin or admission staff should add an alert to both records on Careflow PAS so records can be easily identified for merging purposes.

9.4.7 If the patient cannot be identified due to capacity concerns also refer to section 9.6.

9.4.8 If the patient has been transferred to the Emergency Department from a Major Incident scene the patient will be wearing a tag containing an incident number. This tag should not be utilised to identify the patient. If the patient can identify themselves an appropriate name band should be applied following guidance in section 8 or following the above guidance. The incident tag should not be removed until the patient is discharged from hospital.

9.5 Identification of the Unconscious, Anaesthetised or Sedated Patient

9.5.1 Patients who have a planned intervention where they will receive sedation or general anaesthesia should be positively identified prior to the administration of any medication in accordance with the SOP for the Implementation of the Invasive Procedures Policy for the Division of Surgery, Critical Care and Anaesthesia (NatSSIPs and LocSSIPs)

9.5.2 If a patient is unconscious but has an identification band in place, this should be utilised to confirm the patient's identity. If the patient does not have an identification band, a relative should confirm the patient's identity, an appropriate identification band should then be put in place and should be utilised to identify the patient going forwards. If the patient's identity is unknown and there are no family members to identify the patient follow section 9.4.

9.5.3 If an unconscious patient is being transferred to a different department, a member of staff from the transferring area must confirm with the receiving department that the information on the identification band is correct.

9.6 Identification of a Patient who lacks capacity (including confusion and Dementia)

9.6.1 If there is concern that a patient lacks capacity, this should be assessed and documented following the Trusts Mental Capacity Act (MCA) Policy.

9.6.2 If the patient is proven to lack capacity following the completion of the appropriate paperwork and is unable to confirm their name, date of birth and address then this information should be confirmed with a responsible relative or care provider (for example an appropriate care giver from a care home).

9.6.3 Once the identity of the patient is appropriately confirmed, an identification band should be applied following the information in section 8.0. Once the identification band is in place, this should be utilised to verify the patient's identification going forward.

9.6.4 If the patient is unable to support with the positive patient identification process (i.e. unable to answer appropriate questions) then the patient must be transferred with a staff member from the transferring department. The transferring staff member must confirm with the receiving department that the information on the identification band is correct. The information on the identification band can then be utilised for positive patient identification within the receiving department.

9.7 Identification of the Deceased Patient

For the process for identifying and tagging the deceased patient, please refer to the Care After Death Policy and the Mortuary notice book.

9.8 Patients Attending the Radiology Department

The need for correct positive identification of patients also applies to patients attending radiology departments for either diagnostic or interventional procedures; specific Ionising Radiation & Medical Exposure Regulations should be followed. These are accessed locally within the radiology department by staff as required.

10.0 RECOMMENDED PROCEDURE FOR PATIENTS UNABLE/ REFUSING TO WEAR IDENTIFICATION BANDS

For those patients who cannot wear a Patient Identification Band due to clinical and/or physical conditions, treatment, allergies or refusal; a registered professional responsible for the care of the patient must undertake a risk assessment and then identify and implement a process to ensure the safe identification of the patient. This must be documented in the medical and nursing notes.

11.0 PROCEDURE IN THE EVENT OF A PATIENT MISIDENTIFICATION INCIDENT

In the event of a patient misidentification incident, the staff member **must** take the following action:

- Stop the intervention/treatment/procedure as soon as it is safe to do so.
- Undertake the positive identification procedure to confirm the identity of the patient.
- Inform the lead clinician responsible for the care of the patient (or designated deputy).
- Inform their line manager.
- A designated clinician **must** inform the patient of the incident and provide them with the advice and support required as a result of the misidentification incident (Duty of Candour).
- The person who was involved in the misidentification incident must submit an incident report to their line manager using the Trust's Incident Reporting Procedures (Datix).

12.0 CLINICAL INVESTIGATIONS AND COLLECTION OF SPECIMENS

The need for the correct positive identification of patients also applies to requesting clinical investigations and the collection of specimens.

