One + all | we care

Royal Cornwall Hospitals NHS Trust

Positive Patient Identification Policy and Procedures

V8.0

August 2022

Table of Contents

1. Introduction 4
2. Purpose of this Policy/Procedure 4
3. Scope 4
4. Definitions / Glossary 5
5. Ownership and Responsibilities 5
5.1. *Role of the Managers* 5
5.2. *Role of Receptionists* 5
5.3. *Role of patient's designated named nurse* 5
5.4. *Role of Individual Staff* 5
6. Standards and Practice 6
6.1. *Procedures requiring positive identification of patients* 6
6.2. *Reporting patient identification errors* 6
6.3. *Positive Patient Identification – Clinic Preparation* 6
6.4. *Positive Patient Identification – Outpatient attendance* 7
6.5. *Positive Patient Identification - Emergency Department* 7
6.6. *Positive Patient Identification – Inpatients* 8
6.7. *Choice of identification band – size* 9
6.8. *Completing the identification band* 9
6.9. *Placement of the patient identification band* 10
6.10. *When to apply and remove the patient identification band* 11
6.11. *Scanning the Patent Identification Band* 12
6.12. *Extreme Emergencies and Critical Care* 12
6.13. *Patient identification in the Operating Theatres, and Day Surgery Unit* 12
6.14. *Deceased Patients* 13
6.15. *Business Continuity* 13
7. Dissemination and Implementation 13
8. Monitoring compliance and effectiveness 13
9. Updating and Review 14
10. Equality and Diversity 14
Appendix 1. Governance Information 15
Appendix 2. Equality Impact Assessment 18
Appendix 3. Guidelines for the Identification of the Newborn 21
Appendix 4. Business Continuity Plan for Positive Patient Identification 23
Appendix 5. Impact Analysis 24

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. Failure to correctly identify patients constitutes one of the most serious risks to patient safety; misidentification errors often take place due to a long line of communication breakdowns.

1.2. Patient misidentification cuts across all sectors of healthcare practice. To safeguard patients, it is essential that correct patient identification procedures are practiced at all patient contacts.

1.3. The Scan4Safety programme requires trusts to adopt GS1 barcoding standards for use on patient identity bands, enabling accurate identification of the patient, with barcode scanning facilitating the upload of clinical data into the electronic patient record.

1.4. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. This policy provides clear guidelines for staff to enable them to deliver safe care and defines the practical aspects that will help minimise the risk of mismatching patients and treatment within all clinical settings. This document outlines the minimum checking requirements.

2.2. It aims to ensure that all staff recognises their responsibility and involvement regarding the managerial and organisational arrangements for correct patient identification.

3. Scope

3.1. This policy applies to all staff involved in the care and delivery of services to patients in all clinical settings.

3.2. The Patient Identification Policy supports, and should be read in conjunction with, other policies and guidelines of the Trust including:

- Pathology user guide policy
- Blood Transfusion Policy
- The medicines policy chapter 5 – preparation and administration
- Blood Culture Guidelines
- Radiation Safety Policy
- Maternity/Neonatal Unit guidance (Appendix 2)
- Generic theatre practice standards clinical guidance

3.3. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4. Definitions / Glossary

All abbreviations are included in the content of the document.

5. Ownership and Responsibilities

5.1. *Role of the Managers*

- Department managers are responsible for ensuring that their staff know and adhere to this policy.

5.2. *Role of Receptionists*

- Receptionists in all areas must ensure initial confirmation of patient's identity.

5.3. *Role of patient's designated named nurse*

- The patient's admitting nurse must confirm the patient's identity at the point of admission and apply the appropriate patient identification band outlined below.

5.4. *Role of Individual Staff*

- All staff members who prepare case notes for clinics will attend Mandatory Case Note Management Training on commencement of their job and attend annual refresher training.

- Should any member of staff finds an inpatient without identification they must take responsibility to ensure this is brought to the attention of the person in charge of the area who must then ensure it is replaced immediately.

