Trust Policy

University Hospitals Plymouth NHS Trust

Identification of Patients Policy

Issue Date	Review Date	Version
August 2020	August 2025	8

Purpose

To ensure that the correct patient receives the correct treatment, in the correct place at the correct time every time. The potential for error is then reduced to a minimum in line with the National Patient Safety Agency (NPSA) Safer Practice Notices November 2005 and July 2007

Who should read this document?

All University Hospitals Plymouth NHS Trust staff who are involved in the delivery of patient care Permanent, locum, agency, temporary and NHSP staff working at UHPNT have a responsibility to adhere to this policy

Key Messages

This policy sets out the UHPNT process for positive patient identification.
Safe and reliable positive patient identification is an essential step in providing safe care for our patients Correct identification of patients starts with the first point of contact with a service and continues at each patient intervention throughout their entire pathway whilst at UHPNT.
Failure to correctly identify patients is one of the most serious risks to patient safety and can result in near miss, minor harm, moderate harm, serious harm and even death.

Positive Patient Identification for patients with an identification (ID) band

- What is your name? This must match the name on the patient's ID band
- What is your date of birth? This must match the date of birth on the patient's ID band
- Checking the NHS number/Hospital number on the patient's ID band. This must be cross-referenced with the medical or nursing healthcare record

Positive Patient Identification for patients without an identification (ID) band

- What is your name?
- What is your date of birth?
- What is your address?
- The responses must be cross-referenced with the medical or nursing healthcare record

Where a local decision has been made **not** to follow UHPNT policy with regard to the wearing of an ID band in outpatient areas, a local risk assessment **must** be performed, in line with the Risk Management Policy and the risk must be added to the Risk Register following assessment and approval by the relevant Care Group. This should only be applied in exceptional circumstances when adherence to policy is not possible.

Use of GS1 barcode technology does not replace the need for patient identity checks

Core accountabilities	
Owner	Patient Safety Manager & Deputy Medical Director
Review	Clinical Effectiveness Group
Ratification	Chief Nurse and Director of Integrated Clinical Professions & Medical Director
Dissemination (Raising Awareness)	Patient Safety Manager
Compliance	Quality Assurance Committee

Links to other policies and procedures

G:\DocumentLibrary\UHPT Trust Documents - for quick access use the search function

- Hospital Transfusion Policy
- Checking Patient Details and Reception of Patients
- Checking patient details when adding a referral to IPM
- Clinical Handover of Care and Internal Transfer and Escorting of Adult Patients (excluding Maternity)
- Consent to Examination or Treatment
- Correct Patient, Correct Procedure and Correct Site Policy
- Care of Deceased Patient Policy
- Hospital Identification Standards (GS1) Policy
- Incident Management Policy
- Managing the care needs of people with a Learning Disability in the Acute Hospital Setting
- Medicines Management Policy and Standard Procedures
- Point of Care Testing Policy
- Registration, Identification & Security of Newborn Infants Standard Operating Procedure
- Unidentified and Hospital Trauma Patients - Identification
- Recording Alerts
- Risk Management Policy
- Specimen Transport Procedure

TechNet

- Guidance for printing barcoded wristbands

http://nww.plymouthict.nhs.uk/helpguidance/clinicalsystemstraining/barcodedwristbandsguidance.aspx

Version History		
1.1	July 2010	
2.1	July 2010	Removal of ward from wristband. Change to definition of day case patient
3.1	July 2010	Clarification of use of NHS number Removal of need to record application in Health record.
3.2	July 2010	Ratified by CGSG
4.1	October 2010	Ratified by CGSG
5	June 2015	Updated to include: Definition of outpatient/ward attender/positive patient identification. Wristband exceptions. Inclusion of sample labelling and request card/referrals
5.1	February 2016	Clarification of Positive Patient Identification
6	August 2019	Extended to January 2020
7	November 2019	Extended to March 2020
7.1	February 2020	Extended to May 2020
7.2	July 2020	Extended to August 2020
8	August 2020	Updated to include – addition of Virtual Consultations. Inclusion of the need for Risk Assessments in outpatient areas if patients do not wear a patient ID band. Addition of coloured band to identify a patient risk

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

UHPNT recognises that a fundamental factor in ensuring patient safety and reducing errors is a reliable method of identifying patients.

Staff will ensure that the following patients must be identified by the use of a **single** hospital ID band.

