The WA Patient Identification Policy has been updated to align with the Australian Commission on Safety and Quality’s specifications for a standard patient identification band (National specifications)\(^1\). Refer to section 13.0 for exceptions to the WA Patient Identification Policy.

This policy is available online at:  
www.health.wa.gov.au

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1 Background
Throughout the health care industry, the failure to correctly identify patients and correlate that information to an intended clinical intervention continues to result in wrong person, wrong site procedures, medication errors, transfusion errors, and diagnostic testing errors.

Patient safety incidents and near misses associated with incorrect patient identification is a recognised international problem. Prevention of such incidents has been identified as a key patient safety goal by all of the major international and Australian patient safety agencies including the World Health Organisation 2,3, National Patient Safety Agency in the United Kingdom 4, Joint Commission International Centre for Patient Safety 5 and the Australian Commission on Safety and Quality in Health Care 1.

2 Purpose
Wristbands containing patient information have been the standard method of identifying patients in WA hospitals/health services for many years.

This document outlines the policy and procedures that must be followed in public hospitals/health services to ensure correct patient identification at all times during emergency and hospital admission. Its purpose is to:

• identify the minimum level of patient identification information that must be collected and documented by WA hospitals/health services
• set out standards for the content, colour and use of patient identification bands in West Australian public hospitals.

3 Scope
The WA Patient Identification Policy (the policy) is based on standards for patient identification and patient wristbands Australian Commission on Safety and Quality in Health Care (ACSQHC) 1.

This policy applies to all West Australian emergency department patients, inpatients and day procedure patients. Health Service Managers and Clinical Directors are advised to bring this policy to the attention of staff to ensure its prompt implementation within their jurisdiction.

All patients must be correctly identified at the time of registration/admission at an Emergency Department, admission and throughout their hospital stay.

Compliance with this policy is required by the following health service staff:
• Clinicians (medical, nursing, midwifery, pharmacy and allied health staff)
• Relevant clerical and ward staff (including ward clerks, patient care assistants and catering staff)
• Quality/Clinical Governance Coordinators.
This policy should be read in conjunction with:


## 4 Principles

The following principles have guided the development of the WA Patient Identification Policy.

- All patients must be correctly identified at the time of registration/admission at an Emergency Department, admission and throughout their hospital stay.
- All patients should wear some form of patient identification, and health care providers should have guidelines in place that guides this identification process.
- The primary purpose of an identification band or other identification mechanism is to identify the patient in the clinical setting. The use of identification bands to signify clinical alerts is secondary.
- Hospitals/health services will need to determine how they meet the specifications for identification bands at a local level.
- Hospitals/health services will need to justify exceptions to the National Specifications ¹.

## 5 Mandatory patient identification descriptors

A complete system of unique identification for each patient is mandatory at all WA public hospitals.

If known, core patient identifiers must include:

- **FAMILY NAME** and **Given Name/s** – Family and given names should be clearly differentiated. Family name should appear first using UPPER case letters followed by given names in Title case. That is, FAMILY NAME, Given Name/s. For example, SMITH, John Paul
- **UMRN** (Unit Medical Record Number or equivalent)
- **DOB** (Date of Birth written as DD/MM/YYYY).

As a minimum, the core identifiers must be used on registration or admission, when care, therapy or other services are provided and whenever clinical handover, patient transfer or discharge documentation is generated.

Patient identifiers on identification bands must be limited to the core patient identifiers.

Issues that will need to be determined locally at the hospital / health service level include:
Inclusion of substitute identifiers, in the instance that one or more of the mandatory identifiers listed above is unknown. Note a minimum of three patient identifiers.

- Cultural naming conventions
- Use of preferred names rather than correct names
- Use of names for neonates.

6 Patient identification bands

6.1 Identification band specifications

All inpatients, day procedure patients and Emergency Department patients must have an identification band securely attached immediately after patient registration/admission and before any treatment, collection of pathology samples, blood transfusion, drug administration or X-rays are undertaken.

The design and specifications of the patient identification band must comply with the ACSQHC’s National Specifications for Patient Identification Bands.

