"A REVIEW: PATIENT IDENTFICATION FOR PATIENT SAFETY"

A Project Report

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By

Saumya Sharma
MBA (Health and Hospital Management)
0988

Under the Supervision of

Dr. Seema Mehta
Associate Professor
IIHMR UNIVERSITY
JAIPUR

INDIAN INSTITUTE OF HEALTH MANAGEMENT RESEARCH

JAIPUR, RAJASTHAN

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CONTENT

Chapter Page no.

PART 1

(SUMMER PROJECT)

Introduction

Patient Identification forms an important link between patient care and patient safety. Incorrect patient identification harms the patient especially when wrong treatment is given with incorrect data entered for treatment. Many health-care practices involve health-care staff to classify patients, often related to the use of health records. Knowing how to accurately identify patients and comply with identification processes is crucial, particularly in countries where patients have similar names. Nonetheless, that dependency on identifiers makes patients' proper matching with their records a keystone to patient safety. Patients are not identified correctly, when nurses doesn't pronounce their names correctly or just call them by their first or last names only, without using any other identifier with it like they fail to check wristbands & encounter language or communication problems.[1] Major issues that occurred due to misidentification of patients are blood transfusion, administration of a wrong drug, low use of wristbands, wrong sample collection, medication errors. Major steps are taken to avoid the critical issues related to patient misidentification, involving efficient methods for patients recognition across the hospice industry through conventional and creative identifiers, and the use of technological tools that can increase both quality and efficiency Wrong and careless procedures for identifying patients will lead to compromised care, treatment & monitoring of patients. This article aims to provide the causes and errors caused due to wrong patient identification & various steps can be taken to improve strategies for the identification of patients for safety.

Keywords - Patient identification, Patient safety, wristbands, barriers, strategies.

BACKGROUND

PATIENT IDENTIFICATION

World Health Organization (WHO) for many years has proposed that health care professionals (e.g., nurses, doctors& healthcare professionals) consider patients appropriately as a fundamental principle of patient safety before any clinical procedure. use of two markers for patient identification (e.g. name, date of birth, medical record and encounter number obtained either through a armband or use of double identifiers) was motivated when medication, blood or blood components was administered by a healthcare provider.

For certain cases, two medical experts gave recommendation to perform independent double checks for further improvement safety and reduce the risk of a medication mistake during the administration.[2].Data collected by the United Kingdom's National Patient Safety Agency (NPSA) show how, over the period from February 2006 to January 2007, there were 24,382 cases of patients misidentified for treatment, with wristband use recorded in more than 2900 cases

Most healthcare practices include, directly or indirectly, recognition of patients by healthcare personnel, including patient enrollment, drug distribution, diagnosis, etc. Computerized or paper records may be needed for such tasks. First name, Last name and DOB are multiple identifiers which are recommended for safe practice. The diversity of communicating structures and classification, and the fact that mixed identification may be viewed as 'too trivial to warrant coverage, impede the compilation of detailed statistical evidence of patient misidentification or records across settings and countries. Results (technological and processes) remains to help accurate patient recognition. Many new innovations such as radio frequency recognition (RFID) are now increasingly used and approached to the efficacy of wristbands and barcodes in hospice. The absolute acceptance of protocols may be hard to conquer, so the use of technology presents risks or unintended effects, such as input failures when patients are registered, 'incomplete technological options maybe they were ideal' or 'human testing procedures elimination in computerized systems .[2] Healthcare personnel's are expected to participate enthusiastically in making of organizations which are safe and provides quality healthcare services to patients. The specific features of the employee, including motivation, engagement, diligence

and care in the workplace, are important to the establishment of healthy organizations, including the recognition of patients as they must be done in day-to-day care [3].

From January1,2003, one of the first joint commission National Patient Safety Goals (NPSG's***)*** - ***'Improve the accuracy of Patient Identification'*** was implemented for all accreditation program . The mechanism by which a health care provider determines that a patient is the person for whom the care or treatment is intended. 1 Patient ID (PT-ID). Two performance elements (EPs) for NPSG.01.01, are specified by the joint Commission as follows:

1.Atleast two patient identifiers must be used when giving medicines, blood, or blood components; when collecting blood samples and other specimens for clinical procedures or blood transfer; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. 2. Label containers used for blood and other specimens in the presence of the patient[4]. The objective is to categorize and align service and therapy with the individual for whom the service or therapy is intended. The WHO also emphasizes the crucial role of patient or family engagement in all Patient Identification process [19].

The key to accurate patient identification is having knowledgeable staff who have education about the correct identification processes. Patient misidentification that results in incorrect-patient errors can be related to less knowledge, education, or training and lack of compliance with the appropriate procedures for précised patient identification. Being knowledgeable about how to rightly identify patients and complying with identification processes are crucial, particularly in countries where there are patients having similar names. Patient identification plays a vital role in patient safety. Now a day's patient identification is as important as providing treatment to patient in a hospital. If the process of patient identification in ignore or not taken care of it will cause problem to hospital.

