International Journal of Allied Medical Sciences and Clinical Research (IJAMSCR)

ISSN:2347-6567

IJAMSCR |Volume 7 | Issue 2 | Apr - Jun - 2019
www.ijamscr.com

Research article *Medical research*

Improve the patient identification and effective communication compliance among healthcare staff at Tertiary Care Hospital, Delhi NCR

Dr. Shaheen Ansari*, Dr.J.Swaminathan

[*]*BUMS & MHM, Delhi Pharmaceutical Sciences and Research University (DPSRU)*
Dept. of Hospital Management, Delhi Pharmaceutical Sciences and Research University (DPSRU) Govt. of NCT of Delhi. Sector- 3 M.B. Road, Pushp Vihar New Delhi-110017 India

***Corresponding Author**: **Dr.J.Swaminathan**
Email id: swamilingam@gmail.com

ABSTRACT

The purpose of this document is to guide the physician and healthcare staff about the patient safety and to decrease medical error and improve safe clinical practise. Effective communication helps the patient safety when the nurse and doctor communication is strong and the patient should also be aware about the condition [7].

Throughout the health-care industry, the failure to correctly identify patients continues to result in medication errors, transfusing blood sample errors, radiology and laboratory testing errors, wrong person procedures, and the discharge of infants to the wrong families [1]. So checklist was used which helps in reducing patient misidentification. A doctor's communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis by counselling appropriately, give orientation and establish caring relationships with patients. These are core clinical skills to achieve the best outcome and patient satisfaction [2]. Basic communication skills helps in reducing medical errors which consists of shared perceptions and feelings regarding the situation of the patient, background of patient and then assessment and recommendation done by Doctor that helps in the treatment [8]. Doctors should always first counsel the patient about the condition and after that consent should be signed so that also protect from the legal issues and patient should be aware about it. Nurse always convey the condition of the patient before giving any treatment to the patient. Wristbands help in identifying the patient correctly [9]. So with the help of counselling reduce medical errors and achieved best outcome.

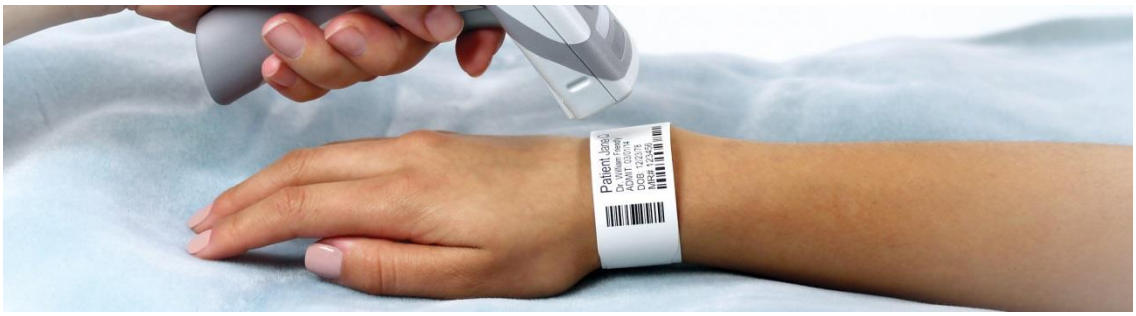
Keywords: Healthcare, Effective communication, Patient identification, Patient safety.

Abbreviation Used

C = Compliance
PC = Partial Compliance
NC = Non Compliance
IPSG = International Patient Safety Goal

INTRODUCTION

Patient identification [3, 5]



Patient in the hospital are identified by using two identifiers that is name and Universal Hospital ID (UHID) and if UHID is not generated at the time of emergency then name and date of birth is checked, without checking these two identifiers healthcare staff should not start the treatment.

Five moments of patient identification

Every patient visiting the hospital must have a unique identifiers. At least two identifiers (UID and full name) must be used for the following.

a) Before administering medications
b) Before administering blood or blood products
c) Before taking samples and other specimens for clinical testing
d) Before providing any treatment or performing any procedures
e) Before shifting the patient from one unit to the other

Identifiers used for identification

a) Full name of the patient
b) UID

There are three types of band which is used by hospital

1. White band for normal patient.
2. Orange band for vulnerable patient.
3. Yellow band for allergic patient.

Effective Communication [4, 6]

There are three parameters that is:

1. To ensure that the orders and directives that are carried out in a verbal or telephonic order are clear to the recipient and confirmed by the individual giving the order.
2. To ensure that the critical results are communicated in an effective manner, timely and accurately through radiologist or laboratory technician to doctor.
3. To ensure safe and effective documented handover communication between the healthcare providers.

