# Positive Identification of Patients Policy

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Positive Identification of Patients Policy</th>
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<tbody>
<tr>
<td>Version:</td>
<td>4</td>
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<tr>
<td>Approved by:</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Date of approval:</td>
<td></td>
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<tr>
<td>Policy supersedes:</td>
<td>Positive Identification of Patients Policy May 2012</td>
</tr>
<tr>
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<td>Positive Identification of Patients Policy March 2014</td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Suzanne Hinchliffe - Chief Nurse</td>
</tr>
<tr>
<td>Policy Lead:</td>
<td>Jackie Whittle - Head Of Nursing For Professional Practice, Clinical Standards &amp; Patient Safety</td>
</tr>
<tr>
<td>Name of responsible committee/group:</td>
<td>Risk Management Group</td>
</tr>
<tr>
<td>Date issued:</td>
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<tr>
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<td>31st Jan 2017</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All Trust Staff</td>
</tr>
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STAFF SUMMARY

The policy for patient identification needs to be followed to ensure that patients receive the correct treatment and are protected from harm.

If a patient is severely harmed or dies as a result of incorrect treatment due to misidentification this is classified as a Never Event.

All clinical areas must have processes in place to ensure that all staff positively identify all patients prior to delivery of care / treatment and when ordering tests, investigations and procedures.

All inpatients/day cases and some outpatients must wear a Trust agreed identification wristband for the duration of their stay (see section 4.3). It is the responsibility of the admitting healthcare professional to positively identify the patient and attach the identification wristband to the patient as soon as they are admitted. The wristband must meet NPSA requirements, i.e. be generated from the Patient Centre administration system and state:

Forename
Surname
Date of birth
NHS number
Case note number

If a member of staff removes the identification wristband, it is their responsibility to make sure it is replaced or makes clear alternative arrangements for the patient’s correct identification if it cannot be replaced immediately.

Any member of staff that discovers a patient does not have an identification wristband has to assume responsibility for correctly identifying the patient and take responsibility for informing the nurse responsible for that patients care who must ensure an identification wristband is issued.

A red alert band must be used to highlight patients with an allergy or sensitivity.

Within Maternity Units and Neonatal Units, babies must have two identification wristbands.

Information on the bed head and/or communication boards should be the patient’s forename and surname and medical consultant. The bed head / communication board should not be used as a source of positive identification of the patient.

Standards of Positive Identification of Patients policy.

1) Positive identification of all patients must be carried out throughout their hospital journey prior to any examination, treatment or procedure, whether they are wearing an identification wristband or not.

2) Patients must be asked to state their name and date of birth and this must be checked against the patient’s case notes / accompanying documentation / wristband.

3) All relevant patients must wear an identification wrist band that meets NPSA requirements as outlined above.
1. CORRECTLY IDENTIFYING A PATIENT

Ask Patient (carer) to state their full name, D.O.B. and check against Patient Centre records. Confirm any allergies

Generate wristband - **RED** allergies present  
**WHITE** no allergies

Check details with patient/carer  
Attach to patient

2. CONFIRMING PATIENT IDENTITY (FOR ANY PROCEDURE OR MEDICINE ADMINISTRATION)

- **VERBALLY** - ask patient to confirm full name & D.O.B.
- **ENSURE** - patient has a LTHT ID band in situ. 2 ID bands required for patients going to theatre.
- **CONFIRM** - cross reference: ID band name, D.O.B. on all documentation and ID band.
- **THEATRE** - 2 ID bands required.  
  - On arrival into theatre suite check ID bands against pre-op checklist.  
  - Only ID bands or if obscured pre-operative checklist can be used to confirm identity of patient once anaesthetised.

3. REMOVAL OF ID BANDS

Wrist bands removed as final part of discharge process. If removed prior to this ensure replaced as soon as possible, ensure patient is able to be identified during this time.

