Leicestershire Partnership NHS Trust

Positive Patient Identification Policy

Policy outlines responsibilities and procedures for ensuring correct & 'Positive' identification of patients in Leicestershire Partnership NHS Trust.

Key Words:	Wristbands, patient identification, photographs	
Version:	7	
Adopted by:	Patient Safety Improvement Group/Quality Forum	
Date Adopted:	April 2024	
Name of Author:	Reviewed by S Arnold/Tracy Ward Corporate Patient Safety Team - 2023	
Name of Responsible Committee/Group	Patient Safety Improvement Group (PSIG)/Quality Forum	
Date issued for publication:	March 2023	
Review date:	June 2026	
Expiry date:	April 2027	
Target audience:	LPT staff	
Type of Policy	Clinical **X**	Non Clinical
Which Relevant CQC Fundamental Standards?	Regulation 12: Safe care and treatment	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	March 2012	Harmonised policy
2	February 2013	Amendments to the format of the policy
3	April 2013	Addition of section on photographs
4	June 2013	Amendment to sentence to 8.1.3
5	July 2013	Amendment of responsible committee and Authors
6	October 2016 7	Full review and revision. Addition of Eating Disorders Process
7	July 2022 - March 2024	Reviewed May 2021 & November 2021 – Title amended to 'Positive Patient Identification Policy', changes to audit – now electronic (AMAT), inclusion of patients without capacity, deceased patients, updated references

Full review and revision to include amendments to include photographic identification, additional information for patients who are unable to provide valid consent or to identify themselves, deceased patients and updated policy title, changes to audit of compliance, updated references/bibliography

For further information contact:
Head of Patient Safety
Leicestershire Partnership NHS Trust
County Hall
Glenfield
LE3 8TH

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex

(gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review. If you require this policy in any other format please contact the Corporate Assurance Team.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

This policy sets out Leicestershire Partnership Trust's (LPT) policy for ensuring the correct identification of patients. Every effort has been made to ensure all equality groups (protected characteristics) are given equal access to service provision, especially in the context of disability. This is demonstrated through the identification of alternatives to the use of identity bracelets for patients with learning disabilities or enduring mental health conditions, for whom the use of bracelets may be distressing

The Due regard assessment template is Appendix 4 of this document

Definitions that apply to this Policy

Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
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.

1.0 Purpose of the Policy

The purpose of this policy is to ensure that all patients within Leicestershire Partnership Trust (LPT) can be correctly identified by confirming the expected standards required to reduce and, where possible, eliminate, the risks and consequences of misidentification. This policy is applicable to all inpatient settings. There is also guidance for patients in their own home.
Patient should receive the right care at the right time in the right place.

2.0 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).
https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf?ua=1
(Accessed 06 Dec 2021).

The NPSA Safer Practice Notice 2005/11 recommends that all in-patients should wear wristbands which must contain accurate details that correctly identify them and match them to their care and to patient records and other documentation. NPSA Safer Practice Notice 2007/24 advocates the standardisation of wristbands to further improve patient safety.

This policy applies to all healthcare workers employed within LPT, who encounter patients in the course of their duties. This includes, but is not exclusive to, doctors, pharmacists, phlebotomists, nurses, podiatrists, healthcare support workers, porters and drivers. It includes staff working on bank, agency or honorary contracts within the Trust.

Patient identification is the process of “correctly matching a patient to appropriately intended interventions and communicating information about the patient’s identity accurately and reliably throughout the continuum of care” (ECRI. ECRI Institute PSO Deep Dive: Patient Identification: Executive Summary. ECRI Inst 2016).
https://www.ecri.org/Resources/Whitepapers_and_reports/PSO%20Deep%20Dives/Deep%20Dive_PT_ID_2016_exec%20summary.pdf.(Accessed 06 Dec 2021)

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.

3.0 Policy statement

Aim:
To ensure that all patients are correctly/ positively identified on admission and before any assessment, investigation, treatment or care whilst under the care of Leicestershire Partnership NHS Trust.
By positive identification we mean “tell me you full name and date of birth” not “are you”

Objectives:

- To ensure all staff positively identify a patient before the delivery of care or treatment.
- Maintain best safe practice of using three identifiers (e.g. name, date of birth and NHS/ hospital number) to verify a patient’s identity.
- To ensure all inpatients wear a Patient Identification Band or the use of a photograph is actively available for all clinical staff.
- To ensure all outpatients who are undergoing invasive procedures under sedation and/or receiving intravenous medicines wear a Patient Identification Band.

