PATIENT IDENTIFICATION POLICY

Policy Type	Clinical
Directorate	Clinical
Policy Owner	Chief Nurse including Midwifery and Allied Health Professionals
Policy Author	Head of Nursing & Quality Medicine
Next Author Review Date	1st November 2022
Approving Body	Policy Management Sub-Committee 23rd April 2019
Version No.	8.0
Policy Valid from date	1st April 2019
Policy Valid to date:	30th April 2023

'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
29 Mar 12	6.0			Logo and Wording updated for new organisation	
Apr 14	6.1		Interim Head of Clinical Services	Updated	
02 May 14	6.1		Executive Director of Nursing and Workforce		Ratified at Clinical Standards Group
20 May 14	7.0	20 May 14	Executive Director of Nursing and Workforce	Subject to minor amendments	Approved at Policy Management Group
9 May 17	7.0		Executive Director of Nursing and Workforce	Extension approved for three month	Corporate Governance & Risk Sub-Committee
11 July 17	7.0		Executive Director of Nursing and Workforce	Extension to review date approved for three months	Corporate Governance & Risk Sub-Committee
14 Nov 17	7.0		Executive Director of Nursing and Workforce	Extension to review date approved for three months	Corporate Governance & Risk Sub-Committee
13 Feb 18	7.0		Executive Director of Nursing and Workforce	Extension to review date approved for two months	Policy Management Sub-Committee
10 Apr 18	7.0		Executive Director of Nursing and Workforce	Extension to review date approved for one months	Policy Management Sub-Committee
8 May 18	7.0		Executive Director of Nursing and Workforce	Extension to review date approved for one month	Policy Management Sub-Committee
Nov 2018	7.1		Executive Director of Nursing	Format change & Minor amendments	
25 Jan 19	7.1		Executive Director of Nursing	Endorsed at	Clinical Standards Group
23 Apr 19	8.0	23 Apr 19	Executive Director of Nursing	Approved at	Policy Management Sub-Committee
29 Jan 2021	8.0	23 Apr 19	Chief Nurse including Midwifery and Allied Health Professionals	12 month blanket policy extension due to covid 19 applied with author review date set 6 months prior to Valid to Date.	Quality & Performance Committee
19 May 2021	8.0	23 Apr 19	Chief Nurse including Midwifery and Allied Health Professionals	Extended policy uploaded and linked back with new cover sheet	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents **Page**

1 Executive Summary

1.1 The policy is designed to ensure the correct procedure for checking a patient's identification in the general Acute, Community and Mental Health settings, to ensure the correct procedure, intervention and information is given to the intended patient.

1.2 The policy is aimed at all professionals who work within Isle of Wight NHS Trust and who have the responsibility for checking a patients' identification.

1.3 A flow chart outlining key actions is in Appendix A

2 Introduction

2.1 The policy is designed to ensure the correct procedure for checking a patient's identification in the general acute and community settings, to ensure the correct procedure, intervention and information is given to the intended patient.

3 Definitions

A&E Accident and Emergency department
NPSA National Patient Safety Agency
PAS Patient Centre
TTO To Take Out medications

4 Scope

4.1 This policy applies to ALL patients in general and community settings. Mental Health inpatient services need not use patient wristbands, although if wristbands are already being used, they should comply with the NPSA/2007/24 recommendations.

4.2 The following patients require an identity bracelet:

- All inpatients, day surgery and day case patients
- A&E attendees who cannot reliably identify themselves e.g. confused, unconscious
- A&E attendees where a decision to admit has been made
- Outpatient attendees who cannot reliably identify themselves e.g. confused,
- Any other patient who in the opinion of a healthcare professional requires an identity bracelet.

All patients should be checked once a day by ward/unit staff and at the time of any transfers between wards or department, to ensure that they are wearing an identity bracelet and that the information on the bracelet is correct and legible. If the bracelet is absent, illegible or incorrect a correctly completed, legible bracelet must be applied as soon as possible.

4.3 In conjunction with this policy please see:

- Identification of New-borns – Appendix B
- Identification within Mental Health & Learning Disabilities – Appendix C
- Identification within Community Nursing and Intermediate Care Services – Appendix D
- Identification of Children – Appendix E
- Collection and labelling of blood samples for pre transfusion testing- Appendix F

5 Purpose

5.1 The purpose of this policy is to ensure that the planned and intended actions of clinical care, interventions and information intended for a patient are carried out on the correct patient.

