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Quality Residency Capstone

Jennie Melham Memorial Medical Center

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Introduction

- 23 Bed Critical Access Hospital located in Central Rural Nebraska
- **Patient identification (ID) errors** can disrupt care and harm patients in virtually every facet of clinical medicine, including diagnostic testing, medication administration, and even billing. Recognizing the magnitude of this problem, The Joint Commission has named improving the accuracy of patient ID as the most important National Patient Safety Goal since 2014. Source: https://www.ecri.org/Resources/HIT/Patient%20ID/Patient_Identification_Evidence_Based_Literature_final.pdf

Team

Patient Identification Task Force

(Interdisciplinary Team)

- Representation from: Business Office Manager, HIM/Medical Records Manager, Nursing support specialist Manager, Acute RN Manager, ED RN Manager, Lab Manager, Radiology Manager, IT RN Analyst, Senior Leadership Designee, and Quality Assurance Coordinator

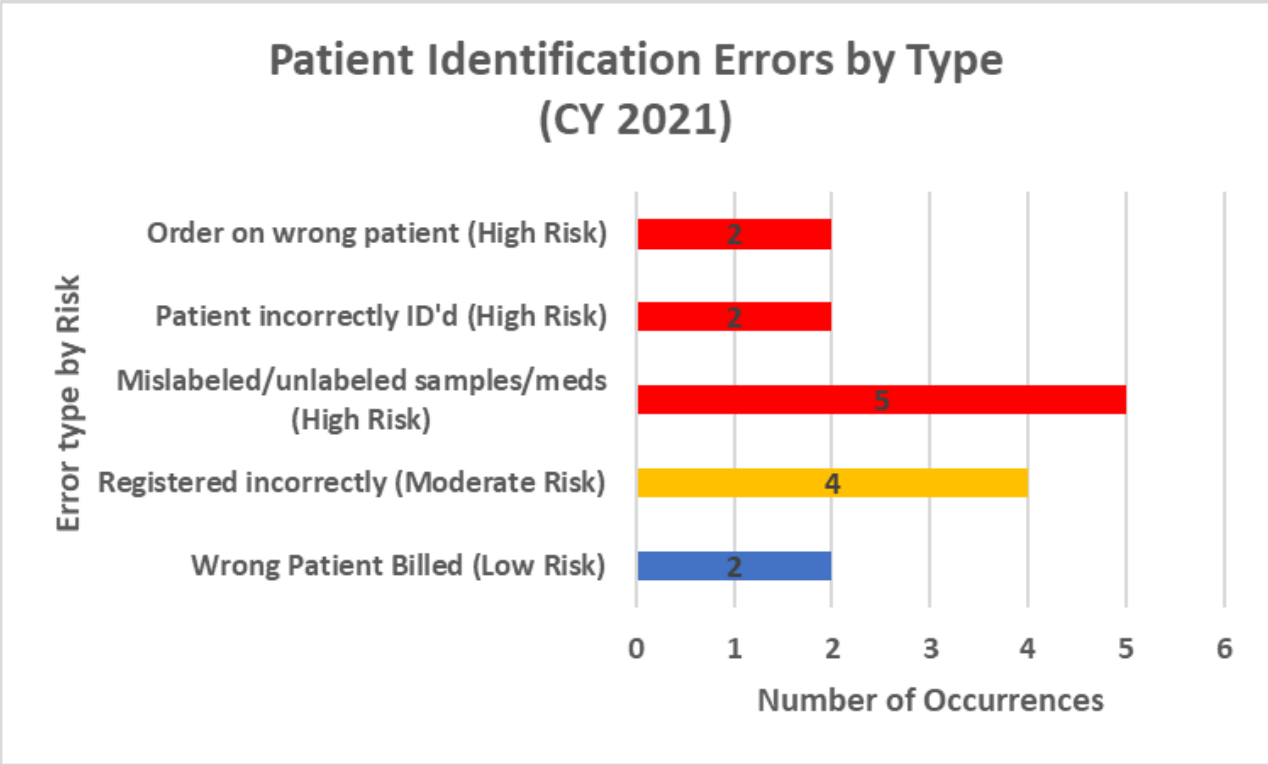
AIM Statement

Decrease High Risk Patient Identification Errors hospital wide to 0, and Low/Moderate Risk Patient Identification Errors to ≤ 6 by July 2022.

