

Patient Identification

The Foundation for a Culture of Patient Safety

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Patients, consumer advocacy groups, and regulatory and accrediting bodies have spoken out about the importance of patient safety in the health care environment. Understandably, patient safety is a leading concern for both consumers and health care providers. These efforts have encouraged health care organizations and providers to review and revise, as necessary, routine practices that contribute to a culture of patient safety and avoid medical errors. This article outlines the process and outcome of a performance improvement initiative to develop a standard patient identification policy. **Key words:** *patient identification, patient safety, performance improvement*

THERE HAS BEEN increasing media attention to issues of patient safety in health care. A consistent flow of news reports regarding breaches of patient safety are detailed by examples of "medical errors" such as incorrect procedures or treatments being performed on the wrong patient. In addition, patients, consumer advocacy groups, and regulatory and accrediting bodies have spoken out about the importance of patient safety in the health care environment. Understandably, patient safety is a leading concern for both consumers and health care providers. These efforts have encouraged health care organizations and providers to review and revise, as necessary, routine practices that contribute to a culture of patient safety and avoid medical errors.

In July 2001, the Joint Commission on Healthcare Organizations (Joint Commission) introduced revisions to its standards man-

ual¹ emphasizing patient safety. Standards were either revised, enhanced, or added under the following chapters: "Leadership," "Performance Improvement," "Management of Information," "Patient Rights and Organization Ethics," "Education," "Continuum of Care," and "Management of Human Resources." To strengthen the safety standards, the Joint Commission released the following in its August 2002 Internet news brief:

The Joint Commission's Board of Commissioners has approved for implementation effective January 1, 2003 a set of six National Patient Safety Goals representing 11 recommendations for improving the safety of patient care in health care organizations.

The Joint Commission 2003 National Patient Safety Goals and associated recommendations are:

1. Improve the accuracy of patient identification.
 - a. Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products. . . .²

Consumer advocacy groups and professional organizations such as the Agency for

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Healthcare Research and Quality, Institute for Healthcare Improvement, and Institute for Safe Medication Practices are continuously publishing or posting to their Web sites information regarding medical errors and patients.

At Memorial Sloan-Kettering Cancer Center, the importance of clarifying defined standards for patient identification was recognized as an essential initiative to enhance the existing culture and environment of safe patient care. Correct patient identification is essential prior to delivering care, treatment, or service. This becomes increasingly important in an environment where high-volume and/or high-risk procedures and treatments are delivered.

Clarifying, defining, or establishing processes or developing a standard of care in large complex organizations is always a challenge. An initial review and analysis of the identified process often indicates variation in its application across the organization—typically the impetus for the change. This makes it imperative that all identified stakeholders participate in the performance improvement process and that a team reflective of the stakeholders be established. To ensure the team's success, all attempts at seeking appropriate representatives must be explored. This does not always lend itself to the small team of 8 to 12 members recommended in the performance improvement literature.³ However, with appropriate planning and facilitation, a larger team is manageable.

PATIENT IDENTIFICATION PERFORMANCE IMPROVEMENT TEAM

In order to review, refine, and implement the organization's patient identification policies, a Patient Identification Performance Improvement Team was established. The goal of the team was to define and develop one patient identification standard to be applied consistently across all departments while accommodating all forms of patient care delivery. Because of its importance and its relationship to patient identification, the team was asked to include "specimen labeling" within its scope.⁴

The team consisted of over 20 members representing the following areas within the hospital: inpatient nursing, ambulatory nursing, perioperative services, pediatrics, medical staff, admitting office, pre-admission testing, pharmacy, administration, medical records, radiation therapy, quality assessment, unit secretaries, clinical laboratories, blood bank, pathology, radiology, escort service, and patient financial services.⁵

Prior to the first meeting, all department-specific written policies and procedures regarding patient identification and specimen labeling were collected and collated. These were distributed at the first team meeting with the expectation that team members would review them prior to the next meeting. This review would provide a "jumping off point" to begin the standardization process.

