



## **Recommended Standards of Practice for Patient Identification**

### **Introduction**

The following Recommended Standards of Practice were researched and written by the AST Education and Professional Standards Committee and have been approved by the AST Board of Directors. They are effective October 27, 2006.

AST developed the following Recommended Standards of Practice to provide support to health care facilities in the reinforcement of proper surgical patient identification in the perioperative setting. The purpose of the Recommended Standards is to provide an outline that health care workers (HCWs) in the perioperative setting can use to develop and implement policies and procedures for surgical patient identification. However, AST refers health care providers to The Joint Commission statements in the document *National Patient Safety Goals* for definitive guidance on improving the accuracy of patient identification, and developing and implementing policies for patient identification. The Recommended Standards are presented with the understanding that it is the responsibility of the health care facility to develop, approve and establish policies and procedures for identification of the surgical patient according to established health care facility protocols.

### **Rationale**

The following are Recommended Practices related to the proper identification of the surgical patient and recognizing the mistakes that can be made in order to prevent operating on the wrong patient. There are many instances when patient misidentification can occur, including invasive procedures, medication administration, transfusion of blood products, and matching pathology specimens to the correct patient.<sup>6</sup> The Recommended Practices are meant to contribute to the efforts of patient safety and reduce the risk of patient misidentification.

### **Standard of Practice I**

**The patient should have at least two corroborating patient identifiers as evidence to confirm identity.**

1. The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Examples of acceptable patient identifiers include<sup>9</sup>:
  - A. Name
  - B. Assigned identification number
  - C. Telephone number
  - D. Date of birth
  - E. Social security number
  - F. Address

- G. Photograph
2. The patient's room number should not be used as a patient identifier; room numbers are not person-specific identifiers, since patients can be moved from room to room.<sup>9</sup>

## **Standard of Practice II**

**All patients undergoing a surgical procedure must be properly identified by the surgical team members prior to transporting the patient to the surgery department.**

1. All surgical team members should recognize that performing an invasive procedure on the wrong patient is a possibility that always exists.<sup>2</sup> No health care facility, small or large, is immune from human errors, poor communication and lack of teamwork.<sup>12</sup> To reduce patient identification errors is not accomplished by trying to perfect human performance, but rather by improving the system where health care providers work. The human condition can't be changed, but the conditions under which people work can be changed.<sup>11</sup> The following recommendations are intended to reduce the risk of performing an invasive procedure or surgery on the wrong patient.
  - A. The following are recommended times for verification of patient identity and surgical procedures:
    - (1) When the surgery is scheduled
    - (2) When the patient is admitted to the health care facility
    - (3) Anytime the patient is transferred to another caregiver
    - (4) Prior to sedation
    - (5) Prior to the patients entry into the operating room
  - B. The following are recommendations for the identification of the conscious, competent patient prior to the start of the surgical procedure<sup>1</sup>:
    - (1) The HCW should address the patient using his/her full name and introduce himself/herself, including job title or position. This will aid in lessening the anxiety of the patient.
    - (2) Patient should be asked to say his/her name, the surgical procedure to be performed, and location of the operation.
    - (3) The patient's name and hospital-assigned identification number on the surgery schedule and transfer slip should correspond with the information on the patient's wristband.
    - (4) The information on the patient's wristband should correspond with the information in the patient's chart.
    - (5) Verify that the procedure listed and described on the informed consent in the patient's chart is the same procedure that the patient verbally stated.
    - (6) Confirm that the correct procedure is on the operating room schedule.
  - C. The following are recommendations for the identification of the mentally incapacitated patient<sup>1</sup>:
    - (1) Verify that the correct patient is being taken to the operating room by asking a family member or designated representative the patient's name.