This clinical policy applies to:

Staff group(s)
All staff

Clinical area(s)

- Trust wide

Patient group(s)
All patients including Adults & Children

Exclusions

- None where local robust procedures are in place (Adult Eating Disorders)

4.0 Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2. Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

4.2.1 Directorate Directors and Heads of Service are responsible for ensuring that policy is embedded across their Directorate/Service.

4.2.2 Managers and Team leaders will be responsible for:

- Implementation of the policy within their clinical area
- Overseeing/undertaking audits and any required service improvements
- Investigating incidents of misidentification
- Ensuring that action is taken to prevent recurrence of any cases of misidentification

4.2.3 Responsibility of Staff with direct patient contact:

- Maintain the standards in this policy and accept accountability for their own practice;
- Report incidents and near misses relating to patient misidentification via the Trust's incident reporting system;
- Undertaking/cooperating with investigations and audits of practice within the clinical setting.

5.0 Patient Identification

5.1 Process for identifying all patients

It is the responsibility of all healthcare workers to confirm the correct identity of patients and match the correct patient with the correct care before that care is carried out. A minimum of three of the following five identifiers must be used to verify patients' identity:

- Patient's full name
- Patient's date of birth
- NHS number
- Patient's address
- A recent photograph of the patient which is attached to their record.

Patient identity must be verified on every occasion that a member of staff comes into contact with them to:

- Administer treatment or medication
- Collect a sample or specimen
- Perform an investigation or examination
- Undertake a clinical assessment
- Provide a diagnosis or management plan
- Give results
- Attends and/or Arrange an appointment
- Transport or transfer the patient
- See them in an outpatient clinic or other setting
- Verification of death

This includes both face-to-face contact and telephone contact.

The means of identifying a patient should be undertaken in the following order (i.e. the first is preferable, but if it is not possible, undertake the second etc.):

1. By asking the patient to tell you their name, date of birth and address. Check this is compatible with the patient identity band (where worn), if an in-patient. For all patients, patient identity should be confirmed by cross referencing with relevant sources such as: healthcare records, results form or the relevant document to which the contact relates.

2. If the patient is unable to tell you their name, refer to the identity band if an in-patient and, if possible, verify the information by asking relatives, the carer.. The identity band is the primary and preferred method where this has not been possible and is documented a photographic record on medication records/care file may be used. If this is not possible

staff should ask the patient's relative or carer to identify the patient by name, date of birth and address.

3. If none of the above are possible, seek advice from your line manager or senior clinical staff.

Patients should be encouraged to participate in decisions regarding their healthcare. This should include them having active participation in identification, being able to express concerns about safety and potential errors and to ask questions about the correctness of their care by confirming with staff the procedure they are about to undertake.

5.2 Patient identity bands (ID)

Patients in inpatient areas should wear identity bands, it is however recognised that patients with acute mental health needs or confusion may not agree to wearing an identity band. In these cases, and where there are documented efforts to explain to patients the purpose in relation to their safety, a patient photograph should be taken with the consent of the patient to provide an alternative means of identification.

All identity bands must be applied as part of the initial admission process and contain the following information, with no additions or omissions:

- Last name
- First name
- Date of birth
- NHS number or unique hospital number if NHS number unknown

NB – Nicknames or familiar names **must not** be used. This will reduce the risk of incorrect identification of the patient.

In units where printing equipment is available, this should be used to print identity bands. In the event that a printer is unavailable for use, the following must be adhered to:

The same layout, order of information and information style should be used on all identity bands (Diagram 1). This helps make identity bands easier to read and avoids errors. Black text on a white background should be used to ensure the identity band is clearly legible in reduced lighting conditions and by those with visual impairments.

