Improving the incidence of missing and illegible wristbands within the Ulster Hospital

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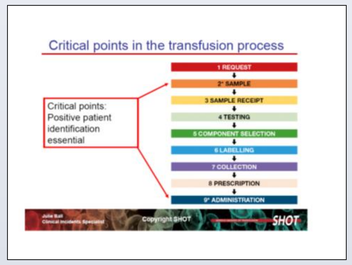
Introduction

The SHOT (Serious Hazards of Transfusion) Report 2013[1] outlined the critical points in the transfusion process where positive patient identification is essential (see figure 1).
Positive patient identification is the use of open ended questioning to verify the patient's identifiers whilst checking against the patient wristband. A "No Wristband, No Transfusion" policy has been implemented throughout Northern Ireland. The phlebotomy team from the South Eastern Health and Social Care Trust (SET) had reported a number of missing or illegible wristbands.

Figure 1.

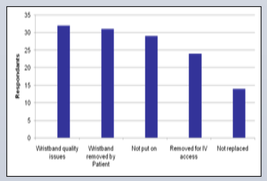


Aim

To reduce the incidence of missing or illegible patient identification wristbands on the Ulster Hospital wards by 50% by April 2014.

Methodology

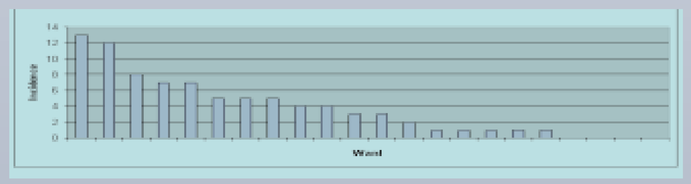
A large audit of 82 staff was initially carried out to identify possible process measures involved in patients not having a legible wristband.



Key process measures identified
- Wristband factors
- Patient influence
- Staff influence

Action measures taken

1. Performance feedback to wards



Action Measures

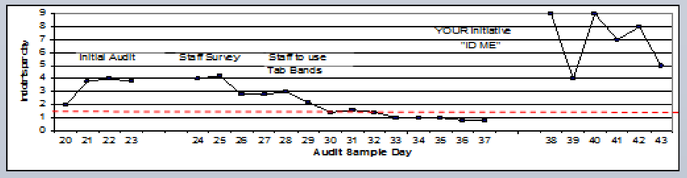
2. Wristbands in use were audited and examined for key criteria. Recommendations of the most suitable option made to wards.

Wristband Type	Audit of 117 patients	Water resistant cover for ID Label	Difficult to remove by breaking or stretching
	77.8%	Yes	Yes
	22.2%	No	No

3. Patient empowerment document created and published in Trust welcome pack

4. Staff "ID ME" education initiative created

Results



Discussion

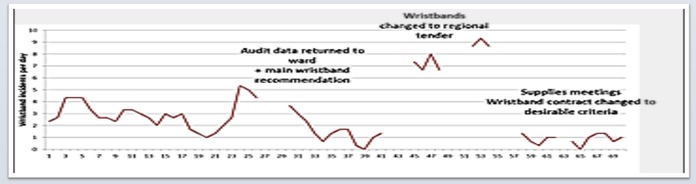
The run-line demonstrates that the project group exceeded its initial aim. However subsequent monitoring indicated a sudden unexpected increase in non-compliance. Investigation revealed the regional tender for patient wristbands was awarded to a brand non-compatible with Trust Policy and key criteria.

Further Action Measures

5. Liaison with Patient Safety led to Trust guidance to only use recommended wristbands but unfortunately led to no appreciable effect on the type used.

6. Subsequent negotiation with Risk Management, Supplies and senior Trust personnel lead to agreement mid-May 2014 to break from regional contract and to purchase wristbands that are policy and key criteria compliant.

Results(2)



As you can see by the results (2) that when the constraint was introduced and the wristbands purchased, the number of patients with missing or illegible wristbands consistently fell below our target.

Conclusion

- Positive patient identification is essential in reducing harm to patients at the various stages of the transfusion process.
- Positive identification requires patients to have a legible wristband.
- Our transfusion teams and committees must be assured that the wristbands we purchase within our own hospitals meet the desired criteria for transfusion.

Only then will we able to examine what human factors are involved with the failure to undertake positive patient identification during the transfusion process.

Reference

Serious Hazards of Transfusion (SHOT) Annual reports and summaries.
http://www.shotuk.org/shot-reports

Acknowledgements

Ulster Hospital phlebotomy team, South Eastern Health & Social Care Trust.
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Risk Management Department, South Eastern Health & Social Care Trust.