Always Events… Every Patient, Every Time:

Hardwiring Safe Habits for High Reliability

Patient Identification
Using Two-Patient Identifiers

Learning Objectives

- Describe error types and the importance of standard work to achieve highly reliable processes

- Define acceptable patient identifiers

- Review the process of placing and replacing an armband

- Evaluate when to use two-patient identifiers

- Analyze the process for verifying patient identification per SHC policy guidelines

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Always Events…Every Patient, Every Time

Our vision is to create a culture where these safe practices are hard-wired, patients are engaged, staff know exactly what is expected, and they have the tools to make it easy to perform them for every patient, every time.

Always Events…Every Patient, Every Time

Sharp HealthCare has identified 7 critical patient safety practices that we expect to happen for every patient, every time. Our goal is to be a high reliability organization that *habitually* performs these 7 practices, which we refer to as Always Events.

1. Patient identification
2. Treatment/Procedure verification
3. Six rights of medication administration
4. Alaris® Guardrails®
5. Line reconciliation
6. Universal protocol
7. Hand hygiene

7 Always Events

1	2	3	4	5	6	7
Patient Identification	Treatment/Procedure Verification	Six Rights of Med Administration	Alaris® Guardrails®	Line Reconciliation	Universal Protocol	Hand Hygiene

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The Problem:
Many Types of Patient Identification Errors

1. Verifying a patient is who you think they are*

2. Matching the service or treatment to the right patient*

3. Choosing a patient's name from a list of names

4. Associating an object with patient's name on a label (e.g. specimen, belongings, telemetry monitors, etc.)

5. Associating an object to another object (e.g. placing forms in chart, connecting a monitor, etc.)

*Focus of 2014 Always Events initiative

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Common Errors at Sharp & Across U.S.

- Diagnostic test performed on wrong patient
- Medication given to the wrong patient
- Lab test performed on wrong patient
- Patient registered under the wrong name
    - All errors, harmful or not, are considered <u>serious</u> because they reveal failure points that could <u>potentially</u> lead to patient harm.

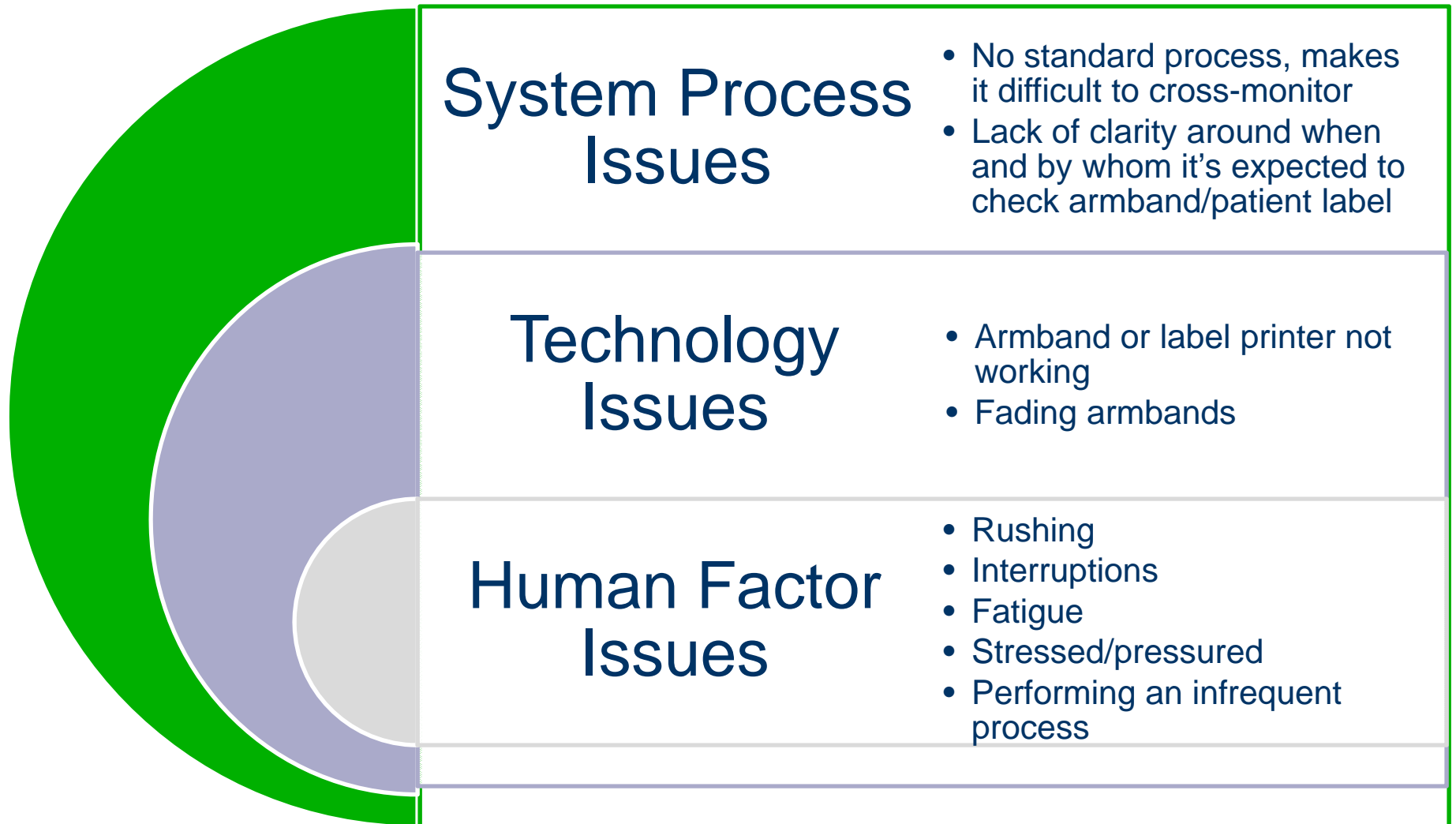# Patient Identification Errors Common Causes and Contributors

