Using a Patient Identification Checklist: How to Make This a Never Safety Event in Perioperative Services

Alita Campbell, MSN, RN, OCN, Soo Ok ,MSN, RN, CPAN, Jarrod Esguerra, BBA & David Luo, MIE, BSIE

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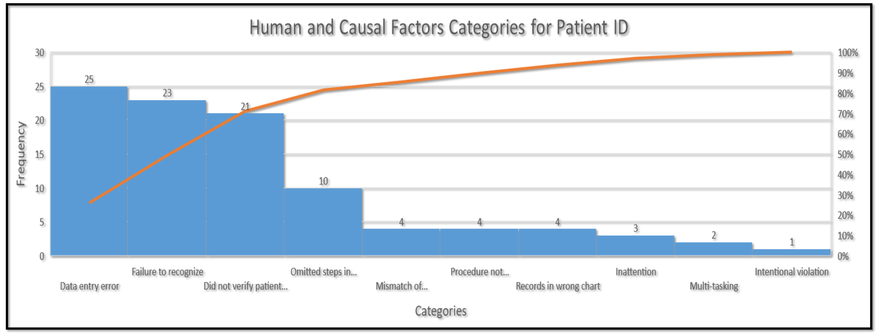

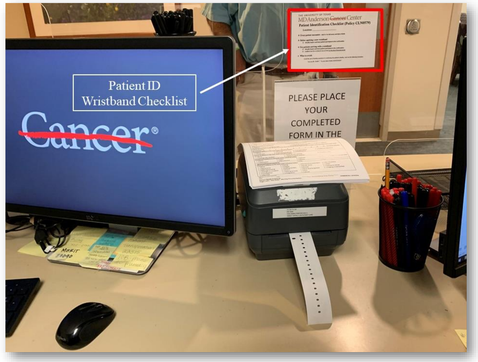

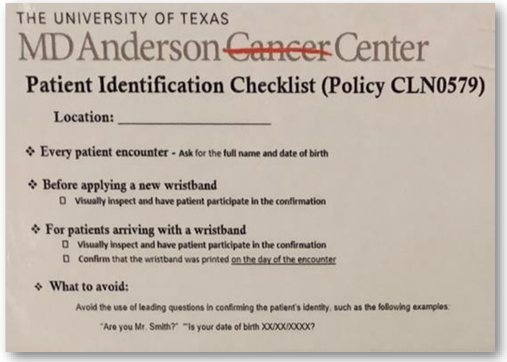

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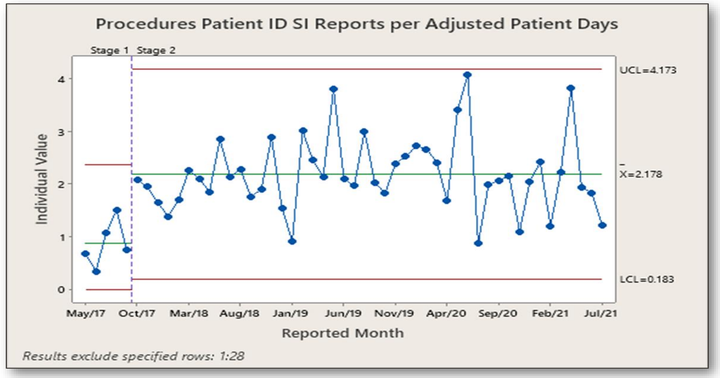

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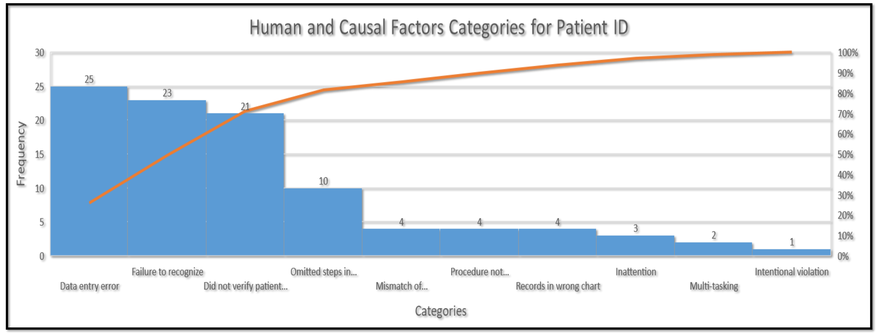