- Staff must confirm the identity of the patient prior to the administration of medicines or the commencement of any diagnostic or therapeutic procedure. This must be done by asking the patient/carer to confirm the patient's full name, date of birth and/or address and checking this against health record or A&E card and/or PAS. For inpatients the information on the patient identity bracelet should also be checked against the health record or prescription sheet and any request form.

- The Trust will use various devices and systems to scan the patient identification band to access patient information, check identity and facilitate the upload of clinical information to the patient's electronic record.

- If, for any reason, the identification band cannot be scanned it should be re-printed immediately.

- Where there is legitimate cause for the patient identification band to be removed other than on discharge from hospital, e.g.

its location interferes with surgery location or placement of an intravenous cannula etc, it is the responsibility of the practitioner who removes the identification band to ensure it is replaced.

6. Standards and Practice

6.1. *Procedures requiring positive identification of patients*

6.1.1. The list below is not exhaustive or exclusive.

- Blood letting / blood sampling
- Blood / blood products transfusion
- Collecting of patient bodily fluid samples
- Confirmation of death
- Administration of all medicines
- Surgical interventions and any invasive procedures
- Transport/transfer of the patient (including transfer between wards/departments)
- In-patient X-rays and imaging procedures
- Patients who attend out patients clinics where safety concerns are raised, for example confused patients

6.1.2. DO NOT PROCEED with any procedure if the inpatient has no patient identification band or if the identity of an outpatient cannot be confirmed as described above.

6.2. *Reporting patient identification errors*

If a member of staff discovers a patient identification error this should be reported as soon as possible to the ward/department person in charge and entered onto the incident reporting system, DATIX, via the intranet homepage. This must include any instance of misidentification, any incident that has occurred as a result with or without evident harm, and near miss situations where the error has been detected before an incident has taken place.

6.3. *Positive Patient Identification – Clinic Preparation*

All staff who prepare case notes for clinics need to attend Mandatory Case Note Management Training on commencement of their job and attend annual refresher training Clinic Preparation. Staff will ensure that the identifying number relates to the patient named on the clinic when requesting the patient's case notes.

6.3.1. As part of the case note preparation procedure staff will ensure that the labels and front sheets in the patient's case notes reflect the most up to date information recorded on PAS.

6.3.2. If there are any changes in the patient's details a new front sheet and labels will be printed and the old ones will be destroyed confidentially.

6.3.3. Staff will ensure and check that any information they file in the patient's case notes belongs to that patient.

6.4. *Positive Patient Identification – Outpatient attendance*

6.4.1. This section applies to outpatient clinics and diagnostic and treatment areas including Clinical Imaging and Antenatal.

6.4.2. All reception staff who handle case notes will attend Mandatory Case

6.4.3. Note Management Training on commencement of their job and attend annual refresher training.

6.4.4. The use of patient identification bands are required for patients in:

- Haematology/Oncology
- Pre-assessment patients who require a group and screen sample

Patient identification bands are not required for any other group of this patient type.

6.4.5. The identity of all those attending for outpatient consultation, investigation or treatment must have their identity confirmed at all stages by asking the patient, parent / carer or partner to provide full details, date of birth and address.

6.4.6. When the patient arrives at the reception desk, ask them to state their full name, date of birth and/or address.

6.4.7. If the patient is unable to tell you their name, confirmation should be obtained by asking the patients" relatives / carers to identify the patient by name, date of birth and/or address.

6.4.8. Check their response is compatible with hospital records e.g. Medical case notes and PAS.

6.5. *Positive Patient Identification - Emergency Department*

6.5.1. Anyone who attends ED but is not registered on PAS must be registered as a new patient.

6.5.2. Anyone who is not usually resident in the United Kingdom should be registered as a new patient in the normal way but using a „ZZ 99" postcode. For further information please refer to the Overseas Visitors Policy.

6.5.3. When a child/young person cannot confirm identity, the information must be obtained from the parent or carer with legal responsibility.

6.5.4. Patients who are unable to tell you their name, and are brought into the RCHT sites by emergency services personnel, may be identified by the accompanying documentation (e.g. WAST document AS11), once the healthcare professional has established the source of information as being appropriate.

