NHS
National Patient Safety Agency

Safer practice notice 11

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Notice

22 November 2005

Immediate action	☐
Action	☑
Update	☐
Information request	☐

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Wristbands for hospital inpatients improves safety

All hospital inpatients in acute settings should wear wristbands (also known as identity bands) with accurate details that correctly identify them and match them to their care.

Between November 2003 and July 2005, the National Patient Safety Agency (NPSA) received 236 reports of patient safety incidents and near misses relating to missing wristbands or wristbands with incorrect information. Research and anecdotal evidence show that patients often do not have wristbands and that this increases the risk of them being incorrectly identified and given the wrong care.[1,2,3,4,5]

NHS staff have told the NPSA that this notice will help them to promote the use of wristbands for inpatients in acute care settings. It is the first phase of a programme of NPSA work on safer patient identification. For further information, see the background and research section on page 3 or visit the NPSA website at **www.npsa.nhs.uk/advice**

Action for the NHS

By May 2006, NHS organisations providing acute services in England and Wales should have **either**:

- implemented the NPSA's recommendations (see page 2), stating that all inpatients should wear wristbands that identify them and match them to their care. Formally risk-assessed alternatives should be made for patients for whom this is not possible or practical such as pre-term babies[6], patients with some skin conditions and those with learning disabilities. Arrangements should also be made for implementing and monitoring this advice; **or**
- other formally risk-assessed arrangements. Monitoring should show that these arrangements are as effective as those set out in this notice.

Wristbands do not remove clinicians' responsibility for checking patients' identity. They are an important way of validating identification particularly when a patient is unable to provide their own details.

The recommendations in this notice relate to care in acute settings. The NPSA will be considering how these recommendations can be transferred to other areas of care such as outpatients and primary care.

For response by:
- NHS organisations providing acute services

For action by:
- Directors of Nursing in England and Wales

We recommend you also inform:
- Medical directors
- Clinical governance leads and risk managers
- Patient advice/liaison service staff in England
- Service managers

The NPSA has informed:
- Chief executives/regional directors and clinical governance leads of strategic health authorities (England) and regional offices (Wales)
- Healthcare Commission
- Healthcare Inspectorate Wales
- NHS Purchasing and Supply Agency
- Welsh Health Supplies
- Royal Colleges and societies
- NHS Direct
- Relevant patient organisations and community health councils in Wales
- Independent Healthcare Forum
- Commission for Social Care Inspection
- National Association of Theatre Nurses
- National Association of Assistants in Surgical Practice
- Association of Operating Department Practitioners
- Quality Improvement Scotland and DHSSPS, Northern Ireland
- Connecting for Health
- Informing Healthcare

NPSA recommended procedures to be included in all relevant local policies

A member of senior clinical or managerial staff should be responsible for making sure the following recommendations are included in all patient identification policies as well as those relating to specific areas such as Serious Hazards of Transfusion[7]; the Ionising Radiation (Medical Exposure) Regulations 2000[8]; and those specified in the NPSA's Correct site surgery Alert[9].

Recommended procedures

Make clear the roles of individual staff responsible for matching patients to their care:

1 Wristbands must be put on patients as soon as they are admitted and worn throughout their hospital stay. If a member of staff removes a wristband:

- it is their responsibility to make sure it is replaced. Make clear alternative arrangements for the patient's correct identification if it cannot be replaced immediately;
- use local risk-assessed checking procedures to confirm the patient's identity.

2 The wristband should be put on the dominant arm, that is the side used for writing, it is then less likely to be removed when, for example, intravenous access lines are inserted.

3 Any member of staff that discovers a patient does not have a wristband, has to assume responsibility for correctly identifying them.

Recommended procedures for patients unable to wear wristbands

Measures should be in place to formally assess and manage the risks associated with identifying patients:

1 who cannot wear a wristband because of their clinical condition or treatment, for example multiple intravenous access lines or dermatology conditions and treatment;

2 who refuse to wear a wristband despite clear explanation of the risks of not doing so;

3 who may or may not be wearing a wristband, but who are critically ill, unconscious, confused or cannot communicate.

Single identification wristbands

The NPSA recommends the use of a single identification wristband[10] that incorporates all essential information.