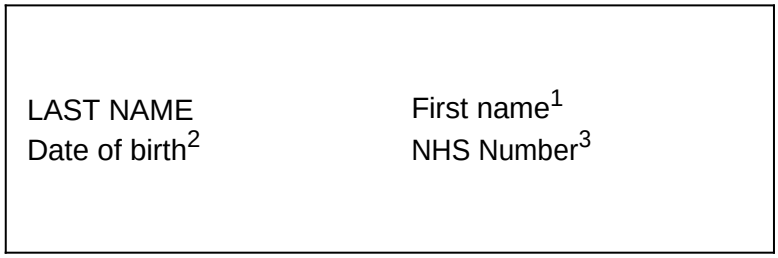

Diagram 1: Layout of information

[1]Priority should be given to the patient's name. First and last name should be clearly differentiated by using lower case letters for first name (with upper case first letter) and UPPER CASE for last name, and should be presented in the order: LAST NAME, First name, e.g. SMITH, John.

[2]The date of birth should be recorded in the short format, in the style recommended by the NHS Connecting for Health Common User Interface Design Guide as follows:

- DD-Mmm-YYYY, e.g. 07-Jun-1965;
- Where DD is the two-digit day;
- Mmm is the abbreviated month name (e.g. Feb);
- YYYY is the four-digit year.
- Day values less than 10 should appear with a zero in the first position e.g. 07
- Month names should abbreviate to the first three letters
- Day, month and year separators should be hyphens

[3]The NHS Number consists of ten digits – the first nine digits constitute the identifier and the tenth is a check digit that ensures its validity. The format of the NHS Number in NHS systems must be 3-3-4, because this format aids accurate reading and reduces the risk of transposing digits when information is taken from a screen. If the NHS Number is not immediately available, a temporary number (e.g. unique hospital number, or the identifier on SystmOne) should be used until it is.

5.2.1 All inpatients should have a white identity band unless they have an identified allergy.

5.2.2 All inpatients with an identified allergy must have either a red identity band with black text on a white panel (Community Hospitals) or a white identity band with a red colour code. The nature of any allergy should not be recorded on the identity band. This information should be recorded in the health record and transcribed onto the drug administration record. (an Alert should be placed on the EPR)

5.2.3 All inpatients should have only one identity band on the wrist or ankle (exception is deceased patient – see section 10.3).

5.2.4 Wherever possible, patients should be asked to check the details recorded on their identity band prior to application. It is safer to ask the patient what their name is and what their date of birth is, rather than asking whether they are John Smith, for example, in case they mishear or just passively agree.

5.2.5 When attaching the identity band, the Nurse should explain the importance of it to the patient and ask them to report to staff if it falls off, if it is removed and not replaced or if it becomes illegible.

5.2.6 Some patients may have difficulty understanding the reason for wearing an identity band. Every effort should be made to explain the reasons to them and, if possible, staff should enlist the assistance of relatives/carers to ensure compliance.

5.2.7 Patient identity bands do not remove the individual healthcare professional's responsibility to check the patient's identity. They are an important method of validating a patient's identity and should be used as such, to augment checking the identity verbally, directly with the patient.

5.3 Size of identity band

Identity bands must fit the range of sizes of patients from the smallest to the largest. Identity bands must therefore be long enough to accommodate:

- Bariatric patients
- Patients with oedema
- Patients with Intravenous (IV) lines

They should be small enough to:

- Be comfortable and secure

5.4 Comfort

5.4.1 Shape – there should be no sharp corners, profiling or edges that can irritate or rub the skin.

5.4.2 Edges – the edges of identity band material must be soft and smooth to ensure comfort over a prolonged use.

5.4.3 Fastenings – fastenings should not be pressed into the skin.

5.4.4 Material – identity band material should be flexible, smooth, waterproof, cleanable and non-allergenic.

5.4.5 The identity band should not catch on clothing, equipment or devices, including IV lines. Special attention should be paid to fastenings and free ends.

5.4.6 Patients must wear only **one** identity band

6.0 Attaching the Identity Band

6.1 Responsibility

- The nurse/health care professional is primarily responsible for admitting/meeting the patient and is responsible for completing and applying the identity band. This must be done as soon as possible and at least **within 1 hour of admission**.

- 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.

- Any healthcare professional performing any treatment is responsible for checking the identity band beforehand to ensure the correct patient.

