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Mersey Care
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Community and Mental Health Services

TRUST-WIDE CLINICAL / DIVISIONAL POLICY DOCUMENT

IDENTIFICATION OF SERVICE USERS POLICY: Ensuring Safety of Service Users

Policy Number:	**SA36**
Scope of this Document:	**All staff**
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Approving Committee:	**Patient Safety Committee**
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Lead Author(s):	**Director of Patient Safety**

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2019 – Version 3

Striving for Perfect Care and a Just Culture

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Identification of Service Users: Ensuring Safety of Service Users

Further information about this document:

Document name	**SA36 Identification of Service Users**
Document summary	**This policy provides clear guidance to staff on what to do in order to ensure that service users in receipt of care and treatment provided by the Trust are correctly identified**
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Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	• **Health Safety and Welfare Policy (SA07)** • **Risk Management Policy and Strategy (SA02)** • **Support of service users who present with challenging behaviour (SD 18)** • **Safeguarding Adults from Abuse Policy (SD17)**

This document can be made available in a range of alternative formats including various languages, large print and braille etc

Version Control:

		Version History:
Version 1	Drugs & Therapeutics Committee	April 2012
Version 2	Executive Committee	March 2016
Version 3	Executive Committee	September 2019

SUPPORTING STATEMENTS

this document should be read in conjunction
with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1 PURPOSE AND RATIONALE

1.2 The National Patient Safety Agency (NPSA) has recognised that failure to correctly identify patients/service users constitutes one of the most serious risks to patient safety and cuts across all sectors of health care practice. Embedding safe checking procedures into clinical practice is extremely important and forms the foundation of all valid patient identification practices.

1.3 This policy sets out the standards required for correctly identifying service users with the aim of reducing and where possible, eliminating the risk and consequences of misidentification and ensuring correct patient identification occurs.

1.4 Service users may experience communication difficulties e.g. lack of capacity to understand what is happening to them or unable to respond appropriately to questions regarding their identity, leading to an increased risk of an incident occurring.

1.5 Service user misidentification can lead to a number of serious outcomes for service users. The following types of incidents could occur:-

1.5.2 Administration of the wrong drug to the wrong service user and the harm that could follow from that.

1.5.3 Performance of the wrong procedure on a service user.

1.5.4 An inability to share accurate identification details about a missing service user with the Police, which might then result in potentially life threatening delays in finding the individual.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.2 To ensure the safe identification of service user's at all times when they are in contact with Trust services and during any part of their care programme e.g. assessment, undergoing procedures / treatments / home visits.

2.3 To provide assurance that mechanisms to correctly verify the identity of a service user are in place

2.4 To assist others to safely identify those service users who abscond or leave the ward without prior agreement.

2.5 To provide a clear corporate and standardised approach to service user identification including the use and contents of name bands and photographs.

2.6 To ensure the policy is adhered to by Trust staff for the purpose of correct service user identification.

3 SCOPE

3.2 This policy applies to all Trust staff that come into contact with service users in the course of their duties. This includes but is not exclusive to doctors, pharmacists, phlebotomists, nurses, care workers, social workers, health care support workers, administrative and clerical staff.

3.3 It is designed to safeguard the identity of all service users engaged with Trust services in all settings, not just relating to hospital or ward based settings, but including service users at home, in other settings and at any stage of their care pathway.

4 DEFINITIONS

4.1 Staff must be able to identify all service users at all times when they are in contact with Trust services and during any part of their care programme e.g. assessment, undergoing procedures / treatments / home visits.

4.2 The policy outlines the following standards to be met relating to the identification of services users.

- In-patient areas:
  - Service users within In-patient areas will have basic biometric information recorded within 6 hours of admission.
  - The use of Identification Wristbands will be adopted as standard practice within older adult services unless photographic identification is used.

- ECT Suites
  - All service users receiving ECT will have an Identity Wristband attached before the commencement of any treatment.

- Community Services/Out-patients Departments
  - All service users attending or utilising hospital or community services and receiving medication will clearly be asked for their identification details and use photographic identification where possible.

- General Standards
  - All service users prior to receiving treatment will be asked their name, date of birth and address.
  - Treatment / therapy should not be given if staff cannot formally and correctly verify the identification of the service user.

- Photographic Identification
  - Use of photographic images will be used in Medium Secure Services, Drugs & Alcohol Services and Acute In-patient settings. Where possible, Community Services will also use this methodology to support the process.

5 IDENTIFICATION METHODS

5.1 Identification on Admittance / First Contact

5.2 The ranking order of acceptable proof of identification is as follows (starting with the highest level of proof to the lowest level of proof for positive identification).

When identifying a service user staff should, endeavor to use the highest level of proof available.

5.2.2 Photographic identification, such as a passport, photographic driving license, photographic identification from their place of employment, bus/train passes.

5.2.3 Use of Name band – securely fitted.

5.2.4 Written proof of identification with current address such as old style driving license, bank or building society statements, utility bills, other bills, benefit statement, or other correspondence with their name and address printed on.

