Sharp HealthCare Safety Training 2015

Module 3, Lesson 3:
Always Event:
Safe, Reliable Patient Identification

Our vision is to create a culture where patients and those who care for them are free from harm.

National Patient Safety Foundation (NPSF)

San Diego's Health Care Leader

SHARP.

Learning Objectives

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

2. Define acceptable patient identifiers

3. Review the process of placing and replacing an armband

4. State when to use two-patient identifiers

5. Describe the process for verifying patient identification per SHC policy guidelines

Sharp's Key Safety Programs, Skills and Tools

- Just Culture
- Workforce Competence / Orientation / Annual Competency Programs
- TeamSTEPPS
- Patient and Care Partner Engagement Programs
- Learning and Reporting Systems to Identify Risks: RL Solutions
- Medication Safety Programs and Tools
- Always Events Program and Tools
- Lean Six Sigma (Robust Process Improvement)
- Change Acceleration Process (CAP) Tools
- Safe Use of Technology Tools
- Environmental Safety Programs

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

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

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

Adapted from The Lean Handbook

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.

*The Joint Commission NPSG 2014

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:

Use two-patient identifiers habitually

Bed/Room number is NOT an acceptable patient identifier

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

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 the patient to <u>spell</u> their last name and <u>state</u> their first name and 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.**

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 Real Learning (RL) Form
  - 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

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:

Place armbands ASAP on admission.

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

- 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

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

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

Step 1:
Ask the patient to state their name and date of birth"

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

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 **out loud** 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</u> <u>document,</u> (e.g. request, label, MAR, Order, etc.) <u>and ensure it matches the</u> <u>armband</u>

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 the patient to state their name and date of birth" As the patient is responding, confirm **from the verifying document <u>(request, label, MAR, order, Med label or photo ID</u>)** matches the patient's verbal information.

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>

Summary

- 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

- The Joint Commission 2014 National Patient Safety Goals; http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf

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

- The Final Check; http://www.thefinalcheck.org/