The NHS ISB 1077 standard has been fully implemented for inpatient ID bands, allowing accurate identification of a patient by scanning a GS1 barcode, and enabling the upload of clinical data into the electronic patient record. A large part of this standard is the encoding of key patient identification data items into a GS1 2D (data matrix) barcode, for printing on patient ID bands

Use of GS1 barcode technology **does not** replace the need for identity checks. Individual patient checking prior to any treatment or intervention is essential. UHPNT will routinely use the patients' NHS number as the primary means of identification. If this is not available, the Hospital Number will be the prime identifier

Patients requiring ID bands

- **All** inpatients – including new-borns
- **All** patients admitted for day case
- **All** outpatients undergoing invasive procedures and/or treatment where consciousness is impaired
- **All** outpatients when receiving blood transfusions
- **All** Dialysis outpatients when receiving blood transfusions or other intravenous therapy/medication
- Patients undergoing **any** procedure where consciousness or capacity might be impaired
- Patients in **any** setting where it is **professionally judged** that there may be a risk of injury or harm that would be significantly reduced by the use of a wristband
- **All** patients in ED who are placed within the Majors area or where a decision to admit has been made
- Deceased patients

This is supported by the UHPNT process for checking the patient's identity on admission, and prior to commencing any consultation, treatment, therapy or invasive procedure.

Where a local decision has been made <u>not</u> to follow UHPNT policy with regard to the wearing of an ID band in outpatient areas, a local risk assessment must be performed, in line with the Risk Management Policy and the risk must be added to the Risk Register once agreed by the relevant Care Group. This should only be applied in exceptional circumstances when adherence to policy is not possible.

Any incidents occurring must be reviewed by Service Line Teams, with learning reported at Care Group governance meetings and shared with other teams.

We recognise that serious incidents have occurred when positive patient identification has not been used within UHP. Positive patient identification must therefore be carried out by reception staff and by all Healthcare Professionals prior to any consultation, requesting of investigations, taking samples or initiating treatment.

2 Purpose

The purpose of this UHPNT policy is to:

- Accurately identify patients in all locations of UHPNT, to ensure that patients receive the correct treatment, in the correct place at the correct time.
- Ensure the correct identity of all patients (inpatients, outpatients and day patients) at all times and before undergoing procedures requiring positive identification, taking reasonable steps to use the NHS number as the national patient identifier or the NHS number in conjunction with the local hospital numbering system
- Reduce the potential for error leading to harm to a minimum by standardising and implementing positive patient identification
  (National Patient Safety Agency (NPSA 2007) Safer Practice Notices November 2005 and July 2007)
- Ensure patient ID bands are scanned at the point of care, where systems have been enabled to further enhance safety.

3 Definitions

Positive Patient Identification

- All staff must positively check the identification of the patient prior to delivering care or treatment. Positive identification involves asking the patient to verbally confirm their identity to you by using open-ended questions to confirm three identifiers. Name, Date of Birth and Home Address, followed by a check against the hospital record.

GS1 Barcoded Identity (ID)bands

- Use of GS1 barcode technology does **not** replace the need for patient identity checks
- The NHS ISB 1077 standard has been fully implemented for in-patient ID bands allowing accurate identification of a patient by scanning a GS1 barcode, and enabling the upload of clinical data eg. products, treatments into the electronic patient record. A large part of this standard is the encoding of key patient identification data items into a GS1 2D (data matrix) barcode, for printing on patient ID bands.
- All systems that require the positive identification of patients will eventually be updated to read the GS1 barcode printed on the patient ID band. Where a clinical system has been enabled to use the patient ID band (scanning the barcode) this should always be used to ensure the correct electronic patient record is updated

Inpatient

- A patient who is admitted to a ward with the intention of staying for more than 24 hours

Ward Attender

- This is a patient who attends a ward to receive **nursing care**, but has not been admitted to hospital, and does not stay on the ward.

Day Case patient

- A patient who comes into Hospital to receive care, have a diagnostic examination, therapy or day case surgery and is discharged on the same calendar day.

Outpatient

- A patient who attends hospital for a clinic appointment under the care of a consultant or specialist nurse or who attends for a procedure or treatment to a department but is not admitted

Datix

- Internal incident and risk reporting system for UHPNT to enable capture of incidents and risks.

