

Theme | Learning from Incidents
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REASON WHY?

Current data shows that patient identification wrist bands contain errors or are sometimes missing altogether. This data is collected by the phlebotomy/pathology teams as they must check the patient wristband before they can bleed a patient. The patient wristband is an essential safety tool to ensure that the patient receives the right care, assessments and treatments during their hospital stay.



To decrease the number of errors or missing patient identification wristbands on Ward 35 by 50% by the end of November 2024 as evidenced by data collected by phlebotomy service

PLAN

Data from the phlebotomy and pathology teams highlighted an issue with patient identification wristbands.

The plan was to design and introduce a check list that would gather information from the ward regarding if patients were wearing their identification wrist bands.

The check list would be completed each morning by the band six nurse, before the drug round.

DO

The initial check list was introduced halfway through May 2023.

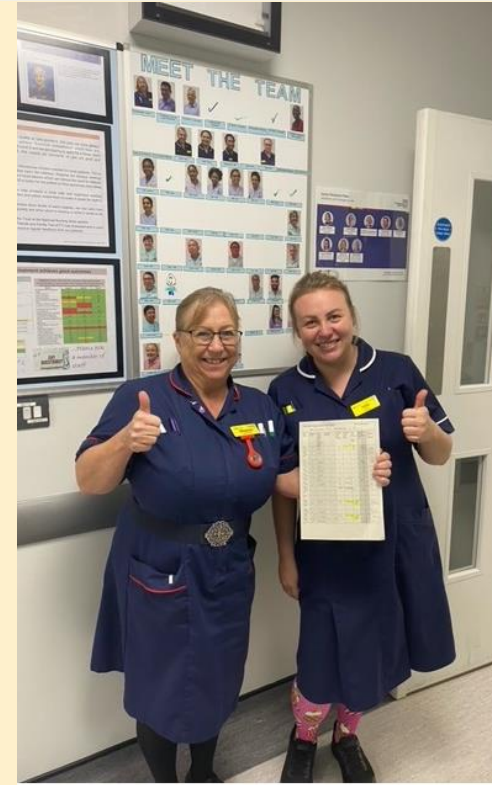
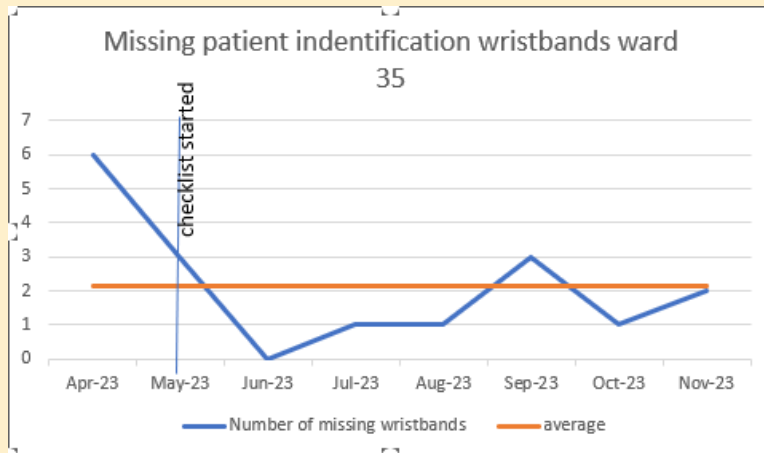
Patient name/bed space	Is the patient wearing a wristband?	Is it the correct colour? Check allergy status	Is the wristband clear and legible?	Has the wristband been changed?
3.1	✓	Red	✓	NO
3.2	✓	Red	✓	NO
3	✓	Red	✓	NO
4	✓	Red	✓	NO
5	Empty		✓	
6	✓	Red	✓	YES

The band six nurses took responsibility for this, but then after a period of testing expanded it so it could be used to check on other essential factors.

Bed No/CC	Wristband in situ?	Correct colour? Allergy status? Is the wristband clear and legible?	Wristband changed?	Does the patient have a catheter?	Is catheter in vital pack dated?	Does it need changing? Can we TWOC?	VIR/AVC (date)? Checked on vital?	Falls wristband on? required?
3.1	✓	Red	X	X			X	✓
3.2	✓	Red	N/A	no			CASHA E. BILWA	X
3.3	✓	Red	X	X			CDOWN E. HANNA CASHA E. BILWA	✓
4.1	✓	white	X	X				X
4.2	✓	white	X	X			X	X

STUDY

The introduction of the form saw an immediate reduction by 50% in missing wristbands, with an average reduction from 6 (pre checklist) to 2.1 (post checklist) a reduction of 65%. The team have found that the check list is a snapshot in time and doesn't prevent people from removing their wristbands after the checklist has been completed. They also noted that the checklist was not being filled in at a weekend when no band 6 staff were on duty, so they are now encouraging the band 5 staff to complete the checklist.

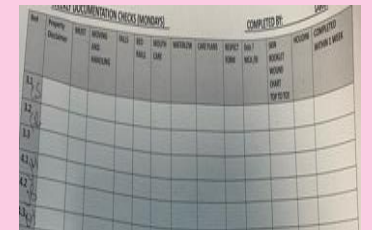


ACT

The team on ward 35 are going to ADOPT the checklist. They are going to ADAPT its use by asking more band 5 staff to complete it at weekends.

Next Steps.

The team are developing a further weekly checklist to support them with other essential tasks and support the overall quality audit for the ward, which currently sits about 90%.



ACKNOWLEDGEMENTS & REFERENCES | With many thanks to the phlebotomy and pathology staff for collecting data and also to the band six nursing team and latterly the band five nursing team for engaging with this process and taking ownership of the checklist. With special thanks to Lacey Jones (pictured above with Sharon Main)