Prior to completion of the verbal order / telephone order / critical results, the person receiving the order shall:

a) Identify the patient
b) Listen the results / order correctly
c) Write the results / order

d) Read the results back
e) Verify the result

MATERIAL AND METHOD

Quantitative study was done by taking sample size of 500 cases at tertiary care hospital. An observational prospective Study was conducted in different departments like ICUs, Nightingale (inpatient department), Emergency, Chemotherapy Day care, inpatient department, Laboratory and Radiology. The study period was from January 2019 to May 2019. The study has been carried at tertiary care Hospital.

A checklist was prepared as per Joint Commission International and National Accreditation Board for hospitals and healthcare providers standards for patient identification include nine sections that is ID band present to identify patient, the patient identification details are correct & legible, two patient identifier's is used, appropriate bands are used to differentiate the patients and **five moments of patient identification** include is: before any treatment, before administering blood or blood products, before administering medications, before shifting from one unit to another, before taking samples or other specimens.

A checklist was prepared for effective communication which include ten parameters that is Read back procedure is followed & documented in verbal orders, written and signed consent form, the patient consented to the procedure by completing their name and signed and dated the form, family educated about the procedure/Instructions, nursing handover communication filled properly, Doctor handover communication filled properly, critical test & critical results from radiology been notified Consultant / Residents / Nurse Supervisor, critical test & critical results from laboratory been notified Consultant / Residents / Nurse Supervisor, proper documentation of patient's condition while shifting from him/her to critical care unit to ward or vice versa (in-house), pre-operative checklist addressing the updated patient details & service to be provided in case of surgery / procedure. The collected data was entered in an excel file and quantitative data report was made according to observation and analysis.

RESULTS

For patient identification (IPSG 1)

It was observed that out of 500 cases, ID band present to identify patient compliance was 79% which further improved to 88%, compliance of patient details are correct and legible was 96% which improved to 97%, two patient identifiers compliance was 16% which improved to 46% and the appropriate band compliance also improved from 78% to 88% after counselling the staff.

Five moments of patient identification: It was observed that before any treatment given compliance was 17% which improved to 68%, before administering blood or blood products compliance was 60% which improved to 84%, before administering medications compliance was 12% which further improved to 37%, before shifting from one unit to another compliance was 19% which improved to 53% and before taking samples or other specimens compliance was 10% which improved to 56% after counselling the staff.

For effective Communication (IPSG 2)

- It was observed that:-
- Read back policy compliance improved from 43% to 70%
- Written and signed consent documentation compliance declined from 100% to 98%
- Patient consent documentation compliance improved from 89% to 91%
- Compliance of Family education form improved from 51% to 62%
- Nursing handover communication compliance improved from 47% to 49%
- Critical test & critical results from laboratory been notified by Consultant / Residents / Nurse Supervisor compliance improved from 73% to 83%
- Proper documentation of patient shifting compliance improved from 53% to 78%
- Pre-operative checklist documentation compliance improved from 82% to 83% after counselling the staff.

Patient safety checklist				
Place of Audit :		**Date :**		
Identification of Patient				
S.no.	**Audit**	**Measure**	**C/PC/NC**	**C/PC/NC**
1	Is ID band present to identify patient?	check whether patient has Id band		
2	Is the patient identification details are correct & legible?	check patient details & ID band details		
3	Is 2 patient identifier's is used?	check for the no. of bands/DOB/UID present		
4	Is appropriate bands are used to differentiate the patients	check patient has Id band to identify the risk (eg: vulnerable patients with orange band)		
5 moments of pt. identification				
A	Before any treatment			
B	Before administering blood or blood products			
C	Before administering medications			
D	Before shifting from one unit to another			
E	Before taking samples or other specimens			