Measures

Baseline Data

- SQSS Occurrence Reports from Calendar year 2021 were used to obtain the baseline data. Reviewed a total number of 15 Patient Identification errors.



Measures

Establishing Measures

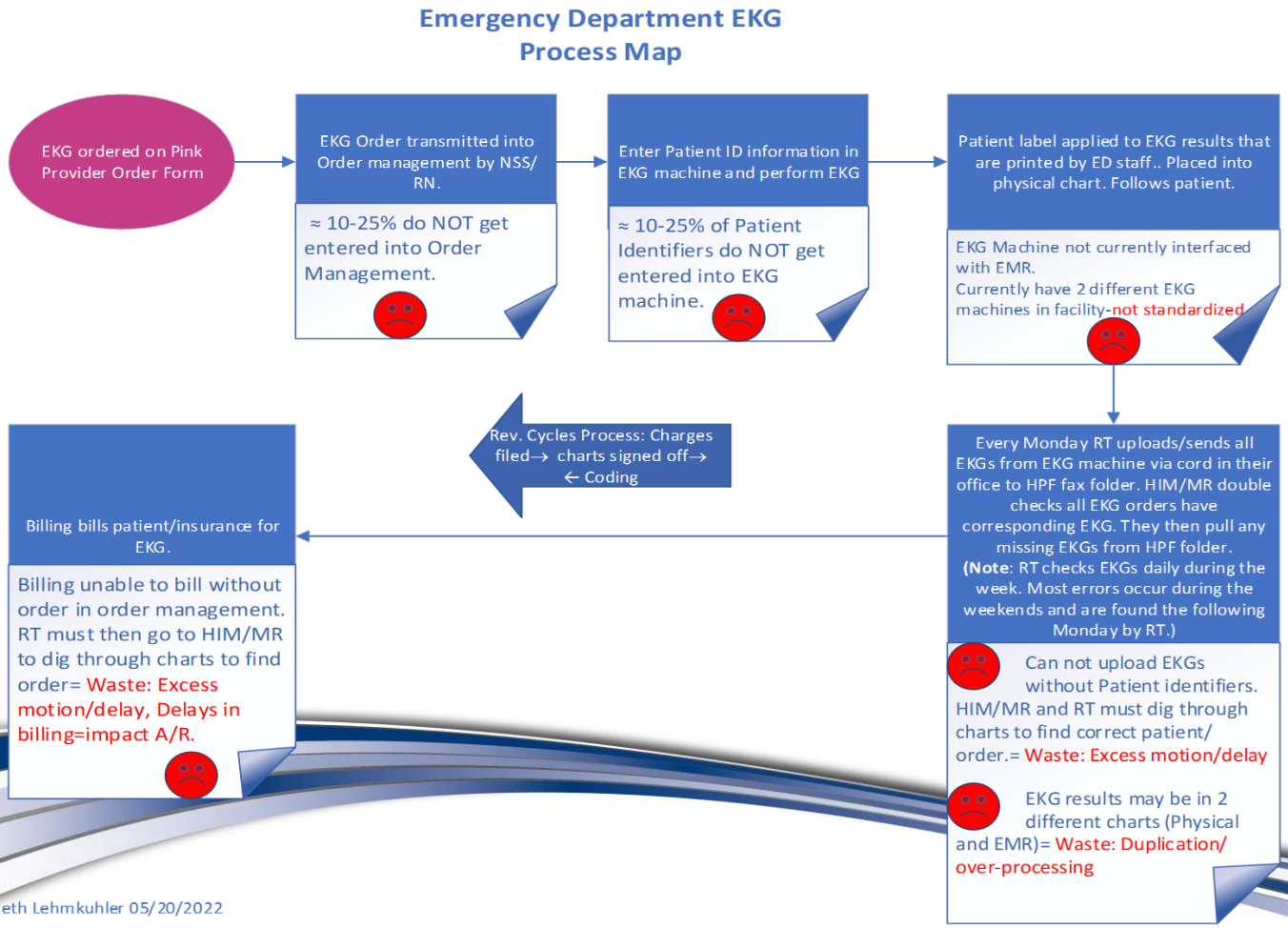
- Monitor number of Patient Identification Errors to include:
  - High Risk: Patient Identified Incorrectly, Order on Wrong Patient, Mislabeled/Unlabeled samples/medications
  - Moderate Risk: Patient registered incorrectly (misspelled name, DOB, etc.)
  - Low Risk: Wrong Patient billed

