

Identity cards help patients identify their doctors

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Abstract

Patients admitted to hospital are immediately overloaded with information from staff in A&E, to subsequent acute medical and inpatient wards. Essential details are conveyed to patients at each step, including diagnosis, management and identification of various team members involved in their care. An initial audit within our South London hospital revealed only one third of patients admitted onto a single medical ward could recall the name of a single member of their treating team, and less than 10% retained that information over 5 days. Identification (ID) cards were devised to facilitate clear transfer of information detailing the patient's treating team. These ID cards were piloted through a series of PDSA cycles on one inpatient medical ward following a consultant led ward round. Post intervention, 67% managed to recall a single member of the treating team, with 67% retaining this information 5 days later, a dramatic improvement. ID cards were then trialed on one surgical ward, demonstrating equally impressive results with over 87% of patients recalling their named consultant following ID card implementation, up from 54% initially. Similar trends were demonstrated for recalling other treating team members. This simple measure improved patients ability to recall and retain names of a least a single member of their treating team, encouraged communication between patients and medical team and ultimately improved patient satisfaction and quality of care. ID cards were quick and easy to implement and have been approved by the hospital patient safety committee to implement throughout the Trust.

Problem

During an inpatient stay in hospital, whilst often unwell, patients must receive and retain a considerable amount of important information from their treating team. From admission, patients interact with a number of different health care professionals, in a number of different departments and settings such as A&E, the acute medical unit and various inpatient wards. As a result, patients often find it difficult to identify and recall the name of their doctors or any single member of their treating team. Such poor identification can lead to communication failures, poor understanding of the roles of each doctor, uncertainty of where and whom to contact for information or concerns, and possible uncertainty of ongoing medical management. This may ultimately lead to poor patient satisfaction, poor patient engagement and compliance, and consequently presents a patient safety concern.

Background

Consultant or senior registrar led ward rounds at a South Thames hospital take place daily. The treating medical or surgical team, which consists of a junior and/or senior house officer, registrar and consultant, review each patient in turn and create a daily plan. As the team proceeds, each patient is left with a plan for their day and is hopefully content with the interaction. Unfortunately, as surgical ward rounds tend to be swift and medical rounds highly complex, a significant amount of information is exchanged, including simple identification and is often misunderstood or forgotten. As daily ward rounds then continue, formal introductions may not take place as it is assumed that each member of the team is known to the patient.

A study from the University of Chicago found that patients are rarely able to identify their doctors by name or describe their role within

the team. Of 2807 patients interviewed nearly 75 percent were unable to name a single doctor assigned to their care. Of the remaining 25 percent who were able to recall a name, only 40 percent were correct. Furthermore, patients who were able to recall and correctly identify at least one of their treating physicians claimed to have understood the roles of their doctors within the treating team (1). The ability to identify one's own doctor or treating team encourages patient involvement which has a strong impact on the quality of care. A survey of 2025 patients, by Saul et al, revealed that greater patient participation results in favourable quality of care ratings, which, amongst a cohort of 788 patients, an inverse relationship between participation and adverse events was observed (2).

Therefore the inability to identify a single member of the treating team may adversely influence patient satisfaction, patient compliance and ultimately patient safety.

Baseline Measurement

To assess the scale of the problem, inpatients on one medical (respiratory) ward in a South Thames hospital were surveyed to assess whether or not they knew who's care they were under. Patients were surveyed only after they had been reviewed by the consultant-led team on the daily ward round. Patients with delirium, dementia, reduced Glasgow Coma Scale (GCS), language barriers or learning difficulties were excluded from the survey. Patients included in the survey were admitted via A&E and the acute medical unit, and were inpatients for an average of 2 - 90 days. In parallel, inpatients on one surgical (vascular) ward were surveyed following the same criteria above; however, these inpatients were admitted via A&E, as well as for elective procedures.

