# IDENTIFICATION OF PATIENTS POLICY

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<tr>
<th>Version Number</th>
<th>3</th>
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<tr>
<td>Version Date</td>
<td>April 2014</td>
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</table>
| Policy Owner   | Medical Director  
Director of Nursing and Clinical Governance |
| Author         | Associate Director of Patient Safety and Quality |
| First approval or date last reviewed | Last reviewed in November 2010 as Version 2.1 |
| Staff/Groups Consulted | Associate Directors of Nursing  
Business Managers  
Caldicott Guardian  
Clinical Directors  
Head of Management Information  
Information Governance Lead  
Maternity Risk Manager  
Matrons  
Pharmacy  
Ward Sisters |
| Approved by Committee / Group | Reviewed by the Patient Safety Committee in May 2014 |
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| Equality Impact Assessment Completed | 14 April 2014 |
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Identification of Patients Policy

1. **RATIONALE**
   Positive patient identification is a process which, when followed, will promote good practice and reduce the risk of misidentification from occurring. This process should be an integral part of patient care. Checking the patient’s identify should not only take place at the beginning of an episode of care but continue at each patient intervention throughout the entire episode to maintain safety.

   Patient misidentification can result in wrong diagnosis and/or treatment which can result in minor or major morbidity and even death.

2. **PURPOSE**

   2.1. This policy aims to assist all staff to positively and safely identify patients while taking account of key principles relating to privacy and confidentiality by:

   - ensuring all patient groups are identified;
   - ensuring all patients are identified through use of ID Bracelets (wristbands) containing minimum detail requirements;
   - ensuring responsibilities are outlined and checks are carried out at all stages of the patient pathway for identification purposes;
   - ensuring those not able to wear ID bracelets are identified by other means;
   - monitoring the use of ID bracelets; and
   - identifying procedures to be followed if misidentification occurs.

3. **DEFINITIONS**

   3.1 **Inpatient**
   An inpatient is a patient who is admitted to hospital ward for a procedure and is expected to remain in hospital for more than one day e.g. for surgery, or for treatment of an acute period of illness.

   3.2 **Day case**
   A day case patient who is admitted to a hospital ward for a procedure and is expected to be discharged from hospital the same day.

   3.3 **Outpatient**
   An outpatient is a patient who attends hospital for a clinic appointment under the care of a consultant, specialist nurse, or midwife who attends for a procedure or treatment to a department where it is unlikely they will need to be admitted to a ward.

   3.4 **Admitting nurse/midwife**
   The named registered nurse or midwife responsible for admitting the patient to a ward/clinical area.

   3.5 **Safeguard**;
   Safeguard is the Trust’s incident reporting system.
4. ROLES AND RESPONSIBILITIES

4.1 Board of Directors
The Board of Directors is responsible for implementing a robust system of risk management within the Trust. This includes having a system for the positive identification of patients.

4.2 Chief Executive
The Chief Executive has ultimate accountability for ensuring there are appropriate processes in place for the effective and reliable identification of patients but delegates this responsibility through the Medical Director and Director of Nursing and Clinical Governance.

4.3 Associate Director of Patient Safety and Quality
The Associate Director of Patient Safety and Quality has responsibility for monitoring the effectiveness of the processes and presentation of a bi-annual review of incidents relating to patient identification to the Clinical Governance Delivery Committee.

4.4 Strategic Business Unit
The Elective Care and Urgent Care and Long Term Conditions Strategic Business Units are responsible for reviewing all incidents relating to patient misidentification, including:

- identifying any trends or themes in occurrence and developing an action plan to address these; and
- identifying risks to the organisation and, where necessary, registering these on the Trust’s risk register.

4.5 Ward and Department Managers
Ward and Department managers are responsible for ensuring all staff within their sphere of responsibility are aware of this policy, and the procedure for the positive identification of patients. They are responsible for investigating all incidents of patient misidentification ensuring actions to prevent reoccurrence are implemented.

4.6 Admitting Named Registered Nurse/Midwife
It is the responsibility of the admitting nurse/midwife to positively identify a patient on admission, or transfer to, a ward or clinical area. They are also responsible for the application of the patient’s identity bracelet, as per the identified process; however they may delegate this to another, such as a non-registered practitioner, although they will retain accountability.