- (2) Verify the information on the patient's wristband is the same as the information in the patient's chart.
- (3) The patient's name and hospital-assigned identification number on the surgery schedule and transfer slip should correspond with the information on the patient's wrist band.
- (4) Verify that the procedure listed and described on the informed consent in the patient's chart is the same procedure listed on the surgery schedule.
- (5) Confirm with the family member or designated representative the procedure that is expected to be performed, as well as location of the operation and verify this matches up with the informed consent.
- D. The following are recommendations for the identification of a minor patient<sup>1</sup>:
  - (1) Complete the recommendations for an alert, oriented patient.
  - (2) Confirm the minor patient's name with the parent or legal guardian, the procedure to be performed and location of the operation.
- E. If, at any point, the verification process fails to confirm the correct patient, correct procedure and/or correct site, the surgeon should be notified and no action taken in transporting the patient into the operating room until the verification is accurate.

### **Standard of Practice III**

**Prior to the start of any surgical procedure, a "time out" should be conducted to verify the correct patient, correct procedure to be performed, and correct surgery site.**

1. Just before entering the operating room with the patient, the surgical team members should ask the patient to state (not confirm) the following<sup>13</sup>:
  - A. Name
  - B. Social Security number or date of birth
  - C. Site of surgical procedure
  - D. Patient's responses should be reconciled against the marked site, patient's hospital identification wristband, and informed consent.
2. With the patient positioned, draped, and anesthetized on the O.R. table, and just before the skin incision of the surgical procedure is made, "time out" is conducted as a final verbal confirmation of the correct patient, surgical procedure, surgical site, and when applicable, implants.<sup>8</sup>

### **Standard of Practice IV**

**All patients undergoing a surgical procedure should wear an identifying marker.**

1. Identification markers on the patient will prevent wrong patient surgery.
2. Identification markers on the patient will prevent wrong-site surgery.
3. Identification markers can include the following:
  - A. Wristband as identification bracelet
  - B. Wristband with unique bar-coded patient identifier
  - C. Radio frequency identification (RFID) marker<sup>3</sup>

4. Health care facilities should still be aware that the reliance on wristbands for identification of the correct patient has, obviously, not eliminated the problem of patient misidentification. HCWs should still follow all other patient identification policies to prevent a mishap. HCWs should be aware of the six most common types of wristband errors as an aid in foreseeing the hazards associated with wearing a wristband<sup>6</sup>:
  - A. Wristband is not present
  - B. Wrong wristband, ie another patient's wristband
  - C. Presence of more than one wristband, and conflicting information is written on both.
  - D. Partially missing information on the wristband
  - E. Erroneous information on the wristband
  - F. Written information on wristband is illegible
5. HCWs should avoid removing the wristband.
  - A. The wristband should be placed on the wrist of the non-operative/non-affected side of the body.
  - B. If the wristband must be removed, it is recommended that it be placed with the patient chart in order to be immediately replaced on the wrist at the end of the procedure, or a new wristband is obtained and placed with the patient chart for immediate placement on the wrist.

## **Standard of Practice V**

**Verifying the correct operative site is the responsibility of the surgical team members.**

1. It is recommended that the operative site be "marked" to identify the intended site of skin incision or insertion, ie trocars. Marking the site unambiguously contributes to the safety of the patient by avoiding wrong site surgery.
2. Recommendations for marking the operative site include<sup>8</sup>:
  - A. No marks of any type should be made on the nonoperative site.
  - B. Use clear unambiguous marks, such as "Yes" or a line marking the proposed skin incision .
  - C. The health care facility should establish a policy for indicating the type of mark and method of marking to promote continuity among the various departments of the facility.
  - D. The individual performing the procedure should be designated as performing the marking of the site.
  - E. Site marking must take place with the patient conscious, alert and oriented, and the patient indicating the surgery site.
  - F. Use a permanent marker in which the mark will remain visible after the skin prep is performed.
  - G. The mark must be visible after the sterile surgical drapes have been placed.

