Belfast Health and Social Care Trust
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Reference No: SG021/08

Title:	**Management of Unidentified Patients**		
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Ownership:	[redacted] Nursing and User Experience Director		
Approval by:	Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting	**Approval date:**	07/03/2019 04/04/2019 12/12/2019
Operational Date:	March 2019	**Next Review:**	March 2024
Version No.	3 **Supercedes**	V2 – March 2011 – May 2014	
Key words:	Emergency identification system, unique identification, pre-allocated hospital number, temporary identification details.		
Links to other policies	• Patient Identification Policy (Reference No: SG 20/08) • BHSCT Major Incident and Mass Casuality Plan (Version 6 15 Dec 2017)		

Date	Version	Author	Comments
November 2018	2.1	[redacted]	Policy review – change of date only
02/01/2019	2.2	[redacted]	Including comments from reviewers
03/01/2019	2.3	[redacted]	Screening outcome and references
22/01/2019	3	[redacted]	Inclusion of comments from ED

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1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

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, young children or babies 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.

This policy outlines the implementation of an alternative, unique identifying process so that appropriate care can be safely provided without delay.

The policy also considers amalgamation of the alternative identifier with the patient's correct identification details when these are confirmed.

1.2 Purpose

To provide an Emergency Identification System for situations where it is not possible to confirm the identity of patients in order to:

- Provide robust and unique identification for patients of unknown or uncertain identity
- Ensure investigations, blood samples, other clinical specimens and medications and blood components meet the minimum labeling requirements

And to outline the correct mechanism for merging emergency alternative identifying information with the patient's correct identification details when these are confirmed.

1.3 Objectives

To ensure that patients of unknown or uncertain identity:

- Are given alternative unique identification details as soon as they are admitted to a hospital in the BHSCT
- Have appropriate investigation and clinical treatment without delay
- To ensure that documentation, blood specimens and other investigations can be linked to the patient concerned at all times during their hospital admission.
- To minimise the risk of patient identification error and consequent inappropriate treatment.

2.0 SCOPE OF THE POLICY

This policy applies to all Belfast Trust facilities where emergency healthcare care is provided.

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3.0 ROLES/RESPONSIBILITIES

All clinical and administration staff involved in registering or checking the identification of a patient.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

Patients can be admitted to hospital requiring emergency medical treatment but unable to give staff their correct identification details

- Forename
- Surname
- Date of Birth
- Hospital Number/NHS Number
- Gender

A patient may not be able to confirm their identity for a variety of reasons:

- Depressed level of consciousness,
- Confusion
- Dysphasia
- Memory loss
- Young child
- Severe learning difficulties
- Unable to communicate adequately in the English language.

The safety of unidentified patients is compromised because the criteria for the normal checking procedures are absent. This risk of personal harm is therefore heightened when the patient is Unidentified.

It is vital that all patients have unique identification details from the time of arrival in hospital so that documentation, blood samples, other specimens and investigations can be linked to the correct patient at all times.

Urgent medical treatment must never be delayed because of lack of or uncertainty in a patient's correct identification details.

In order to expedite appropriate clinical investigations and treatment with minimal risk of wrong patient incidents, each hospital within the Trust must have a mechanism for rapid generation and allocation of temporary identification details.

As soon as a patient's correct identity has been confirmed, the hospital's patient administration system (PAS) should be accessed by an authorized member of staff to merge temporary identification details with confirmed patient identity and with any pre-existing hospital number(s) The latter

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facilitates retrieval of pre-existing clinical notes for optimisation of safe patient care.

4.2 Key Policy Statement(s)

4.3 Policy Principles

- If the patient is unable to confirm their identity, staff should attempt to do this 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.
- Patients of unknown or uncertain identity must be issued a unique pre-allocated hospital number and temporary unique identification details as soon as they are admitted to hospital
- Emergency Department staff are responsible for ensuring that a pre-allocated number is issued for the unidentified patient.
- Emergency Department staff are responsible for ensuring that two identity bands that state the pre-allocated number and temporary identification details are applied on two of the patient's limbs.
- The temporary unique identification details and pre-allocated hospital number must be entered in all patient documentation e.g. drug charts, consent forms, specimens accompanying request forms, identity band
- The temporary unique identification details and pre-allocated hospital number should continue to be used until the patient's correct details are confirmed.
- When the patient's identity (name with correct spelling and date of birth)is confirmed, it is the responsibility of the clinical unit currently looking after the patient to immediately inform the appropriate Health Records Department.
- The hospital's Patient Administration System (PAS) must be updated, by merging temporary with correct patient identification details and by merging the pre-allocated hospital number with any pre-existing hospital number. This will allow amendments to be made to the Patient Master Index.
- A repeat Group and Screen sample must be sent to the blood bank with the correct patient identity details on the request form, for cross-referencing with the temporary unique identification details.

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- Two patient identity bands with the confirmed patient identification details must be applied to two limbs.

- Note that the initial identity bands with temporary identification details must remain on the patient until all prescribed blood components are either transfused or no longer required.

- When the identity is realised, any pre-existing hospital clinical notes for the patient should be brought to the clinical unit looking after the patient. Current clinical documentation must be merged with pre-existing clinical notes with the patient's original hospital number.

- The Manual Register, held in a central location (Health records or Accident and Emergency department) must be updated as soon as the patient's correct identification details are confirmed.

- Temporary unique identification details and pre-allocated hospital number must cross-referenced to the patient's correct identity and any pre-existing hospital number(s).

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy will be published in the Trust's formal documents library, accessible through the Trust Hub.

- All clinical and administration staff involved in registering or checking the identification of a patient should be aware of this policy.
- All staff working in the Emergency Department should be aware of this policy.
- All staff registered for Trust Escalation and Major Incident Rota should be aware of this policy.

5.2 Resources

None

5.3 Exceptions

None

6.0 MONITORING

Following any occurance where the use of temporary identification measues are taken,an audit of patient care including the timeliness of treatment should be audited.

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7.0 EVIDENCE BASE / REFERENCES

"*Safer temporary identification criteria for unknown or unidentified patients*"
NHS Improvement, December 2018

8.0 CONSULTATION PROCESS

The following groups were involved in the review of this policy

- Emergency Department
- RBHSC
- Laboratories
- Health/Medical Records
- Emergency Planning

9.0 APPENDICES / ATTACHMENTS

None

10.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

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A full data protection impact assessment <u>is not</u> required ☒

<u>If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.</u>

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

[redacted]

_____ **Date:** 22/01/2019

[redacted]
Author

[redacted]

_____ **Date:** 22/01/2019

[redacted]
Director

Agreed