4.7 Clinical Staff
All clinical staff are responsible for familiarising themselves with the content of the procedures identified within this document and they must:

- ensure the positive identification of any patient on admission or transfer to a ward/clinical area and prior to undertaking any procedure; and
- report failures to comply with the policy and all misidentification of patients, including missing patient identification bracelets, via Safeguard.
4.8 Potering Staff

All potering staff are responsible for checking the identification of patients that they are transferring between wards and departments.

5. PATIENT IDENTIFICATION

5.1 Patient groups requiring an identity bracelet

All inpatients admitted for treatment/care, or where an admission is suspected, must have a standardised Trust identity bracelet applied on admission. This includes:

- All hospital inpatients
- All day case patients
- All outpatients undergoing diagnostic or invasive procedures and/or treatments that impair their conscious levels during the appointment
- Any outpatient who is cognitively compromised and/or impaired
- Patients undergoing a transfusion of blood or blood products (if an appropriately completed identification band is not attached the transfusion will not be permitted until the patient’s identification is verified)
- All infants at the time of birth must wear two identification bands at all times whilst an inpatient.
- All patients in the Emergency Department meeting any of the following requirements:
  - All patients where a decision to admit has been made
  - Patients with a Glasgow coma scale of less than 15
  - Patients placed within the resuscitation area
- Patients assessed and treated within the Frail Older People Assessment Unit

5.2 Patients receiving chemotherapy

Patients undergoing chemotherapy treatment do not require a wristband; in line with the Policy for the Safe Prescribing, Dispensing, Administration and Disposal of Oral and Injectable Cytotoxic Drugs, and the Macmillan Unit’s Verification Policy, patients are asked their name, date of birth and address as described in section 5.3. Patients will be asked to verify their details on each and every change, or addition, to treatment whilst they are in the department.

5.3 Positive identification

On admission to a ward or clinical area it is the admitting nurse/midwife’s responsibility to positively identify the patient.

1. Ask the patient to tell you their:

   a. Forename and surname
   b. Date of birth
   c. Address

   Do not state their name, date of birth and address and then ask them to confirm or deny by a ‘yes’ or ‘no’ response.

2. Cross reference the confirmed patient identification details and demographic information with the patient’s health record.
5.3.1 Patients unable to confirm their identity

If the patient is unable to tell you their name (e.g. unconscious, babies/infants, patients with dysphasia, expressive disability or mental capacity issues) their identity should be verified by asking a relative or carer the patient’s name, date of birth and address.

Every effort must be made to positively identify the patient. The inability to clearly identify the patient must be clearly documented in the patient’s health record.

An identification band must be applied as soon as an Emergency Department number has been allocated and must include the patient’s identity status (unknown), gender and the ED number.

5.3.2 Mental Capacity Act 2005

This policy should be read and managed in line with the Mental Capacity Act 2005, which came into force in October 2007. The Act will be relevant when the policy involves any decision where the patient may lack capacity. Refer to the Vulnerable Adults Policy Best Interest Checklist (Annex B) and the capacity flow chart (Annex C) for further guidance.

5.3.3 Use of interpreter

An interpreter must be used if English is not the patient’s first language and there is a communication problem. The use of an interpreter should be clearly documented within the patient’s health record.

5.3.4 Identification of the Newborn

Two identification bracelets must be used to identify newborns. Each one should state the baby’s mother’s name and NHS number, sex of the baby and the date and time of birth.

The identification bracelets should be placed on each ankle of the baby at birth with the details having been checked by the mother or father of the baby. A security tag will be applied to one band.

If transferred to SCBU, the baby will have two identification bracelets applied with his/her own name, date of birth and individual NHS number. If the baby is transferred to the post-natal ward he/she will retain these identification bracelets until discharge.

If a baby is found with both labels missing all other babies in the unit should be checked for adequate ID; the reason for this should be explained to the parents. If more than one baby is found without labels genetic testing would need to be considered unless other distinguishing marks allow for positive identification. In such circumstances an incident form should completed via Safeguard.

5.3.5 Deceased patients

All deceased patients must be properly identified with two identification bracelets; one on the wrist and one on the ankle.

