2014 Gage Awards

Reference #	7493652
Status	Complete
Name of hospital or health system	Truman Medical Centers
Name of project	Naming Conventions for Trauma Activation, Unidentified and Mass Casulaty Incident Patients
CEO name	John Bluford
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Quality

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	This organizational change was a coordinated approach with an objective of ensuring appropriate identity verification using dual identifiers for the safe delivery of emergent care to a vulnerable patient group. Although the original intent was for use in the trauma patient, it was extended to mass casualty and unidentified patients who were initially recognized with a single identifier. Following an adverse event involving dual identifiers, it become apparent that the method of identifying a high risk population was inadequate and did not meet the national patient safety goal requirements. With a non-electronic process in place, a similar occurrence with potential for patient harm was inevitable. Key stakeholders in all impacted areas were identified, a multi-disciplinary work group was formulated, and a process map was developed to identify all components in the sequencing from patient arrival through the acute resuscitation phase. It was necessary to complete a literature review to determine existing practices and to network nationally with other trauma centers for the same. A temporary naming convention using the military alphabet was devised as an electronic preregistered process for trauma, unidentified or mass casualty patients. The military alphabet provided a logical basis and provided expansion capability using traditional alphabet lettering. All patient documentation utilizes the temporary name and medical record number (MRN) as the dual identifier for 24 hours to complete emergent diagnostic and surgical interventions, while reinforcing the safe delivery of patient care to patients and family members. The corporate policy was drafted and the merge/ notification process was developed with a specified time constraint for conversion to the valid patient name. The “go live” date was established to allow for corporate training and process trial in a scheduled emergency management event. Post implementation, 100% of patients had a pre-assigned MRN upon arrival with an average electronic activation time of one minute accounting for patients arriving without pre-notification. The laboratory had instant usability of the MRN accompanying the specimen rather than waiting for identity verification for diagnostics. The time from specimen arrival to first order placed decreased from 5 to 2.2 minutes and the Type A activation initial lab results decreased from 16 to 7.1 minutes. The merge process to a verified identity merited changes that allowed exceptions for physician request, patient transfer, discharge or death to allow for continuity of care. This project provides substantiation for a standardized electronic process for pre-assignment of a MRN to a temporary name to improve the acute patient care process. In implementing this improvement/ change project, TMC focused on an evidence-based, patient centered approach that could be replicated as a best practice for other facilities.
1A. Attachment, if applicable (Applicable examples include a peer reviewed journal article, other content published in the literature, or a presentation at a national meeting)	AnnCon_T25_Lienhop-UHCBreakoutPresentation10.17.13.pptx (1397k)

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	Following the initial root case analysis (RCA) for the adverse event, attempts at modifying the existing single identifier process to include a physical description using race and sex was not feasible and had the potential for duplication given the demographics for the trauma population. A strategy was necessary to address this “controllable” factor identified in the RCA and to develop a process/ policy for identification of trauma activation and unidentified patients. Key stakeholders in all impacted areas were identified, a multi-disciplinary work group was formulated, and a process map was developed. Baseline data for MRN activation, specimen results, and first order placed exceeded expected turn-around times for trauma patients requiring immediate results. A literature search yielded little concrete information. University trauma centers with Cerner applications were identified as a vehicle for external networking to identify existing naming conventions. The regional trauma society was polled as to their processes. Upon data review, the temporary name template was determined using the military alphabet as a base (Alpha, Alpha – Zulu, Zulu). Multiple revisions of the process map insured inclusion of all crucial departments impacting the implementation. With the process originating in Patient Access, the pre-registration and activation process was finalized and packet assembly was coordinated with the Emergency Department. The corporate policy was drafted and then expanded to include unidentified and mass casualty incident patients as these patients also used the BB numbering system for identification. The emergent nature of the traumatic injuries or illness created a time constraint for verification of patient identity and when to merge the MRN to the valid patient name. Patients may require multiple transfusions or repetitive diagnostic or operative intervention in the initial 24 hour period. The merge/ notification process was developed with specified time constraint for conversion. The “go live” date was established to allow for corporate training and trial of the process in a scheduled emergency management event. It was essential that all hospital staff were knowledgeable and were able to validate the correct dual identifiers for this patient population as this was an organizational change. The dual identifier was reinforced in all venues as the temporary name + MRN. Mandatory compliance training was required for clinical and non-clinical staff and physicians across all hospital campuses via the online learning application and live education was conducted in committee venues. Data collection and monitoring continues to evaluate process improvement and need for policy modification. Based on physician input and to ensure coordination of care post discharge or transfer, the policy was modified related to exceptions to the 24 hour merge time frame.