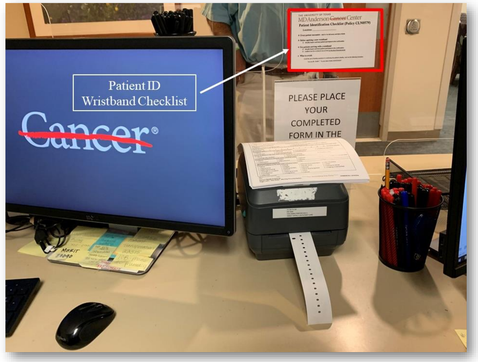

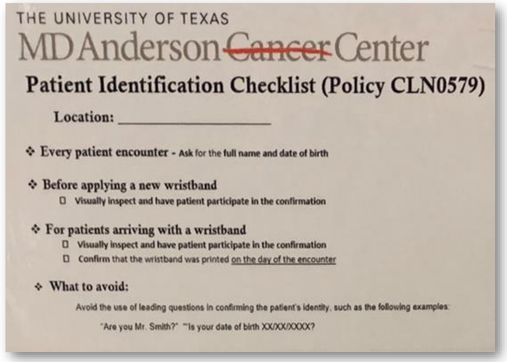

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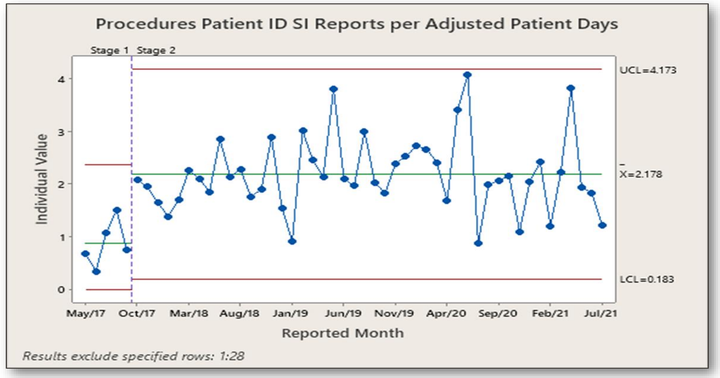

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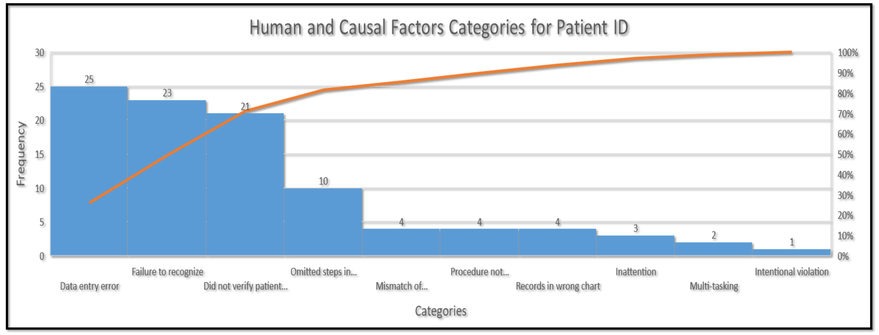