Initial results from the respiratory ward demonstrated that < 38% of

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patients could identify the name of a single doctor treating them. In addition to this, after spending a few days on the ward that value decreased even further to < 10% . (Figures 1 & 2, initial data collection). These findings were noted despite patients clearly understanding the information that was exchanged whilst in consultation with their team. In parallel, only half of patients admitted to the vascular ward could identify their named consultant (Figure 3).

This initial result clearly demonstrated a need for improved communication between patients and doctors, a more sustainable transmission of information, and a means to consolidate that knowledge.

Design

When considering the underlying cause of this problem it became clear that, for the majority of patients, an inability to recall the names of their treating doctors stems from a difficulty in retaining the wealth of information presented to them during the ward round consultation. As such, a simple memory aide would facilitate the sustained transfer of information. In previous years, several interventions were considered; writing the named consultant on each patient's head of the bed, posting a series of photos of the ward staff within the corridor, but these attempts were unfortunately unsuccessful and posed confidentiality issues.

We therefore proposed a new intervention in the form of a small identification (ID) card, similar to the size and style of a business card that would contain the names and titles of each member of the treating team, the listed speciality and the name and contact details of the inpatient ward. ID cards would be distributed to patients by the consultant or treating team during the first introductory ward round. Patients could then keep these cards for future reference. In particular, on the medical (respiratory) ward, as consultants on duty rotated each week, an up to date ID card would be distributed each week to reflect the new named consultant of the week. Estimated costs were minimal, as the cards were created using a simple A4 template and then printed and cut according to size.

Strategy

Our aim was to improve identification of the named consultant and/or single member of the treating team to 80%, within one week of admission. Our main outcome measure was patient recall of the named consultant and/or any member of the treating team. Patients were given ID cards during the consultant- or senior-led ward round which clearly indicated the names and grades of all doctors involved in their care. The card can be kept by each patient for future reference. Patients then surveyed to ascertain if the desired outcome measure was achieved and based on results, further cycles were refined as appropriate, and where possible the scale and scope of the implementation was increased.

PDSA Cycle 1

ID cards were distributed to patients during their first encounter on

the respiratory ward with a named consultant. Improved short term recall and awareness of doctor's names was clearly evident (Figures 1 & 2, cycle 1) . Patients however could still not retain this information after a few days spent on the ward as ID cards were found to be too small and often went missing. ID cards were then re-fashioned to have a larger font and to be permanently fixed to the bedside. A parallel cycle was carried out on the vascular ward with a dramatic improvement in patient recall observed (Figure 3).

PDSA Cycle 2

Larger ID cards were distributed to patients during their first encounter on the respiratory ward with a named consultant. Cards were placed in protective plastic sheets and fastened to bedside tables. Improved short term recall and awareness of doctor's names was then demonstrated (Figures 1 & 2, cycle 2).

Post-Measurement

Following the distribution of ID cards during cycle 1, a marked improvement in the ability of patients to recall the names of their doctors was noted on both respiratory and vascular wards. Results are demonstrated in Figures 1-3 (see Figures attached).

On the respiratory ward, the ability of patients to recall at least one member of their treating medical team improved from an initial 37% to 67% (Figure 1). In particular, an improvement in the ability to recall the named consultant improved from 38% to 50% following the first PDSA cycle, and a further improvement was noted up to 83% following cycle 2 (Figure 2). This retention of this information was also demonstrated over the course of 5 days on the ward (Figures 1 & 2, Mondays). On the vascular ward, following a single PDSA cycle, 100% of patients surveyed could recall meeting their consultant and 87% were able to recall their name (Figure 3), up from an initial 54%. A similar trend was noted for registrar and junior doctor identification (Figures 2 & 3).

Lessons and Limitations

Carrying out this project revealed many challenges and learning points.