> "**National Patient Safety Goals Effective 1 January 2016 for the Hospital Program-Goal 6-**Reduce patient harm associated with clinical alarm systems-individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them".[18]

PATIENT SAFETY

Patient safety is a strata that emphasizes health safety preventing ,minimizing ,recording and evaluating medical errors which often lead to severe effects. The severity and extent of preventable adverse effects suffered by patients was not well known until 1990's when a number of countries reported alarming numbers of patients injured and deceased by medical error.Recognizing that health errors have an effect on 1 in every 10 patients worldwide. Recent figures in the United Kingdom indicate that, on average, one patient injury event is recorded every 35 seconds. Similarly, a combination of various adverse factors in developing nations, such as understaffing, insufficient infrastructure and overcrowding, lack of healthcare services and lack of essential facilities, and poor hygiene and sanitation, lead to unsafe care for patients A poor safety and quality culture, defective treatment procedures, and unselfish leadership teams further undermine the capacity of health care facilities and organizations to ensure reliable patient care.

Fig 2 - Six patient safety goals

The WHO will provide assistance in 10 primary areas in moving forward the third Global Patient Safety Challenge:

1. Leading the initiative to advance the demanding main components;
2. Facilitating regional programs;
3. Commission expert reviews on the steps to be taken to prepare and guide;

4. Developing healthy drug management techniques, protocols, plans and tools;

5. To develop a plan outlining research goals as a consequence of medication-related unfavorable events and mobilize capital for foreign study in hospital admissions;

6. To begin regionally to gain political support as a follow-up to the global launch;

7. To build strategies for communication and advocacy alongside a regional initiative of in-country advertising and education materials;

8. To ensure that all facets of the program, including the creation of patient services, are actively involved in patients and families;

9. Monitoring and evaluating the Challenge impact;

10. Mobilize resources to allow the Challenge to succeed.

Culture for safety of patient is described as common behaviors, views, values, and expectations of safety issues within an organization. Patient Safety Culture requires a safety environment, which is the perceived importance that the organization places on safety. A good Patient Safety Culture would mean that patients are shielded from harm once they enter healthcare. There is also a lack of this security and there are multiple incidences of patients experiencing harm inside health care facilities. Healthcare professionals are encouraged in the use of these measurement instruments to define areas for improvement which can promote change in the culture of patient safety. Health care professionals may use a number of approaches to make changes to the culture of patient health. For instance, walk rounds- an informal way for senior leaders to tell about safety concerns with nurses & doctors and demonstrate their support for protection-or training initiatives that concentrate on teamwork and collaboration. In approximately 70 per cent of the recorded research, doctors commented on Patient Safety Culture more negatively than other health professionals. At ward level, staff comment on Patient Safety Culture more positively than at hospital level, with consistent results across all professional classes. Positive PSC managers and their personnel support workplace health programs can affect how the clinicians feel about the health of patients. It is therefore not known if management supports the clinical management techniques of the company to ensure appropriate actions of the clinic and the hospital[6].

OBJECTIVES

1. To identify the potential barriers of patient identification for patient safety
2. To discuss about the strategies for the identification of patients for safety.

RESEARCH METHODOLOGY

The review is written utilizing Google Scholar, PubMed, ResearchGate, Wiley searches to locate publications deemed to be relevant to the aims of this review, namely to patient identification in hospital and laboratory setting were searched from December 2003 to December 2019.

Article inclusion criteria was (1) patient identification (2) hospitals (3) patient safety (4) errors due to patient misidentification (5) strategies to improve it.

Keywords - identification of patients, safety of patients, hospitals, barriers, strategies.

DISCUSSION

CASE ON PATIENT IDENTIFICATION

"Patient Identification The Foundation for a Culture of Patient Safety [5] ***"***

The study discusses the operations and results for improvement in performance initiative for establishing a quality framework for identification of patients. The value for safety of patients in the healthcare system has been addressed by doctors, consumer advocacy groups, and regulatory and accrediting bodies. Safety of patients is rightly a significant concern for one patient and the other health care giver. Both initiatives have enabled health care consultants and physicians to reconsider and revisit common procedures that lead to safety of patient culture and prevent medical errors when required The Joint Commission on Healthcare Organizations (Joint Commission) implemented revisions to its Manual of quality in July 2001, throwing efforts in patient safety. Standards were else changed, improved, or added under the following chapters: "Leadership," "Performance Improvement," "Management of Information," "Patient Rights and Organization Ethics," "Education," "Continuum of Care," and "Management of Human Resources." ***The value of clearing established patient recognition standards was described at Memorial Sloan - Kettering Cancer Center as a major step towards improving existing patient safety culture and climate. The appropriate identification of patients is necessary before care, medication or service is provided. For an atmosphere in which high-risk procedures and services are given, this is very relevant.*** It is often challenging to explain, describe, or set procedures or establish a quality care in huge, mingled organizations. An initial evaluation and examination of the method described also shows variations in its implementation across

the organization. Any efforts to obtain suitable members need to be discussed to ensure the performance of the team. A small team of 8 to 12 members were not sufficient for performing procedures, suggested on the literature on performance improvement. Whereas, a larger team is achievable with sufficient preparation and facilitation.

