York Teaching Hospital NHS
NHS Foundation Trust

Identification of Patients Policy

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Relevant Regulations and Standards	CQC Essential standards of quality and safety
Links to Organisational/Service Objectives, business plans or strategies	Risk Management Strategy Patient Safety Strategy

Executive Summary
This policy describes the organisational requirements in terms of ensuring that patients are correctly identified at all stages of their pathway

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
3	Jan 08	Michelle Carrington	Horizon	Now put in new NHSLA template. Additional advice regarding identification of unidentified patients and recommendations included from internal audit report Jan 08.
4	April 08	Michelle Carrington	Horizon	Updated policy template and agreement on wrist bands. Addition of audit tools.
5	April 10	Becky Hoskins	Horizon	Updated policy template. Inclusion of information relating to mortuary, stillbirths & miscarriages. Included informal RMSAT feedback; definition of patient groups; inclusion of documentation re misidentification.
6	Nov 11	Becky Hoskins	Horizon	Inclusion of guidance for checking ID bracelets in SCBU
7	September14	Head of Patient Safety	Horizon	Integrated policy which also addresses

				recommendations from internal audit report Aug 13

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Process flowchart

These are included in the protocols (See Appendix 1a)

1 Introduction & Scope

This policy aims to ensure that patients are correctly identified on admission and prior to any assessment, investigation or treatment whilst under the care of York Teaching Hospital NHS Foundation Trust (hereafter known as the Trust).

This policy has been developed to assist all staff to positively and safely identify patients while taking account of key principles relating to privacy, dignity and confidentiality.

This policy applies to all patients under the care of the Trust. Adherence to this policy is the responsibility of all staff employed by the Trust.

2 Definitions / Terms used in policy

All patients – includes inpatients & day case patients, both adult & paediatric who are receiving care on Trust premises.

All staff – includes all staff employed by the Trust.

3 Policy Statement

All patients must be treated with respect for their right to privacy, dignity and confidentiality. Although confidentiality is paramount within Clinical Professions Code of Ethics and Conduct (NMC 2009) it is important that confidentiality issues do not hinder the provision of prompt and effective patient care.

The consequences of failing to positively identify patients could prove fatal. We know from the completion of Datix Incident forms and Serious Incident (SI) reports that patients, are not always positively identified and that our patients can suffer potential harm as a result.

To ensure that risk of patient harm is minimised:

- Printed identification bracelets are used in all areas across the Trust. In the Maternity units babies wear two hand written identification bracelets (See Identification of Mothers and Babies, Maternity Service Guideline).

- All staff must follow the guidance with regards to the wearing of patient identification bracelets (patient wrist bands).

- All staff must positively identify a patient prior to delivery of care, investigation or treatment.

- It is the responsibility of all staff to report any patient identification incident immediately using the Datix incident reporting system.

- Staff who fail to positively identify patients in line with this policy may be subject to disciplinary action, which could result in dismissal.

- Interpreters will be obtained where required.

The procedures relating to the positive identification of patients are attached in Appendix 1a.

4 Training

There is no formal training associated with this policy.All managers should ensure that staff are aware of this policy and the requirement to adhere to this.

Managers are responsible for arranging appropriate training in the event of a trend/theme being identified in Adverse Incidents in their area.

5 Trust Associated Documentation:-

- Blood Transfusion Policy
- Medicines Code
- Completing Request Forms and Labelling Samples Policy
- Laboratory Medicines Handbook
- Operator's procedure for identifying a patient (IRMER 2000)
- Procedure for incorrect use of case notes
- Identification of Mothers and Babies Maternity Service
- Guideline
- Newborn Security Guideline
- Death of an Adult Patient Policy
- Child Protection Policy and Procedures
- Safeguarding Adults Policy
- Still birth guidelines
- Records Management Policy and procedures
- Consent to Examination and Treatment Policy
- Documenting patient details on Prescription charts
- Procedure for Recording of Allergies/Sensitivities

6 External References

- National Blood Transfusion Service and Royal College of Physicians (2008) National Comparative Audit of Blood Transfusion National Blood Transfusion.
- National Health Service Executive (1999) The Caldicott Committee: Report on the review of patient-identifiable information – December 1997. Leeds, NHSE.

