Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

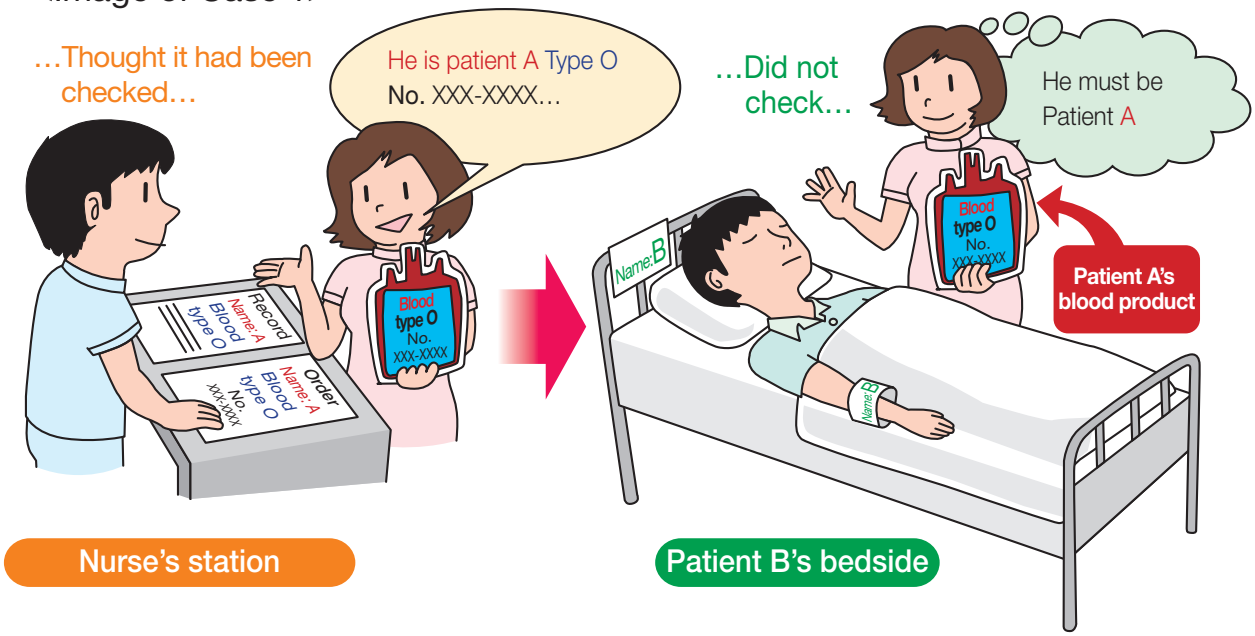
No. 11, October 2007

Blood transfusion to wrong patient

There have been eight reports of blood transfusions to wrong patients. (information collection period, from October 1, 2004 to June 30, 2007; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 9th Quarterly Report).

Six of the cases reported were cases in which the blood product to be used on the patient was not finally checked when connecting blood product for transfusion use.

<Image of Case 1>



- In five out of six reported cases, the blood product used for transfusion was checked with the transfusion sheet or medical chart, etc. at the nurse's station, but the blood product was not checked against the patient.

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Case 1

The physician ordered a blood transfusion to be given to Patient A. The nurse performed a check of the blood product for transfusion use against the patient's name and blood type on the card at the nurse's station with another nurse. The nurse then went to the bedside of Patient B and connected the blood product without checking if the patient was Patient A. Two hours later, the physician went to the bedside of Patient B and found unordered blood product was connected.

Case 2

The physician was called away for another patient's treatment while preparing the blood product for transfusion to 2 patients - Patient C and Patient D. Thirty minutes later, the physician moved to perform the transfusion to Patient C, placed blood product for transfusion to Patient D in the tray, went to Patient C's room and connected the blood product for transfusion without checking if it was for Patient C. Later, the physician noticed that he had connected Patient D's transfusion blood product to Patient C because Patient C's was still left unconnected.

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

Adhere to the hospital's blood transfusion manual, and perform final checks of the patient and the blood product to be used when connecting blood product for transfusion use.

* 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 "Comprehensive Evaluation Panel" to prevent 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 can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

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