Project Title

Improving Compliance to 2 Patient identifiers

Project Lead and Members

Project lead: Dr Carmen Goh

Project members: Dr Lee Yin Fei, Dr Nicole Soh, Dr Woon Juen Nin, Charlene Lim, Thiynyhya Sathis, Muhammad Rafiq Bin Sumri, Rayner Heah, Dr Juan Sze Joo

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Medical, Nursing, Healthcare Administration

Applicable Specialty or Discipline

Operations, Emergency Medicine

Project Period

Start date: Jan 2020

Completed date: Mar 2022

Aims

Decrease Incident Response Improvement System (IRIS) incidents due to non-compliance to 2 patient identifiers by 50% compared to FY2020 (from 5 to 3 incidents every 2 months) in the Emergency Department.

Background

See poster attached

Methods

See poster attached

Results

See poster attached

Lessons Learnt

See poster attached

Project Category

Care & Process Redesign

Value Based Care, Safe Care, Adherence Rate, Quality Improvement, Lean Methodology

Keywords

Patient identifiers, Driver Diagram, Plan Do Study Act

Name and Email of Project Contact Person(s)

Name: Dr Carmen Goh

Email: carmen_goh@nuhs.edu.sg

IMPROVING COMPLIANCE TO 2 PATIENT IDENTIFIERS

✓ SAFETY
❑ QUALITY
❑ PATIENT EXPERIENCE
❑ PRODUCTIVITY
❑ COST

MEMBERS:
Team leader – Dr Carmen Goh
Doctors: Dr Lee Yin Fei, Dr Nicole Soh, Dr Woon Juen Nin
Nursing: Charlene Lim, Thiynyhya Sathis
PSA: Muhammad Rafiq Bin Sumri
Ops: Rayner Heah
Facilitator – Dr Juan Sze Joo

Define Problem, Set Aim

Problem/Opportunity for Improvement

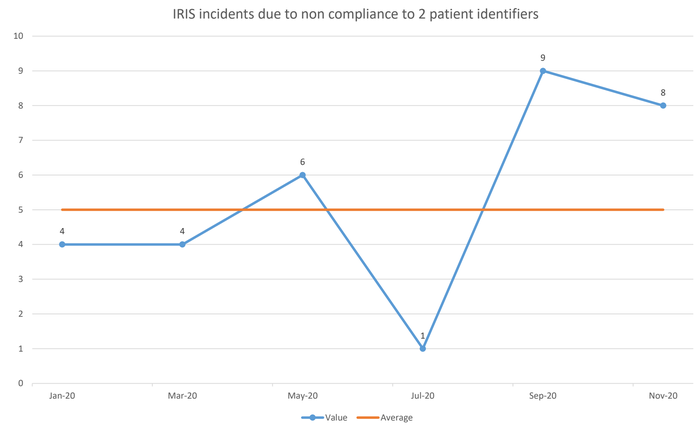
Non compliance to 2 patient identifiers in the ED causing laboratory and medication errors such as mislabelling of blood or point-of-care specimens leads to delayed diagnosis and treatment, increased length of stay in the ED, as well as increased healthcare costs.

Aim

Decrease IRIS incidents due to non compliance to 2 patient identifiers by 50% compared to FY2020 (from 5 to 3 incidents every 2 months) in the Emergency Department

Establish Measures

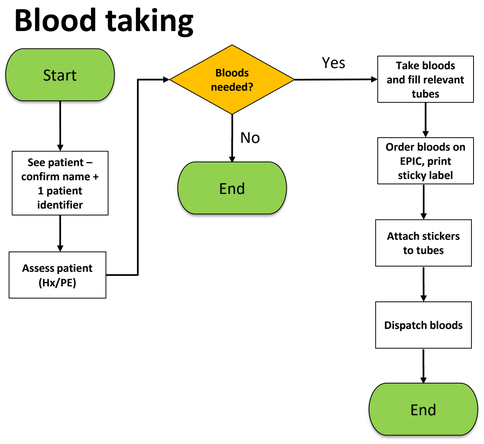
Baseline: There is an average of 5 IRIS incidents every 2 months in FY2020
Outcome measure: IRIS incidents due to non compliance to 2 patient identifiers