- Nursing and Midwifery Council (2008) The Code. Standards of conduct, performance and ethics for nurses and midwives.
- National Patient Safety Agency (2007) Standardising wrist bands improves patient safety. London, NPSA

7 Appendices

Appendix 1a	Protocols
Appendix 1b	Protocol – Unidentified Patient Details – Police Form
Appendix 2	Equality Analysis
Appendix 3	Checklist for Review and Approval
Appendix 4	Implementation Plan

Appendix 1a – Protocols

Protocol on the use of Identification Bracelets

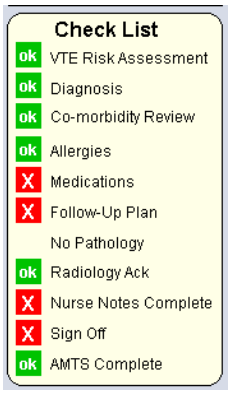
Inpatients

- All inpatients **must** wear an identification bracelet.
- All patients required to wear an identification bracelet must be assessed for suitability and ability to keep the bracelet in place e.g. patients with skin conditions, very obese patients, confused patients, patients who refuse to wear a bracelet or take them off themselves.
- Contingency plans must be arranged and documented if the patient cannot or will not wear an identification bracelet.

Red Alert Bracelets.

- **Red bracelets must not be worn.**
- All allergies must be recorded on CPD.

Documenting Allergies



Allergies should be reviewed and any new allergies recorded on the electronic Inpatient Care Record on CPD as soon as possible after patient admission. There is a Checklist item to remind all staff about this and the requirement to complete this is also visible on Ward status boards.

Recording allergies is important as this information supports safe care of the patient during their current and any future hospital attendances.

The Trust document ‘Procedure for Recording of Allergies/Sensitivities’ should be followed for recording allergies.

Outpatients:

- Health professionals undertaking invasive procedures or injections via any route on conscious patients will take the appropriate steps to confirm with the patient, their correct identity.

- All unconscious non admitted patients, when receiving invasive procedures or injections via any route must wear an identification bracelet.

- Patients with Glasgow Coma Score of less than 15 as well as patients with confusion, attending the Emergency Department must wear an identification bracelet.

- Ambulatory patients attending the Emergency Department where it is professionally judged to be appropriate, for example patients with confusion, must wear an identification bracelet.

- All patients in the Emergency Department, where a decision to admit has been made must wear an identification bracelet.

GUM clinic

- To maintain patient confidentiality, patients are able to select to be identified by a unique clinic number (not their NHS number) rather than their name. The patient's Date of Birth is always used in addition to the patient number.

Laboratory Medicine Request Forms and Sample Labelling

Staff **must** ensure that they are aware of the Completing Request Forms and Labelling Samples Policy and the Laboratory Medicines Handbook (available via Staffroom).

- It is the responsibility of the person completing the request form or label to ensure that sufficient information is provided and that it is correct. The onus is **not** on the laboratory to make

assumptions about the origins or nature of specimens or the accuracy of any given details.

- Where a patient is unidentified, unique identification must be provided in the form of e.g. an accident and emergency number. The surname must be given as “unknown” and the gender of the patient entered in the forename box.

- The requestor must ensure that both specimens and request forms EACH have:-

  The patients full name. Both forename and surname correctly spelt. Initials are not sufficient.

  And

  One other identifier (which could include date of birth or a unique numeric identifier, such as the NHS number).

In the case of Blood Transfusion requests, special conditions apply. Please refer to page 8 of the Completing Request Forms and Labelling Samples Policy.

Sample Identification

For Crossmatch or Group and Save Samples:

It is essential that the sample contains the following correct minimum patient identification. These must be hand written onto the specimen tube.

(i) Surname (correctly spelt);

(ii) Full first name (correctly spelt and not initials);

(iii) Date of birth (not age or year of birth);

(iv) A unique numeric identifier, for example the NHS number.

It is further recommended that the specimen tube is labelled with date and time of collection, and has the signature of the person who collected the sample.

