Implementing Change

Sydney Hentush, Talia Lomax, Tahija Mcclure

Lakeview College of Nursing

April 8, 2020

Implementing Change

Identifying the Problem

"Medical errors – the third leading cause of death in the U.S. – signifies a moral, professional, and public health dilemma" (Lahr, 2019, pg. 20). Medical errors can be anything from identifying the wrong patient for medication or procedures to discharging an infant to a different family. Many methods can be taken to help prevent medical errors, especially medication errors. One of the most signification prevention methods is patient identification. Yet, many healthcare professionals seem to skip this step almost every shift. The nurses, on the floor where the change process was being implemented, failed to ask for additional patient identifiers. The nurses would only scan a patient's wristband. There were several times that a nurse was in the wrong patient's chart. The nurse would only become aware of this because the computer program would not allow the nurse to document the medication since it did not match the medication regimen. This incidence quickly became a growing concern.

Literature Review on Change Topic

The standard of practice, according to The Joint Commission, is two patient identifiers, which can include a patient's full name, date of birth, and medical identification number (Callender & Callender, 2019). This process is used for every patient encounter. This process is essential because there are many opportunities for patient misidentification within any healthcare setting. These include, but are not limited to, incorrect patient registration, reliance on wrong patient data, mistakes of order entry, and inappropriate or incorrect labeling (Lippi et al., 2017). Patients, especially in a hospital setting, can see up to over five healthcare providers a day. The providers can range from certified nursing assistants to physicians, to nutrition services, and even

to individuals who work in transporting patients. The number of providers a patient sees in a day leaves a huge window for error.

One issue that became noticeable during this process was how many near misses were happening in the hospital. A near miss is considered to be an error that can harm a patient but did not cause any harm as a result of the change, prevention, or mitigation, according to the World Health Organization (Sheikhtaheri, 2014). A near miss can also be considered an incident where a patient experiences an error but has no harm following the mistake, also known as no harm incidents (Sheikhtaheri, 2014). On multiple occasions, the nurses on the floor were in the wrong patient's chart and almost administered the wrong medication to the wrong patients. These incidents are near misses. There were too many near misses occurring on the floor due to a lack of patient identifiers. A lack of patient identifiers can put the patients at serious risk for harm.

The use of patient identifiers helps to decrease the occurrence of major traumatic events for patients such as sentinel events. "A sentinel event is an unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition. A sentinel event may occur due to wrong-site, wrong-procedure, wrong-patient surgery" (Healthmanagement, 2020, p.3). These types of events usually occur due to the lack of appropriate identification techniques that are useful in hospitals. "As regards the US, the Joint Commission (JC) sentinel event statistics includes 130 cases of patient safety incidents attributable to identification errors in 2015 (including transfusion errors with the wrong patient, wrong-site, wrong-procedure), all of which had variable degrees of impact on patient health" (Lippi et al., 2017, p.2). In high-stress situations such as emergency surgeries, disasters, and multiple patient disasters can lead to providers forgoing the traditional two patient identifier process. In the inpatient hospital setting, this is a less stressful environment, and therefore

providers have an adequate amount of time to identify patients accurately. There are many other ways that a patients' identifier tags may have the wrong numbers or information, and this is why a two separate patient identifier process has been implemented. When patients are not correctly identified, their treatment plan must be delayed because the use of the information received under the mismatched name cannot be used. "Notably, treatment delays are also unavoidable, since the current guidelines mandate that diagnostic test results plagued by reasonable suspicion of mismatch should not be delivered" (Lippi et al., 2017, p.4).

Selection and Application of Change Theory

Lewin's change theory is one of the most commonly used methods of implementing change. Lewin's change theory consists of three stages; unfreezing, change/movement, and refreezing. The first step, unfreezing, helps identify the need for change. The second step, change/movement, consists of detecting obstacles and implementing strategies. The last step, refreezing, assesses if the change is successful, and the system is now re-stabilized. Lewin's change theory was selected because it is easiest to perform the steps needed for a change in patient identification.

Collect and Analyze Data

The data was collected through observations while rotating through clinical sites in the hospital. Patient identifiers should occur every provider and patient encounter. For almost every meeting, there were no patient identifiers used. "The frequency of misidentification in laboratory medicine is around 0.01-0.1%" (Lippi et al., 2017, p. 562). While this number may seem minor, misidentification can cause harmful consequences. Out of the misidentifications, approximately 10-20% of these errors led to the patients experiencing some form of a physical injury (Lippi et al., 2017).

This change process will cost little to no money and will need little to no resources. This change process requires a change in personal practice. Not only does the process use little money and resources, but it also provides many benefits. Accurate patient identification not only protects the patient from physical harm but also protects healthcare providers. Improving the accuracy of patient identification is also a national patient safety goal by The Joint Commission, which went into effect in January 2015 (The Joint Commission, 2015). If healthcare facilities work on implementing this practice, then it strengths a provider's training and the safety of the healthcare facility.

Planning the Change Strategy

The biggest goal is to have healthcare providers use one of the patient identifiers, particularly the ones approved by The Joint Commission, for every patient encounter. The goal is to have every provider ask for one patient id as they walk into the patient's room. Nurses are the providers that should implement this change as soon as possible. This reason is that nurses work one and one with the patients more than any other provider in a healthcare facility. Every clinical rotation monitors the progress. The first evaluation occurs around a week after the implantation takes place. The second evaluation will take place approximately a month following the second evaluation. The last assessment will take place in the final week of clinical rotations, which will be at the end of the semester, around two months following implementation.

