

# Reducing Slips in Patient Information Transfers

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# Reducing Slips in Patient Information Transfers

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## Introduction:

- Community-Based Clinical Mentoring Program
  - Carol and Frank Morsani Center for Advanced Healthcare
  - USF Health Family Medicine
  - Site Preceptor: Dr. Kira Zwygart
  - Senior Lead LPN: Dee Richardson
- Project: reduce frequency of handing patients the wrong paperwork
  - Benefits both patients and providers
  - Appeals to personal interests in quality, safety, and confidentiality

## Act:

- Survey
  - Perceived understanding of HIPAA laws
  - Thoughtfulness of security of patient information
  - Opinions on who is responsible for security of patient information
- The survey was completed by 15 members of the team in mid-March.
- Based on the initial survey results, the following strategies are being used to address the issue.
  1. Presentation to the physicians and pharmacist
  2. Presentation to the nurses
  3. Presentation to primary care medical students at the beginning of clerkships
  4. Creation of a flyer that is placed on or near each printer

## Connection to Community Based Clinical Mentoring Objectives:

- Demonstrating knowledge of and conducting an action research project.
- Inter-professional communication with providers, medical assistants, and the pharmacist was crucial to understanding why this problem was occurring and developing strategies to overcome it.
- Reflects the objective of values-based and patient-centered care increasing patient and family partnership and trust of the healthcare team.

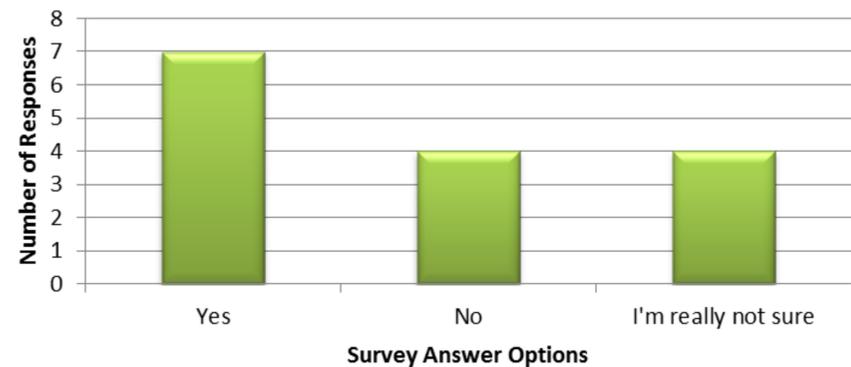
## Objectives:

- To determine the frequency healthcare providers and staff accidentally give patients another patient's information at the time of discharge from the exam room.
- To identify strategies for reducing the number of times this slip occurs.
- To develop a protocol to be used by the entire healthcare team hopefully eliminates the number of slips in patient information transfers.

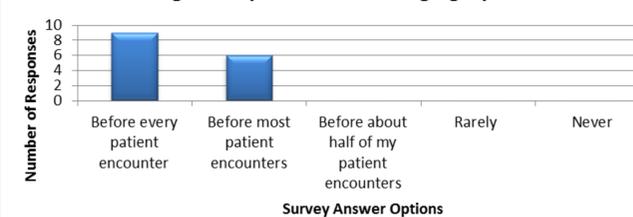
## Share:

The initial survey that was conducted to assess the current situation showed that eleven out of the fifteen team members either definitely had or were unsure if they had handed the wrong paperwork to a patient. This shocking result is in spite of the fact that everyone on the team claimed to double check the paperwork before most, if not all, patient encounters. Another interesting result was the wide variety of opinions on who is responsible for making sure the patient had the correct information prior to leaving the examination room. These results prove the necessity for continuing this project and working towards team-based solutions.

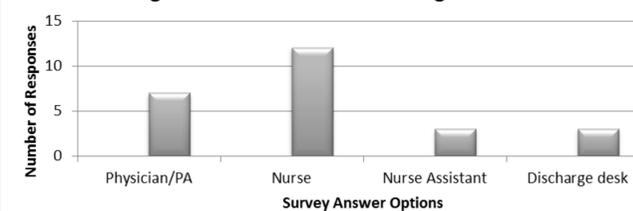
### Have you ever handed the wrong paperwork to a patient?



### How often do you double check paperwork before handing it to a patient or discharging a patient?



### Whose responsibility is it to make sure a patient has the right information before leaving the office?



## Plan:

- Multiple healthcare providers interact with each patient
- Clinic previously identified this problem
  - Systemic problem
  - Security concern
  - Professionalism
- Hypotheses:
  - Rush to be efficient
  - Healthcare team may underestimate importance of securing patient information
  - Members of the healthcare team might not think it's "their job" to make sure the paperwork is correct.

## Reflections and Conclusions:

- Conclusions
  - Demonstrated the need for comprehensive conversations
  - Started by leading an open discussion at a faculty meeting.
  - The results of the survey sparked creative brainstorming, which led to a variety of ideas
- Limitations
  - Time available to investigate and find solutions to problem
  - Reliability of the survey
  - Social Desirability Bias
- Future directions
  - Meeting with nursing staff
  - Meeting primary care medical students at beginning of clerkships.
  - Collect follow-up data