Patient identification performance improvement team - A Patient Identification Performance Management Team were formed to review, develop and enforce the patient identification policies of the organization. The team's goal was to identify and establish one model of patient recognition that would be uniformly enforced to all departments while implementing all types of patient care delivery. The team includes 20 members presenting the following strata's within the hospital: inpatient nursing, ambulatory nursing, perioperative services, pediatrics, medical staff, admitting office, pre-admission testing, pharmacy, administration, medical records, radiation therapy, quality assessment, unit secretaries, clinical laboratories, blood bank, pathology, radiology, escort service, and patient financial services. Before first meeting, specific policies and procedures were written by all department members regarding patient identification were collected and complied. And then it is given to team members with the expectation to review it before next meeting. In first team meeting, a identify potential barriers for patient misidentification a brainstorming session was initiated - Incorrect Identification Process, Lack of clinical experience, problems in understanding language, taking wrong spelled names, Yes or no answers, Too much notes, Work load, Source of information, zero involvement of patient in processes, Changes in patient name, Copied medical record number, Error in "blue" cards, Difficulty in reading numbers, Information Difference in IPD/OPD blue card, Removal of patient wristbands, Less computerized system, Patient false identification information, Name cannot be corrected by appropriate department, problem of Team working various departments, Generation of mat labels which in turn are not properly disposed, various methods of covering patient location in clinic, depending on spoken communication, similarity in names, Assumptions (familiarity with patient), thinking process of patients that Doctors know them, Patient cooperation Transcription incorrect, Two cards; valid source of patient identification?, Lack of "true standard" misidentification area, Wrong stamp (patient identification), No identification on order - blank forms, Misfiling, stamped names incorrectly written. However, Benchmarking was expected to be an integral aspect of the group efforts with other organizations. Specific team members have approached another hospice and oncology centers to assess the current procedures and strategies for patient recognition. Despite the exception of

patient recognition armbands, a traditional medical procedure, little additional information was gained from health care organizations via benchmarking.

Establishing the standards **-** The development of a new patient identity norm considered the description of elements required for patient identification, regardless of the method. The elements would decide where and by whom the information would be gathered, the information & documents of source would be needed, and where those elements would be observed and/or checked in the care taking process. patient identification elements would be ***patient's name, DOB, sex (M/F/Other), and Social Security number or medical record code*** & ***source documents were determined to be driver's license, passport, visa, birth certificate, and Social Security card***. ***Three stages of patient identification have been established: new entry /registration; admission / transfer; and care, treatment and service provision***. New entry / registration of patients was more significant identification step along the process of patient caring. It is the phase at which patient records and data are first collected and inserted into the HIS in the admission process. Therefore, this was a stage where the rigorous standards, requirements were to be set. They decided that the continuum of care would be an exact model for identifying many areas for patient identification. The decision has been made to get a State ID card, passport, International identification card or a government visa. A certificate of birth is mandatory for children aged 17 and younger, the parent or caregiver must be identified according to previously established strict patient identification regulations. The upcoming step was the admitting / transferring and putting bands in the patient recognition process. This phase happens with patients registered to the hospital and using the service. In order to carry out this method of patient identification, the records of the patient must be available in the database system of the hospital. During this step the patient may need the following identifying elements: last and first name pronounced by patient; medical record code or DOB indicated by patient; or hospital card presented. This text has to suit the pre-printed wristband and/or information inside the HIS exactly. Some misfits instantly prevent further processes; a professional is informed. The use of patient identification wristbands became a conversation field for the group, raising obstacles and challenges to achieving team objectives. Many team members resisted enforcing this policy in divisions that did not typically position them (e.g., radiation cancer and outpatient unit). Of course, there was no resistance to placing wristbands in those places where they are usually placed (e.g., inpatients, preoperative patients, and patients in emergency care). However, those areas with a high regular patient volume and a perceived non-traditional patient setting (e.g., ambulatory services center and radiation oncology where the same patient can be seen

five days a week for six weeks) represented the team's biggest origin of issues. Higher management was been consulted about the major hurdle of the team regarding implementation in an ambulatory environment. ***It was recommended that a performance of patient perception survey should be based on some of the patient identification guidelines of the team. Patient representatives were asked to make a patient survey. Following three questions were asked from random samples:***

1. How do you feel about an armband before you undergo chemotherapy, transfusion of blood, intravenous hydration or switch to another facility?

2. Whenever you come for an ambulatory appointment even though you have no chemotherapy (for example, doctor appointment), how would you feel about getting an armband?

3. How will you feel that many times during your ambulatory visit you are asked about your name and DOB?

Outcome of the study suggested that most patients were in approbation of getting the names requested multiple times during stay, or having a patient armband for high-risk procedures if for their health. The study backed group guidelines for the use of patient identification wristbands in ambulatory environments. Penultimate point along the patient identification continuum was identified as care delivery, diagnosis, and service provision. It is the method of patient identification that takes place prior to transport, care, operation, diagnosis, and administration of the drug. There is a minor difference to the norm depends on whether the patient wears a wristband for patient identification or not. The doctor is expected to do the following for patients with a wristband: observe last and first name, medical record number and DOB on wristband. Compare these three elements with the sample name, requisition, series, etc. The patient is motivated to tell their last name and first name for patients without a wristband, and to state their medical record number or date of birth. Comparison of these 3 pointers with the name, necessity or series of the specimens. ***Execution-Last proposal of patient identification was made which is administratively approved, all higher authority in various departments received an In-service on its fulfillment and defined deadlines. The policy was reviewed, changes were highlighted, and dates and deadlines to fulfill staff education were implemented. Once the new regulations were working, an institutional e-mail was mailed indicating that it was in effect the updated patient identification incidents of misidentification will be monitored and trended through the hospice standard assurance department to ensure and measure performance of the organization.***