- i. Ensuring the support from a key stakeholder was a vital component in the study as engaging all doctors and nurses on the ward to carry and distribute the ID card was challenging. Once a senior consultant introduced them during their ward round and demonstrated their use, other members of the team were willing to participate as well. This held true for increasing the scope of the project from the medical ward to including the surgical ward, as another series of discussions were required in order to begin initial data collection and trial the first PDSA cycle.
- ii. Momentum of the project largely depended on the motivation and enthusiasm of the junior doctors based on the ward and therefore posed the biggest challenge to successful implementation and future sustainability of the ID card. However, since the project findings were presented at a Trust wide consultant's meeting, the

Trust policy has been amended to allow the named consultant to appear above the patient's bedside, thereby inviting other ward staff (e.g.: matron, nurse, health care assistant) to participate in this incentive.

iii. Issues with the logistical details of the study itself such as misplaced or damaged ID cards required an extra PDSA cycle to trial larger cards, permanently fixed to the bedside tables. This required communication with the nursing staff and housekeeping to ensure that these documents were not removed during the patient's admission. Further discussions with the media office to help produce more durable forms of this card were proposed to consider the possibility of creating an electronic ID card which is displayed as a screen saver onto every patient's bedside television.

Conclusion

The initial problem identified was that the majority of inpatients could not identify a single member of their treating team (< 38%). Following implementation of a simple ID card, which outlined all members of the relevant medical team, there was a clear improvement in the ability of patients to recall this information (67%), in particular the named consultant (> 83%). All patients found ID cards helpful to identify their doctors, they improved clarity both during and after ward consultations, patients felt more involved in their own care and were able to direct their questions appropriately, thereby improving overall satisfaction, and ultimately patient safety. ID cards were easy, cheap and quick to implement however a more permanent durable replacement is recommended.

References

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2. Saul N. Weingart, Junya Zhu, Laurel Chiappetta, Sherri O. Stuver, Eric C. Schneider, Arnold M. Epstein, Jo Ann David-Kasdan, Catherine L. Annas, Floyd J. Fowler, Jr and Joel S. Weissman. Hospitalized patients' participation and its impact on quality of care and patient safety Int J Qual Health Care. 2011. 23 (3): 269-277.

Declaration of interests

Nothing to declare

Acknowledgements

DAPS Global

Schematic 1: A representative ID card

Respiratory/Vascular ward

Consultant of the week: _____

Senior doctors (Registrars): _____

Senior house officer (SHO): _____

Junior doctors (FY1): _____

Ward contact number: _____

Figures:

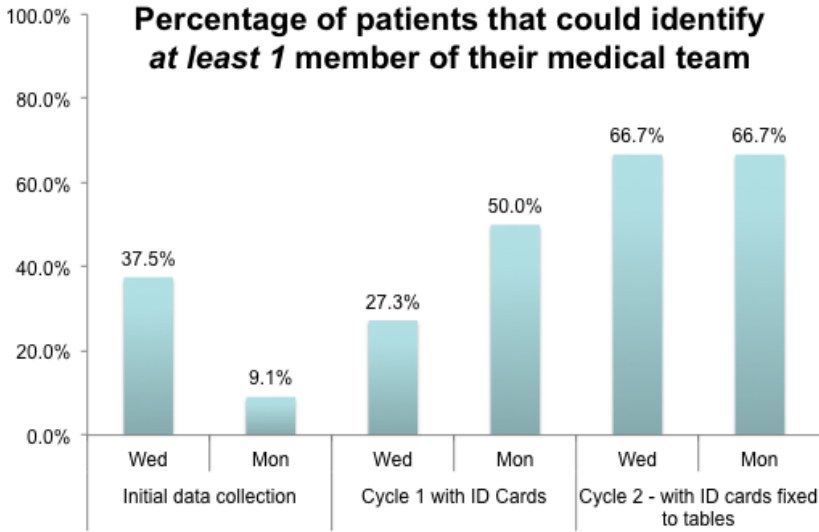


Figure 1: Percentage of patients on the respiratory medical ward that could identify at least 1 member of their treating team, initially, during cycle 1 and during cycle 2 following distribution of ID cards. Patients were surveyed on Wednesday and Monday as noted.