3. Describe the results of the project. What data was used to support improvement results?	Pre-implementation, a MRN was not immediately available to process with patient laboratory specimens, and activation time varied dependent on patient presentation. Baseline turnaround time for specimen processing exceeded standards related to the manual processing and time delays for merging of the BB number with a verified identity. The potential for error or repeat of a similar adverse event was the major impetus for the organizational effort in completely revamping the process for the trauma, unidentified and mass casualty patients. Additionally, it was necessary to be in compliance with the National Patient Safety Goal for dual identifiers. The focus on delivering safe patient care in an emergent situation was the “mantra” in addressing this critical initiative. With 28% of the trauma center’s patients self - presenting, this fact contributed to delays. As a previous manual process, there were time delays related to validation of patient identification. Post implementation, 100% of patients had a pre-assigned MRN upon arrival with an average electronic activation time of one minute to account for patients arriving without pre-notification. The laboratory had almost instant usability of the MRN accompanying the specimen rather than waiting for patient identity verification for specimen analysis or blood bank testing. The time from specimen arrival to first order placed decreased from 5 minutes pre-implementation to 2.2 minutes post implementation and the first lab result for a Type A activation decreased from 16 minutes pre-implementation to 7.1 minutes post implementation. Evaluation of the process regarding the merge to a verified identity merited changes that allowed exceptions for physician request, patient transfer, discharge or death to allow for continuity of care. Monthly monitoring continues for first order placed and first lab result for all trauma activation patients. Additional planned monitoring of the merge process will include verification of patient identity and MRN in all aspects of the electronic health record including diagnostic, radiologic and laboratory procedures. This initiative was educated across all levels of the organization and remains an annual compliance assignment as well as an orientation presentation.
3A. Attachment, if applicable (Only graphically displayed data such as charts will be accepted. Data should include baseline and improvement data)	CumulativeNamingConventionGraphResults2012-20132.pptx (79k)

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	As a result of this project, the organization revamped a manual process that had been in place for 25 years to a standardized electronic process that had measurable results and immediate safety implications. In terms of quantifiable measurements, MRN assignment, activation, and accompaniment with laboratory specimen as well as time to availability of first lab result were key to quantifying improvements or identifying gaps for the trauma patients with the highest level of acuity. Following implementation of the policy and accompanying education, there was significant improvement in the lab turnaround times for specimen processing as well as instant usability of the pre-assigned MRN to the temporary name. This project's value is in the reduction or elimination of medical errors associated with patient identification for a vulnerable patient group. There is substantiation for a standardized electronic process for pre-assignment of a MRN to a temporary name to improve the acute patient care process. In implementing this improvement/ change project, TMC focused on an evidence-based, patient centered approach that could be replicated as a best practice for other facilities. This organizational change performance improvement project was shared with the Joint Commission during the 2012 hospital survey.
5. Describe how patients, families, and if appropriate, community was included in the work.	This project stemmed from an adverse patient event. In accordance with the disclosure of adverse event policy, the family was notified in a meeting with the anesthesiologist, surgeon and the Medical Director for Quality. The disclosure provides the provider with verbiage as a guideline for providing information and progress reports. Prior to implementation, peer groups and other facilities were contacted in an effort to understand what similar processes were in place for these patient populations. Each had their own perspective and others had similar adverse events or near missed. Similarly, a query was made related to similar blood bank scenarios. Following implementation, it was important to be able to verbalize to patients and family members the reason for a temporary naming convention for the initial 24 hour period as the safe delivery and documentation of emergent patient care. It was equally important to reinforce to patients that the verified identity was known, but the time constraint for conversion was related to emergent care, blood transfusions or diagnostic procedures. The end-users of this process (patients, families, physicians) contributed input into policy modification related to time exceptions in merging to the verified patient identity.
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