QLL 16

Clinical Audit on the Adherence of Radiology Staff towards Two Patient Identifiers before Radiological Procedures

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INTRODUCTION

The World Health Organization (WHO) described patient safety as a discipline of healthcare that developed with the growing complexity in health care systems and the resulting rise of patient harm in health care settings. The objective of patient safety is to prevent and reduce risks, errors and harm that can happen to patients during their stay at the health care facilities. In order to monitor patient safety in Malaysia, the Ministry of Health has launched the Malaysian Patient Safety Goals (MPSG) 2.0 on 17 September 2021. Goal no 6 is to reduce number of patient safety incidents caused by wrong patient identification. Patient identifiers are unique information used to identify an individual patient in a healthcare system or medical setting. These identifiers are essential for accurate and secure patient identification, ensuring that the right care is provided to the right patient, and in the case of Radiology specifically, the right patient receives the right imaging or interventional procedure. Accurate patient identification is critical for providing safe and high-quality healthcare. Implementing robust patient identification protocols and systems helps prevent medical errors, enhance patient safety, and improve overall healthcare outcomes.

PROBLEM STATEMENT

In the Radiology department, an individual patient may encounter multiple levels of Radiology staff prior to their imaging or interventional procedures.

According to the Radiology department Standard Operating Procedure (SOP), all Radiology staff who encounter patients must ask each patient their identity using two identifiers: which is Patient's full Name and Patient's identification card number in an open-ended manner, avoiding Yes/No answer from patients.
E.g: When asking patient's name, ask: "What is your full name and IC number?" instead of "Is your name Mr John Doe? Is your IC number xxxxx..?"

In our initial audit, we found that not all Radiology staffs adhered to this policy.

OBJECTIVES

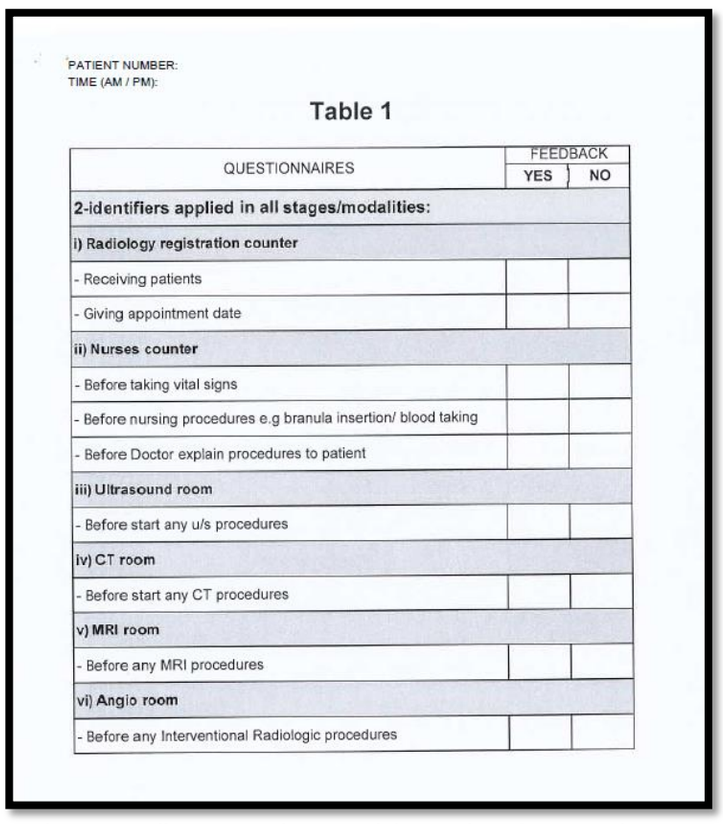
a) To increase the Radiology staff's adherence towards two patient identifiers.
b) To raise awareness of the importance of correctly identifying patients at all times and before undertaking any imaging or interventional procedure.

