SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Identification of Patients within Inpatient Mental Health Care Settings
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/288
DATE OF PUBLICATION	January 2022
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 6 - (6.5, 6.6) Patient Identification and Procedure Matching
REVIEW DATE	January 2025
FORMER REFERENCE(S)	SESIAHS Procedure PD 296
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Director, Mental Health Service
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FUNCTIONAL GROUP(S)	Mental Health
KEY TERMS	Inpatient identification, hospital armband
SUMMARY	This procedure has been developed to standardise the system of patient identification across SESLHD Mental Health Service inpatient facilities, in accordance with NSW Ministry of Health Policy Directives regarding inpatient units (acute and non-acute care) and patient identification bands.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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1. POLICY STATEMENT

Correct identification of a patient promotes patient safety and prevents errors in procedures, administration of medication, and diagnostic testing. The South Eastern Sydney Local Health District (SESLHD) Mental Health Service (MHS) is committed to privacy and patient safety through the accurate identification of patients who are receiving care.

2. BACKGROUND

The MHS is committed to the reduction and elimination of errors in the matching of patients with their care. Misidentification can result in the wrong treatment and care being provided to patients. In order to minimise misidentification, and in accordance with NSW Health Policy Directive PD2017_032 - Clinical Procedure Safety this procedure outlines the process for correct identification of patients within mental health inpatient units.

A hospital armband is the preferred method of identification for the purpose of ensuring appropriate health care, with photographic identification an option.

3. Definitions

Throughout this document, the terms *patient, client* and *consumer* may be used interchangeably to acknowledge the varying preferences of people who give and receive services in the SESLHD MHS.

4. RESPONSIBILITIES

4.1 Employees will:

- Follow local procedures established for the use of hospital armbands
- Follow local procedures established for access to hospital armbands
- Follow local procedures established for photographic identification, if used.

4.2 Line Managers will:

- Ensure that all staff receive suitable and sufficient training to promote utilisation of hospital armbands as the primary source of identification
- Ensure that local procedures for the implementation, governance, maintenance and use of hospital armbands, or photographic identification if used, are enacted within their workplace.

4.3 District Managers/Service Managers will:

- Assign responsibility for ensuring implementation and maintenance of the hospital armband, or photographic, identification systems
- Ensure local procedures for the implementation, governance, maintenance and use of hospital armbands, or photographs, are developed and communicated to all managers and staff.

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4.4 Medical staff will:

- Follow local procedures established for the use of hospital armbands, or photographs.

5. PROCEDURE

5.1 Entry into Inpatient Mental Health Care

Patients shall be correctly identified on admission to inpatient units. To improve the accuracy of identification, at least three identifiers must be used:

- Name (family and given names)
- Date of birth
- Three forms of identification such as driver's licence, Medicare card, social services card.

Staff must obtain and confirm all identifying and special needs information relating to the patient including, where possible, the full family and given names, date of birth, Medical Record Number (MRN), allergies and alerts.

A full physical description of the patient's appearance must be documented within the 'Physical Appearance' module of the electronic Medical Record (eMR) software.

5.2 Mental Health Inpatient Setting

Staff must ensure that patients are adequately identified prior to their hospital armband being fitted, or photograph being taken, with a minimum of three forms of identification being used (driver's licence, Medicare card, social services card, health care card etc.) to confirm identity. If these are not available from the patient, a relative/carer or relevant other should be able to verify identification information pertaining to the person, identifying the patient and their relationship to the patient. This must be documented in the health care record.

A full explanation of the need to protect patients and ensure they receive the correct treatment, in accordance with NSW Health Policy Directive PD2017_032 - Clinical Procedure Safety, should be provided to the patient and/or designated carer or relevant other, prior to the armband being fitted, or photograph being taken.

It is recommended, where possible, that the hospital armband be prepared and fitted as part of the admission procedure so that early identification can be established. Only **one** armband should be applied per patient, from a choice of two colours: white for a patient with no allergies, and red for a patient with allergies. Text should be on a printed label, black on a white background, (or on a white panel within red armbands) and only handwritten when a printed label is not available.

While armbands are seen as the primary system of identification, if the patient refuses to have a hospital armband fitted, photographs should be considered as an alternative means of identification.

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How photographic identification is managed should be determined by local clinical governance processes. Standards of practice should include storage, disposal and management of patient photographs, consistent with privacy and security.

Patients must be informed that declining consent to the wearing of a hospital armband, or having a photograph taken, does not affect the planning or delivery of their treatment or care.

However, should a patient refuse to wear an armband, or have their photograph taken, an alternative system of identification must be instigated and documented in the eMR, such as two staff members to attend to confirm identification, whenever there is a requirement to identify a patient (eg such as before medication or a procedure).