4. IN THE EVENT OF MISIDENTIFICATION

Instigate immediate actions to minimise harm/risk to patient:

- Inform senior staff.
- Report via Datix.
- Inform patient and relatives.

1. PURPOSE
This Policy document sets out the Trust's expectations in relation to positive identification of a patient. It provides the framework for ensuring that the Trust has in place effective patient identification processes. The LTH guidance on positive identification of patients accompanies this Policy (appendix A). These documents taken together meet the relevant requirements in relation to positive patient identification of the following national guidance:

- NMC (2008), The Code: Standards of conduct, performance and ethics for nurses and midwives.
- NMC (2010), Standards for Medicines Management.

Misidentification of patients is listed as a 'Never Event' by the Department of Health (2011). ‘Never events’ are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. This policy describes the specific preventable measures to be taken to avoid misidentification of a patient.

<table>
<thead>
<tr>
<th>Failure to follow this policy could result in the</th>
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<tr>
<td>instigation of disciplinary procedures.</td>
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</tbody>
</table>

2. DUTIES WITHIN THE ORGANISATION

2.1 Chief Executive

The Chief Executive has overall accountability for ensuring that the Trust meets its obligations in respect of maintaining appropriate standards of patient identification. The Chief Executive devolves the responsibility for monitoring and compliance to the Chief Medical Officer and Chief Nurse.

2.2 Chief Medical Officer and Chief Nurse

The Chief Nurse and Chief Medical Officer are responsible for ensuring that Trust staff apply the principles of correct patient identification and that appropriate policies and procedures are developed, maintained, and communicated throughout the organisation in conjunction with other relevant organisations and stakeholders.

2.3 Responsibilities of Heads of Nursing and Clinical Directors in Clinical Service Units (CSU)

Any specific risks relating to patient identification at a local level should be assessed and added to the local Risk Register with actions agreed to mitigate the risk.

Audit results (patient identification) should be shared and reviewed at the CSU
Governance Forum and action agreed where these are required.

Any incident arising from the incorrect identification of a patient should be investigated at a local level and actions taken to prevent recurrence and minimise risk. Lessons to be learnt should be shared at the CSU Governance Forum. Any residual ongoing patient identification risks should be registered on the Risk Register.

Heads of Nursing & Clinical Directors within the CSU have a responsibility to ensure nurses and other health professionals follow this procedure.

2.4 Matrons

Any incidents arising from patient identification should be investigated and reported to the Matron (Clinical Site Manager out of hours) or Senior Manager via the incident reporting system.

Any incident arising from the identification of a patient should be reported through the incident reporting system, investigated at a local level by Matrons and actions taken to prevent reoccurrence and minimise risk. Any lessons to be learnt should be shared at the Speciality Clinical Governance forum. Any recurring/serious patient identification risks should be escalated by the Matron to the Head of Nursing/ Clinical Director and recorded on the CSU risk register.

2.5 Ward Manager/Departmental Manager Responsibilities

It is the Ward / Departmental Manager’s responsibility to ensure that annual audit of positive patient identification is carried out and that the results of which are shared with staff locally and acted upon.

2.6 All Staff

It is the responsibility of every health care worker to ensure that patients are positively identified as outlined in this policy (see section 4). All staff have a duty to report any incidents arising from misidentification via the incident reporting process.

3. POSITIVE IDENTIFICATION OF PATIENTS

Positive Identification of the patient refers to a process of ensuring that the patient to be treated is the patient for whom the treatment is intended.

All health care providers have primary responsibility for checking / verifying a patient’s identity. Failure to correctly identify patients can lead to medication errors, transfusion errors, testing and investigation errors, wrong site surgery and wrong patient procedures.