Figure 1: Patient safety checklist

Effective Communication Checklist			
Sno.	**Audit**	**Measure**	**C/PC/NC**
1	Is "Read back" procedure is followed & documented in verbal orders?	check the medication chart	
2	Is there a written and signed consent form?	check is there consent form with sign	
3	Has the patient consented to the procedure by completing their name and signed and dated the form?	check patient consent form completed with name, sign and date	
4	Is family educated about the procedure/Instructions?	check family education form is completed	
5	Is nursing handover communication filled properly?	check nurses have signed the handover & received communication	
6	Is Doctor handover communication filled properly?	check the Doctor have signed the handover communication	
7	Has the critical test & critical results from radiology been notified Consultant / Residents / Nurse Supervisor	check from radiology department & then check from the ward	
8	Has the critical test & critical results from laboratory been notified Consultant / Residents / Nurse Supervisor	check from laboratory department & then check from the ward	
9	Is there a proper documentation of patient's condition while shifting from him/her to critical care unit to ward or vice versa (in-house)	check the in-house form should be properly documented	
10	Is there a pre-operative checklist addressing the updated patient details & service to be provided in case of surgery / procedure	check in the pre-operative checklist that date, time, surgery / procedure & sign should be there	

Figure 2: Effective Communication Tool

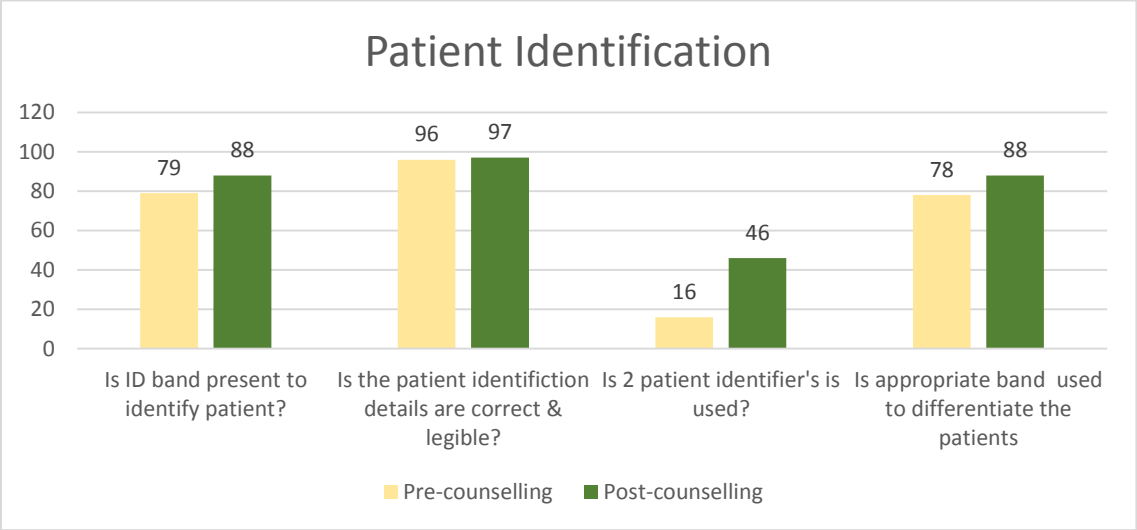


Figure 3-Patient Identification compliance before and after counselling

Interpretation

It was observed that before counselling compliance of using patient identifier was low and after counselling it had increased which results in improvement in patient safety.

