



Patient Safety Alert

Safer temporary identification criteria for unknown or unidentified patients

5 December 2018

Alert reference number: NHS/PSA/RE/2018/008

Resource Alert

Emergency departments (EDs) often care for patients unable or unwilling to give their identity including people who are unconscious or who have a critical illness, people with a mental health condition or delirium, and people affected by drink or drugs. Several unidentified patients may arrive together after an accident, or in mass casualty situations. Giving a unique identity to each unknown patient ensures safe and prompt diagnostic testing and treatment. For example, it helps prevent allocating blood test results to the wrong patient and fatal ABO incompatible blood transfusion.^{1,2,3,4}

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

- the same or similar names, eg unknown male, unknown female
- pre-allocated numbers that differ sequentially by one digit, eg T0000123, T0000124
- identical dates of birth (DOB), eg 01.01.1900.

These systems create a risk of misidentification compared to other patients for whom first name and surname, unique NHS number and individual date of birth are all used. Also, temporary numbers that are unique locally may not be suitable when a patient transfers between hospitals. While many EDs have created less error-prone combinations of identifiers, their differing practices can confuse staff when changing jobs and moving between hospitals.

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

For **temporary numbers**, a distinctive method is to prefix a randomly generated seven-digit number (see resources) with the relevant standard NHS trust code (eg RPH). If this is not possible due to local IT system incompatibility then any randomly generated series of digits should be used, with the trust code or name added to the patient wristband.

For **DOB**, the convention of using 01Jan1900 for adults and 01Jan2000 for children has become impractical: pathology systems can reject 1900 as implausible and 2000 no longer indicates a child. Using the same DOB for any unidentified patient may also lead to misinterpretation of pathology results because normal ranges are given by age and does not meet age-related transfusion guidelines.

The best option is to combine 1 Jan with an estimated year of birth, eg 01Jan1950, 01Jan2015. While unlikely to be the patient's true age, this approach is safer than using a standard DOB.

This alert signposts resources for safer temporary identification of unknown patients, including random name and number spreadsheets/generators and the associated emergency preparedness resilience and response (EPRR) standards⁵ and blood transfusion standards on identification.^{3,4} The resources are available via the [NHS Improvement website](#).

Actions

Who: All organisations with emergency departments*

When: To begin as soon as possible and be completed by 5 June 2019

- 1 Identify a leader who can bring together key parties including hospital informatics, emergency admissions, major incident response and pathology services.
- 2 Develop a system for the unique temporary identification of unknown patients using: the numbering system outlined in this alert, sex, estimated DOB, and 'name' based on non-sequential phonetic alphabet.
- 3 Ensure all IT systems can accept the names and numbers in these formats.
- 4 Develop a robust system for merging medical records once a patient's identity is confirmed.
- 5 Communicate the key messages in this alert and your organisation's plan for safer identification systems to all relevant staff.

*The actions in this alert are directed at EDs or equivalent services (that is, services providing similar investigations and treatment for patients who arrive directly).

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Alert stage: Two - Resources

Patient safety incident data

The Serious Hazards of Transfusion (SHOT) Annual Report 2017¹ describes 115 errors involving incorrect patient identification.

Additionally, review and debrief following recent mass casualty events showed widespread variation in local policies and procedures for the identification of patients once they leave the care of the emergency rescue services and present to hospital. National standardisation of identification of such patients was recommended. Adding sex and estimated age were identified as helpful to ensuring safe and prompt diagnostic testing and treatment at local level while also facilitating best use of available blood products.

Resources

Resources to support the implementation of this alert, including an edited randomised phonetic alphabet list, are available via the NHS Improvement website <https://improvement.nhs.uk/resources/resources-to-support-safer-temporary-identification-criteria>

References

1. Serious Hazards of Transfusion Annual report 2017 <https://www.shotuk.org/wp-content/uploads/myimages/SHOT-Report-2017-WEB-Final-v4-25-9-18.pdf>
2. White J, Milkins C, Rowley M Labelling of transfusion samples from unknown patients in emergency situations. *Transfusion Medicine* 2013; 23 (Suppl 2): 30-71. Poster (PO57, page 53). <https://rdcu.be/bcbC4>
3. Hunt B, Allard S, Keeling D, et al A practical guideline for the haematological management of major haemorrhage: a British Society for Haematology Guideline. *British Journal of Haematology*, 2015, 170, 788–803 <https://onlinelibrary.wiley.com/doi/full/10.1111/bjh.13580>
4. Robinson S, Harris A, Atkinson S, et al The administration of blood components: a British Society for Haematology Guideline. *Transfusion Medicine* 2017 <https://b-s-h.org.uk/guidelines/guidelines/administration-of-blood-components/>
5. Emergency preparedness resilience and response core standards <https://www.england.nhs.uk/ourwork/epr/r/gf/>

Stakeholder engagement

- Serious Hazards of Transfusion (SHOT) Haemovigilance Scheme
- NHS Blood and Transplant
- NHS England Emergency Preparedness, Resilience and Response
- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see <https://improvement.nhs.uk/resources/patient-safety-alerts/>)

Advice for Central Alerting System officers and risk managers

This alert asks for a systematic approach to deciding how your organisation identifies unknown patients and therefore needs co-ordinated implementation rather than separate action by individual teams or departments. If you are unsure who will do this, seek initial advice from someone in your trust such as the emergency department matron or clinical director, emergency planning liaison officer and/or accountable emergency officer, who will be able to identify the key individuals needed to lead and co-ordinate implementation.

Although the alert is directed at organisations with emergency departments or equivalent services, some principles may be helpful to other services that admit patients unwilling or unable to identify themselves eg mental health services.

Sharing resources and examples of work

If you are aware of any resources or examples of work developed in relation to this alert that you think would be useful to others, please share them with us by emailing patientsafety.enquiries@nhs.net