

# Problem

## Failure of correct patient identification in an emergency

Two patients with the same first name were having identical procedures in theatre. The first patient bled excessively, but the MHP (Mass Hemorrhage Protocol) was activated for the wrong patient. Red cells were sent to the clinical area for the patient who was not subject to an MHP. The blood was returned to the transfusion laboratory issue refrigerator. Blood was then sent to theatres for the correct patient. The incident occurred out-of-hours at the end of the week. The notes of the wrong patient were used for identification.



*Page 59, Error Reports: Human Factors, (PHB Bolton-Maggs (Ed) D Poles et al. on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group. The 2015 Annual SHOT Report (2016)*

## How we can help



Let's run the same scenario at a Hospital using MSoft Blood Management and tracking system Bloodhound. There are 3 occasions when the system would have stepped in and stopped the user from making the wrong decision.

**1. Red cells sent to the clinical area for the wrong patient** – Bloodhound controls access to the blood fridge, the Nurse (we will call her Sally) would have to use a kiosk that requires her to enter her identification. This could be a number of different options, including a unique user name & password word, biometrics (fingerprint access) or an ID card.

Nurse Sally would first scan the patient's notes. Bloodhound then identifies the correct blood to be taken out and the fridge is unlocked. Sally scans the Blood unit, if she has taken out the wrong blood unit an alarm alerts Sally and a message is also sent to the Lab informing

them of the mistake. If the blood unit matches the patient's notes then the blood can be transported to the ward or clinical area in this case.

**2. The notes of the wrong patient were used for identification** – in our scenario Nurse Sally would be using MSoft's PPID360 wristband printing solution. When Sally scans the patients wristband the system knows Sally is scanning the patient's wristband and not the patient's notes because PPID360 uses 2D barcodes that are version controlled. If a duplicate wristband or a barcode on the notes are scanned then the system steps in and you cannot proceed with the transfusion.

**3. Two patients with the same name having identical procedures in theatre** – before Nurse Sally can start the Transfusion the patient's wristband must be scanned using a hand held device running the Bloodhound Bedside app. If Sally scanned the wrong patient she is alerted on the hand held device and the system will not let her proceed with the process. A message is also sent to the Lab informing them of the mistake.

When Nurse Sally positively identifies the correct patient, the blood unit is scanned and the system then checks if it is a match for the patient. Only when these two number match up and the system has checked if the blood unit has not expired can Sally start the blood Transfusion.

### Outcome:

- Time efficiency savings
- Patients positively identified every time
- Right Blood for the Right Patient when they need it
- Patient safety improved
- Procedures followed with no cutting of corners
- Full audit trail of blood units including nurses and patients identification

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