In the event of the patient’s name not being known the identification bracelet must state ‘UNKNOWN MALE/FEMALE’ and the Emergency Department number if available.
5.3.6 Major incident (MAJAX)

In the event of a major incident all incident patients will be identified as per the ED Majority Incident Plan, until such time as their identity is confirmed. At which time incident patients will be identified in line with this policy.

6. PRODUCTION AND APPLICATION OF IDENTIFICATION BRACELETS

6.1 Creation of patient identification bracelets (wristbands)

All patient identification bracelets must be printed from the PAS system using Trust agreed printers.

The bracelet must be white and all details on the identify bracelet must be in black only.

The table below shows the details required on patient identification bracelets according to location and patient group.

Table 1 shows the information that should be included on the bracelet, depending on the patient group and area of use:

<table>
<thead>
<tr>
<th>Area(s) of use</th>
<th>Patient group</th>
<th>Information required</th>
<th>No. of bands to be worn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Suite Postnatal Ward</td>
<td>Newborns</td>
<td>• Mothers name&lt;br&gt;• Mothers NHS number&lt;br&gt;• Sex of baby&lt;br&gt;• Date of birth&lt;br&gt;• Time of birth</td>
<td>Two (one on each ankle)</td>
</tr>
<tr>
<td>SCBU Postnatal Ward</td>
<td>Infants</td>
<td>• Baby’s forename and surname&lt;br&gt;• Baby’s date of birth&lt;br&gt;• Baby’s NHS number</td>
<td>Two (one on each ankle)</td>
</tr>
<tr>
<td>All adult wards</td>
<td>Adults and children</td>
<td>• Patients forename and surname&lt;br&gt;• Patient’s NHS number&lt;br&gt;• Patient’s hospital number&lt;br&gt;• Date of birth&lt;br&gt;• Sex</td>
<td>One (dominant arm where possible)</td>
</tr>
<tr>
<td>Children’s ward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All areas</td>
<td>Deceased patients</td>
<td>• Patients forename and surname&lt;br&gt;• Patient’s NHS number&lt;br&gt;• Patient’s hospital number&lt;br&gt;• Date of birth&lt;br&gt;• Sex&lt;br&gt;• If unknown: UNKNOWN MALE/ FEMALE&lt;br&gt;• Emergency Department number</td>
<td>Two (one on wrist and one on ankle)</td>
</tr>
</tbody>
</table>

Table 1
6.1.1 Patients name not known
In circumstances where the patient’s name is not known, the identification bracelet must state ‘Male (or Female) Unknown’ and state the Emergency Department number.

6.1.2 NHS number not available
In an emergency, if the NHS number is not available, the Emergency Department number should be used. A patient’s NHS number may not be immediately available at the time of initial assessment; however, all patients must still be fitted with an identification bracelet containing other available information and a new one attached when the NHS number has been confirmed. The attachment of this new identification band must be recorded in the patient’s health record.

In this situation, and if the patient requires a blood transfusion, the identification bracelet should not be removed until a new transfusion sample with the hospital unit number has been taken.

6.2 Application of identification bracelet

6.2.1 When to apply the identity bracelet
The patient’s identity bracelet must be applied on admission to the hospital, or once the patient has entered a department for treatment. It should be placed on the patient by the patient’s designated named nurse, or midwife, who will retain responsibility and accountability even where they delegate the task to someone else, this includes:

- patients in the Emergency Department who have been through triage and are receiving treatment;
- elective inpatients as they upon entry to the ward/department; and
- patients in the Day Surgery or Endoscopy Unit.

6.2.2 Attaching identification bracelets
Whenever possible the patient should be asked to read the details on the identity bracelet and confirm correctness, or instruct corrections, prior to the attachment to their wrist.

The identification bracelet should be placed, where possible, on the dominant arm (e.g. the arm used for writing) as it is less likely to be removed if, for example, intravenous lines are inserted.

If a limb is not available, or in emergency or operative situations where clothing is removed, identification should be attached to the patient’s skin using see-through plastic adhesive film.

The identity bracelet should be put on tight enough to avoid it sliding off, but loose enough to reduce the chance of it constricting circulation where a patient becomes oedematous. Where a patient is very oedematous, two identity bands may need to be joined together to go around a wrist or ankle.

