Patient Safety Notice

PSN066 / 29th September 2023

Safer Temporary Identification Criteria for Unknown or Unidentified Patients

To: All NHS Chief Executives, Medical Directors, Directors of Nursing and Patient Safety Teams

Emergency Departments (EDs) often receive patients who are unable or unwilling to give their identity. These include patients who are unconscious or who have a critical illness or trauma, patients with a mental health condition or dementia and patients under the influence of drugs and/or alcohol.

Unidentified patients may arrive together following an accident or in a mass casualty situation. Providing a unique identity to each unknown patient ensures safe and prompt diagnostic testing and treatment. This includes preventing incorrect blood test results being allocated to the wrong patient with the potential to cause a fatal incompatible blood transfusion.[1,2,3,4].

Temporary identification (ID) systems can have a high potential for error if they use:

- The same or similar names e.g. unknown male, unknown female.
- Pre-allocated numbers that only differ sequentially by one digit, e.g. ED0000123, ED0000124.
- Identical dates of birth (DOB), e.g. 01/01/1900.

These systems create a risk of misidentification compared to other patients when their first name and last name, unique patient/NHS number and individual DOB are all used. Additionally, temporary numbers that are unique locally may not be suitable if a patient transfers between Health Boards/Trusts (HBs/Ts). Whilst many EDs have created combinations of identifiers to **potentially** resolve these issues, differing practices can confuse staff when changing jobs and moving between HBs/Ts.

Actions

When: To begin as soon as possible, with full compliance no later than 29th September 2023.

Who: All organisations with Emergency Departments (EDs)* *(*the actions in this notice are directed at EDs or equivalent services, i.e. services providing investigations and treatment for patients who arrive directly).*

1. Ensure that a plan is in place for the development of a system with a unique temporary identification of unknown patients using the system outlined in this PSN. Sex, DOB + estimated age range, non-sequential unique ID number and first and last name based on an edited phonetic alphabet.
2. Obtain executive agreement on the date for implementation of this system.
3. Identify a team of key stakeholders who can implement this PSN. These include, hospital informatics, emergency admissions, major incident teams and pathology services.

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For **names**, a distinctive method is to randomly generate combinations of first names and last names from an edited phonetic alphabet, e.g. Foxtrot Whisky (see resources).

For **temporary numbers**, a distinctive method is to provide a unique non-sequential identifier from local numbering system or emergency NHS number, prefixed by an agreed letter to denote it is an unknown patient (see resources). If this is not possible due to local IT system incompatibility, then a non-sequential series of digits should be used with the HB/T or hospital code added to the patient's wristband. *Suggested prefix of 'e' for emergency numbers.*

For **DOB** the convention of using 01Jan1900 for adults and 01Jan2000 for children has become impractical. Using the same DOB for any unidentified patient may also lead to misinterpretation of pathology results as normal ranges are given by age and do not meet age-related transfusion guidelines.

The optimum option is to combine 01Jan with an estimated year of birth e.g. 01Jan1950, 01Jan2015. While unlikely to be the patient's true age, this approach is safer than using a standard DOB.

For neonates below the age of 1 year an estimation of months would be required.

For **sex**, a determination of the patient's sex as assigned at birth should be made based on the evidence available; **note:** this may not be the same as the gender the patient identifies as.

This PSN signposts resources for safer temporary identification of unknown patients, including random name and number spreadsheets/generators[3,4] and the associated Emergency Preparedness Resilience and Response (EPRR) standards[5].

Patient Safety Incident Data
The Serious Hazards of Transfusion (SHOT) Annual Report (2020)1 identifies 207 errors involving incorrect patient identification.

SHOT also state that 'There should be a clear, defined procedure for allocation of emergency identifiers in all hospitals. For HBs/Ts in Wales, this should be in accordance with the patient safety notice 'Safer temporary identification criteria for unknown or unidentified patients''.

4. Establish capability of all current IT systems to ensure they can accept the proposed name and number format.

5. Identify actions to address problems relating to the capability of current IT systems to enable the implementation of this notice.

6. Ensure a robust system for the management and merging of a patient's medical records is implemented once identity is confirmed.

7. Ensure that a communication plan is established so that all relevant staff are informed of changes.

Resources
Resources to support the implementation of this PSN, including an edited randomised phonetic alphabet list are available from the NHS Improvement website Resources to support safer temporary identification criteria for unknown or unidentified patients | NHS Improvement (nationalarchives.gov.uk)

References

1. SHOT 2020 SHOT-REPORT-2020_V2.0_Chapter-14.pdf (shotuk.org)

2. BSH Milkins C, Berryman J, Cantwell C, et al. Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories. Transfus Med 2013;23(1):3-35. Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories -- 2013 - Transfusion Medicine - Wiley Online Library [accessed 25 March 2021].

Emergency Preparedness Resilience and Response (EPRR)

The biggest transfusion risk in the context of Major Incidents is the accidental transfusion of ABO incompatible blood due to misidentification. This notice provides guidance for temporary identification to accommodate hospital transfers, which cover names, temporary numbers and options for indicating age. It is recommended that Transfusion Teams discuss this notice and have local clinical agreements in place, which are compatible with their LIMS.

Guidelines for identifying "unknown" patients in emergency and mass casualty situations recommend non-sequential unique patient identifiers and gender as a minimum requirement. This is particularly important if several unknown patients are admitted together. All samples, whether from known or unknown patients, should also include the date and time of sampling and signature of the person taking that sample.

Stakeholder engagement

- Digital Health & Care Wales (DHCW), Service Management Board
- Welsh Blood Service (WBS)
- Blood Health National Oversight Group (BHNOG) Blood Health National Oversight Group - BHNOG (wales.nhs.uk)
- Health Board Transfusion Teams
- EPRR
- Health Board ED Teams/South Wales Trauma Network
- All Wales Patient Safety Solutions Reference Group (consultation with HBs/Ts).
- Welsh Government Clinical leads relevant to this issue.

3. Stanworth S. Dowling K.Curry N Doughty H Hunt B,et al., A guideline for the haematological management of major haemorrhage: A British Society for Haematology Guideline. British Journal of Haematology, 2022;198:654-667. Haematological management of major haemorrhage: a British Society for Haematology Guideline - Stanworth - 2022 - British Journal of Haematology - Wiley Online Library

4. BSH Robinson S, Harris A, Atkinson S, et al. The administration of blood components: a British Society for Haematology Guideline. Transfus Med 2018;28(1:3-21. The administration of blood components: a British Society for Haematology Guideline - Robinson - 2018 - Transfusion Medicine - Wiley Online Library [accessed 25 March 2021].

5. Emergency preparedness, resilience and response guidance for UK hospital transfusion team. Emergency preparedness, resilience and response guidance for UK hospital transfusion teams - Doughty - 2020 - Transfusion Medicine - Wiley Online Library

Share any learning from local investigations or locally developed good practice resources by emailing:

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