CY 21 Identification Occurrences	QTR 1 (Jan.-March)	QTR 2 (April-June)	QTR 3 (July-Sept.)	QTR 4 (Oct.-Dec.)	YTD
Wrong Patient Billed (Low Risk)	0	1 (Great Catch)	1 (Near Miss)	1	1
Registered incorrectly (Moderate Risk)	0	2	1 (Near Miss)& 1 occ		3
Mislabeled/unlabeled samples/meds (High Risk)	2	0	0		2
Patient incorrectly ID'd (High Risk)	1	1 (Great Catch)	0		1
Order on wrong patient (High Risk)	0	1 (Great Catch)	0		0
Total	3	2	1		6

Selecting Changes

- Selected changes based on risk and number of occurrences, which helped prioritize projects.
- Created audit checklist using references such as Patient Identification SAFER Guide: https://www.healthit.gov/ to help define current state.
- Conducted research for best practices (ECRI, WHO, ASM, HealthIT, etc) and compared to current facility practices to define expected process.
- Developed process maps of current processes, compared those to expected processes to identify gaps.

Selecting Changes



Rev. Beth Lehmkuhler 05/20/2022

PDSA

We had multiple projects with PDSA cycles based off the gaps that were identified and occurrence reporting trends.

- Policies: (Patient Identification Policy, Laboratory Specimen Collection, Labeling, and Rejection Policy)

1. Plan: Identify current state vs expected outcome. Research best practices. Identify gaps. Meetings held with interdisciplinary discussion. Draft/revise policies. Identify forms and charting that will need to change as a result. Identify staff that will be affected by the changes. Identify potential barriers.
2. Do: Trial of policy processes, feedback obtained, and revisions made. Implement policy and provide education.
3. Study: Monitor occurrence reporting for improvement. For example: Zero (0) Lab mislabeled specimens since implementation of revised Laboratory Specimen Collection, Labeling, and Rejection Policy on 4/12/22.
4. Act: Adopt policy and process.

PDSA

We had multiple projects with PDSA cycles based off the gaps that were identified and occurrence reporting trends.

- EKG Patient ID issues:

1. Plan: Identify gaps using process maps. Provided action plan based on those identified gaps. Prioritized actions. Meetings held with interdisciplinary discussion. Identified barriers- Had to table EKG integration with EHR, until new EHR budgeted/implemented.
2. Do: Education provided to staff. Implemented double checks daily instead of weekly.
3. Study: Monitor SQSS reports for improvements. Currently have hade Zero (0) EKG Patient Identification occurrences since May.
4. Act: Adopt daily double checks.