Review of our adverse events and near misses revealed several common themes when errors occurred:

- The room number was relied on for patient identification

- Caregivers <u>stated</u> the patient's name rather than <u>asking the patient</u> to state their name

- Staff were rushed, distracted or interrupted, then left out critical steps of the two-patient identifier process

Patient Identification Errors
General Causes and Contributors
That Must Be Addressed

System Process Issues

- No standard process, makes it difficult to cross-monitor
- Lack of clarity around when and by whom it's expected to check armband/patient label

Technology Issues

- Armband or label printer not working
- Fading armbands

Human Factor Issues

- Rushing
- Interruptions
- Fatigue
- Stressed/pressured
- Performing an infrequent process

It Could Happen to Anyone

- Even careful, conscientious people make mistakes.

- The risk is often not obvious and can occur at any part of the patient identification process, or may occur because an error in an earlier process wasn't detected.

- Following the standard *two-patient identifier process* would have likely caught these errors.

- Using the standard two-patient identifier process *every time* protects your patients and yourself!

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Patient Identification - Myth vs. Fact

Myth: I've been in healthcare for 10 years and I've never had a patient identification error.

Fact: Most errors are first time errors; everyone is vulnerable no matter how careful they try to be.

Myth: I've done it my way and it works for me.

Fact: The new standard work process is designed to rigorously address risks that an individual process may not. If everyone does it the same way, it's easier to cross-monitor one another.

Patient Identification - Myth vs. Fact

Myth : Double checking something when I am already certain is a waste of time.

Fact: Mistakes in patient identification and treatment verification have occurred even when staff knew the patient. Making the practice a habit even when the risk seems low is how we hardwire safe <u>habits</u> and create reliable systems. What we do <u>habitually</u> is what we do in a hurry.

Patient Identification - Myth vs. Fact

Myth : Patients feel the service I provide is not personal if I keep asking them to say their name. They may feel like I keep forgetting.

Fact: There may be some social awkwardness when performing the two-patient identifier process numerous times for the same patient. Using key words and phrases that emphasize we follow this process because *safety is our priority* can help.

Patient Identification - Myth vs. Fact

Myth : If I state the wrong patient's name, they will correct me.

Fact: Many mistakes have occurred when staff have stated the patient's name and the patient agrees to the wrong name because either the patient is confused, scared, doesn't hear accurately or has a language barrier.

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Patient Identification - Myth vs. Fact

Myth : The person who brought me the patient, SURELY must have already identified the patient. Why would I need to double check someone else's work?