The identification band must comply with the Mandatory Patient Identification Descriptors (refer to section 5). Where possible, the patient must view and verify that these details are correct. If the patient is unable to do so, the next of kin/legal guardian/carer may undertake this responsibility; otherwise, a second staff member must check the information on the identification band against the admission details.

6.2 Identification band use

Where possible, the identification band must remain on the patient throughout the hospital admission.

If a detached identification band is not replaced immediately, it cannot be reattached. In this case, the patient must be re-identified and a new identification band attached.

Prior to procedures, sample collection, investigations, intravenous infusions and medication administration, the patient shall be positively identified by:

- Checking the identification band that is securely attached to the patient
- Following the process for confirming the patient’s identity as per section 7.
6.3 Coloured identification bands

A single white identification band should be used for patient identification.

As per current hospital procedure, the admitting clinician must ascertain and document whether the patient has an allergy, has ever had an adverse reaction or another known risk.

Patients with a known allergy or other known risk can be issued with a RED patient identification band. No other coloured patient identification band is to be used.

Only one identification band should be used at any one time. When an allergy alert condition exists the white identification band is replaced by a RED identification band.

If an allergy is identified subsequent to admission the standard white identification band will be replaced by a RED identification band by nursing/midwifery staff caring for the patient.

Where RED identification bands are used they should comply with all requirements of the ACSQHC Patient Identification Band Standards. The RED identification band will have patient identifiers in black text on a white background.

The RED identification band should not contain details of the meaning of the alert. This information should be recorded in the patient’s health care records. The patient’s health care record must be reviewed by clinical staff to determine the meaning of the alert.

In the instance that a RED identification band is removed for a procedure or treatment, the staff member responsible for removing the identification band must also take responsibility for replacing it as per Section 6.

7 Process for confirming the patient’s identity

7.1 Identification of patients on admission

All patients shall be positively identified prior to patient registration/admission by:

- asking the patient to spell their family and given names and state their date of birth and address
- where the patient is unable to give this information all reasonable attempts must be made to confirm the patient’s identity which can include an accompanying adult, checking with other identification (e.g. driver’s licence) or
via an interpreter. This should be documented in the patient’s health care record. Refer to section 7.1.2 if the patient’s identity cannot be reliably confirmed.

This information will be used to identify existing records in the Central Patient Index (CPI). Any discrepancy with an existing record shall be investigated and rectified according to local operating procedure. If a CPI record does not already exist, a new UMRN must be created.

Wherever possible a Medicare card and/or other documented identification should be provided by the patient.

7.1.1 Procedures if two or more patients in a ward have the same family name

If two or more patients in a ward have the same family name a local “PATIENT WITH THE SAME NAME IN WARD” cautionary card must be applied to each patient’s health care record. Alerts must also be applied to all ward bed lists and other patient documentation while both patients remain in the ward. The patient’s given name should also be printed on these cards.

7.1.2 Procedures if the patient’s identity cannot be confirmed

When a patient’s identity cannot be reliably confirmed (e.g. patient is unconscious, intoxicated, mentally impaired, or experiencing language difficulties) they must be registered as ‘Unknown Male’ or ‘Unknown Female’ using an emergency UMRN.

Pre-printed ‘Unknown’ files are recommended for emergency patients for resuscitation where samples/investigations must be initiated prior to patient registration.

Once the patient is identified, patient information should be updated and a new identification band attached.

Local operational policy must stipulate procedures to ensure that such patients can be correctly identified throughout their admission; particularly, in relation to the reconciliation of samples/investigations.

If a previous UMRN is found, the pre-existing medical record will be merged with the new medical record.

7.1.3 Procedures if the patient’s identity is changed/updated

In the event that core patient identification details (Family name and given names, DOB) are legitimately changed or updated (e.g. Unknown patient or baby name change):
• patient details must be updated in the Patient Administration System (UMRN must not change)
• a new identification band must be attached to the patient

If the Transfusion Medicine Unit has already performed tests or cross matched blood they must be notified immediately

Departments that have performed investigations, such as blood tests and X-rays must be notified.

7.2 Identification of patients at handover, transfer and discharge
Health services/sites must develop policies to ensure the correct identification of patients at handover, transfer and discharge.