Protocol for completion of request cards

The need for the correct identification of patients also applies to request cards for clinical investigations. The person signing the request should complete all fields on the card themselves, ensuring the patient identification information on the card is correct.

All request cards must have the following details:

- First name
- LAST NAME
- Gender
- NHS number
- Date of Birth (written DD-MM-YYYY)
- Ward
- Consultants Name.

(All details must be spelt correctly and no abbreviations must be used).

- Investigations must **NOT** be carried out until patient identification has been established.

- Checking the request card against the patient identification bracelet must be adhered to and where possible this must also be verbally confirmed with the patient.

- All paperwork relating to the patient must include and be identical in every detail, with the minimum patient core identifiers contained on the patient's identification band.

- The practice of bulk pre-signing of request cards is illegal, dangerous and unacceptable.

- The standards for labelling of request cards and specimens for Laboratory Medicine investigations should be adhered to.

- Labelling of specimens **must not** be carried out prior to taking the sample.

N.B. The above information is not always sufficient to ensure that all requests are processed. Additional information will be required on a department specific basis within Laboratory Medicine and Radiology.

The following action will be taken when insufficient information is provided:

Specimens

Specimens without the full name and at least one other identifier **will not** be processed. **The ward/department will be informed and a repeat sample requested. (Transfusion requests will require a unique identifier in addition to the above).**

Request Forms

- The identification information on the request form MUST MATCH that provided on the specimen.

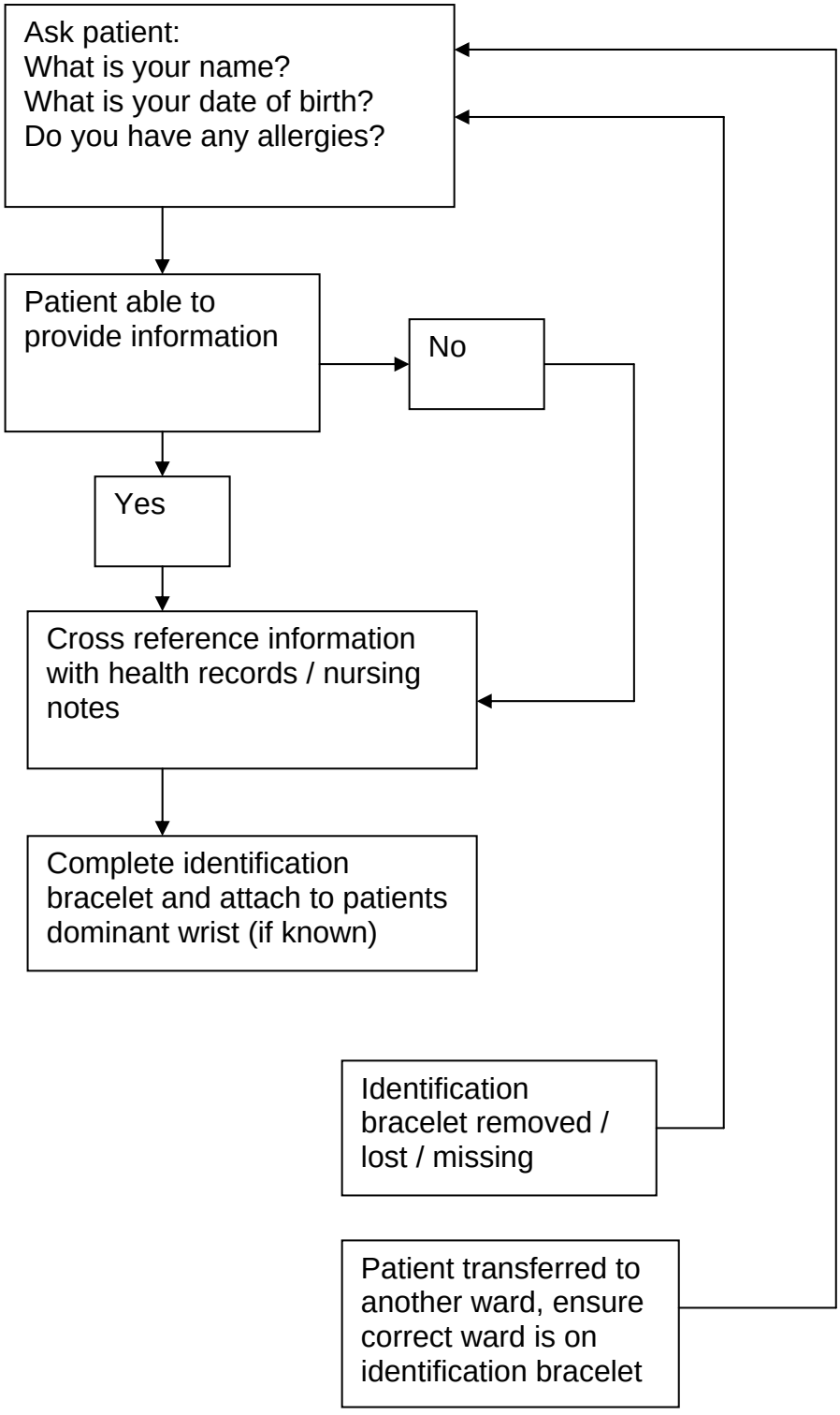
- Any immunology requests without the name of the referring clinician will not be processed.