Fact: Each one of us represents a needed safety check in the system. Taking a shortcut by assuming others are always 100% perfect and not performing our own safety check creates risk for ourselves and our patients.

A True Story
When *Name Only* Was Used for Patient ID and Assumptions Were Made

- Patient A, was transferred from a facility outside Sharp. On admission, the demographics, health plan information provided were that of Patient B (same first and last name).

- Patient A was admitted under the Master Patient Index number of Patient B.

- Patient A's correct date of birth was on the face sheet from the sending facility.

- The error was discovered <u>after discharge</u> by a SNF employee.

- Patient B received bills for Patient A's stay. Service recovery was done with Patient B and it took over 20 hours to fix the records.

Lesson Learned:

1. Use two-patient identifiers habitually – even if you think someone else already checked.

2. Since Patient A's date of birth was correct on the face sheet, had they used two-patient identifiers, the error would have been discovered at admission.

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The Solution: Standard Work

Standard work is a written description of the safest, highest quality, and most efficient way to perform a process or task* and benefits include:

- Clearly defines specific steps
- Captures best, safest practice
- Reduces variation
- Increases consistency
- Applies to all settings
- Easy to recognize deviation from the norm
- Allows for cross-monitoring

- The Standard Work for Patient Identification Using Two-Patient Identifiers is outlined in SHC P&P # 30326.99.

- For special situations, refer to Refer to:
  - P&P # 17022.99 Registration Standards,
  - P&P 15307.99 Patient Secure – Palm Vein Scanning, and P&P #47404.99 – Infant Banding

National Patient Safety Goal - Patient ID

- *Use at least TWO ways to identify patients when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.**

- Acceptable Two-Identifiers Include:
  - Name (First and Last)
  - Date of Birth (DOB)

- Acceptable third-identifiers if DOB is not available/reliable:
  - FIN #
  - SHC #
  - Medical Record Number
  - Photo ID
  - Blood Bank # (for blood administration)

  (Phone number and address are used with caution as family members with same name share phone #s and addresses)

2014 Hospital
National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly
NPSG.01.01.01   Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Unacceptable Patient Identifiers

The following are NOT acceptable for patient identifiers:

- Accession Number

- Diagnosis

- Procedure

- Patient's Room/Bed number

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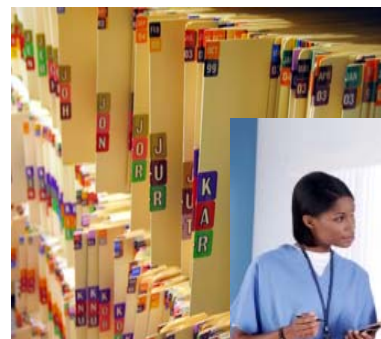
A True Story
When Room Number is Used for Patient ID and Assumptions Are Made

- In the ED, Patient A in Bed 1 and Patient B in Bed 11, both had same first name. A head CT was ordered for Patient A.

- The transporter hand-off form listed the patient's name correctly, but the radiology assistant inadvertently wrote Bed 11 rather than Bed 1.

- The transporter used the bed number to identify the patient and took the wrong patient to CT.

- Verification of the patient's identity was not done on arrival in CT and the CT was completed on the wrong patient

Lesson Learned:

1. Use two-patient identifiers habitually

2. Bed/Room number is NOT an acceptable patient identifier

3. Patient identification MUST occur at admission, assuming care, prior to transfer, upon arrival to dept., immediately prior to any medication, treatment or procedure

When to Use Two-Patient Identifiers

- When placing or replacing an armband

- When assuming care of the patient (nursing)

- Prior to transferring the patient to another unit or department (anyone who is transporting a patient)

- On arrival to a department (receiving provider)

- Immediately prior to any of the following:

  - Medication administration

  - Treatment, test or procedure including: imaging tests, lab tests, transfusion, respiratory treatment or test, antenatal testing, physical therapy, EKG, etc.

- Prior to consultation by ancillary personnel

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Standard Work for Placing an Armband

If patient is <u>willing & able</u> to participate ONE care provider verifies patient identification and involves the patient:

Step 1:
Prior to placing the armband, confirm the armband is accurate by asking, "**For your safety**, will you please <u>spell</u> your last name and <u>state</u> your first name and your date of birth**?**

Step 2:
Read back **out loud** from the armband the patient's first and last name and DOB.