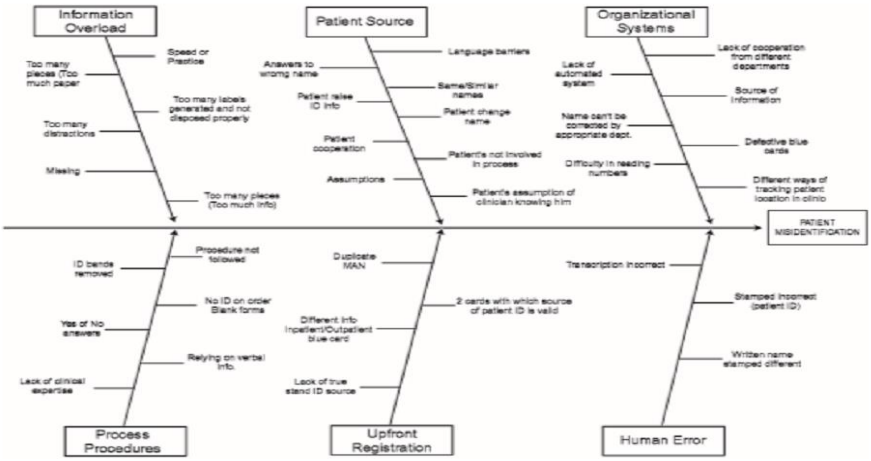

Figure 1. Potential causes for patient misidentification.

Fig 1- Potential reasons for Patient Misidentification.

Source- Parisi, L. L. Patient Identification: The Foundation for a Culture of Patient Safety. *J. Nurs. Care Qual.* (2003). doi:10.1097/00001786-200301000-00010

PATIENT PERCEPTION TOWARDS PATIENT IDENTIFICATION

Before deciding on patient identification, it is very important to understand what patient perceives about the methods used to identify patients as they are concerned about their health and safety. Acc. to the study byStrudwick.et.al[12] The most (n = 38.73.1 percent) research participants reported taking medication and thus had existing experience with BCMA. Half (n = 26, 50%) of participants said that they prefer a mixture of recognition processes like wristbands and/or photos and/or alternate photo IDs. In comparison, most of the participants had either a favorable experience (n = 26, 53.1%) or a neutral experience with BCMA (n = 6, 12.2%). Eleven (22.4%) participants reported to date negative BCMA experience

As a result, from the thematic study of the participants' transcripts from all hospital settings, six themes emerged. Which included: (1) knowledge security, (2) solitude and health, (3) stigma, (4) connections, (5) protection and convenience and (6) not positive technical linkages. Patients stated in the paper-based program that they wished to provide both interpersonal (e.g. patient reviews and 'tests with another nurse') and technological identifiers (e.g. picture or wristbands). Although BCMA had issues mainly related to the technology (example- solitude and picture recognition safety) that affected the choice Furthermore, there were no variations between young participants' experiences in contrast with older participants..[12] This study depicts that patient have various concerns about their identification process there are patients who are fine with barcode technology but there are patients who have major concern about privacy of data.

STAFF PERCEPTION TOWARDS PATIENT IDENTIFICATION

To improve patient safety, knowing how major healthcare givers interpret the PT ID & how it influences the daily activity is vital. While the text on patient safety procedure is full of arguments of change measures, little is known about the specific opinions of those at the frontline.

Qualitative analysis has informed about how nurses perceive them as a shield, buffer and patient protector to avoid errors. Nonetheless, the health of patients has become a central component of career and nursing education. On the other hand, residents may have a minimum access during the years of residence to patient safety education

DAILY PRACTICES TO PATIENT IDENTIFICATION

Verbal initiation—carried out a range of personal styles—is most common way to continue identification of patient in-patients care. In terms of verbal introduction, both caregiver (nurses and doctors) identified their first PT ID experience, forming a relationship by changing their names. There was a general understanding in both groups that establishing verbal contact with the patient was in most cases adequate proof of identification.

Checking wristbands is considered the domain of nurses. The present PT ID validation by examining the ID wristbands is performed by the nurses more than often; residents seldom. Nurses regularly report testing PT ID when medicine or a procedure is administered. Residents seldom check the wristbands until they are unable to communicate with the patient and rely on the verbal patient to warn them if misidentification is occurring.

Nurses and residents may develop their own methods for ascertaining or confirming patient identity

Some nurses has developed their own methods to ensure, each and every patient is correctly identified, including bringing lists of patients, to slow down to calm down and focus on the job they do, and to conduct surreptitious checks on wristbands.

Many respondents thought that even if they were exceptionally tired, busy and hard-working, the experience had ability for substantial patient harm, and if the patient was not verbal would follow the formal procedure of a PT ID. Resident participation in the procedure tends to be little satisfactory, perhaps because the nurses do the examination[4] Therefore, nurses and residents realize that there is potential harm in not checking patient identification doctor tends to depend on nurses because they want to maintain their relationship with patients. As hospitals tends to overcrowded most of the time it is very important to look for patient identification.