5.2.5 Letter from their GP, medical card with their NHS number on, national insurance card.

5.2.6 Verbal confirmation of the service user by a friend, relative, carer or associate.

5.2.7 Visual confirmation of identity from an employee of the Trust or visiting professional who knows the service user.

5.2.8 Verbal confirmation by the service user.

5.3 Photographic Identification on the Ward or Clinic

5.3.2 Any photography carried out in High Secure Services (HSS) should be carried out in strict accordance with the divisional Photographic Policy HSS 19.

5.3.3 The service user should be told that a head and shoulders photograph against a plain background will be taken solely used to confirm their identification and a note made in their clinical record.

5.3.4 Photographs should be destroyed at the end of admission.

5.3.5 Photographs will generally be taken after informed consent has been obtained from a service user, or their representative. In the case of a person not being able to give such consent due to incapacity, photographs must only be taken if it is deemed in the service users best interests.

5.3.6 A copy of the photograph should be securely attached to the service user's Pharmacy cards and clinical records, where appropriate.

5.3.7 If a digital camera is used the photographs should not be stored electronically after the photograph is taken and printed out and should be wiped off the cameras memory.

5.3.8 Photographs should be contained in a clear plastic wallet with the service user's name and date of birth on the back of the photograph.

5.3.9 If service users are being cared for, over a long period of time, staff should review on a six monthly basis that the picture still reflects accurately the identity of the person i.e. takes into account, the loss or gaining of weight, growth of a beard etc.

5.3.10 Photographs will not be shared with anyone other than staff from the Trust and the police. A certificate to be signed by the police on the receipt of the photograph as shown in Appendix 5.

5.3.11 All photographic images passed to the police by the Trust must be destroyed when a service user is located and returned to the Trust. The certificate for the Police to complete to confirm this has been actioned is shown in Appendix 6.

5.4 Wristband Identification on the Ward or Clinic

5.4.2 Were appropriate staff should ensure the wristband is placed on the service user's dominant arm (the side the service user uses for writing) on admission and worn throughout their stay. If it is not possible to use the wrist, then the wristband may be placed on the ankle.

5.4.3 All clinical staff in the in-patient area will have responsibility for the ongoing observation of service users and the wearing of wristbands.

5.4.4 Staff must always remember that a wristband is an aid to identifying service users and staff should not assume that because a service user is wearing a wristband they do not need to confirm their identification.

5.5 Factors to Consider when Choosing a Method(s)

5.5.2 Likelihood of service user complying with the method i.e. removing the wristband.

5.5.3 Need for interim identification i.e. when a photograph is not available such as on admission.

5.5.4 Mitigate risk through the use of multiple identification methods due to:

- A service user's stay being relatively short.
- A service user being unable to confirm their identity with certainty, due to the effects of their illness.
- Wards with high levels of Bank and Agency staff which can make personal identification difficult.
- Administering of higher risk medication.

6 IDENTIFICATION STANDARDS

The policy outlines the following standards to be met relating to the identification of services users.

6.1 General Standards

6.1.2 All service users (except for walk in center's and community phlebotomy services 6.1.3) prior to receiving treatment will be asked as a minimum for:

- First Name
- Last Name
- Date of Birth (in the following format dd/mm/yyyy)
- NHS Number

6.1.3 For the Walk in Centers and Community Phlebotomy Services, First Name, Last Name, Date of Birth and Address will be asked for as a minimum.

6.1.4 Treatment / therapy should not be given if staff cannot formally and correctly verify the identification of the service user. Staff should check the identity of the service user each and every time they carry out medical treatment, intervention or procedure. There should be no reasons for not formally checking the identity of any service user.

6.1.5 If the service user is already wearing an identification band or has photographic Identification cross check the details with existing information. This is a positive check to confirm all information.

6.2 In-Patient Areas:

6.2.2 Service users within In-patient areas will have basic biometric information recorded within 6 hours of admission.

6.2.3 This will include:

- Height in feet / inches or meters / centimeters
- Weight in kilograms or stones & pounds
- Colour of hair, eyes, skin
- Speech or language impairments and accent
- Build Type (Athletic, Slim, Average, Stocky, Large, Very Large etc.)
- Visible distinguishing marks
- Limits to Mobility, use of prosthetics, mobility aids

6.2.4 Where the information is not known, or the service user refuses or is not in a position to provide this information then an approximation of height and weight should be recorded.

6.2.5 Any changes to the above during or between contacts or admissions must be recorded.

6.3 Transfer of Service Users between Wards, Teams and Sites:

6.3.2 Information relating to a service user identity should be communicated to the receiving ward, team or site if the service user is to be transferred.

6.3.3 The details should be checked at this time and transposed accurately.

6.4 ECT Suites

6.4.2 All service users receiving ECT will have an Identity Wristband attached before the commencement of any treatment.

6.5 Community Services/Out-patients Departments

6.5.2 All service users attending or utilising hospital or community services and receiving medication will clearly be asked for their identification details and use photographic identification where possible.