6.5.5. Where patient identification cannot be established they are registered on Datix as unknown and an identification band printed. ED reception should keep 5 make and 5 female unknown files ready at all times to ensure that the CR numbers are not consecutive.

6.5.6. Any patient within the emergency department assessed as being an attendance type of major, paediatrics or resus must have a patient identification band placed on their person in accordance with the procedure for inpatients (see Section 7 below). Those attending the Minor Injuries Unit (MIU) need not be given a patient identification band.

6.5.7. Prior to commencing any examination or procedure, or administering any medication or blood product, the identity of the patient must be confirmed by either:

- Checking patient identification band against the ED card and asking the patient to state name and date of birth if possible, or

- In MIU, by asking the patient to state their name and date of birth and checking this against the A&E card.

6.6. *Positive Patient Identification – Inpatients*

6.6.1. Wherever possible the identity of the patient must be confirmed by asking them to state their full name, date of birth and/or address and checking this against the Medical notes, A&E card and/or PAS.

6.6.2. If the patient is unable to tell you their name, confirmation should be obtained by asking the patients" relatives / carers to identify the patient by name, date of birth and/or address and checking this against Medical case notes, A&E card and/or PAS.

6.6.3. Once the patient's identity is confirmed, a patient identification band must generated using the electronic printing facility. This process works in parallel to the RCHT Real Time Bed Management (RTBM) practice being introduced across all sites whereby admission, transfer and discharge of patients are entered onto PAS immediately.

6.6.4. The ward clerk will usually maintain RTBM within service hours; it is however the responsibility of the ward / department manager to ensure RTMB practice is maintained. Ward / department leads should ensure that agreed operational procedures are in place that outlines staff roles and responsibilities for out of hours and that staff understand and comply with the procedures.

6.6.5. The patient identification band procedure is discussed with the patient, and their consent obtained to continue. Where patients‟ decline a patient identification band, they should be informed of the potential risks involved and all discussions should be documented within the patients‟ notes.

6.6.6. The patient identification band must then be scanned to ensure the barcodes have been printed correctly and the information matches the patient.

6.6.7. The standard patient identification band will be white and compliant with the ISB 1077 standard and NPSA standards outlined in Safer Practice Notice No.24 issued 3rd July 2007ISO http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59824

6.6.8. The use of personal alert bracelets, such as those worn by diabetics, epileptics and others is allowed, however the patient should be notified of the risk of staff confusion following a risk assessment based on the distinctiveness or otherwise of the personal bracelet from the hospital patient identification band.

6.7. *Choice of identification band – size*

6.7.1. Printable wristbands are available in three sizes: adults, children and neo-natal.

6.7.2. The most appropriate size of identification band for the patient's wrist (or ankle if there are safety concerns) should be used to avoid harm to the skin and constriction of blood flow. In some circumstances it may be appropriate to use the smaller wrist band for example on frail adults, but in all cases the patient identification band must :

- Be able to rotate freely around the wrist/ankle to avoid compression and fastenings should not press into the skin.
- Not be so loose that it could slip off or be easily removed
- Not have any sharp corners or edges (including those caused by adjustments during fitting).

6.8. *Completing the identification band*

6.8.1. The appropriate wristband must be inserted into the printer. The following information is generated from the PAS and printed onto a patient identification wristband.

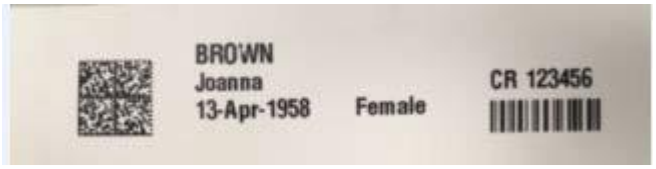
SMITH 07-Feb-1975 CR 00000	**John NHS number**

6.8.2. The ISB 1077 standard requires trusts to adopt GS1 barcoding standards for use on patient identity bands, enabling accurate identification of the patient, with barcode scanning facilitating the upload of clinical data into the electronic patient record.