CRITERIA AND STANDARD

Criteria	Standard
All Radiology staff should adhere to two patient identifiers before radiological procedures.	100%

METHODOLOGY

Study Design: Prospective, observational study.
Inclusion Criteria: All patients who attend the Radiology department for imaging studies/interventional procedures.
Exclusion Criteria: Nil.
Audit Locations:
a) Initial Phase (Sept 2022): the Radiology Department registration counter only.
b) Re-audit Phase 1(April 2023): several radiology working stations including CT scan, MRI, Ultrasound and Angiography rooms.
c) Re-audit Phase 2 (June 2023): encounters follow individual patient's journey, starting from the radiology registration counter until the patient enters the examination room of various modalities.
Data Collection And Analysis: Data is recorded audit form as below, entered into Microsoft Excel 2010 sheet and is analyzed using simple descriptive analysis.



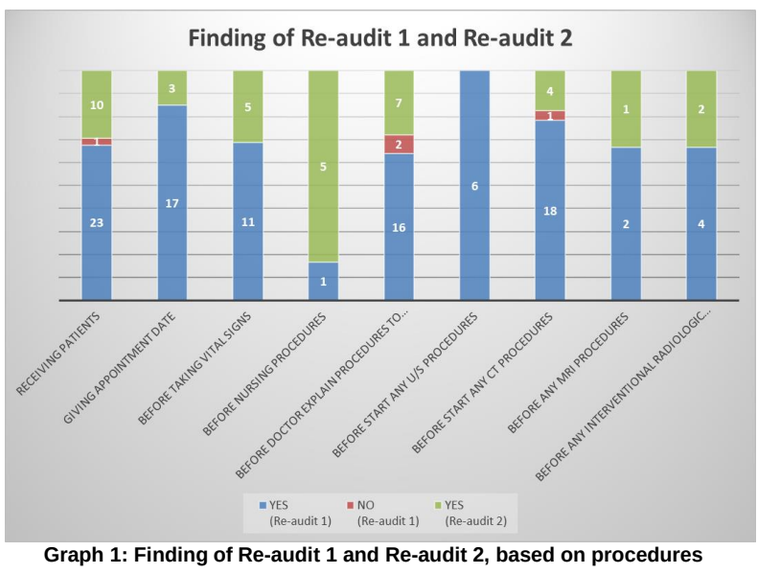
PATIENT NUMBER:
TIME (AM / PM):

Table 1

QUESTIONNAIRES	FEEDBACK YES	NO
2-identifiers applied in all stages/modalities:		
i) Radiology registration counter		
- Receiving patients		
- Giving appointment date		
ii) Nurses counter		
- Before taking vital signs		
- Before nursing procedures e.g branula insertion/ blood taking		
- Before Doctor explain procedures to patient		
iii) Ultrasound room		
- Before start any u/s procedures		
iv) CT room		
- Before start any CT procedures		
v) MRI room		
- Before any MRI procedures		
vi) Angio room		
- Before any Interventional Radiologic procedures		

Figure 1: Audit Form used to record the number of opportunity

FINDINGS



Graph 1: Finding of Re-audit 1 and Re-audit 2, based on procedures

SUMMARY OF AUDIT FINDINGS

	Initial audit (September 2022)	Re-audit 1 (April 2023)	Re-audit 2 PATIENT JOURNEY (June 2023)
Total number of opportunities / audit	10	102	37
Audit location	Radiology registration counter	Various Radiology sites	Various Radiology sites
Radiology staffs' adherence	20%	96%	100%

Table 1: Summary of findings for each audit phase

REMEDIAL MEASURES

Targeted Contributing Factors	Staffs' attitude and perceptions towards two patient identifiers.
What to change?	To provide better understanding and awareness about two patient identifiers.
How to change?	Individual level: 1. Place reminder tags on computer monitors. Service level: 1. Place educational posters at the consultation room, near nurses' counter and the Patient Safety & Clinical Risk Management Corner. 2. Deliver department CME Patient Identification. 3. Give feedback to staffs in WhatsApp working group.

