

Radiology Transport – Patient Identification

The Problem

The Radiology Transporters lacked a tool to help them correctly identify in-patients for transport. We needed to develop a tool they could take with them to the units/floors that would have two patient identifiers as described by the National Patient Safety Goals. We were relying on the transporters handwriting information (name, DOB) to match with the patients being transported. Often, for the sake of time, they were only writing down last names. This manual system allowed the potential for incorrect information or only one identifier to be used

Aim/Goal

A new system or tool was needed to give portable patient identification data to the Transporters.

The Team

- Betsy Grady – Diagnostic Radiology Manager
- Valerie Portway – IS CCC Programmer
- Donna Hallett – Radiology Operations Director
- Fritz Honore – Radiology Transport Supervisor
- Radiology Transport Staff

The Interventions

- CCC programmer, Valerie Portway, wrote a program in the Radiology information system that pulls patient identification information for the request. The transporters print out this information which they can take with them to the unit/floor.
- IS installed a sticky label printer at the transport desk.

The Results/Progress to Date.....

Below are examples of the labels that print out for the transporter to take with them for patient pick-ups. They are now able to use two patient identifiers, as well as have available precaution alerts.

EXAMPLE

```
=====
Frogg, Kermit   M  1/1/60
MR#9999999
Radiology Modality
Precaution * (print if any) MSRA
PICKUP
```

EXAMPLE

```
=====
Frogg, Kermit   M  1/1/60
MR#9999999
Radiology Modality
Precaution * (print if any) MSRA
RETURN ** Post Procedure Precaution.
```

Lessons Learned

If we expect staff to meet National Safety goals, we need to provide them with the necessary tools. Since this tool proved to be an easy and effective way to ensure patient identification it was added to the ED Radiology workflow for techs and tech assistants.

Next Steps/What Should Happen Next:

Continue to monitor how we can do better!



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