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Promoting Proper and Correct Patient Identification – A Transfusion Medicine Perspective

By Homer Wiland, M.D., pathology resident, Cleveland Clinic Foundation, and Roslyn Yomtovian, M.D., quality scholar fellow, Louis Stokes VA Medical Center, and clinical professor of pathology, Case Western Reserve University, Cleveland, Ohio

Proper and correct patient identification is especially important to ensure patient safety during transfusion. Blood transfusion is one of the most common, yet high-risk procedures performed on hospital inpatients.

Transfusion of an ABO-incompatible red blood cell unit is associated with significant morbidity and mortality; however, despite the high risk of this procedure, patient misidentification remains a significant problem in transfusion medicine and is a leading cause of ABO-incompatible transfusions.¹ More than 1,000 blood samples are estimated to be collected from the wrong patient each day in the United States.^{2,3}

This article will offer simple solutions designed to enhance patient identification prior to blood transfusion. Our ideas may or may not be relevant for other VA medical facilities, but we hope that our efforts will encourage readers to take second look at local procedures.

Recommendations

Our recommendations include actions to improve the patient identification process and to detect instances in which misidentified patient blood samples reach the blood bank.

Issue a patient identification checklist

We have designed a checklist (Table 1) that highlights essential steps we believe can enhance the patient identification process, including asking a patient to state his/her name and social security number. We believe the social security number, used throughout the VHA at this time, is the most useful unique patient identifier in that patients should be able to state it by memory, unlike a medical record number, and it is more reliable than a birth date in confirming correct identity. The checklist has been distributed to all phlebotomy personnel at the

Louis Stokes VA Medical Center (LSVAMC) so that each phlebotomist can carry it alongside their identification badge.

In addition to acting as a reminder, we believe a checklist can serve other purposes. For example, patients may sometimes be reluctant to provide their name or social security number before having blood drawn, especially if they are familiar with a phlebotomist or a nurse. Phlebotomists, too, may be reluctant to comply with proper identification protocol in such circumstances. The checklist, however, serves as a reminder to all involved that patient identification protocol is required at all VA hospitals.

Eliminate complex steps in patient identification

After reviewing our institution's protocol for phlebotomy, we found that all transfusion phlebotomies, as opposed to phlebotomy for other purposes, incorporate two additional steps designed to correctly identify patients and enhance patient safety:

- Verification by a second person (i.e., the patient's nurse)
- Use of a second identification band on the patient's wrist

Ironically, we contend that these additional steps can *reduce* patient safety by increasing the complexity of the process. For instance, if two people are responsible for correct patient identification (i.e., phlebotomist and nurse), this diffusion of responsibility can result in a lack of clarity and loss of individual accountability.

We incorporated the second identification band into our checklist because it is currently a mandatory protocol at our institution. We would prefer a "checklist," as it were, to consist of nothing more than "ask patient to state name and social security number." The second and third checks are separated because we

Developing a Culture of Safety: One VA Facility's Story

By Joe Murphy, APR, NCPS public affairs officer

Staff members at the Kansas City VA Medical Center have taken a wide range of actions to improve patient safety at their facility.

"It took a tremendous amount of effort," said Glenna Greer, staff assistant to the director. "It started with leadership identifying that improved communication at all levels of the organization was needed."

The facility had scored significantly below VHA averages in all 14 dimensions of the 2005 patient safety survey; however, that would not be the case four years and a lot of hard work later.

Scores from the 2009 survey indicated that Kansas City had risen dramatically in each dimension and matched the scores of the majority of VA medical centers.

NCPS conducts a VHA patient safety culture survey nationally every three to five years to measure changes in the patient safety culture, the first having been conducted in 2000.

More than 54,000 employees participated in the 2009 survey; 45,000 in 2005.

Placing Strategic Messages

One of the first things the facility did was to purchase 15 48-inch plasma screens and place them strategically throughout the facility, initially to promote patient safety and quality improvement.

Greer said when the screens were first purchased, she thought they should be geared toward patients, and visualized them in waiting rooms. But the director had a different idea: He wanted them to focus on employees.

"We placed them strategically in elevator lobbies," she said. The idea was to make the wait for an elevator be perceived as shorter because those waiting could focus on the screens.

"Everything is very bold and very colorful. We have a team that works on this."

Imaginative contests were combined with related patient safety information to attract attention. For instance, the facility's patient safety manager, Sharon Klein, used a contest to underline the importance of patient identification.