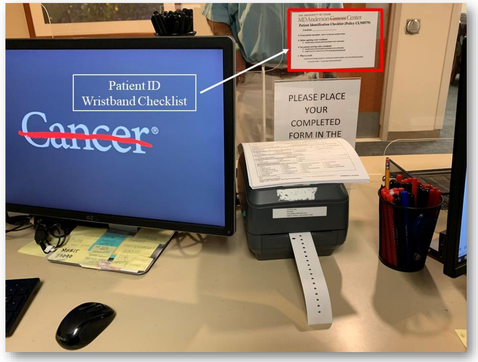

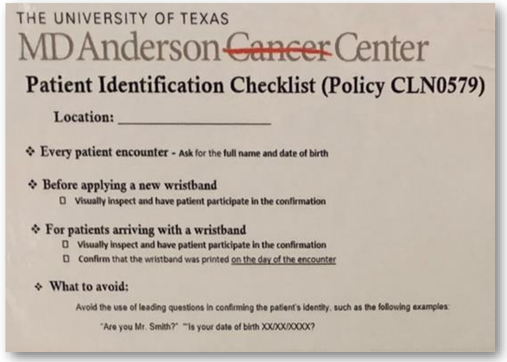
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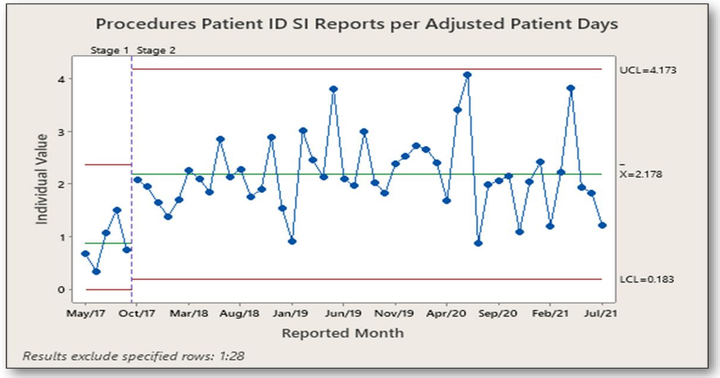

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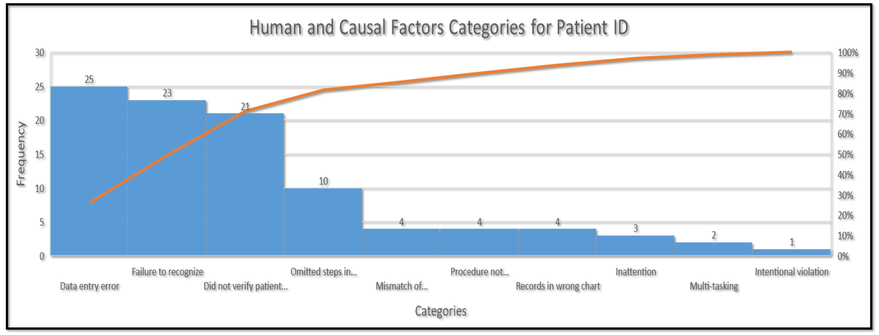

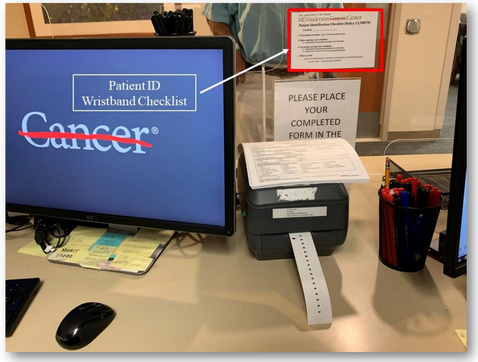

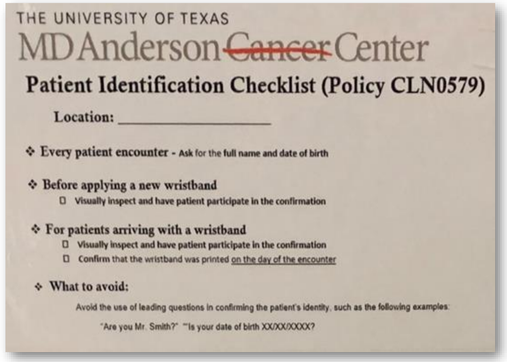

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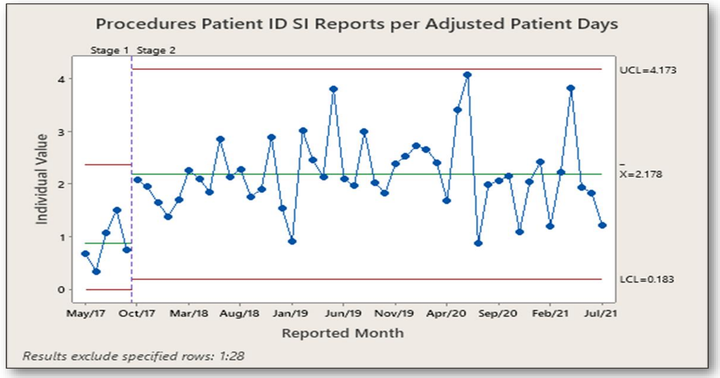

