Who Am I?

Western Health and Social Care Trust

Mary P. Mc Nicholl,
Haemovigilance Practitioner

Who Am I?

Alexander Browne

Alex Browne

Sandy Browne

John Alexander Browne

Alexander Brown

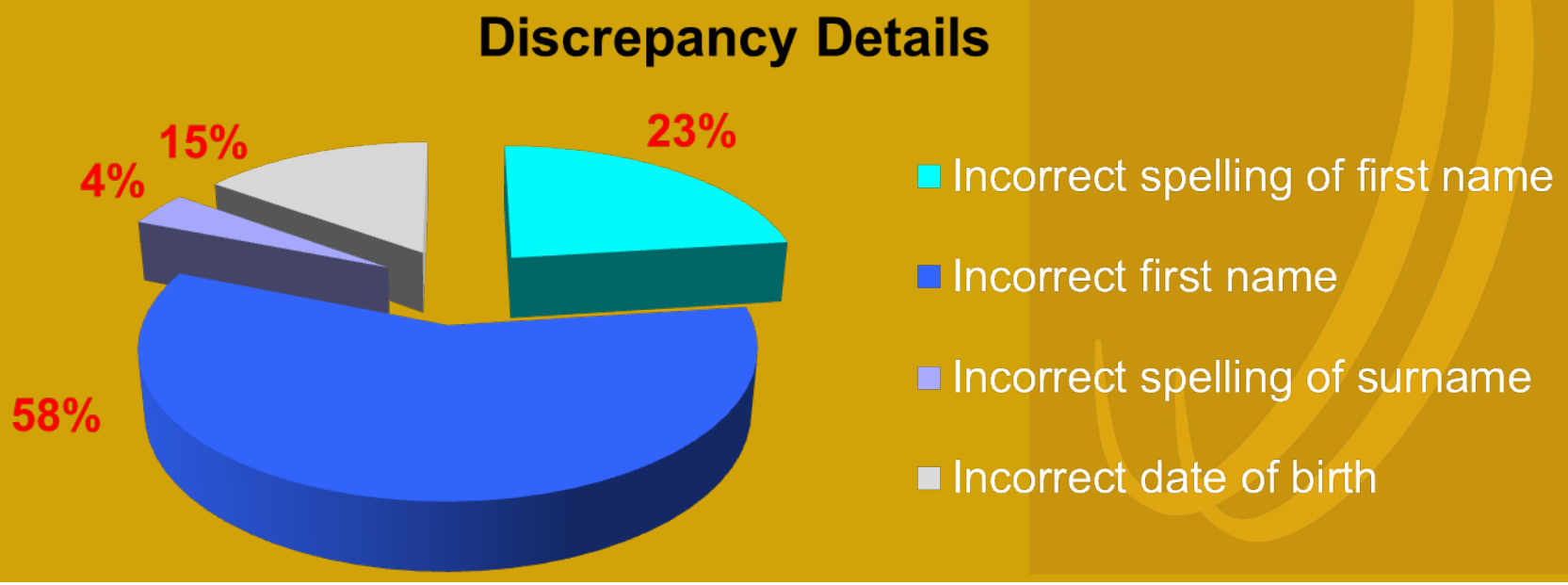
Alex Brown

Sandy Brown

Extent of problem with patient not being correctly identified

Audit in Altnagelvin 01.03.14 to 31.05.14:-

- 26 patients (approx 9 per month) – patient details on Admissions system different from Laboratory system (which were confirmed as correct by Clinical Area).



