

# A case of mistaken identity!

Wrong Blood in Tube

**Sue Wardle** 

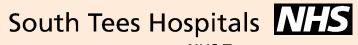
**Transfusion Practitioner** 

South Tees Hospitals NHS FoundationTrust



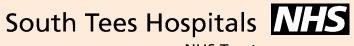
### What happened?

- 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



### How did it happen? Trust

- 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

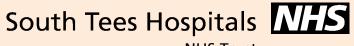


### How did it happen? How did it happen?

- 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



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!



## Why did it happen? NHS Trust

- 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- She was out of date with her training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!



#### 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



#### 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!