For premature babies within SCBU, that are too small for identity bracelets, or where their skin does not allow the wearing of identity bracelets, both bracelets should be placed within the cot/incubator.

In extreme cases clinical care may take priority over attaching an identity bracelet to the patient. Where this has occurred, the nurse responsible for patient care must take
appropriate steps to identify the patient using the hospital number and/or the ED number. Once the surname, forename, date of birth and hospital number are confirmed an identity bracelet must be attached to the patient immediately.

The member of staff applying the identity bracelet must document the creation and placement of it in the patient’s health records.

6.2.3 Patients unable/unwilling to wear identification bracelets

Patients may be reluctant or unable to wear an identity bracelet, such as those who:

- Refuse to wear the bracelet
- The bracelet causes skin irritation
- The bracelet is too large
- The patient removes the ID bracelet

Patients who are not willing to wear an ID bracelet should be made aware of the risks of misidentification. Any communication issues should be addressed to ensure the patient, or parent, fully understands and this should be fully documented within the patient’s health record.

If the clinical condition does not allow them to wear an ID bracelet (e.g. dermatology conditions or burns) the nurse/midwife should ensure that a risk assessment is undertaken and clearly documented within the patient’s health record.

In such circumstances an incident form should be raised, the patient’s consultant should be informed and other methods of identification should be explored including verbal and non-verbal means of confirming a patient’s identity throughout the episode of care.

6.3 Allergy/Alert bracelets

6.3.1 Alert clasp

The use of a red alert clasp is mandatory if a patient has a history of, or develops, an allergy or sensitivity. The allergy or sensitivity should be recorded in the patient’s notes using an alert sticker which should be placed on the inside cover of the notes. Details of allergies or alerts should not be written on the patient wristband.

The absence of a red clasp should not lead clinicians to assume anything about a particular patient. The red alert clasp does not replace the need to ask relevant questions of the patient prior to treatment and to ensure that the appropriate documentation is completed.

6.3.2 Personal alert bracelets

The use of personal alert bracelets, such as those worn by diabetes, epileptics and others is allowed, but in addition to the hospital identity bracelet. However, the risk of staff confusion should be notified to the patient, following a risk assessment based on the distinctiveness or otherwise of the personal bracelet from the hospital ID bracelet.

6.3.3 Bed or cot head labels

The information on any bed-head should be made with due regard for the patient’s privacy, dignity and confidentiality and balanced with the safety of the patient.
Information on the bed-head label and/or communication boards should be the patients forename, surname, preferred name where applicable, and the patient’s consultant. The information required on the cot head label should be baby/mother’s surname, date and time of the birth and the gender of baby.

7. **ONGOING POSITIVE IDENTIFICATION OF PATIENTS**

The named nurse/midwife is responsible for ensuring the presence of the identity bracelet at every shift change, to ensure secure attachment and legibility. If any errors are detected, the identity bracelet must be changed. The details on the bracelet must not be written over to correct.

Establishing correct patient identification regularly during a patient’s stay is essential, including when transferred to new clinical areas. Using the principles outlined in section 5.

Correct identification of a patient is paramount throughout the course of their care to ensure their safety and minimise occurrence of any misidentification. To support this:

- Frontline staff must always verify that the patient they are attending to is intended and match the treatment to that patient.
- Should any alteration to the content of an identity bracelet be required, the bracelet should be replaced in its entirety by a newly provided bracelet with the correct information. Written alterations to the content of the wristband are not permitted.
- In the event of identity bracelets being obscured or removed due to theatre restrictions, arrangements must be in place to safely identify the patient during the procedure. This may include other methods such as the marking on the skin of the patient’s identity with an indelible marker.
- If an identity bracelet is removed by a member of staff, e.g. to gain venous access, then it is their responsibility to ensure it is replaced correctly as soon as is reasonable possible. Clear alternative arrangements for the patient’s correct identification if the wristband cannot be applied immediately must be documented.
- If a member of staff discovers a patient does not have an identity bracelet, they must assume responsibility for correctly identifying the patient and replacing the bracelet, or inform the appropriate registered nurse who must assume the responsibility for replacing the bracelet and for raising an incident form.
- Each time a patient is transferred to another ward or department e.g. Emergency Department to Ward, Ward to X-Ray for example, the bracelet must be checked for accuracy by both the transferring and the receiving registered nurse or a member of the clinical team.
- Patients must not leave their base ward or department until a bracelet has been correctly applied.
- Except in emergency situations, should the verification process fail at any stage all activities for the patient must be halted until the patient’s identity can be accurately determined. In these circumstances an incident form should be completed.
7.1 Procedures requiring positive identification of patients

