Overview of NPSA work on patient ID and wristbands

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Wristband incidents from reports to NPSA 03-09

• “confused patient arrived in X-Ray with no wristband. X-Ray delayed for over 45 minutes until ward staff could attend and confirm their identity”

• “Various patients could not be bled due to no wristbands or errors with the data on wristbands”

• “Pt knew he had the wrong details and stated he’d asked staff on numerous occasions to change his wristband and details to no avail until admission to [another] ward”
Right patient – right care; framework for action

December 2004

• Wristbands were often missing or had inaccurate details

Key message

- Better manual checking and use of technologies, located in the wristband, can help prevent errors in matching patients with care
NPSA recommendations on safer patient ID

- NPSA is standardising wristband design across the NHS – SPN and design requirements

- Coding facilitates identifying the patient and ensuring care and treatment match
For action by Chief Executives

Standardising wristbands improves patient safety

Wristbands are used to identify hospital inpatients. Over the 12 month period February 2006 to January 2007, the NPSA received 24,382 reports of patients being mismatched to their care.

It is estimated that more than 2,900 of these related to wristbands and their use. Standardising the design of patient wristbands, the information on them, and the processes used to produce and check them, will improve patient safety.

This Safer Practice Notice sets out the action to be taken by the NHS to ensure wristbands are standardised.

Action for the NHS

From 18 July 2008, all NHS organisations in England and Wales that use patient wristbands should:

1. Only use patient wristbands that meet the NPSA’s design requirements. See www.npsa.nhs.uk

2. Only include the following core patient identifiers on wristbands:
   - last name;
   - first name;
   - date of birth;
   - NHS Number (if the NHS Number is not immediately available, a temporary number should be used until it is);
   - first line of address (this only applies to Wales, where this is required by a Welsh Health Circular).?

If any additional identifiers are thought to be necessary, these should be formally risk assessed.

3. Develop clear and consistent processes, set out in trust protocols, specifying which staff can produce, apply and check patient wristbands, how they should do it and what information sources they should use.
By 18 July 2009, all NHS organisations in England and Wales that use patient wristbands should:

5. Generate and print all patient wristbands from the hospital demographic system (for example Patient Administration System; PAS) at the patient’s bedside, wherever possible. Healthcare organisations that are unable to implement this recommendation within two years should ensure that their Strategic Health Authority (SHA) or the Welsh Assembly Government (WAG) are fully informed of the reasons why. They should agree with the SHA/WAG a plan that includes timescales which the SHA/WAG confirm are reasonable.

Where this alert applies
This alert applies to hospital inpatients in general acute and community settings. Mental health inpatient services need not use patient wristbands, although if wristbands are already being used, they should comply with these recommendations. While accident and emergency departments should try to comply with the NPSA recommendations, they may not be able to do so given the high turnover of patients, delayed registration because of treatment needs, and limited or inaccurate identification information when a patient arrives in the department.

Further details
For further details about this safer practice notice, including design guidance and FAQs, please see www.npsa.nhs.uk/alerts.
For any further queries about this safer practice notice, please contact: spn@npsa.nhs.uk
Printing Labels

June 2009 – NPSA statement

• Printing several labels with patient details at one time, so they can be used as required for the patient's care, is unsafe.

• Labels should be printed as and when required for the patient's care and, where electronic systems permit, by the bedside so that the risk of the label being used for another patient is minimised.
For action by Chief Executives

Risk to patient safety of not using the NHS Number as the national identifier for all patients

Action deadline for the Central Alerting System (CAS)

Deadline (action underway): 2 October 2008
Deadline (actions completed): 18 September 2009
Action plan to be agreed and actions started

By 18 September 2009, all NHS organisations in England and Wales that provide primary, secondary and all other types of care such as community pharmacy, should take the following action:

1. Use the NHS Number as the national patient identifier; OR the NHS Number as the national patient identifier in conjunction with a local hospital numbering system (NB where local hospital numbers are used they must be used alongside and not instead of the NHS Number).

2. Use the NHS Number (and its barcoded equivalent) in/on all correspondence, notes, patient wristbands and patient care systems to support accuracy in identifying patients and linking records.

3. Put processes in place to ensure that patients can know their own NHS Number and are encouraged to make a note of it (for example through patient literature that explains the NHS Number, its uses
Identifiers now an ISB Standard

- March 2009
  NPSA patient identifiers on wristband became Information Standards Board standard – mandatory for the NHS and a NHS CFH minimum dataset

- First name, last name, date of birth and NHS Number
Why is bar coding wristbands important?

- Improving accuracy of patient ID and matching patients with care - through use of technologies and bar coding in line with NPSA wristband and NHS Number SPNs
- Greater patient safety and efficiency – in line with QIPP objectives – Jim Easton strongly supports use of technologies
What is the context?

- **DH policy** – *Coding for Success* recommended GS1 system should be adopted throughout healthcare system in England
- **Health Select Committee** - asking for update on *Coding for Success* implementation across NHS in England
- **GS1 Guidelines for Automatic Identification and Data Capture for Patient Identification** – endorsed by the NPSA
- **ISB DSCN Advance Notice AN/0709 (Oct 09)** will mandate bar coding
Suite of six tools – NPSA and other guidance on patient wristbands

**SPN - Wristbands for hospital inpatients improves safety – November 2005**

**SPN - Standardising wristbands improves patient safety - July 2007**

**SPN - Risk to patient safety of not using the NHS Number as the national identifier for all patients – September 2008**

**Information Standards Board (ISB) – mandatory standard for the NHS in England (Data Set Change Notice 04/2009)**

**GS1 UK - Guidelines for Automatic Identification and Data Capture for Patient Identification on the wristband – December 2008**

Conclusions

• DH, NPSA and other initiatives have moved the NHS forward to greater readiness for AIDC and 2D bar coding

• Time is right for GS1 with NHS CFH to supplement the human readable requirements for patient ID with guidelines for the necessary standards for the implementation of AIDC