
مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
QUALITY & SAFETY COMMITTEE MEETING #17
Thursday, 30th June 2022 (3:30 - 5:30 pm)

Patient Safety Story/Patient Identification

Patient A was identified to require DNAR care and the family were made aware. Although the paper record was signed correctly for patient A, the electronic order for patient B was changed to DNAR. This patient (patient B) had the same last name and was also in the EMS and was supposed to be full code. Patient B was admitted and the incorrect order was noticed by the primary nurse on the floor. So the code status of patient B was changed back to a full code on the same day within less than 2 hours.

Further review revealed that the primary consultant shared his password with a resident covering the floor. The trainee completed the DNAR paper order/documentation form for the correct patient (which was cosigned by consultant from the other service (EMS) in addition to the primary consultant). However the electronic order was entered by the trainee on the wrong patient. Once the discrepancy was brought to the attention of the medical team, the patient code status was changed appropriately to DNAR the following day.

Patient Safety Story – Cont.

LESSONS LEARNED:

- Non compliance by the consultant in sharing his credentials with another health care provider.
- Non compliance by the trainee in not following the hospital policy for patient identification using Two patient identifiers (patient MRN and Full Name).
- Non compliance by the two consultants cosigning the code status without identifying the patient.
- Situational Awareness and vigilance by the floor nurse comparing the patient overall status and the change in the code status and act accordingly.
- Just culture was applied to the involved the consultant.
- The case was presented by the chairman at the M&M meeting and as email via MCA.
- DNAR paper form is no longer used and is replaced by a fully automated process for the form and the order.