A CASE ON HOSPITAL WRISTBANDS

"Designing evidence-based patient safety interventions: the case of the UK's National Health Service hospital wristbands[15]***"***

In a new National Patient Safety Agency (NPSA) pilot report, 15 inappropriate patient identification mis happenings were observed in 18 UK acute care hospitals over a 5-month period and forty four

occurrences were identified in an study ,covering 28 acute hospitals, over 9 months[16]. Precise identification of patients in acute hospitals is a centerpiece of patient safety. Patient wristbands are the pillar for identification of patients in acute hospitals. These were normally applied on wrist and contain details required for health care workers for patient identification (usually the initial name and last name of the patient, DOB and identifiers). Since armbands are the main means of identifying patients in healthcare setting, it follows that ensuring adequate patient care needs that wristbands should be in hand of patients; (ii) that wristband details is reliable and readable;(iii) that hospice staff review the armband before delivering a patient therapy. The lack of continuity in using different colors to classify different patient status / risk is another issue with color-coded wristbands Most of the data available in relation to this question comes from the USA. A patient nearly died of a misunderstanding on the part of staff in an almost miss in a Pennsylvania hospital over the significance of a yellow wristband. Due to the case color coding in the state of Pennsylvania was submitted to the study. In 2005, 78 percent of state health facilities responded with a color-coding survey by the Pennsylvania Patient Safety Authority[17]. A similar concern with current use of the wristband is that wristbands are also used to indicate specific hospital marking. Special hospital status involves allergies, fall-prone patient, disturbed patient, patient who does not accept blood related products, from no one. The purpose of the survey is to notify NPSA's national guidelines on wristband design and color coding. The research aims to respond to the various queries: 1 How much knowledge provided on wristbands? 2 How are wristbands given, checked and applied to patients? 3 how many kinds / designs of wristbands (including color coding) are present? 4 What are the key issues faced by nurses with respect to wrist banding patients? A pseudo-random selection of National Health Service's (NHS) acute hospitals was chosen in England and Wales. They hired 99 acute NHS hospitals. The project team created a survey method the method was designed to attain several interrelated goals. Firstly, the tool aimed at compiling the characteristics of the wristbands currently used in NHS hospitals throughout England and Wales (color & make). Secondly, tool also aimed at supplying the basic details for project evaluation. Thirdly, the survey was intended to provide a basis for a number of sessions organized and coordinated by NPSA for NHS staff and patients. The result was a questionnaire collected from 62 hospitals, one hundred and sixty-six. In the case of missing or unreadable information, the hospital could not be identified by eight questionnaires, reducing to 54 the number of hospitals identified. The utility of the individual patient identifiers, the system for issuing and checking bracelets and the related issues were both assessed by the respondents' data. However, color-coding research was carried out at hospital level. In

Aim1 **problem with usage of patient identifier on wristbands**, the most commonly reported issues were patient-related (75 respondents) with lucid, unintentional, impaired or impaired patients without a family or caregiver. In Aim2 following **the procedures for issuing, checking and applying wristbands** The most repeated concern in following the procedure of band assigning are as follows: • Patient-based: patients become frustrated or uncomfortable; employee-related practices: wristbands not released first or subsequently removed by stabs and not replaced; and • Working environment: time constraints, lack of levels of personnel, lack of clarification about who is responsible for issuing, tracking or using information: Data is unreliable, unreadable or illegible Aim3- **Designing wristband and color coding,** The most frequently reported concern was that armbands were not waterproof most of the time, which resulted in often illegible information on wristbands. Many participants confirmed that the material or band shape and band size issues are present. The interviewees were also asked to describe which armband type they prefer. Staff also confirmed that in certain responses they prefer colorful wristbands, because they can easily identify special patient status. However, other interviewees noticed that white / transparent bracelets are safer because they prevent ambiguity about the significance of the various colors. , ***the patient's last name, first name, DOB & NHS number should be included in the wristbands in this order. To ensure readability, this information should be written in black against white background. In respect to color-coding, only red wristbands can be used if a recognized danger or special patient status is indicated by the wristbands and the caregiver will refer the patient's notes for more details.***

RESULTS

POTENTIAL BARRIERS

Patient wristbands for errors over a 2-yearperiod were checked in a quality management analysis. The findings indicate that 70% of the patients has lost wrist bands, 10% do not have proper identification data, 7.7% had unreadable identification bands, 6.8% had wrong identification data, 3.7% had inconsistent data and 1.1% had a false patient wristband[13]. The amount of information on a wristband has steadily increased, usually with the aim of assisting the delivery of care e.g. consultant name, ward name, allergies, and address. Whilst there are justifiable needs for this information, multiple information categories reduce the clarity of patient identifiers and the wristband has become multi-

functional. Wristband design need to meet a large number of design criteria: they need to be waterproof, tamperproof and comfortable to wear. Comfort is a particular concern – patients wear wristbands throughout an episode of (sometimes bed-ridden and immobile) acute care and for vulnerable users such as new babies, the elderly or those with frail skin a wristband can cause discomfort and can even damage skin over time.[14] If a patient armband is attached to side tracks in hospital beds, patients exit the unit for tests or treatments without identification. In the bags, sacks, or wallets of patients, the wristbands are kept less visible [1]

Patient misidentification errors may occur when caretaker mispronunce patient's names or call patients from their first name or last name only. Rather of asking the name of a patient ,nurses passively obtain name verification creates a risk of the incorrect paient resction. Infact,as they leave the examination unit for examination,patient wristbands inserted into the side trails of hospital beds leaving patient without identity.Wristbands kept in the pockets,bags or wallets of patient makes them less useable.In the same way,nurses may feel that thet know their patient,especially those who have undergone regular outpatient care have been admitted for a long time.Infact making jokes and not understanding patient identification process seriously can leads to mishappenings. For eg. A nurse opened the door of a waiting room for pediatric oncology and called it "Jennifer."