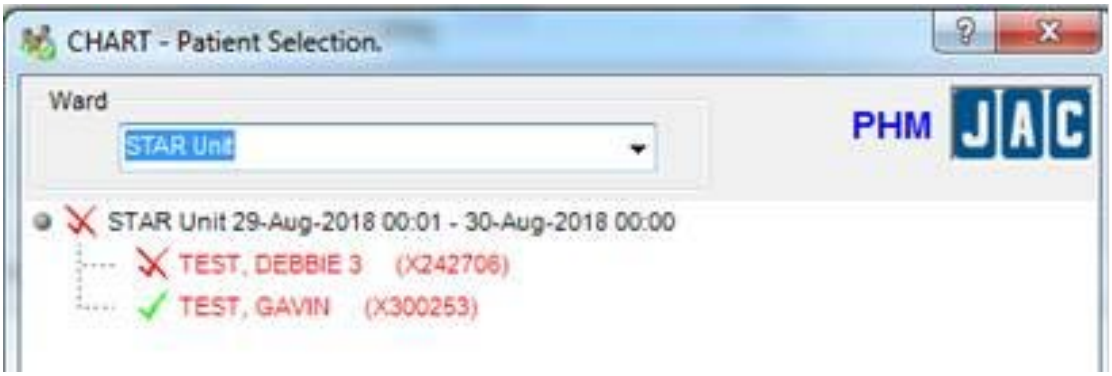
6.6 Photographic Identification

6.6.2 Use of photographic images will be used in Medium Secure Services, Drugs & Alcohol Services and Acute In-patient settings. Where possible, Community Services will also use this methodology to support the process.

6.7 Wards Using Electronic Prescribing (EPMA)

6.7.2 Check the ward selected at the top of the EPMA CHART screen is correct.

6.7.3 Staff should note that service users with similar surnames are highlighted in red in the CHART screen. In such cases the details on the system such as the NHS number, age, height etc. should be cross checked with other sources of patient ID.



6.8 Patients Treated in Care Homes

6.8.2 Health professionals rely on care home staff to identify their residents at every visit with the patient.

6.8.3 The health professional maintains the responsibility for giving the correct treatment to the correct resident.

6.8.4 Return the patient to their room and check their identity with the care home staff, and where available the photograph held by the care home.

6.8.5 They should not carry out a procedure if they are not totally confident as to the identity of the resident.

6.8.6 Residents in Care Homes can be identified by the following examples:-

- Residents being asked their identity;
- Staff confirming identity;
- Photographs in notes/drug prescription charts;
- Resident's description in notes
- Names on doors

6.9 Children

6.9.2 For children and adolescents who are deemed competent to make informed decision and provide consent to treatment, care should be taken to check patients against their health care records. (Mental Capacity Act Code of Practice (TSO 2007). Staff working with children should ask the parent/guardian to positively identify that it is the correct child prior to any intervention or treatment e.g. child measurement programme; child development screening. This should also be confirmed with the Personal Child Health Record ('red book').

6.9.3 The identity of children presenting for treatment unaccompanied and for whom the health professional treating them is satisfied that they are 'Gillick' competent should be ascertained by asking the child to give their name, address and date of birth and check these against the details within the medical records, or other appropriate records e.g. school nursing records in the same way they would for an adult. Note Sexual Health Services should also consider 'Gillick' competence when considering mental capacity to ensure the adolescent has understood advice offered and implications prior to treatment.

7 REFUSAL & CAPACITY

7.1 Service users who refuse to engage with the method of identification used can be considered in relation to two issues - those who have capacity to make the decisions and those who have been assessed as not having capacity.

7.2 Service Users with Capacity

7.2.2 If a service user is able to understand the potential outcomes of the decision they are making then, they cannot be forced to participate in the chosen method of identification. They should have the risks of receiving medication, having samples and specimens taken, or receiving an invasive procedure, without a suitable form of identification explained to them, and the discussion and its outcome recorded in the clinical notes.

7.2.3 The clinical team must identify a plan to address a service user refusal; this could include, for example, liaison with the service user's carer and approaching the service user when appropriate to repeat the request. Each contingency plan should include regular reviews (every 2 days) of the service user's wish not to have their photograph taken.

7.3 Service Users who Lack Capacity

7.3.2 Where it is deemed that the service user refusal to engage in a suitable form of identification as a consequence of their mental health and level of capacity, this should be recorded in the clinical records. The care professional must make the decision whether it is in the best interests of the service user to continue to use the preferred method of identification. This decision must be made based on the following:

- The level of risk the individual would be exposed to without full adherence to the chosen identification system.

- The level of safety that could be provided by the use of other methods of identification
- The level of distress that adherence to the identification system would cause to the service user.

