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Identify Patients Correctly in the Inpatient Ward of Aceh Government Hospital: Case Study

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Abstract

The impact of patient care errors has become a global concern. Hospitals must have a safety program to minimize the risk of unexpected events and improve patient safety. Unexpected events can occur due to errors in implementing patient safety objectives, including correct patient identification. Not confirming the patient's ID bracelet, not explaining the purpose of the service, and not using active communication are problems in unsafe patient responses. This case study aims to determine the implementation of correct patient identification in the Aceh Government Hospital inpatient ward. This case study is a quantitative study with a cross-sectional design. The sample was determined using a total sampling technique of 21 nurses. The data collection tool uses observation sheets to identify patients correctly based on standard operational procedures, and data analysis uses descriptive statistical tests. The results of this case study show that 66.7% of respondents have optimally identified patients by ensuring the ID bracelet is installed correctly, 57.2% of respondents have not optimally identified patients by introducing themselves to the patient, 95.2% of respondents have not optimally identified patients by using active communication, 81.0% of respondents had optimally identified patients by providing informed consent before nursing actions, and 85.7% of respondents had not optimally identified patients before nursing actions. The results of this case study show that respondents generally have not implemented patient identification correctly. As a result, it is hoped that first-line managers, as direct superiors of respondents, can carry out routine supervision and guidance and that the Hospital Patient Safety Committee can provide ongoing training regarding patient safety goals to improve patient safety in hospitals.

Keywords: Nurses, Patient Safety Goals, Patient Identification

1. Introduction

The impact caused by patient service errors has become a global concern. Patient death is the worst thing that can happen due to medical errors [21]. Based on research, it was found that medical errors are the third cause of death in the United States after cancer and heart disease. In addition, it was also reported that one patient injury in the UK occurs on average every 35 seconds. Studies conducted in America, such as Utah, Colorado, and New York, have reported that every year, as many as 980,000 Americans die in hospitals due to preventable medical errors such as diagnostic, surgical, and medication errors [6].

Mistakes in identifying patients have a significant risk of causing problems and threats to patient safety. Therefore, hospitals must have a safety program with safe patient services to minimize the risk of these incidents and increase patient safety. The program refers to six standard patient safety goals, namely: Correctly identifying patients, increasing effective communication, increasing the safety of cautionary medicines, ensuring the correct surgical location, the correct procedure for surgery on the proper patient, reducing the risk of infection due to health care responses, and reducing the risk of patient falls [7].

Correctly identifying patients is the first step in providing safe health services or treatment appropriate to the patient. The identification process requires a minimum of two ways to identify the patient: The patient's name, medical record identification number, and date of birth listed on the patient's identity bracelet. In contrast, the room number or location of the patient's bed cannot be used to identify the patient [17]. Patient identification can be done using a patient identification bracelet. This identification bracelet verifies or confirms the patient's identity to reduce service errors [15].

The research results conducted at hospitals in Jakarta show that 65.5% of patient identification errors out of 117 cases mainly occurred in inpatient wards [10]. Another study in an Islamic hospital found that 46.0% of errors occurred in identifying patients [22]. Research at Yogyakarta found that the implementation of patient identification was still not optimal; there was no use of patient identification bracelets [5]. Likewise, the research results on implementing six patient safety goals at the Padang Pariaman Regional General Hospital still have not reached the standard. As many as 50.0% of inpatient wards do not wear identity bracelets [12].

Health workers, especially nurses, have an essential priority on patient safety. Therefore, to avoid errors that can threaten patient safety, a high level of knowledge is required as a reference for patient safety [16]. Nurses are health workers who spend the most time with patients compared to other health workers, so they are more at risk of making mistakes in identifying patients when providing care. Correctly identifying patients that are not optimal can cause patients to receive poor-quality health services. Errors that result in patient injury can be in the form of inaccurate patient identification, which results in errors or delays in diagnosis, failure to act, medication errors, and errors in dosage or method of administering drugs [20].

Based on the results of observations in the inpatient ward, it was found that two to three nurses identified patients when administering procedures or administering medication, still mentioning the room number and calling the patient's name without matching it with the patient's identity bracelet. The accuracy of patient identification was still found to have faded identification writing on the patient's identification bracelet, and there was no identification, dosage, or date on the label of the intra-venous fluid bottle. Identification that is not yet optimal causes patients to receive incorrect medical procedures. Based on the description above, this is a case study regarding correctly identifying patients in the inpatient ward of Aceh Government Hospital.

2. Methods

This case study is a quantitative observational study. The sampling technique used total sampling, and all 21 nurses in the Nabawi inpatient ward were sampled. Data was collected in July 2023 after obtaining institutional permission and filling out informed consent to be a case study respondent. The data collection tool uses an observation sheet developed based on standard operational procedures for correct patient identification. Data analysis uses descriptive statistical tests; the results are presented as frequency distribution tables and percentages.

3. Results

Table 1 below shows the characteristics of the respondents: 90.5% were female, 71.4% had a nursing vocational education, 52.4% had civil servant status, and 47.6% had 5-10 years of work experience.

