Evaluation of the results of the Clinical Audit of Patients Identification in a Private Hospitals Network

Introduction: Patient identification errors can occur, from admission to discharge, at all stages of diagnosis and treatment. Some factors may potentiate risks in patient identification such as: patient's state of consciousness, bed, sector or professional changes within the institution and other circumstances in the environment. (Ministry of Health, 2013)

Given the importance of the correct identification for risk reduction and mitigation of adverse events of patient exchanges, the World Health Organization prioritized some actions, among them the identification of the patient as an international strategy for patient safety (Goal 1).

Objective: With this study it is expected to measure the effectiveness of the actions proposed and implemented in the Patient Identification Safety Protocol.

Methodology: A total of 600 patients were evaluated in the areas of the Emergency Room, Inpatient Unit, Maternity Unit, and Intensive Care Unit. The period of analysis was from June to August 2018. The study was conducted in 30 private hospitals belonging to a network operating in the states of São Paulo, Rio de Janeiro, Pernambuco and Maranhão.

The evaluation was performed considering the following moments in the same patient: if the patient had the legible identification bracelet (containing the two standardized markers in the institution), if all the printed forms contained labels or full identification (in case of manual registration), whether the labels of the medications being prepared were duly identified and direct observation to verify that during the administration of the medication the employee confirmed the identification of the patient (asking the patient to confirm his/her full name and birth date and simultaneously checking the bracelet) or evaluating the patient's report of the full name and birth date check before any diagnostic, therapeutic or drug intervention.

Results: Only patients who had the three steps performed with positive results were considered in the construction of the result. The general mean of identification of the patients was 58% and the biggest problem identified was related to medical records with incomplete filling when the registry was manually performed and the interface with third services whose identification policy was different from that used in the hospital.

Final considerations: Studies show that adherence to protocols that aim at safety goals has a significant impact on the reduction of adverse events. Since the launch of the National Patient Safety Program, institutions have been invited to strengthen the Safety Protocols, but it is clear that improvement actions are still needed.

Based on the results identified, each hospital developed actions according to the findings of the clinical audit, which will be evaluated for their effectiveness in December 2018 in a new evaluation.