7.3.3 If the staff member believes that it is in the best interests of the service user then the most appropriate method of identification can be used, this must be undertaken with a proportional amount of force and distress to the service user.

7.3.4 Alternative arrangements if refusal of a service user continues should include:

- The service user and or their next of kin/main carer should be approached to provide a recent suitable photograph that can be used for identification.
- Biometric information must be used to confirm the individual's identification.
- Two nurses (one of whom must be a registered nurse) must confirm the identification of the individual.

See appendix 4 – for further clarification of legal Implications.

8 RISK MANAGEMENT

8.1 Major risks are associated with the incorrect identification of service users during the prescribing dispensing, administration, supply of medication and the administration of treatments.

8.2 If an error occurs any staff member discovering the incident must complete the Trust's Adverse Incident form, in line with Trust Policy. For example if the service user receives the wrong treatment or medication, immediate local action to remedy the error should be taken to ensure the service users safety.

8.3 Each incident should be reviewed by the Modern Matron / Community Manager to identify the root cause and develop preventative actions. The Chief Pharmacist will monitor trends of medication errors and agree strategic action with the Medication Management Committee.

9 SHARING WITH THIRD PARTIES

9.1.2 Photographs and other identification information, height, weight, build, facial characteristics etc. Will not be shared with anyone other than staff from the Trust and the police.

9.1.3 The decision to provide information and or a photograph to the police should be undertaken based on the risks known at the time.

- Detained under the Mental Health Act cared for under the MAPPA (Multi-Agency Public Protection Arrangements) process .
- They may also have a history of displaying high risk behavior.

9.1.4 Where possible, the next of kin / carer should be informed of the action to be taken. On admission, service users should be informed under what circumstances their photographic identity will be shared.

9.1.5 Sharing with the police is undertaken in accordance with clarification as to

how the picture will be used; how it will be disposed of and when. The police officer should sign the form 'Certificate of receipt of Service user photograph' (see Appendix 5). This will then be stored in the service user's case notes.

9.1.6 All photographic images passed to the police by the Trust must be destroyed when a service user is located and returned to the Trust. The certificate for the Police to complete to confirm this has been actioned is shown in Appendix 6.

9.1.7 If the risk assessment identifies that the risks associated with the individual concerned are high, it is essential that the Police are given every opportunity to find and return the person as quickly as possible into a safe environment.

10 STANDARD OPERATING PROCEDURE

10.1 The standards identified in the Identification of Service User Policy should be incorporated in a Standard Operating Procedure (SOP) for a specific service area.

10.2 The Standard Operating Procedure should describe for a service area:

10.2.2 How the service user is identified before the correct medication and or treatment is given.

10.2.3 How the right physical or therapeutic observations are conducted on the right person.

10.2.4 Were appropriate how the right service user is identified before going on leave from an in-patient ward or unit.

10.2.5 On referral how Information relating to a service user identity should be communicated to the receiving ward, team or site.

11 DUTIES

11.1 **Executive Medical Director**

Responsible for ensuring that there are systems in place across the trust to monitor the implementation of this policy and that any gaps in implementation are reported and remedial actions put in place.

11.2 **Chief Pharmacist**

Will monitor the number and type of medication error incidents occurring and report trends to the Drugs and Therapeutics Committee. Remedial action will be agreed and monitored. The Chief Pharmacist will also consider new mechanisms available to improve identification and the safety of medication administration and share them with colleagues for consideration.

11.3 **Director of Patient Safety**

Is responsible for writing and developing the policy and liaising with Clinical Divisional leads to ensure that it is implemented within their services. The Director of Patient Safety is also responsible for monitoring the implementation of the policy through their role as chair of the Patient Safety Committee. The level of incidents re misidentification will be monitored by this committee.

11.4 **Clinical Division Chief Operating Officer / Director of Operations**

Will nominate a staff member to take a lead on the implementation of this policy

and feedback progress on use to the Divisional Governance Board. They are responsible for ensuring that staff adhere to safe practices and have the equipment to do so.

11.5 **Service Implementation Lead**

Will oversee the implementation of this policy and provide assurance to the Clinical Division's governance network that practices are in adherence with the policy. Gaps in provision will be shared with the Clinical Divisional management team and remedial action taken. They will report progress with implementation and adherence to the Drug and Therapeutic Committee and Patient Safety Committee.

11.6 **Modern Matron**

Will ensure that staff have the equipment needed to implement this policy appropriately and ensure that audits are undertaken as described in this document.

11.7 **Ward/Team Managers**

This Group of staff are responsible for ensuring that all staff have access to the policy and understand its practice implications. They are tasked in association with their line manager, that they have the equipment installed to implement the policy fully. They should undertake spot checks to ensure that staff are following the process to identify service users.

11.8 **Members of staff**

All staff involved in the administration of medication or provision of invasive treatments to service users must ensure that they understand the implications of this policy and adhere to it at all times. Any gaps in provision which will affect its implementation should be highlighted and shared immediately.

