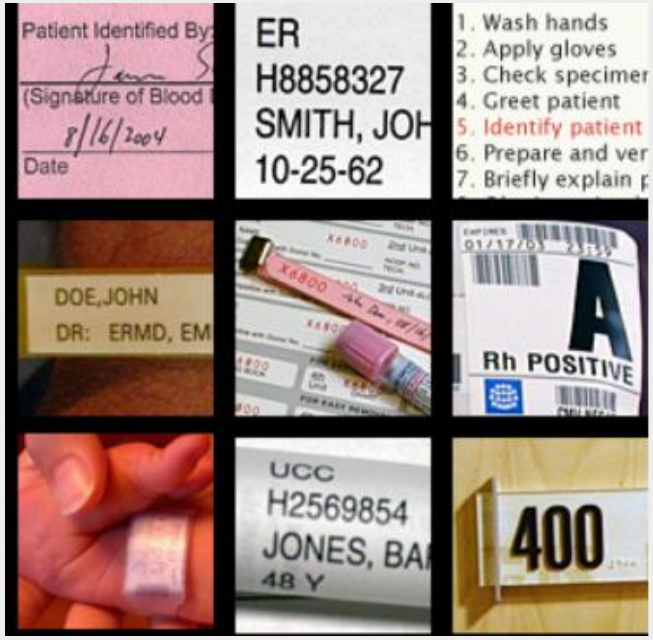
UnityPoint Health

Patient Identification

MARCH 2017

Introduction



After reviewing this information, technical staff will be able to:

List the identifiers needed in patient ID

Define double checking and why it is critical to patient ID

Describe how to maintain the link between patient, tests ordered, and specimen label.

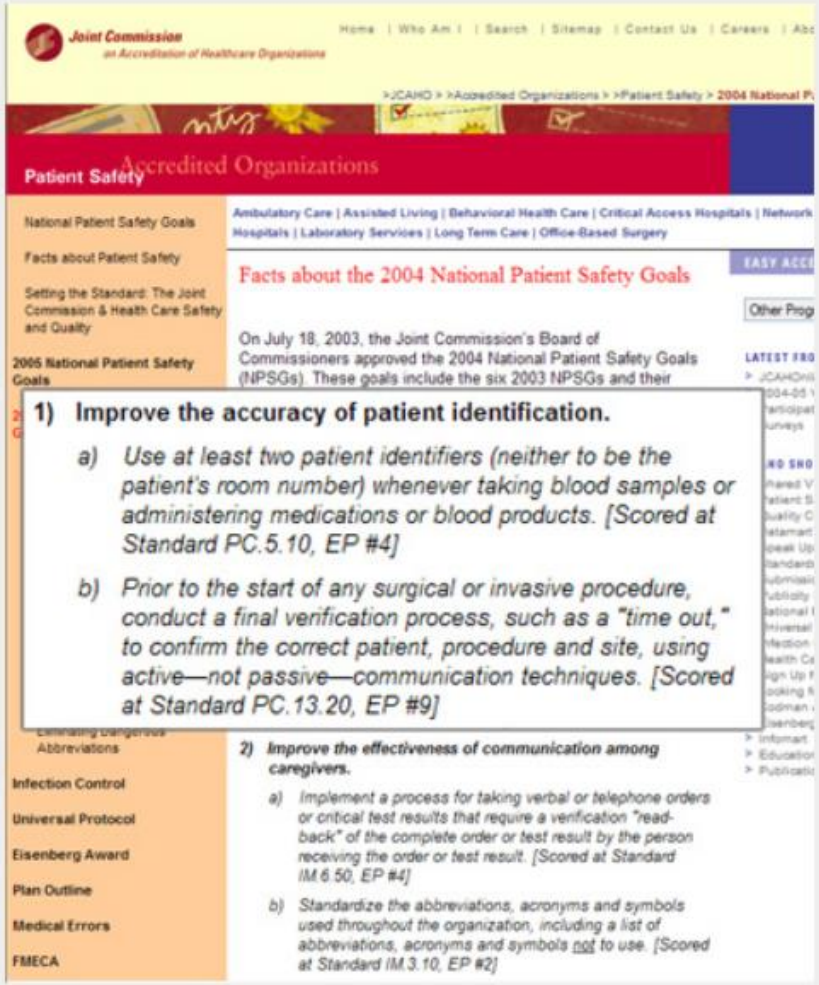
Overview

One of the critical challenges in the laboratory testing process is to identify the patient, transfer the ID to the specimen and maintain this link throughout the entire testing process. If a specimen is not linked to the correct patient, all other laboratory processes are invalid, and may lead to incorrect diagnosis, treatment, or even death of the patient.

A thorough understanding of a standard patient ID procedure combined with the determination to detect discrepancies and eliminate doubt in patient ID is key to avoiding errors.

Laboratory Regulations

JACHO



Laboratory accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organization (JCAHO), College of American Pathologists (CAP), American Association of Blood Banks (AABB) all have standards for patient ID.