See Appendix 2: Standard Operating Procedure for Clinical Investigations and Collection of Specimens

13.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Patient safety incidents associated with the identification of patients.	Heads of Service/ Governance Lead	Review of patient safety incident reports on non-adherence to policy via the incident reporting procedure (Datix).	Monthly	Speciality Governance meeting/Divisional Governance Forum / escalation to Patient Safety and Quality Board.
Nursing Metrics include questions on checking positive identification of patients and allergy status.	Ward Leader/Matron	Nursing metrics tool	Monthly	Monitored through the Ward Assurance meeting and the Performance and Governance Committee.

14.0 TRAINING AND IMPLEMENTATION

No specific training requirements are associated with the application of this policy. It is the responsibility of all staff to be aware of and read the policy and apply it in practice.

15.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 3
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 4

16.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- British Medical Journal (BMJ) (2005). **Making Sure the Right Patient Gets the Right Care**. Available at: https://qualitysafety.bmj.com/content/13/5/329 [Accessed 3rd Jan 2020].
- Department of Health (DOH) (1997) **The Caldicott Committee: Report on the review of patient-identifiable information**. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068404.pdf [Accessed 3 Jan 2020].
- Nation Health Service Improvement (NHSI) (2018). **Resources to Support Temporary Identification Criteria for Unknown or Unidentified Patients**. Available at: https://improvement.nhs.uk/resources/resources-to-support-safer-temporary-identification-criteria/ [Accessed 2nd Jan 2020].
- National Patient Safety Alert (NPSA) (NHSI) (2018) **Safer Temporary Identification criteria for Unknown Patients**. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient_Safety_Alert_-_unknown_or_unidentified_patients_FINAL.pdf [Accessed 3rd Jan 2020].
- Nation Patient Safety Alert (NPSA) (2007). **Standardising wristbands improves patient safety** – Safer Practice Notice 3rd July 2007 No 24.
- Nursing and Midwifery Council (NMC) (2015) **The Code: standards of conduct, performance and ethics for nurses and midwives**. Available at: https://www.nmc.org.uk/standards/code/ [Accessed 3 Jan 2020].
- Royal College of Physicians (2005). **National Comparative Audit of Blood Transfusions. Available at:** https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjsouvmiufmAhWJSxUIHYS8CxgQFjABegQIAhAC&url=https%3A%2F%2Fwww.transfusionguidelines.org%2Fdocument-library%2Fdocuments%2Fnca-newsletter%2Fdownload-file%2Frtc-sw_news_nca_newsletter.pdf&usg=AOvVaw3PE06GPGFmMP_srGRstjAN [Accessed 3 Jan 2020].
- World Health Organisation (WHO) (2007). **Patient Identification**. Available at: https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf?ua=1 [Accessed 3rd Jan 2020].

Related Trust Documents:

- Transfusion Policy, procedures and Guidelines
- Medicines Policy
- Invasive Procedure Policy
- Incident Reporting Policy and Procedures
- Allergy and Anaphylaxis Identification and Management Policy
- Care After Death Policy
- Consent to Examination, Treatment and Care Policy
- Mental Capacity Act (MCA) Policy
- SOP for the Implementation of the Invasive Procedures Policy for the Division of Surgery, Critical Care and Anaesthesia (NatSSIPs and LocSSIPs)
- Handover of maternity care on site guideline

Acknowledgements:

- Portsmouth Hospital NHS Trust. **Patient Identification Policy** 2016.
- Gateshead Health NHS Foundation Trust. Patient Identification Policy 2011.

17.0 KEYWORDS

ID; positively; identifying; identity; identifiable; name band; wristband; bracelet; patient with or without; red allergy wristbands; raw; allergies; penicillin allergy; alert; bands; of; patients; Multiple births, positive patient identification of the newborn, twin birth, triplet birth,

18.0 APPENDICES

- Appendix 1: Standard Operating Procedure for the Identification of the new-born
- Appendix 2: Standard Operating Procedure for Clinical Investigations and Collection of Specimens
- Appendix 3 – Equality Impact Assessment
- Appendix 4 – Environmental Impact Assessment

Appendix 1: Standard Operating Procedure for the Identification of the new-born

- Two Patient Identification Bands are required for each expected baby: Band One and Band Two.

