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|---|---|
| Permission to print: | Yes |
| Near Miss or Accident | Accident |
| Type of incident: | Management |
| Catagory | clerical / data entry |
| Knowledge Error | No |
| Protocol issue | No |
| Rule Error | Yes |
| Skill Error | Yes |
| Team Issue | No |
| Violation | No |
| Chance Chance event: | No |
| Description: | The first blood gas was taken during CPB was handed to the anaesthetic technician by th perfusionist for ACT and analysis. The tech asked for a patient label and took one of two sitting on the heart lung machine and processed the sample. The result did not automatically transfer into the HLM data system and the paper result revealed a patient name different to the patient in theatre.9(a prevoius patient). |
| Contributing factors: | Inattention the the perfusionist from the previous case not removing the label at the end of the previous case, by the perfusionist for the current case not noticing that an incorrect label as on the heart lung machine for the case concerned and by the person taking the sample when afixing the label to the sample syringe. |
| Corrective action: | Advised the laboratory of the error and the results were immediately deleted from the incorrect patient record |
| Preventative action plan: | review label/sampling processes and added to checklist "no [prevouis patient labels" |
| Manufacturer advised: | No |
| Discussed with team: | Yes |
| Ext Authority Advised | No |
| Patient outcome variance f | Nil |