ABSTRACT
In 2014, we found a significant increase in Patient Identification errors. These errors included incorrect wristbands information, no ID bands, inaccurate patient information on demographic face sheet, incorrect label placement on medical record forms, and a significant finding of laboratory specimens originating from the Emergency Department found to be unlabeled or mislabeled.

A multi-disciplinary operational and clinical workgroup convened to identify sources and solutions to the multi faceted errors in the patient identification process. Detailed analysis was completed regarding the process and practices related to the identification process, from point of patient entry into the system and through the hospital stay; ID processes re-designed and streamlined; education of clinical and administrative staff regarding adherence to best practices in patient ID; and implementation of processes for redundancy to decrease errors and improve accuracy.

Following implementation of improvement intervention, we demonstrated an 83% decrease in incidents of Patient ID errors from 2014 to 2015.

METHODS
- Leadership: Identify problem, initiate multidisciplinary work groups
- Operations:
  - Directors of patient access, laboratory, emergency department and quality/patient safety convened to identify and analyze details of processes and vulnerable areas prone to errors
  - Reviewed, revised and strengthened current policies to ensure best practices
  - One to one education of registration staff in all registration entry points, including redundant steps
    - Ask for personal identification at registration outset
    - Have patient review wristband, demographic sheet
    - Have patient state out loud name and date of birth prior to placing wristband
  - In Procedural units, admitting nurse initials the patient’s ID wristband after verifying accuracy of information with the patient/caregiver
  - Education and re-education of ED technicians and RN staff regarding redundant process for bedside patient verification and labeling of lab tubes
  - Registration department developed pre-registration enhancements to minimize errors in transition between MD offices and hospital admission process
- Information Technology:
  - Increased adoption of electronic documentation and forms with resulting decrease in use of paper forms that required patient labels

RESULTS
- From 2014 to 2015, reported errors in patient identification decreased overall by 83%
- Mislabeled/unlabeled laboratory specimens went from 28 incidents in 2014 to 4 in 2015
- Chart form mis-matches decreased from 19 in 2014 to 0 in 2015
- Incorrect ID wrist bands demographic ID errors collectively decreased by 70% in 2015 after interventions

CONCLUSIONS
- Creating meaningful and sustainable change requires collaborative multi-disciplinary commitment from executive, administrative, and clinical operations leadership and direct staff engagement
- Patient identification is a National Patient Safety Goal that is taken seriously at BIDN and process improvement initiatives will continue to be ongoing in the effort to eliminate ID errors