If patient is <u>NOT willing and able</u> to participate, TWO care providers verify patient identification:

Step 1:
Prior to placing the armband, care provider #1: Spells the patient's last name and states the first name and DOB **from a reliable source document** (government issued ID or reliable photo ID).

Step 2:
Care provider #2: Spells the patient's last name and states the first name and DOB out loud from the **armband.**

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Changing an Armband

- If original band has <u>incorrect</u> patient's name or DOB:

    - Remove the incorrect band

    - Simultaneously replace with correct band

    - Complete a Quality Variance Report

  - If original band is unreadable or removed for clinical reasons (e.g. swelling, IV start, surgical procedure, etc.):

    - Place new band on patient immediately after removing the old band or immediately after the procedure

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A True Story
When There is No Double Check, the Risk of Error in a Critical Process is High

- Patient A presented to ED with extremely labored breathing and was not banded at the time of admission.

- A radiology tech arrived to do a portable chest x-ray, however could not do it because the patient had no identification band.

- The ED staff member handed the tech a band, it was for Patient B.

- The radiology tech banded the patient without verifying the patient's identity.

- The x-ray was taken and results were placed in Patient B's medical record.

- The error was discovered when the patient was admitted to the inpatient unit and patient was re-banded with correct information.

Lessons Learned:

1. Place armbands ASAP on admission.

2. Habitually use two-identifiers and involve the patient (or a 2nd care provider) prior to placing or replacing an armband

Standard Work for Using Two-Patient Identifiers Requires Reading Out Loud

- The new standard work requires:
  - Confirming the patient's name and DOB on the armband as the patient is saying it out loud
  - Staff reading patient identifiers <u>out</u> <u>loud</u> from the source document

- Reading the patient's identifiers <u>out</u> <u>loud</u> improves safety* by:
  - Forcing the provider's attention on the task / creates mindfulness
  - Engaging both auditory and visual senses to help detect an error
  - Allowing the task to be cross-monitored
  - Engaging the patient

*The Final Check, 2012

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Standard Work for Using Two-Patient Identifiers with Armband in Place

If patient is <u>willing and able</u> to participate:

Step 1:
Ask, "**For your safety,** will you please state your name and your date of birth**?"**
As the patient is responding, confirm the **armband** is accurate

Step 2:
Read back **out loud** the patients first and last name and DOB <u>from the verifying document</u>, (e.g. request, label, MAR, Order, etc.) **and ensure it matches the armband**

If patient is <u>NOT willing or able</u> to participate (read it out loud twice):

Step 1:
Confirm the **armband** is accurate by reading <u>out loud</u> the patient's first and last name and DOB.

Step 2:
Read back **out loud** the patients first and last name and DOB <u>from the verifying document</u>, (e.g. request, label, MAR, Order, etc.) **and ensure it matches the armband**

Standard Work for Using Two-Patient Identifiers with NO Armband in Place (Outpatient Visit)

If patient is <u>willing and able</u> to participate:
Step 1:
Ask, "**For your safety** will you please state your name and your date of birth**?**" As the patient is responding, confirm <u>from the verifying document</u> (request, label, MAR, order, Med label or photo ID) that name and DOB are accurate.

Step 2:
Read back **out loud** the patient's first and last name and DOB <u>from the request, label, MAR, order, Med label or photo ID and ensure it matches the armband</u>

If patient is <u>NOT willing or able</u> to participate:

Step 1:
Confirm patient's first and last name and DOB with a photo in EMR or a photo ID

Step 2:

Read back **out loud** the patients first and last name and DOB <u>from the request, label, MAR, order, Med label or photo ID and ensure it matches the armband</u>

Example of Risk Created When Standard Work for Patient Identification is Not Followed

- Patient A's full name (Lynn Smith*) was called from a waiting room for an x-ray.
- Patient B (with her mom) stood up and the nurse asked if her name was "Lynn Smith". She said, "yes". Patient B spoke very little English.
- The nurse asked for her DOB and heard Patient B say, "five". Patient B suddenly became unsteady and to prevent a fall, was hurried onto the x-ray table and x-rays were completed.
- After a few minutes, Patient A went to the front desk to say she thought the wrong patient was taken back, but was afraid to say anything at the time.
- Patient B received the wrong x-rays.   *fictitious name*

Frequently Asked Questions (FAQs)

- Why is there a change in the two-patient identifier process?

