DRIVING CONSISTENCY IN PATIENT IDENTIFICATION THROUGH FAILURE MODE AND EFFECTS ANALYSIS

Humber River Health Lighting New Ways in Healthcare™

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DESCRIPTION

Ensuring the correct patient receives correct service and treatment is crucial to prevent patient harm. Humber River Health (HRH) promotes patient safety by using two patient identifiers: patient's full name and their unique hospital number. Staff must always check the two patient specific identifiers and match these with the service or treatment they are providing. To ensure that correct procedures were being followed and to prevent the patient identification related incidents, HRH started reviewing and analysing incidents that were reported related to Patient Identification. The Quality and Patient Safety (QPS) team at HRH initiated process mapping and a Failure Mode and Effects Analysis (FMEA) in collaboration with clinical teams to identify possible failure modes in current practices and develop an action plan.

OBJECTIVE

To mitigate patient identification errors at HRH through the standardized enforcement of a two-patient identifier verification process.

ACTIONS TAKEN

Incident reports related to patient identification errors for Fiscal Year 2024/25 were reviewed and analyzed. The trends and findings were shared with clinical teams. The QPS team collaborated with clinical teams to map patient identification and verification processes from registration through to point of care. Various process maps were developed for registration, outpatient and inpatient areas. The process maps were shared with clinical leaders for feedback, which was incorporated, and the next steps to initiate FMEA were communicated to them.