3.1 Choosing the correct patient

When treating a patient it is the responsibility of the health care worker to make sure it is the intended patient. This should be done both verbally with the patient (as far as possible) by asking ‘what is your name and date of birth?’. Staff must always ‘ask’ patients to state their name and date of birth the patient should not be passively asked i.e. ‘are you patient x,’ as this can lead to patient misidentification if the patient mishears the member of staff.
3.2 Checking against patient documentation

Once the patient’s name and date of birth have been given by the patient this must be cross referenced to the patient case notes / accompanying documentation e.g. request forms, consent forms, prescriptions. Staff must ensure that patients names are spelt correctly by checking with the patient or relative. The identification wristband must also be checked for applicable patients (see section 4.3). All patient identifiers on the wristband must be checked i.e name, date of birth and NHS number against the case notes / accompanying documentation.

If the patient is having a procedure their name, date of birth and NHS number must always be checked against the consent form signed by the patient.

3.3 Initial positive identification of the patient

On admission to the hospital it is the responsibility of the healthcare professional dealing with that patient to positively identify them. This should be done by asking the patient to state their full name and date of birth, this must then be checked against Patient Centre records to ensure that the correct patient is chosen so that an identification wristband can be printed.

It is the responsibility of the nurse/midwife caring for the patient to ensure that the patient has an identification wristband applied if appropriate on admission. (See section 4.3)

In outpatient clinics it is the responsibility of the healthcare professional dealing with that patient to positively identify them. This must be done by asking the patient to state their full name and date of birth, this must then be checked against the accompanying documentation e.g. case notes or consent form prior to consultation/treatment. Some outpatients must wear an identification wristband, see section 4.3

Special care should be taken if communication with the patient is not possible or if their first language is not English. In this instance confirmation may be gained from relatives or carers or advice be sought from the Trusts Interpreting Service. At: http://lthweb/sites/interpreting-services/interpreting-service/?searchterm=language%20link

3.4 Requests for investigation / treatment

All request forms / prescriptions completed for the patient should be checked with the patient that the details are correct by asking the patient to state their name and date of birth and cross referencing with the form. Identification wristband (where applicable) should also be checked to ensure the request is made for the correct patient.

4. PATIENT IDENTIFICATION WRISTBANDS

4.1 Provision of identification wrist bands.

The identification wristband must be generated from the Patient Centre administration system. Ward areas must ensure that sufficient numbers of staff are trained (i.e. at least one person on duty at any time that is trained) to use the Patient Centre administration system and wristband printer so that identification
wristbands can be applied in a timely manner on admission and in order to re-apply any wristbands that have been removed. Staff training is available via e-learning.

The following information is required on the wristband.

Forename  
Surname  
Date of birth  
NHS Number  
Case note number  

4.2 Attaching the wristband

Whenever possible the patient should be asked to read the details on the identification wristband and confirm they are correct prior to attaching it to the patient.

The wristband should be put on the dominant arm then it is less likely to be removed when, for example, intravenous access is required.

4.3 Who should wear an identification wristband?

The following patients must wear an identification wristband:

- Inpatients
- Day-cases
- Outpatients:
  - When receiving blood transfusions or invasive treatments / procedures
  - Where it is professionally judged there is a risk of injury or harm to the patient that would be reduced by the use of an identification wristband.
  - When receiving sedation.
  - Prior to drug administration
- Newborn babies
  - Two identification wristbands must placed one on each ankle of the baby at birth stating the mother's name and NHS number, sex of the baby and date and time of birth. The details should be checked with the parent/s.
- Patients in the Emergency Department
  - Patients attending the Emergency Department with Glasgow Coma Score of < 15 must wear a wristband, also where it is professionally judged to be appropriate e.g. patients with confusion/lack of capacity.
  - All patients in the Emergency Department where a decision to admit has been made must wear an identification wristband.
  - See ‘Outpatients’.
4.4 Removal of identification wristbands.

If the identification band is removed at any time during the patient’s stay, it is the responsibility of whoever has removed it to ensure it is replaced or make clear alternative arrangements for the patient’s correct identification if it cannot be replaced immediately. Where the patient has removed it, it is the responsibility of the nurse/midwife/ODP caring for the patient to ensure that the patient is wearing an identification wristband.