## **Competency Statements**

Competency Statements	Measurable Criteria
<p>1. Certified Surgical Technologists (CSTs) and Certified First Assistants (CFAs) have the knowledge and proper skills to assist in patient identification in a manner that promotes patient safety.</p> <p>2. The CST and CFA are qualified to communicate to the surgical team members the confirmation of the correct patient or communicating a failure during the verification process.</p>	<p>1. Educational standards as established by the <i>Core Curriculum for Surgical Technology</i> and <i>Core Curriculum for Surgical Assisting</i>.<sup>4,5</sup></p> <p>3. The subject of correct patient identification is included in the didactic studies as a surgical technology and surgical assistant student, including concepts of correct patient identification. Additionally, the studies include the proper documentation of correct patient identification.</p> <p>4. Students demonstrate knowledge of correct patient identification in the lab/mock O.R. setting and during clinical rotation.</p> <p>5. As practitioners, CSTs and CFAs perform correct patient identification procedures implementing patient safety policies. Health care facilities whose protocols and policies allow, CSTs and CFAs can complete the intraoperative record to include the information pertaining to correct patient identification.</p> <p>6. CSTs and CFAs complete continuing education to remain current in their knowledge of correct patient identification, including annual review of the policies of the health care facility.</p>

**References**

1. Beyea SC. *Perioperative Nursing Data Set*. 2<sup>nd</sup> ed. Denver: Association of PeriOperative Registered Nurses; 2002.
2. Chassin M., & Becher, E.C. (2002). The wrong patient. *Annals of Internal Medicine*, 136(11), 826-833.
3. Collins J. *Remedy for medical errors*. 2004.

- <http://www.rfidjournal.com/article/articleview/961/1/1>; Accessed October 10, 2006.
4. *Core Curriculum for Surgical Assisting*. 2<sup>nd</sup> ed. Littleton, CO: Association of Surgical Technologists; 2006.
  5. *Core Curriculum for Surgical Technology*. 5<sup>th</sup> ed. Littleton, CO: Association of Surgical Technologists; 2002.
  6. ECRI. Patient identification. Risk analysis. Risk and quality management strategies 16. *Healthcare Risk Control, Supplement A*. 2003.  
<http://www.saferhealthcare.org/uk/IHI/Topics/PatientIdentification/CaseStudies/DeliveringSaferPatientIdentification.htm>. Accessed October 9, 2006.
  7. Joint Commission, The. Implementation expectations for the universal protocol for preventing wrong site, wrong procedure, and wrong person surgery. 2003.  
[http://www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal\\_protocol.pdf](http://www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal_protocol.pdf). Accessed October 10, 2006.
  8. Joint Commission, The. 2003 national patient safety goals.  
[http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/03\\_npsgs.htm](http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/03_npsgs.htm). Accessed October 10, 2006.
  9. Joint Commission, The. 2006 national patient safety goals.  
[www.jointcommission.org/NR/rdonlyres/88ED0EA4-395A-4DBA-A12E-25C70AF72C00/0/06\\_npsg.ppt](http://www.jointcommission.org/NR/rdonlyres/88ED0EA4-395A-4DBA-A12E-25C70AF72C00/0/06_npsg.ppt) . Accessed October 12, 2006.
  10. Joint Commission, The. Protocol for preventing wrong site, wrong procedure, wrong person surgery. 2003.  
[http://www.jointcommission.org/NR/rdonlyres/DEC4A816-ED52-4C04-AF8C-FEBA74A732EA/0/up\\_guidelines.pdf](http://www.jointcommission.org/NR/rdonlyres/DEC4A816-ED52-4C04-AF8C-FEBA74A732EA/0/up_guidelines.pdf). Accessed October 10, 2006.
  11. Reason JT. *Managing the Risks of Organizational Accidents*. London, United Kingdom: Ashgate Publishing; 1997.
  12. Strelec, SR. Anesthesia and surgery: Not always a one-sided affair. *American Society of Anesthesiologists Newsletter*, 60. 1996. 2006, from [http://www.asahq.org/Newsletters/1996/06\\_96/feature4.htm](http://www.asahq.org/Newsletters/1996/06_96/feature4.htm)  
Accessed October 10, 2006.
  13. Veterans Administration National Center for Patient Safety. Steps to ensure correct surgery.  
[http://www.va.gov/ncps/SafetyTopics/CorrectSurg/ECS\\_StepsBg.doc](http://www.va.gov/ncps/SafetyTopics/CorrectSurg/ECS_StepsBg.doc)  
Accessed October 11, 2006.