6.8.3. The information shown on the bracelet will be this type of format and spacing:

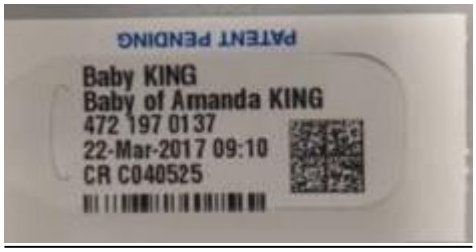
Adult and Child NHS Number Surname Forename Date of Birth

Organisation Code Number Type Patient ID Number



Neo-natal NHS Number Surname Forename Date of Birth

Organisation Code Number Type Patient ID Number (x of x)
Mother Surname Mother date of birth Time of birth



Notes

The member of staff applying the patient identification band should sign in the patient records to indicate that the demographic details have been confirmed as correct by the patient (or a relative or carer where the patient is unable to do so in cases of incapacity)

**Please not the above patient identification label is example only and not real patient data.*

6.9. *Placement of the patient identification band*

6.9.1. The patient identification band should be placed, where possible, on the dominant arm (e.g. arm used for writing) as it is less likely to be removed when, for example, intravenous access lines are inserted (NPSA 2005).

6.9.2. Any surgical or medical patient undergoing any procedure is required to have TWO bracelets; one placed on the dominant wrist and the second placed on the opposite ankle. In certain circumstances, the identification band may need to be applied to each upper limb or each lower limb depending on the underlying rationale. Having two identification bands in place will ensure positive patient identification occurs should removal of one identification band occur whilst in theatre.

6.9.3. In all other cases, if an upper limb is not available then a bracelet may be attached to the patient's lower limb. If no limbs are available, then securely attach the bracelet to the patient's clothing in an area of the body which is clearly visible. In these cases then the bracelet must be reattached as clothing is changed and must accompany the patient at all times. In emergency or operative situations where clothing is removed, identification must be attached to the patient's skin using see- through plastic adhesive film (first checking for allergies).

6.9.4. For patients with Arterio-venous shunts/fistula, such as are used in renal dialysis, the patient identification band should not be applied to the shunted arm.

6.10. ***When to apply and remove the patient identification band***

6.10.1. In-patients must always wear an identification band(s).

6.10.2. The patient's patient identification band (s) must be applied on admission to the hospital, or once the patient has entered a department for treatment, by the patient's designated named nurse, who will retain responsibility and accountability even where they delegate it to someone else. This includes elective inpatients as the first step upon entry to the ward or department including day surgery/day case units and Endoscopy Unit (also refer point to18)

6.10.3. Also included are patients in the Emergency Department (ED) who have been through Triage, classed as majors and are receiving treatment in the main department, but those triaged to, and treated in, the MIU are excluded.

6.10.4. Should there be any legitimate cause for the patient identification band(s) to be removed prior to discharge, e.g. its location interferes with surgery location or placement of an intravenous cannula etc, it is the responsibility of the practitioner who removes the bracelet to ensure it is replaced with a printed wristband.

6.10.5. For infection control purposes a patient identification band(s) should be changed if it becomes visibly soiled, otherwise they are not a risk. Patients should have their identify bands replaced every 2 weeks during their stay.

6.10.6. The named nurse accountable for the patient's care at the point of departure from the ward or Unit and is responsible for the removal or delegating the task of removing the patient's patient identification band(s).

6.10.7. The patient identification band(s) may be removed once all discharge processes such as drug handover and on-going care explanations have given to the patient or their carer, i.e. at the point when no further RCHT care requiring patient identification is required.

6.10.8. Unless pre-arranged by the discharging ward staff with the Discharge Lounge staff agreement, the patient's identification band (s) should be removed upon departure from the ward, on the basis that the patient is self- caring, i.e. all medications are now in their possession or that of their carers. Exceptions to this rule may be where the patient is confused or has a learning disability or where take-home medicines (TTOs) are still to be given to the patient/carer.

6.10.9. Patients being transferred to community hospital settings should retain their wristband(s).

6.11. *Scanning the Patent Identification Band*

Details of scanning requirements will depend on the system and device being used. This will form part of the individual training package on deployment.

