

## **Safer Patient Identification: A Report from Two Workshops**

### **Introduction**

This is a report from two workshops set up to discuss issues surrounding patient identification. The first was held on 22 April 2005, involving patients known to the NPSA from earlier projects. The second was held on 15 June 2005, involving people recruited by advertisement. In all, 20 patients took part in the first meeting and 15 in the second; in addition, five and two NPSA patient safety managers respectively attended these meetings to assist with the facilitation.

This report aggregates comments arising from both workshops. It should be noted that the number of people attending each workshop enabled them to have a good discussion about key issues, but one cannot draw statistical inferences from any of the comments made.

### **Plenary**

The Plenaries for the two sessions differed slightly, as the participants in the second had little familiarity with the NPSA. The following paragraphs summarise key issues raised across the two workshops.

Peter Mansell, the Director for Patient Experience and Public Involvement, opened each workshop by introducing himself and others present, including from the NPSA and the facilitation team. He also provided some background about the role and responsibilities of the NPSA. In the second workshop, this included providing some statistics on the use of the NHS last year, to put information on adverse incidents in perspective. In all, 13 million people used NHS Direct, including online; 13.5 million people saw a hospital consultant for the first time; 15.5 million people attended Accident and Emergency departments; there were 270 million GP consultations and 698 million prescriptions issued. In short, it can be seen that the NHS is an enormous enterprise. (These data are from the NHS Chief Executive's Annual Report to Parliament, aside from those on GP consultations which stem from research.)

There are no good data on the number of people who are harmed through contact with the NHS, but some research suggests that roughly one in ten patients suffers from some sort of error in hospital, resulting sometimes in harm and occasionally in a patient's death; about half of these were thought to be preventable. The total number of people affected, including families, is massive and it also affects costs, where patients have to remain in hospital to remedy damage done to them. The NPSA was set up to learn from patient safety incidents and try to develop new ideas to avoid them. It is not a regulatory body. Much of its work is concerned to understand how systems work and how to motivate and help health care professionals do what they should in practice.

Chris Ranger, Head of Safer Practice, with the lead for the Safer Patient ID programme, introduced some issues on patient identification. She called attention to three types of misidentification errors. Some patients get the wrong treatment because samples,

specimens or x-rays are not matched with the right patient, perhaps due to a confusion over similar names. Some patients are wrongly identified and receive treatment intended for someone else. Finally, there are failures in communication, for instance checking x-rays about which kidney is due to be removed.

The NPSA commissioned some research on this subject, summarised in a report called *Right Patient - Right Care*. This led to a concern with the problem of missing patient wristbands: one recent study in a London hospital found that one-third of patients surveyed did not have a wristband. Other technologies are being developed, including radio tags and biometric indicators (such as eye scans), and they will all require location in a wristband, so the wristband will continue to be important.

Julie Parry, Patient Safety Manager in Wales, spoke about issues emerging from the NPSA's National Reporting and Learning System (NRLS) on patient safety incidents and near-misses. There is no standardised process for identifying patients, including matching them to their records, particularly an issue where patients or staff move across different parts of the system. There is a need for more consistency for both patients and staff. Staff often intervene to prevent a patient being exposed to risk, for instance by refusing to proceed with treatment to patients who are not clearly identified. Problems arising with wristbands include their being missing, giving inaccurate information and multiple wristbands, sometimes with differing details.

Participants in both workshops were asked to note the ways in which they had been identified in their most recent visit to their GP, hospital, dentist, optician and chemist. The full responses are provided in Annex 1. It can be seen that the most common method of checking identification is asking a person's name, followed by asking for name and address. Asking for name, address and date of birth was not uncommon. In many cases, participants noted that the receptionist (or whoever was asking) knew them because they attended so often. There are some notable differences between locations (hospitals tend to include date of birth in what they ask; dentists tend to ask solely for the name; GP receptionists are felt to know patients already). It would not be appropriate to give too much weight to this information, as it is not derived from a proper sample and, even if it were, it must be recognised that people may not have remembered accurately. Nonetheless, the patterns were quite similar across the two workshops.

