SOP Template: Verification of Patient Information Accuracy

This SOP details the process for **verification of patient information accuracy**, emphasizing the importance of confirming patient identity, cross-checking demographic details, medical history, and current treatment records to ensure data integrity. It aims to minimize errors, enhance patient safety, and maintain reliable and up-to-date medical documentation through standardized verification procedures.

1. Purpose

To outline a standardized process for verifying patient information accuracy in clinical settings to prevent errors, improve patient care, and ensure data consistency.

2. Scope

This SOP applies to all healthcare staff involved in patient registration, data entry, medical record management, and clinical care services.

3. Responsibilities

- **Front Desk Staff:** Initial verification at registration/check-in.
- **Clinical Staff:** Validation during examinations and treatments.
- **Health Information Management (HIM):** Ongoing audits and corrections.

4. Procedure

1. **Confirm Patient Identity**
    - Ask patient to state their full name and date of birth.
    - Verify with photo identification (if applicable).
    - Cross-check with patient ID number or medical record number.
2. **Cross-check Demographic Information**
    - Verify address, phone number, and emergency contact details.
    - Confirm insurance information and update as needed.
3. **Review Medical History**
    - Ask patient to confirm existing medical conditions, allergies, and medications.
    - Compare with prior records and clarify discrepancies.
4. **Validate Current Treatment Records**
    - Ensure diagnosis, treatment plans, and medication orders are up to date.
    - Document any changes and seek confirmation from the provider and patient.
5. **Document Verification**
    - Record verification steps in the patient's medical record.
    - Note date, time, and staff member performing the verification.
    - Report and correct any discrepancies immediately per facility policy.

5. Documentation

- All verification actions and updates must be documented in the electronic health record (EHR).

- Corrections must follow audit trail requirements.

6. Quality Assurance

- Periodic audits of patient records for completeness and accuracy.
- Staff training and reinforcement of SOP adherence.
- Error reporting and continuous improvement processes.

7. References

- Facility Policy on Patient Identification
- Joint Commission Standards on Patient Safety
- HIPAA Privacy and Security Regulations

8. Revision History

Date	Changes	Authorized by
2024-06-20	Initial Version	QA Manager