In order to engage the team during the initial meeting, a brainstorming session was conducted to identify potential causes for patient misidentification (see the box titled "Brainstorming Session: Potential Causes for Patient Misidentification"). This technique also was used as an opportunity to begin to educate the team on performance improvement tools, techniques, and statistical process control tools. Once the list of potential causes of patient misidentification was exhausted, the team engaged in an "affinity diagram" exercise. This was used to group similar causes and allow the team to prioritize and focus on specific areas as it moved forward. Six different categories emerged from the exercise: the patient as a source of information, organizational systems, information overload, upfront registration, processes/procedures, and human error (see Figure 1).

The first two team meetings proved extremely successful. The team's initial impressions were that this initiative was already raising institutional awareness of this important issue. Team members were appreciative of the broad representation at the meetings, their ability to gain consensus on the issues, and the opportunity to share their perspectives with other departments. The team also viewed this as a chance to improve performance improvement skills and participate in

**Brainstorming Session:
Potential Causes for Patient
Misidentification**

Procedure not followed
 Lack of clinical expertise
 Language barriers
 Answers to wrong name/spelling
 Yes or no answers
 Speed of practice
 Too many pieces (too much information/too much paper)
 Too many distractions
 Source of information
 Patients not involved in process
 Patient changed name
 Duplicate medical record number
 Defective "blue" cards
 Difficulty in reading numbers
 Different information than inpatient/outpatient blue card
 Identification bands removed
 Lack of automated system
 Patient false identification information
 Name cannot be corrected by appropriate department
 Lack of cooperation from different departments
 Too many labels generated and not disposed of properly
 Different ways of tracking patient location in clinic
 Relying on verbal information
 Same/similar names
 Assumptions (familiarity with patient)
 Patient assumption of clinician knowing him or her
 Patient cooperation
 Transcription incorrect
 Two cards; which source of patient identification is valid?
 Lack of "true standard" identification source
 Stamp incorrect (patient identification)
 No identification on order—blank forms
 Misfiling
 Written name stamped differently

Benchmarking with other organizations was determined to be an important part of the team's work. Individual team members contacted other hospitals and cancer centers to ascertain existing patient identification processes and practices. With the exception of patient identification wristbands, a customary practice in health care, little additional insight from health care organizations was obtained through the benchmarking process.

Team members also evaluated identification processes within other industries such as motor vehicle departments and the Social Security Administration to ascertain what documents were acceptable and required for processing consumer documents. Highly technological identification systems also were explored such as retinal scanning, fingerprinting, etc. These technologies were not considered to be an option within the organization at this point due to the required resources.

ESTABLISHING THE STANDARD

Defining the required elements for patient identification, regardless of the process, was seen as the first step in establishing a new patient identification standard. The elements would determine where the information would be collected and by whom, which source documents would be required, and where along the continuum of care these elements would be observed and/or verified. The team reached consensus and determined that the patient identification elements would be patient's name, date of birth, gender, and Social Security number or medical record number. The documents, which would be used to ascertain these elements, were determined to be driver's license, passport, visa, birth certificate, and Social Security card (see the box titled "Patient Identification Elements and Source Documents").

Defining the points at which patients would be identified was the topic of subsequent meetings. It was determined that the continuum of care would be an appropriate model for defining various points where the patient would be identified. It was decided that the

an important initiative. Some concerns that were raised initially by the team that would need to be addressed were: the enormity and complexity of the task, the focused attention that the team was receiving from senior management, the need to ensure the process would not take too long, technical/resource constraints, and, most important, how to get patient buy-in to the process.