In the second workshop, participants were also asked to note the consequences that they thought would arise from misidentification. Participants answered this at a number of levels. The most frequent responses concerned the immediate impact: patients being given the wrong diagnosis, the wrong medication or not being given medication, being given the wrong operation or not getting urgent treatment. It was also noted that a patient could be inappropriately sent home. Some then commented on the effects of these events, such as harmful side effects arising from the wrong medication (coma, stroke and even death were mentioned), potential shock for a patient following a misdiagnosis and the lack of treatment if a patient were sent home. An unnecessarily prolonged hospitalisation was also noted. Some other effects noted included being given food when a patient should have nil by mouth or the wrong diet.

At another level, some participants referred to the fact that misidentification could lead to time wasting and inefficiency, including lack of communication and confusion over notes. One participant suggested that it could lead to a law suit.

## **Discussion Sessions**

The participants broke up into small discussion groups on each occasion. These explored views on the general problem of patient safety, their own experience of adverse incidents regarding identification and a range of potential solutions.

### ***General comments on patient wristbands***

There was general agreement among the participants that patient identification was an important issue. They were sympathetic that professionals were only human and mistakes could easily be made, especially when staff were busy. With patients being moved around wards, it became even more difficult for staff to know who was who. High job turnover among NHS staff could make it difficult to ensure consistency in hospital procedures. There were also problems arising from turnover of staff over the course of a day. It was questioned whether the fact that stays in hospital for treatment were getting shorter made patient identification more complicated.

Nonetheless, there was felt to be considerable public ignorance about safety and health care in general. This was partly because many people were not involved in health care. Many, particularly men, were not registered with a GP or had never attended a practice ('they wait until they are very ill, that's when they decide to go'). Where there was concern about something going wrong, it had more to do with side effects from medication or MRSA ('it's a fear that sticks at the back of your mind...there's always that little niggle') than patient identification as such. It was once people got into the system that they began to think about such issues ('I have spent some time in hospital; there's not been any problems with the wristbands, although it was something I did think about, whether something could go wrong, especially when I was asleep.')

Participants were very positive about employing some system for identification, whether via a wristband or some other means. Few felt any reluctance to be tagged in some way, particularly those who had been in the armed services ('I spent my whole life in the services wearing ID, both on tags round my neck and carrying a card'). Wristbands were not thought to be uncomfortable, except to certain people, such as those with arthritis or an allergy to plastic. It was noted that some very old people were very reluctant to wear a wristband. The one query was which wrist should be used, with some preferring the use of an ankle. A few participants also spoke about the system of having a patient's name over the bed.

Some recounted their own experiences in hospital. Most had had wristbands, although several women said that they had never had one when giving birth, although their babies were properly tagged. One participant found that key information on her wristband had come off in the shower; although she asked to have another, the nurses said it was not necessary as her name was over the bed and they knew her in any case ('you have to basically fight to get a new one - you shouldn't have to, you shouldn't have to insist on anything'). Several noted that they had been given two wristbands with the same information, in case one fell off.

The key question was checking the identification and participants recounted a variety of experiences here:

‘When I had my hip operation, I was checked every time before they gave me any pain killers or anything else. I couldn’t fault the system there for patient identification. They checked it at every opportunity.’

‘I was in for about five days and I reckon that I was probably only checked about once and I had various procedures; the nurses knew me at the end of five days, but that doesn’t alter the fact that they should have checked who I was’

‘In the last year , my wife went in six times for angina and in only one was her name put on the board above her bed. At least twice, they left the name of the previous patient there. She had a wristband on...’

It was argued that there was no consistency in practice, with some nurses being very careful and some not appearing to care (‘there’s not really any enforcement’). One woman found this very worrying, as her son has a serious enzyme deficiency and everyone treating him had to be aware of this. Indeed, her son’s wristband had been removed because he needed a drip and he was without one for ten days, although nothing went wrong. One participant thought that younger trainee nurses were more meticulous; agency nurses and night nurses were thought to be particularly casual about checking (‘the night nurses would come in and give medication and leave you to sleep...they don’t even check your number, they just give you what they give you’).

There was general agreement that it was good for identification to be checked frequently, as this offered reassurance (‘better than to have the wrong bit taken out’). Only one woman said that she had been irritated by a system of double-checking when she was in serious pain and wanting medication quickly.

It was noted that although patients were not supposed to be able to get their wristbands off, some did manage to do so (‘if you’re a determined person and you’ve got all day sitting in a hospital bed and you’re not doing anything else, eventually you will break it’). This was thought to be particularly common with geriatric patients, who could be bothered by something on their wrist that was not normally there. Some patients were also ‘quite stropy’ or intoxicated. Some wristbands could fall off, if not put on tightly.