5.2 This policy also incorporates the recommendations of the National Patient Safety Agency, Safer Practice Notice Ref: NPSA/2005/11 and NPSA/2007/24.

6 Roles and Responsibilities

All staff that have responsibility for direct patient care will ensure they follow the patient identification policy to ensure patients can be identified as per the relevant procedure for the clinical setting.

7 Policy detail/Course of Action

7.1 Electronic wristbands must be put on patients as soon as they are admitted and worn throughout their hospital stay. If a member of staff removes a wristband: It is their responsibility to make sure it is replaced. Make clear alternative arrangements for the patient's correct identification if it cannot be replaced immediately. (Hand written wrist band are only acceptable in the Outpatients Department)

7.2 The wristband should be put on the dominant arm that is the side used for writing; it is then less likely to be removed when, for example, intravenous access lines are inserted. Also, for patients undergoing upper limb surgery, consider placing the band around the patient's ankle.

7.3 The patient should have a single identification electronic wristband that incorporates all essential information.

7.4 The electronic wristband is to be white and secured with a WHITE clasp, and printed from a designated electronic wristband printer that is located in the clinical area.

7.5 The non-electronic wrist bands used in outpatients department should be white unless patients has an allergy or is not able to receive blood or blood products this should be red.

7.6 Electronic wrist bands, if the patient has known allergies or sensitivities, or patients do not want to receive blood or blood products then a RED clasp must be used to secure.

7.7 Wristbands do not remove clinicians' responsibility for checking patients' identity. They are an important way of validating identification particularly when a patient is unable to provide their own details. It is the responsibility of all health workers to check the patient's identity, via the wristband, before procedure/action/treatment/specimen collection.

7.8 Any member of staff that discovers a patient does not have a wristband has to assume responsibility for correctly identifying them. To minimise risk, they should also ensure that the correct wristband is immediately placed on the patient.

7.9 If the electronic wristband printer malfunctions then the next nearest clinical area with a printer should be used to gain an electronic wristband for a patient, until the malfunction is repaired or the printer replaced.

7.10 PATIENTS OF KNOWN IDENTITY

The ONLY information detailed on the electronic wristband will be:

First Name(s)
Surname
Date of Birth
Gender
IW Number (if the IW Number is not immediately available then a temporary number should be used until it is).
NHS Number (when available)
Barcode

7.11 Hand written wrist bands should have the same information as above but without the barcode.

7.12 It is recommended that a single identification wristband that incorporates all relevant information (as above) be used.

7.13 For elderly people who may be agitated and are likely to "pick" at their wristband, an ankle band in addition or instead of a wristband may be necessary.

PATIENTS OF UNKNOWN IDENTITY

7.14 On admission, patients whose identity is unknown will be issued with a temporary Isle of Wight case note number.

7.15 This can be obtained by contacting the Patient Information Team (out of hours 17.00 – 09.00 the Bed Manager is to be contacted) who will generate the number via PAS.

7.16 In the event of the PAS being off-line, a unique "U" number will be issued by the Accident and Emergency Department.

7.17 Once the patient's identity becomes known, any previous case note number issued must be included on the patient's wristband until any duplicate case notes and IW numbers are merged by the PAS team.

7.18 Until this occurs the first number issued MUST be used and when an IW number is available the wristband must be changed.

7.19 The PAS team will be responsible for informing Pathology and Diagnostic Imaging of changes to the patient's IW number when records are merged.

7.20 The IW number or NHS number should be used as the patient's unique identification and should be used in all circumstances for patient identification.

7.21 PROCEDURE THROUGHOUT THE PATIENT'S JOURNEY

Prior to any diagnostic test, sample collection, medication administration and review of results the patients' wristband must be checked by the appropriate health worker to ensure the correct patients identity using the wristband and the request form, by asking the patient where the patient condition allows for verbal checking of name and date of birth. In outpatients details should be checked both verbally with the patients checking against the notes and request form.

