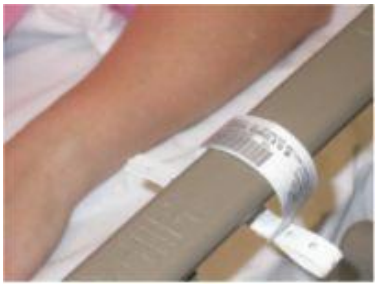
From the Center for Phlebotomy Education's Educational Toolbox

Blood Collector's ATM

Abbreviated Teaching Modules for staff development, competency, and classroom

Patient Identification #3206

How often do patients receive care without the healthcare worker ever verifying the patient's identification? Probably more than any of us can even imagine. Proper patient identification is critical and the first step in blood specimen collection. Unfortunately, proper patient identification is one of the most widely ignored patient-care processes. Ignoring this important first step also has the most potential to do harm. Most facilities have a process in place whereby an identification band is placed on the patient, whether an inpatient or outpatient. Is going by the patient's arm bracelet enough to properly identify the patient? Not according to CLSI (Clinical and Laboratory Standards Institute). CLSI's GP41 standard states the patient should be asked to state his full name, spell his/her first and last name, and provide a birth date. This information is to be checked against the identification bracelet and test requisition. Just verifying information on the wrist band against the requisition is not enough. It is not uncommon for wrist bands to have erroneous information or even be on the wrong patient. Patients who are unconscious, cognitively impaired, or do not speak the language of the phlebotomist must be identified by a family member or caregiver. Record the name and relationship of the person who identified the patient.



In the picture to the right, the ID bracelet is attached to the bed rail. Can this be used to identify the patient? No. The identification bracelet could have been from a prior patient who occupied that bed. It could also be the identification of the patient in the other bed in the room and the two patients just decided to trade beds. It happens, and not just with elderly patients who are cognitively impaired. It is important for the identification bracelet to be <u>on</u> the patient.

In one case of mistaken identity, two male patients were admitted at the same time to the same room from a nursing home. Both had identification bracelets placed on their wrists. Forty eight (48) hours later, a prn phlebotomist asked the patient in Bed One to state his name. It did not match his ID bracelet. The phlebotomist then asked the patient in Bed Two to state his name. It also did not match his ID bracelet. Each man was wearing the identification band meant for the other patient. How did this get by so many caregivers for forty eight hours? Obviously, proper procedure had not been observed. Fortunately, these gentlemen did not suffer any apparent harm, but it could have turned tragic if either had received medication they were allergic to or a blood transfusion. There have been unfortunate cases where this has occurred and led to patient death.

In some facilities, hand-held scanning devices have significantly reduced patient identification errors. This does not however, prevent errors from occurring when the ID band was placed on the wrong patient to begin with. There is no substitute for positively identifying patients by asking them to state their name and birth date and comparing that information with the identification bracelet and requisition. This holds true for outpatients as well. If patients get out of their chair in the waiting room when a name is called and follows the phlebotomist into the draw station, it does not mean they are the intended patients. A hearing-impaired patient could easily mistake another name for theirs, and if the phlebotomist does not follow proper patient identification procedure, they would not know they were collecting the specimen from the wrong patient. Failing to properly identify a patient can have tragic consequences.

Tubes must be labeled <u>after</u> the sample is obtained and while in the presence of the patient. To be sure the correct labels are affixed to the specimens; CLSI states the phlebotomist should ask the patient to verify that the labels on the tubes are correct. Alternatively, labeled specimens should be compared against the patient armband.

Healthcare workers can avoid a preventable tragedy by following CLSI standards for properly identifying every patient before collecting the specimen:

1. **Ask patients to state their full name, spell their first and last names, and provide their birth date. Do not say the information and request them to affirm it. Patients may not hear correctly and say yes. Patients should <u>STATE</u> their name and birth date.**
2. **Compare the STATED information with the identification bracelet, test requisition and labels.**
3. **Do not obtain any specimen until all discrepancies have been resolved.**
4. **Always label specimens while in the presence of the patient.**

5. Ask the patient to verify tube labels are correct or compare label with patient ID band.

Patient Identification #3206

Test your knowledge:

1. How will you know you are collecting a specimen from the correct patient?
   a) the requisition and identification bracelet on the patient match
   b) the room and bed number match the information on the requisition
   c) the patient has stated his/her full name, spelled the first and last names, and provided his/her birth date, all which match the identification bracelet and test requisition and labels
   d) the identification bracelet on the bed rail matches the requisition

2. When should an identification bracelet attached to a bed rail be used to identify a patient?
   a) when the patient is unable to speak
   b) an identification bracelet on a bed rail should never be used to identify a patient
   c) when the patient does not speak the same language as the phlebotomist
   d) when the identification bracelet on the rail matches the requisition

3. True or False
   An identification bracelet on a patient is adequate information to complete a specimen collection.

4. If there are any discrepancies of information between the patient's verbal statement, the identification bracelet, and the requisition, how should the situation be handled?
   a) the blood sample should not be collected until all discrepancies have been resolved
   b) to avoid delays, obtain the specimen then bring the issue to the supervisor's attention
   c) as long as the identification bracelet and requisition match the sample can be collected
   d) ask the patient for permission to obtain the sample

5. How should comatose patients be properly identified?
   a) as long as the identification bracelet and requisition match the sample can be collected
   b) ask a family member or other caregiver to identify the patient, then record the name and relationship of the person who identified the patient
   c) if nursing staff is busy and no family is available, proceed with the collection as long as all identifiers match
   d) note in the record that the patient is unable to state his/her name and proceed with collection

6. What are some consequences of patient or specimen misidentification?
   a) the patient may be treated according to another patient's blood work
   b) the patient may receive medication or a transfusion according to another patient's blood work
   c) the patient could suffer ill effects from treatment or death
   d) all of the above

7. True or False:
   CLSI states the tube should be labeled <u>after</u> obtaining the specimen, while at the patient's bedside, and the label should be verified by the patient or be compared with the arm bracelet for accuracy.

Name: _____ Date: _____

Facility/Supervisor_____ Dept: _____