Figure 2: Plan for remedial measures

1

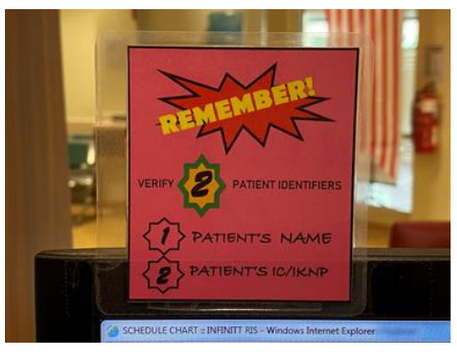
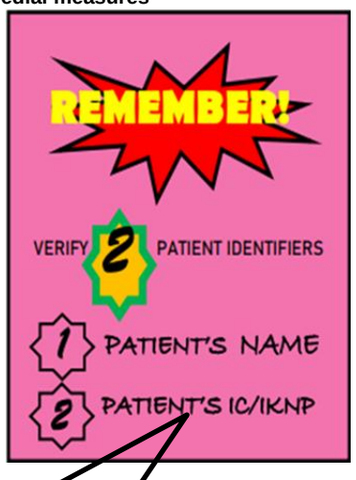


Figure 3: Reminder tag



Prominent two patient identifiers reminder tags in bright colours are placed on each computer monitor, in high traffic areas such as at the Radiology registration counter and modality rooms as a constant reminder to staff.

2

Figure 4: Educational posters at the consultation room & Patient Safety and Risk Management corner at the center of the department

3

Figure 5: Continuous Medical Education (CME) regarding correct patient identification was also held. Participant knowledge is evaluated using a pre- and post- CME questionnaire

4

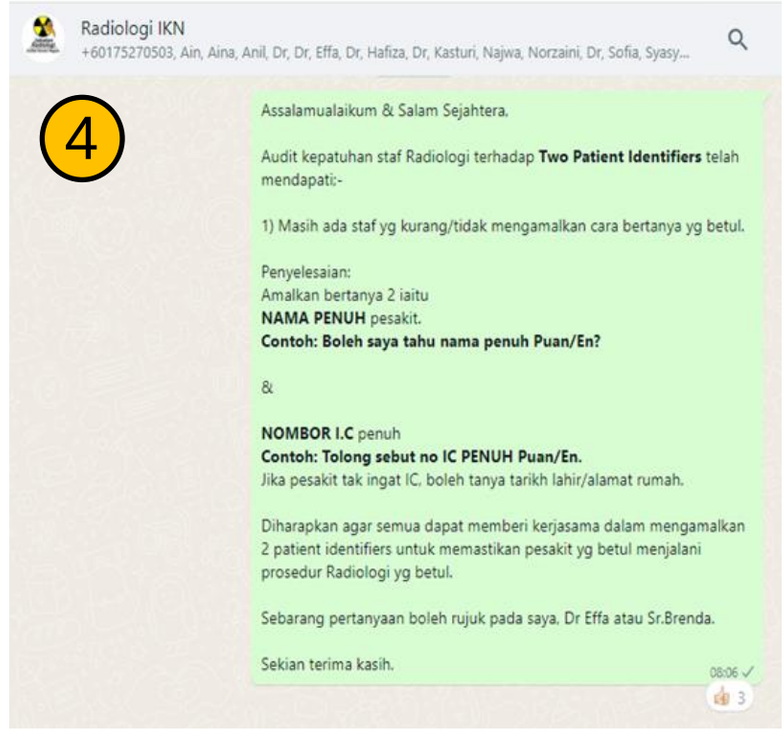


Figure 6: Feedback to staffs in Whatsapp Group and department meeting given by our audit team members

DISCUSSION

Adherence to two patient identifiers is mandatory to prevent patient safety incidents. The audit also found that most cases of non-adherence happen in the morning when patient load in the department is highest. Continuous education, prominent visual reminders and feedback to staff enabled them to improve their attitude and perceptions towards two-patient identifiers, which can be a repetitive process and easily undervalued.

RECOMMENDATIONS

In order to ingrain the culture of using two-patient identifiers within the workplace, we recommended giving visual reminders and regular education regarding the importance of adhering to performing two patient identifiers for each patient encounter. Other than that, we propose teaching and practicing two-patient identifiers as early as during college training and during new staff orientation.

ACKNOWLEDGEMENT

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