- A standard comment will appear on the patient's result indicating other deficiencies of information.

Operating Theatre

The process for the proper handling and care of surgical specimens is contained in the Standard Operating Procedure for the Labelling and Handling of Specimens in Theatres and this must be strictly adhered to.

Process for Patient Identification prior to applying Identify Wrist Bracelets



On admission to the hospital or transfer within clinical areas, it is the responsibility of the admitting nurse to positively identify the patient. This should be done both verbally with the patient (as far as possible) by asking **'What is your name?' and 'What is your date of birth?'** and by reference to the medical notes. For inpatients, an up-to-date identification bracelet must then be issued and applied to the patient's dominant wrist (where known) or ankle. Thereafter it is the responsibility of any nurse caring for the patient to ensure that the patient is wearing an identification bracelet.

- It is the responsibility of all other health care providers/ professionals to identify when a patients identification bracelet is not valid or is missing.

- 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.

- Where the patient has removed it, it is the responsibility of the nurse caring for the patient to ensure that the patient is wearing an identification bracelet. If a person lacks capacity then consult with other relatives and friends to enable positive identification.

Pre printed bracelets should be used wherever possible but in the event of printer breakdown, the following information is required on the bracelet if it is handwritten (Patient core identifiers):

- Patient's LAST NAME (in capitals) and first name (to be written in this order to avoid confusion with first or last names).
- Hospital number and NHS number if available should be used.
- Date of birth (written DD- MM-YYYY e.g. 01-01-1954).
- Current Ward.

It is imperative that all spelling and number sequences on the bracelet are correct and are clear and legible.

- In an emergency, if the hospital number is not available, the Emergency Department number should be used.

- In circumstances where the patient's name is not known, the identification bracelet must state 'Male, Female or unknown' and state their Emergency Department number.

Any patient who has an Emergency Department number on their identification bracelet must have their identification bracelet changed as soon as the patient's hospital number is available and any other departments involved informed of withdrawal of the temporary number to provide safe merging of patient records.