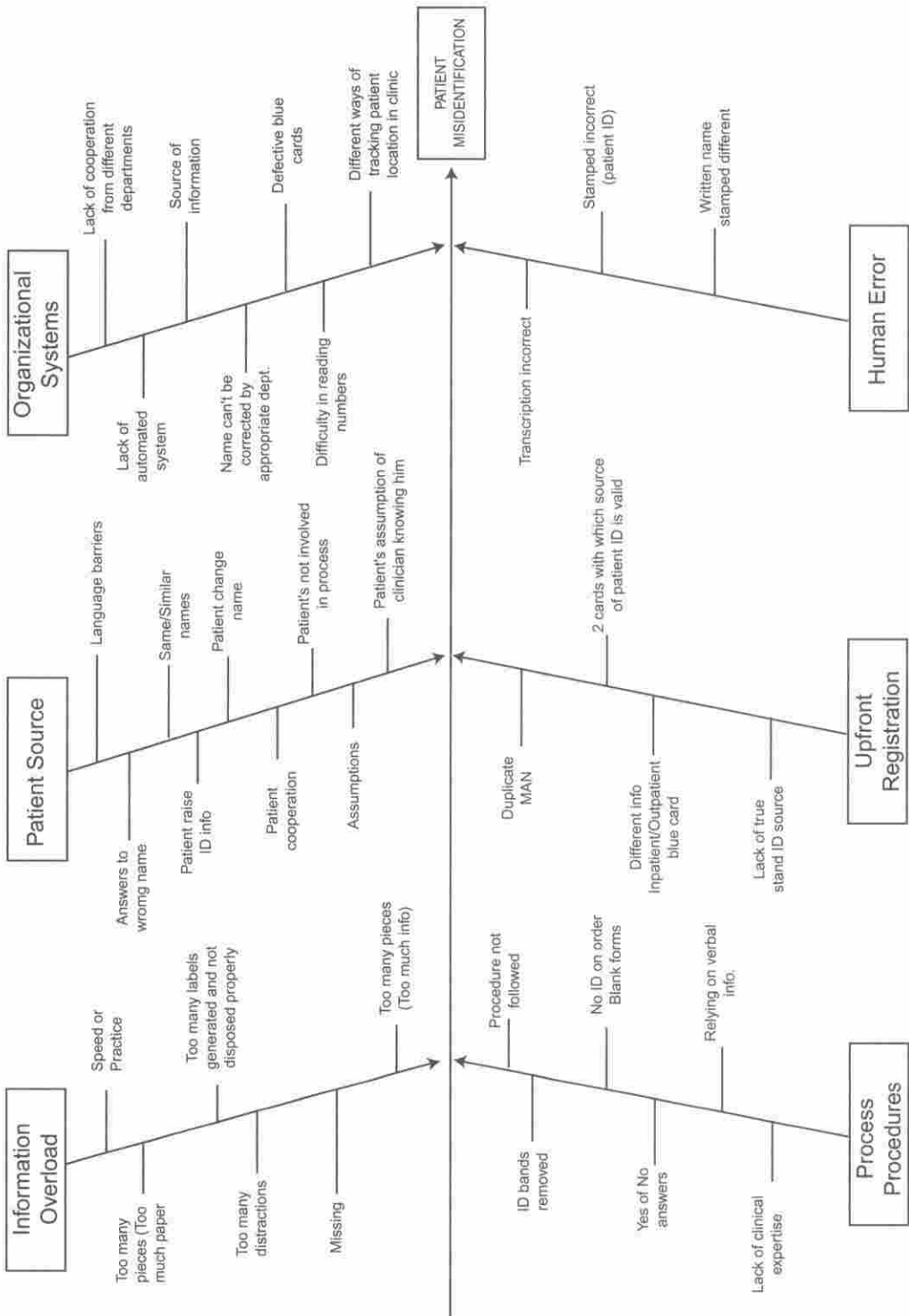


Figure 1. Potential causes for patient misidentification.