12 CONSULTATION

11.1 Consultation has been held with Leads from Divisions

12 TRAINING AND SUPPORT

12.1 The training the Trust provided on this policy related to its initial implementation. It includes:

- The rationale for and importance of adhering to this policy and procedure.
- Use of the photographic equipment used
- Safe storage of the photographic equipment
- What to do if a service user does not want his photograph taken or to wear a name band.
- The process for using name bands and or photographs to identify Service Users patients
- The confidential storage and destruction of photographs.
- The correct use of the EPMA system to identify service users.

12.2 Any future training relates to individual needs of staff and departments who are seen not to be adhering to the policy.

12.3 Local induction will provide guidance to new staff on the use of this policy.

13 MONITORING

13.1 Annual Audit

There should be an annual audit of compliance with this policy within each Clinical Division led by the Modern Matron for In-patient settings and the Service Manager for community settings. The audit information collected will include:-

- Number and percentage of service users wearing name bands, with photo ID or both.
- Documented accuracy and legibility of information relating to the service user.
- Reasons why service users are not wearing name bands
- The level of adherence to procedures used to identify service users during the administration of medication.

13.2 The implementation of this policy will be monitored via:

- Team Leaders and Ward Managers will monitor the implementation of this policy in their area of responsibility.
- The adverse incident system will highlight level of reporting and learning from medication error incidents involving mis-identification and report to Clinical Divisions so, that adherence to the policy can be checked.
- Modern Matrons will coordinate annual audits of this policy using the checklist in Appendix 1.
- The Patient Safety Committee as part of its terms of reference will monitor each Divisions response to this policy and highlight any gaps to the Executive Director responsible.

14 SUPPORTING DOCUMENTS

14.1 References

- National Health Service Litigation Authority. (May 2007). NHSLA Pilot Risk Management Standards for Mental Health & Learning Disability Trusts NHS Litigation Authority
- Department of Health. (2004). *Building a Safer NHS for Patients: Improving Medication Safety. A Report by the Chief Pharmaceutical Officer*. London: Department of Health.
- National Service User Safety Agency. (2005). *Wristbands for Hospital Inpatients Improves Safety. Safer Practice Notice 11, 22 November 2005*. NPSA

- National Patient Safety Agency (2004). *Right Patient Right Care*. London: National Patient Safety Agency
- HM Government (1984) *Mental Health Act 1983* London: HMSO
- HM Government (2006) *Mental Capacity Act 2005* London: HMSO
- HM Government (1999) *Data Protection Act 1998* London HMSO

14.2 Related Mersey Care NHS Trust Policies, Guidelines and Strategies

- Health and Safety and Wellbeing Policy (SA07)
- Risk Management Policy and Strategy (SA02)
- Policy for the Recognition, prevention and therapeutic management of Aggression and Violence (SD 18)
- Policy For Safeguarding Vulnerable Adults From Abuse (SD17)
- Procedure for the Systematic Approach to the Analysis and Learning from Incidents, Complaints and Claims (SA32)

15 APPENDICES

Appendix 1

Mersey Care NHS Trust Name Band Audit tool

		YES	NO
1.	Is the service user wearing a Mersey Care NHS Trust service user identification name band?		
2.	If yes, does it contain a readable service user's surname?		
3.	If yes, does it contain a readable service user's first name?		
4.	If yes, does it contain a readable service user's gender?		
5.	If yes, does it contain a readable service users date of birth		
6.	If yes, does it contain a readable service user's identification number?		
7	If the service user is NOT wearing an eye readable service user identification name band, identify, if possible, the reason why, using the checklist below and give details:-		

Please write an X in one box

Don't know	
Not put on by nursing staff	
Taken off by service user	
Taken off by staff and not replaced	
Service user is unable to wear a name band	
Carried by but not worn	
Further details of why name band is not worn	
Other reason, please state:	

Use of Photo ids

		YES	NO
1.	Are you using photo id for service users in your area of work?		
2.	If yes, are the photos labelled on reverse with the service users details?		
3.	If yes, are the photos securely attached to all medication cards?		
4.	If yes, are photographs destroyed after usage?		
5.	If yes, is the camera equipment readily available/stored securely on the ward/in the team office?		
6	If you do not use photos ids for service users in your area of work, identify, if possible, the reason why, using the checklist below and give details:-		

Please write an X in one box

Don’t know	
Scheduled implementation has not taken place yet	
Available to use but too complicated	
Equipment is faulty/broken	
Equipment too difficult to access	
Further details of why photo id not used	
Other reason, please state:	

APPENDIX 2

Do's and Don'ts:- A Staffs Guide to Service User Identification

The following Do's and Don'ts are a guide on how to minimise or eradicate incorrect identification of Service Users

Do's

- Do identify the service user correctly on admission or first contact. The first most important step is to correctly identify the service user as soon as they make contact with the service. As far as service user identification is concerned, the data is only as good as the information that is captured on registration.