- Any healthcare professional who removes an identity band (perhaps to perform a procedure) is responsible for ensuring another is applied immediately. A supply of identity bands must be readily available in all wards and departments.

- Should a healthcare professional identify a patient without an identity band, they must assume responsibility for correct identification of that person and for ensuring a replacement identity band is applied.

- The identity band must not be removed until discharge procedures are complete; they should be disposed of in the confidential paper waste.

- In the event of a patient being transferred between wards, the identity band should be checked with the patient and/or case notes for accuracy. This may be from ward to ward, ward to department, or between hospitals.

- On admission to Children and Young Peoples Services, the patient identification band must be confirmed by a responsible adult who has parental responsibility or corporate parental responsibility (looked after children) 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.

- **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).

7.0 Photographs of patients

For patients where an identity band is not possible a photograph of the patient should be taken with the consent of the patient.

Another benefit of a photograph for vulnerable patients is that Leicestershire Police advise that the first few hours are critical in the safe return of a vulnerable person should they go missing or absent without leave, and access to a current photograph would be of great benefit.

For Mental Health Rehabilitation, Mill Lodge and Phoenix/Griffin Hershel Prins Centre (HPC) - A photograph will be taken and if refused this will then be reviewed and documented at every Multi-Disciplinary Team (MDT) Ward Round.

A local operational procedure is in place within the Forensic Service at the HPC. As part of the admission process, a photograph will be taken of the patient and this will added to a Patient ID form which is stored at the front of each patient's healthcare record. Any patient refusing to cooperate with this process will not be granted any external leave until a photograph is in place.

7.1 Consent for taking photographs

7.1.1 Taking and using a person's photograph constitutes an invasion of privacy and so should only be undertaken with the person's informed consent. Individual patients must have the reason for taking their photograph explained to them, they have the right to refuse. They have the right to have their photograph returned to them at a later date should they change their mind after originally giving permission.

7.1.2 In the case of persons who are capable of giving informed consent, explicit informed consent is necessary before the photograph is taken and refusal of consent must be respected. Consent may be given to avoid medication error and provide a photograph to Police in certain circumstances where potential for being vulnerable of harm to selves or others has been identified.

7.1.3 It must be made clear to the patient that, while the Trust regards the taking of photographs as potentially beneficial in the delivery of safe high quality care, it is not a prerequisite to receiving care. Failure to explain this may render any consent given invalid and lay the Trust open to challenge on the issue of failure to respect human rights.

7.1.4 Patients with the capacity to make the decision whether or not to have their photograph taken or wear an identity band have the right to refuse (see separate process for Forensic in patients), although should be advised of the risks and benefits of this decision to not adhere to this policy. Patients must not be coerced or pressurised to comply. The information shared, and the discussion and decision should be recorded in the patient's clinical notes. Where patients are assessed as lacking capacity to make these decisions then a capacity assessment should be documented in the clinical records and a 'Best Interest' decision made with the decision maker being either a doctor or nurse. This must be in accordance with the Mental Capacity Act 2005 policy and documented.

7.2 Storage of the photograph

7.2.1 Only one printed photograph will be in existence at any one time. The photograph will be taken with a digital camera, printed off and stored in medication folder, in clinic room. The digital image will then be immediately deleted from the camera's memory in the presence of the patient so that no additional prints can be made. On discharge this photograph is shredded and destroyed via confidential waste

7.2.2 Any patient who significantly changes their appearance whilst an inpatient (e.g. removal of beard) will have a new photograph taken and the old photograph destroyed or returned to them. (Consent will be re-affirmed prior to a new photograph being taken.)

7.2.3 The photograph will not be used for any other uses except identifying the patient at the time of treatment/medication administration and when a vulnerable person or ,mental health inpatient is reported as missing. The photograph will be on the patient's record and it will be considered to be the patient's property. Any additional usage can only be given with the patient's consent or for patients who lack capacity as part of a 'Best Interest' decision.