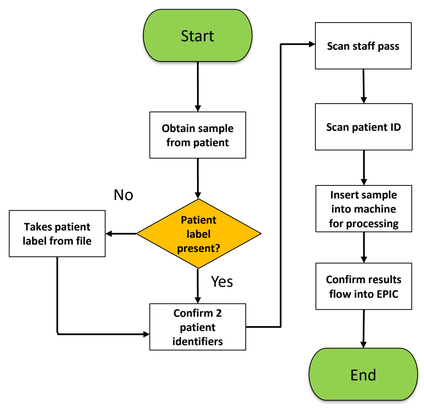
Analyse Problem

Prior to intervention, there is no standardized process of blood taking, collection and dispatching the sample.

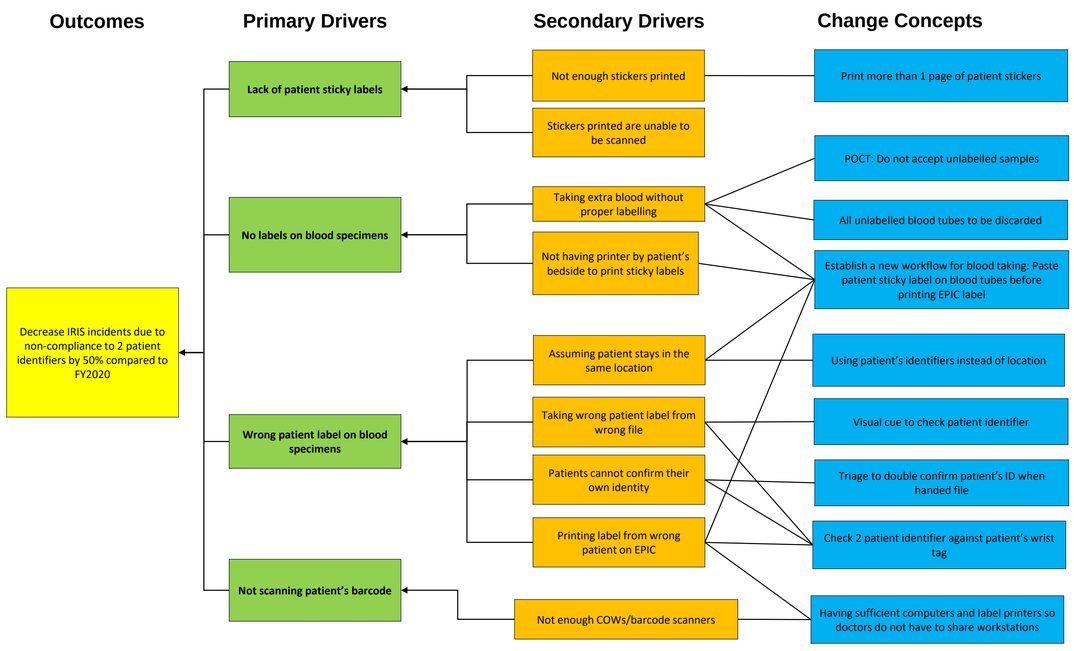
Blood taking



POCT (UC10, UPT / ABG, VBG)