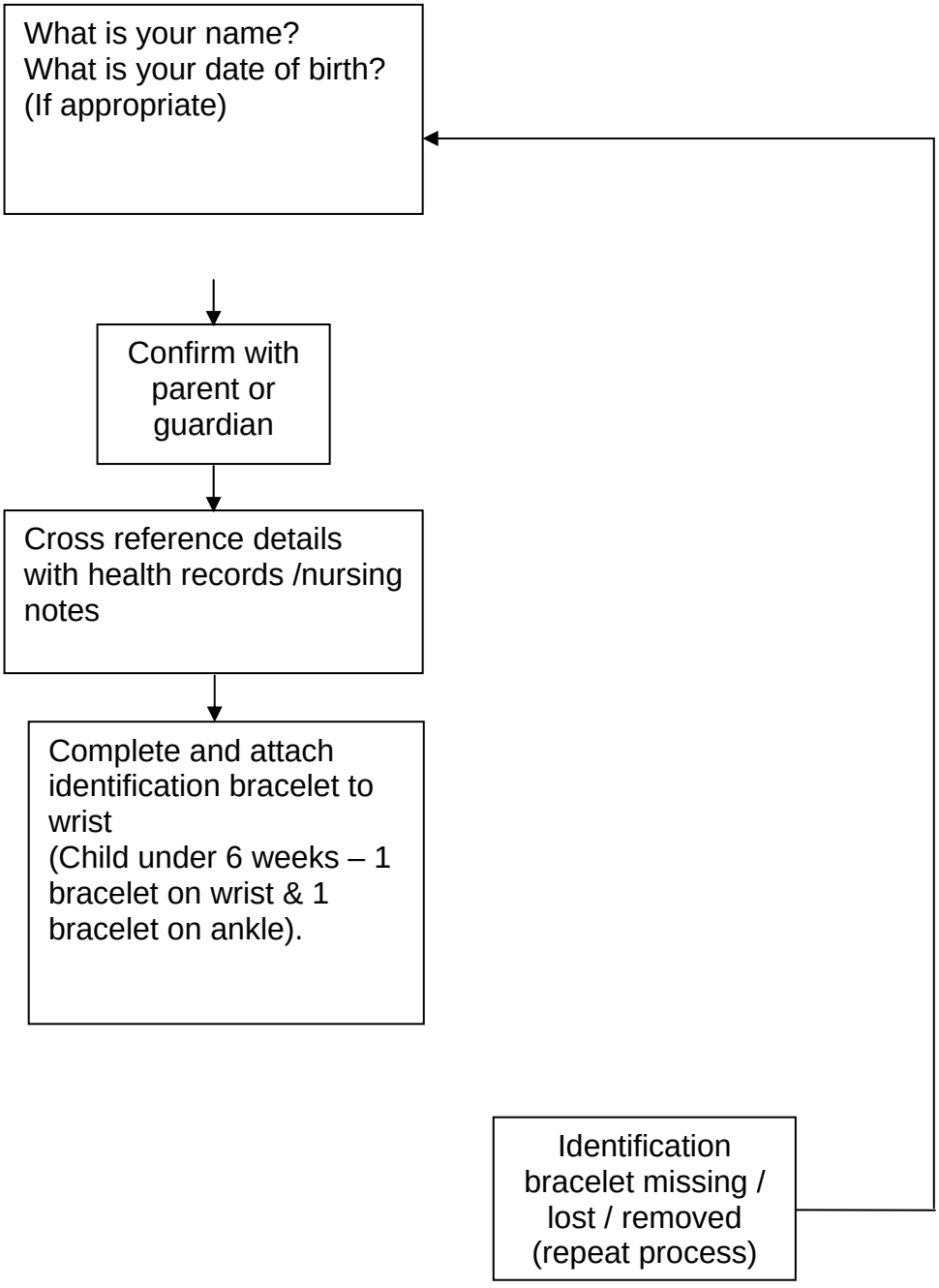
If an inpatient receives treatment or care without a wrist band in situ or where misidentification occurs, the incident must be reported on the Datix incident reporting system.

- Medical assistance should be sought where appropriate and the member of staff in charge of the ward / department must be informed.

- Patient misidentification must be documented in the patient's health records.

- Staff should also follow the 'Procedure for Incorrect Use of Case Notes' process for Patient Identification prior to applying the identification bracelet.

Identification bracelets in Paediatric patients:



All children must wear identification bracelets on the children's ward and day unit.

- All babies up to the age of 6 weeks on the children's ward must wear 2 identification bracelets, one on the wrist and one on the ankle.

- Children attending as booked admissions to the child assessment unit (CAU) are required to wear identification bracelets if undergoing an invasive procedure (except booked blood tests).

- Acute admissions to the CAU are required to wear identification bracelets.

- Ward staff must ensure that a check of identification bracelets is performed once a day and where identification bracelets are not in place this is rectified immediately.

- In the case of positively identifying children, this must be carried out and confirmed with the parent or guardian. These details must be cross-referenced with either the health records or an identity bracelet worn by the patient.