7.2.4 All patients will be given a leaflet explaining the reasons for the photograph. (See Appendix 7 for leaflet.)

7.3 Providing Photographs to the Police

In relation to providing the photograph to the Police, the following considerations apply:

Photographs taken in this way form part of a confidential record and can be disclosed without consent in the usual circumstances where Trust staff can breach confidentiality namely:

- Where the patient is at risk of serious harm
- Where a third party is at risk of serious harm
- In order to prevent or detect serious crime
- If a statutory duty of disclosure exists
- If ordered to disclose by a court
- If a photograph is given to the Police they must either be returned or destroyed it and any copies made, once it is no longer needed to identify the missing person.

8.0 Patient Records/Documentation

In order to ensure correct identification of the patient to their records it is essential that when verifying patients' details against their records and any addressograph labels, changes to personal details such as name or address are amended as soon as practically possible. Patients should be asked if they know or have a card with their NHS number on.

Where possible, the patient should be asked to give name, date of birth and address to check there is correct identification. **If there is any doubt about the information given by the patient, the details in the patient's electronic record must be checked and verified.**

9.0 Communication (Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

To help someone make a decision for themselves, all possible and appropriate means of communication should be tried.
• Ask people who know the person well about the best form of communication (try speaking to family members, carers, day centre staff or support workers). They may also know somebody the person can communicate with easily, or the time when it is best to communicate with them.
• Use simple language. Where appropriate, use pictures, objects or illustrations to demonstrate ideas.
• Speak at the right volume and speed, with appropriate words and sentence structure. It may be helpful to pause to check understanding or show that a choice is available.
• Break down difficult information into smaller points that are easy to understand. Allow the person time to consider and understand each point before continuing.
• It may be necessary to repeat information or go back over a point several times. 32 Mental Capacity Act Code of Practice
• Is help available from people the person trusts (relatives, friends, GP, social worker, religious or community leaders)? If so, make sure the person's right to confidentiality is respected.
• Be aware of cultural, ethnic or religious factors that shape a person's way of thinking, behaviour or communication. For example, in some cultures it is important to involve the community in decision-making. Some religious beliefs (for example, those of Jehovah's Witnesses or Christian Scientists) may influence the person's approach to medical treatment and information about treatment decisions.
• If necessary, consider using a professional language interpreter. Even if a person communicated in English or Welsh in the past, they may have lost some verbal skills (for example, because of dementia). They may now prefer to communicate in their first language. It is often more appropriate to use a professional interpreter rather than to use family members.

• If using pictures to help communication, make sure they are relevant and the person can understand them easily. For example, a red bus may represent a form of transport to one person but a day trip to another.
• Would an advocate (someone who can support and represent the person) improve communication in the current situation?

10.0 Process for positively identifying Patients: Ask, Check, Confirm

10.1 Patients with Identification Bands

10.1.1 Always **ASK** the patient (or responsible parent/ relative if the patient is a child/ has communication difficulties, learning disabilities **and** lacks capacity) to make the decision related to ID bands.
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.

Consider alternatives if the patient is unable to communicate a decision regarding ID see section 10.2 if the patient is not a child but does not have the capacity.

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

10.1.3 Also check the unique identifier on the identityband (NHS or hospital number) and

CONFIRM this against the relevant paper or electronic health record.

Ask the patient/relative/carer	• "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/hospital 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).

10.1.3
This also applies to patients in their own home who will not routinely wear wristbands. Patients in their own home should also be asked to confirm their name and date of birth and address and this should be checked against their records.

If records are to be left in the home this process should be followed and checked against the minimum data set left in the home

NB – staff need to be aware that on occasions wrong notes have been left in homes in error

Where patients who are in their own homes and are unable to confirm their name and DOB due to cognitive difficulty or end of life for example a plan of care should be agreed with family carers – this may include photographs or identity bands

10.2 Identification of a Patient who lacks capacity regarding ID related decisions

10.2.1 If there is concern that a patient lacks capacity whether or not to consent to the ID process, this should be assessed and documented following the Trusts Mental Capacity Act (2005) (MCA) Policy (2021). https://www.leicspart.nhs.uk/wp-content/uploads/2021/09/Mental-Capacity-Act-Policy-exp-Jul-24-updated-Sep-21.pdf

10.2.2 If the patient is assessed to lack capacity for this decision following the completion of the appropriate assessment/documentation 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 (i.e. an appropriate care giver from a care home). The application of an ID band can be assessed through best interests if the patient is assessed to lack capacity

10.2.3 Once the identity of the patient is appropriately confirmed, an identification band should be applied using the agreed process. Once the identification band is in place, this should be utilised to verify the patient's identification going forward.