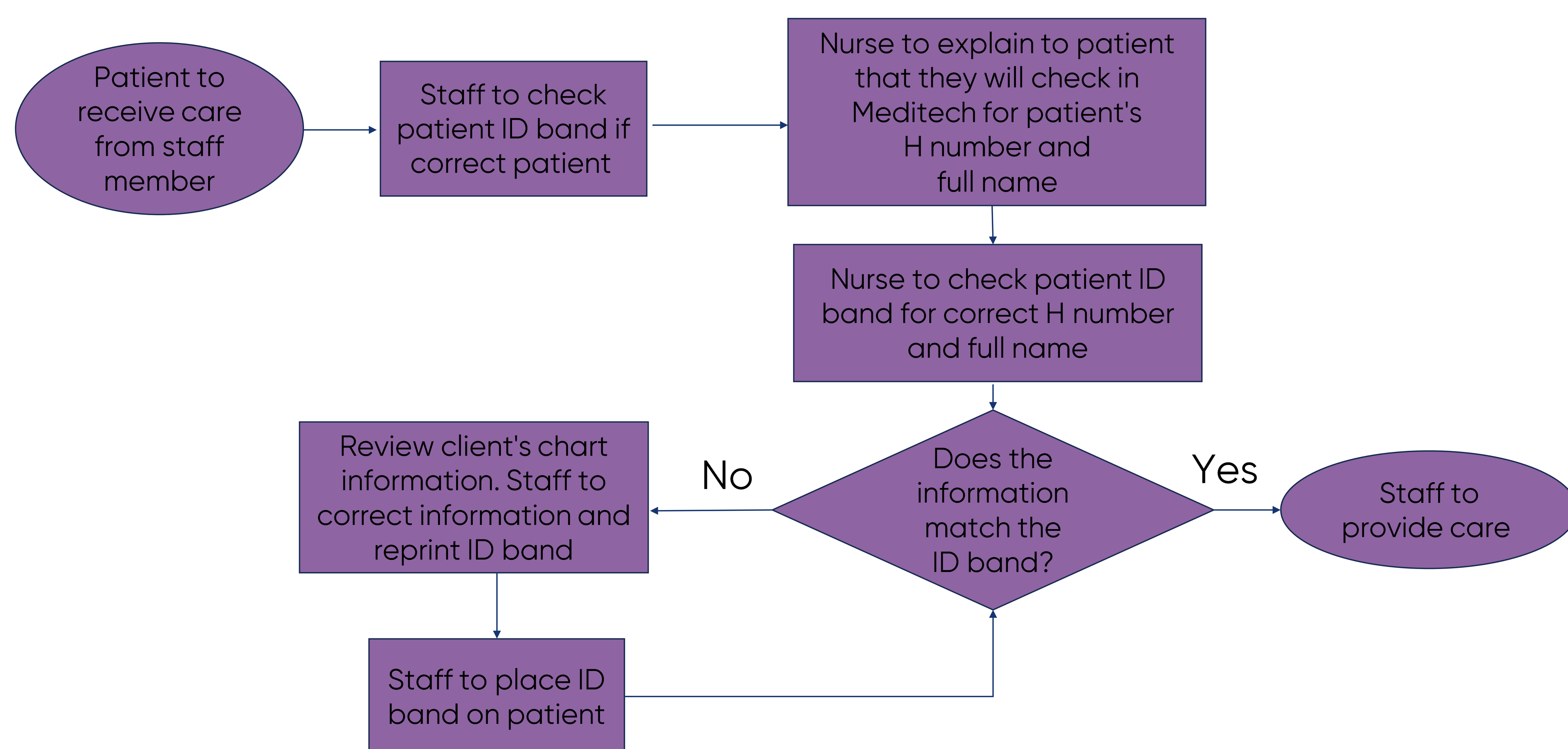

Figure 1. Point of Care for Alert and Oriented Patients Process Map at HRH

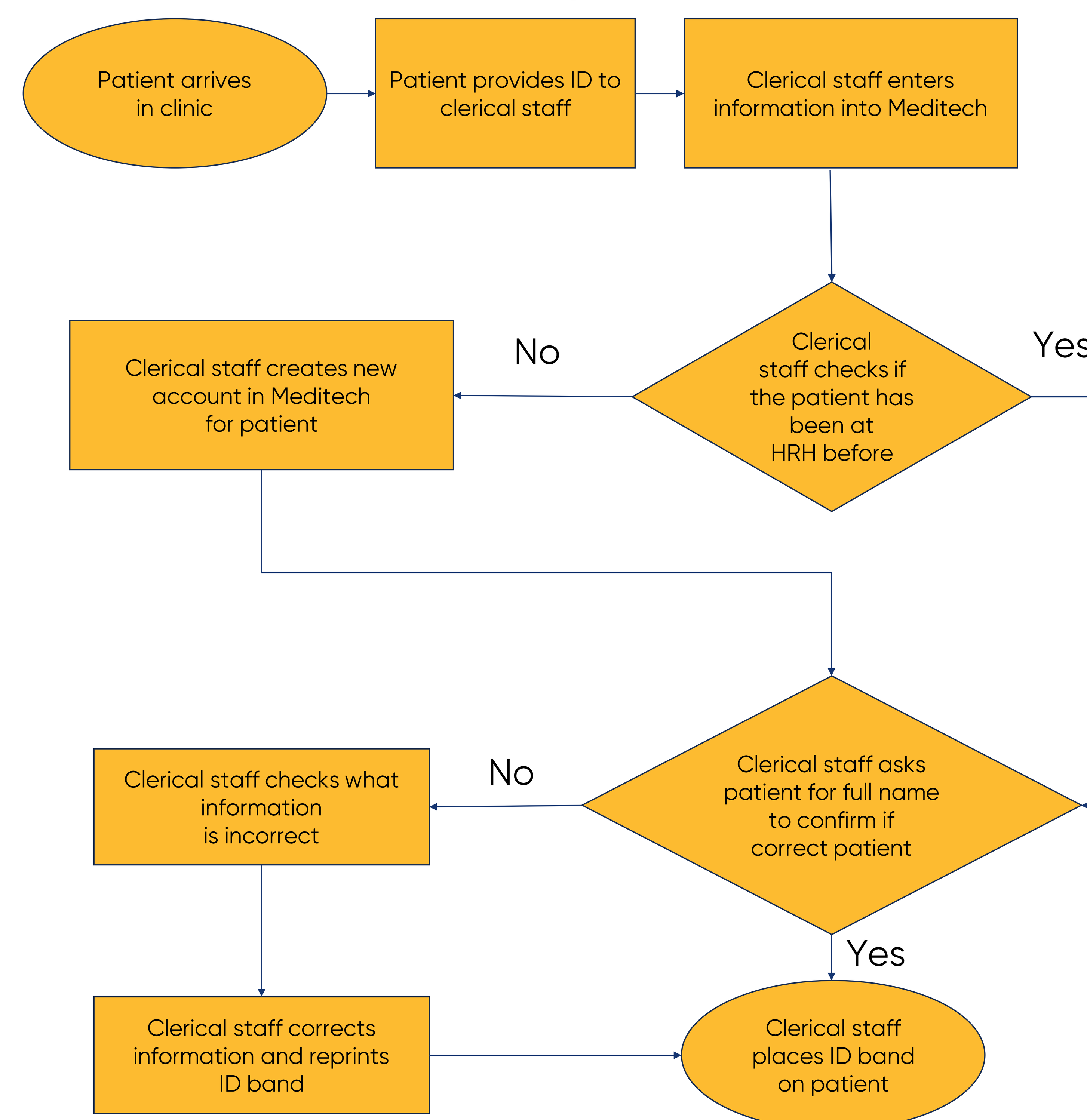

Figure 2. Clinic Registration Process Map at HRH

SUMMARY OF RESULTS

The review of patient identification incident reports identified recurring themes, including wrong patient transfers, missing or illegible identification (ID) bands, and ID bands not applied to patients. The identification of these themes resulted in having conversations with clinical teams to develop process maps for each clinical area. These results provide a clear foundation for conducting FMEA and developing actionable strategies to strengthen patient identification and verification practices across HRH.

LESSONS LEARNED

Engaging clinical teams early in process mapping enhances accuracy, promotes shared ownership, and ensures frontline perspectives are reflected in safety improvements.

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