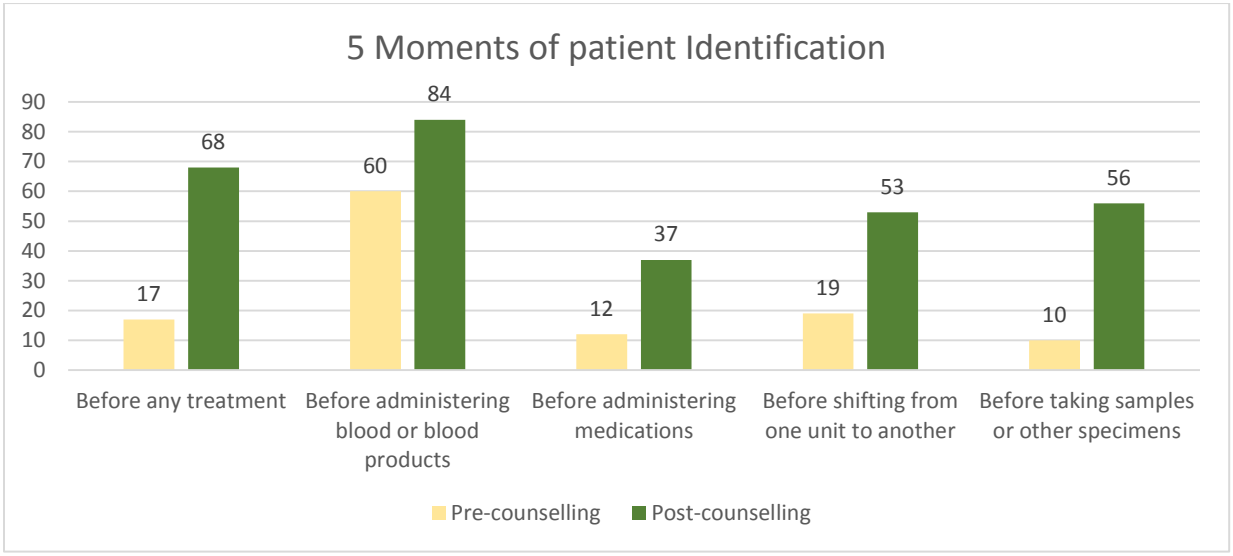


Figure 4- Five moments of Patient Identification Compliance

Interpretation

It was observed that before counselling compliance was low and after counselling improvement has been taken which results in reducing medical errors.

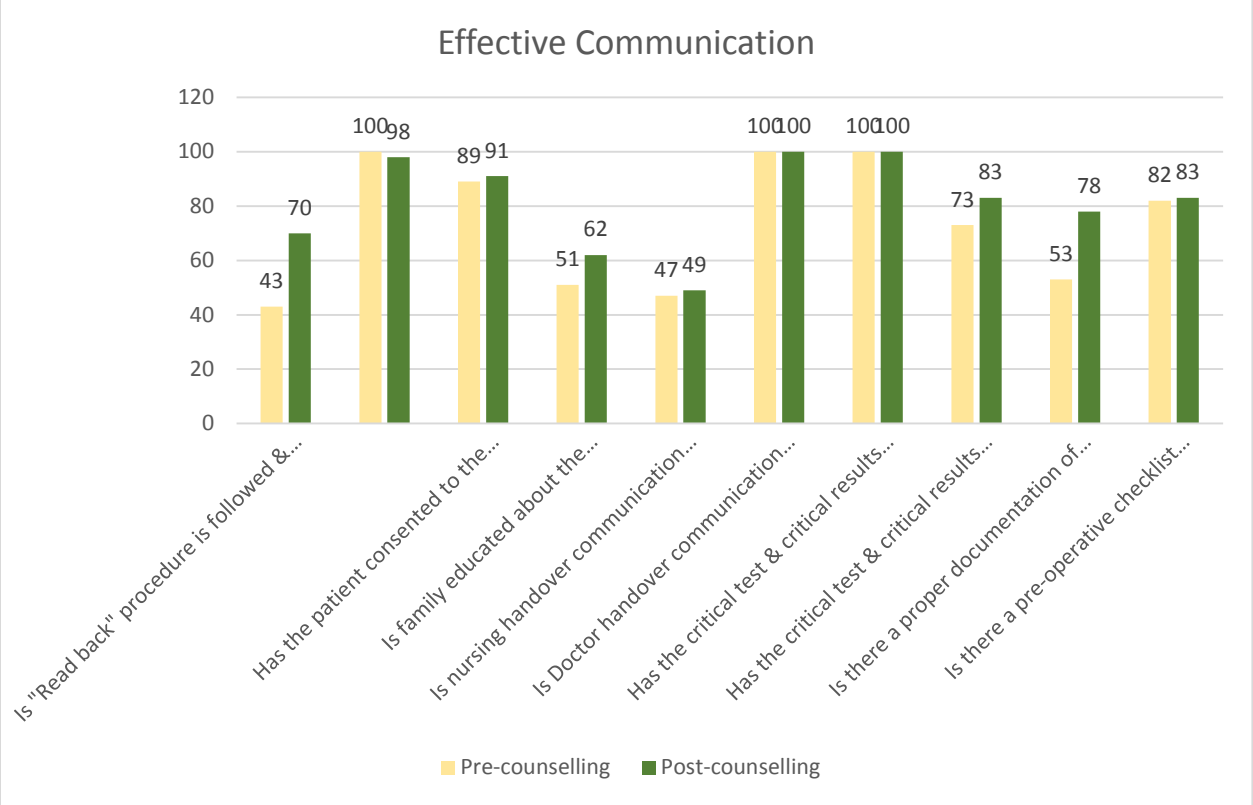


Figure 5= Compliance of Effective Communication before and after counselling

Interpretation

It was observed that before counselling compliance was low and after counselling improvement has been taken which results in reducing medical errors.