Positive identification

- In the absence of the patients health records identification must be confirmed with the patient or in the case of confused, unconscious patients or where there is a language barrier, a relative or carer.

Asking a patient to confirm a date of birth or a name verbalised by a member of staff is not considered to be acceptable positive identification.

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

- Staff in the receiving area must also confirm the identification of the patient.

Protocol for Unidentified Patients

- If the patient cannot positively identify themselves a relative or friend may identify the patient.

- This identification process should be documented, and its status made clear.

- It is not acceptable for members of the clinical team to identify the patient even if they feel they recognise the patient.

- For unidentified patients the Emergency Department number should be used and the name band must state 'male unknown' or 'female unknown'.

- If 48 hours after admission the patient still cannot be identified a call must be made to the Police in order to gain assistance in identifying the patient.

- It is legally and ethically justified to give certain information to the Police regarding the patient details 'in order to protect the vital interest of the patient' (Data Protection Act). The following process must be used:

9am – 5pm Monday to Friday –telephone the Contact Centre on extension York 6400. The contact centre will ask the staff member a series of questions (See appendix 1b). The contact centre will then contact the police providing details of the unidentified patient and requesting support.

Out of hours and weekends – contact the bed management team (York) bleep 998 (Scarborough bleep 601 and 536) who in turn will contact the Police.

If the Police need to discuss the situation further after the initial phone call from the Bed Manager/Contact Centre, the Police will contact the ward direct.

Contact number for the Police is 0845060247 – this is a central office in Northallerton. Staff must state they wish to speak to local Police in York/Scarborough.

For children abandoned in the hospital follow the Trust child protection procedures.

Patient identification in major incidents

- All staff must be familiar with major incident numbering system used.

- There should be regular drills to ensure familiarity with emergency processes. (Please refer to Majax procedure).

Protocol for Deceased patients

The information below provides key points; you **must** ensure that you refer to the Death of an Adult Inpatient Policy for further information.

- Nursing staff must complete (handwritten not addressograph labels) two Patient Identification Labels by checking the details with both the patient's identification bracelet and health records.

- The mortuary staff will use these labels for identification and not the patient's identification bracelets it is therefore imperative that the information on the labels is correct.

- Nursing staff must ensure patient's identification bracelets remains securely in situ – if it is necessary to remove them due to soiling etc. a replacement identification bracelet must be completed and placed on the patient immediately, taking care to ensure the correct patient identification.

- Nursing staff must complete the notification of death form and record the entire patient's property and money in the property book.

- Nursing staff must attach one of the patient identification labels to one of the great toes. The second patient identification label is attached to the outside of the sheet (around the chest area) by the use of tape. The body is then covered completely with another clean bed sheet.

Stillbirths

For stillbirths please refer to Stillbirth Guidelines & Dealing with Foetuses and Foetal Tissue from Under 24 Weeks.

Protocol for Discharge Lounge Patients

- All patients transferred to the discharge lounge must have an accurate identification bracelet in situ.

- On arrival of the patient's transport, and the patient is being discharged from the discharge lounge, the patient identification bracelet can be removed.

Community

- This policy applies to all patients admitted to Community Hospitals.

- For patients nursed in their own home setting there are no requirements for them to wear patient identification bracelets.

- Labelling of patient sample requests would still include the key information for identification as contained in this policy.

8 Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 2.

9 Accountability

Operational implementation, delivery and monitoring of the policy reside with:-

- Head of Patient Safety.

However there are a number of key responsibilities placed on individuals within the organisation to ensure the effective implementation of this policy:-

- All managers must ensure that their staff (including temporary staff) is made aware of this policy.

- All staff must adhere to the contents of this policy.

10 Consultation, Assurance and Approval Process

10.1 Consultation Process

The Trust will involve stakeholders and service users in the development of its policies.

Consultation has taken place with the following stakeholders:

- Patient Flow Manager; Head of Patient Access; Medical Director; Radiology Governance Group; Clinical Standards Group; Quality and Safety Group; Risk and Legal Services; Labour Ward Forum; Divisional Manager– Women & Children; End of Life Lead Nurse; Laboratory Medicine; Blood Transfusion Practitioner; members of the Patient Safety Team and Community Services representative.