The nurse was accompanied by a teenager who played music through earphones. Some minutes later, one woman opened the door of the exam and said, "That's not my child." It was scheduled to be seen that morning in two patients, first name Jennifer. [1] (As you can see that, in this scenario, the nurse uses a single identifier and, on the other hand, it is the patient's duty to listen to the cues.) confirming name of patient again & again and it seen as no interest in serving patients and it puts question in caretaker's connection with patient or the caretaker's professionalism. caregivers say that they tend to establish a special connection with patients. Nurses hesitate irritating patients by excessively checking, and doctors aspire to represent the gesture that they remember patients by name and appearance.

"I find that it may come across as a little rude if someone is oriented and with it that I'm, like, checking because it almost feels a little bit unprofessional sometimes, even though it might not be. Just . . . it's like you're unable to remember their name, you know, so you have to check to figure out who they are or remember what their name is." [R][4].

Using patient position to classify patient- A number of encounters involves patient identification mistakes connected to the custom of consulting patients to their position (room number bed position) instead of their name. doctors speak of making communication mistakes, in which they goes in the

room, interact with patient, and understand, they might be treating in incorrect cabin then tends to "delicately back out". Nurses also mentioned fairly regular instances of physicians dealing with wrong patient, typically because they depended on the patient's position. Always the common errors were detected by nurse who caught and these errors were resolved by nurses most of the time. Interactive errors were usually characterized as not problematic to the patient, but one such error almost until the nurse found out the mistake: "He [the resident] gave orders for discharge to the lady in window bed but it was for the lady in the door bed. He thought the lady in the door was the lady in the Window.

Workplace distractions, quick speed and exhaustion of the provider lead to disturbance in patient recognition practices. Sometimes, when nurses either skip to check patient identification proof because of difficult setting, over fast speed, or simply their own exhaustion. Mistakes were reported by nurses and doctors where they missed the ID check and tend to make an error or nearly made an error because they were distracted, overworked or overwhelmed: "nobody have much time to pay much attention because we have many patients who also needs to be monitored. Still, anyway. And we perceive that we know the patient -you know, we take it lightly

Cultural issues, including: [1] Problems related to taking a wristband in hand all the time.[2] Increased problems related to patient misidentification due to naming pattern, near name similarities and DOB inaccuracies in the aged. [3] Clothes hinders identification process. [4] Lack of awareness of local names for more and more foreign health professionals. [5] Cost factors- needs a high amount of capital for potential technical solutions for implementing new technologies to cure this problem. [6] Insufficient generally reasonable cost-benefit analysis, evidence, and economic justification for implementing these recommendations.

Several approaches have been implemented to reduce patient recognition after reading several academic posts, reports, journals. The following techniques are intended to reduce patient recognition errors. Such strategies involve creating specific written protocols, improving occupational healthcare instruction, tracking patient metrics.

1. Ask patients about their full identification information in passive agreement.

[e.g., -the question should be asked like- "can you tell me your full name and DOB" instead of "Are you Mr. Gandhi"].

2. Before admitting the patient, clearly instruct/teach patients about the importance of patient safety.
3. Encourage patients not to remove wristbands and to correctly wear them and it causes any problem to inform the nurse about it and ask for a solution.
4. In hospitals where wristbands are not used, patients should be recognized with 2 patient identifiers without adding the patient's room number or location because they tend to change with situations.
5. Encourage the patient's family to focus more on patient identification and ask for questions if any doubt prevails to ensure the safety of their loved ones.
6. Color coding

Colored wristbands are increasingly being used by healthcare organizations, although again this has not been standardized. Colored wristbands may be used as an indicator of a patient's special status or to indicate type of care, for example, allergies, risk of falling, "do not resuscitate" etc. Color coding has been introduced across the service on an ad-hoc basis and currently performs a number of functions:

- Warning: the color is an indicator to staff unfamiliar with a patient that they may require special care e.g. when handling a confused patient or one at risk of falls
- Reminder: the color is used to remind staff who may be familiar with a patient of their special status, for example, to remind staff during drug rounds of already known penicillin allergy.
- Action required: the color is used as an initiator of action for example consultation with notes must be made before administration of care to check for details of allergies before drugs prescription.[2]

7. Identification and removal of ineligible wristbands from patients [the wristbands with extra or excess of information increase the chances of misidentification, so it is necessary to remove those illegible wristbands.]

8. Allow the introduction of biometric methods for registration to boost the identification of patients .[24]

9. To decrease the likelihood of selecting the wrong patient name, all double identifiers should be distinctly displayed on screens.