Staff training

The policy should be explained in training sessions and induction programmes and include examples of incidents that demonstrate what can go wrong. This will help staff appreciate the importance of making sure wristbands are worn.

Reporting incidents

Staff should be encouraged to report to the NPSA's National Reporting and Learning System (NRLS), via their local risk management system, any patient safety incidents, including near misses, related to patients who have no wristband or one with incorrect information.

Patient awareness

The Director of Nursing is responsible for ensuring that the patient briefing is incorporated into all appropriate patient information. It should be explained to patients in pre-admission letters the importance of wearing a wristband for their own safety at all times during their hospital stay. It could also be included in any relevant leaflets or posters.

Monitoring and review

The local ongoing audit of procedures should include checking:

- the number and percentage of patients wearing wristbands;
- the accuracy and reliability of the information included on them;
- the reasons why patients may not be wearing wristbands;
- the efficacy of alternative arrangements;
- safety incidents related to wristbands.

Information to be included on wristbands

The NPSA is standardising wristband design and the information on them. The NPSA will issue a publication about this in 2006-07.[11] This will help staff moving between NHS organisations across England and Wales. This in turn will help make patient care safer.

The NPSA is also leading work on establishing an NHS Information Standards Board standard[12] on patient identification and matching the right patient with the right care.

There will be wide consultation with the NHS and patients regarding these areas of work.

Background and research

Reducing and where possible eliminating errors in matching patients with their care is one of the key ways to improve patient safety. There are no accurate figures on the frequency or cost of mismatching errors but research and reports received by the NPSA to the NRLS indicate that mismatching errors form a significant proportion of the errors that occur in healthcare. There are many reasons for this including patients not wearing a wristband or wearing a wristband that does not provide reliable and unique identifiers.

In 2003 the NPSA commissioned research on manual checking processes and the use of technologies in matching patients with their care.[13] This revealed published evidence of failure in the effective use of wristbands. For example, an audit at Guy's and St Thomas' Hospital in 2003 identified that 34 per cent of patients were not wearing a wristband.[14] Other research found that two to three per cent of bedside wristband checks were unsuccessful and the most common reason for this was that wristbands were absent.[15]

The research also showed that NHS staff have often intervened to prevent errors that are due to the lack of systematic and standardised processes for identifying patients.

New technologies can help identify patients. However, wristbands will continue to be important. Barcodes or radio tags will need to be located in wristbands alongside printed details. The NHS will have to make sure that wristbands are worn by all inpatients, if new technologies are to succeed.

Patient and public views on wearing wristbands

The NPSA held two workshops with patients and members of the public. Key points were:

- patient identification is a very important issue;
- shorter stays in hospital can make it more likely that inpatients will not be recognised;
- several patients had experienced inadequate identification including being left without a wristband for several days;
- patients want effective identification methods, whether wristbands or other means.

NHS staff views

NHS acute trusts have been keen to work with the NPSA on promoting the effective use of wristbands. The NPSA was invited by acute trusts to five local fora to discuss the issues with staff. There was unanimous support for a national wristband standard in acute care settings. Other key points were:

- all staff recognise the importance of wristbands for accurately identifying inpatients;
- there is wide variation in the information on wristbands and the way staff check inpatients' identity;
- it can be difficult to apply wristbands to some patients because of their clinical condition or treatment;
- training on checking patients' identity is not consistently available or provided for all staff groups.

Professional organisations' views

The NPSA has sought advice from the royal colleges and other medical, nursing and allied health professionals' organisations about the guidelines and training available for NHS staff. Their responses show:

- there is not a standard or consistent training programme for NHS staff on identifying patients;
- identifying patients is mainly covered as part of other training courses such as those on patient assessment or drug administration;
- staff are often unclear about the best way to identify patients, what information to include on a wristband, and when wristbands should be applied.

The bodies consulted agree that safer patient identification needs to be specifically included in the range of skills training for all NHS staff providing care and treatment, carrying out procedures related to investigations such as collecting blood specimens for analysis, and performing complex investigative procedures.