- Do ensure that you have the full birth-registered name of the service user. Many service users will give you the name that they are known by e.g. Mary, known to her friends as Molly. This is not acceptable. As far as the Integrated Clinical Records is concerned Mary Smith and Molly Smith will be two different people, even if they share the same D.O.B. remember to check if you have got the right notes belonging to the right individual.

- Before ECT is performed do check again with the service user that all the details are correct, when you place their wristband on prior to the procedure taking place.

- Do regularly check the legibility of Identity Wristbands. Replace those identity wristbands where any part of the service user's details have become illegible

- Do initial the addressograph label to demonstrate that you have checked that the service user details are correct

- Do always check the details of service users even if you think you know them well.

- Do double check verbally and physically that the details of a service user matches the details on a fully completed request form, especially if another member of the Health and Social Care team has completed the form

- Do take care in out-patients. Some people would admit to being anyone just to jump the queue! So when you call Mary Ann Smith (and full demographic details), make sure that it is Mary Ann Smith (and full demographic details). Also make sure if Molly is in out-patients that she responds to the name Mary

- Do label samples taken from the service user straight away. The safest way is to label the bottles after the sample has been taken and before leaving the service user

Don’ts

- Do not read the service user’s details to them and allow them to passively agree with you. Ask the individual concerned to give you their full details

- Do not take bloods from a service user without checking their details against a fully completed request form

- Do not label a sample bottle before you take blood. You may get distracted before you have completed the task

- Do not perform two tasks at the same time e.g. taking bloods from several service users and labelling them afterwards or filling out requests forms for several service users at the same time, giving medication to several service users at the same time

- Do not perform tasks remotely from the service user if at all possible. Try to fill out request forms and complete tasks in their presence.

- Do not print off more addressograph labels than are required at any given time. They have a habit of finding their way in to other service user’s clinical notes.

And Remember

- To check for multiple service user registrations

- Service users can give more than one name and date of birth/ naming date especially non-English speakers

- Even when service user’s have equipment such as identity wristbands in situ or there is photographic identification and/or biometric information is at hand, it is easy for protocols guiding the practice of service user identification to be easily circumvented or performed incorrectly

APPENDIX 3

Guidelines to be followed where Identification Wristbands are used

The use of identity wristbands (ID bracelets) will be explained to the service user and information about them will be included in service user information leaflets/booklets.
When an I D bracelet is worn by a service user it must contain the following information: -

- First Name
- Last Name
- Date of Birth (in the following format dd/mm/yyyy)
- NHS Number

(Following the guidelines of the NPSA in their document "*Wristbands for Hospital In-patients Improves Safety. Safer Practice Notice 11"* (NPSA 2005))
In addition to the above information Mersey Care NHS Trust requires the following information to be included: -

- Ward name or number
- RMO (or admitting RMO)

In extreme emergencies and possible life threatening situations, clinical care may take priority over attaching an Identity Wristband to the service user, or in exceptional circumstances where staff, service user or others may be at a serious risk of violence and harm if an Identity Wristband is attempted to be attached

ALL service users MUST be asked if they are allergic to anything when they are admitted / treated. If they are allergic to the identity wristbands (Note that an 'allergy' can include latex and other material components as well as medicines), then the individual will be exempt from having an Identity Wristband.

When this occurs the Nurse in charge is responsible for take the appropriate steps to identify the service user and maintain safety until full identification is possible

Placement of Identity Wristbands
The Identity Wristband will normally be placed around the wrist of the individual's dominant arm usually the one used for writing with – there will be exceptions to this and these should be accommodated as per procedure described earlier

Who is responsible for applying and removing Identity Wristbands?

Nursing staff will generally be responsible for the application and removal of service user Identity Wristbands

The Health and Social Care professional treating a service user for ECT is responsible for ensuring an Identity Wristband is applied

If a Health and Social care professional removes an Identity Wristband for any reason it is their responsibility to replace the band, or have someone replaces it immediately.

If a Health and Social Care professional finds a service user without identification it is their responsibility to ensure it is replaced or have someone replace it immediately

Do not proceed with any procedure if the service user is not wearing an Identity Wristband. The Identity Wristband must be replaced by the Health and Social Care professional caring for the service user before a procedure can begin,

If a service user refuses to wear an Identity Wristband or if a service user is unable to wear an Identity Wristband or it is not clinically viable or safe for them to wear an Identity Wristband, then clear documentation must be made in their clinical records detailing the reason and the management strategy to ensure their correct identification.

If the person is already wearing an Identity Wristband check the details with your information, this is a positive check to confirm all information.

Changing Identity Wristbands

For infection control purposes Identity Wristbands should be changed if they become visibly soiled, otherwise they are not a risk. Breaches of the policy should be reported using the risk incident system

If an Identity Wristband has become worn, obscured or illegible it should be replaced immediately

Identity Wristbands if worn for longer than three months need to be changed.