The nurse manager and charge nurse are the first two notified of the plan to implement change. These two should be the first to be notified so they can help plan how the process is presented to the staff. This step can be part of both the freezing and the change/movement stages of Lewin's change theory. The nurse manager can work with additional services needed to help require the necessary resources to make the change. These resources can include healthcare

providers receiving a small sheet of paper to check off for every encounter that signals they asked for at least one patient identifier. Another more challenging option is implementing a program on computers that require providers to ask for more ids than just scanning the patient's wristband.

While taking the additional step of asking one further question when entering a patient's room may not seem difficult, there may be providers who have concerns or issues with the change. Many patients have altered mental status. This dilemma can mean that these patients will not be able to give any information to help with patient identifiers when asked. These patients would become the exception of asking for additional identifiers. Healthcare providers should then double-check that the information on the patient's wristband matches the information in the patient's medical record. The nursing manager and charge nurse can help ease these concerns by holding meetings to allow providers to openly express their feelings on the topic. These meetings will enable a discussion between managers and providers to take place on how to move forward along with what can help them successfully implement the change into their everyday practice.

Implementation

The easiest way to implement this change was to ask healthcare providers to ask the question as soon as they walk into the room. This way, the identifier is requested at the beginning of the patient encounter and would not be forgotten. Some of the healthcare providers, particularly the nurses, wrote it on top of their assignment sheets so they could remember. The charge nurse was very helpful in creating a supportive clime for change. The charge nurse would always be sure to remind the nurses to remember patient identifiers. They would also ask how the process was going a few times a shift. The charge nurse was very helpful and supportive in encouraging the nurses to continue the process. Many of the nurses had a specific routine they

followed in regards to how they performed assessments, medication passes, and so on. Some of these nurses seemed to struggle to remember to ask about patient identifiers. The charge nurse would allow them to express their frustrations along with tips on how to make the transition easier.

Stabilize the Change

The charge nurse took over the responsibility of the continuation of the change implementation. This charge nurse agreed strongly about this change process and the importance of patient identifiers. The change process is going to continue with daily reminders at change-of-shift reports and floor meetings with supervisors. The charge nurse even discussed offering small incentives to get more nurses to participate in the change.

Evaluation the Change experience

The overall process went well. The last evaluation at the end of the semester was unable to be completed due to the pandemic and inability to do further clinical rotations. Due to this, more frequent evaluations could have allowed the opportunity to obtain more information regarding how well the change process was working. However, the pandemic and inability to further evaluate was something out of anyone's control. There is enough evidence to support the success of this project.

The biggest strength found in this process was the nurse's willingness to work on changing their practices. A lot of nurses recognized the importance of patient identifiers throughout the process. The nurses on the floor, where the change process was being implemented, began to ask for patient identifiers when it was appropriate. The area of nursing that saw the most significant area of change was medication passes. Before the change process implementation, almost every nurse on the floor did not ask the patient for any identifiers outside

of scanning their wristband. This practice led to a handful of near misses on medication errors. Following implementation, nurses began asking for the patient's name and date of birth along with scanning the patient's wristband. This practice allowed the nurses to make sure they have the right patient and the right medication for each patient. This small step significantly cut down on near errors. This result was more than expected.

The project was a success from a quality point of view and a cost point of view. The project helped protect patients from medication errors and was at no additional cost to the hospital. The downside to this project was that the nurses were the only healthcare providers that can be evaluated. The nurses were the providers being followed so many times when a physician or healthcare provider went into a patient's room; it was hard to assess if they were using patient identifiers. Additional providers, such as in the imaging departments, were still not using patient ids other than the patient's wristband.

References

Callender, D.L., & Callender, T.R. (2019). The importance of being identified by the patient care team with two forms of identification. *UTMB Resource Center*. Retrieved March 19, 2020, from https://www.utmb.edu/health-resource-center/partner-in-your-care-patient-safety/two-patient-identifiers-for-every-test-and-procedure

HealthManagement.org. (2020, April 6). Understanding and Preventing Sentinel and Adverse Events. Retrieved from https://healthmanagement.org/c/icu/issuearticle/understanding-and-preventing-sentinel-and-adverse-events

Lahr, K. (2019). *What the U.S. Healthcare System Doesn't Want You to Know, Why, and How You Can Do Something About It*. San Francisco, CA: Thought Collection Publishing.

Lippi, G., Chiozza, L., Mattiuzzi, C., & Plebani, M. (2017). Patient and sample identification. Out of the maze. *Journal of Medical Biochemistry*, *36*(2), 107-112. DOI: 10.1515/jomb-2017-0003

Lippi, G., Mattiuzzi, C., Bovo, C., Favaloro, E.J. (2017). Managing the patient identification crisis in healthcare and laboratory medicine. *Clinical Biochemistry*, *50*(1), 562-567. DOI: 10.1016/j.clinbiochem.2017.02.004

Sheikhtaheri, A. (2014). Near misses and their importance for improving patient safety. Iranian Journal of Public Health, 43(6), 853-854. Retrieved March 20, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4475608/

The Joint Commission. (2015). National patient safety goals effective January 1, 2015. Retrieved March 19, 2020, from https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system folders/assetmanager/2015_npsg_happdf.pdf?db=web&hash=653D52D69E2A1A351D7EDAA88273EF8C

Appendices

- February, 2020 we all met to discuss the group and possible topics
- February through March 2020 we all emailed and texted regularly discussing our group and how to write our paper
- Friday March 27, 2020 an email was sent in regards to who is in the group and the group’s topic