10. Patients who are in critical condition or unable to understand due to a language barrier should be taken into context.

11. Correctly verify the patient's identification from the patient's wristband provided to the patient.

12. Educate the patient to show the wristband again and again at the time of recovery, medication, procedures, etc.

13. Implementation of policy in compliance with the policies of suggested boards like WHO, JCI, NABH.

14. Upon removal of wristbands for any procedure promptly replace with a new wristband.

15. All patients should be identified before taking to any procedure or treatment.

16. Involvement of barcode and barcode readers on a patient sample before and after every laboratory test.

17. Patients must know and rely on the need, process, and the risk of misidentification to interact with patients and their families .[22]

18. Health managers should monitor the process and measures that are taking place in the hospital.

19. Encourage a community in which workers understand the significance of incidents and missed reports involving reporting errors as part of the overall safety commitment of the company .[24]

20. Special attention should be given to patients who have similar names and it should be acknowledged by staff.

CONCLUSION

Patient identification is one of the complex processes in hospitals to ensure patient safety and to maintain their reputation in the market to maintain it this process should be monitored more intensively and acutely On the grassroots level, it is observed that when a patient is admitted into the hospital the doctors or the staff doesn't ask for identification because they are attending them for a long time. So, more practical solutions should be devised. It is recommended that a subject related to patient identification & patient safety to be incorporated into the course curriculum of clinical (Doctors, nurses)

& non-clinical (administrative) staff working in a hospital or to design a course as a part of training for them before they enter hospital in enable them to understand about the severity of patient identification process for safety of patients. Strict instructions and proper protocols should be adopted to improve patient identification & it is advised to do time to time monitoring of these protocols by identifying whether these protocols are running in compliance with the standard protocol. Safety of patients is a moral duty which should be religiously performed by hospital as hospital is fully responsible for safety of patients. Overall, the basic fundamental of each and every hospital is to "save Lives" therefore, more light should be thrown on patient identification for patient safety.

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PART-2

(ONLINE COURSE REPORT)

HUMAN RESOURCE FOR PEOPLE MANAGER: RECRUTING, HIRING AND ONBOARDING EMPLYOEES

-University of Minnesota

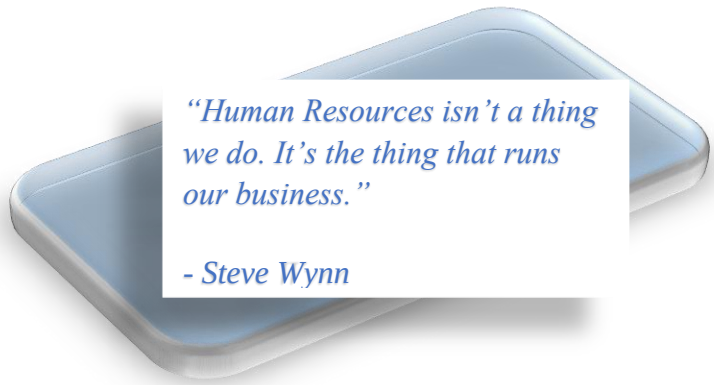
HUMAN RESOURCE (HR)

Human resource management (HRM or HR) is a proactive approach to successfully handle staff within a corporation or organization to help their business achieve a competitive edge. This seeks to improve employee productivity in the pursuit of an employer's strategic targets. The quotation for validating management of human resources primarily concerns the management of people within organizations. HR Divisions oversee the design, recruitment, training and production of workplace programs, assess performance and administer rewards such as salary control and programs. The overall goal of HR is to ensure that the organization is successful through people.

HUMAN RESOURCE IN HEALTHCARE

Health Human Resources (HHR) is characterized by persons interested in conducting activities which aims is to improve health. Human health services is known to be major key building blocks of a health system. It covers doctors, nursing practitioners, midwives, dentists, allied health professionals, community health workers, social health workers and other health care providers, as well as health care professionals.

Figure1: - Human Resource Management Functions
Source- https://bohatala.com/human-resource-management-introduction-report/



COURSE DESCRIPTION

The right individuals are frequently cited today as the number one organization concern for searching and hiring. It seems like we all aim for the brightest and better workers. One crucial aspect of the Personal Manager Quality Proposal – as you can see together in the second stage – is to hire skilled people who help the organization achieve its strategic objectives. This course provides an introduction to recruit, select and onboard.

At the beginning of the course we will discuss the importance of linking recruitment objectives to the whole strategy of the company. We then consider a range of options to recruit and select employees efficiently and legally. We may discuss current concerns with respect to talent acquisition in the course such as how businesses now use social media and participate in reviews to guarantee higher recruitment efficiency.

INSTRUCTORS

- Amy Simon (Senior Lecturer) - Department of Work and Organization
- Stacy Doepner-Hove (Director) - Carlson School of Management, Department of Work and Organizations.

DURATION

- Duration - 15 hours and 53 minutes.

LEARNING METHODOLOGY

Course content was online with videos followed by quizzes and peer graded assignment which can be accessed after paying.

COURSE OBJECTIVE

To have a brief knowledge about Human Resources

- Recruitment.
- Selection.
- Onboarding.

