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POLICY:

Patients must be properly identified using at least two identifiers prior to providing care, treatment, and services; comparing and matching the patient's two identifiers to the clinical documentation. The room number or bed/chart number is not to be used as a patient identifier. The patient identification process is an active process involving Beaumont staff, the patient and/or the family/*surrogate.

Definition: As used in this policy, *surrogate means the parent of a minor, court appointed guardian, patient advocate acting under a durable power of attorney for health care or closest next of kin with priority. See Patient Care, Corporate Policy #304 "Informed Consent".

I. IDENTIFICATION PROCESS

1. The patient's identity will be verified prior to providing care, treatment and/or service.

2. Procedure for Patient Identification:
   a. Identify:
      - In a private setting (i.e. patient room or away from a waiting room), patients/surrogate will be asked to state their first name, last name and date of birth. The identifiers are to be recited by the patient/surrogate and checked by the Beaumont Employee. The identifiers are NOT to be read to the patient.
      - In a public area (i.e. waiting room) the department may use a surname followed by the first name (optional). Once in the exam room or private area, the identification will occur as stated above.

   b. Verify:
      1) The staff compares the wristband to the medical record document that pertains to the clinical intervention / encounter and verifies the name and Date of Birth, MRN, or CSN that matches the care, treatment, or services being provided. They MUST match.
      2) Outpatients without identification wristbands are to be identified by verifying the patient related documentation with what the patient/appropriate surrogate states. The information on the documentation must match what the patient/surrogate recites in order to properly identify the patient prior to any procedure, medication, specimen collection or test.

   - Below are examples (not all inclusive) of the department specific documents that are used in the identification process.

Area	Pieces of Identification
Patient Registration	Driver's license, Insurance Card
Patient Transport	Transport Log/Tracker, Pager Information
Dietary	Tray ticket
Nursing	EMAR, e-orders, labels, blood form
Physicians	EMR, consult form, Facesheet
Lab	Orders, labels

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I. IDENTIFICATION PROCESS (Cont'd)

3. Specific patient medical records/forms such as Medication Administration Records (eMAR), diagnostic materials, video recordings, radiology/cath films, EKG's and printed images MUST have the correct patient name and medical record number. If the patient name or medical record number is incorrect, a new record/form MUST be obtained.

4 All Laboratory and Blood Bank specimens must have a label containing the correct patient name, medical record number, and the band identifier (if ID bands are used).

5. If the patient is unable to verbally communicate or a language barrier exists, verify identification of the patient with a family member; surrogate; use of communication tool; interpreter; picture ID at the initial identification.

6. A Patient Safety and Quality Improvement (PSQI) report is to be completed if there are discrepancies between the patient identification band / document and what the patient reports.
   - Band does not match what patient states
   - Documentation does not match what patient states
   - Documentation does not match ID band

   a. Contact Manager and Patient Registration
   b. Do not proceed with care until discrepancy is resolved

II. SPECIAL CAUSE/OTHER:

A. SAME OR SIMILAR NAME

1. Registration:
   a. Never assume it is the same patient and/or the last user mistyped information:
      - Twins may have very similar names with only one or two different letters in the first/middle names, the same birth dates and may have the same street names.
      - Jr / Seniors, II, III, IV, etc – have the same names, sometimes the same street names but different birth dates.
      - Nursing homes send patients to the hospital without family and sometimes contribute to erroneous identification. If family is not present and patient cannot communicate staff should verify the patient identity information with the nursing home via phone before completing the registration process.
      - EC – Ambulance drivers get basic information but do not validate in detail so staff need to use the driver license/other legal ID, patient interview or family to properly select the patient from the data base – do not use the EMS Run Sheet to select the patient.
      - Name and birth date "almost" match. Never assume that "It is probably the same patient because the address and phone number are the same." The record may belong to a different patient or some kind of error may have occurred.

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- If an error is identified notify your supervisor. Create a new patient number if a visit is needed immediately.

Note: When doubt exists, always error on the side of creating a new MRN before selecting an MRN that may belong to another patient resulting in medical records being blended.

2. Patient Care Units will designate the Clinical Assistant/Unit Secretary and/or Charge Nurse to routinely review lists (unit census, schedules, etc.) at a designated time for name similarities.

3. When a name is noted to be similar or same:
   a. Place a "Name Alert" sticker (Stores #31142) next to the name on the list/schedule.
   b. The chart will be flagged.
   c. White boards will be flagged.
   d. Patient name is red and highlighted on the oneChart system list (i.e. unit census, physician list).

4. Patients should be separated as appropriate:
   a. Move to another unit, if possible.
   b. Move as far apart on the same unit as possible (Different halls/procedure rooms).
   c. Avoid whenever possible, sequentially scheduling patients with similar names.
   d. Staff will reinforce with the patient the importance of being an active participant in their care, highlighting the identification process.

B. ALIAS NAME

1. Security will determine the need for an alias name and choose an alias name. Security will contact the Nurse Manager/Assistant Nurse Manager and Patient Registration with the request for the alias name assignment and give the alias name.
2. Registration will prepare a second identification bracelet for the patient (Under the alias name). Copy the alias bracelet and document the legal name on the paper copy and tube to the blood bank. Tube or take the alias bracelet up to the nursing unit.
3. Patients with an "alias name" will have one identification wristband for their real name and another identification wristband with their alias name. Note: The patient must wear both bracelets on the same extremity throughout their hospital stay.
4. Registration will complete the Alias Check-off list and notify the correct departments.
5. The alias name must be cross-referenced to the patient's real name prior to any procedure, medication administration, specimen collection, treatment, test, transportation or discharge.

C. JOHN DOE / JANE DOE - Registration

1. In the event that a patient cannot be positively identified prior to initial treatment, in the Emergency Center, a John, Jane or Unknown Gender Doe name will be temporarily assigned.
2. All John and Jane Does must be registered with a middle name. When the patient's gender is unknown, an "Unknown" doe will be registered and only a middle initial will be used.

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3. Assign medical record number using "Anonymous" check box. The birthdate will default to 01/01/1900. Record the date, MRN and full name used in the Doe logbook.

4. Print wristband and labels and deliver to the treatment area. If Registration is unable to band the patient, hand the band directly to the nurse who has the patient or is expecting the patient's arrival.

5. Upon positively identifying the patient (a picture ID or verbal communication by patient/family member/legal guardian); update all information, except the name field and date of birth. Input the patient's actual name in the alias field and the date of birth in the account notes. Document how the name was obtained in the Hospital Account notes. No other action will be taken until the patient leaves the Emergency Center.

    - **Note: This identification process should only occur at a point in the patient's care when the identification process can be performed completely and accurately without distraction, i.e. after the stabilization of an acute trauma victim.**

6. Registrar will go bedside once the patient is admitted as an IP or OPPM to complete the Registration Process (if necessary) once the patient is no longer in EC, OR (Surgery) or Cath Lab.

    - **Note: Do not make updates to the name/DOB/Gender while the patient is in the Cath Lab, Surgery or EC. Wait until the patient has been admitted to the floor.**

7. Once a John Doe/Jane Doe is identified and the patient's name and date of birth have been updated, generate an identification wristband and paperwork with the patient's real name. Make a photocopy the identification wristband and record the John/Jane Doe name on the paper copy and tube to the blood bank. If the patient has a pre-existing medical record number, follow normal protocol for merging records. Remove "Anonymous" flag from patient type field.

8. Have the patient/Family member/Legal Guardian verify the information on the wristband and place the wristband on the same extremity as the "Doe" Wristband.

    - **Note: Do not remove the "Doe" wristband.**