NHS
National Patient Safety Agency

03 July 2007 No. 24

For action by Chief Executives

Standardising wristbands improves patient safety

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

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

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

Action for the NHS ✓

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

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

2. Only include the following core patient identifiers on wristbands:

- last name;
- first name;
- date of birth;
- NHS Number (if the NHS Number is not immediately available, a temporary number should be used until it is);
- first line of address (this only applies to Wales, where this is required by a Welsh Health Circular).[1]

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

3. Develop clear and consistent processes, set out in trust protocols, specifying which staff can produce, apply and check patient wristbands, how they should do it and what information sources they should use.

4. Only use a white wristband with black text. If you wish to have a system for identifying a known risk (for example, an allergy or where a patient does not want to receive blood or blood products), the wristband should be red with patient identifiers in black text on a white panel on the wristband.

1 Welsh Health Circular WHC (2007) 042 *Blood transfusion procedures.*

Information about implementing the recommendations, including frequently asked questions and answers, can be found at ***www.npsa.nhs.uk/alerts***

NHS
National Patient Safety Agency

03 July 2007 No. 24

Action deadlines for the Safety Alert Broadcast System (SABS)
Deadline (action underway): **18 July 2007** Action plan to be agreed and actions started
Deadline (action complete): **Actions 1-4: 18 July 2008** **Action 5: 18 July 2009** All actions to be completed

Further information about SABS can be found at:
www.info.doh.gov.uk/sar2/cmopatie.nsf

By 18 July 2009, all NHS organisations in England and Wales that use patient wristbands should:

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

Where this alert applies

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

Further details

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

Evaluation

The impact of this notice will be evaluated in England through the SABS one year after issue, and in Wales through WAG. The NPSA has carried out a 'before' audit in the NHS on the areas covered in this notice and will carry out an 'after' audit of compliance with the recommendations through a questionnaire to a sample of NHS healthcare organisations in England and Wales.

Acknowledgements

The NPSA would like to acknowledge the contribution of the many NHS trusts, staff and patients who have contributed their views to the NPSA's safer patient identification work and that of the healthcare industry and professional organisations.