Verifying Patient Identification
at the direction of the Patient Safety Committee
April 27, 2021

For *immediate direct* communication and acknowledgment via Send Word Now to all Harris Health Workforce Members. Send Word Now will track acknowledgment of this Patient Safety Alert. Maintaining manual logs of workforce members notified is not required.

Leaders: Please emphasize this alert in your daily unit huddles for the next 21 days in order to capture all staff members and hardwire the message. Questions? Contact your leadership or the Harris Health System Office of Patient Safety 24/7 through the page operator.

KEY MESSAGE
- Verifying patient identification is the basis of effective care.
- Failure to properly identify a patient may result in patient safety issues, a violation of the patient's privacy rights, and may impact the patient's satisfaction with the care, treatment, or services they are receiving.

VERIFY TWO PATIENT IDENTIFIERS BY ASKING EVERY PATIENT, EVERY TIME

The two patient identifiers used at Harris Health are: **1) Patient's Name 2) Patient's Date of Birth**.

If you have multiple patients that have the same name and date of birth, each patient's medical record number, address, or other personal identifying information must be used as additional patient identifiers. Unless it's an **EMERGENCY** circumstance, workforce members are not to provide care, treatment, or services, including sharing patient information, until the patient's identification can be verified.

ASK YOUR PATIENTS THEIR NAME & DATE OF BIRTH, DO NOT TELL THEM IT

ALWAYS Ask the patient:	*NEVER Ask the patient:*
For your safety, can you please tell me your full name? And what is your birthday?	*You are … and your birthday is …, correct? Is your name … and your DOB is …?*

EXAMPLES OF PATIENT IDENTIFICATION ERRORS

Example 1
A nurse attempted to scan the patient's ID armband to administer medication. An alert triggered from EPIC regarding the armband not matching the patient for which the medication was intended. The nurse checked the armband and discovered the armband was identified to be that of another patient on the unit. Upon review, it was discovered that an incorrect sheet of labels/armband were placed in the wrong chart. The labels/armband belonged to another patient.

Example 2
A procedure was completed on the wrong patient due to the failure to use two patient identifiers. The clinicians involved used the name on the patient door to guide their care delivery. Upon further review, the name card on the door was incorrectly labeled with another patient's name. The primary nurse caring for the patient discovered the error and informed the patient's provider.

REFERENCES

- Policy 7.11, Patient Identification
- Policy 71, Patient Secure Registration
- Policy 7.20, Universal Protocol
- Policy 3466.01, Red Rules
- Policy 565.00, Medication Administration