Wristbands were also seen as a way of identifying those people who belonged in hospital. People often wandered into hospitals and this would be a quick way of knowing who should be there. This did raise questions about what to do about hospital visitors or those coming into hospital for a blood test or x-ray (‘it almost looks as though one might need a swipe card to get into hospital’).

A lot of concern was expressed about the identification of patients who were themselves not alert. People could be confused when in hospital, due to an infirmity (‘people with Alzheimer’s don’t even remember who they are’) or because of being sedated (‘if they have muddled you up [via drugs], you’re quite likely not going to be aware that you are muddled up’). Some concern was also expressed for patients coming out of intensive care, as well as those entering hospital in an unconscious state. People with mental health problems were another concern, as they might remove a wristband and use it to

harm themselves. It was noted that those in mental hospitals did not appear to wear wristbands at all, although they were often on strong medication ('how do they know they're giving the right person the right drugs?'). A query was raised about dental hospitals, where it was said that wristbands were not used, although they can give patients full anaesthetic. Several groups noted the problem of the Piano Man.

### *Experience of adverse incidents*

A surprising number of participants had experienced problems of erroneous identification in hospital. One man discovered, while waiting to go to the theatre for an angiogram, that he was wearing another patient's wristband; it not only had the wrong name (not related to his own) but was for a woman. On asking for the wristband to be changed, he was at first refused until the nurse realised the error. A woman with a partial visual impairment was given no identification on a day admission to hospital for a fairly serious operation; it was only when she was in her bed and talking to a doctor that she found the doctor had the wrong notes. It was her mother who first recognised the situation.

Problems with identification resulted in delays to treatment in two cases. One woman was waiting for an endoscopy when it became apparent that the doctor had her sister's notes, although she was wearing a wristband. The procedure was delayed for roughly 45 minutes while this was sorted out ('I was asked a lot of questions about what I was doing there') and, contrary to what had been planned, she had to stay in hospital overnight. Another woman had a series of problems concerning her wristband, resulting in a day's delay to her operation. Prior to the procedure, it was found that she had a wristband omitting her date of birth; this wristband was then removed, replaced by another, which fell off on her way to the theatre. She called attention to this fact and was told it would be sorted out later, but the nurses forgot. The result was that her operation had to be delayed until the next day. Aside from anything else, she was in acute discomfort, as she had not been allowed to eat for 24 hours beforehand.

In contrast to these 'near misses', one woman recounted an actual adverse incident resulting directly from a wristband problem. She had multiple allergies, so that the specific names did not fit neatly on a wristband; nurses sometimes abbreviated these in such a way that they were not easy to read. In one case, her allergy to a particular medication was in shorthand and she was given some, leading to an asthmatic attack. She was left alone for 15 minutes afterwards and only got help when another patient walked past and saw her distress.

The same woman recounted problems of misidentification on two other occasions. Following an operation, she was complaining about a lot of pain and a doctor came to see her. He tried to soothe her by saying she had just had a hysterectomy, and at first refused to believe that this was not the case ('he didn't even look at my notes; he came into the room and started talking...my heart started beating and I was thinking oh my God, did they really give me a hysterectomy yesterday?'). He did eventually apologise for not reading the notes beforehand; she was only 24 years old at the time. On the second occasion, she had been in hospital for three weeks, when a priest arrived, with her correct name, intending to give her the last rites ('it was scary, especially when you're ill and you're waiting to find out what's wrong with you and then a priest comes in...').

Other participants noted more minor errors in hospital and elsewhere. One man noticed that the name above his bed in hospital was wrong and simply changed it himself; since it stated not only a different patient but also the wrong doctor, he was concerned that this could have affected his treatment if his consultant had walked past. One woman noted that, when she was pregnant, her notes listed the wrong date of birth. One mother said that her son's first name and surname were constantly being confused, despite regular efforts to put this right ('we always have this trouble and even though they corrected it, no one's corrected it properly on the system'). Two participants noted that their dentist had had the wrong notes at some point. Another found that she had the same full name as another patient in her GP practice; when she moved house, the other woman's medical notes, including detailed gynaecological ones, had been sent to her new doctor. All these mistakes were uncovered only when questions were asked which made no sense to the participant. A few participants knew others where similar situations had occurred. One woman had requested all the medical records for her son, as part of a complaint following treatment in hospital; one x-ray came back, showing someone with a chain around the neck with the name 'Mary'. She wondered whether this could have been a joke, as it was not, of course, her son, but a chain would normally be removed before an x-ray.