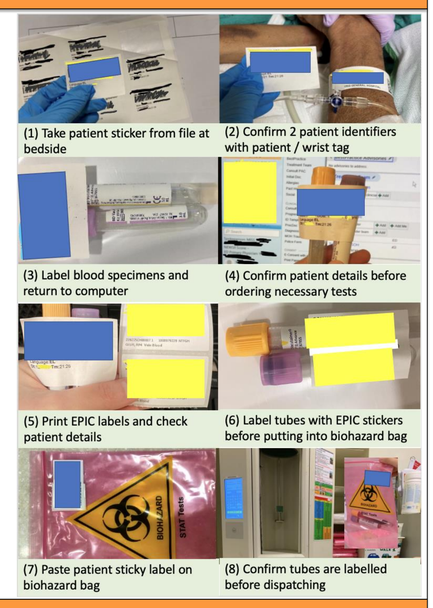


Driver diagram analysing possible causes



Select Changes

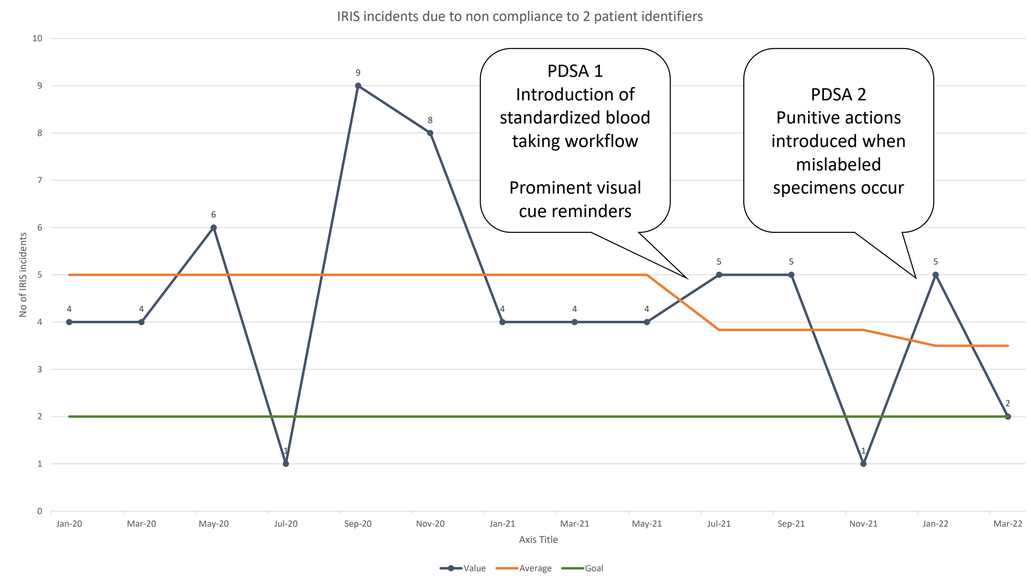
Root Cause		Potential Solutions
Specimens are not labelled with correct patient's sticky label	1	*Print more sticky labels*
	2	*Visual cues at prominent locations to reinforce compliance*
	3	*Standardized workflow for blood taking*
	4	*Regular reminders via broadcasts, orientation for new doctors*
	5	*Punitive action for repeat offenders*
	6	*Compulsory barcode scanning for all patients*



Test & Implement Changes

How do we pilot the changes? What are the initial results?

CYCLE	PLAN	DO	STUDY	ACT
1	Introduce standardized workflow for blood taking and labelling specimens. Visual reminders at prominent locations to reinforce compliance to 2 patient identifiers Collect data by random audits of MOs on shift.	Standardized workflow for blood taking introduced to MOs Visual cues pasted on all sticky label printers and at pneumatic tubes Feedback – low rates of compliance, insufficient stickers, stickers inaccessible	No significant improvement in results	Include standardized blood taking workflow as part of orientation for new MOs Regular broadcasts. Introduce punitive actions for repeat offenders in next cycle
2	Discussion with department seniors and quality team regarding punitive actions	Punitive action for repeat offenders 1st – Counselling by mentor 2nd – Verbal warning from HOD 3rd – Lapse will be documented in the Drs personal file and submitted to their training institution	Slight rise in initial months after introduction (MOPEX changeover), subsequently lowered average number of cases to ~3.8 in 2 months	Introduction of small monetary penalty with each mislabeled specimen incident to contribute to end of posting MOPEX dinner Ensure every MO has his/her own workstation on shift



Spread Changes, Learning Points

To spread change:
- Repeated reminders via visual cues in the department and regular broadcasts
- Standardized workflow for blood taking included in MO orientation guide

Key learnings:
- Finding root causes for non compliance is important to find appropriate solutions

Ng Teng Fong General Hospital

Jurong Community Hospital