10.2.4 If the patient is unable to support with the positive patient identification process (i.e. unable to answer appropriate questions) and then requires transfer between wards/departments 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.

10.3 Identification of the Deceased Patient

To ensure the legal, correct and easy identification of the body in the mortuary/ funeral directors nursing staff must ensure two identification bands with the following information are present:

- Patient's NHS number
- Date of Birth
- Name

Always place one label on the deceased's right wrist.
https://www.leicspart.nhs.uk/wp-content/uploads/2019/11/Care-of-the-Deceased-Policy-exp-Oct-22.pdf

11.0 Extreme emergencies

In extreme emergencies and possibly life-threatening situations (such as an individual collapsing on the ward/reception/car park), clinical care may take priority over attaching an identity band to the patient. Where this has occurred, the healthcare professional responsible for the patient **MUST** take appropriate steps to identify the patient.
Once the surname, forename, date of birth, gender and NHS number are confirmed, a new identity bracelet MUST be attached to the patient immediately.

11.1 Patients who do not or will not wear identity bands in inpatient areas

There are some situations where a patient may not wear identity bands:

- The patient refuses to wear the identity band
- The identity band causes skin irritation
- The patient continuously removed the identity band

The patient must be informed of the potential risks of not wearing an identity band. This discussion and the reason for the patient not wearing the identity band **MUST** be witnessed by another member of staff and clearly documented in the patient's records.

For Acute Mental Health Inpatient Wards and Psychiatric Intensive Care Unit (PICU), **patients will either have an identity band or a photograph**; if both are declined by the patient then 2 registered staff (if possible and know the patient alternatively unregistered substantive staff should be used) will check the patients name and date of birth on administering medication. This will then be reviewed and documented at every MDT/ward round and the patient could then accept either option as their mental health improves.

11.3 Areas where Identity Bands are not used (Mill Lodge)

Any area not using identity bands should use the photograph procedure outlined in Section 7 to ensure correct identification of service users within that area.

Death or severe harm as a result of administration of the wrong treatment to the wrong patient following inpatient misidentification due to a failure to use standard wristband identification and check-in processes is included in the current 'Never Events list 2018' (Updated Feb 2021).

If the identity of a particular patient is not known, the staff member should refer to the patient identification process described in 5.1.

- **A local operational procedure** is in place within the Forensic Service at the HPC. As part of the admission process, a photograph will be taken of the patient and this will added to a Patient ID form which is stored at the front of each patient's healthcare record. Any patient refusing to cooperate with this process will not be granted any external leave until a photograph is in place.

12.0 Training needs

No specific training needs have been identified but clinical staff must be aware of the process as part of local induction and medicines management competency (Appendix 3).

13.0 Monitoring Compliance and Effectiveness

Compliance against the standards set out in this policy will be monitored via a monthly audit (AMAT – electronic audit data collection) reported locally and actioned accordingly. This will be monitored by the appropriate Directorate's governance through quality and safety meetings.

The Policy will be reviewed every 3 years or sooner if required in light of any local or national guidance.

14.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
All inpatients will have either an identity band or photograph as a means of supporting accurate patient identification	Monthly Audit-Medication Administration via 'AMAT' and reviewed through local governance
All in-patients within Learning Disability Services and Agnes Unit will have appropriate patient identifiers on their patient record, including an up-to-date photograph of the service (patient) user	Monthly audit- Medication Administration via 'AMAT' and reviewed through local governance

15.0 References and Bibliography

National Patient Safety Agency (NPSA) (2007) Safer Practice Notice no. 24 *Standardising wristbands improves patient safety.* London: NPSA Available at: www.npsa.nhs.uk **(Archived)**

National Patient Safety Agency (NPSA) (2005) *Patient Safety Alert, Correct Site Surgery.* London: NPSA. Available at: www.npsa.nhs.uk **(Archived)**