Two participants noted that they had been prescribed medication erroneously, although these seemed due more to doctor or pharmacist error than to misidentification. In one case, a woman was prescribed a contraceptive pill inappropriate for someone who was breast-feeding. In another, a gel to overcome toothache was contraindicated for someone on Warfarin. It was only because they read the information that came with the medication very carefully that these errors were uncovered.

Patient identification errors resulted in one happy outcome. One participant noted that he had the same name as a famous local footballer, of about the same age; when he had to go into hospital, he was given a private ward and a lot of nursing attention until he pointed out the possible confusion.

### *Suggestions*

Participants were asked for suggestions both to improve patient awareness of the need for identification checks and to improve the process of identification.

#### *Improving awareness*

A number of ideas were proffered for improving patient awareness of the broad issue of identification. Some proposed that admission letters should have information on this issue, explaining the purpose and importance of wearing a wristband; this should be put very clearly ('make sure you wear your wristband'). This could be part of some general information, such as a map, often on the back of letters. If people subsequently questioned their doctor about why they needed a wristband, it could be pointed out that it was explained in the initial letter.

A related suggestion was that safety issues should be included in patient information leaflets or packs given to patients on admission. Some thought that people would not read them, but others said that they read such leaflets if they were waiting a long time and became bored. The key information would need to be put simply ('a lot of leaflets are far

too verbose for most people to grasp'). Only crucial information should be given ('if you go on the ward, get a wristband and get a relative to check it'). Leaflets could be placed on the locker beside beds, together with the NPSA slogan arising from the workshop; this would alert patients to the importance of wristbands and, incidentally, publicise the NPSA. All such information should also be discussed by a nurse, especially as people in hospital were in any case ill and not in the mood to read leaflets. A proportion of the population also cannot read.

Some proposed that there should be advertising on the televisions provided to patients in hospital ('something flashing up about the importance of wristbands'). A sticker could also be easily placed on patient telephones (or on the television), which would be immediately visible to patients. Other ideas were for information, such as the slogan, to be placed on hospital gowns. One participant proposed a wristband to tell patients to wear a wristband! ('get McDonald's to sponsor it'). GP surgeries should also be used to mention the importance of wristbands, possibly via the electronic announcement boards for the next patient.

As requested, all groups discussed three posters currently in use. First, there were mixed views on the brightly coloured poster stating 'Don't be one of the crowd'. Some saw this as too 'fussy' or 'just a blur'. It was suggested that it had too many colours; it would be no good for colour blind people and the light grey print was not easily read. It was questioned what 'don't be one of the crowd' really meant and the discussion of the top ten names in Wales was seen as a diversion from the main message. One compared it to posters for an illegal rave. Others, however, felt that the colours 'draw you in'. It was seen to give one simple message, regarding the difficulties of healthcare professionals in remembering large numbers of patients. The fact that it pointed out the need to ask for name, address and date of birth each time a patient is seen was felt to be useful. A couple of participants liked the information on surnames being similar.

Second, the green poster with the words 'Who are you?' was generally disliked. It was seen to have too much verbiage ('I wouldn't stand there and read it'), as well as too much small print ('it looks like an eye test'). One summed it up as 'ever so boring' and another compared to publicity from his local council. The words in bold needed to be in a different colour. It needed a major heading ('that doesn't tell me that it's telling me about safety'). It would benefit greatly from a picture to go with the question. Several participants said they were not engaged by it ('totally switched off'). One participant, however, liked this poster as being 'sensible', although it needed a picture to make it more eye-catching.

Finally, the poster with the picture of children was generally liked the best. It acted as an instant alert, speaking directly to parents and their need to take responsibility for their children. It was felt that people were encouraged to read on 'thinking of the missing child'. It seemed the most direct ('you know what they're talking about straight away and you know it's a way of identifying someone'). It could be amended to be suitable to adults, by having pictures of adults instead of children, but was especially poignant in the context of children. On the other hand, there were some who did not like it; the use of capital letters was seen as inappropriate as they are difficult to read. One participant called it 'too busy', with too much information to take in and with no visual reference to a wristband. Some felt it was not particularly accessible. One said he would not bother to read on, having read the initial question.

