RISK PROFILE

CARE – Wrong Patient/Site/Procedure

Adverse events relating to treatment provided to the wrong patient, wrong site or wrong procedure may lead to significant physical or psychological harm. Mitigation strategies and controls can be utilized to reduce risks. This document contains information entered by HIROC Subscriber healthcare organizations (acute and non-acute) in the Risk Register application to help you in your assessment of this risk.

Key Controls / Mitigation Strategies

- Patient Identifiers
  - ✓ Clearly defined policies and standard procedures for at least two patient identifiers before any treatment or service provision
  - ✓ Use of patient identifiers specific to the individual (e.g., date of birth, first *and* last name, patient's address verification)
  - ✓ Inclusion of the patient as an active participant in the process of two patient identifiers. If the patient is confused or non-verbal, standard procedures developed
  - ✓ Barcode technology to support positive patient identification
  - ✓ Staff education including patient identifiers and refresher training
  - ✓ Visual cues utilized as a reminder for two patient identifier confirmation *prior* to any treatment or service provision.
  - ✓ Team huddle for regular communication and promotion of improvement opportunities.
  - ✓ Annual review of accreditation standards related to two patient identifiers with action plan to address gaps

- Information
  - ✓ Forcing functions as available when entering information into electronic systems
  - ✓ Automation incorporated into Lab Information Systems
    - Unique record number system within the lab to cross-check and assist to reduce test results going to wrong chart and to find if wrong record number
    - If there is a discrepancy test results are not transmitted until reviewed and manually released
  - ✓ Health Cards scanned at registration

- Blood Administration
  - ✓ Defined policy and processes of all issued blood products requiring blood sample(s) from the patient for cross matching prior to issuing the blood product
  - ✓ Verification of physician order against requisition received at time of blood administration
  - ✓ Process for labelling of blood specimen at the bedside and double check
  - ✓ Delivery of blood product process includes double-checks (patient identifiers, blood type and blood number)
  - ✓ Barcode scanning at patient level
  - ✓ Safety reports generated for any errors and quality review for improvement opportunities

RISK REGISTER

Date last reviewed: November 2022

This is a resource for quality assurance and risk management purposes only, and is not intended to provide or replace legal or medical advice or reflect standards of care and/or standards of practice of a regulatory body. The information contained in this resource was deemed accurate at the time of publication, however, practices may change without notice.
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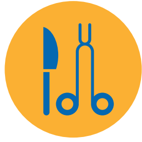

- Surgical
  - ✓ Surgical time out and surgical safety checklist implemented for communication and teamwork
  - ✓ Surgical site identification with engagement of patient prior to the patient being brought into operating room
  - ✓ Enhancing safety culture in surgical program to better identify patient risk
  - ✓ Feedback on positive patient identification, inter-professional team huddles
  - ✓ Simulation programs to support development

Monitoring / Indicators

- ✓ Compliance and monitoring of adherence to established standard practices through audits (e.g., two patient identifiers)
- ✓ Competency testing for users and entering unique patient numbers
- ✓ Incident reports, reviews, and analysis for trending
- ✓ Staff engagement on surgical checklist completion and improvement opportunities

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