Over a period of days, a well-known employee's silhouette was created on the screen in black and white, piece by piece: Different facial features would be revealed, like a nose, an ear or the hair.

The contest to identify the employee was also promoted and a significant number of staff members participated. "And on the screen it always said, 'Be sure and identify your patient using full name and full social security number,'" noted Klein.

Leadership and the Greeter Program

What began as a "Greeter Program" significantly enhanced patient safety efforts, in large measure due to senior management involvement.

Among those who volunteered to spend one hour a week as a greeter were the director, associate director and a number of service chiefs. "All of them got a fresh look on what was going on down on the front lines," said Klein.

"Our director targeted leadership to help," she continued. "With the success of the Greeter Program we were included in the 'Affirming the Commitment' video developed by VA Central Office, because it was considered a 'best practice.'"

"And I will tell you, there were so many things identified to improve. We didn't have enough wheelchairs. That's

a huge safety issue. People couldn't find a wheelchair when they dropped their family member off," said Greer.

"And they didn't have any idea where to go. The signage wasn't very good," added Klein.

More wheelchairs were added, a facility map was developed, and signage improved.

"Benches were placed out in front, too," said Greer, "so patients who were frail would have some place to wait prior to being picked up if they didn't need a wheelchair."

One of the greeters had identified the problem, saying: "Think about a frail WWII Veteran waiting for his wife to go get the car."

To help make it more convenient for patients and families, a shuttle service was also implemented throughout the parking lot.

"The shuttle drivers became our lookouts. We've had super responses from shuttle drivers who identified someone about to fall and could intervene," Greer added. "And Sharon and I talked about all this – it's like all of these things started coming together. There has been this cultural change."

Improving Root Cause Analysis

To promote the quality and timelines of root cause analysis (RCA), NCPS developed the Cornerstone Recognition Program in fiscal year 2008.

"We were struggling with the RCA teams," Klein noted. "We wanted to meet the Cornerstone goals and really pursue improving the RCA process at our facility."

The program incentivizes VA facilities to complete stronger RCAs. The recognition criteria focus on timeliness and strength of actions, as

well as reporting back on the impact of actions taken.

Facilities can earn bronze, silver or gold awards, based on the number of RCAs completed and the quality of the them.

One of the facility's challenges was to get more care givers to participate: An internal award program was developed to enhance this effort.

"We said that if you participate, do things like help develop strong actions and outcomes, you will get an award. Team members are awarded \$150 each if they fulfill the award criteria," she said.

The plasma screens were also used to promote the RCA teams. "We'd take a picture of the team," Klein continued, "and put it on the plasma screens along with the title of what they worked on. It always makes participants feel good."

Greer noted that Healthcare Failure Mode Effect Analysis (HFMEA) team members were also eligible for the personal awards.

Developed by NCPS, HFMEA is a five-step process used by interdisciplinary teams to evaluate a health care process.

More than 1,000 have been conducted VA-wide on issues ranging from developing backup medication delivery systems to improving how laboratory specimens are drawn.

The facility director, Mr. Kent Hill, wanted to go a step further and began annual team awards ceremonies that include RCA and HFMEA teams.

Greer said that more than 30 teams have been recognized in a single ceremony. "We wanted them to know they were being recognized for what they worked on and the results they had achieved," she added.

A Facility Patient Safety Log

The facility developed an interactive patient safety log for its Intranet site in 2007. It is open to all employees and it can be used anonymously. New entries are prepared daily for leadership's morning report.

Klein said the reason it was developed was to enhance the facility's incident report system.

"It's a backup system," she said, "but it also allows people to report something they don't think is an 'incident,' per say, but could be a safety hazard."

Greer continued: "You know, someone might say, 'There's a broken tile in the patient bathroom. I've spoken about this three times and no one has responded.' We take something like this to morning report along with a hard copy that is handed to the service chief for facilities."

"I recently got one," said Klein. "We are working to migrate our policies to a SharePoint® and there's a learning curve with it."

A nurse was having a difficult time using the search engine. "The nurse thought of this as a patient safety issue, because she couldn't find a policy she needed concerning an aspect of patient care," Klein continued.

If it appears employees are not using the log routinely, Klein noted: "We'll go out with an email to everyone as a reminder not to forget to use the patient safety log."

Emails are also used to present specific patient safety tips to employees, as are screen savers.

Patient Ambassador and "Mystery Shoppers"

The facility patient ambassador includes questions about safety when speaking with patients.

