

CASE OF MISTAKEN IDENTITY

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A CASE OF MISTAKEN IDENTITY

Case Study:

Patient attends A&E 21:17

- Dropped off in ambulance bay by friend in car
- “Post 10 pints and ketamine”
- “May have fallen on steak knife. Twice”
- CODE RED called (immediately on admission to A&E)
 - BP 95/66
 - HR 115 BPM
 - 5cm incisional wound lower chest/upper abdomen
 - Patient successfully resuscitated – 2 units of Emergency Red Cells



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Case Study:

- Patient admitted to ITU after resuscitation
 - Small haemothorax
 - Small pneumothorax
- Patient self-discharges straight from ITU after a capacity assessment was completed



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Case Study:

- Code Red call audited by Transfusion Practitioner Team the following morning
- All units allocated and fated

BUT

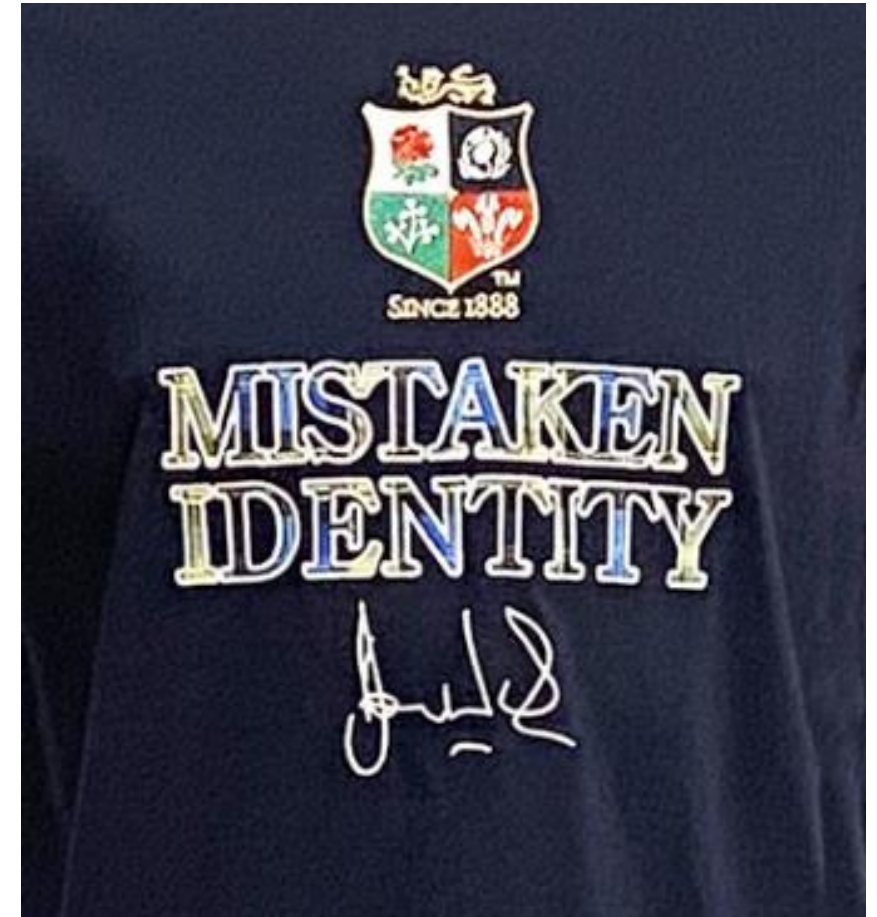


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At the very bottom of his A&E notes:

“After doing all treatment and all the scans, police notified me that this patient is not *****”

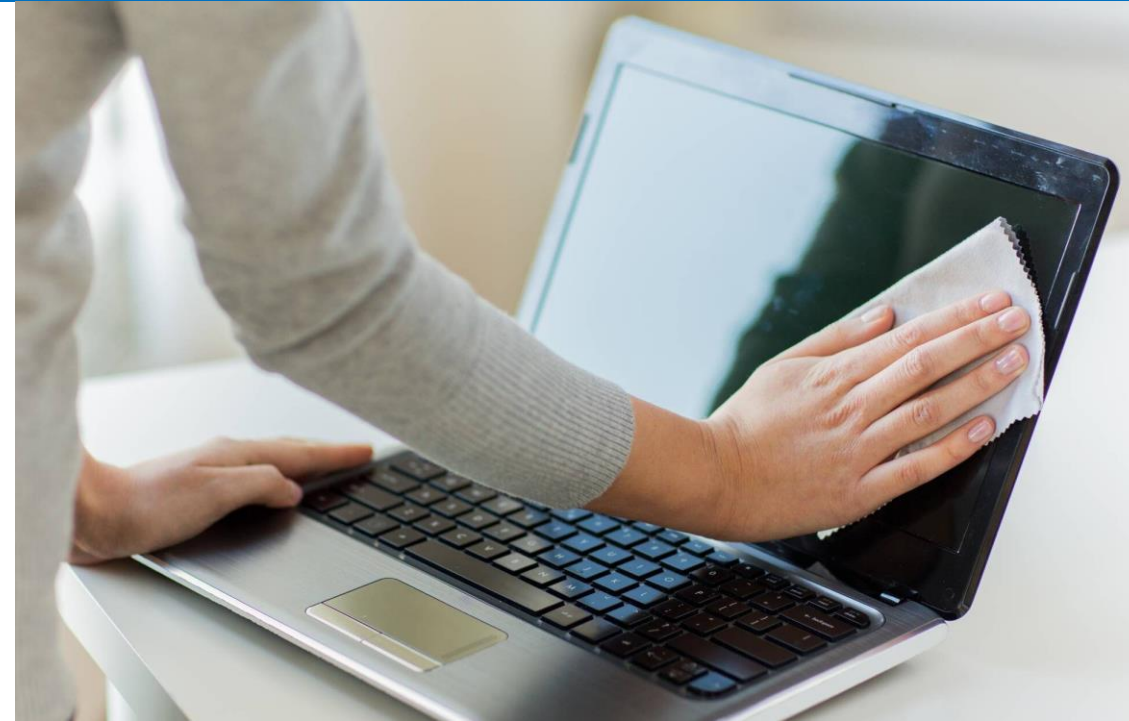
THE PATIENT HAD THOUGHTFULLY GIVEN THE DETAILS
OF A FRIEND ON CLERKING



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Issues:

- Samples had been processed by the lab already – now known to have results against wrong patient's records
- ITU and A&E had informed the Data Cleansing Team of the issue
- The lab was not informed



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Potential consequences:

The blood group result was recorded against the wrong patient:

- At best a delay if his “friend” was admitted in future
- At worst – had his friend been in hospital at the time, transfusion reaction



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Actions:

- Results were merged to the correct patient record and removed from the incorrect ID on the lab system
- TP Team took up the lack of clear communication of the error with the Data Cleansing Team
- The Data Cleansing Team were impressed with the processes already in place in the lab
- A new process has been introduced so that the Data Cleansing Team contact Blood Bank as soon as similar issues become apparent



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Learning:

- Consider exploring your processes with your local Data Cleansing/IT Team
- Processes for remedying data integrity MUST include lab results

KEEP PULLING ON THOSE THREADS!

