Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

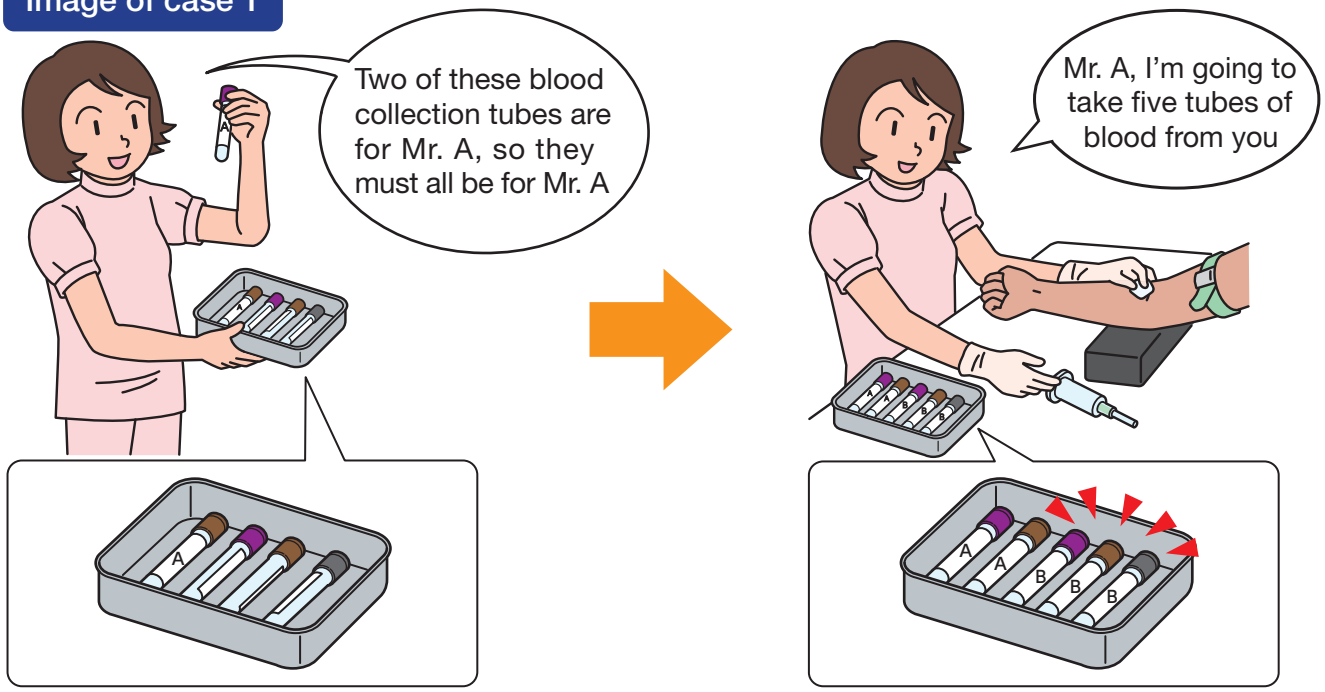
No.109, December 2015

Wrong Specimen Container When Taking Blood Samples

Nine cases have been reported involving misidentification of specimen containers intended for another patient when taking blood samples (information collection period: from January 1, 2012 to October 31, 2015). The information is compiled based on “Individual Theme Review” (p.134) in the 31st Quarterly Report.

All nine cases were caused by the failure to check the patient against the label on the specimen containers immediately before taking the blood samples.

Image of case 1



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Case 1

As the blood collection tubes had not arrived from the clinical laboratory department, the lead nurse prepared two blood collection tubes for Patient A (complete blood count and biochemistry) and three for Patient B (complete blood count, biochemistry, and coagulation), and then placed them on a single tray. When taking blood samples, the charge nurse caring for Patient A confirmed that the names on two of the five blood collection tubes on the tray were labeled with Patient A's name, but did not check the name on the other three tubes. The charge nurse took Patient A's blood sample and divided Patient A's blood between all five blood collection tubes before submitting them to the clinical laboratory department. As there were no blood collection tubes for Patient B, Patient B's physician prepared some, took the blood sample, and submitted the tubes to the clinical laboratory department. At that stage, it was pointed out that specimens for Patient B had already been submitted.

Case 2

The nurse placed the blood collection tubes for Patient A and Patient B on the cart before going to Patient A's bedside and carrying out a patient check. Immediately before taking the blood sample, the nurse call sounded for Patient C, who required assistance with toileting, so the nurse placed the blood collection tube back on the cart and went to assist Patient C. Another nurse was already assisting Patient C to the toilet, so the nurse returned to Patient A and resumed taking the blood sample. When doing so, the nurse picked up the blood collection tube for Patient B, which was also on the cart, and took the blood sample without checking the name on the tube against the patient. After comparing the latest results against the previous set, the clinical laboratory department queried them with the ward.

Preventive measures taken at the medical institutions in which the events occurred.

- **Immediately before taking a blood sample, staff members will check the labels on all blood collection tubes against the patient's name band.**
- **When resuming taking blood samples after an interruption, staff members will return to the first step in the process of checking the labels against the patient.**

Complementary comment by the Comprehensive Evaluation Panel

- **Devise a way to ensure that specimen containers for different patients are kept separate from each other.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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