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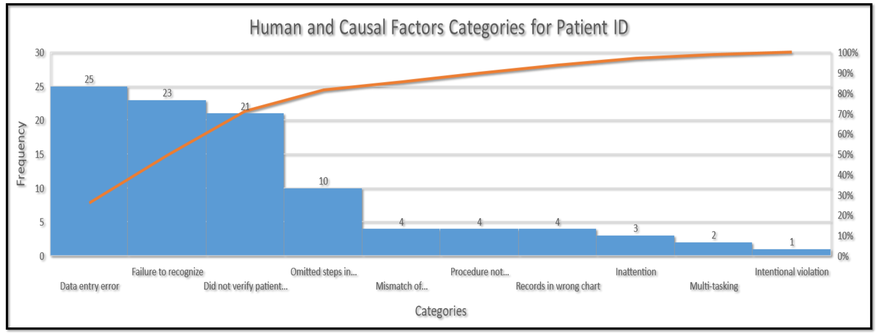

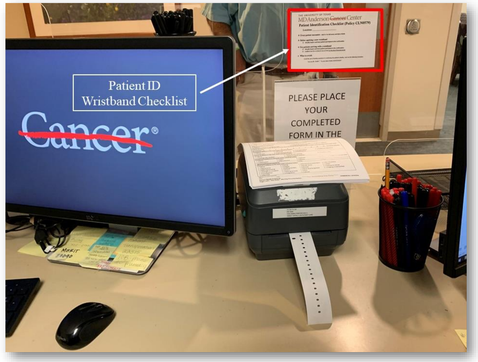

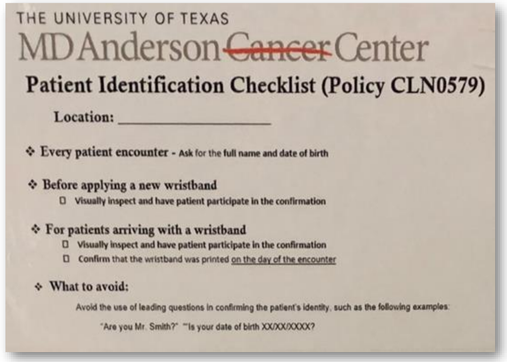

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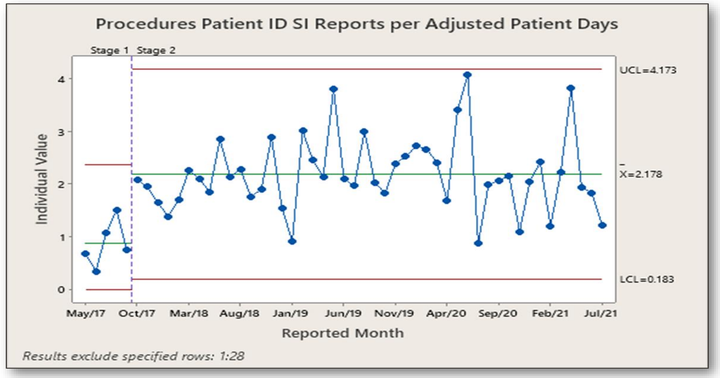

