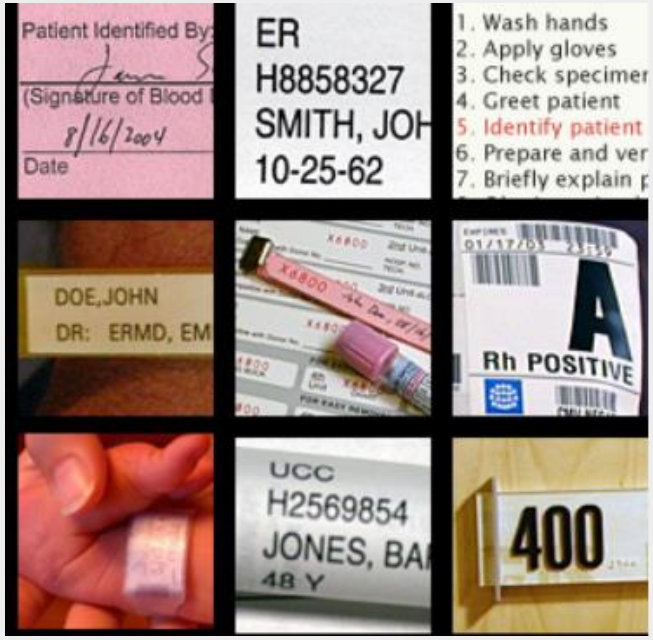
UnityPoint Health

Patient Identification

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.

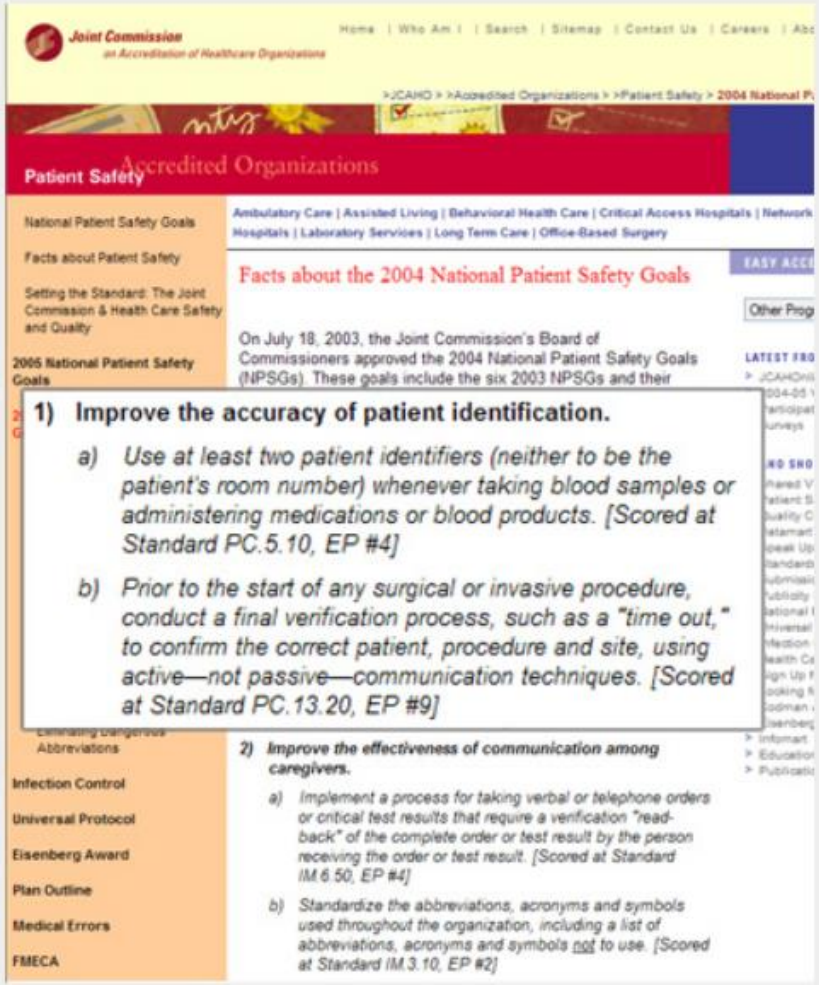
Overview

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.