On discharge the member of staff responsible for managing the patient’s discharge from the hospital should remove the wristband as the final part of the discharge process.

5. PATIENT TRANSFER WITHIN THE HOSPITAL

Whenever a patient is transported from a ward or department for investigations or treatment, a positive identification must take place and be confirmed by a member of staff responsible for the care of the patient.

When collecting a patient from a ward, porters must ask the ward staff to identify the patient. Details of the patient to be collected should be checked against the patient’s identification wristband and cross referenced with the case notes or accompanying documentation.

Patients without a wristband must not be moved from the ward until one is applied. The receiving area should then confirm the identity of the patient on arrival.

6. ACTIONS TO BE TAKEN FOLLOWING MISIDENTIFICATION

If an error occurs e.g. there is a misidentification and / or the wrong patient receives treatment / investigations or consultation, staff must take immediate local action to remedy the error where possible and to minimise the risk of further harm. Staff involved in the incident should be informed of the error as soon as possible. The incident investigation process should be followed. The patient/carer or relative should be informed of the error where possible.

7. REFERENCES


8. MONITORING COMPLIANCE AND EFFECTIVENESS

An annual audit will be undertaken by each CSU. The audit will establish adherence to the three policy standards;

1) Positive identification of all patients must be carried out throughout their hospital journey prior to any examination, treatment or procedure, whether they are wearing an identification wristband or not.

2) Patients must be asked to state their name and date of birth and this must be checked against the patient’s case notes / accompanying documentation / wristband.

3) All relevant patients must wear an identification wrist band that meets NPSA requirements as outlined above.

This should include an observational audit of positive identification at points in the patient pathway, such as prior to blood transfusion, administration of medicines and pre operative/ procedure. The responsibility for ensuring this occurs is with the Head of Nursing.

Information from the audit and the review of incidents will be included in an annual monitoring report to Risk Management Group. All risks should be escalated through the Trust’s clinical governance structure. In addition to the annual audit any incidents relating to patient misidentification will be reviewed by the CSU and actions taken to identify and resolve immediate problems.
## PROCEDURE MONITORING TABLE

<table>
<thead>
<tr>
<th>Procedure element to be monitored</th>
<th>Standards and Performance indicators</th>
<th>Process for monitoring</th>
<th>Individual or group responsible for monitoring</th>
<th>Frequency or monitoring</th>
<th>Responsible individual or group for development of action plan</th>
<th>Responsible group for review of assurance reports and oversight of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication</td>
<td>The policy is published on Leeds Health Pathways</td>
<td>Corporate Nursing to check this is published</td>
<td>Head of Nursing Professional Practice, Clinical Standards &amp; Patient Safety</td>
<td>2 Yearly - to be revised in the interim if required</td>
<td>Professional Practice, Clinical Standards &amp; Patient Safety team</td>
<td>Professional Practice, Clinical Standards &amp; Patient Safety team</td>
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<tr>
<td>Use of the policy</td>
<td>The policy is in use in wards &amp; departments</td>
<td>Annual Audit as part of the Trust’s Annual Audit Programme Ward assurance metrics</td>
<td>Matron, Head of Nursing Professional Practice, Clinical Standards &amp; Patient Safety team</td>
<td>Annually Monthly</td>
<td>Head of Nursing for the CSU</td>
<td>Clinical Director &amp; Head of Nursing for the CSU</td>
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<tr>
<td>Incidents</td>
<td>That there are no Never events relating to patient misidentification</td>
<td>Incidents are reviewed at the weekly quality meeting</td>
<td>Quality Team</td>
<td>Weekly</td>
<td>Quality Team/Investigating Officer</td>
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- Annual Audit as part of the Trust’s Annual Audit Programme Ward assurance metrics
- Matron, Head of Nursing Professional Practice, Clinical Standards & Patient Safety team
- Annually Monthly
- Head of Nursing for the CSU
- Clinical Director & Head of Nursing for the CSU