6.12. *Extreme Emergencies and Critical Care*

6.12.1. In extreme emergencies and possible life-threatening situations (such as in Emergency Department), clinical care may take priority over attaching a patient identification band to the patient. Where this has occurred, the nurse responsible for patient care MUST take appropriate steps to identify the patient using the hospital/NHS number and/or the HIN system and then apply a identification wristband.

6.12.2. Once the surname, forename, date of birth and /NHS number are confirmed, a new patient identification band MUST be attached to the patient IMMEDIATELY. Patients who are unable to wear the patient identification band because of their treatment e.g. multiple intravenous access lines, may have a patient identification band applied to an unaffected limb. Any 'unknown' identification band must remain in situ alongside the confirmed patient details for a minimum of 24 hours to allow any cross matched blood components to be matched to the 'unknown' identification while a new sample labelled with the confirmed information is processed.

6.12.3. In the event of a major incident all incident patients will be identified as per the Major Incident Plan, until such time as their identity is confirmed, at which time incident patients will be identified as per this procedure

6.13. *Patient identification in the Operating Theatres, and Day Surgery Unit*

6.13.1. In the Operating Theatre departments theatre personnel will confirm the identity of the patient using the theatre checklist and both patient identification bands, in line with theatre protocol.

6.13.2. Should it prove necessary prior to or during the course of the operation/procedure, to remove one of the patient's identification band, The bracelet that has been removed should be attached to the front of the patient's notes and a record of the event documented in the theatre record. The remaining patient identification band will ensure that positive patient encounters continue throughout the procedure. The identification band must be replaced once the procedure/operation is complete.

6.14. *Deceased Patients*

All deceased patients must be properly identified with two identification bands, one on the wrist and one on the ankle. They must show the patient's name, hospital/NHS number, date of birth, and religion if known. In the event of the patient's name being unknown the HIN system is used, and the identification band must state UNKNOWN MALE / FEMALE.

6.15. *Business Continuity*

6.15.1. All ward / departments must be aware of the measures to be taken to maintain safe practice in positive patient identification in the possible event of printer failure or PAS disruption. This includes immediate steps and recovery actions.

6.15.2. All ward and department leads should ensure that staff are familiar with the steps provided in Appendix 4.

7. Dissemination and Implementation

7.1. The document is available on the document library. Significant updates will be communicated via Trust wide email.

7.2. Implementation of the policy will be via Trust wide communication and supported by appropriate training for the relevant members of staff.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	In total of Positive Patient Identification
Lead	Deputy Director of Nursing
Tool	WHO audit checklist
Frequency	Daily 6 monthly spot audits of compliance
Reporting arrangements	Safer Surgery Group

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Safer surgery group to make recommendations and identify relevant lead.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 4 weeks of spot auditing A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

9. Updating and Review

9.1. The Positive Patient Identification Policy should be reviewed no less than every three years.

9.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Positive Patient Identification Policy and Procedures V8.0
This document replaces (exact title of previous version):	Positive Patient Identification Policy V7.3
Date Issued/Approved:	20 July 2022
Date Valid From:	August 2022
Date Valid To:	August 2025
Directorate / Department responsible (author/owner):	Louise Dickinson– Deputy Director of Nursing
Contact details:	01872 258594
Brief summary of contents:	The policy describes the Trust's policy and process for positively identifying patients
Suggested Keywords:	Patient Identification Positive
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Director of Nursing, Midwifery and Allied Health Professionals
Approval route for consultation and ratification:	Nursing Midwifery and AHPs clinical cabinet.
General Manager confirming approval processes:	Kim O' Keefe, Dual Director of Nursing, Midwifery and Allied Health Professionals
Name of Governance Lead confirming approval by specialty and care group management meetings:	Louise Dickinson, Deputy Director of Nursing, Midwifery and Allied Health Professionals
Links to key external standards:	Governance Team can advise

Information Category	Detailed Information
Related Documents:	Pathology user guide policy Blood Transfusion Policy The medicines policy chapter 5 – preparation and administration Blood Culture Guidelines Radiation Safety Policy Maternity/Neonatal Unit guidance (Appendix 2) Generic theatre practice standards clinical guidance
Training Need Identified?	No – any training will be linked to Scan4Safety and Inventory Management
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Corporate Clinical