Additional work on matching patients with their care

This safer practice notice is part of a wider programme of NPSA work on safer patient identification and matching patients correctly with samples, specimens, records and treatment. To date the NPSA has:

- published *Right patient – right care* in December 2004, which summarises research on manual checking and the use of technologies for patient identification;[13]
- published a patient safety alert on correct site surgery[11] on ways to minimise the risk of surgery on the wrong part of the body.[11]

The NPSA is also promoting safer ways of identifying patients through:

- working with Connecting for Health (CfH – formerly NPfIT) in England and Informing Healthcare in Wales, the NHS and the healthcare industry on appropriate technologies for identifying patients;
- exploring local NHS initiatives for reducing incidents of incompatible blood transfusions;
- assisting the Department of Health conduct a regulatory impact analysis on the proposed use of barcodes and/or radio frequency tags on medicines and blood products in the UK.

Evaluation

The impact of this notice will be evaluated in England through the Safety Alert Broadcast System (SABS) six months after issue and in Wales through the Welsh Assembly Government. There will also be a 'before and after' audit of compliance with wristband wearing carried out through a questionnaire to a sample of NHS organisations providing acute services.

Further details

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For more information on the NPSA, visit **www.npsa.nhs.uk**

For more information about how you can improve patient safety, visit **www.saferhealthcare.org.uk** – a one stop for knowledge and innovation for safer healthcare.

References

1 National Blood Service and Royal College of Physicians. *Comparative Report for Blood Transfusion in England.* November 2003.
2 Guthrie, D. *Positive Patient Identification. Frontiers in Laboratory Medicine.* The Royal College of Physicians: London, February 2003.
3 Human Reliability Associates. *Mismatching between planned and actual treatments in medicine – manual checking approaches to prevention.* 2004. Available at **www.npsa.nhs.uk**
4 Cambridge Consultants. *Ensuring patients are correctly matched with samples or specimens taken from them and treatment planned for them.* January 2004. Available at **www.npsa.nhs.uk**
5 Royal College of Nursing. *Right Blood, Right Patient, Right Time, RCN guidance for improving transfusion practice*. London, June 2004.
6 The Royal College of Paediatrics and Child Health recommend that identification bands are placed on babies immediately after birth and that care is taken to ensure they do not become dislodged or removed. Particular care should be taken in the identification of twins, where both babies are admitted, either to postnatal wards or, in particular, special care baby units.
7 For further information regarding Serious Hazards of Transfusion, refer to: **www.shotuk.org**
8 For further information regarding Ionising Radiation Regulations 2000, refer to: **http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4007957&chk=FkG/YB**
9 National Patient Safety Agency. *Patient Safety Alert: Correct site surgery.* Available at **www.npsa.nhs.uk/advice**
10 In some specific circumstances there may be a need for an ankle band or a second wristband, for example, babies usually lose weight in the first few days of life and having two bands helps to ensure that danger to the baby is lessened if one band slips off. For elderly people who are agitated and are likely to pick at their wristband, an ankle band in addition or instead of a wristband may be necessary.
11 The NPSA cannot recommend what information to include on a wristband until the next phase of this work is completed, but it is common for trusts to use first name and surname, date of birth and a unique number, for example the NHS number or the hospital or unit number. The standard for transfusion medicine specifies sex as well (British Committee for Standards in Haematology. *Transfusion Medicine.* vol 9, September 1999).
12 The Information Standards Board provides the assurance and sign-off process for information standards in the NHS in England.
13 National Patient Safety Agency. *Right patient – right care: improving patient safety through better manual and technology-based systems for identification and matching of patients with care.* London, December 2004. Available at **www.npsa.nhs.uk**
14 Guthrie, D. op.cit
15 College of American Pathologists (CAP). Q-Probes and Q-Tracks Studies: 92, 93, 94 and 02.

Acknowledgement
The NPSA would like to thank the many NHS acute trusts and staff who have contributed their views to the NPSA's safer patient identification work.

A safer practice notice strongly advises implementing particular recommendations or solutions.

This safer practice notice is written in the following context:

It represents the view of the National Patient Safety Agency, which was arrived at after consideration of the evidence available. It is anticipated that healthcare staff will take it into account when designing services and delivering patient care. This does not, however, override the individual responsibility of healthcare staff to make decisions appropriate to local circumstances and the needs of patients and to take appropriate professional advice where necessary.

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