Some offered thoughts for the design a new poster. This should have a simple and clear message, such as 'wear your wristband for your own safety' or 'What's your number? Look on your wristband', which would immediately get people interested. Pictures and symbols were much better than words. One idea was to show a wristband ('just a simple image') or a pile of wristbands and a question 'Are you wearing one?' or a statement about its importance for safety purposes. It was important to get the word 'safety' displayed visibly. One group thought that a poster should target children directly ('children are great at making their parents do things'). For example, a poster might show a picture of a child putting on a wristband. Several participants proposed ideas to frighten people, such as linking wristbands to MRSA or someone with the wrong kidney taken out ('if you don't wear a wristband, this can happen to you').

General comments about posters were that they needed to be very simple and eye-catching. A good example was seen to be the one in the Clean Your Hands handbook, where there is a photograph of a doctor with the slogan 'I do, do you?'; this was seen as simple and effective. A picture or cartoon was often useful ('quite often people won't read – or can't read for whatever reason – but they will look at pictures'). One person noted that a poster should speak directly to the person in front of it – not to the general public ('if you're reading it, you need to feel that that poster's talking to you and no other patient'). It was also noted that there were inevitable problems arising from the fact that many could not read or read English. Posters needed to be able to reach everybody, educated or not, English speaking or not.

Some thought that there tended to be too many posters on wards, which stopped people from looking at any of them. Hospitals should do an audit of their notice boards to check that material was not out-of-date. Posters must be put in the right place ('it's no use putting it in the corridor'), which might be at the entrance to wards or the cafeteria; the outpatients clinic was another proposed location. One group were enthusiastic about putting posters outside hospital, for instance on the side of a bus. It was noted that although the NPSA was concerned about the issue, there appeared to be no posters on this issue on its premises.

In one group, there was a strong feeling that there should be patient involvement in the development of posters ('if this was done by professionals, they need sorting out'). It was noted that poor communication was often the root cause of problems.

Finally, a number of additional ideas for improving awareness were explored. Television advertising was a common suggestion ('everyone would catch something on the telly'), although it was noted that this might be expensive. Radio was another useful medium. One group suggested that awareness might be improved through having a story of a patient misidentification incident in a popular TV programme, such as Casualty or Eastenders. Newspaper advertising was also proposed. A note could be placed on forms which patients need to fill in, rather like information on supermarket receipts or on bus tickets. Another idea was to get a celebrity involved. Some liked the idea of a one day campaign, a National Wristband Safety Day.

A number of discussions centred on the need to get children more aware of the issues at an early age, including education at school or a cartoon on the television ('if kids grew up with it, they'd know it...it's like the green cross code and road safety').

### *Improving identification*

There was considerable discussion about methods of improving identification systems themselves, with many ideas raised. In one group, it was suggested that instead of a wristband, one might label a patient's clothing. Iron-on labels were seen as easy to use, as well as easy to remove once a patient was discharged. This could be on the cuff of a patient's pyjamas or on the theatre gown. Against this idea, there was concern that it would be an irritant to patients, possibly causing an allergic reaction. In addition, many patients had frequent changes of clothing.

A more popular suggestion was labelling people directly on their skin. One participant suggested using the invisible ink that is used to identify property, which can only be seen in an infra-red light; this would be permanent for a period, but would then fade after a few weeks as skin regenerated itself. This was liked because 'you can't cut it off'. Children would find it fun and, as they grew older, would have become accustomed to the idea. While this was immediately seen as a good idea by some, others were concerned that it would be seen as reminiscent of Auschwitz or, indeed, of tagging a person 'like a piece of luggage'.

Another suggestion was making better use of photographs. This was common in nursing homes, with every patient record having a photograph ('a mug shot'). It would be especially easy now, with digital cameras. On the other hand, some thought that photos can be very poor ('I took an old snap of my mother-in-law and sent it off to the passport office and got a passport back – it doesn't look that much like her'). A student commented that it was common to use other people's driving licences for identification of age for drinking.

There was also some discussion about the potential for electronic tagging or use of biometric information, such as fingerprints or eye scans. One woman who had been through such an identification check at an American airport had no difficulty with it. This was seen as an expensive option, however. Some groups spoke of the practice of placing a computer chip in pets and queried whether this could be done with human beings. Some people were quite keen on this idea, which avoided the problem of wristbands being removed. Others questioned the appropriateness on ethical and practical grounds. At a minimum, it was suggested, it should not be undertaken until people were old enough to accept it for themselves, i.e. it should not be done at birth. It was queried whether electronic tagging might be implemented for those who were vulnerable or confused.

