

## Family Medicine-Primary Care Program Safety Learning Summary

Occurrence Reporting Summary
Quarter 3 – Fiscal 2012/13

Category: Clinical Care – Two Client Identifiers

## Summary - What happened?

During Quarter 3 there were a total of 73 Occurrences reported to the Primary Care Program. Of those reported, there were a total 12 Occurrences (16%) specifically related to "Client Care" with the majority of those (25%) a result of Primary Care staff not verifying client identity according to best practice and guidelines.

## What were the review findings?

- While completing an intake, writer missed checking date of birth on new client that coincidentally had the same name as another patient of the clinic. As a result, some data had been accidently entered into the chart of another patient before the mistake was discovered.
- Wrong child was roomed for an immunization. The provider was expecting a 4 year old instead of a 6 month old and therefore inquired with the parents upon entry to the clinic room. It was discovered the patient that had been checked into the room was not the same one the provider had been told was roomed.
- It was a busy clinic day and the Primary Care Assistant was working alone at Front Reception, checking in patients, and answering switchboard. The wrong patient was roomed. The RN confirmed the patient's identity upon entry to the clinic room. The error was discovered before treating and/or providing clinical information.

## What was recommended?

- While "Two Client Identifiers" is a Required Organizational Practice for Accreditation, no written documentation or Operating Guideline existed for the Primary Care Program up until March 2013. PCOG#23 was approved and distributed globally on March 2013. All Managers were asked to share this guideline with staff and educate all team members at site meetings. In conjunction with the guideline, "Two Client Identifier" posters were sourced and distributed for hanging within Primary Care clinic rooms and waiting rooms for public awareness purposes.
- Managers should continue to regularly educate team members around the importance of using "Two Client Identifiers" as best practice for patient safety.
- Future events should continue to be reported by completing Occurrence Reports for both learning and tracking purposes.

This report has been prepared as a learning opportunity from the regional primary care quality team and is based on actual occurrences reported by the wrha direct operation clinics, family medicine teaching clinics, and community health agencies. All occurrences reported are summarized quarterly to create an environment for sharing and learning across the different program sites. Identifying information has been removed in order to maintain privacy.