All handover, transfer and discharge documentation should include the three national patient identifiers (refer to section 5).

8 Identification procedures for neonates
The same patient identifiers outlined in this policy must also apply to neonates

A single white patient identification band should be placed on the neonate at birth to indicate the mother’s identification details (i.e. Mother’s UMRN).

Once the infant’s name is registered, the identification band with the mother’s details can be removed and replaced with an identification band listing the infant’s details.

9 Procedures for clinical areas where no identification bands are used
The primary focus of this policy is to ensure the correct identity of patients and correct wearing of patient identification bands by inpatients.

The policy has been developed based on the principle that all patients must be correctly identified, and wherever possible, inpatients should wear some form of patient identification.

The policy recognises that there are some situations where a patient may not be able to wear a patient identification band, including:
• mental health patients
• patients who refuse to wear the patient identification band
• patients who cannot wear a patient identification band because of their clinical condition or treatment.

In situations where the wearing of a patient identification band is inappropriate, due to a patient’s condition or treatment, consideration may be given to the use of photo identification. Any form of identification should comply with the ACSQHC’s National Specifications for Patient Identification Bands 1.

While patient identification bands may not be acceptable or appropriate for outpatients, WA hospitals/health services should implement alternative strategies to ensure that all patients are correctly identified before treatment is commenced. Consideration should be given to the use of name tags or identification for use in these areas.

In non-inpatient areas where the identity of a patient needs to be checked and the patient is not wearing a name band, the patient’s name, address and date of birth must be checked against the health care record identification label.

10 Procedures in the event that a patient is incorrectly identified

If a patient is incorrectly identified:
• the previous identification band with incorrect patient details should be removed
• patient health care records should be corrected and a new identification band with the correct patient details should be provided immediately
• all departments that have performed investigations and treatment, such as X-rays, pathology and pharmacy, should be notified as a matter of urgency
• the event should be thoroughly documented in the patient’s health care record and reported as a clinical incident.

Transfusion medicine presents a particularly high risk to patient safety with regard to patient misidentification. It is therefore critical that incidents relating to patient and/or sample misidentification are communicated appropriately and immediately.

11 Action in the event of a wrong patient, wrong procedure or wrong site clinical incident

In the event of a patient being incorrectly identified or a clinical incident occurring as the result of incorrect patient identification, the most senior member of the clinical team must ensure the patient involved in the incident is safe and that all necessary steps have been taken to support and treat the patient and to prevent injury to others. If the procedure was incorrect or performed on the wrong patient or wrong site, the clinician should also ensure that relevant steps are taken to perform the correct procedure on the correct patient as soon as practicable.
The WA Department of Health requires all hospital/health service staff to identify, report, investigate and disclose clinical incidents that occur in public hospitals (and private hospitals providing health care services to public patients) across Western Australia. In the event of a wrong patient, wrong procedure or wrong site clinical incident, please refer to the following policies for further guidance:

- Department of Health (2012): Clinical Incident Management Policy
- Department of Health (2013): The Western Australian Review of Death Policy

12 Guidelines for patient identification in transfusion pathology services

WA Health Pathology Service laboratories are accredited with the National Association of Testing Authorities (NATA) Australia and the Royal College of Pathologists of Australasia.

A requirement of accreditation is that all specimens should be clearly and unambiguously labelled.

Accurate reconciliation of patients with their clinical samples, and the appropriate labelling of samples, is a critical element of correct patient identification. Refer to the PathWest Laboratory Medicine WA standard operating procedure, Minimum requirements for clinical samples and request forms, for procedures to follow with regard to the collection and accurate identification of clinical samples.

13 Exceptions to the WA Patient Identification Policy/National Standard

WA Health acknowledges that exceptions to the WA Patient Identification Policy may be required.

Prior to implementation of any exceptions, hospitals must assess potential risks (including inter hospital risks) using a risk management approach as detailed by the Australian Commission on Safety and Quality in Healthcare. Refer to the WA Health Clinical Risk Management resources for additional guidance.

It is also acknowledged that there will be case-by-case circumstances where exceptions to this policy will be necessary for best patient care. Clinicians must justify and document these exceptions within the medical record.