The positive identification of the patient must be undertaken prior to undertaking any procedure, and in particular:

- Administration of all medicines
- X-rays and imaging procedures
- Surgical interventions and any invasive procedures
- Blood transfusion
- Collecting of patient bodily fluid samples
- Transport/transfer of the patient
- Confirmation of death

Prior to undertaking a procedure the clinician must confirm the identification of the correct patient by asking the patient (where possible) to state their name, last name and date of birth, and checking these details against the identity bracelet and the health records.

Clinicians must always take the time to satisfy themselves that they have the correct patient for whatever intervention they plan to carry out.

If the patient is unable to give their name refer to the identity bracelet and, if possible verify the information by asking family, relatives or another member of staff who is familiar with the patient.

When relatives or carers are not available, two clinical staff will undertake the positive identification and both will sign for the check in whatever documentation is associated with the process.

Do not proceed with any procedure if the patient has no identity bracelet. The identity bracelet must be replaced by the named nurse caring for the patient, before the procedure can begin. Any clinician identifying a patient with a missing identity bracelet must immediately inform the named nurse.

7.2 Identifying patients undergoing imaging

It is the ultimate responsibility of the Technician operating the imaging device to ensure that the correct patient is being examined according to the request that has been made. The exposure must not be performed until the patient’s identification has been verified.

If the patient details stated on the request form are incomplete or inaccurate, further information must be obtained before an exposure is performed.

The operator must correctly identify the patient prior to performing any exposure by:

- Asking the patient to state their full name and date of birth;
- Checking the details against the identity bracelet; and
- Checking the details against those on the request form.

If the details match proceed with the exposure. If there is more than one patient on the radiology information system with the same name double check the identity against the address.
If an inpatient arrives for radiographic/radiological examination without an identity bracelet, an accompanying ward nurse may confirm the patient’s identity. If this procedure is required a record must be made on the patients request form, including the nurses name, and an incident report form must be completed.

If an appropriate ward nurse is not available, the patient must be returned to the ward and the nurse in charge informed of the situation and the need for the completion of an incident report form.

7.3 Identifying patients in the Operating Theatre, Day Surgery and Endoscopy Unit

In the Operating Theatre departments theatre personnel will confirm the identity of the patient using the theatre checklist and identity bracelet, in line with the approved theatre protocol.

Should it prove necessary to remove the patient’s identity bracelet prior to, or during, the course of the operation/procedure, this should be carried out by the named nurse in theatre. It will remain their responsibility to immediately re-attach the identity bracelet on the patient.

The bracelet that has been removed should be attached to the front of the patient’s health record and a record of the event documented in the theatre record.

7.4 Missing identity bracelets

If a patient’s identity bracelet is found to be missing, positive patient identification must be undertaken, as outlined in section 5, immediately and a replacement secured. In addition the person in charge of the ward must be informed and an incident form completed.

8. REMOVING THE IDENTITY BRACELET

The identity bracelet must remain on the patient during the whole of their admission and only be removed as part of the formal discharge process.

The named nurse accountable for the patient’s care at the point of departure from the clinical area is responsible for the removal of bracelet. The identity bracelet may be removed once all discharge processes, such as drug handover and ongoing care explanations, have been given to the patient, relative or their carer (i.e. at the point when no further Yeovil District Hospital care requiring patient identification is required).

In normal circumstances a patient’s identification bracelet must only be removed on discharge home. As many patients use the discharge lounge, the identification bracelet must not be removed until the patient leaves the hospital premises.

Identification bracelets must not be removed if a patient is discharged to another hospital, into social service or private nursing care.

9. MISIDENTIFICATION

In all instances of misidentification it is essential that positive identification of the patient is undertaken as soon as possible, as outlined in this policy.