Making Sure the Right Patient Gets the Right Care. British Medical Journal (BMJ) (2005). Available at: https://qualitysafety.bmj.com/content/13/5/329 (Accessed 3 Nov 2021).
National Patient Safety Agency (NPSA) (2004) *Wristbands for hospital inpatients improve safety.* London: NPSA. Available at: www.npsa.nhs.uk **(Archived)**

Patient Identification Techniques – Approaches, Implications, and Findings (2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7442501/#ORriplinger-1 (Accessed 3 Nov 2021)

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 Nov 2021)

Never Events List 2018 (last updated Feb 2021) https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf (Accessed 5 November 2021)

Mental Capacity Act (2005) Policy (2021) https://www.leicspart.nhs.uk/wp-content/uploads/2021/09/Mental-Capacity-Act-Policy-exp-Jul-24-updated-Sep-21.pdf (Accessed 6 December 2021)

Care of the Deceased Policy and Guidelines (2019) https://www.leicspart.nhs.uk/wp-content/uploads/2019/11/Care-of-the-Deceased-Policy-exp-Oct-22.pdf (Accessed 6 December 2021)

Medication Error Policy (2021) https://www.leicspart.nhs.uk/wp-content/uploads/2021/10/Medication-Error-Policy-exp-Oct-24.pdf (Accessed 6 December 2021)

Acknowledgements
Positive Identification of Patients Policy and Procedure (2020) Sherwood Forest Hospitals Foundation NHS Trust (Accessed 5 November 2021) https://www.sfh-tr.nhs.uk/media/8345/positive-identification-of-patients-policy.pdf

Patient Identification Policy (2020) Lincolnshire Community Health Services (Accessed 6 December 2021) https://www.lincolnshirecommunityhealthservices.nhs.uk/application/files/2715/9499/7817/P_CS_24_Patient_Identification_Policy.pdf

Due Regard Screening Template	**Appendix 1**
Section 1	
Name of activity/proposal	Patient Identity Policy
Date Screening commenced	30/05/2023
Directorate / Service carrying out the assessment	Enabling – CPST
Name and role of person undertaking this Due Regard (Equality Analysis)	Tracy Ward, Head of Patient Safety

Give an overview of the aims, objectives and purpose of the proposal:

AIMS: The aim of this policy is to ensure that all in-patients within Leicestershire Partnership Trust (LPT) can be correctly identified in order to reduce and, where possible, eliminate, the risks and consequences of misidentification.

OBJECTIVES: Policy outlines responsibilities and procedures for ensuring correct identification of patients in Leicestershire Partnership Trust.

Section 2

Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	There is neutral impact on all the characteristics mentioned.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No x	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision:

The policy applies to all patients and does not impact on any protected characteristics.

Signed by reviewer/assessor		**Date**	11/10/2016
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	T Ward	**Date**	April 2024

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐✓
Respond to different needs of different sectors of the population	☐✓
Work continuously to improve quality services and to minimise errors	☐✓
Support and value its staff	☐✓
Work together with others to ensure a seamless service for patients	☐✓
Help keep people healthy and work to reduce health inequalities	☐✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐✓

Training Requirements **Appendix 3**

Training Required	YES x	NO
Training topic:	Patient Identification – part of local induction and medicine management	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific **x** ☐ Personal development	
Directorates to which the training is applicable (=X):	☐ **x** Directorate of Mental Health (including the Older Person) ☐ **x** Community Health Services ☐ Enabling Services ☐ **x** Families Young People Children & Learning Disability Services	
Staff groups who require the training:	all staff on induction to services should be informed of local & trust requirements	
Regularity of Update requirement:	Once only	
Who is responsible for delivery of this training?	Local Ward Manager/or Deputy allocated	
Have resources been identified?	None required	
Has a training plan been agreed?	NA	
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)	
How is this training going to be monitored?	Local Induction	

Appendix 4 - Information Leaflet

Information leaflet and consent or decision form for the photographing of adult inpatients to reduce the risk of medication or treatment errors and for use when a vulnerable adult goes missing

It is Leicestershire Partnership NHS Trust's policy that all adults admitted to our inpatient units are photographed. There are two reasons for this:-

1. To reduce the risk of medication or treatment errors caused by patients being wrongly identified.

2. To assist in the early identification and return of missing vulnerable patients.

Leicestershire Partnership NHS Trust recognises the sensitivity of this issue but this process enables us to run a safe and effective service and to assist the Police in every possible way at times when vulnerable patients are missing.