Table 1: Respondent Characteristics

Characteristics	f	%
Gender:		
Male	2	9.5
Female	19	90.5
Nursing Education:		
Vocational Nurse	15	71.4
Professional Nurse	6	28.6
Employment status:		
Civil servants	11	52.4
Government Employees with Employment Agreements	9	42.4
Contract	1	4.8
Work Experience:		
<5 Years	7	33.3
5-10 Years	10	47.6
>10 Years	4	19.0

Table 2: Frequency Distribution of Identify Patients Correctly

Identification Activities	f	%
Confirming Identity Bracelet:		
Optimal	14	66.7
Less Optimal	7	33.3
Introduce myself:		
Optimal	9	42.8
Less Optimal	12	57.2
Using Active Communication:		
Optimal	1	4.8
Less Optimal	20	95.2
Providing Informed Consent:		
Optimal	17	81.0
Less Optimal	4	19.0
Confirming before doing Nursing Care:		
Optimal	3	14.3
Less Optimal	18	85.7

Table 2 shows that 66.7% have optimally confirmed the correctness of the patient's bracelet, 57.2% have not optimally introduced themselves to the patient, 95.2% have not optimally used active communication, 81.0% have not optimally provided informed consent, and 85.7% have not optimally carried out patient identification before providing care nursing.

4. Discussion

The first is identifying patients correctly; 66.7% of the identity bracelets fitted to the patient are optimal, starting from policy to implementing patient identification, such as installing an identity bracelet containing the name, date of birth, and medical record number. Nurses have also educated patients about the importance of using patient identification bracelets. The results of other studies explain that educating patients and families about the risks associated with misidentification is a way that is in line with those mentioned by the Joint Commission International to overcome barriers to patient identification [4]. However, as many as 33.3% were still found to have suboptimal implementation in this case study. This is in line with the findings of research in England, Thailand, and India, which

states that patient identification errors often occur because staff do not confirm the identity on the patient's bracelet when administering medication or collecting/labeling specimens [14]. In identifying patients, nurses must compare patient data with the patient's identity bracelet. However, not all nurses are thorough in this matter [9]. Other research states that there are still nurses who only call the patient's name without checking the patient's identity bracelet because nurses do not realize that to carry out patient identification correctly, they need to confirm the identity bracelet [13]. It was also found that the results of other research showed that the incidence of patient identification errors related to inaccurate identification on the bracelet was 6.85%, the bracelet came off as much as 2.74%, the mismatch in the color of the bracelet was 3.42% and the bracelet was not attached as much as 0.68% [2].

Identifying patients by introducing themselves to patients by nurses 47.2% is not optimal. Another study found that 85.0% of nurses had not explained the purpose of the services and had not educated patients regarding the function and purpose of the identity bracelets worn by patients. One way to anticipate errors is to involve patients in every stage of hospital care [8]. The principles that must be applied to prevent the mistakes are creating policies to reduce identification errors and providing training related to verification procedures with orientation and education, sustainability, and actively involving patients and families by educating them about the goals of service and risks [1].

Patient identification using active communication by nurses at 95.2% is not optimal. The majority of nurses identify patients just by asking their names. Still, others already know that identifying patients correctly is an important thing to do. Still, nurses do not realize that to identify patients verbally, they must use at least two methods [11]. Other research found that some nurses often did not ask about the patient's identity because they assumed the patient had been in the hospital for a long time or the nurse felt they already knew the patient [9].

The implementation of patient identification by providing 81.0% informed consent has been carried out optimally; before carrying out nursing care, the nurse first offers informed consent for the patient, both express (written) and implied (verbal). The results of other research using the in-depth interview method found that nurses could act as advocates and educators because nurses considered themselves more accessible in providing patient information than doctors. This is because doctors have limited time to provide information to patients and families, so there are mandated and delegated nursing assignments [19]. Informed consent includes necessary patient rights before any action is taken. Not only that, but informed consent is also vital for legal protection, responsibility, and accountability. The nurse's role as an advocate and educator is to help patients and families interpret information from various service providers and assist patients and families in providing health education or other needed information. Nurses also have the right to educate and advocate for patients regarding the actions to be taken. So informed consent does not only occur between patients and doctors but also among other health workers such as nurses [18].

The results of the final case study were that the implementation of patient identification by carrying out identification before nursing care was provided was 85.7% not optimal. Observation results showed that several nurses did not reconfirm the patient's identity in at least two ways, such as the patient's name and medical record number on the identity bracelet. Nurses only call their full names, and there are still nurses who draw blood from patients without first identifying the patient or explaining the purpose of the action. Another study showed that 96.7% of patients were not identified using at least two identification methods before administering the drug [11]. There are also still 25.0% of patients who have not been identified before blood collection [3]. Based on the observations in other studies, it was found that nurses who would draw blood from patients only identified by asking the patient's name. Incorrect patient identification will, of course, have negative impacts on the patient, such as physical disability, permanent disability, and death [13].

5. Conclusion

The case study results show that implementing patient identification correctly in the inpatient ward of Aceh Government Hospital is not optimal. Regarding these results, it is hoped that first-line managers, as direct superiors of nurses, can carry out routine supervision and guidance. The Hospital Patient Safety Committee can provide ongoing training regarding patient safety goals, improve patient safety, and prevent patient safety incidents in hospitals to enhance the quality of health services.

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