**Incidents**
- That there are no Never events relating to patient misidentification
- Incidents are reviewed at the weekly quality meeting
- Quality Team
- Weekly
- Quality Team/Investigating Officer
- Quality Team
9. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This policy will be consulted on through the Trust peer review process to include all relevant stakeholders. It will be sent to the CSU as part of the launch. It will then be disseminated through the CSU management structure and hosted on the Leeds Health Pathways site.

10. POLICY APPROVAL AND RATIFICATION

This revised policy has been peer reviewed by a multidisciplinary selection of staff. Including doctors, nurses and matrons, nurse specialists and divisional nurses. It will be reviewed by the Patient Safety Group prior to final approval by SMT.

11. EQUALITY ANALYSIS

This Policy has been assessed for its impact upon equality. The Equality Analysis can be seen in annex 1.

The Leeds Teaching Hospitals Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

12. PROCESS FOR REVIEW/REVISION

This policy will be reviewed 2 yearly. It may be revised in the interim depending on new, or changes to, existing technologies.
The LTH guidance on positive identification of patients

GUIDANCE NOTES to accompany the LTH Positive Identification of Patients policy document.

1. Confidentiality
   1.1 Bed labels
   1.2 White boards

2. Patient identification numbers

3. Patient identification numbers in the Emergency Department

4. Safer Surgery Checklists

5. Patient Identification in the Operating Theatre

6. Babies transferred to Neonatal wards from Delivery Suite

7. Red alert wristbands

8. Major incident

9. Other methods of positive patient identification and the use of Technology

1. Confidentiality

All NHS staff have a responsibility to protect patient confidentiality. The clinical professions have requirements in their codes of ethics and conduct with regard to confidentiality. Each patient must be treated with respect to their right to privacy, dignity and confidentiality however this should not be at the detriment to ensuring that their correct identity is confirmed prior to treatment.

1.1 Bed labels

The information on any bed head label should be made with due regard for the patient's privacy, dignity and confidentiality. The only information required on the bed head label is the patient's full name and name of consultant. This information should not be used to positively identify the patient.

1.2 Patient information/communication boards

Other than the patient's name, no patient identifiable information may be written on ward whiteboards, notice boards or other systems on public view. Where possible, whiteboards should be positioned out of direct public view.

2. Patient identification numbers

All patients should have an NHS number, this should be used as the primary patient identifier as it is unique to that patient. Case notes numbers are not a unique identifier and should be used with caution.

3. Patient Identification numbers in the Emergency Department

In the Emergency Department if the NHS number is not available the Accident &
Emergency number can be used.

In circumstances where the patient's name is not known, the identification wristband must state ‘Male / Female Unknown' and state the Accident & Emergency number.

All patients transferred to a ward from the Emergency Department must have a Patient Centre generated wristband applied on admission to the clinical area. However caution should be used: If a patient in the Emergency Department has a transfusion sample taken with the A&E number, whether they are an unknown patient or not, the identification wristband should not be removed until a new transfusion sample with the NHS number and name has been taken.) Please refer to: LTHT Safer Transfusion Procedures.


4. Safer Surgery Checklists

Safer Surgery Checklists should be used in the operating theatre prior to surgical procedures taking place as an additional check to ensure positive patient identification and that the procedure matches the intended patient. Similar checklists prior to any surgical procedures in other hospital settings e.g. outpatients should be encouraged as an additional check to ensure that the correct patient is chosen.

5. Patient Identification in the Operating Theatre

Patients in the operating theatre must wear 2 identification wristbands (either on wrist or ankle) in case one of the bands needs to be removed to gain access to that area of the body for surgery or anaesthetic purposes. The wristband that has been removed should be disposed of.