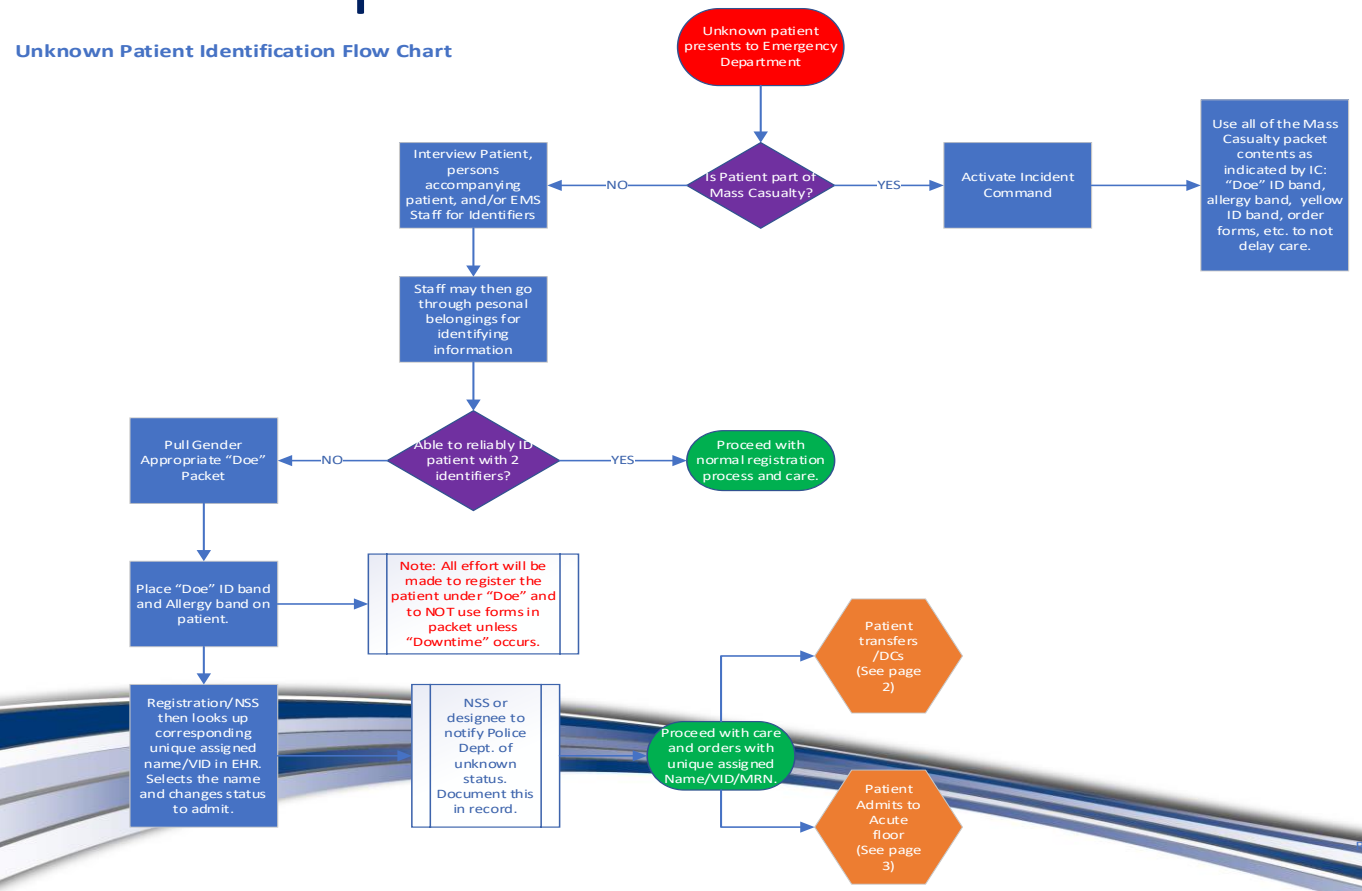
Implementing Change

Unknown Patient Identification Policy:

- Policy Drafted
- Process Map Created
- Packets revised
- Forms updated
- (Current State) Trial new process in ED using process map to obtain feedback. May need to conduct multiple trials with different ED staff (Day shift vs Night shift).
- Adopt, Adapt, or Abandon?

