

Why Armbands Matter FAQ

Use this
document to
discuss the
importance of
confirming
patient
identification with
the use of facility
armbands.



Q: Why are patient armbands required?

A: Accreditation standards for lab require confirmation of patient identity using an armband for all inpatients. Future technology will require scanning of armbands prior to procedures or treatment and will facilitate electronic charting.

Q: What are the required identifiers to confirm with patients prior to arm banding?

A: Confirm with the patient their full legal name, DOB and PHN. Then affix the armband. Many patients have similar names or birthdays. Some people may be hard of hearing and respond to a similar name.

Example: A patient was not identified or given an armband for a procedure and a biopsy was performed on the incorrect patient with a similar name.

Q: If I don't have time to armband a patient, is this acceptable?

A: No. The amount of time lost fixing an error and correcting a medical record in addition to potentially treating a wrong patient is far greater than the time it takes to identify the patient and affix an armband.

Example: In a trauma room, patients had incorrect armbands and wrong blood was transfused.



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Q: How can we ensure compliance with staff affixing armbands on patients when presenting for medical treatment?

A: Add the task to a staff checklist. Perform random audits, looking for patient armbands on wards and in ED departments by clinical staff. Discuss at huddles and team meetings.

Q: Who can place an armband on the patient?

A: Registration or Nursing staff must attach an armband when patients first present to the facility.

Q: Why must I swipe the care card to retrieve patient information?

A: This is to confirm the correct patient is selected and to prevent selecting a patient with a similar name and DOB. Manually typing in a name or partial name is high risk for error. A Care Card swipe pulls up the patient that matches the identification presented, which should be used to create the armband.

Example: A patient presented, was registered under the wrong name without swiping a care card as the staff "knew" the patient. The syphilis test came back positive, and the wrong patient was notified.

Q: Can multiple missing armband events be reported in one PSLS?

A: Yes. Note that they will be counted separately for monthly reports.

Q: How can we address barriers with patients not having an armband?

A: Clinical staff may be asked to place an armband on a patient. Lab accreditation standards require inpatients to wear a facility identification band, and that information is confirmed by the patient verbally, if possible.

O: How do we know errors are even happening?

A: Identification errors are one of the top PSLS events each month. Patients have even detected errors when reviewing wrong results on My Health Portal.

Example: A positive urine pregnancy test went onto the mother's health record instead of the daughter, as the mother's account was chosen in error during the registration process. This breached confidentiality and caused a delay in surgery.