Service Priorities and Programmes

Electronic Presentations

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Patient Identification betterment program by Multi-disciplinary approach

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Introduction
Accident and Emergency department (AED) was an incident prone area. The high flow and high volume nature created stress that coerce emergency nurses to cut corner. In addition, distraction and frequently interrupted by urgent but not important tasks contribute high error rate. Medication and specimen incident was most common error in AED. When investigate in detail about those incidents. The major root cause was misidentification. The Patient Identification Betterment can demonstrate reduce mis-identification.

Objectives
1. Nurses were comply to patient identification Standard Operation Procedure (SOP)
2. Monthly misidentification rate reduced 50 percent by the end of 2013

Methodology
PDCA Cycle Planning Set Objective: 1. Nurses were comply to patient identification Standard Operation Procedure (SOP) 2. Monthly misidentification rate reduced 50 percent by the end of 2013. Seek top management support on Patient Identification Betterment (PIB) program. Share related incidents and show statistic in nurse handover to arouse colleagues' awareness. Form a workgroup including multiple discipline involvement, project plan including lecture, Pre and post audit. Do: Conjoint meeting invited Tseung Kwan O Hospital (TKOH) AED doctor and nurses, KEC Q&S department colleague and TKOH pharmacy colleagues. Five improve measures follow by five project team. 1. Develop Patient Identification Standard Operation Procedure (SOP) 2. Technology aid: Computer aid discharge project 3. Lecture on patient identification 4. Patient engagement (video show to education patient engaged in patient identification) 5. Audit (pre and post).

Result
Check: Pre and Post Audit Pre-audit on comply on patient identification completed on 21 Sept 2013, over ninety percent of TKOH AED nursing staffs participated in this observational audit. The compliance rate was sixty-two percent. Two main non-compliant items were call patient's name instead of ask patient's name and had

not engaged patient to check handover documents. Briefing the audit result and remind staff non- compliant items through shift handover and by email. Post audit completed on 28 Sept 2013 with 100 percent compliance rate. Act / Adjust: Patient Identification SOP developed and implemented in TKOH AED, compliance was monitor by audit. Computer aid discharge project demonstrated can reduce patient mis-identification. From multiple disciplinary participate lecture, we can enhance mutual trust and think win-win solution to reduce medication error. Patient engaged education TV is showing in Tseung Kwan O hospital waiting hall. This program demonstrated can reduce patient misidentification and reduce medication incident,