Implementation

After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

- The checklist was laminated and posted at eye level of the Patient Service Coordinator.
- The wristband and label printer were relocated closer to the workstation for ease of use.
- The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
- The level of lighting was also adjusted to improve visualization by patients and staff.

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.

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carmen Edwards, Patient Service Coordinator
Shelita Hilton, Patient Service Coordinator
Nora Khronoe, Patient Care Technician
Nicole Monroe, Patient Service Coordinator
Julie Nichols, Patient Service Coordinator
Raquel Porter, Patient Service Coordinator
Deddie Simms, Patient Service Coordinator
Latrisa Smith, Patient Service Coordinator
Elisy Puthenparampil, DNP, RN
Carmen Gonzalez, MD

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

Background

Positive patient identification is one of the Joint Commission National Patient Safety Goals, which involves accuracy, verification and two-way communication. Incorrect patient identification can result from patient armbands not matching patient labels or paperwork.

Patient identification errors are reviewed at the executive level as high-risk safety events. These events can lead to potentially serious errors in the perioperative area. The surgery check-in area identified opportunities for improvement in the workflow, interview techniques and equipment locations.

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carmen Edwards, Patient Service Coordinator
Shelita Hilton, Patient Service Coordinator
Nora Khronoe, Patient Care Technician
Nicole Monroe, Patient Service Coordinator
Julie Nichols, Patient Service Coordinator
Raquel Porter, Patient Service Coordinator
Deddie Simms, Patient Service Coordinator
Latrisa Smith, Patient Service Coordinator
Elisy Puthenparampil, DNP, RN
Carmen Gonzalez, MD

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.

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carmen Edwards, Patient Service Coordinator
Shelita Hilton, Patient Service Coordinator
Nora Khronoe, Patient Care Technician
Nicole Monroe, Patient Service Coordinator
Julie Nichols, Patient Service Coordinator
Raquel Porter, Patient Service Coordinator
Deddie Simms, Patient Service Coordinator
Latrisa Smith, Patient Service Coordinator
Elisy Puthenparampil, DNP, RN
Carmen Gonzalez, MD

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

Background

Positive patient identification is one of the Joint Commission National Patient Safety Goals, which involves accuracy, verification and two-way communication. Incorrect patient identification can result from patient armbands not matching patient labels or paperwork.

Patient identification errors are reviewed at the executive level as high-risk safety events. These events can lead to potentially serious errors in the perioperative area. The surgery check-in area identified opportunities for improvement in the workflow, interview techniques and equipment locations.

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.
Implementation

After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

 The checklist was laminated and posted at eye level of the Patient Service Coordinator.
 The wristband and label printer were relocated closer to the workstation for ease of use.
 The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
 The level of lighting was also adjusted to improve visualization by patients and staff.

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.

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.

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carrie Edwards, Patient Service Coordinator
Shelita Hilton, Patient Service Coordinator
Nora Khronne, Patient Service Coordinator
Julie Nichols, Patient Service Coordinator
Raquel Porter, Patient Service Coordinator
Deddie Simms, Patient Service Coordinator
Latrisa Smith, Patient Service Coordinator
Elsy Puthenparampil, DNP, RN
Carmen Gonzalez, MD
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

Background

Positive patient identification is one of the Joint Commission National Patient Safety Goals, which involves accuracy, verification and two-way communication. Incorrect patient identification can result from patient armbands not matching patient labels or paperwork.

Patient identification errors are reviewed at the executive level as high-risk safety events. These events can lead to potentially serious errors in the perioperative area. The surgery check-in area identified opportunities for improvement in the workflow, interview techniques and equipment locations.

Aim

The aim of this project was to reduce patient identification errors by 25% during procedures within 6 months. The overall goal was to provide Just Culture and accountability training to sustain no high harm and reduce patient ID reported procedures events.

Implementation

After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

- The checklist was laminated and posted at eye level of the Patient Service Coordinator.
- The wristband and label printer were relocated closer to the workstation for ease of use.
- The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
- The level of lighting was also adjusted to improve visualization by patients and staff.

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.

Statement of Successful Practice

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carmen Gonzalez, MD

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.
Implementation

After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

- The checklist was laminated and posted at eye level of the Patient Service Coordinator.
- The wristband and label printer were relocated closer to the workstation for ease of use.
- The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
- The level of lighting was also adjusted to improve visualization by patients and staff.

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.

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.

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.
Implementation

After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

- The checklist was laminated and posted at eye level of the Patient Service Coordinator.
- The wristband and label printer were relocated closer to the workstation for ease of use.
- The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
- The level of lighting was also adjusted to improve visualization by patients and staff.

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

<table>
<thead>
<tr>
<th>Procedures Patient ID 51 Reports per Adjusted Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Month</td>
</tr>
<tr>
<td>Jan '21</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>2.1</td>
</tr>
</tbody>
</table>

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.

Acknowledgements

Ashley Ajala, Patient Service Coordinator
Carrie Edwards, Patient Service Coordinator
Shelita Hilton, Patient Service Coordinator
Nora Khronre, Patient Service Coordinator
Julie Nichols, Patient Service Coordinator
Nicole Monroe, Patient Service Coordinator
Raquel Porter, Patient Service Coordinator
Deddie Simms, Patient Service Coordinator
Latrisa Smith, Patient Service Coordinator
Prep Nursing Staff

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.
After reviewing the current workflow and observation audits, a Patient Identification Checklist supporting hospital policy was developed.

- The checklist was laminated and posted at eye level of the Patient Service Coordinator.
- The wristband and label printer were relocated closer to the workstation for ease of use.
- The filing order for patient charts was changed from OR room number to alphabetical order of last name to reduce chart adjustments.
- The level of lighting was also adjusted to improve visualization by patients and staff.

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.