2024 Patient ID (Communication)

Permission to print:	Yes
Category	Patient ID
Category 2	Communication
Severity	Good Catch Near Miss
Description:	Wrong patient label was used on blood gas syringes and analysed on a Radiometer ABL90 FlexPlus Blood Gas Analyser. This was not picked up either the primary perfusionist drawing the sample, a second perfusionist who ran the first blood sample with the incorrect label or anaesthesia who received the sample printout [with the incorrect details]. The incorrect label then was brought back to the OR with the ABG printout and reused for subsequent blood gases as well. Blood gas results were taken to the Perfusionist in theatre immediately following analysis and manually recorded into the patient perfusion data file by the perfusionist. The Blood gas machine to Heart Lung machine network connection [blood gas analyser to HLM] was not working for that theatre. This meant that the correct result was entered into the HLM patient file and acted upon correctly during CPB. However, because of the wrong label the results were recorded into the main hospital patient file against the wrong patient - this was detected by a third party and deleted against that patients file at a later time. The Primary perfusionist involved had pumped for a complex elective heart operation, and was on call for that night . An emergency patient presented in theatre approximately 2 hours later for complex surgery emergency case which finished approximately 2300hours. Total hours at work was 16 hours that day. Blood gas syringes are normally personally labelled with a new label each time and closing checking that it is correct label for the patient Although this has always religiously been done always done in the past by the perfusionist pumping the case fatigue may have been a contributing factor and a slip of normal performance. .
GOOD CATCH - what went wel	A third party was able to detect and correct the error by deleting the result against the incorrect hospital patient file
What could we do better	Attaching new patient labels to each sample syringe per normal practice.
Preventive actions	Routine sample practice with a checked patient label attached to the syringe reiterated with the perfusion team and update protocols
Type of incident:	Management
Duration of incident:	hours
Hospital incident file	Yes
Ext Authority Advised	No
Knowledge issue	No
Protocol issue	Yes
Rule issue	Yes
Skill issue	Yes
Team Issue	Yes
Patient outcome varianc	Nil