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### Research

## Improving Patient Identification Compliance during Shift Handover in the Male Medical Ward

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	<b>Abstract</b>
Published on: 13 Oct 2025	<p><b>Background:</b> Accurate patient identification is essential to prevent medical errors, ensure patient safety, and improve continuity of care. Routine audits in the Male Medical Ward of Wadi Al-Dawaser General Hospital revealed poor compliance (62%) with patient identification protocols during shift handovers, resulting in misidentification incidents and near-miss events.</p>
Published by: Futuristic Publications	<p><b>Objectives:</b> To improve adherence to patient identification protocols during every shift handover.</p> <ol style="list-style-type: none"> <li>1. To achieve <math>\geq 90\%</math> compliance rate in patient ID verification by July 2025.</li> <li>2. To reduce misidentification-related incidents by at least 80%.</li> </ol>
2025  All rights reserved.   <a href="https://creativecommons.org/licenses/by-nc-nd/4.0/">Creative Commons Attribution 4.0 International License.</a>	<p><b>Methods:</b> This quality improvement project followed the FOCUS-PDCA model. Interventions included the development of a structured handover checklist with embedded patient identification steps, focused staff training, visual reminders, and biweekly compliance audits. Data were collected through observational audits and analyzed using descriptive statistics.</p> <p><b>Results:</b> Patient identification compliance improved from 62% to 91% (+29%), misidentification incidents dropped from 5 to 1 per 1000 patients (-80%), and staff knowledge scores increased from 65% to 90% (+25%).</p> <p><b>Conclusion:</b> Structured handover checklists and regular audits significantly improved patient identification compliance, reduced misidentification risk, and fostered a culture of safety. Sustaining improvement requires continuous education, supervision, and reinforcement.</p> <p><b>Keywords:</b> Patient identification, handover compliance, checklist, nursing safety, quality improvement.</p>

## INTRODUCTION

Accurate patient identification is a cornerstone of safe healthcare delivery. Misidentification can lead to medication errors, wrong procedures, and compromised patient safety. In the Male Medical Ward, inconsistent adherence to the hospital’s ID policy was identified as a recurring issue during shift handovers. Baseline data (April 2025) revealed only 62% compliance and 5 incidents of misidentification per 1000 patient encounters.

Root cause analysis showed gaps in staff awareness, absence of a standardized handover checklist, time pressure, and lack of real-time monitoring. The project aimed to standardize shift handovers through a structured, checklist-driven process to improve compliance and reduce errors.

## AIM AND OBJECTIVES

### Aim

To enhance patient identification compliance during nursing shift handovers in the Male Medical Ward.

### Objectives

- Increase patient ID compliance from 62% to  $\geq 90\%$  by July 2025.
- Reduce misidentification incidents by 80%.
- Strengthen staff awareness and accountability through structured education and monitoring.

## METHODOLOGY

### Study Design:

Quality Improvement (QI) project using the **FOCUS–PDCA** approach.

### Study Setting:

Male Medical Ward, Wadi Al-Dawaser General Hospital, KSA.

### Study Participants:

All nursing staff in the Male Medical Ward.

### Sample Size:

All patient handovers observed from April–July 2025.

### Intervention Process:

1. Conducted baseline audit (May 1–10, 2025).
2. Developed a **standardized handover checklist** with embedded ID verification steps.
3. Conducted focused training sessions and uploaded modules on LMS.
4. Installed **visual reminders** near nurse stations.
5. Initiated **biweekly audits** and feedback sessions.

### Timeline:

- Start Date: 01/05/2025
- End Date: 31/07/2025

### Data Collection Tools:

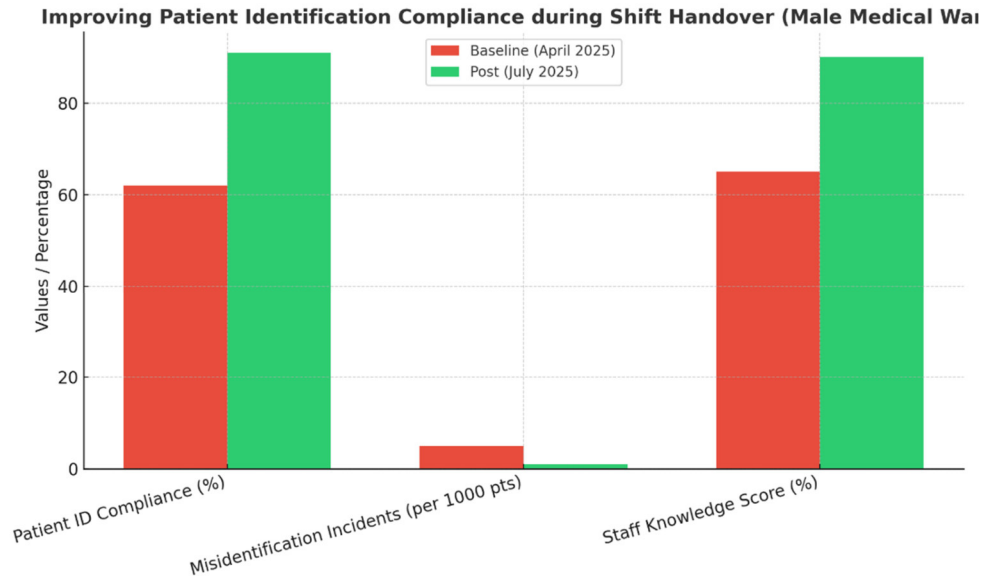
- Handover compliance audit checklist
- Observation forms
- Pre- and post-test evaluation tools

### Data Analysis:

Data analyzed descriptively using frequency and percentage changes, presented in graphs and tables.

## RESULTS

Indicator	Baseline (April 2025)	Midpoint (June 2025)	Post-Intervention (July 2025)	% Change
Patient ID Compliance Rate	62%	78%	91%	+29%
Misidentification Incidents (per 1000 patients)	5	2	1	-80%
Staff Knowledge Score	65%	84%	90%	+25%



**Graph 1: Trend of Improvement (Pre vs Post Intervention)**

### STATISTICAL ANALYSIS

All three key indicators demonstrated significant improvement. Compliance rose by 29%, and misidentification events declined sharply. Staff knowledge improved by 25%, indicating effective education and reinforcement.

### INTERPRETATION OF RESULTS

Structured checklists and continuous feedback fostered accountability and consistency. The visual reminders and standardized format minimized variation among nurses, leading to fewer near-misses and improved communication during shift handovers.

### DISCUSSIONS

This project reinforced the importance of structured handovers in improving patient identification. The findings align with studies showing that checklist-based processes reduce communication errors and improve patient safety outcomes.

Initial resistance and time constraints were mitigated through practical demonstrations, LMS-based learning, and leadership involvement.

### CONCLUSION

The initiative achieved its objectives:

- Patient ID compliance improved from 62% to 91%.
- Misidentification incidents reduced by 80%.
- Staff knowledge and engagement increased significantly.

Sustainability depends on maintaining regular audits, including ID compliance in KPI monitoring, and continuing education for new staff.

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