Watch Out for...

PMID – Patient Misidentification. Label blood samples from the wristband.

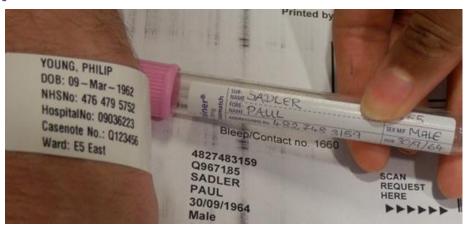
Watch Out Notice: 10

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What Happened?



- A blood sample from Philip Young was labelled (erroneously) from the ICE lab form
- The patient was therefore misidentified
- Transfusion of blood cross-matched with Paul Sadler's blood is not compatible with Philip Young

The Facts:

- At least 59 PMID episodes occurred in 2014 and 9 were in transfusion. These errors only come to light if a previous blood sample has a different blood group (hence the safety of the 2 sample protocol).
- This is not an infallible test as some patient may have the same blood group, so the error is not detectable.
- Misidentified samples leads to morbidity and potentially mortality

Protect Your Patients:

- Label blood samples (only) from the wristband

 Not from the request form (or from notes or consent forms).

 Ideally confirm some of the 4 points of ID with the patient
- Do not label bottles until the sample has been taken
 Hence it can only be done at the bedside, from the wristband
- Patients rely on our professionalism doing the right thing right
 The GMC and GNC and Trusts may be critical of staff who do not follow standard procedures