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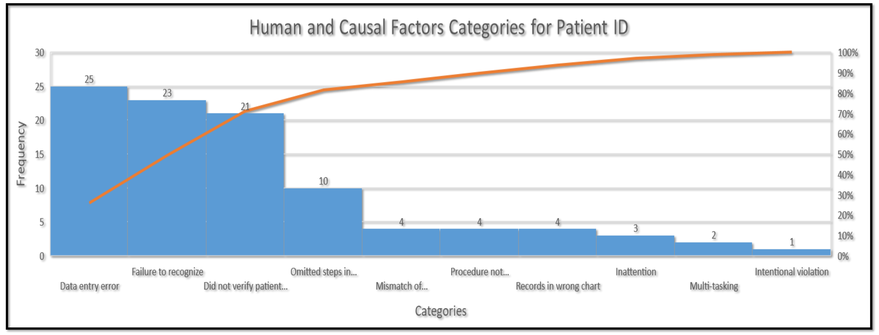
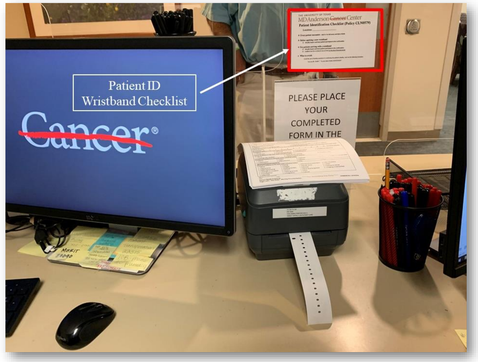
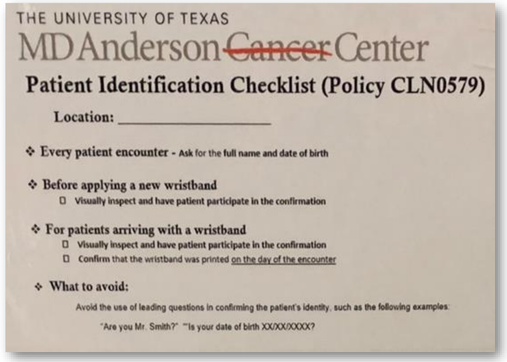






THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

Patient Identification Checklist (Policy CLN0579)

Location: _____

- ❖ **Every patient encounter** - Ask for the full name and date of birth
- ❖ **Before applying a new wristband**
  - ☐ Visually inspect and have patient participate in the confirmation
- ❖ **For patients arriving with a wristband**
  - ☐ Visually inspect and have patient participate in the confirmation
  - ☐ Confirm that the wristband was printed on the day of the encounter
- ❖ **What to avoid:**

Avoid the use of leading questions in confirming the patient's identity, such as the following examples:

"Are you Mr. Smith?" "Is your date of birth XX/XX/XXXX?

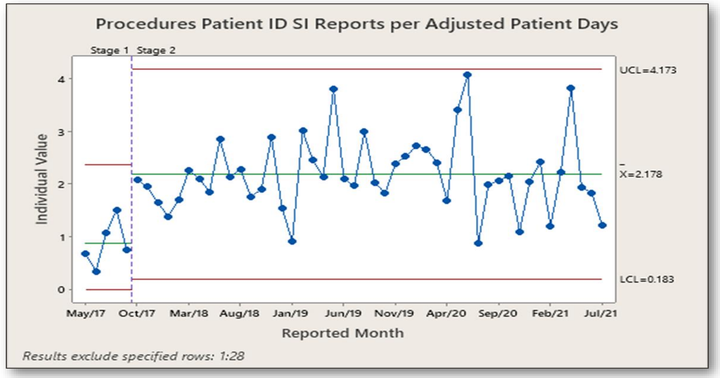
Statement of Successful Practice

After education was provided for the staff, 50 in-person audits were completed to observe the improved wristband check-in process.

The baseline data included five patient ID safety events for PACU/Pre-op. With the implementation of the new workflow, there were zero patient ID events.

The patient ID wristband checklist helped reduce the number of patient ID events related to wristbands. but is dependent on the employee adhering to the checklist..

Patient Identification Procedures Data



Implications for Peri-anesthesia Nursing

Not verifying patient information is a top causal factor for patient ID errors overall.

Adhering to a standardized checklist and following best practice standards for patient identification can help ensure this becomes a "Never Event" in Perioperative Services.

Enhancements

- ❑ Provided double monitors to open multiple applications for the check in process.
- ❑ Purchased clipboards and Real Time Location System (RTLS) tracking devices to interface with OR status board technology.
- ❑ All first start case charts are provided in an alphabetical file box.
  - ▪ RN checks documents prior to entering room with a two-person verification for accuracy.

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