If it is the right patient but the wristband contains the wrong information then the procedure/diagnostic test should be withheld until the patient's identity has been correctly established and a new accurate wrist band secured to the patient. An incident form should be completed indicating a near miss episode. (Record on Datix)

All specimens that are incorrectly/incompletely labelled will be discarded and the appropriate personnel informed, to repeat the specimen collection. An incident form should be completed to provide a record so that inadequate practice can be identified and additional training can be completed by the individual. (Record on Datix)

7.22 OUTCOME

All departments/ward managers will determine the frequency of auditing the process to ensure that the policy is being adhered to and all patients can be identified. It is recommended that this activity should be carried out at least monthly. Results should be feedback through Division board meetings via Care Group Quality report

8 Consultation

8.1 This policy has been updated with all relevant clinical stakeholders and users of this policy and approved at the correct ratification groups.

9 Training

9.1 This policy should be implemented and disseminated throughout the Trust immediately following ratification and will be published on the Trusts intranet site. Access to this document is open to all.

This policy does not have a mandatory training requirement or any other training needs

10 Monitoring Compliance and Effectiveness

10.1 The compliance of this policy is monitored monthly through the medicines administration audit undertaken by ward and department leaders.

10.2 Compliance of neonatal identity labels is monitored through daily checks and an ongoing audit process.

11 Links to other Organisational Documents

11.1 This policy relates and refers to the following policy and guideline documents, which are in place on the Isle of Wight.

- Transfusion of Blood and Blood Components policy
- Diagnostic Imaging: Procedures for Ionising Radiations Medical Exposures
- Ensure Correct Surgery Undertaken policy
- Photography of mental health Patients for identification purposes