Klein said: "She has standard questions that she asks them. One or two of them always go something like: 'How safe do you feel about the care you are receiving?' And if they don't answer in a positive manner, she asks them, 'What is the issue and how can we address it to make you feel safer?' This information is brought to leadership's attention, too."

"Mystery shoppers" are part of the facility's Veteran Advisory Group and their identity is unknown to care givers.

"They are our eyes and ears out there," said Klein. "If they see things like a safety issue, or a communication issue, it is reported. We don't publicize their names, but they are patients and we have one family member on the team."

Turning the Ship

Developing a culture of safety takes time, commitment and patience – not to mention consistent leadership involvement and participation by staff members at all levels.

"You know, you have been working on this for years and then you begin to see it happen," said Klein, "and it's based on all the work that everyone has been doing."

Developing a culture of safety is somewhat like turning a huge, ocean-going ship.

"It is," noted Greer, "and it's been a slow turn, but we are starting to see results and it's really exciting."

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wanted to slow the process down and make sure it was completed properly; i.e., at the patient's bedside and based on the patient's hospital identification band. (More on this issue below.)

Standardizing the phlebotomy procedure

We propose that a single, standardized approach to all phlebotomies can facilitate the process of learning, remembering and adhering to proper phlebotomy protocol, including verbal verification of patient identification.

All phlebotomies carry significant risk. If a misidentified blood sample results in a healthy patient being treated for hyperglycemia or hypokalemia, clinical consequences can be fatal: Therefore, we argue that *all* phlebotomies are *equally important* and should be performed in a standardized fashion. It is prudent, however, for hospitals to have a system in place to independently verify the results of blood collected for typing, once it is received by the blood bank, as this system may detect blood collected from a misidentified patient, which we discuss below.

Implement a two-specimen requirement for ABO verification prior to transfusion

Although efforts to improve verbal verification of a patient's identity may significantly reduce the rate of patient misidentification, problems in the identification process can still occur and should be anticipated by the hospital laboratory. While clinical-pathologic correlation may at times hint that a blood sample was drawn

from a misidentified patient and warrant a re-draw, it's not possible with transfusion phlebotomies, which test for a trait (i.e., blood type) rather than a disease marker. For this reason, the blood bank should employ a system to independently verify transfusion phlebotomy samples.

New innovations, such as mechanical barrier devices, bar coding and radio frequency identification technology, all offer promising methods of independently verifying a patient's identity at the time of transfusion; however, the new technologies are not available at all VA medical centers.

A two-specimen requirement for ABO verification represents a more immediate option, one that is growing in popularity and use: It's a proven and cost-effective practice designed to detect wrongly collected blood samples prior to blood transfusion.

We believe that use of an independent ABO sample can eliminate the need for a second identification band and the vulnerabilities associated with such cognitive aides. For instance, a second identification band is incapable of detecting incorrect information on the initial identification band – but ABO verification has the ability to do so. This system entails verifying a patient's ABO blood group with two independently collected samples, one of which may include a prior historic blood type. In essence, those patients who require a second sample drawn (i.e., check-type sample) are those patients who:

- Require non-emergent blood transfusions
- Are of any blood group, including blood group O. (Re-checking patients initially typing as blood group O, while not always performed by facilities that perform a duplicate type, is nonetheless advocated because it will provide uniformity and ensure accuracy of blood group results of all VA patients on file.)
- Do not have a historic blood group on file at any VA facility

Several studies at large institutions have documented the effectiveness of this system in preventing ABO-incompatible transfusions due to patient misidentification.^{4,5} A cost analysis at a nearby institution determined the marginal cost of a single check-type phlebotomy to be \$2.39.⁴ With an estimated 140 check-type phlebotomies required at our institution every year, the predicted yearly cost of conducting the ABO verification system at our institution is less than \$1,000. Second identification bands at our institution currently cost \$2.60/band, making the estimated yearly cost of their use about \$2,600/year.

Conclusion

We believe our recommendations are achievable and that they can ensure correct patient identification and improve the safety of blood transfusion. We urge readers to investigate current systems in their institutions designed to enhance patient identification prior to transfusion – with our recommendations for improvement in mind.

References and Note

References online: www.patientsafety.gov

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Table 1: Prototype Checklist

*Mandatory Steps to Ensure Correct Patient Identity
Based on Current LSVAMC Procedures*

Before conducting a phlebotomy, my employer requires me to...

- ✓ Ask the patient to state his/her full name and social security number
- ✓ Prepare the patient's second ID band at the bedside
- ✓ Prepare the second ID band using identifier information found on the patient's hospital band