Invasive Procedure

Procedures that have the potential to be associated with patient harm, examples include, but are **not limited** to:

- All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within an organisation.
- Surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.
- Invasive cardiology procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Endoscopic procedures such as gastroscopy and colonoscopy.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.

4 Duties

Chief Executive

- Has overall responsibility for ensuring the safety of patients in UHPNT

Medical Director and Chief Nurse and Director of Integrated Clinical Professions

- Accountable to the Trust Board in ensuring compliance with this policy in all areas of UHPNT

Deputy/Associate Medical Director for Quality and Safety

- Responsible to the Medical Director ensuring that this policy is reviewed and revised to facilitate appropriate implementation within all areas of UHPNT

Deputy Chief Nurses and Associate Chief Nursing Officers

- Responsible to the Chief Nurse and Director of Integrated Clinical Professions, ensuring that this policy is implemented within all areas of UHPNT.

Heads of Nursing

- Responsible to the Associate Chief Nursing Officers for implementing and embedding this policy in all areas of UHPNT

Care Group Managers

- Hold Service Lines to account for compliance with the policy
- Ensure Service Lines comply with any audit requirements.

Service Line Management

- Ensure that all staff within the Service Lines comply with positive patient identification
- Ensure that internal transfers are according to policy and that handovers of care include positive patient identification

- Ensure that local procedures do not contravene this policy.
- Ensure audit is completed within the Service Lines and that Quality Improvement takes place, where required, with regards to positive patient identification
- Ensure all incidents relating to misidentification of patients are reviewed in line with the Incident Management policy, appropriate actions are taken, and escalation has occurred if necessary. Learning is shared at Service Line meetings

IT Service Desk Manger

- Where issues with barcode technology has been reported these should be investigated according to standard IT operating procedures.

All Staff

- Responsible for compliance with the contents of this policy
- To keep our patients as safe as possible, all staff must report any incidents relating to patient identification, which will be reviewed by the service line team, and escalated as necessary to enable the issues and learning to be shared.
- Report any issues with the printing of patient wristbands, to your line manager and the IT helpdesk as a matter of urgency

5 Positive Patient Identification

Positive Patient Identification for patients who are required to wear an ID band

All staff must positively check the identification of the patient prior to delivering care or treatment. Positive identification involves asking the patient to verbally confirm their identity to you by using open-ended questions

- **What is your name? This must match the name on the patient's ID band**
- **What is your date of birth? This must match the date of birth on the patient's ID band**
- **Checking the hospital number/NHS number on the patient's ID band. This must be**
- **cross-referenced with the medical or nursing healthcare record**

For the administration of medication, the prescription chart or electronic pharmacy record is part of the healthcare record. If any doubt exists – refer to the clinical notes or the patient's clinician

Where systems have been enabled, the patient's 2D barcode should also be scanned

Positive Patient Identification for patients without an ID band – including Virtual Consultation

The patient will have their details verified at the first point of contact between hospital staff and the patient, and by the Healthcare Professional prior to consultation or treatment

Positive Identification will include asking the patient to verbally confirm their identity to you

- **What is your name?**
- **What is your date of birth?**
- **What is your address?**

The responses must be cross-referenced with the medical or nursing healthcare record or the clinical referral information provided

For all patients

It is necessary to take into account any communication issues, gender, mental capacity, culture, disability and religious naming systems, and age. Any patient has the right to be known by any name they wish.

- An interpreter must be used if there is a significant spoken language barrier with a patient and their relatives
- Consider the involvement of the Learning Disabilities Specialist Nurse for a patient with a Learning Disability in line with the policy for Managing the care needs of people with a Learning Disability in the Acute Hospital Setting
- Portable hearing loops are available for use on most wards
- SignLive tool for deaf and hard of hearing patients may also be used without the need for a face to face interpretor and is available to download through the App catalogue – for further details contact the Patient Services Team

  plh-tr.Interpreters-Translators@nhs.net

Confirmation of identity may need to be gained from relatives or carers if patients are unable to verbally confirm their own identities. However, please ensure the relatives themselves fully understand and do not have communication barriers of their own

If the patient is unable to state their name, and no relatives or carers are available - any wristband generated must be checked by two members of staff with the health records available to ensure all details match.