Patient Identification Elements and Source Documents

Patient identification elements
 Patient's name
 Date of birth
 Gender
 Social Security number
 Medical record number
 Source documents
 Driver's license
 Passport
 Visa
 Birth certificate
 Social Security card

same level of scrutiny would not be necessary at each point. Therefore, three levels of patient identification were established: new patient entry/registration; admission/transfer; and provision of care, treatment, and service.

New patient entry/registration is the most critical patient identification point along the patient care continuum. It is the point in the admission process where patient information and data are obtained and entered into the health information management system for the first time. Thus, it was at this point that the most stringent guidelines and criteria would be set. The process was established such that when patients present for the first time they would be asked to spell their last and first name, state their date of birth, and give their Social Security number. The employee obtaining the information would observe patients' gender and validate the requested data elements (name, date of birth, and Social Security number) by obtaining a picture identification card that corroborated the information. Only the following picture identification sources were deemed acceptable: state driver's license,

state identification card, passport, alien registration card, or government visa. For children age 17 and younger, a birth certificate is required; the parent or guardian must be identified according to the stringent patient identification policy detailed previously.

The next point along the patient care continuum of patient identification was defined as admission/transfer and placement of wristband. This step occurs for patients who are known to the hospital and are accessing service after it has been determined that a new patient entry patient identification has been completed. In order to perform this type of patient identification, the patient's information must exist in the hospital's information system. The following identification elements are required from the patient during this process: last name and first name spelled by patient; medical record number or date of birth stated by patient; or hospital card presented. This information must match exactly with the preprinted wristband and/or information in the health information system. Any mismatch immediately prevents further processing; a supervisor is notified of any issues that cannot be addressed. If a wristband is indicated according to policy, and all information correlates, it may be placed at this time.

The application of patient identification wristbands became a major discussion area for the team, posing barriers and delays to accomplishing team goals. Early in the team process, a recommendation to place wristbands on every patient was put forth. Many team members were opposed to implementing this recommendation in departments that traditionally did not place them (e.g., radiation oncology and ambulatory care). There was, of course, no opposition to placing wristbands in those areas in which they are typically placed (e.g., inpatients, preoperative patients, and urgent care patients). However, those areas with a large daily volume of patients and a perceived nontraditional patient environment (e.g., the ambulatory services center and radiation oncology where the same patient may be seen five days per week for six weeks) posed the greatest source of debate for

New patient entry/registration is the most critical patient identification point along the patient care continuum.

the team. To complicate the issues further, some departments (e.g., radiation oncology) had stringent identification processes in place (the use of patient photographs). It was determined through team consensus that individual departments would be permitted to apply a higher standard of patient identification; however, all departments would be required to comply with wristband requirements as outlined in the policy.

The universal application of patient identification wristbands in the ambulatory environment was another topic of major discussion and disagreement for the team. The team members were concerned about the volume of patients seen and the delay in processing that extra step would cause. Many team members also were concerned about the change in the ambulatory environment that was not "hospital-like" to an environment where patients would be "banded" as if in the hospital. The team reached consensus on establishing criteria for placing patient identification wristbands in the ambulatory environment for high-risk procedures or treatments. These procedures and treatments were defined as chemotherapy administration, blood transfusion, stereotactic radiosurgery, conscious sedation, intravenous hydration, Moh's surgery, and transfers to other units or facilities.

Senior management was consulted about the team's stumbling block regarding implementation in an ambulatory environment. It was recommended that a patient perception survey be performed regarding some of the team's recommendations for patient identification. Patient representatives were consulted to create a patient survey. A random sample of patients was asked the following three questions:

1. How would you feel about receiving a wristband before receiving chemotherapy, blood transfusion, intravenous hydration, or transfer to another facility?
2. How would you feel about receiving a wristband whenever you come for an outpatient visit even if not receiving chemotherapy (e.g., doctor visit)?
3. How would you feel about being asked your name and date of birth several times during your outpatient visit?