- ID Band One is completed prior to the birth; this is written by hand in black ink by a Registered Midwife (or student Midwife). Label One must show the mother's name and surname,, mother's Date of Birth and mother's unique NHS number. ID Band one is attached to the baby immediately following birth and prior to the Registered Midwife leaving the birthing room.

- Before handing the baby to the parent, the Registered Midwife must check the baby's Patient Identification Band Label One with the baby's mother or partner (verbally) and by visual check of the mother's Patient Identification Band, prior to application to baby's ankle. Where parents are unable to check identity bands, checking will be carried out by two members of staff (one of which MUST be a Registered Midwife) and shown to either parent as soon as possible.

- ID Band Two is completed (written by hand by a Registered Midwife or student Midwife) following the birth and must state infant of … mother's first name and surname, baby's NHS number, the baby's date and time of birth. **Note**: The newborn baby must be weighed, have a centile and these must be entered in the Labour and Birth > Baby > Post-Birth Smart Form once the mandatory fields are completed on the form to obtain the baby's NHS number. Registered Midwife to confirm baby's ID Band Two with the baby's mother or partner (verbally) and by visual check of the mother's Patient Identification Band, prior to application to baby's other ankle. Where parents are unable to check identity bands, checking will be carried out by two members of staff (one of which MUST be a Registered Midwife) and shown to either parent as soon as possible.

- The Registered Midwife is responsible for checking the accuracy of the baby's Patient Identification Bands and for firmly securing the baby's Patient Identification Bands. Note: the preferred site is for one Patient Identification Band to be applied to each ankle or wrist if ankle is unsuitable.

Multiple births:

- In event of expected multiple births, Patient Identification Bands will be identified as Twin 1, Twin 2 etc. All Band Ones will be completed prior to the births.

- The first baby born must be labelled at once, and before the birth of the next baby, and identified as Twin 1, Twin 2 etc. The same procedure should be followed for subsequent babies, identified in number order by birth time.

- On transferring the baby and the mother to the postnatal ward at handover of care,

- Both the baby's Patient Identification Band will be checked daily by a Registered Midwife or student midwife (as delegated by a Registered Midwife) with the mother and a recording made on Badgernet that both Patient Identification Bands are in position and that the details are correct.

- Recording the ID check on Badgernet is completed by searching the woman using her NHS number > following the search > under Baby 1 > go to Summary of Care > click on the + sign > select Examination > select applicable Examination Type > location examined select applicable area in drop-down section > ID Check > Method of ID Check - select applicable method from the drop-down section

Transfer from Birthing Unit to Maternity Ward:

- The Registered Midwife is responsible for handing over the care of the baby and the mother to the Registered Midwife receiving the baby and mother – handover is done face to face using the SBAR tool on Badgernet.

- The Information required for the Maternity handover sheet is to include the following

- Consultant Name, Name of the Woman or Birthing Person, Parity, Postnatal Day, Mode and Time of Birth, Blood Group, Obstetric Details, VTE Risk Assessment, Admission Date, Doctors Review, Risk, Feeds, Sex, Birth Weight, Centile, Paediatric Plan, Antenatal Plan, NIPE, then both Midwives are to sign the SBAR accountability on Badgernet.

- Prior to the baby and the mother being transferred to the postnatal ward; the Registered Midwife transferring must check the baby's two Patient Identification Bands against the mother's Patient Identification Band, in the presence of the mother. The baby and the mother will be escorted to the postnatal ward by a Registered Midwife or another member of staff (student Midwife and/or Health Care Support Worker); the Registered Midwife is responsible for assessing the escort required. On arrival on the postnatal ward; the receiving Registered Midwife must check the baby's two Patient Identification Bands against the mother's Patient Identification Band in the presence of the mother.

- Both of the baby's Patients Identification Band will be checked daily by a Registered Midwife or student midwife (as delegated by a Registered Midwife) with the mother and a recording made on Badgernet that both Patient Identification Bands are in position and that the details are correct.

- If one of the baby's Patient Identification Bands is found to be missing: a new one will be prepared and checked against the information on the remaining Patient Identification Band and against the mother's Patient Identification Band, before replacing it in the mother's presence. In the absence of the mother, two members of staff may carry out this procedure (one member must be a Registered Midwife). This must be explained to the mother or partner and shown to either parent as soon as possible

- If both of the baby's Patient Identification Bands are found to be missing: all babies on the ward must have their Patient Identification Bands checked against their mother's Patient Identification Band by two members of staff (one of which must be a Registered Midwife) before replacing the missing Patient Identification Bands. A Datix must be completed and the Senior Midwife informed.