  - Creating standard work regarding using two-patient identifiers is an evidence-based practice which is repeatable and making it a habit makes it a highly reliable process for patient safety.

- Do I have to say "for your safety"?

  - Saying "for your safety" or something similar will inform the patient why he or she is repeatedly asked to say or spell their name…..They will expect this process every time and understand that their safety is our priority.

FAQs

- Do I need to do the *Always Events* process for patient identification each time I see my patient throughout the day?

    - Yes, patient identification using two-identifiers is an Always Event, which means that it needs to be done for every patient, every time.

    - Even if you are certain of the patient's name, a major part of the process is matching the treatment, test or service to the right patient. Errors have been detected and patient harm has been minimized through performing this basic standard process for patient identification.

FAQs

- Why do I have to say or repeat the name out loud?

  - Reading the name out loud improves focus and attention as well as makes the process cross-monitorable.

- When can the armband be removed?

  - Armbands are to be removed at time of discharge by the discharging RN or designee and placed in a secure container to properly dispose of protected health information (PHI), unless patient prefers to keep the band

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FAQs

- What if the patient is sleeping?
  - If the patient is asleep and the procedure does not require them to be awakened, you can follow the "*patient is NOT able*" guideline. Read armband out loud, then read source document out loud (e.g. label, order).*

    *Excludes situations when a second provider is required.

- What if when admitting a patient, the patient/care partner is unable/unwilling and there are no source documents?
  - Answer: If a patient cannot be identified, follow the Unidentified Patient- Identification and Family Notification P & P (30012.99).

FAQs

- Does the patient identification process need to be done when relieving for breaks / lunch?
    - No, however, it should be performed with any treatment, procedure or medication administered during the primary RN's absence.

- Is this process still required with barcoding?
    - Barcoding is a technology that provides a process for verifying patient identification; however, it still requires a visual check to confirm patient identity. Refer to the barcoding standard processes..

FAQs

- What if it is an emergency?
  - Lifesaving efforts should not be delayed. Staff will need to use critical judgment in an emergency situation.

- I have never made an error with patient identification before: why do I need to adopt this process now?
  - Even if you think you have never made an error it is probable that you have or may do so in the future. Everyone is vulnerable to making errors, no matter how careful they try to be.

Summary

Patient Identification Errors
General Causes and Contributors
That Must Be Addressed

System Process Issues	• No standard process, makes it difficult to cross-monitor • Lack of clarity around when and by whom it's expected to check the armband/pt. label
Technology Issues	• Armband or label printer not working • Fading armbands
Human Factor Issues	• Rushing • Interruptions • Fatigue • Stressed/pressured • Performing an infrequent process

- Patient identification errors have common causes that can be addressed as system process issues, technology issues or human factor issues

- Contrary to common myths, errors can happen to anyone. Following the standard work process every time protects your patients and yourself

- SHC policy guides standard work process for the conditions in which patient identification must be followed.
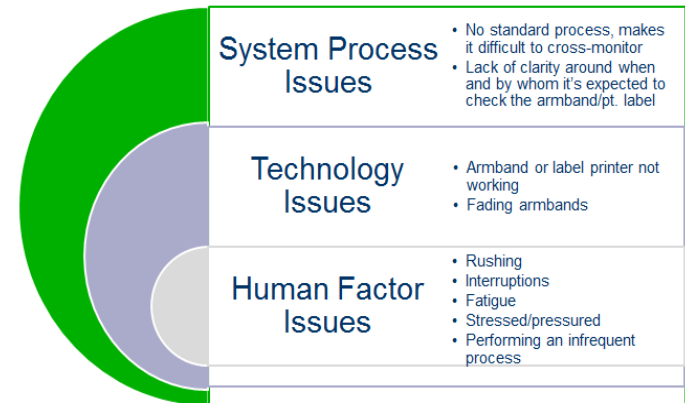
References

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- The Lean Handbook, Quality Press, 2012 and Jaiswal and Anderson, www.oregon.gov/DAS/trfm/docs/**standard_work**.ppt accessed 11/1/2013

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Exit

- Click on the "X" (close button) in the upper right hand corner of the screen when you are ready to complete the requirements for this course.