The results of the survey (Figures 2 through 4) indicated that most patients were in favor of being asked their name several times throughout their visit, or wearing a patient identification wristband for high-risk procedures if it was for their safety. The survey supported team recommendations to implement the use of patient identification wristbands in the ambulatory environment and allowed the team to reach consensus and move forward.

The third and final point along the continuum of patient identification was defined as provision of care, treatment, and service. This is the patient identification process that occurs prior to patient transport, care, service, treatment, and medication administration. There is a slight variation on the standard depending on whether or not the patient is wearing a patient identification wristband. For patients with a wristband, the practitioner is expected to perform the following: observe the last and first name, medical record number, and date of birth on wristband. These three elements are compared with the specimen label, requisition, order, etc. For patients without a wristband, the patient is asked to spell their last and first name and state their medical record number or date of birth. These three elements are compared with the specimen label, requisition, or order. If any discrepancy is determined during implementation of the above processes, immediate clarification must be determined prior to data entry, care, treatment, or service; an immediate

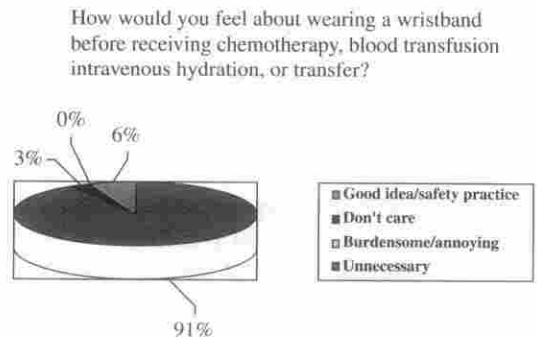


Figure 2. Survey question 1 results.

How would you feel about wearing a wristband whenever you come for an outpatient visit even if not receiving chemotherapy (e.g., doctor visit)?

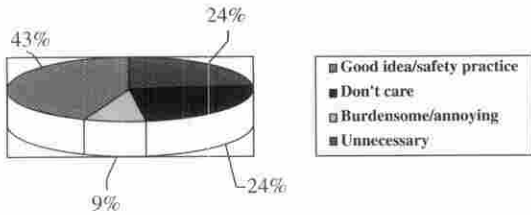


Figure 3. Survey question 2 results.

How would you feel about being asked you name and date of birth several times during your outpatient visit?

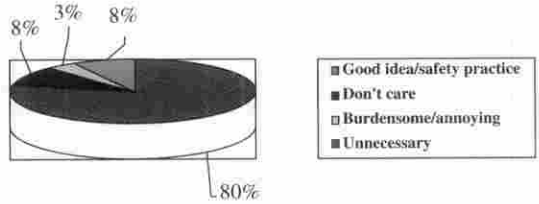


Figure 4. Survey question 4 results.

report must be made to the employee's supervisor.

Specimen labeling was addressed after the final patient identification recommendations were made. Technology such as bar scanning was not considered to be an option at this point as there were no allocated resources for it. This resulted in recommendations for a defined manual process. The final recommendations specified that specimens obtained from patients are to remain in the proximity of the patient until appropriately labeled. Specimens may only be labeled after the implementation of the provision of care, treatment, and service patient identification process.

IMPLEMENTATION

Once final recommendations for the patient identification and specimen labeling policy were made and administratively ap-

proved, all department heads received an in-service on its implementation and defined timelines. The policy was reviewed, changes were highlighted, and dates and deadlines to accomplish staff education were reinforced. Once the new policy was in effect, an institutional e-mail was sent out indicating that it was in effect.

In order to ensure and evaluate success of the organization's revised patient identification and specimen labeling policy, occurrences of misidentification and specimen mislabeling will be tracked and trended through the hospital quality assessment department. Reports of these events will be continued and compared with prior data to demonstrate improvement. A subsequent decision was made to support bar scanning technology; efforts are underway to explore and implement this technology in 2003.

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