The pre-operative checklist may be used as the next best means of identification if it is not possible to access either of the patient’s identification wristbands for checking purposes because they are obscured by the theatre drapes. The pre-operative check list should have been checked against the patient’s identification wristband on entry to the theatre suite and should therefore mirror the information on the wristband. No other form of identification from the patients case notes should be used to identify the patient.

6. Babies transferred to Neonatal wards from delivery suite

If transferred to the neonatal unit, the baby will have two identification wristbands applied with his/her own name, date of birth and NHS number and case note number. If the baby is transferred back to the post-natal ward he/she will retain these identification wristbands until discharge. Any communication issues should be addressed to ensure the patient or parent fully understands e.g. an interpreter may be required.

7. Red Alert wristbands

All patients must be asked if they are allergic to anything on admission or prior to treatment and information may also be obtained from the patients medical records. If the patient has a history of allergy / sensitivity or develops one then a Red Alert wristband must be worn. An allergy can include latex and other material components as well as medicines.
The Red Alert wristband should be printed from the wristband printer via the Patient Centre administration system (change the cartridge to the red wristband then replace afterwards with the white). The red wristband will then contain the patient's details and the one wristband can fulfil both functions. There is no requirement to have both a red and a white wristband. The exception to this is paediatric areas where red labels are not available. In this case a plain red label should be worn in addition to the white identification wristband. Patients must be asked to verbally confirm allergy details as part of the Trust’s checking procedures such as drug prescribing and administration and pre operative checks.

In the case of patients who refuse treatment with blood or blood components a red alert wristband may be worn.

There may be instances where a patient wears a medic-alert. In these cases, they should not be removed except for example if the patient is undergoing surgery or MRI scan.

8. **Major Incident (MAJAX)**

In the event of a major incident all incident patients will be identified as per the Major Incident Policy until such time as their identity is confirmed. At which time incident patients will be identified as per this policy.

9. **Other methods of positive patient identification and the use of Technology**

This guidance should be used in the context of changes in technology which may be related to patient identification. Any new technology which assists with or is relevant to the identification of the patient must meet the standard set out in this policy.

Use of barcode technology does not currently replace the need for identity checks. Individual patient checking to establish identity is still crucial prior to any treatment or intervention.

Methods of patient identification such as photograph ID can be used for appropriate patient groups.
A screening process can help judge relevance and provides a record of both the process and decision. Screening should be a short exercise that determines relevance for all new and revised strategies, policies, services and functions.

Completed at the earliest opportunity it will help to determine:
- the relevance of proposals and decisions to equality, and
- whether or not it is necessary to carry out a full equality analysis

<table>
<thead>
<tr>
<th>Division/Programme:</th>
<th>Corporate Nursing</th>
<th>Service area/Project:</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Lead person:</td>
<td>Jackie Whittle - Head of Nursing, Professional Practice, Clinical Standards and Patient Safety</td>
<td>Date:</td>
<td>06/03/15</td>
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</tbody>
</table>

1. Title: Positive Identification of Patients Policy

Is this a:
- Change to an existing Strategy / Policy ✓
- New Strategy/policy □
- Change to Service(s) / Function (s) □
- Other □

If other, please specify:

2. Summary of the strategy, policy, Service(s) for function(s) being assessed:

The policy for patient identification needs to be followed to ensure that patients receive the correct treatment and are protected from harm.

If a patient is severely harmed or dies as a result of incorrect treatment due to misidentification this is classified as a Never Event.

All clinical areas must have processes in place to ensure that all staff positively identify all patients prior to delivery of care / treatment and when ordering tests, investigations and procedures.
### 3. Relevance to equality

All the Trusts policies, projects, strategies, services and major developments affect patients, carers, service users, employees or the wider community. These will also have a greater or lesser relevance to equality and diversity.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation, pregnancy and maternity and any other relevant characteristics (for example socio-economic status, social class, income, unemployment, residential location or family background and education or skills levels).