Process for establishing the patient's identity and applying ID bands

The Member of staff responsible for admitting the patient to the clinical area must:

Be competent to confirm identity by:

- Having the appropriate training in order to access and record patient information using the relevant IT system to enable accurate and compliant registration.
- Establish the patients identity immediately upon admission/arrival using all the available information including:
  - The patient or their relatives /carers
  - Electronic Information
  - The Patient's Health Records

(Ref. Administrative Procedure Note: Checking Patient Details and Reception of Patients)

Print the approved wrist band (at the nurses' station). Access details on how to print wristbands from SALUS is available on TechNet

- Check the wristband details with the patient. Where this is not possible, check with the relatives/carers. If the patient is unable to state their name, any wristband generated must be checked by two members of staff with the health records available to ensure all details match.
- All reasonable steps should be taken to ensure the NHS number is recorded.

For all patients (excluding Neonates immediately after birth), hand written labels must **only** be used in **exceptional** circumstances where there is a problem with the electronic ID band system. Writing must be done in black permanent/indelible ink with the following information only

- Patients first and last name
- Last name in upper case
- First name in lower case with first letter in upper case eg**. SMITH Patricia**
- Date of Birth in DD-MM-YYYY format eg**. 08-12-1996**
- NHS Number - this should be the **primary** means of identification
- Local Hospital Number is also written (There are occasions when the NHS Number is not available)
- **No** other information should be included on the ID band**.**

Attach the ID band to the wrist of the **dominant** hand unless:

- That is the intended site of the procedure.
- It is impossible to do so due to the patient's physical condition.
- It is impossible to do so due to ongoing therapy e.g. IV infusions.

Where it is impossible to fit the ID band on to the patient's wrist (dominant or non-dominant)

- Use the ankle.
- If no limb can be utilised (eg patients without limbs or burns or multiple venous access sites) the wristband must be secured to the patient's clothing.

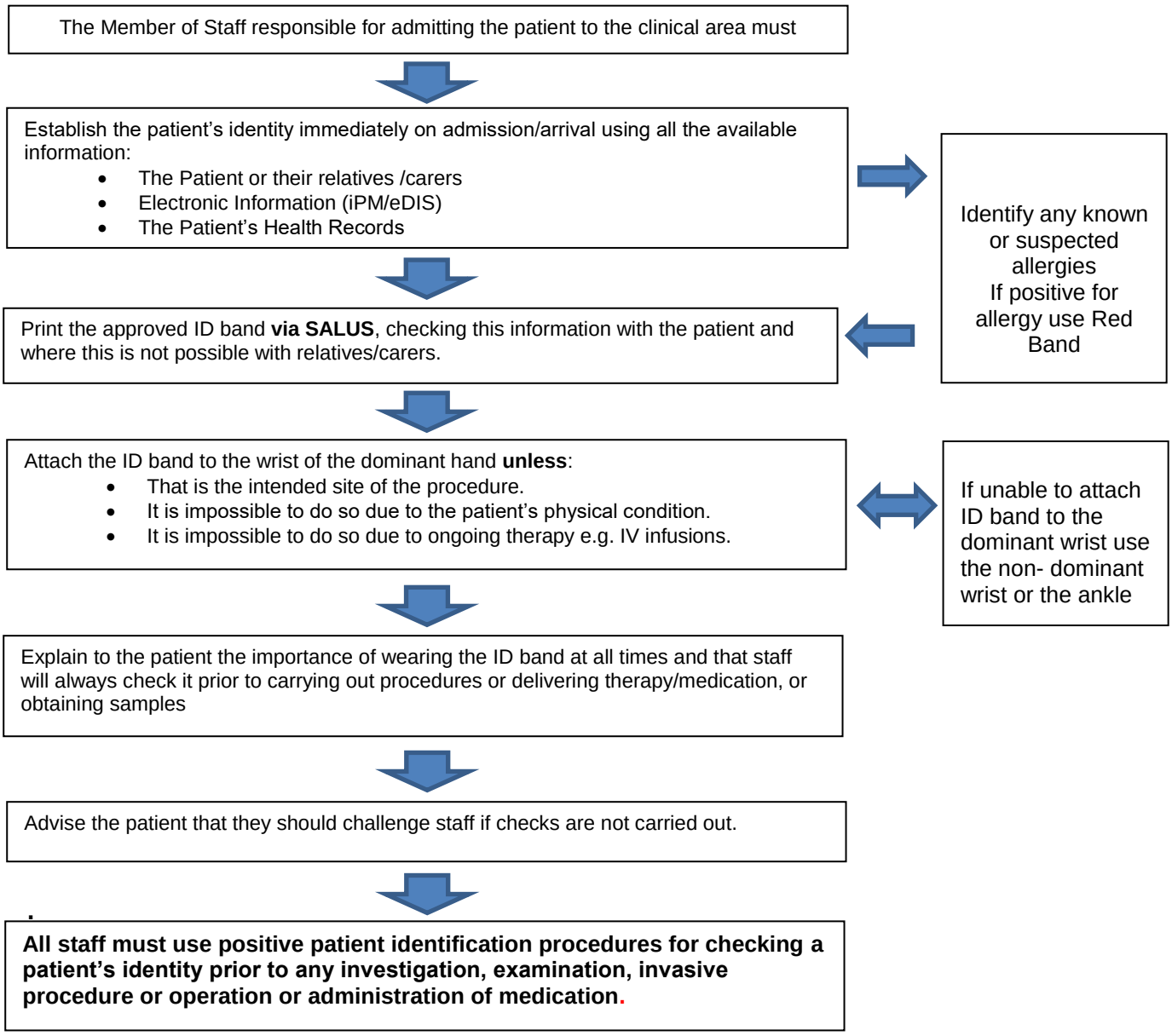
In **all** instances, the wristband must be accessible and visible