DISCUSSION

The result showed that Patient safety still has many areas for improvement that need continuous evaluation and monitoring to maintain a safe environment both for patients and health-care providers. Mostly, Patients are identified through Bed Number instead of Name and UID. Before counselling, in most of the cases, nurses are providing treatment without checking the ID band and after counselling compliance has improved.

During auditing, Doctors and nurses are not maintaining the patient record file completely. If the patient refuses to wear ID band then it should be mentioned in the patient file by nurse but most of the time not mentioned in the patient file. Nurse are counselled about the handover while handling the over, nurses give all the verbal orders to the next duty nurse but most of the time documentation was incomplete.

Doctors most of the time not signed the family education form though everyday they counselled the patient along with the attendant. While transferring the patient, nurse most of the time not check the Name and UID and sometimes not signed the file while transferring the patient along with that documentation part was incomplete.

CONCLUSION

After regular auditing and counselling the staff, compliance had increased which help in reducing patient misidentification as well as increase in effective communication among the healthcare staff. Consent form was also documented completely. Doctor-nurse communication was also improved after counselling the staff. Medical errors can further be reduced by doing regular audits.

After counselling the staff, ID Band was checked along with the correct color band, Effective communication compliance was also improved.

Result suggest that counselling helps in improvement in patient safety. Regular audits should be done to ensure patient safety, encourage patients to participate in all stages of the process.

Educate patients on the importance and relevance of correct patient identification in a positive way that also respects concerns for privacy, training on procedures for checking/ verifying a patient's identity. Certain innovative activities like skit, competitions should be carried out to create awareness about improving effective communication.

ACKNOWLEDGEMENTS

I express my deepest gratitude to my mentor **Dr. J. Swaminathan, Dept. of Hospital Management DPSRU** who in spite of being very busy took time out to hear, guide and keep me on the correct path and allowing me to carry out my project in their esteemed organization.

I also thank all the staff of organization who directly and indirectly gave support and assistance while conducting the study.

REFERENCES

[1]. The joint commission Journal on quality and Patient safety: Patient Safety Solutions, 1(2), 2007.
[2]. Jennifer Fong Ha and Nancy Longnecker: Doctor- Patient Communication, A Review, Ochsner Journal 10(1), 2010, 38-43.
[3]. Joint Commission International Accreditation Standards for Hospitals Including Standards for Academic Medical Center Hospitals, patient identification: 6, 2017, 43-45.
[4]. Joint Commission International Accreditation Standards for Hospitals Including Standards for Academic Medical Center Hospitals, effective communication: 43(6), 2017, 45-47.
[5]. National Accreditation Board for Hospitals and Healthcare providers guide book to accredited standards for hospitals, patient identification: 9(6), 2015, 46.
[6]. National Accreditation Board for Hospitals and Healthcare providers guide book to accredited standards for hospitals, effective communication: 215(6), 2015, 110-111.
[7]. Henrdon J., Pollick K. Continuing concerns, new challenges, and next steps in physician-patient communication. J Bone Joint Surg Am **84-A** 2, 2002, 309–315, pmid: 11861738.
[8]. Mannos D. NCPS patient misidentification study: a summary of root cause analyses. VA NCPS Topics in Patient Safety. Washington, DC, United States Department of Veterans Affairs, 2003 (http://www.va.gov/ncps/TIPS/Docs/TIPS_Jul03.doc, accessed 11, 2006).
[9]. Wristbands for hospital inpatients improves safety. National Patient Safety Agency, Safer practice notice 11, 2005, 22. (http://www.npsa.nhs.uk/site/media/documents/1440_Safer_Patient_ Identification_SPN.pdf 4).

How to cite this article: Dr. Shaheen Ansari, Dr.J.Swaminathan. Improve the patient identification and effective communication compliance among healthcare staff at Tertiary Care Hospital, Delhi NCR. Int J of Allied Med Sci and Clin Res 2019; 7(2): 515-521.
Source of Support: Nil. **Conflict of Interest:** None declared.