10.2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy has been through quality assurance checks prior to being reviewed by the authorising committee to ensure it meets the NHSLA standards for the production of policy and equalities legislation and is compliant with the Development and Management of Policies policy.

10.3 Approval Process

The approval process for this policy complies with that detailed in section 6.3 of the Development and Management of Policies Policy. The approving body for this policy is the Patient Safety Group.

The Checklist for Review and Approval has been completed and is included as Appendix 3 and the completed Virtual Policy Review Group Checklist is included as Appendix 5.

11 Review and Revision Arrangements

On reviewing this policy, all stakeholders identified in section 6.1 will be consulted. The person responsible for review is:

- Head of Patient Safety.

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Patient Safety Group.

12 Dissemination and Implementation

12.1 Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Teaching Hospital NHS Foundation Trust following the completed Plan for Dissemination of the policy (Appendix 4).

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

12.2 Implementation of Policies

This policy will be implemented throughout the Trust by all Trust staff.

In addition to this the Policy Author will collate the following evidence to demonstrate compliance with this policy:

- See arrangements identified in Section 10.1
- Documents eg agendas minutes and papers – Patient Safety Group/Risk Review Group etc.

13 Document Control including Archiving Arrangements

13.1 Register/Library of Policies

This policy will be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal's search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies

must not be stored for local use as this undermines the effectiveness of an intranet based system.

13.2 Archiving Arrangements

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

It is the responsibility of the Healthcare Governance Directorate to ensure that version history is maintained on Staffroom and Q-Pulse.

13.3 Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

14 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

14.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements of the NHSLA Risk Management Standards for Acute Trusts are met, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Review of all significant identification of patient issues	Any critical/serious incidents related to patient identification will be reviewed and investigated as appropriate	Serious Incident Group and Quality & Safety Briefing	Monthly/ Weekly	Serious Incident Group and Medical Director	Serious Incident Group / medical Director	Serious Incident Group/Medical Director

13.2 Standards/Key Performance Indicators

Not applicable

Appendix 1b – Protocol for Unidentified Patient Details - Police Form

York Hospitals NHS
NHS Foundation Trust

Note: This form is to be completed by Contact Centre staff or the Bed Management team only.

Time and date of call:		Date:	Time:
Name of member of staff calling from ward with details (this is the person to whom the Police will contact if necessary):			
Ward area patient admitted to:			
Patient details:			
Male or female?		Hair colour?	
Facial hair?		Eye colour?	
Approximate age?		Ethic origin?	
Description of any clothing / personal effects			
Average weight and height?		Weight:	Height:
Distinguishing features (e.g. scars, tattoos, limbs missing)?			
Details of location patient admitted from (e.g. street, area)			
Time call made to Northallerton 0845060247			
Name of police officer receiving information			

Unidentified patients - details for police (cont'd)

Details of outcome / further instructions from police (given at the time of the phone call – further information from the Police will be given directly to the ward)?		
Date and time ward area informed that details have been given to the police?	Date:	Time:
Name of ward staff informed?		

Name of contact centre staff / bed manager:
Signature:

- **Please photocopy form and send one copy to ward area.**

Appendix 2 Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	Identification of Patients Policy
1.	**What are the intended outcomes of this work?** To ensure that patients are correctly identified on admission and at all points throughout their patient journey/pathway
2	**Who will be affected?** Patients, Staff
3	**What evidence have you considered?** See external references – Section 13 of policy Equalities Act 2010
a	**Disability –** See appendix 1a pages 17 and 22
b	**Sex –** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
c	**Race –** Interpreters would be obtained where appropriate. See page 5.
d	**Age –** Appendix 1c relates to paediatric arrangements
e	**Gender Reassignment –** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
f	**Sexual Orientation –** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
g	**Religion or Belief –** This policy is inclusive and does not differentiate between people on the basis of this characteristic.
h	**Pregnancy and Maternity**.- covered by separate Maternity Service Guideline
i	**Carers** – Covered in appendix 1a page 17
j	**Other Identified Groups** – None identified