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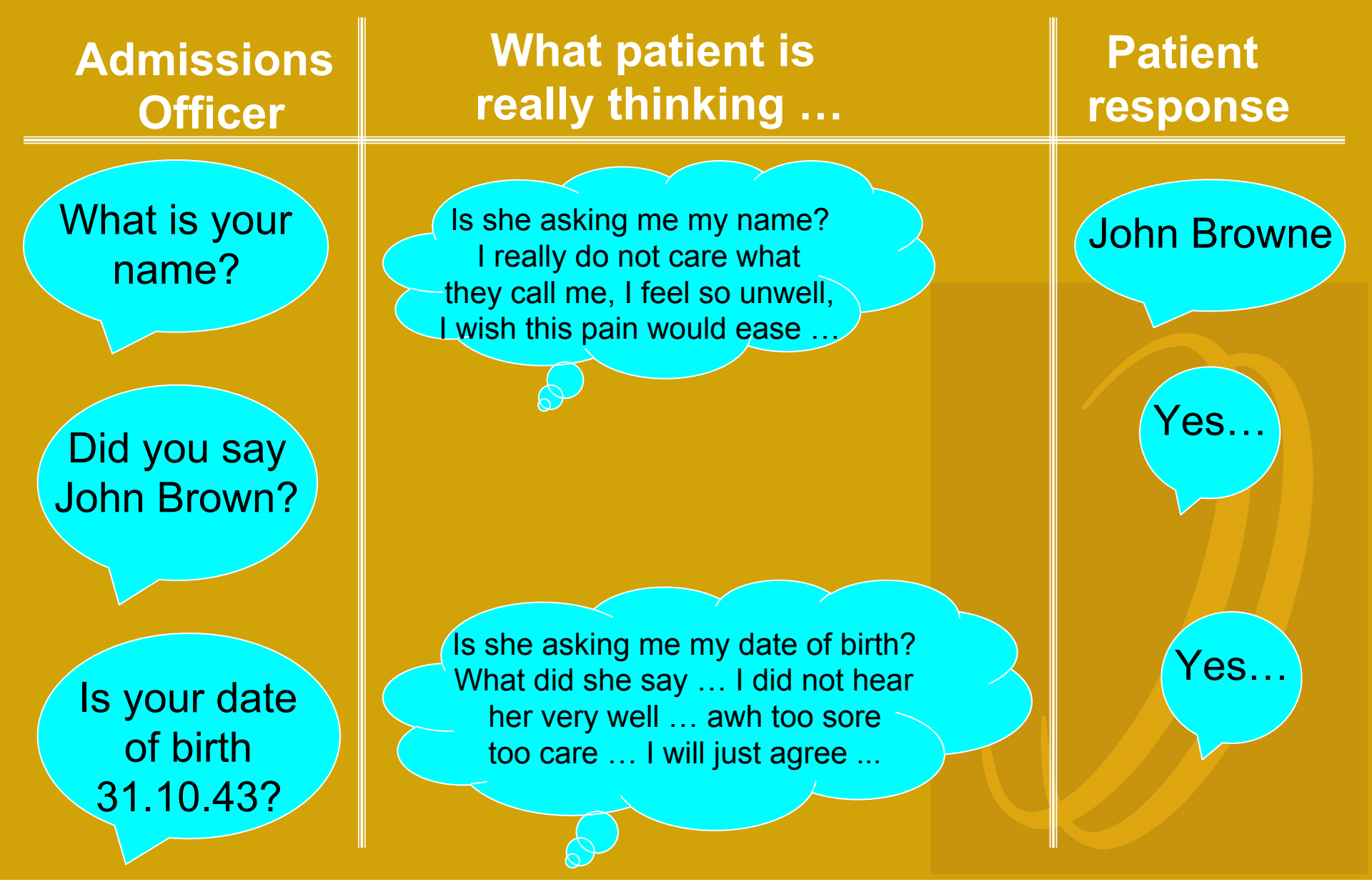
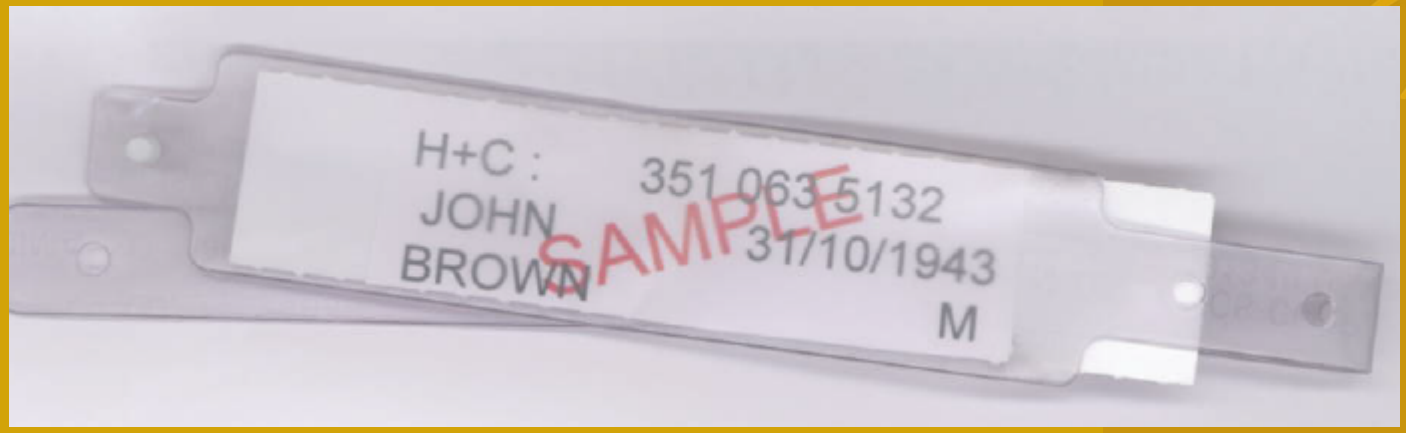
Admissions Officer	What patient is really thinking …	Patient response
What is your name?	Is she asking me my name? I really do not care what they call me, I feel so unwell, I wish this pain would ease …	John Browne
Did you say John Brown?		Yes…
Is your date of birth 31.10.43?	Is she asking me my date of birth? What did she say … I did not hear her very well … awh too sore too care … I will just agree ...	Yes…



Patient admitted to Clinical Area

- Patient identification wristband applied to patient - sent from Admissions Office.



- Patient now requires pretransfusion sample.