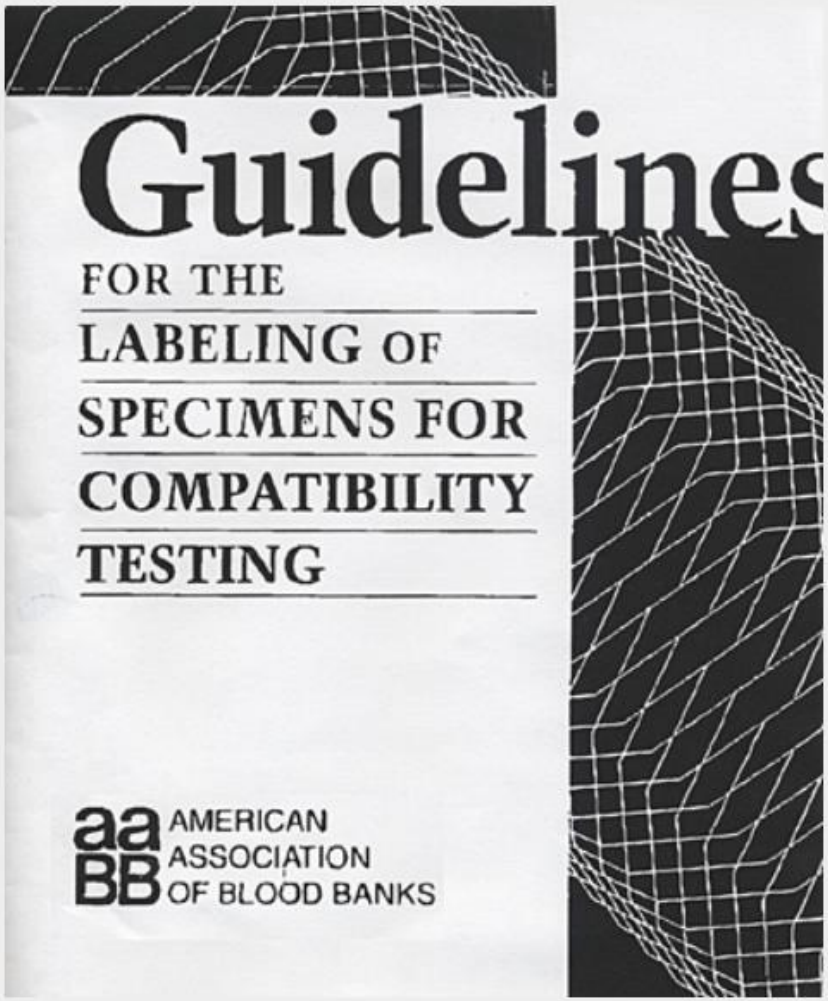
The primary 2004 National Patient Safety Goal published by JCAHO is:

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

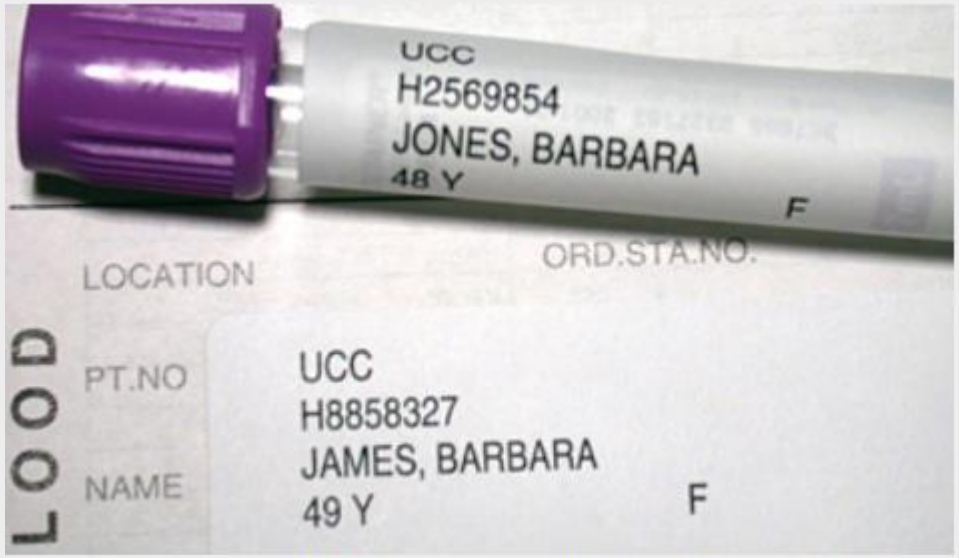
AABB



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:

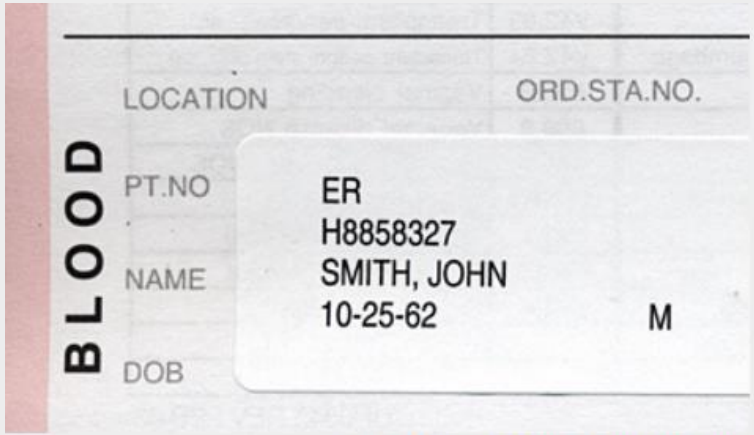
1.The patient ID on the lab order

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:

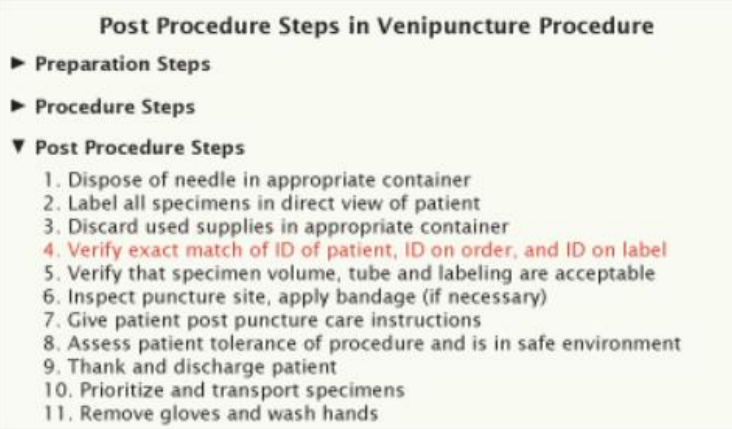
1. Full name
2. A numeric secondary identifier

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
Proctor

Main Lab Quality Indicators Dashboard - Proctor Laboratory

Clinical Main Lab Only Indicators - Performance Improvement 2017	Monthly Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2017YTD	2016 YTD
Mislabeled/Unlabeled Specimens (Lab Only)	1	0	0	0	1	0	0	0	1	1	1	1		5	6
Stroke Pt ED Door to Lab Result <46 85 %	>85%	50.00%	66.70%	50.00%	53.80%	55.60%	66.70%	72.70%	66.70%	58.80%	89.50%	54.50%		62%	68.3
Stroke Pt Receipt to Lab Result < 26 minutes	> 90%	77%	66.70%	83.3	69%	100%	66.70%	91.80%	66.70%	82%	84.20%	63.6%			67.1
% of Routine AM labs reported by 0730	95%	94.0%	93.0%	94.6%	95.5%	95.8%	93.9%	95.0%	96.9%	93.2%	95.7%	97.3%		95.0%	94.5
Blood Culture Contamination Rate, PERCENT (ED)	3%	1.2%	2.0%	3.70%	2.00%	1.00%	0.80%	1.40%	1.30%	2.30%	0.80%			1.65%	2
Delay - Testing/Reporting Delay	3	2	2	3	0	1	7	2	9	6	17	1		50	40
Wrong Results/Corrected Reports	3	5	4	6	5	2	3	4	5	4	13	10		61	42
ED TAT (Collect to Results (avg<45 min) (CBC,PT,MP,Trop)	avg < 45 min	40	39	43	41	38	34	39	38	38	35	37		38.4	40.9
(Collect to Result) % of ED Tests Resulted within 45 min	90%	72.4%	74.8%	65.3%	67.1%	70.4%	79.6%	76.3%	74.3%	73.4%	81.5%	74.4%		73.6%	67
ED TAT (Receive to Results (avg<=25 min) (CBC,PT,MP,Trop, HCG)	avg <=25 min	21	23	24	23.0	22	20	24	23	23	22	22		22.5	22.5
% of ED Tests Resulted within 45 min of RECEIPT	90%	96.6%	94.5%	92.7%	94.9%	95.0%	95.0%	93.5%	94.3%	93.5%	94.3%	93.8%		93.8%	93.8%
Frozen Section Turn around Time Specimen received to diagnosis issued	Avg TAT <20min	12.4	10.6	12.7	14.2	14.2	10.8	11.3	12.2	13.1	10.8			12.2	12.6 min
Proficiency Survey Exception Reports- Missed Analytes	1	0	0	0	3	1	1	2	1	0	1	1		10	15
Number of Lab Related Occurrences	NA	14	18	23	26	26	14	15	29	23	41	21		250	221
Number of occurences with Lab as Primary Department Involved	10	10	10	13	13	10	12	9	18	12	29	13		149	124

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