Pathology – *Blood Transfusion*

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A case of mistaken identity!

Wrong Blood in Tube

Sue Wardle

Transfusion Practitioner

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What happened?

- Blood for Group and Save was taken from a neonate on SCBU
- The sample was grouped by the laboratory
- When reported, the nurse on SCBU realised she had not bled the baby whose report was received
- She alerted the laboratory that the sample had been incorrectly labelled with the wrong baby's details

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How did it happen?

- The nurse was taking a sample for serum bilirubin estimation
- She thought the baby may need an exchange transfusion so decided to take a sample for Group & Save to avoid bleeding the baby twice
- She did not have access to the Order Entry system, so gave the samples to the doctor to print labels and then label the samples
- The doctor did not have a password to access the ward computer, and was told by a member of staff it was Summer xxx. He then accessed the OES using his own password

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How did it happen?

- Once he accessed the computer and OES he saw a list of all babies on SCBU
- One baby was named Summer!
- He picked this baby and printed forms for her
- Having labelled the chemistry sample with a barcode he proceeded to label the transfusion sample from the form printed by the OES

- **Samples were sent to the laboratory bearing the wrong baby's details**

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When the result was phoned, the nurse realised she had not bled the baby whose name was on the tube and she was horrified at her own mistake!

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Why did it happen?

- She did not follow policy to identify the baby
- She did not label the tube at the bedside
- She allowed someone else to label the sample

- She was out of date with her training
- She was not competency assessed

Both the nurse and Dr were trying to be helpful!

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What did we do?

- Complete an Incident Reporting Form (Datix) to inform ward manager
- Interview the Nurse and Dr and discuss the potential consequences
- Organise retraining and competency assessment for both Nurse and Dr
- Request a written reflection of the incident from both parties
- Inform Clinical Supervisor/Educational Supervisor for Dr
- Give support to all parties
- Complete a Root Cause Analysis

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What if…..?

No-one was injured in the making of this incident, but…

- If the nurse had already gone home…
- If she had not taken the call from the laboratory…
- If she had not noticed her mistake…

What then!