Where harm has occurred, as a result of misidentification, the person in charge of the clinical area should decide the most appropriate person to inform the patient or their carers of the error, as per the principles of Being Open.
9.1 Reporting patient identification errors

Any member of staff discovering a patient identification error must report it as soon as possible to the person in charge of the ward/department and complete an incident report form. Examples may include:

- Wrong addressograph labels in the health records
- Wrong information on the identity bracelet
- No identity bracelet on the patient
- Misidentification of documentation within the health records
- Misidentification of x-rays
- Misidentification of investigation reports
- Misidentification at appointments
- Duplicate registration on PAS

This would include an incident that has occurred as a result of misidentification or failure to identify, with or without evident harm, and also near miss situations where the misidentification or lack of identification was detected before a procedure has been undertaken.

10. ACCESSING SUMMARY CARE RECORDS

Summary Care Records are electronic records produced by GPs containing information about patients’ medications, medication sensitivities and allergies. These records are accessible by other healthcare providers, once consent has been gained from the patient.

10.1 Patients presenting to the Emergency Department

On registering at the Emergency Department, patients must be asked for their consent to access their Summary Care Record; this will be recorded on Symphony. The process for accessing Summary Care Records in the Emergency Department is outlined in Annex A.

10.2 Pharmacy accessing Summary Care Records

As part of the medications reconciliation process the pharmacy team may access patients Summary Care Records, with their express permission. The process for accessing Summary Care Records for medicine reconciliation is outlined in Annex B.

10.3 Patients unable to give their consent to access their Summary Care Record

In cases where a patient is unconscious and unable to give their permission to access their Summary Care Record can be accessed without their consent.

11. APPLICABILITY

This policy applies to all permanent, locum, agency, bank and voluntary staff who encounter inpatients and outpatients, including patients visited in their own homes or clinics during the course of their duties.
12. IMPLEMENTATION, MONITORING AND EVALUATION

Responsibility for implementation, monitoring and evaluation is identified in the Trust’s Policy on Procedural Documents. This section needs to specify how the aims of the policy will be monitored through audit etc. Specify who will do what, where the results will be reported, to whom and how frequently, identify how actions will be taken in the event of unsatisfactory implementation or compliance, what the arrangements are for checking on actions, use of an action plan should be considered.

13. REFERENCES AND ACKNOWLEDGEMENTS

- Leeds Teaching Hospitals NHS Trust. Policy for the Positive Identification of Patients

14. EQUALITY IMPACT ASSESSMENT

This document has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and equitable, and does not discriminate against individuals or groups. A completed Equality Impact Assessment can be found at Annex C.
ANNEX A  PROCESS FOR ACCESSING SUMMARY CARE RECORDS FOR PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT

Patient presents to Emergency Department

Walk-in

Via ambulance

Receptionist asks for Consent to access Summary Care Record – decision recorded on each visit via mandatory field on Symphony

Consent given?

No

Yes

Reason for attendance:
- GP referral
- Chest pain/condition
- Nose bleeds
- Paediatric patients
- Speciality patients
- Trauma patients
- Emergency/major (unable to ask patient for consent)

Field populated on casualty card indicating that patient consents to access to summary care record if required.

Receptionist searches for patient’s Summary Care Record and prints off

End
Medication reconciliation for inpatients undertaken by Pharmacy Team

Is medicines reconciliation information available from any of the following sources?
- GP summary
- Medical notes
- Patient/carer
- Patient’s own drugs
- Repeat prescription slip
- MARs

Yes

Is the patient present and/or able to give consent to access summary care record?

No

Patients' summary care records should only be accessed without their consent in emergencies and only if it is in the best interest of patient care.

Yes

Consent given?

Yes

Access Summary Care Record system stating reason for access as medicines reconciliation.

No

End

No
ANNEX C  EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

**Policy Title:** Identification of Patients Policy

<table>
<thead>
<tr>
<th></th>
<th>Yes / No / N/A</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
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<td></td>
<td>Race</td>
<td>No</td>
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<td>Ethnic origins (including gypsies and travellers)</td>
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<td></td>
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<td>Sexual orientation including lesbian, gay and bisexual people</td>
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<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
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</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
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<td>4.</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust’s lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust’s lead for Equality & Diversity.

**Signed**

Name: Jo Howarth, Associate Director of Patient Safety & Quality
Date: 14 April 2014