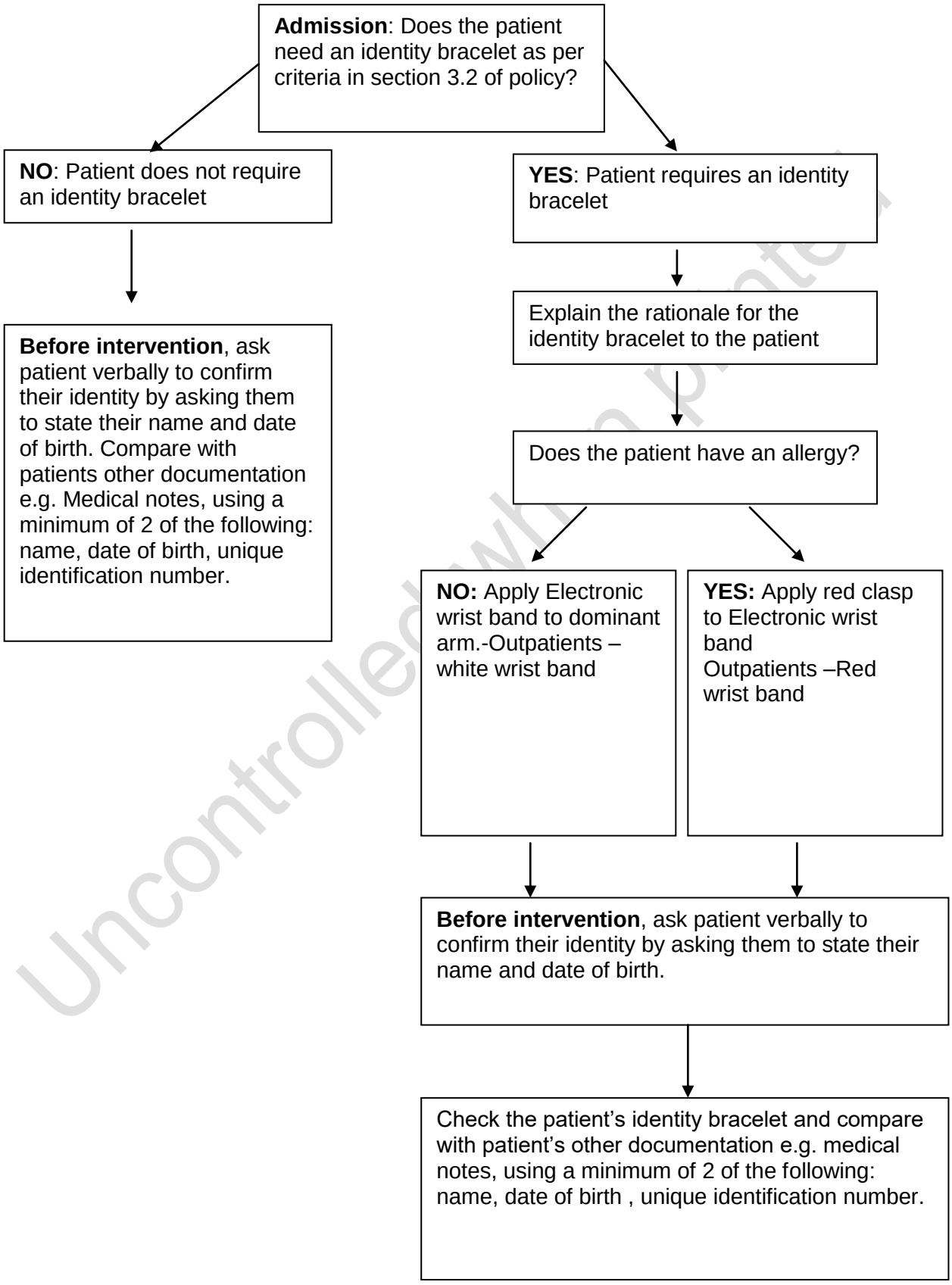
12 References

12.1 Standardising Hospital Wrist Band NPSA Alert 2008
12.2 Risk to patient safety of not using the NHS Number as the national identifier NPSA/2009/SPN002

13 Appendices

Appendix A

Flowchart summarising Policy



Appendix B

GUIDELINES FOR IDENTIFICATION OF THE NEWBORN

1. PURPOSE OF THE DOCUMENT

1.1 These guidelines are prepared as one component of security on the Maternity Unit and outline the procedure for identification of the new-born within the Unit.

2. SCOPE OF DOCUMENT

2.1 All staff working on the Maternity Unit.

3. COURSE OF ACTION

3.1 Two hand written wristbands to be prepared by the midwife or under the midwife's supervision and attached to the baby in Labour Ward after the birth of the baby.

Data to include on handwritten labels

- Forename of baby if known
- Mother's surname
- Date of birth
- Time of birth
- Gender
- Mother's IW number

3.2 hand written wristbands to be checked by mother or partner and then applied to each ankle. Document in mother's notes that labels were checked, applied or changed before baby leaves the Labour Ward.

3.3 All babies being transferred in an incubator or on a Resuscitaire to the SCBU should have the wristbands checked by mother or partner before leaving Labour Ward.

3.4 Prior to transfer ensure cot is labelled.

Data to include:

- Mode of delivery
- Forename of baby or sex
- Mother's surname
- Date and time of birth
- Mother's IOW number
- Birth weight

Ongoing checks

- Under no circumstances should mothers and babies be separated without the mother's consent / knowledge.
- Wristbands to be checked on warding of mother and baby and on returning baby to mother if separated during the day or night.
- Daily checks of wristbands to be made and documented on baby observation chart monitored as per daily check process
- Wristbands to be checked prior to discharge and left in situ until baby leaves hospital premises.

ALL MOTHERS SHOULD BE INSTRUCTED TO INFORM MIDWIFERY STAFF IMMEDIATELY IF LABELS ARE NOT INTACT / NOT IN SITU

4. BABIES READMITTED TO THE MATERNITY WARD

4.1 On admission two wristbands to be made by midwife / under midwife's supervision

Data to include:
- Forename of baby
- Mother's surname
- Date of birth
- Gender
- IW Number
- Mother's IW number [if thought appropriate]

4.2 Both wristbands should be checked by mother or partner and applied to each ankle.

4.3 Cot heads must also be labelled with above data.

4.4 Documentation should be made of the wristbands and identification of baby on baby observation chart or in mother's notes if baby is greater than 10 days of age.

4.5 wristbands should be checked daily and on returning baby to mother if separated during the day or night. They should be checked prior to discharge and left in situ until the baby leaves hospital premises hospital premises.

5. PROCEDURE WHEN LABELS ARE NOT IN SITU

5.1 RATIONALE

To ensure consistent procedure when an infant is found not to have a wristband on each ankle; there are three possibilities:

- Only one wristband in place
- No wristband in place
- More than one baby on the unit with no wristband in place

5.1.1 One wristband in place
- Mother is informed by the midwife that only one wristband is in situ.
- Using baby's medical notes, a second wristband must be written and checked by mother or partner prior to attachment and details to be checked to ensure compatibility with other wristband and cot head.
- Document that wristband reapplied on baby's observation chart with date time and signature of midwife.