4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes see Section 6 of policy
b.	How have you engaged stakeholders in constructing the policy	Discussion and circulation of document
c.	If so, how have you engaged stakeholders in constructing the policy	As above
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs See section 6 and engaged via discussion & circulation of document for comment. Key output is a usable policy to provide guidance to staff on positive identification of patients	
5.	**Consultation Outcome**	
a	Eliminate discrimination, harassment and victimisation	No group is discriminated against
b	Advance Equality of Opportunity	No group is discriminated against
c	Promote Good Relations Between Groups	Encourages dialogue between Trust and service users
d	What is the overall impact?	No group is discriminated against
	Name of the Person who carried out this assessment: Head of Patient Safety	
	Date Assessment Completed 17 March 2014	
	Name of responsible Director Medical Director	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix 3 Checklist for Review and Approval

Authors need to be confident that their policy meets all of the criteria identified below before submitting this to the appropriate committee(s) for consideration and approval.

	Title of document being reviewed: Identification of Patients Policy	Yes/No	Comments
1.	**Development and Management of Policies**		
	Is the title clear and unambiguous and meets the requirements of page 3 of the Development and Management of Policies Policy?	Yes	
	Is it clear whether the document is a policy, procedure or protocol?	Yes	
	Does the style and format of the policy meet the requirements of section 3.2 of the Development and Management of Policies Policy?	Yes	
	Does the policy contain a list of definitions of terms used?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with all relevant stakeholders and users?	Yes	
4.	**Content**		
	Is the document linked to a strategy?	Yes	
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Does it meet all of the requirements of NHSLA RMSAT or other relevant body, if applicable?	Yes	
5.	**Evidence Base**		

	Title of document being reviewed: Identification of Patients Policy	Yes/No	Comments
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are supporting references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
	Are all associated documents listed and updated?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Does the dissemination plan identify how this will be done and is it clear?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
	Does the policy detail what evidence will be collated to demonstrate compliance with it?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation, evidencing, monitoring and review of the documentation?	Yes	

Policy Owner's Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval. (This can be completed electronically with an electronic signature)			
Name	Alastair Turnbull, Medical Director	Date	October 2013
Signature	*A Turnbull*		
Committee Approval			
If the Chair or Vice Chair of the committee is happy to approve this document, please sign and date here and enter the name of the committee/group. The Policy Author will contact the secretary/administrator of the committee/group to obtain a signed copy of this checklist. The Policy Author will then submit this together with the approved policy (ensuring the "draft" watermark is removed) to the Policy Manager for logging and publication.			
Name	Alastair Turnbull, Medical Director	Date	December 2014
Signature	*A Turnbull*		
Committee/ Group title	Patient Safety Group		

For Policy Manager's use only	
Is there a signed and completed Checklist for Review and Approval accompanying the policy?	Y
Is the policy logged on Qpulse?	Y
Has the old version of the policy been archived? (if applicable)	Y
Has the policy been published on Staffroom?	Y
Author notified that policy has been published?	Y

Appendix 4 Plan for the dissemination of a policy

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

Title of document:	**Identification of Patients Policy**
Date finalised:	**December 2014**
Previous document in use?	**Yes**
Dissemination lead	**Head of Patient Safety**
Which Strategy does it relate to?	**Risk Management**
If yes, in what format and where?	**Electronic on Staffroom**
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**

To be disseminated to:	**1) Executive Board Members**
	2) Senior Managers, Directorate Managers, Matrons and Heads of Department
	3) All Trust Staff
Method of dissemination	• **Each directorate governance meeting** • **Exec board** • **Team brief** • **PNLF** • **Risk review group**
who will do it?	**Head of Patient Safety**
and when?	**On approval**
Format (i.e. paper or electronic)	**Electronic**

Dissemination Record

Date put on register / library	**On approval**
Review date	**September 2016**
Disseminated to	**All of the above**
Format (i.e. paper or electronic)	**electonic**

Date Disseminated	
No. of Copies Sent	**As above**
Contact Details / Comments	**Head of Patient Safety 7712341**