COURSE CONTENT

WEEK 1 - Aligning Recruitment and Selection with Company Strategy

We lay the essential foundation for your training in this module: to harmonize recruitment and selection practice with the overall strategy of your company. In order to understand the interdependent components of the organization and how the internal and external environmental factors influence the strategy, we use the System Theory method. The value of workplace preparation is addressed and this section ends with a summary of the key components of the recruiting process: work design, task review and job requirements.

WEEK 2 - Recruitment: Finding the Best Candidates

In this section, we discuss the strategic implications of recruitment at the macro level. We will also consider what makes an efficient recruiter and where future employees can be found. Present topics such as social media and mobile technologies have been addressed in recruitment. We then take time to focus on important legal and ethical recruitment issues and complete this module with a worldwide view of recruitment.

WEEK 3 - Selection: Choosing the Best Candidates

We examine the selection process in this module. We start from the broad picture, as in the first two modules – what are the selection and how do we link it to the strategic objectives? We then examine the important legal factors, such as the elimination of partialities and background checks, as well as other best practice in the field of selection. We'll then see various selection tools you can use to make a better decision on the recruitment process. Eventually, by designing and delivering proposals to applicants, we finish up the third section and evaluate our recruitment process for performance.

WEEK 4 - Special Topic: Onboarding

We will discuss the introduction of your new hire in Module Four. You want to make sure that your new staff is up-to - date and becoming a committed, motivated member of your team after only interviewing and hiring a new team. Module 4 discusses how a large integration process works and why an employee is involved with the company.

KEY LEARNINGS

WEEK 1 - Aligning Recruitment and Selection with Company Strategy

- ✓ A brief introduction about course was given how system thinking plays a role for recruitment and Selection, as system consist of both internal and external factors which in turn depicts about an organization's working**.** There are 4 main elements of system thinking- 1) System can be open or close 2) System have interdependent parts that are interdependent and form a complex whole 3) System have input, throughput and output 4) Feedback from the environment is necessary.
- ✓ In a system how internal and external environment plays a role before recruitment and selection both factors are seen. Internal environment is seen on factors- turnover, employee development, current work profile, performance whereas external environment is observed on factors- economy, competitors, threats of substitution, labor market, customer demand, geography
- ✓ Workforce planning plays a major role as after understanding the environment, the planning of recruitment and selection takes place according to to the needs and requirement.
- ✓ Essential parts of hiring process- Job Analysis, Job Descriptions, Job specification. These are the most important parts of recruitment and selection process as a right candidate will be selected if these are clearly understood by candidate and clearly written and analyzed by recruiter.

WEEK 2 - Recruitment: Finding the Best Candidates

- ✓ Before recruitment, strategic planning is done to successfully recruit candidates these are- how many, where, who, when. There are various responsibilities of HR- target recruiting, environment and fit, strategies & recruiting methods, cost of recruiting method, speed of recruiting method.
- ✓ Characteristics of effective recruiter- 1) trustworthy, 2) Friendly, 3) Reasonable, 4) Affectable. Technology plays major role for getting a large chunk of candidates according to the profile and how to manage negative messages that floats on internet.

- ✓ To hire a passive candidate for uplifting your organization. Passive candidate are the one which is not actively searching for job but a HR wants to hire him/her because of a particular skillset which helps a company to grow. There are various ways to reach out passive candidates i.e., networking, moving this quickly, giving them what they are not getting already, on point emails.

<u>WEEK 3</u> - Selection: Choosing the Best Candidates

- ✓ Steps of selection process-
    1. Screening applications.
    2. Testing and reviewing work samples.
    3. Interviewing Candidates.
    4. Checking References.
    5. Making selection & offer.
    6. Acceptance and background check.

  A recruiter should be very careful before selecting any candidate.
- ✓ Sometimes decisions made will be quick due to which Biases occurs. There are 5 types of biases that occurs while selection process- 1) Confirmation Biases, 2) In group Biases, 3) Contrast Biases, 4) halo effect, 5) Prejudice. History of work, education, credit history, record driving, criminal record, medical history, use of media and drug screening are all part of the background checks. History examinations that actually verify if the applicant has a legitimate license. Qualified licenses
- ✓ Before moving to selection tools, selection tool standard should be utilized to make valid and reliable selection tools. There are steps for good hire – 1) Job Analyses +KSA+competenices +JD. 2) Determine selection methods to use. 3) Conduct method. 4) Evaluate Candidates.
- ✓ Structured Interviews are best way to conduct effective interview. A Predefined set of questions provided before interview could be a valid predictor for performance. On the other hand, a candidate should be well prepared with all basic etiquettes to make sure that the interview conducts in a smooth manner.
- ✓ Candidate evaluation should be made after interview because after conducting all the interview and later deciding on candidate would be a difficult task or at least to record the interview for late

evaluation. Any candidate evaluation form can design or adopted by HR team with ratings & weights in it to evaluate a candidate.

<u>WEEK 4</u> - Special Topic: Onboarding

- ✓ New staff onboarding processes are to integrate a new staff member with a firm and culture and to recruit the tools and information necessary to become a productive team member.
- ✓ Tools for onboarding- checklists can be made for every employee before and after onboarding to make sure that candidate feels comfortable in an organization.
- ✓ After candidate is onboarded and individual development plans should be given them to fill in a time period so as to understand their expectations and what else needs to be done for more improvement.