5.1.2 No wristbands in place
- Mother is informed by midwife that there are no wristbands in place.
- All other babies on the unit must have their identification labels checked
- If all other babies' wristbands are correct two wristbands must be printed (using the baby's medical notes), checked with mother or partner and applied to each ankle.
- Document that wristbands have been re-applied on baby observation chart with date time and Midwifery manager on call that an incident has occurred. An incident form must be completed.

5.1.3 Procedure if two or more babies are not labelled

- Mothers informed of situation by Shift coordinator on duty.
- Shift coordinator on duty to inform Midwifery manager on call. The Trust senior manager on call will be informed.
- The Midwifery Manager and On call Consultant Paediatrician will counsel the parent(s) in the presence of the Supervisor of Midwives and Head of Clinical Services, as to the procedure to be followed.
- Parents' wishes to be considered regarding care of the babies whilst investigations are being undertaken.
- When agreement is reached both babies to be re-labelled in accordance with the identification of the new-born guideline.
- An incident form must be completed.

Links to other policies, documents, guidelines

- Guidelines for New-born Security
- Transfusion of Blood and Blood Components policy
- Immediate Care of the New-born

Appendix C

IDENTIFICATION WITHIN MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

1. INTRODUCTION

1.1 The patients/clients cared for by staff within the Mental Health and Learning Disability Services Care Group receive this care in a wide variety of environments. The nature of the patient/client group makes it inappropriate to adopt systems commonly used in general hospital/ward-based environments. The principles of the majority of mental health and learning disability care are based around the development of a trusting nurse – patient/client relationship. Therefore, it is this that forms the foundations for ensuring that the correct patient/client is identified when administering care (in particular, the administration of medication).

1.2 Given the wide range of skill mix, qualified staff/patient ratios and environments applicable within the Mental Health and Learning Disability Services Care Group, actual practices vary. They are summarised in outline form as follows:

2. LEARNING DISABILITY SERVICES

2.1 All clients using Learning Disability Services are known by staff, having been identified at commencement of care provision through a series of introductory visits to services or through regular home visits. Clients generally use services long term (for all or most of their lives). As a result, staff knows clients very well and uses this relationship as the basis for identification. If, for any reason, a member of staff is unsure of the identity of a client (e.g. if the staff member is new/temporary), they are required to establish this before any identity specific care is given.

3. MENTAL HEALTH INPATIENT SERVICES

3.1 At each of three nursing handovers that take place through the day, any patient that is not known to the nurse in charge of the shift is identified. The incoming nursing staff team are introduced to the patient before the previous shift goes off duty. A registered nurse always undertakes medication administration. If the registered nurse has any doubt about the identification of a patient, this is established before proceeding with administration. If a patient cannot be clearly identified, medication is withheld until their identity is established.

4. COMMUNITY BASED MENTAL HEALTH TEAMS

4.1 The medication administered by Community Mental Health Nurses consists mainly of intra-muscular injections of long acting (depot) anti-psychotics and potentially controlled drugs. These are administered either in the patient's own home or at a clinic within a Community Mental Health Team base or other premises such as a Health Clinic or GP Practice). Nursing staff administering depot injections or medication are either the patient's care co-ordinator or clinic coordinator. The process of awareness of the identity of a patient occurs when the nurse checks the person's name and their prescription sheet with them and in the case of controlled drugs, a nurse colleague.

4.2 There are separate protocols and guidance for staff in the delivering of TTO medications, home detoxification regimes and one off prescriptions prescribed in a crisis situation. Staff are required to ensure the person's identity matches the

prescription through their personal knowledge of that person or through asking them to check their names with them.

5. Electro-Convulsive Treatment (ECT)

5.1 Identification bands are used for all patients undergoing Electro-convulsive treatment. These are placed on the patient pre-treatment so staff can ensure the right patient/right wristband. Identification is confirmed when the patient enters the clinic and all staff are aware of any concerns pre-treatment. The identification wristband stays on the patient through treatment and is removed by staff once they leave the clinic.

No intervention shall be carried out on any patient unless the member of staff is satisfied that they are applying the intervention to the individual for whom it is intended.

