Permission to print:	Yes
Category	Donor Blood
Near Miss or Accident	Near Miss
Type of incident:	Management
Knowledge Error	No
Rule Error	Yes
Violation	No

Description: A paediatric patient scheduled for theatre had a code blue on the ward and was rushed to theatre. Pump was already set up and clear primed. Whole blood was added to the prime in a hurry (it was checked by two perfusionists). It was noted later in the case that the swing tag on the unit had the incorrect year in DOB. (correct DOB 2012 - swing tag 2013), ALL other details were correct. Surgeon and anaesthetist were notified immediately & units in the fridge were returned to blood bank and reissued.

Contributing factors: Emergency situation - focused on patient name/NHI, blood type and blood expiry date. It was then found out that blood bank had been given the wrong DOB as per an incorrect passport. This error was picked up prior to the case but blood bank had not been notified

Corrective action: Everyone notified and units reissued.

Preventative action plan: Check blood with someone else who is not busy trying to get pump in theatre

Manufacturer advised:	No
Discussed with team:	Yes
Ext Authority Advised	No
Hospital incident filed:	Yes
Patient outcome variance	Nil