Staff must ensure that all hospital armbands, or photographs, are robustly and accurately identified with the three core patient identifiers:

- Name (family and given names)
- Date of birth
- Unique Patient Identifier, also referred to as Medical Record Number or MRN.

5.3 While in Care

No assumptions about identity can be made. At least three identifiers should be used to confirm identity. The robustness of identification accuracy is paramount.

Hospital armbands, or photographs, are to be used by staff to aid in the identification of patients prior to the administration of medication. However, the patient should also be asked to state their full name and date of birth.

Any staff member discovering a band is missing with no photograph available, or noticing a band contains inaccurate/unreadable information, must assume responsibility, or must actively transfer responsibility, for verification of the patient's identity and replacement of the missing/incorrect identification band PD2021_033 - Patient Identification Bands.

For non-acute care admissions (e.g. Mental Health Rehabilitation Unit), where the inpatient length of stay is greater than 12 continuous months, hospital armbands, and photographs if used, must be updated annually.

5.4 Documented Allergy

Where a patient has a documented allergy/adverse reaction to a medicine, a red armband must be placed on the patient. Staff should refer to the patient's health care record for details of the allergy and/or adverse reaction. No allergies are to be written on the armbands. This should be in addition to any photographic identification, if used.

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5.5 Transfer of Care

On transfer of care between mental health services, hospital armbands, and photographs if used, must be updated. Existing hospital armbands, and photographs if used, must be destroyed using confidential means (e.g. confidential shredder/bin) or given to the patient, a relative/carer or relevant other.

5.6 Exit from Care

On discharge from the inpatient unit, or exit from care/discharge, all current inpatient hospital armbands, or photographs if used, must be destroyed using confidential means (e.g. confidential shredder/bin) or given to the patient, a relative/carer or relevant other.

5.7 Insufficient or Inaccurate Information

The robustness of identification accuracy is paramount. Where staff are unable to gain verification of a person's identity, consideration should be given to advising the Nursing Unit Manager, Medical Officer and/or NSW Police of an unknown person.

In the event that identification of the patient is incorrect, the treating psychiatrist must be informed, and the incident notification procedure commenced.

6. DOCUMENTATION

Staff must ensure that:

- Verbal or implied consent to the wearing of a hospital armband, or the taking of a photograph, is given.
- All hospital armbands, or photographs, are robustly and accurately identified (i.e. with the patient's family and given names, date of birth and MRN).

7. AUDIT

An audit is to occur bi-annually via the Service Clinical Governance protocols.

8. REFERENCES

NSW Health

- PD2021_033 - Patient Identification Bands
- PD2007_094 - Client Registration Policy
- PD2017_032 - Clinical Procedure Safety

SESLHD

- SESLHD Clinical Governance Unit Memo, 21 February 2014: 'New Patient Identification Bands' (TRIM No: T14/6006)

Other

- Health Privacy Principles in the NSW Health Records and Information Privacy Act 2002
- NSW Work Health and Safety Act 2011

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9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2013	1	Angela Karooz, SESLHD MHS Risk Manager. Policy revision to include NSW Ministry of Health Patient Identification Standard April 2013 (content including three core identifiers and allergy band).
June 2013	1	Approved by SESLHD MHS Clinical Council following amendment by Assoc Prof Brian Draper.
August 2013	2	Reformatted by Scarlette Acevedo, District Policy Officer.
October 2013	2	Final version published.
April 2014	3	SESLHD MHS Clinical Governance Committee (CGC) determines the MHS should revert to hospital armbands as the sole recommended form of identification in all inpatient mental health units. It follows a small-scale survey of mental health consumers conducted by Irene Gallagher, SESLHD MHS Consumer Partnerships Coordinator, and Angela Karooz, SESLHD MHS Risk Manager, and views shared at the CGC meeting, including feedback from Clinical Operations Managers.
April 2014	3	Policy edited by Victoria Civils-Wood, SESLHD MHS Senior Executive Officer, to reflect SESLHD MHS Clinical Governance Committee decision.
July 2014	3	Endorsed by SESLHD MHS Clinical Council.
September 2017	4v1	Under review by A/Clinical Risk Manager. Inclusion of armband identification as the primary method and photographic identification as optional. Processes for non-armband identification procedures will be managed by the local clinical governance committee.
March 2018	4v2	Endorsed by DDDCC. Endorsed by MHS Clinical Council on 22 March
May 2018	4v2	Endorsed by SESLHD Clinical and Quality Council
December 2021	5.0	Routine review commenced. Links checked and updated. Minor changes to wording. Circulated to DDCC for feedback.
December 2021	5.1	Standards updated. Addition of what to do when a consumer declines to wear an arm band or have photo ID. Endorsed by SESLHD MHS Document Development and Control Committee
January 2022	5.1	Endorsed by Executive Sponsor.

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