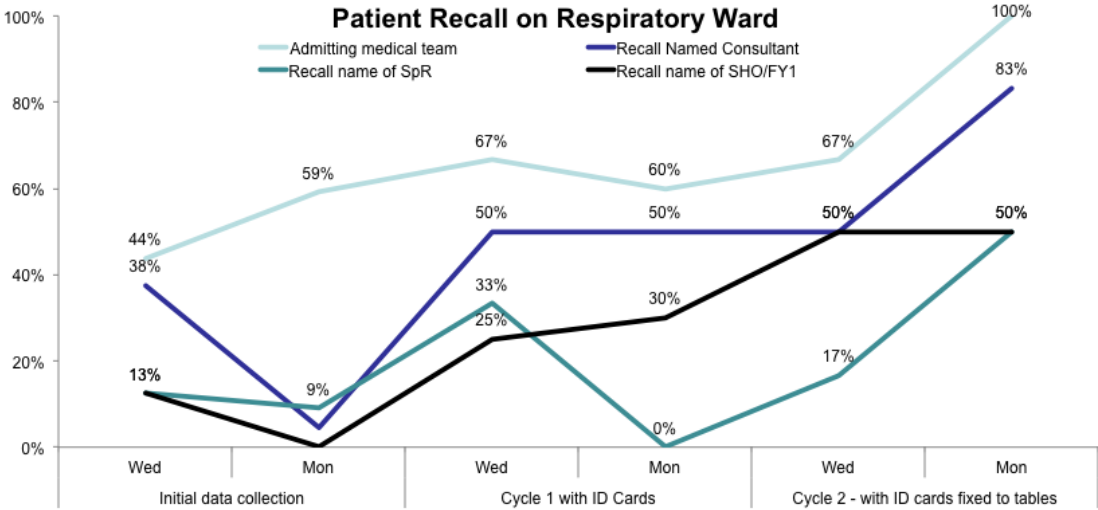


Figure 2: Patients surveyed on a respiratory medical ward before (Initial, n=18), after (Cycle 1, n=12) the distribution of ID cards, and again after the modification and re-distribution (Cycle 2, n=12) of ID cards. Patients were surveyed on Wednesday and Monday as noted.

Patient Recall on Surgical ward

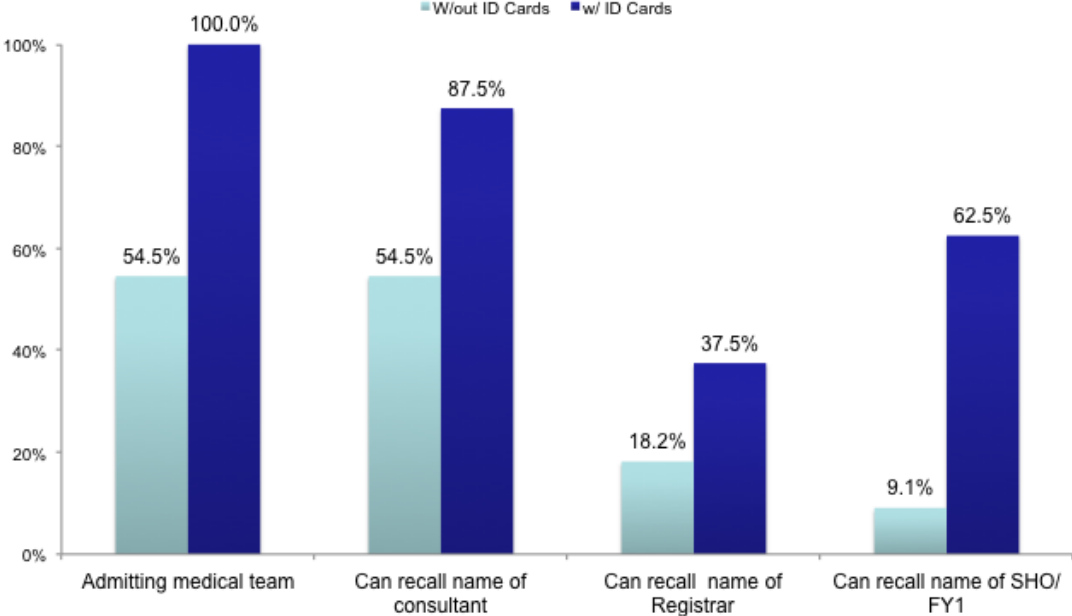


Figure 3: Patients surveyed on a vascular surgical ward, before (light blue, n= 11) and after (dark blue, n=8) distribution of ID cards.