If it becomes apparent that misidentification of a patient has occurred then the untoward incident policy to be invoked

Revised 2014

Appendix D

IDENTIFICATION WITHIN COMMUNITY REHABILIATION TEAM AND INTERMEDIATE CARE SERVICES

1. INTRODUCTION

1.1 The patients cared for by staff within the Community Rehabilitation Teams receive care in a wide variety of environments; patients own homes, residential care homes and clinics. The nature of the patient group makes it inappropriate to adopt systems commonly used in general hospital/ward-based environments.

1.2 Patients are known by staff, having been identified at commencement of care provision through a referral system. Community Rehabilitation Teams are required to ensure the person's identity matches the referral through their name, address, date of birth, also personal knowledge of that person and/or through asking them or their carer or other health or social care professional to confirm their identity.

1.3 Community Rehabilitation Teams administering medication will ensure correct identity following the Trusts Medicine Policy, by checking with the patient or their carer that the patient's name, address, date of birth and prescription chart correspond exactly.

1.4 No intervention will be carried out on any patient unless the member of staff is satisfied that they are applying the intervention to the individual for whom it is intended.

Appendix E

IDENTIFICATION OF CHILDREN

1. PURPOSE

1.1 The purpose of this document is to ensure that the planned and intended actions of clinical care, interventions and information intended for a child are carried out on the correct child. This policy was written with reference to the National Patient Safety Agency (NPSA) safer practice notice November 2005

2. SCOPE OF DOCUMNET

2.1 This policy applies to all children/adolescents admitted to the Children's Unit within St. Marys Hospital.

3. POLICY

3.1 At the point of admission, the admitting nurse will check with the parent/carer the child's name; date of birth and with the notes the recorded IW number.

3.2 The admitting nurse will then print an electronic wristband from the designated wristband printer within the clinical area.

3.3 The nurse will then recheck the child's name and date of birth with the parent/carer prior to attaching the electronic wristband to the child's wrist or ankle with a WHITE clasp, dependant on age. If the parent/carer is not available, the details may be checked with the child if the paediatric nurse assesses them to be Gillick competent (Frazer ruling).

3.4 The nurse will document date and time of attaching the identification band in the Integrated Care Pathway (ICP).

3.5 If the child has known allergies or sensitivities a RED clasp must be used to secure the electronic wristband.

3.6 The information detailed on the electronic wristband will be:

- First Name(s)
- Surname
- Date of Birth
- Gender
- NHS Number (when available)
- IW Number
- Barcode

The Isle of Wight number is the patient's unique identification and is to be used in all circumstances for patient identification.

4. REMOVAL OF IDENTIFICATION BAND

4.1 Any member of staff that discovers a patient does not have an identification band has to assume responsibility for correctly identifying them (NPSA 2005), and ensuring a wristband is attached either to the patient or their cot / bed

5. ALLERGY OR INTOLERANCE TO IDENTIFICATION BAND

5.1 Any child who cannot wear the identification bands because of allergies/skin conditions, or children who do not tolerate a wristband in place.

5.2 The nurse will:

- Tape the child's electronic wristband to their cot/bed/wheelchair so it is available to check with the parent/carer prior to administration of any treatment/care.
- The nurse will record in the care plan where the identification band is placed.
- Check the child's name and date of birth as well as the identification band with the parent/carer prior to any administration of treatment/care.

6. ADMINISTRATION OF TREATMENT TO TWINS/TRIPLETS

6.1 If twins/triplets are admitted the correct identification band is to be checked with the parent/carer before application and the child's details will be checked by two nurses as well as with the parent/carer prior to administration of treatment.

An electronic wristband audit will be carried out on the Children's Unit a minimum of once a month to ensure that there is 100% compliance to this policy.

7. OUTCOME

7.1 All children will be issued with an accurate electronic wristband on admission to the Unit.

7.2 An audit will be carried out monthly on the Unit to ensure that the policy is adhered to and all children can be identified.

References:

www.npsa.nhs.uk/advice Wristbands for hospital inpatients safety. November 22 2005

Appendix F

COLLECTION AND LABELLING OF BLOOD SAMPLES FOR PRE TRANSFUSION TESTING

1. The process of collecting and labelling a sample should be completed on one patient before commencing another.

2. The patient must be positively identified immediately prior to sample collection by the use of 'open' questioning i.e. by asking the patient to state their full name and date of birth. Details must be checked / confirmed against patient's identification wristband (or by documentation in the outpatient setting only). Patients living with dementia or are unconscious or sedated and children must be identified by the information on their wristband.

