

Evidence-Based Practice (EBP) - E175

Poster

Abstract Title:

Naming Conventions for Trauma Activation, Unidentified, and Mass Casualty Incident Patients

Authors:

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Background & Purpose:

Following an adverse event involving dual identifiers, it became apparent that the method of identifying high risk trauma or mass casualty patients was inadequate and did not meet the national patient safety goal requirements. With a manual process in place, a similar occurrence with potential for patient harm was inevitable. A new naming convention for identification of this population would require an electronic process that is activated on patient presentation and provides a consistent standardized dual identifier that is accessible and searchable in the electronic health record.

Study/Project Design:

Establish a standardized process for identification of all trauma and mass casualty patients.

Setting:

Urban Core Academic Safety Net Hospital with a level 1 state trauma center designation

Sample:

Since implementation, the temporary naming convention process has been used on 226 trauma activation and 13 unidentified patients.

Procedures:

A temporary naming convention using the military alphabet was devised as a standardized, preregistered process for trauma, unidentified or mass casualty patients. All patient documentation utilizes the temporary name and medical record number (MRN) as the dual identifier for the first 24 hours to complete emergency surgical and diagnostic interventions. Upon either arrival or notification that a patient is en route, Patient Access activates the preregistered MRN to allow for initiation of emergent care or procuring blood for trauma resuscitation. A master reference list matches the temporary name with the verified identity prior to the merge process. A mandatory organizational educational activity reinforced this as a safe process for identification, documentation and provision of care.

Findings/Results:

As a previous manual process, there were time delays related to validation of patient identification. Upon patient presentation, a MRN was not immediately available to process with patient laboratory specimens. 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 and the first lab result for a Type A activation decreased from 16 to 9 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.

Discussion/Conclusions/Implications:

This organizational change was a coordinated approach to ensure the appropriate identity verification using dual identifiers for the safe delivery of emergent care. Although the initial 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. The military alphabet provided a logical basis and provided expansion capability using traditional alphabet lettering. The 24 hour merge process allowed completion of critical surgical and diagnostic procedures prior to transition to the verified identity.