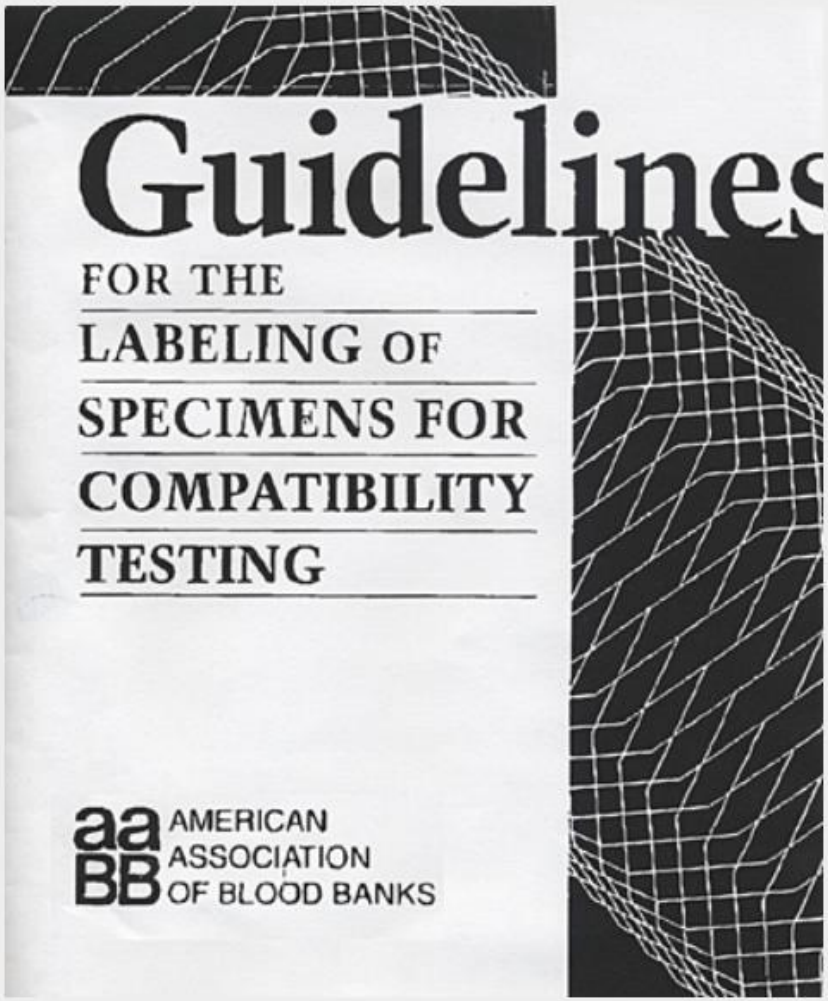
The primary 2004 National Patient Safety Goal published by JCAHO is:

1. Improve the accuracy of patient identification.

These goals are derived from research and consensus aimed at identifying the most pressing issues to patient safety.

Laboratory Regulations

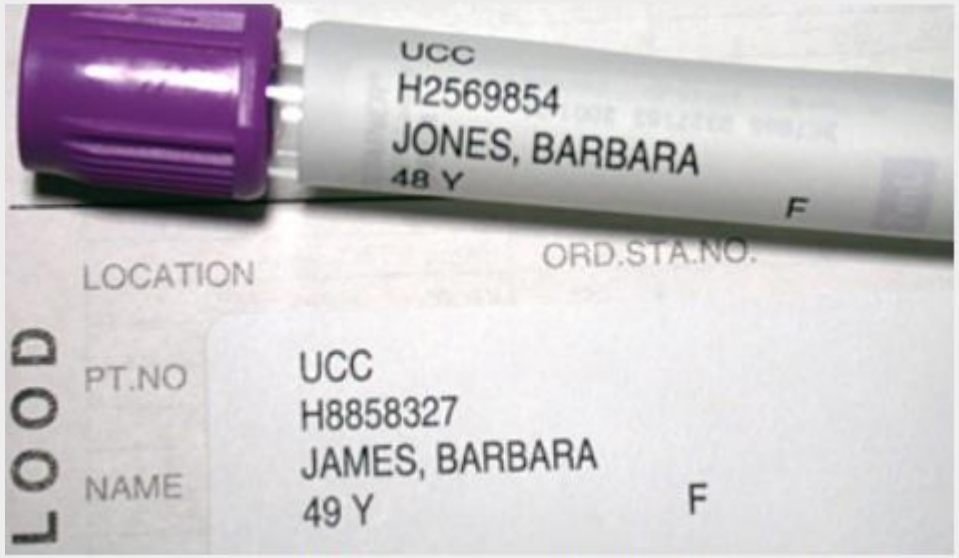
AABB



The American Association of Blood Banks (AABB) standards include:

Requests for blood or components and records accompanying blood samples from the recipient shall contain sufficient information to uniquely identify the recipient, including 2 independent identifiers. The transfusion service shall accept only complete accurate and legible requests. AABB 5.11.1

Key Principles



This tube was packed with the incorrect requisition

Quality laboratories, have a standard ID procedure, training and competency assessment programs, and double check systems to detect mistakes.