- Each baby should stay with its mother at all times but if they are separated for any reason then the baby's Patient Identification Bands should be checked before returning the baby to its mother. The details need also to be checked with those on the mother's Patient Identification Band before handing the baby over.

- The mother should be transferred home with her Patient Identification Band still in place and one Patient Identification Band **must** be left on the baby. The mother can then remove both identification bands **at home.**

Re-Admission of A Mother And Her Baby To The Maternity Unit.

- Should a mother and baby be readmitted to the maternity unit, the Patient Identification Bands will be prepared as above and attached as soon as possible after readmission.

Appendix 2: Standard Operating Procedure for Clinical Investigations and Collection of Specimens

Requesting Clinical Investigations

- The need for the correct positive identification of patients also applies to requesting clinical investigations. The standards for labelling of request cards and specimens for pathology investigations should be adhered to.

- The person requesting clinical investigations is responsible for ensuring that every request is checked for accuracy; whether the request is electronically generated (Careflow PAS) or manually (by Request Card).

- Requesting clinical investigations electronically, the requestor must use their own Smart Card (their electronic signature).

- Requesting manually, the requesting clinician should complete all fields on the request card themselves and sign the request with their usual signature and print their full name. **The practice of bulk pre-signing of request cards is dangerous and unacceptable.**

- The requesting clinician completing the request card, is responsible for ensuring that the patient identification information on the card is correct.

- All request cards must have the following details: **(All details must be spelt correctly and no abbreviations should be used).**
  - Forename
  - Surname
  - NHS unique patient identifier number
  - Hospital (District) patient identifier number (D Number).
  - Date of birth
  - Ward/Department
  - Consultant's Name

N.B. The above information is not always sufficient to ensure that all requests are processed. Additional information will be required on a department specific basis within pathology and radiology.

Clinical Investigations and Clinical Sample Collection

- The need for the correct identification of patients also applies to Clinical Investigations and Clinical Sample Collection.

- Clinical Investigations must **NOT** be carried out until positive patient identification has been established.

- The patient should be positively checked by verbal confirmation of the patient verified with visual check of Patient Identification Band (for patients required by this Policy) against the electronic request (printed labels) and/or written request card; prior to the any clinical investigation and/or collection of samples. .

- Labelling of specimens **must not** be carried out prior to taking the sample.

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Positive Patient Identification Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 27/01/2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	NA	None
Gender	Currently the Trusts system 'Medway' can only record patients as their officially registered gender. This is to prevent incorrect changes to GP and National Spine records. This may affect transgender patients who have not officially changed their gender via deed pole as their name band may state a different gender to which they identify.	The patient's gender is not utilised within the positive patient identification process and therefore patients will not be asked this during this process. All unknown patients, where identity cannot be ascertained should default to female sex to ensure females of potential child-bearing age are given Rh D and K-negative red cells.	Ability to record the patients preferred gender within Careflow PAS.
Age	Paediatric patients may not be able to answer the necessary questions to support the positive identification process.	There are specific processes for Paediatric and Neonatal patients within this policy.	NA
Religion	None	NA	None

Disability	Some patients may not be able to answer the necessary questions to support the positive identification process.	Guidance for patients who lack capacity or have a learning disability are discussed within section 9.1.1/9.6 of this policy.	NA
Sexuality	None	NA	NA
Pregnancy and Maternity	Guidance for new born's/ maternity services are discussed within appendix 1.	Guidance for new born's/ maternity services are discussed within appendix 1.	
Gender Reassignment	None	NA	None
Marriage and Civil Partnership	None	NA	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	NA	None

What consultation with protected characteristic groups including patient groups have you carried out?

- N/A

What data or information did you use in support of this EqIA?

- See p.1 Consultation undertaken section

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Alison Davidson

Signature: A.Davidson

Date: 27/01/2023

APPENDIX 4 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	NA
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	NA
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	NA
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	NA
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	NA
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	NA