PDSA Cycle 1

Aim: what are you trying to accomplish?

To improve identification of the treating team and recall the name(s) of doctors to 80%, within one week of admission.

Plan: what will your test be?

Distribute ID cards to patients during their first encounter with the consultant-led ward round on the respiratory ward. ID cards list the named consultant and treating medical/surgical team. Survey patients at the end of the day to assess if they can recall the named consultant and/or any member of the treating team. Repeat the survey following 5 days on the ward to assess if this information was retained long term. A parallel cycle will be performed on the vascular consultant-led ward round as well.

Prediction: what do you think will happen as a result of your test?

As patients will have the use of a simple memory aide, recall of the named consultant and/or member of the treating team will improve on both respiratory and vascular wards.

Do: what happened when you carried out your test?

Respiratory ward: Improved short-term recall and awareness of doctor's names was clearly evident (Figures 1 & 2, cycle 1). Patients however could still not retain this information after a few days spent on the ward as ID cards were found to be too small and often went missing.

Vascular ward: A dramatic improvement in patient recall was observed as predicted (Figure 3).

Study: how did the results of your test compare with predictions?

Respiratory ward: Firstly, the initial results of short-term recall improved as we predicted, albeit not as high as 80% (Figures 1 & 2, cycle 1, Wednesday). Secondly, the initial improvement was not sustained and the results of long-term recall declined, which was the opposite of what we predicted. (Figures 1 & 2, cycle 1, Monday).

Vascular ward: A dramatic improvement in patient recall was observed as predicted, likely due to pre-operative introductions to the treating team in most of the surgical population. These patients were often discharged soon after their procedures therefore long-term recall was not possible to assess.

Act: how will you change your previous test in light of what you have learned?

We discovered that patients with poor recall were either losing the ID cards initially distributed, they were being damaged or in fact they were just too small. ID cards were then re-fashioned to have a larger font and to be permanently fixed to the bedside in protective plastic sheets.

PDSA Cycle 2

Aim: what are you trying to accomplish?

To improve identification of the treating team and recall the name(s) of doctors to 80%, within one week of admission. To improve both short- and long-term recall of the above.

Plan: what will your test be?

Distribute larger ID cards to patients during their first encounter with the consultant-led ward round on the respiratory ward. Cards were placed in protective plastic sheets and fastened to bedside tables. As before, ID cards list the named consultant and treating medical/surgical team. Survey patients at the end of the day to assess if they can recall the named consultant and/or any member of the treating team. Repeat the survey following 5 days on the ward to assess if this information was retained long term.

Prediction: what do you think will happen as a result of your test?

As patients will have the use of a simple, now larger, more durable and permanently fixed memory aide, short- and long-term recall of the named consultant and/or member of the treating team will improve.

Do: what happened when you carried out your test?

Respiratory ward: Improved short- and long-term recall of the named consultant and/or single member of the treating team was demonstrated (Figures 1 & 2, cycle 2, Wednesday and Monday).

Study: how did the results of your test compare with predictions?

Respiratory ward: Short-term recall improved as we predicted, again however not as high as we initially predicted. However, this information was clearly retained following 5 days on the ward, as recall remained stable, and in fact improved to our target aim of > 80% for the named consultant.

Act: how will you change your previous test in light of what you have learned?

Further cycles can be performed to determine if a more durable and/or permanent ID card will be of even greater benefit. However, this current format clearly leads to a more sustainable means of retaining information.