What's in a Name? A Multidisciplinary Journey to Safer Patient Identification

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Background

- Accurate patient identification is a key component of The Joint Commission's National Patient Safety Goals (NPSG)
- Our Level 1 Trauma Center has 21 operating rooms and serves a diverse population speaking 20+ languages
- This diversity introduces complexity in patient identification due to patients having interchangeable names and patients have multiple first names
- There is increased risk of mismatched identifiers across patient charts, ID bands, and consent forms

Clinical Issues

- Frequent discrepancies noted between patient identifiers on ID bands, patient charts and consent forms
- Case delays due to time spent resolving mismatches
- Patient and staff dissatisfaction stemming from prolonged preoperative process, having to redo consents, and input Keepsafes for near misses
- Vulnerabilities prompted a Performance Improvement (PI) initiative using the Plan-Do-Study-Act (PDSA) model to standardize verification and strengthen safety practices.

Multidisciplinary Team Involved

- ✓ Perioperative Leadership Team
- ✓ Frontline Preoperative Nursing Clinical Team
- ✓ Surgical Teams & Surgery Office Coordinators
- ✓ Patient Access & Admitting Department

References available upon request

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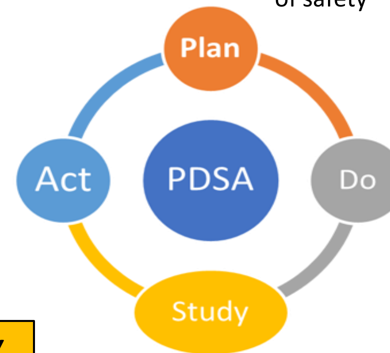
Implementation - PDSA Model

PLAN

- Conduct root cause analysis of patient identification errors
- Identify inconsistencies in check-in process across admitting, clinical & preop areas
- Form a multidisciplinary team (Patient Access/Admitting, Nursing, Surgical, Quality & Patient Safety)
- Review current patient identification policy s

DO

- Standardize the patient verification policy by using a government-issued ID card as primary method of verification across all departments
- Deliver comprehensive staff training via small group sessions
- Review, reinforce, and re-integrate existing patient identification policy to promote compliance and foster a culture of safety



STUDY

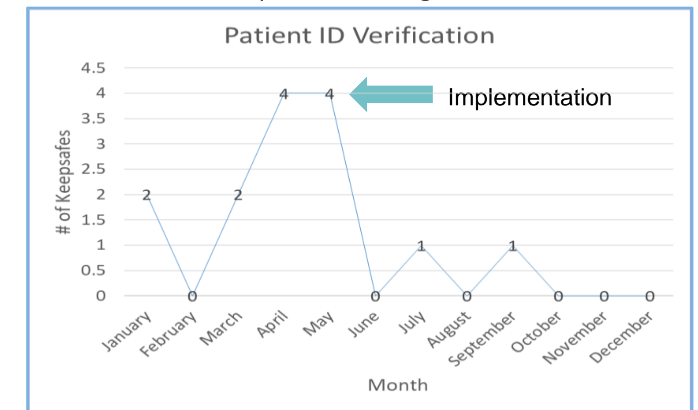
- Refine processes based on data and feedback.
- Sustain improvements through ongoing audits and continuous education
- Share results and best practices across departments to foster a culture of safety

ACT

- Monitor for discrepancies in patient identifiers post-implementation
- Track metrics for decrease in mismatched identifiers via Keepsafe reporting
- Collect feedback from staff on process improvements

Outcomes

- Eliminated discrepancies, reduced patient identification errors, as evidenced by the reduction in Keepsafe reportings
- Reduced surgical delays, improved operational efficiency and patient flow in surgical units
- Increased staff confidence in verification process
- Improved patient satisfaction due to reduced wait times
- Enhanced patient safety and continuous quality improvement with reduction of Keepsafes starting June



Nursing Implication

- Ensure strict adherence to standardized patient verification protocols using patient's government-issued ID card
- Communicate clearly with patients, utilizing interpreter services for patients with language barriers
- Report any discrepancies or near misses promptly to maintain safety
- Collaborate with multidisciplinary teams to streamline workflows and reduce delays
- Promote a culture of safety by modeling compliance and encouraging feedback

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