The idea of an identification card (carried in the wallet, with information like a credit card) also received considerable attention. It might be linked to the electronic patient record. This raised the broad topic of national identity cards and whether people were willing to accept them. Some could see benefits in such a system ('having grown up hearing bad things about the NHS – this mix-up and that mix-up – I'd want to go into hospital knowing that I'm properly ID'd'). One participant was part of a trial for the new ID cards and showed it to his group; it contained a photograph, a fingerprint, date of birth and other information, including a number.

This gave rise to discussion of having a unique identifying number associated with a patient on a national basis, possibly on the card ('wherever you go, that number is clicked into the computer and it identifies you straight away'). This could be the national insurance number, an NHS number or a different number altogether. Some participants spoke of other numbers they were issued, such as for their passport, driving licence, student or teacher ID. If a number were issued at birth, young people would grow up accustomed to the system, making it less contentious. It should be used at every contact with the NHS – hospital, GP, pharmacy, dentist and, indeed, in any location in the country. It was noted that everyone was due to be issued with European health identification card shortly, but it was unclear what that would be used for. Such a number could also be printed on a patient's wristband.

But many were cautious about having detailed information about themselves on a card. Some focused on the fact that the information might be incorrect in the first place. It was important that patients could themselves check and verify the information held. Those who had experience of adverse incidents in identification were particularly wary ('once you've been through a situation with inaccurate information in your medical records and you didn't know - and that would have gone straight onto the electronic database - there's got to be means of a patient being able to correct information.'). It was noted that accessing one's own records was not as easy as it should be.

There was also concern about the potential for such information to be misused. It should not be easy for it to be passed on to others ('it's a lot of personal stuff'). A number of people felt that there was too much sharing of information across agencies already ('I could be in prison and someone could sign on for me'). There was also concern about the potential for identity theft, which could start from information openly displayed on a wristband, such as name and date of birth. There were also fears of losing the card, with the potential for others to access the information (as well as the hassle of replacing it).

In addition to considering new methods of identification, some considered how to make existing systems work better. In one group, attention was given to the potential for monitoring hospitals regarding their use of wristbands. Some issues might be built into hospital performance targets or staff appraisal systems ('so that becomes part of their responsibilities and it's written down and actually reported'), using the outcomes from monitoring. This would enable managers to be aware of a problem in a particular area. It was also suggested that there could be league tables on this issue. There could be some sort of award to staff where there was exceptional practice. Some concern was expressed about adding to bureaucracy, however.

One idea for monitoring wristband use was for patients to be required to hand their wristband in at the time of discharge ('a bit like a deposit'), calling attention to where the patient did not have one. This would have an added advantage in that the wristband could go into the patient's notes and be used on the next admission. An alternative would be an exit interview with patients, like an exit poll. Another system might be spot checks with patients on wards, asking if their wristband had been checked and ascertaining that there was one. A man who worked in manufacturing said it was normal in his business for people to check up on them.

Monitoring could also be done in a range of locations by 'mystery shoppers'. This was common practice in some retail businesses and would be a good way of checking how chemists or even A&E Departments checked people.

Another route to improving identification was to improve staff awareness of the issue. Although most staff tried to be careful, they might benefit from additional training, for instance in their induction programme or other updating ('they're all under pressure, so the more you keep that awareness in their minds all the time, hopefully we won't hear of so many horror cases'). They should be made more conscious of the consequences of their actions on patients' health, possibly through the use of a catchphrase or slogan (something 'friendly'). This might be developed by talking with them. One participant said that it should be on their uniform: 'have you checked the ID?'. Particular attention should be given to agency staff, who were thought to be less careful. One idea was to put information in with salary cheques. It was proposed that any such information should go to all staff, including consultants.

Comparisons were made here with efforts to improve staff awareness about MRSA, which were thought to have improved cleanliness. Arising from this was a suggestion that patients should be encouraged to ask nurses to check their wristband, in much the same way as in the current hand washing campaign; this would encourage staff attention to the issue ('you've got to do this on every patient or the patient is going to ask you'). This was liked as a way of empowering patients, but was thought likely to be more successful with younger patients than older ones ('they think that they haven't got the right').