- Check that the ID band is of a suitable size and fit for the patient and that it will remain in situ and is comfortable. For patients with larger limbs, it may be necessary to join two bands together
- Ensure that the barcode is able to be scanned, and not obscured by clothing or jewellery
- Explain to the patient the importance of wearing the ID band at all times enables correct identification and helps keep them safe
- Explain that staff will always check it prior to carrying out procedures, obtaining samples, or delivering therapy/medication in line with the documented Trust policies and local procedures.

Patients must be advised they should challenge staff if checks are not carried out, their wristband is not legible or the barcode does not appear to scan.

Report any incidents, including near misses, arising from the misidentification of patients, through the Trust's incident reporting process. (See Trust policy - Management of Incidents)

Process Flow Chart for establishing the patient's identity and applying wrist bands



Patients must only ever wear one ID band unless

- The patient is a newborn infant
  Refer to the Registration, Identification and Security of Newborn Infants Standard Operating Procedure
- The patient has been previously unidentified. When identity is realised, **both** wristbands remain in situ until the patient is discharged from hospital.
  Refer to the policy for Unidentified and Hospital Trauma Patients-Identification

Ongoing Identification of Patients

- All staff involved in providing care are responsible for ensuring that the patient they are caring for has an electronically generated wristband. This is essential to ensure positive patient identification prior to administration of medications, or any treatment, investigations, surgery.

- Except in an emergency situation, should the identification of patients process fail at any stage, **all** activities for the patient must cease until the patient's identity can be confirmed.

- For Theatre patients – Safer Surgery checklists are used. Patient identity must be confirmed prior to anaesthetising the patient and prior to commencement of surgery. A final patient identification check is undertaken as part of the 'time out' check.
  Refer to the Correct Patient, Correct Procedure and Correct Site Policy

Identification of patient pressure ulcers

- Photographic images of patient pressure ulcers are taken using the SNAP app. The patient is identified by scanning of the patient ID band.

Transfer of Patients from another Hospital

- Patients must have their identity confirmed, and UHPNT ID band attached on arrival. The original wristband must be removed to avoid any confusion of identifying details

Internal transfer of patients

When admitting a patient from another ward or department the admitting person must check the details on the wristband and with the patient in line with the above process.

- Take the necessary corrective action if there is any doubt as to the patients' identity or a wristband is not in situ.
- Patients requiring wristbands MUST NOT be moved, transferred or discharged from a ward or department until a wristband has been applied, unless there is a documented exception
- When transferring patients refer to the:
  Clinical Handover of Care and Internal Transfer and Escorting of Adult Patients (excluding Maternity)

Removal and Replacement of ID bands

- ID bands should never be removed unless it is essential for clinical care, there is an error in the detail or it becomes illegible. Wristbands should be checked and replaced immediately if damaged.
- Where the wristband has to be removed it is the responsibility of the person who removes it to replace it. The ID band must be disposed of in the confidential waste bin
- If a staff member discovers a patient who is not wearing an ID band, then they are responsible for confirming the correct identity of the patient and affixing an ID band as per the above process.