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
V1.0 – V6.0	-	Previous details of versions not known	-
30 May 17	V7.0	Previous policy taken and updated to provide initial draft with changes to add in about GS1 standards to sections 5.7 Positive Patient Identification – Inpatients Choice of identification band - size	Ian Rowland Scan4Safety Programme Lead
17 Jan 18	V7.1	Updated technology information around ISO standards and procedures Sections: 1.3, 5.9.2 ISB Standards added, 5.12 5.7.7 link to NPSA standards embedded	Serena Knight Scan4Safety Deputy Programme Lead
23 Jan 18	V7.2	Minor changes to wording for clinical staff, comments provided by Claire Martin Deputy Director of Nursing to Sections 5.6.5, 5.6.6 and 5.7.7	Serena Knight Scan4Safety Deputy Programme Lead
6th April 2018	V7.3	Information around u/k identifier remaining on the patients for a minimum of 24 hours	Sue Preston Associate

Date	Version Number	Summary of Changes	Changes Made by
		so blood products readied against this number may still be used Sections: 5.13.3 Extreme Emergences Wording updates to sections: 5.12 Extreme Emergencies and Critical Care section 5.12.1 updated Patient identification in the Operating Theatres, and Day Surgery Unit section 5.13 included	Director Nursing Surgical Services, Nicki Jannaway Lead Transfusion Practitioner
23rd May 2018	V7.4	Amendment to wording section 5.12.2	Nicki Jannaway Lead Transfusion Practitioner
July 2022	V8.0	Transposed to latest Trust template	Louise Dickinson, Deputy Director of Nursing

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Positive Patient Identification Policy and Procedures V8.0
Directorate and service area:	Corporate Clinical
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Louise Dickinson, Deputy Director of Nursing
Contact details:	01872 258574

Information Category	Detailed Information
Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To ensure safe and effective patient identification processes with RCHT
Policy Objectives	To promote safe PPID practice in clinical areas
Policy Intended Outcomes	Prevention of misidentification errors Support Real Time Bed Management
How will you measure each outcome?	Datix reports Audit of practice
Who is intended to benefit from the policy?	Staff and Patients
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Nursing midwifery and AHPs clinical cabinet.
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:

Louise Dickinson, Deputy Director of Nursing

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Guidelines for the Identification of the Newborn

PRINCIPLES	NOTES
Prepare two infant identity bands once the woman is in established labour	Using black security ink biro, enter the mother's surname and hospital number onto a neonatal identity band. Check these details against the mother's patient identity band.
Ensure the infant is identified immediately at delivery	Check with one or both parents that the details entered onto the neonatal identity band corresponds with the mother's printed patient identity band. The midwife must place both bands - one on each of the infant's ankles, before the leaves the room. **NB**: Both bands must be tight enough not to slip over the ankle, but not to cause any tissue damage or compromise circulation.
Transfer and handover to postnatal ward staff.	If transferred to the Postnatal Ward or Neonatal Unit, they will require a printed wristband (this will have the Baby's name, Baby's CR number, Baby's NHS number, DOB, Time of Birth and Mother's full name). A member of the postnatal and labor ward teams will check together, the infant's and mother's patient identity bands and cot card. Document this check, both staff members to sign.
On-going checks of identification	Discuss the importance of patient identity bands with the mother; and ask her to report missing bands to a member of staff. Advise that the bands are not to be removed until the infant has left the hospital With the daily infant check, the midwife/ MSW documents that two bands are secure and correct Always check cot card when replacing infant to cot.
If ONE band is lost, detached or damaged	Another patient identity band is printed checked by the midwife/ MSW with the mother and reapplied to the infant's ankle. Document in the midwifery record.
If BOTH bands are lost or detached	Inform the midwife shift leader. Two midwives to check, with the mother, and replace the identity bands only after checking the other infants on the ward. Document in the midwifery record.
Inform the maternity bleep holder when:	More than one infant is found with both identity bands missing, or any patient questions the identity of their baby. This will be investigated and reported to the Assistant Director of Midwifery and clinical incident report completed where necessary

PRINCIPLES	NOTES
Discharge home	The mothers and infants identity bands are checked before they leave hospital.
Transfer to/from another unit	The mothers and infants identity bands are checked before they leave hospital. The midwife in the receiving unit checks details with parent/parents and, where appropriate, the accompanying midwife.
Re-admission of mother or infant	It is the admitting midwifes responsibility to secure identity bands to both mother and infant.