Staff member taking pretransfusion sample	What patient is really thinking …	Patient response
Is your name John Brown?	Is he asking me my name? I really do not care what they call me, I feel so tired …	Yes…
Is your date of birth 31.10.43?	Is he asking me my date of birth? What did he say … I did not hear him very well … awh too tired too care … I will just agree ...	Yes…

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Sample sent to Blood Bank

	Details on Request Form & Sample	Details on Laboratory System
First name	John	Alexander John
Surname	Brown	Browne
Date of birth	31.10.43	31.10.43
H&C Number	351 063 5132	351 063 5132

- Blood Bank contact Clinical Area to confirm patient's official first name & spelling of surname.
- Clinical Area inform Blood Bank that patient is **Alexander** John Browne.
- Sample rejected, patient to be rebled.

Impact of sample / form labelling errors

- Potential for adverse consequences for patients.
- Substantial time and effort for Blood Bank and Clinical Staff to investigate and safely resolve issues.
- Patients having to undergo a second venepuncture due to sample discrepancy.
- Resource issues when staff have to repeat task.
- Potential in delay in getting compatible blood for patient in emergency situation.

What is the evidence to support correct patient identification?

It is important to follow procedure even though it can be quite prescriptive - evidence demonstrates that when we **disregard procedure, errors occur** (University Hospital, Southampton).

62% of serious transfusion incidents were caused by **human error**, often due to **misidentification of patient** at sampling or at time of transfusion (SHOT, 2013).

At each step of the transfusion process & **every other intervention in medicine**, identification of right patient is absolutely essential (SHOT, 2013).

Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to **accurate recording of information on first entry** (Francis Report, 2013).

Doctors generally dislike standardisation (nurses warm to it more) – but **standardisation is a crucial part of improving the quality and safety of healthcare** (Donaldson Review, 2014).

Addressing the problem of poor patient identification

- Discussed at WHSCT Hospital Transfusion Team (HTT) meeting May 2014.
- Developed ‘Who Am I?’ flowchart to assist staff with procedure to be followed when undertaking patient identification check prior to obtaining a pretransfusion sample.
- ‘Who Am I?’ flowchart published in ‘Weekly Safety Lesson’ on Trust Intranet.

Who am I?

I am alert, orientated & able to communicate with you

Ask me (using open ended questions):

- *What is my official first name as it appears on my birth certificate?*
- *How do I spell my name*
- *What is my surname, how do I spell my surname?*
- *What is my date of birth?*

These details and my unique identification number must correspond exactly with details on my wristband, pretransfusion sample & request form.

If I am not wearing an accurately labelled wristband, *do not* take a pretransfusion sample from me.

If emergency situation and there is a discrepancy with my identification details, do not take a pretransfusion sample; use emergency uncrossmatched O negative blood until discrepancy resolved.

I have just been admitted, I am on my own and I am unable to tell you my *exact* patient identification details

Details on my wristband will be

Unique Identification Number and Gender

These details must correspond ***exactly*** with details on my pretransfusion sample and request form.

I am unable to tell you who I am

Next of kin or carer available

Ask my next of kin or carer to confirm (using open ended questions):

- *What is my official first name as it appears on my birth certificate?*
- *How do I spell my name?*
- *What is my surname, how do I spell my surname?*
- *What is my date of birth?*

These details and my unique identification number must correspond exactly with details on my wristband, pretransfusion sample & request form.

Next of kin or carer not available

Two members of staff must confirm that my first name, surname, date of birth and unique identification number on my wristband corresponds exactly with my casenotes, pretransfusion sample and request form.

As soon as my identification details are available and I am stable, ie, NOT in middle of surgery/transfusion, I need a new wristband with my official first name, surname, date of birth, and unique identification number. Inform Blood Bank so that results can be matched to me. If I need another transfusion, repeat my sample.

Recommendations to improve practice

- Correct patient identification should be core clinical skill & be given formal consideration by GMC & NMC (SHOT, 2011).
- Actively involve patient (where possible) - use open ended questions when asking patients to state their first name (official name), surname & date of birth.
- Patients are often keen to be helpful & answer 'Yes' without paying full attention or may be hard of hearing (Davidson & Bolton-Maggs, 2014).
- Each staff member should take own responsibility for patient identification – should not rely on steps taken before or after (SHOT, 2012).

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Staff member can inform the patient they must ask their name etc to make sure the sample is labelled correctly - not because they do not know who patient is!

What next?

- Reaudit September 2015.
- Ongoing education regarding positive patient identification – open ended questions, confirmation of spelling of names & use of official name.
- ‘Who Am I?’ flowchart focuses on pretransfusion sampling – concept must be incorporated into all aspects of care & treatment in order to improve patient safety where positive patient identification is required to be undertaken.
- As correct patient registration is essential this may need to be starting point.

Drivers know the Highway Code and have passed a driving test, but human nature seems destined to bend rules to achieve a more desirable aim. We take risks that there will be a low chance of an accident or speeding ticket & put it in the back of our minds …

… and so it is with blood transfusion – we all know the rules (or where to go and review the rules) but we do not always get it right (Copplestone, 2006).

Remember … Who am I?

I Am ?

Ask me and I can tell you but ….
do not forget to get me to tell you:-

- My official first name & how I spell my first name.
- My surname & how I spell my surname.
- My date of birth.

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