Wake Forest Baptist Medical Center	**Patient Identification** Lab Admin 15 Formerly: PPB-WFBMC-83	**Type:**	**TIER 2**
		Original Effective Date:	**7/2002**
		Current (Revised) Date:	**2/2015**
		Contact:	**Clinical Compliance & Regulatory Services**
Approval Signature:		**Date Approved:**	2/26/15
Name and Title: Russell M. Howerton, MD, VP Clinical Operations, CMO			
Approval Signature: Cathleen Wheatley		**Date Approved:**	2/26/14
Name and Title: Cathleen A. Wheatley, VP Clinical Operations, CNE			

1) **General Policy Statement:**

The purpose of this policy is to establish that two patient identifiers must be utilized for reliable patient identification; as well as to provide guidelines for the identification process prior to performing any specimen collection, administration of medications, blood product infusion, treatment, procedure or surgery, to ensure that the appropriate task or intervention is administered to the appropriate patient.

a) **Scope**: All WFBMC employees, faculty and staff are responsible for complying with this policy. This policy also applies to Ambulatory Clinics except for ID bracelet requirement.

b) **Responsible Department/Party/Parties**:

i.	Policy Owner:	Clinical Compliance & Regulatory Services
ii.	Procedure:	All departments within the Medical Center and Ambulatory Clinics who have patient contact
iii.	Supervision:	All managers with employees who have patient contact
iv.	Implementation:	All departments within the Medical Center and Ambulatory Clinics

2) **Definitions:** For purposes of this Policy, the following terms and definitions apply:

a) ***WFBMC***: Wake Forest Baptist Medical Center and all affiliated organizations including Wake Forest University Health Sciences (WFUHS), North Carolina Baptist Hospital (NCBH), all on-site subsidiaries as well as those off-site governed by WFBMC policies and procedures.

b) ***Policy***: As defined in the Policy on Creating and Amending Policy, a statement of principle that is developed for the purpose of guiding decisions and activities related to governance, administration, or management of care, treatment, services or other activities of WFBMC. A policy may help to ensure compliance with applicable laws

and regulations, promote one or more of the missions of WFBMC, contain guidelines for governance, and set parameters within which faculty, staff, students, visitors and others are expected to operate.

3) Policy Guidelines:

A. Verification of patient identity should occur at the time of registration.

B. Upon presentation to the Admitting Office, the patient shall be asked to show proof of identity. The following are examples of acceptable forms of identification: Driver's License, Social Security Card, Insurance Card or Passport.

C. Staff shall not state name and date of birth for patient to confirm; instead this information must come from the patient and staff shall confirm that appropriate identification has been made. Even if patients are known to staff the patient must still be appropriately identified by having the patient state his/her name and date of birth.

D. Patients presenting for admission through other avenues, such as direct admissions from the clinics or transfer from other organization, that do not have a hard copy form of identification, should be asked to state his/her full name and date of birth.

E. If a patient is unable to assist with verifying their identity, a family member or designated person may be approved to assist with identification of the patient.

F. Prior to presentation to a patient care area, Admitting Office personnel are responsible for placing an identification (ID) bracelet on the patient during the registration process.

G. An identification bracelet should be placed on the patient upon arrival to the patient care area when directly admitted from a location other than the Admissions Office.

H. Placement of the ID bracelet on the patient's ankle is acceptable in situations when wrist placement is inappropriate.

I. The admitting nurse, or designee, places the ID bracelet on the patient after verify that the patient's full name and date of birth are correct.

J. Verification of patient identification by staff shall be completed by having the patient state his/her full name and date of birth, and comparing that information to the document label on the paper or electronic chart. Medical record number may also be utilized if necessary as a patient identifier.

K. The patient or patient's family should be utilized in the patient identification process, when appropriate.

L. Trauma patients, whose identity is unknown, are assigned a medical record number and a Trauma Identification Number. In the Emergency Department, patient identification information on the ID bracelet is compared to the document label on the order sheet.

M. Each patient should wear an arm or ankle identification bracelet during their entire hospitalization. In situations where placement of a bracelet on an extremity is not feasible due to patient condition, a reasonable alternative that meets identification standards may be used. If the alternative method is chosen, staff needs to follow the same identification process of all patients in that area at all times. The following is *an example* of an acceptable, reasonable alternative:

- A photograph of the patient is placed in the clinical record, where patient's name and medical record number can be verified when visual identification by staff is necessary.

Placing the ID bands or patient ID labels on bed rails, head or footboards, bedside charts, tables, computers, or note cards/worksheets, are not acceptable alternatives.

N. All staff members are responsible for ensuring correct patient identification throughout the hospitalization.

O. If an identification bracelet is removed from a patient for any reason (soiled, unreadable or does not contain current information), the person removing the bracelet, or who finds it missing, is responsible for the following actions:
- Whoever removes a bracelet should notify nursing personnel that it has been removed.
- Nursing personnel will prepare a replacement bracelet as soon as possible.
- The Unit Secretary, under the direction of the Registered Nurse, is responsible for making identification bracelets on the nursing units.
- Verification of patient identification and the information on the bracelet is completed by nursing personnel prior to placement of the new bracelet on the patient.

P. Any discrepancies discovered with the patient's identity must be resolved prior to proceeding with the collection/administration process.

Q. Specimens received in the laboratory without a label, or are mislabeled will be discarded, with the exception of irretrievable samples. Irretrievable samples are tissue or fluid samples that cannot be replaced.

R. The ordering location will be notified of any labeling error and the disposition of the samples. The physician, charge nurse, or nurse taking care of the patient will be notified in the event of a mislabeled or unlabeled sample that is irretrievable. Requests to correct labeling errors of irretrievable specimens must be approved by the Department of

Pathology resident-on-call. Labeling corrections must be made in the laboratory by the person collecting the sample and documented appropriately.

4) **Review/Revision/Implementation**
   a) **Review Cycle**: This policy shall be reviewed by Legal at least every three years from the effective date.
   b) **Office of Record**: After authorization, the Legal Department shall house this policy in a policy database and shall be the office of record for this policy.

5) **Related Policies**
   None

6) **Governing Law or Regulations**
   The Joint Commission. (2015) Hospital National Patient Safety Goals NPSG.01.01.01

7) **Attachments**
   None

8) **Revision Dates**
   12/04, 1/09, 9/11, 7/13, 4/14, 2/15