Patient Identification Wristbands Ward 24

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 band is an essential safety tool to ensure that the patient receives the right care, assessments and treatments during their hospital stay .

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND

To decrease the number of errors or missing patient identification wristbands on Ward 24 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.

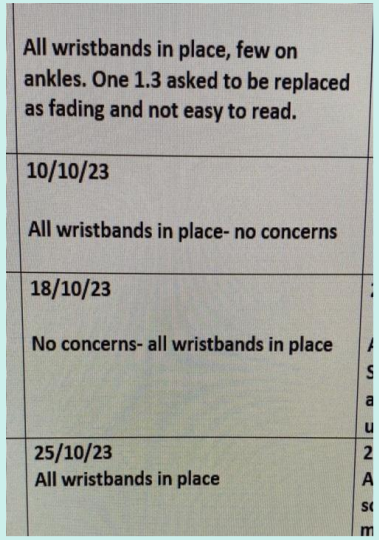
The data for Ward 24 showed that there were problems with wristbands being illegible or missing.

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 by the ward manager three times a week .

DO

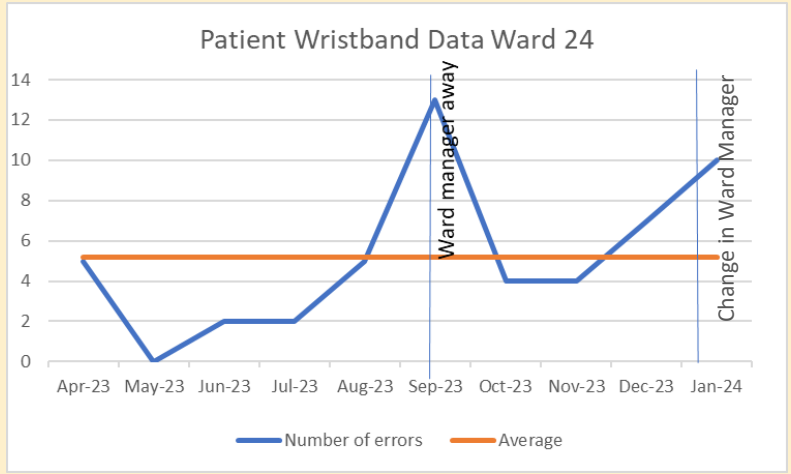
The initial check list was introduced halfway through May 2023.



All wristbands in place, few on ankles. One 1.3 asked to be replaced as fading and not easy to read.	
10/10/23	
All wristbands in place- no concerns	
18/10/23	
No concerns- all wristbands in place	
25/10/23	
All wristbands in place	

STUDY

The introduction of the form saw an immediate reduction in wristband errors , with an average reduction from 5 (pre checklist) to 1.3 (post checklist) for the first three months (a reduction of 74%). However, this wasn't sustained and in August it began to creep back up with a big jump in September. During September, the ward manager was away, and it was felt that the checklist had not yet become part of standard work for the Band Sixes. Following conversation with the Ward Manger the senior nurses did begin to take the checklist on and the numbers of errors did reduce again. They did rise in December and in January a change in Ward Manager was announced and therefore the new Ward Manager will take this work forward. The data shows the importance of the checklist being done by the whole team and not being reliant on one key person.



ACT

The team on ward 24 are going to **ADOPT** the checklist.

They are going to **ADAPT** its use by asking the band 6 staff to complete it on a daily basis, and also adding it to the nurse in charge checklist.

Next Steps.

The team will work to embed the checklist into their standard work in order to reduce the error rate.

ACKNOWLEDGEMENTS & REFERENCES | With many thanks to the phlebotomy and pathology staff for collecting data