IAKH

Critical incident report from the IAKH-Fehlerregister

in cooperation with the DIVI and the CIRSmedical Anästhesiologie of BDA/DGAI and ÄZQ

Report via ☒ **IAKH Fehlerregister** ☐ **CIRSmedical AINS of BDA/DGAI and ÄZQ**

Topic/Title	**Blood sample for type and screen test in unlabeled tube**
Case -ID	**CM5141/2010**
Case report (approx. as entered)	**At a medical ICU, doctor withdrew the blood sample of an intubated und unconscious patient x in an unlabeled tube and put the tube at the nurses desk. Nurse labeled and filled in the blood order form for the blood bank with the doctors urgency /emergency order: „warming and immediately administration of 2 packed red cells “. Following blood group and compatibility test /screening for antibodies, the 2 blood units were released by the blood bank and fetched from wards personell. Bedside check for ABO blood group compatibility was performed as required and the units transfused by the doctor who took the blood sample. After start of the transfusion, the nurse mentioned the name of another patient y on the match form attached to the blood units (stating the antibody screening was negative and the blood is compatible for patient y)- the units were tested and dedicated for another patient. Transfusion was stopped and the blood bank was called- they reconfirmed the congruence of the name tag y on the blood tube and the form. Since no other blood for the blood bank was drawn this morning, the nurse who labeled the tubes could be identified who thought the blood was indicated for patient y instead of patient x. The name y on the compatibility form was erased and replaced by the handwritten right name x.**
Problems (here: questions that arise the possibility of problems- there had been no possibility for follow up queeries)	• **Unlabeled tubes had been used for blood group and antibody screening test. The labelling process of the blood sample is frequently a source of errors.** • **The declaration of urgency or emergency on the blood order is obviously not necessary since blood match was awaited for. However, emergency declarations changes a lot and increases the risk of errors.** • **Administration was started although blood matching form indicated another recipient! The identity check**

	of recipient and the identity with the person the unit was tested with is of paramount importance for the avoidance of mismatch! Assumably this happened since the doctor had only that patient to transfuse. After end of his shift, or if there would have been another patient to transfuse, the mixup possibly would have been undetected. This might have been lethal to one of them and/or a delay of anemia correction caused (due to the necessary redo of the blood match for one of them). • **The match form is not to „correct“ with a handwritten note**
Process Step concerned **	**1- Blood sample, 5-administration, 6 ID check**
Circumstances	**Routine, OR/ICU-interface, ASA 3, experienced doctor,** at the same time acute admission on adjacent ward – same doctor
Good elements (“as reported” or criticism of the CIRS Board	
***Risk of reoccurrence/Likleyhood**	**3 of 5**
***Potential risk for patient damage**	**5 of 5**
Board recommendation (Suggestion of a change of process and/or structural quality by introduction /installation/reeducation of the following measures) **SOP= Standard operating procedure**	**Process quality:** • **SOP- Blood probe withdrawel: Labeling obligatory before the withdrawel** • **SOP- Identity check at sedated and unconscious patients** • **SOP- Blood order- give the indication of transfusion and the correct urgency** • **SOP- Administration of blood** **– no warming of packed red cells** **– no transfusion with a mismatch of identity** **Struktural quality:** • **Use electronic help: A software enabled match of identities in the electronic patient data file and the electronic blood order, no adminstration without an electronic bar code match at bed side** • **Communication of blood banking software with hospital data management system/patient data file**

*Risk Grades:

Frequency, Risk of reoccurrence		Potential risk for patient damage	
1/5	very rare max 1/100 000	1/5	very little acute injury/no permanent damage
2/5	rare max. 1/10 000	2/5	minor acute injury/slight permanent damage
3/5	medium max. 1/1000	3/5	considerable acute injury/ minor permanent damage
4/5	frequent, min. 1/100 damage	4/5	profound acute injury / considerable permanent
5/5	usual/common, min. 1/10	5/5	death/severe permanent damage

****Allocation of errors/near misses in the process of administration of blood or coagulation products**

1. -blood sample withdrawal
2. -blood order
3. -laboratory
4. -handling or storage
5. -blood product release, transportation, or administration
6. -sample/product/patient identification