In passing, the question of staff training brought up some discussion about handling people with visual and hearing disabilities. Some participants had experienced problems in this respect and felt there was a need for much better awareness among staff of their difficulties. There should be a clear protocol for handling patients with disabilities, including learning disabilities, such as inviting a relative to check. There were differing views amongst patients as to whether they wanted an indication above their bed (for instance, that they were blind), but they should always be asked. There was also some discussion about meeting the needs of people with limited command of English or confused elderly people. Interpreters, social workers and others would need to alert them to safety issues. It was noted that some hospitals have talking signs.

Staff literacy, particularly in English was the source of some concern. One woman recounted an incident when she was in hospital, with a sign above her bed 'nil by mouth', yet a young nurse left a tray of food on her table; it transpired that the nurse did not understand the word 'nil'. This could have been serious if she herself had not understood what was expected of her.

Finally, some discussion centred on wristbands themselves. These should definitely include full name and date of birth, plus the unique patient number if one were to be developed. One participant thought that more attention should be given to spelling names correctly, noting that nurses did not always ask ('I've not got a particularly unusual name, but it's often incorrectly spelt'). Barcoding was seen to be a good idea, as long as the patient could verify that the information elicited was correct. One group discussed whether a willingness to give organs should be on the wristband, but it was seen as too much to put on; there was also a slight fear that it might affect a doctor's willingness to carry out an operation.

There was considerable consensus in favour of using colour coding, but less on what it should be used for. Ideas raised include the use of colour to denote department or type of surgery, allergies, hearing or visual impairments or other problems, such as diabetes or intoxication or being on drugs (one participant had an adverse incident in A&E due to this fact). Where wristbands were used to identify allergies, there should be more than one if the information did not fit on one band (as happened to one participant). A colour was seen to alert nurses to some kind of problem. ('it's a prompt mechanism isn't it?'). An alternative was a use of symbols or letters to denote different conditions, such as 'D' for diabetic, but there was some concern that patients would query this.

Children were seen to bring particular problems and there was a concern to make wristbands more attractive to them, so that they were happy to wear them ('they could have the Incredible Hulk on them').

In one group, participants thought suggested that wristbands should be developed with some in-built system for showing that it had been checked. This might be a place where it could be hole punched or a cover that could be peeled off. This might also show that a patient has verified that the information is correct ('any nurse walking past will see that that's been checked already'). It was also questioned whether others might get involved in checking wristbands, such as volunteers or even patients' visitors.

Overall, there was a concern that the system should be much more consistent across the service. Some thought that wristbands should be put on by the GP at the time of referral to hospital. Another idea was for wristbands to be posted to patients before they arrived at hospital. There was some enthusiasm for such an idea, although it might then be left at home; even if two were printed off (in the case one was forgotten), this might encourage their use. If the details were to be supplied by the patient, there could be problems with hand-writing.

Some participants argued that there was the need for standardisation in wristbands across hospitals. People who were transferred tended to need to go through all the procedures all over again ('you're the same person, you've got an ID band already') and it was particularly annoying when a person was ill in any case. It was also suggested that standardisation should be across countries, so that wristband information signalled the same information wherever a person was.

Some participants argued that, at the end of the day, it was up to patients themselves to watch their own safety ('it's not just them, it's us taking control as well'). Some kind of patients charter should encourage patients to query doctors and nurses ('when I had my leg done, I said "will you mark it before I go under the anaesthetic so that I can see it?" and he did it with a half inch marker...And when I had my eye done I said "will you mark my forehead?"'.')

### **Slogan competition**

In the early afternoon, there was a brief slogan competition. Participants were asked to invent a slogan that might go onto a wristband, which would help patients feel safer and

more confident that their wristband would not be removed. Two slogans were chosen as the winning ones on each occasion. These were:

‘If you cut this, you cut me off!!’

‘Stay safe, keep me in place!’

‘You won’t die if you identify’

‘Wear a wristband and make yourself safe’

The full list of ideas is set out in Annex 2.

### **Final Plenary**

The participants were thanked for their hard work and assured that their comments would be listened to. A report would be prepared (and a copy sent to them) and this would feed into other work being undertaken on the wearing of wristbands, due to be completed by the late summer.

### **Other comments**

Several participants suggested that they would like more information about the aims of the workshop prior to attending. Those who were active in their local community felt they could have investigated their local situation more fully and brought additional information.

June 2005