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Is there any indication or evidence (including from consultation with relevant groups) that different groups have different needs, experiences, issues and priorities in relation to the proposed policy or proposal?</td>
<td>✓</td>
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<tr>
<td>Is there potential for or evidence that the proposed policy or proposal will affect different population groups differently (including possibly discriminating against certain groups)?</td>
<td>✓</td>
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<tr>
<td>Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the policy or proposal?</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Could the proposal affect our workforce or employment practices?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Is there potential for or evidence that the proposed policy or proposal will not promote equality of opportunity or promote good relations between different groups?</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

If you have answered no to the questions above please complete section 6
If you have answered yes to one or more of the above and;

- Believe that the policy or proposal is equality relevant, please complete section 5 and carry out a full Equality Analysis
- Believe you have already considered the impact of your proposal on equality and diversity and there is little or no relevance, please go to section 4
- Believe that whilst the policy or proposal is equality relevant, a full Equality Analysis is not necessary at this stage, please go to section 4

4. Considering the impact on equality and diversity

If you have answered yes to one or more of the screening questions and believe that the policy or proposal is not equality relevant or that a full equality analysis is not required at this stage, please provide specific details for all three areas below:

- **How have you considered equality and diversity?**
  (think about the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

  All patients within LTHT will be affected by the Positive Identification of Patients Policy as we need to positively identify every patient before any kind of procedure or dispensing of medication. When patients cannot understand or communicate in English, we need to use other methods in order to positively identify them. The required method is to use a qualified interpreter. If this was not available at a particular time e.g. in an emergency or when dispensing medication, the alternative method would be for two qualified members of staff to check the patients wristband and identify the patient. A relative or carer may be able to verify the patients identity as an additional check. The positive and discreet identification of Trans patients that have not changed their NHS records will be picked up in the Trans Policy.

- **Key findings**
  (think about any potential positive and negative impact on the different protected characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another)

  By following the Positive Identification of Patients Policy, it ensures that all patients are positively identified and therefore mistakes, never events and patient harms are avoided. This promotes a positive impact for both staff and patients.

- **Actions**
  (think about how you will promote positive impact and remove or reduce negative impact)

  The Positive Identification of Patients Policy will be positively promoted via Patient Care and Safety day and Professional Forum. It will also be communicated via the ‘In Touch’ electronic newsletter. This communication will ensure staff are aware of the updated policy and in turn patients will be positively identified before receiving safe and effective care. An annual audit undertaken against the patient identification
standards, led by the Head of Nursing for each CSU, will ensure to identify equality-related matters and any issues that particularly affect a certain group of people.

5. If the policy or proposal is equality relevant, you will need to carry out a full Equality Analysis

| Date to scope and plan your equality analysis: | N/A |
| Date to complete your equality analysis: | N/A |
| Lead person for your equality analysis: (Include name and job title) | Deborah Smith, Project Nurse, Corporate Nursing. |

6. Governance, ownership and approval
Please state here who has approved the actions and outcomes of the screening

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgina Duncan</td>
<td>Lead Nurse - Professional Practice, Clinical Standards and Patient Safety</td>
<td>22/12/14</td>
</tr>
</tbody>
</table>

For use by the Equality Analysis sub-group

1. Governance, ownership and approval
State here which members of the Equality Analysis sub-group have approved the actions and outcomes from the equality analysis relevance screening.

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emma Judge</td>
<td>Equality and Diversity Manager</td>
<td>6/3/2015</td>
</tr>
</tbody>
</table>

2. Publishing
This screening document will act as evidence that due regard to equality and diversity has been given. If you are not carrying out a full equality analysis the screening document will need to be published.

Please send a copy to the Equality Team for publishing.

| Date screening completed | 1st February 2015 |
| Date received by Equality Team | 1/3/2015 |
| Date published | Part of the Positive Identification of Patients Policy. |