Appendix 4. Business Continuity Plan for Positive Patient Identification

1. Introduction

The Trust delivers a wide range of healthcare services that requires safe and effective processes that promotes positive patient identification. The RCHT Positive Patient Identification (PPID) Policy addresses the roles and responsibilities of staff and guides their practice when undertaking identification procedures.

PPID is considered a critical organisational function in maintaining patient safety throughout delivery of their care. This business continuity plan is concerned with identifying and managing risks and directing actions that will ensure the Trust continues operating in the event of any disruption and to provide a platform from which a recovery can be initiated and managed.

2. Scope

This plan applies to:

- All staff involved in the care and delivery of services to patients.
- NHS supplies
- Cornwall Information Technology Services

Note: It is not the intention of this document to replace existing business continuity plans in the above service areas, but aims to clarify reporting mechanism and actions of staff in the context of PPID.

3. Potential points of failure

PPID is dependent upon the following areas:

- CITS / PAS – server disruption
- Equipment (wristband printers) – breakage, local network disruption
- Ward/ departments - inadequate stock replenishment level
- NHS Supplies – manufacturer issues, e.g. change to procurement contract, design alteration, production disruption.

4. Minimum level of continued output:

Patient identification must continue in light of any event.

Appendix 5. Impact Analysis

1. CITS / PAS disruption:

- The ability to register, admit, transfer and discharge patients is an essential requirement for Real Time Bed Management and PPID. The potential loss of access to the Patient Administration System (PAS) poses significant patient safety and operational / diagnostic issues. CITS are responsible for maintaining RCHT access to PAS and in the event of server disruption will adhere to their own contingency plans. Patient Administration

  Department will also hold contingency plans for the practice of administration and clerical staff.

  It is not the intention to replicate the business continuity plans of either service but to ensure that a parallel plan is in place that supports PPID practice at an operational level.

- In the event of ward staff being unable to access PAS and obtain a patient's unique hospital identifier / NHS number, then the patient's FULL name and date of birth may be handwritten onto a patient identification band using an appropriate pen. A log must be maintained detailing patient admissions, transfers and discharges.

- Recovery Actions following PAS access being restored will include retrospective patient data entry onto the system using the data held on the manual log. Handwritten patient identification bands to be replaced by printed patient wristbands.

2. Equipment malfunction:

- A wristband printer that fails to operate and which cannot be resolved locally must be reported to the CITS Help Desk. Ext 1717.

- CITS will contact the relevant IT personnel with responsibility for the system or equipment who will determine whether a replacement printer is required. These are held in stock by CITS.

- In the event of a faulty printer the need for its replacement should be logged by CITS as a high priority.

- Should the printer replacement be delayed, CITS will redirect the PAS network to the nearest printing facility. Ward / departmental staff will be notified of the location and must ensure that this information is disseminated at all handovers.

- In the event that a suitable relocation is unavailable, patient identification labels may be completed by hand using the specific pens supplied. PLEASE NOTE: These pens have been secured to the printers for safe-keeping. Do not remove and use for other purposes.

- Staff must adhere to the PPID identifiers and processes as in the RCHT PPID policy when hand-writing patient wristbands.

- Recovery actions include replacing all hand-written wristbands with printed versions when printer becomes available.

3. Wards/ Departments (Replenishment):

- Wards / departments should ensure that sufficient stock of wristband are held locally, either through the top-up service, or for areas with low usage via the Unit 4 stationery order.

- Recovery Actions include contacting other clinical areas for immediate re-distribution of their stock and contacting NHS supplies must be contacted to determine whether an emergency order is available.

4. NHS Supplies

- Changes of supplier can have serious consequences for PPID. The NHS supplies will initiate their contingency arrangements.