Type of Identity Wristbands to be used

Staff should only use Identity Wristbands that comply with the NPSA's standardised design requirements.

Use only a white Identity wristband with black text with no additional colours to indicate allergies or any special risk factor about the service user.

APPENDIX 4

Legal Implications of Using Photographic Images to Identify Service Users

1. Introduction

Photographic images form part of a service user's Personal Data and as such come under the normal rules of confidentiality and the Data Protection Act 1998. A service user's right to confidentiality is paramount and as such consent should always be sought from the service user to use photographic images for treatment, administration of medication and to assist the police in identifying service users that go missing or are absent without leave from the hospital. **A service user's consent to having their photograph taken for such purposes should never be assumed.**

Confidentiality is a service user's right and may only be waived by the service user or someone legally entitled to do so on their behalf.

Any misuse of photographs may be considered a breach of confidentiality which may lead to internal disciplinary action and failure to comply with current data protection legislation is an offence and punishable by law.

If any guidance is required in respect of any of the legislation referred to in this Appendix or the policy please contact the Trust's Legal Management Team.

2. Service User consent received to take and store a photographic image

When consent is received from service user that is assessed as having the capacity to consent to have their photograph taken and stored it must be explained to the service user that the photograph will only be used in relation to their treatment and for identification purposes. Service users are giving their consent with the legitimate expectation that Trust staff will respect the sensitive nature of this personal data. It is imperative that assurances are given to service users in this respect and NHS Code of Confidentiality is adhered to at all times.

Consent may be given verbally by a service user but there should be a signed and dated note to this effect in the clinical record. **The Service User must be informed that they may retract their consent at any time.**

In addition to gaining the service user's consent the Trust will need to comply with a number of Data Protection Act 1998 (DPA 1998) principles including:

- The Third Principal that personal data must be adequate, relevant and not excessive
- The Fifth Principal that it should be kept for no longer than the purposes require.
- The Seventh Principal that adequate measures will be taken against accidental loss, destruction or damage.

3. Service User Consent NOT received to take and store their photograph

a) A service user that lacks capacity

Every adult has the right to make their own decisions if they have the capacity to do so and all available support should be given to allow a service user to make their own decisions. Therefore, if

staff feel a service user may lack capacity to understand the reasons why the Trust wishes to take and store their photograph, they may look to take the image in the best interests of the service user.

Staff should always apply the 5 statutory principles in Section 1 of the Mental Capacity Act 2005 (MCA 2005) which underpins the legal requirements of the MCA 2005. Principle 4 of the MCA 2005 states *'an act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests'*. If photographing a servicer user is in the best interest of the individual who lacks the capacity to make the decision for themselves or to consent to acts concerned with their care and treatment, then the decision maker should be protected from liability. Section 4 of the Mental Capacity Act 2005 (MCA 2005) sets out a checklist of steps to be taken in order to determine what is in the best interests of a service user and follows principle 4 of the MCA 2005.

By looking to apply the 'best interests' principle the staff are actively balancing the service user's right to make a decision alongside their safety and protection when they cannot make decisions to protect themselves. A decision taken in the best interests of a service user should be recorded in the service user's clinical record ideally by completing the Trust's Capacity Assessment Form.

The staff must check if the service user has made a personal welfare Lasting Power of Attorney as the attorney's consent may be required.

In addition to determining the justification to take the photograph in the absence of consent i.e. in the best interests of the service user, the data protection principles detailed in point 2, paragraph 3 above must be observed.

b) A service user who has capacity

If a capacity assessment has been carried out and the outcome is that the service user has: -

- A general understanding of the decision they are taking
- An appreciation of what the likely associated consequences of their decision may be
- Are able to understand, retain, use and weigh the information and
- Able to communicate their decision

The fact the decision appears unwise to family, friends, or staff is irrelevant. The decision must be accepted as valid and followed accordingly.

This is in accordance with Principle 3 of the MCA 2005 section 1(4), which states '*a person is not to be treated as unable to make a decision because he makes an unwise decision.*'

Therefore, if the service user has capacity and withholds consent, no photograph should be taken. Further attempts to gain consent must be made at regular intervals. The outcome of these attempts should be documented in the service user's notes.

Human Rights Act 1998 implications if a photograph is taken and stored from a service user who has capacity and does not consent to the taking of it

From research there has not arisen through the courts a challenge to the practice of photographing a service user without their consent so there is no precedent to dictate how such a procedure may be judged. Therefore, the following view is based on how the law as it stands may be applied in this area following consultation with the Trust's solicitors.

If the Trust adopted a policy of taking a service user's photograph for the purposes in this policy without a capable person's consent or not in the incapable service user's best interests it may face a

challenge for breach of the Human Rights Act 1998 (HRA 1998). Article 8 of the European Convention of Human Rights (ECHR) is the ***Right to respect for private and family life*** and states:

1 Everyone has the right to respect for his private and family life, his home and his correspondence.

2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Whilst Article 8 is a qualified right and as such may be derogated from i.e. here in the "protection of health", the derogation must be necessary, lawful and proportionate. A service user may claim the action taken is disproportionate to the aim intended i.e. it is inappropriate and excessive in the circumstances.