Patients who refuse to wear ID bands

Patients who refuse to wear an ID band should have the risks associated with non-compliance explained.

- Where it has been assessed that the patient does not have the capacity to make the decision not to wear an ID band, the ID band can be placed under 'best interests'. This must be fully documented in the patient records and explained to the parent/guardian/carer/partner.
- Non-compliance must be documented in the patient record, and verification of name /address/date of birth must occur before any consultation, treatment or intervention in order to positively identify the patient
- Where the ID band causes skin irritation – consider placing the ID band over a skin barrier eg tubigrip to avoid contact with the skin
- Verification of the patient's identity must be documented at each shift change. These patients must be highlighted on the ward safety brief, and all members of the multidisciplinary team should be made aware.

The use of ID bands to identify patients with allergies

When admitting patients to wards/clinics/departments, it is the responsibility of the healthcare practitioner admitting the patient to establish if the patient has any known allergies.

- Once it is established that a patient has a known allergy it is the responsibility of the healthcare practitioner admitting the patient to attach an approved ID band with a red strap which will alert staff that the patient has an allergy or sensitivity to a product(s), drug(s) or substance(s), and to record this in the Health Record and on the Medication Prescription Chart.
- In addition to the bedside handover, the importance of knowing the allergy status of patients should be highlighted at the ward safety brief
- Staff must refer to the Health Record for details of allergies.
- A green 'ALERT' sticker on the Health Record is a visual aid to checking the inside cover where the allergy should be documented, and the written medical notes for allergy details.
- Staff must ensure a Clinical Alert is added/ updated as necessary on iPM
  Ref: Administrative Procedure Note-Recording Alerts

This wristband becomes the patient identifier and must be the only wristband worn.

- The absence of a wristband with a red strap does **not** guarantee the patient does not have an allergy and all staff must make an appropriate risk assessment **prior** to any intervention.

SALUS Patient Care Manager – Real time patient bed management

The electronic boards are used by all staff to admit, transfer and discharge patients and to display attributes relevant to that patients care.

Patients with the Same or Similar Name

- Wherever possible, patients with the same or similar name should be cared for in different bays or areas in the ward/department.
- All patients with the same or similar name should be highlighted at the ward safety briefs and on SALUS Patient Care Manager using the attribute below

- Managers must ensure all new and temporary staff understand how to identify patients with the same/similar name.

Completion of Request Cards/Referrals/IT requests etc

Some tests carry quantifiable risk for patients, for example the unnecessary exposure of a patient to radiation is reportable to the Care Quality Commission

- The person signing the request should complete all fields on the request themselves, including the application of the correct patient identification label and be assured that the patient identified on the card is the one for whom the investigation is intended.
- For IT systems, it is a referrer's legal responsibility to:
  - Log in and off of the ISOFT Clinical Manager system
  - Ensure the correct patient is selected when ordering investigations
  - Search for and select patients by Hospital Number/NHS number within the iCM system:
  - Check that the correct examination is requested for the correct patient
  - Provide enough clinical information to justify a request for imaging and lab tests

Sample labelling

All patient samples must be labelled at the bedside, after taking the sample, with the details obtained from the patient's ID band. Samples with less than 3 points of patient identification should be rejected. Scanning the wristband at point of care will occur where the technology exists

There should be positive identification of patients when samples are taken from the bedside to a nearby analyser for POCT testing. In cases when it might be difficult such as with blood gas syringes or urine collected into a paper tray then affix an addressograph label to the tray or syringe.

Inaccurate labelling causes delays, misdiagnosis, and inappropriate treatment..

- For further details on specimen labelling and completion of test requests, whether paper, ICM or ICE, see the Pathology Handbook

Coloured Bands to identify a risk to the patient

The use of coloured bands to identify a risk to the patient are generally not recommended, as misinterpretation is possible. The application of a coloured band to identify a risk, eg. a vaginal pack in situ must be documented, and must not be applied to the dominant wrist, where it may occlude a patient ID band.