While we recommend that all in-patients have their photograph taken you have the right to refuse and your refusal will not affect your care in any way. You can also agree to have your photograph taken for the use of reducing medication/treatment errors but refuse to have it released to the Police.

Only one printed photograph will be in existence at any one time. The photograph will be taken with a digital camera. The digital image will then be immediately deleted from the camera's memory in your presence so that no additional prints can be made.

We appreciate your co-operation with this policy and reassure you that the photograph will only be used for the reasons above and not for any other purpose. Should you be unhappy about the need to have your photograph taken, or wish to refuse, please talk to your Primary Nurse who will explain the reasons to you in more depth.

Thank you for your co-operation.

If you require this document in another format such as large print, audio or in another community language, please contact the Communications Team on 0116 295 0994

Above Present in Policy from 2017

Photographing of adult inpatients consent or decision form

Patient Name…….
Date of Birth…….
Ward / Unit……

Part 1 - Patient has capacity to make the decision to have a photograph taken or not

The policy on the photographing of adult inpatients has been explained to me by:
Staff member's name……
Position…… Ward……..

Consent to photograph being used in relation to medication

I agree/do not agree* to my photograph being taken and used to ensure the safe administration of medication *(*delete as appropriate*)
Signed (patient)……
Date……..…….
Witnessed by (staff) ……
Staff Signature …….

Consent to photograph being used by the Police.

I agree/do not agree* to my photograph being taken and used to assist the Police in locating and supporting me if I am at serious risk of harm *(*delete as appropriate).*
Signed (patient)…….
Date……...
Witnessed by (staff)……
Staff Signature…….

Part 2 – Best interest decision

A relevant capacity assessment has been made and the patient does not have capacity to make this decision thus a best interest decision ~~. Based on a lack of mental capacity to make this decision a 'best interest' decision~~ has been made to take / not take* a photograph and the decision recorded in the notes *(*delete as appropriate).*
Signed (doctor or senior nurse)…….
Name……..
Date…….

Reviewed and updated July 2022

Stakeholders and Consultation **Appendix 7**

Key individuals involved in developing the document

Name	Designation
Sue Arnold (2021)	Corporate Patient Safety Team Lead Nurse

Circulated to the following individuals for comment – May 2021/2023 review (limited feedback only)

Name	Team/Designation
Tracy Ward, Jo Nicholls	Head of Patient Safety & CPST
Michelle Churchard-Smith & Jane Martin	Head of & Deputy Head of Nursing DMH
Paul Williams	FYPCLD
Maureen Williams & Sandra Marshall	FYPC – Eating Disorders Senior Ward Nurses
Anthony Oxley, Joanna Charles & Tejas Khatau	Pharmacy Services
Caroline Towers & Jenny Dolphin	Governance representatives
Kerry Palmer	Trust Medical Device Lead
Jane Capes, Elizabeth Compton, Bernard Masanga, Olivia Adams, Jon-Paul Vivers, Jodhun Persand, Emily Jarvis, Jeya Babudas	DMH(Inc. MHSOP) In-Patient Matrons & Senior Ward Nurses
C Knott & S Roost	Health & Safety
Sam Kirkland	Data Privacy
Zayad Saumtally, Carmela Senogles, Paul Howley, Francine Bailey, Danica Izycki, Clare pope, Judith Pither	Senior Nursing & Ward Nurses FYPCLD
Robert Lovegrove	Security Specialist
Jonathan Dexter	On behalf of ANP's
Alison Taylor-Prow	Safeguarding Lead
Michaela Ireland, Sarah Latham, Margot Emery, Sarah Staunton, Jade Beavis, Roshnee Gill, Patsy Huband	Senior Nursing & Ward Nursing - CHS
Mark Grigg	Senior Nurse/Lead Low Secure Inpatients

Recirculated to PSIG Group 6 Dec 2021 following ‘Patient ID’ Meeting November 2021 DMH
Trust policy experts