In broad terms the Trust must show it has a justification for taking a photograph against a service user's wishes, and be able to show it is proportionate to the problem in hand. If the Trust cannot show it has acted in a proportionate way the interference is not acceptable and the Article 8 right will have been breached.

4. Summary

There is no question that that the Trust must: -

1. Observe a service user's Article 2 *Right to Life* right by taking all reasonable steps to protect life;

2. Fulfil its duty of care to take all reasonable steps to prevent a service users from receiving incorrect medication or treatment: and

3. Take all appropriate steps to aid the police following a service user going missing or AWOA.

Notwithstanding these obligations, the possibility remains that some service users will exercise their right not to have their photograph taken for the purposes in this policy and this must be accepted by the Trust. Also, the proposed use of photographic images does bring with it a number of obligations particularly under the Data Protection Act 1998, with regard to how personal data is stored, how long it is stored for, controlled, protected against loss etc.

Naturally consent should be sought in all cases, and an absence of consent may be overridden if in a particular case the use of photography can be justified on the basis of the best interests of an incapable service user. However, where the Trust interferes with a service user's Article 8 rights it must be confident that what is being done is proportionate to the problem in hand and may not be addressed in a less restrictive and invasive way.

The Trust by applying a procedure to offer service users the opportunity to have their photograph taken for identification purposes, which will be actively followed up should the service user not initially consent will be seen as having taken appropriate and reasonable steps to fulfil its duty of care and HRA 1998 obligations.

When the Police request a copy of a photograph of a service user in the case of the individual being absence without leave, staff must consider the risk to the service user and make decisions to release based on the importance of finding the service user and enhancing their safety.

Appendix 5

Certificate of Receipt of Service User Photograph

Service user Name_____

Service user Number_____Date of Birth_____

I certify receipt of a printed photograph of the above named from Mersey Care NHS Trust for the purpose of assisting in the search for them as a missing person.

I confirm that it will not be used for any purpose other than the location and return of the above named to the above Trust premises.

I understand that it will not be used for any purpose other than those stated above.

Signed_____(on behalf of the relevant Policy service)

Name _____

Contact Details _____
(Address)

_____

Date _____

Appendix 6

Certificate of Destruction of Service User Photograph

Service user Name_____

Service user Number_____Date of Birth_____

I certify that the printed photograph of the above-named received from Mersey Care NHS Trust for the purpose of assisting in the search for them as a missing person has now been securely destroyed.

Signed_____(on behalf of the Relevant Policy service)

Name _____

Contact Details _____
(Address)

_____

Date _____

Mersey Care NHS
NHS Trust

Equality and Human Rights Analysis

Title: IDENTIFICATION OF SERVICE USERS POLICY: Ensuring Safety of Service Users
Area covered: Trust Wide

What are the intended outcomes of this work? *Include outline of objectives and function aims* This policy sets out the standards required for correctly identifying service users with the aim of reducing and where possible, eliminating the risk and consequences of misidentification and ensuring correct patient identification occurs.
Who will be affected? *e.g. staff, patients, service users etc* Service users and staff

Evidence
What evidence have you considered? National Guidance, Discussions with clinical leads, EPMA rollout, Pharmacy ID audit work.
Disability (including learning disability) Includes specific reference to service users who may lack capacity to give consent for photographic ID to be taken.
Sex Nothing noted
Race Nothing noted
Age Consent for children and adolescents for ID to be taken.
Gender reassignment (including transgender) Nothing noted
Sexual orientation Nothing Noted
Religion or belief Nothing Noted
Pregnancy and maternity Nothing Noted
Carers Nothing noted

Other identified groups Nothing noted
Cross Cutting Nothing Noted

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	*It is supportive of a human rights based approach*
Right of freedom from inhuman and degrading treatment (Article 3)	*Not engaged*
Right to liberty (Article 5)	*It is supportive of a human rights based approach*
Right to a fair trial (Article 6)	*Not engaged*
Right to private and family life (Article 8)	*Not engaged*
Right of freedom of religion or belief (Article 9)	*Not engaged*
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	*Not engaged*
Right freedom from discrimination (Article 14)	*Not engaged*

Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

No engagement undertaken

Summary of Analysis

n/a

Eliminate discrimination, harassment and victimization

n/a

Advance equality of opportunity

n/a

Promote good relations between groups

Considered

What is the overall impact?

Supportive of a human rights based approach

Addressing the impact on equalities

This policy identifies and addresses where inequalities may occur

Action planning for improvement

No further actions

For the record

Name of persons who carried out this assessment:
Frank Westhead
Christiana Vasiliou

Date assessment completed:
10/08/2019

Name of responsible Director:
Arun Chidambaram

Date assessment was signed:
11/08/2019