2020 Patient ID (Blood Product)

Permission to print:	Yes
Incident type	Good Catch Near Miss
Category	Patient ID
Type of incident:	Management
Duration of incident:	seconds
Description:	A 70-year old patient undergoing coronary artery bypass grafts with associated renal failure dialysed the day before had a pre-bypass Hb of 84g/dL. I requested the anaesthetist to order two units of blood, as I was instituting bypass, which he proceeded to do. The forms were filled out and signed by the anaesthetist and the anaesthetic nurse looked for patient labels to put on both the request and collection forms. This request was sent down to the blood bank using a theatre technician. Two units arrived at a busy perfusion time and two nurses checked the blood behind me. The 2nd nurse was also a relieving nurse for the primary anaesthetic nurse, but both checked the blood. I was asked if I wanted to put it in now, but I asked them to put it onto the pump tray so I could check it again when I had time. I got that look! Once the cardioplegia was in and I had started hemofiltration, I picked up the blood to check. The first thing I noticed was that we had the wrong patient name on the blood release form and blood packs. The nurse must have found labels the surgeon had left with his notes from the morning case and put them onto the forms. The morning patient's blood group had been AB positive. The afternoon case was a very different name and had an O negative blood group. The two nurses checking the blood did not use any patient identification band or form other than the release form to check the patient details with, the patient was under the drapes at this stage. The blood was taken back to the lab, New forms were sent and the correct blood arrived and was checked by me using the correct hospital procedure. An incident [hospital incident] form was completed.
GOOD CATCH - what went well	[The fact that] I always check any blood before putting it into the pump no matter who has checked it. I also check it with the patient consent form. This incident reinforced my OCD practice to continue to do so.
What could we do better	The patient details confirmed before the blood was ordered. The Anaesthetist confirm patient ID before signing the request form. Following blood order protocols.
Preventive actions	Following the correct procedure for ordering and transfusing blood products by all staff members. Group discussion to confirm correct protocol. Awating reccomendations from internal review.
Hospital incident filed:	Yes
Ext Authority Advised	No
Discussed with team:	Yes
Manufacturer advised:	No
Protocol issue	No
Rule issue	Yes
Skill issue	No
Team Issue	Yes
Violation	No
Commentary	Incompatible red cell transfusion is a rare but potential life threatening event. An additional comment from the reporter follows:"I always check any blood before putting it into the pump no matter who has checked it. I also check it with the patient consent

form. This incident reinforced my OCD practice to continue to do so." PIRS2 Ed