The critical links that must be reviewed by technical staff are:

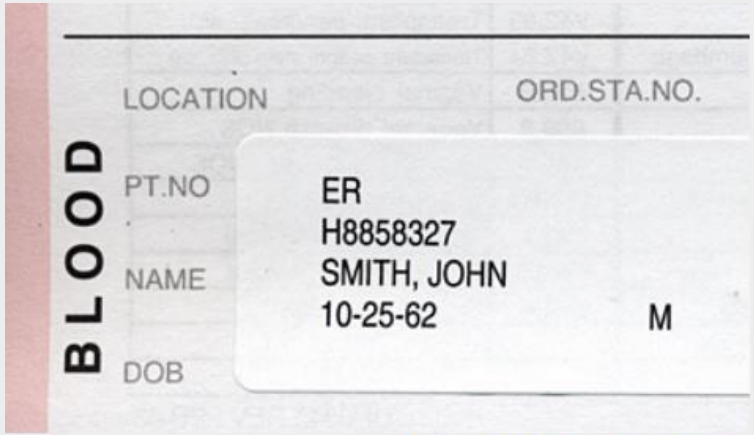
1.The patient ID on the lab order

2.The patient ID on the specimen label

Both of these IDs must be compared and match exactly. This is called a **2-Way Exact Match**.

Whether collecting blood, urine, or any other specimen for laboratory testing, a standard ID procedure must be followed.

Identifiers



Patient Identifiers on a requisition form

Every patient must be positively identified using two identifiers:

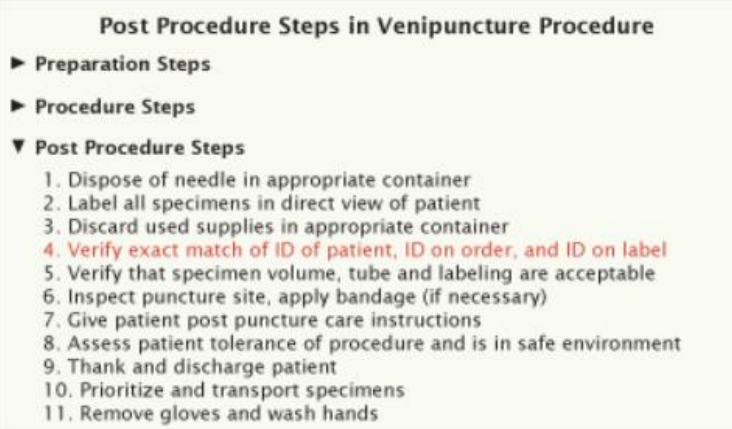
1. Full name
2. A numeric secondary identifier

Many patients have the same name so always check the first name and last name.

In addition to first and last name, always check the numeric secondary identifier as specified by our policies.

Examples of reliable secondary identifiers include: date of birth (preferred), social security number, and medical record number. The secondary identifier cannot be a hospital room number. Patients change rooms often so a room number is never a reliable identifier.

Detecting Errors



Double check systems are used to reduce the possibility of human error. Any ID system by itself is not foolproof. The best lab ID procedures perform checks at multiple points throughout the laboratory testing process.

To ensure that the specimen is linked to the correct patient, double check ID information for a 2-Way Exact Match:

1. Patient ID on the specimen, and

2. upon computer entry into the laboratory information system.

In a national study, it was found that in 8% of cases there were discrepancies between patient ID, lab orders and specimen label information.

Quality Indicators

Patient identification directly affects two quality indicators on our dashboard. They are "Mislabeled/Unlabeled Specimens" and "Wrong Result Verified".

Please see the dashboard below.

UnityPoint Health Methodist

Methodist Main Lab Quality Indicators Dashboard 2017

Clinical Main Lab Only Indicators - 2017	Monthly Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2017 YTD
Mislabeled/Unlabeled Specimens	2	2	2											
% of Routine AM draws from Acute Care Floors completed by 6 am	85%	N/A	N/A											
% of STATS collected by Lab on Acute Care Floors within 30 Min of Order	80%	N/A	N/A											
% of Timed Studies Collected on Acute Care Floors within 30 min of Expected Collection	80%	N/A	N/A											
Delay – Collection Delays	2	0	1											
Delay – Receiving Delays	3	10	8											
Delay– Testing/Processing Delays	5	8	3											
Wrong Test Ordered/Test Not Ordered	3	1	2											
Lost Specimens (goal <5 per year)	0	0	2											
Wrong Result Verified	4	10	5											
Specimen Recollections Required Due to	monitor	14	4											

Conclusion

- Throughout the health-care industry, the failure to correctly identify patients continues to result in medication errors, transfusion errors, testing errors, and wrong person procedures.
- Regardless of the technology or approach used for accurately identifying patients, careful planning for the processes of care will ensure proper patient identification prior to any medical intervention and provide safer care with significantly fewer errors.
- The following strategies must be implemented:

  It is a responsibility of technical staff to check the identity of patient specimens and match the correct patients with the correct care (e.g. laboratory results, specimens, procedures) before that care is administered.

  Technical staff must question laboratory results or other test findings when they are not consistent with the patient's clinical history.

Thank You

UnityPoint Health