Implementing Change

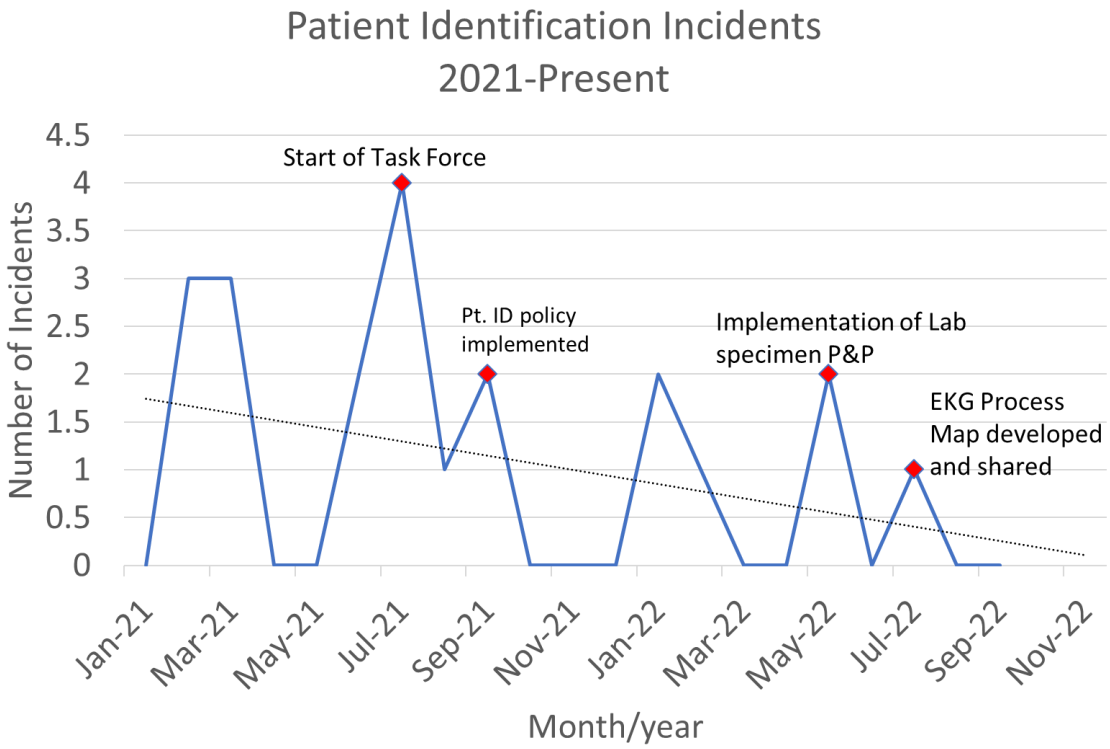
- Process Map



Implementing Change

- Some action items had to be tabled due to budgeting such as CPOE in ED due to new EMR.
- Talking Points, One-skill Competency Checklists, and Train the Trainer concepts used for education.

Data


Patient Identification Incidents
2021-Present
Number of Incidents
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Start of Task Force
Pt. ID policy implemented
Implementation of Lab specimen P&P
EKG Process Map developed and shared
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22
Month/year

Spreading Changes

- Interdisciplinary Team Approach
- Sharing Results (Shadow Box display)
- Celebrating Wins

Questions?

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References

- IHI: The Science of Improvement: How to Improve http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

- Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

- The Plan-Do-Study-Act (PDSA) cycle was published by W. Edwards Deming in *The New Economics for Industry, Government, and Education* [Cambridge, MA: The MIT Press; 2000]. For more on the development of the PDSA cycle and how it differs from PDCA, see: Moen RD, Norman CL. Circling back: Clearing up myths about the Deming cycle and seeing how it keeps evolving. *Quality Progress*. November 2010.

- Patient Identification Issues, ECRI Institute: https://www.ecri.org/Resources/HIT/Patient%20ID/Patient_Identification_Evidence_Based_Literature_final.pdf

- Patient Identification SAFER Guide: https://www.healthit.gov/