Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.110, January 2016

Blood Transfusion to Wrong Patient (1st Follow-up Report)

Information about the blood transfusion to wrong patient was provided in Medical Safety Information No.11 (October 2007). As 17 similar events have been reported over the 8 years and 5 months since then, information about this issue is provided here again (information collection period: from July 1, 2007 to November 30, 2015). The information is compiled based on “Recurrence of Events and Occurrence of Similar Events” (p.191) in the 34th Quarterly Report.

Events involving the failure to check the blood product to be used against the patient immediately before connecting it for transfusion have been reported again. In 13 of these cases, the medical institution had an authentication system for carrying out checks, but it was either not used or was used inappropriately.

Usage of the Authentication System	Number of Cases
Not used	5
Used	8

Details of inappropriate use	Number of Cases
The authentication system was used in a place located some distance from the patient and the blood product was taken to a different patient	3
After the authentication system was used, the blood product was stored in a cool box and a blood product intended for another patient was removed at the time of administration	2
The authentication system displayed an error stating that it was the wrong blood type, but this was ascribed to a malfunction of the machine	1
The failure to progress to the next screen on the authentication system was ascribed to a problem with the physician’s order	1
The authentication system was used after administration had commenced	1

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Case 1

When Patient A's RCC-LR (type A) arrived from the Blood Transfusion Department, the physician checked the docket against the blood product and then registered the start of the transfusion (checking the patient against the blood product). However, the patient was receiving a transfusion of FFP at the time, so the physician told Nurse X to store the RCC-LR in the cool box. Nurse X placed the RCC-LR on a tray on which the bed number had been written and stored it in the cool box, Nurse X then handed over to Nurse Y, saying, "The start of the transfusion has already been registered." When preparing the RCC-LR for Patient A, Nurse Y misread the number on the tray and removed RCC-LR for Patient B (type AB), which s/he placed on a drip stand. Subsequently, while providing nursing care, Nurse Y noticed that the FFP transfusion had been completed. Without checking the blood product against the patient, Nurse Y connected Patient B's RCC-LR, which was on the drip stand. When a check was carried out after a report that Patient B's transfusion was missing, it was discovered that Patient B's RCC-LR had been administered to Patient A.

Case 2

FFP was being administered to the patient (type A). When preparing the next pack of FFP for administration, the nurse intended to remove FFP for Patient A (type A) from the freezer, but took out type O FFP (of which there were the same number of packs) from the drawer immediately above and placed it in the thawing device without checking it. Subsequently, when the barcode was used to authenticate the blood transfusion, an error stating that the blood type was wrong was displayed on the authentication system screen, but the nurse assumed that the error was due to machine failure and connected the blood product. When dealing with the transfusion docket, the nurse noticed that the sticker attached to the transfusion bag was a different color and realized that the wrong FFP had been administered.

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

- **Staff members will check the patient against the blood product to be administered immediately before connecting it for transfusion, in compliance with the institution's Blood Transfusion Manual.**

Complementary comment by the Comprehensive Evaluation Panel

- **Check the patient against the blood product when you are beside the patient, immediately before administration.**
- **If the authentication system generates an error or alert, stop what you are doing and check the cause.**

* 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.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.jcqhc.or.jp/