3. Samples must be labelled immediately after blood collection, at the "bedside", by the same person that took the sample.

4. Samples and request forms will need to be re-written if changes are made and key information is not readable (alterations to the request form are allowed if minor),

5. Sample tubes must not be pre-labelled.

6. Addressograph labels MUST NOT be used on samples

7. Labels produced from the electronic blood tracking system by scanning the barcodes on the patient's wristband together with identification badge of the person obtaining the sample are acceptable. Staff identification barcodes MUST not be used by any other person than the person it was issued to

8. The minimal acceptable labelling requirements are:
   (a) Surname
   (b) Forename (for unnamed infants use MI or FI)
   (c) Date of Birth
   (d) IW number (NOT case note or NHS number), 'U' Numbers will be issued by A&E and 'M' Numbers will be issued by Maternity, in the event of a computer failure. 'E' Numbers will be issued in the event of a Major Incident.
   (e) Signature of person taking the sample
   (f) Date of collection

   For emergency admissions of 'unknown' patients, the minimal acceptable labelling requirements are:
   (a) Surname "Unknown"
   (b) Forename "Female or male"
   (c) Hospital No "IW Number or Unique 'U' or 'E' Number
   (d) Signature of person taking the sample
   (e) Date of collection

   The Blood Transfusion Laboratory will not accept inadequately or inaccurately labelled samples.
   (See NHS Isle of Wight Primary Care Trust Patient Identification Policy)

BLOOD ADMINISTRATION

Checks MUST be performed at the bedside

1. Proper identification of blood or blood components and the recipient must be carried out. This should be by two people, one of whom must be a Medical Practitioner, or holding current registration of the UKCC Professional Register as a Registered Nurse (RGN) / Midwife (RM) / Sick Children's Nurse (RSCN), or Operating Department Practitioner / Assistant and will take responsibility for the checks and sign the Blood Transfusion Chart.
2. Positive Identification of the patient MUST be carried out before each unit is transfused as per the Trust Patient Identification Policy

   The following checks MUST be performed at the bedside.

   (a) PID:
   - Surname
   - Forename(s)
   - IW Hospital No.
   - Date of Birth

   These must be checked where possible, by asking the patient to confirm their
   - Full Name (i.e. Surname and Forenames).
   - Date of Birth

   This MUST be checked and found to be identical with:
   - Patient's wristband
   - Blood Transfusion Chart
   - Compatibility Label
   - Patient's Medical Records.

   If there is any discrepancy it MUST be investigated before the transfusion is commenced.

Appendix G

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Patient Identification Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**		
Training Staff	**0**		
Equipment & Provision of resources	**0**		

Summary of Impact: Nil

Risk Management Issues: Nil

Benefits / Savings to the organisation: Neutral

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	0	0	0
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
	0	0

Totals:		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed	0	
Building alterations (extensions/new)	**0**	
IT Hardware / software / licences	**0**	
Medical equipment	**0**	
Stationery / publicity	**0**	
Travel costs	**0**	
Utilities e.g. telephones	**0**	
Process change	**0**	
Rolling replacement of equipment	**0**	
Equipment maintenance	**0**	
Marketing – booklets/posters/handouts, etc	**0**	
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	**NA**
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix H

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Patient Identification Policy
Purpose of document	Patient Safety
Target Audience	Acute Trust Staff
Person or Committee undertaken the Equality Impact Assessment	Head of Nursing & Quality Medicine

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	*x*		
	Women	*x*		
Race	Asian or Asian British People	*x*		
	Black or Black British People	*x*		
	Chinese people	*x*		
	People of Mixed Race	*x*		
	White people (including Irish people)	*x*		

	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	*x*		
Sexual Orientation	Transgender	*x*		
	Lesbian, Gay men and bisexual	*x*		
Age	Children	*x*		
	Older People (60+)	*x*		
	Younger People (17 to 25 yrs)	*x*		
Faith Group		*x*		
Pregnancy & Maternity		*x*		
Equal Opportunities and/or improved relations		*x*		

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact: NA			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or

improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	