Misidentification of patients

Any member of staff who discovers a patient without an ID band, or with incorrect details displayed must assume responsibility for ensuring the patient is correctly identified

Where a patient is misidentified the member of staff should:

- Take all steps to mitigate any harm caused
- Ensure the misidentification is reported through the Trust's incident reporting system (Datix). This would include an incident that has occurred, and also 'near miss' incidents where the error has been detected before an incident occurred
- If electronic records have been mixed, this must be reported to Plymouth ICT service for the attention of the Cinical Systems team.
- Take all steps to prevent any future harm

For unidentified patients refer to the:

Unidentified and Hospital Trauma Patients – Identification

6 Overall Responsibility for the Document

The Patient Safety Manager has delegated authority for reviewing this policy in conjunction with the Deputy Medical Director.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the **Clinical Effectiveness Committee** and ratified by the Chief Nurse and Director of Integrated Clinical Professions and the Medical Director

Non-significant amendments to this document may be made, under delegated authority from the Chief Nurse and Director of Integrated Clinical Professions and the Medical Director, by the nominated owner. These must be ratified by the Chief Nurse and Director of Integrated Clinical Professions and the Medical Director

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with Executive Director of Nursing and the Medical Director, and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

- Observational walk arounds by Matrons, to observe crucial checking of patient identity eg theatre checklists, invasive procedures, medication rounds – any concerns to be addressed in real time.
- Monthly Fundamentals of Care Audits for Adult wards, Paediatrics, ED, Theatres, reported at service line governance meetings
- Incidents and complaints monitoring by Service Line Management teams

10 References and Associated Documentation

NPSA/SPN/2009/002 Risk to patient safety of not using the NHS number as the national identifier for all patients

NPSA/2007/PSA/24 Standardising Wristbands improves patient safety

NPSA/2009/PSA002/U1 WHO Safer Surgery Checklist

NHS/PSA/RE/2015/008 Supporting the introduction of the National Safety Standards for Invasive Procedures

Internal Safety Bulletin No156 (2018) IRMER Regulations/ Information Governance Positive Patient Identification

NHS/PSA/RE/2018/008 Safer temporary identification criteria for unknown or unidentified patients

Scan4Safety website **http://www.scan4safety.nhs.uk/**

Dissemination Plan and Review Checklist | Appendix 1

Dissemination Plan	
Document Title	Identification of Patients Policy
Date Finalised	August 2020
Previous Documents	
Action to retrieve old copies	Remove from StaffNet

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff		Vital Signs	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
Rationale	Are reasons for development of the document stated?	
Development Process	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
Content	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
Evidence Base	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
Approval	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
Document Control	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
Review Date	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	August 2020
Title	Identification of Patients Policy
What are the aims, objectives & projected outcomes?	To ensure that patients receive the correct treatment, in the correct place at the correct time and that the potential for error is reduced to a minimum in line with the National Patient Safety Agency (NPSA) Safer Practice Notices November 2005 and July 2007.
Scope of the assessment	
Collecting data	
Race	Consideration will be made for patients whose first language isn't English. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored
Religion	There is no evidence to suggest that there is a disproportionate impact on religion or belief and non-belief regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Disability	Consideration must be made for patients who have communication difficulties. Consideration must be made for patients with learning disabilities who will be referred to the learning disability liaison team. Consideration will be made for patients with other disabilities as required. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Sex	There is no evidence to suggest that there is a disproportionate impact on sex regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored
Gender Identity	Data for this protected characteristic is not currently collected. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Sexual Orientation	There is no evidence to suggest that there is a disproportionate impact on sexual orientation regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored
Age	There is no evidence to suggest that there is a disproportionate impact on age regarding this policy. Data collected from Datix incident reporting and complaints will ensure this is monitored.
Socio-Economic	Data for this protected characteristic is not currently collected.
Human Rights	Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
What are the overall trends/patterns in the above data?	Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored

Involving and consulting stakeholders	
Internal involvement and consultation	Internal consultation via email with staff groups including Executive Governance Team Ward /Clinic/Theatre Managers Matrons Heads of Departments IT Emergency Planning & Liaison Officer Pathology Service Line Cluster Managers Consultants Service Line Clinical Directors Clinical Directors Quality Managers Head of Patient Access
External involvement and consultation	Not Applicable

Impact Assessment	
Overall assessment and analysis of the evidence	Considerations will be made for patients where English is not their first language, who have communication difficulties, and patients with a disability.

Action Plan				
Action	Owner	Risks	Completion Date	Progress update
Collect and monitor data collected from Datix as necessary	Risk & Incident Team Service Line Governance			This action will be addressed as required

Specific issues and data gaps that may need to be addressed through consultation or further research	