Health PEI

SAFER PRACTICE NOTICE

Blood Transfused to Wrong Patient

Safer Practice Notice
DATE: August 2024

Issue:

A patient safety incident occurred in a Health PEI facility related to a blood transfusion and incorrect patient identification. The error was discovered by staff shortly after the transfusion was started and the transfusion was stopped. Fortunately, this incident resulted in no harm to the patient.

However, as little as 50 mLs of incompatible blood can cause an acute hemolytic reaction followed by disseminated intravascular coagulation (DIC) and acute kidney injury (AKI), or even death (Namikawa, 2018).

The practice of **Positive Patient Identification (PPI)** means using **at least two person-specific identifiers** to ensure that the right person receives their intended care. PPI is a crucial safety check and completing PPI is a professional practice standard for all healthcare workers.

Positive Patient Identification is also an Accreditation Canada **Required Organizational Practice (ROP)**. "Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as blood transfused to the wrong patient, allergic reactions, discharge of clients to the wrong families, medication errors, and other wrong-person procedures" (Accreditation Canada, 2024).

Health PEI has a policy called "Client Identification" that states client identification is completed in partnership with patients/clients/residents and families, by explaining the reason for this safety practice and asking them for the identifiers.

Recommendations for Leaders and Health PEI staff:

Blood transfusion incidents can be prevented by confirming that the name and MRN on the patient armband match the name and MRN on the blood transfusion tag just prior to hanging the blood for transfusion.

- Review and distribute the following resources in your service/care area:
  - Client Identification Policy & ROP of the Week: Client Identification (available on the Health PEI Staff Resource Centre)
  - Patient Identification Video (https://www.youtube.com/watch?v=A8hqTTCq_Ak)

- Evaluate positive patient identification processes in your service/patient care area to ensure the correct identifiers are used prior to administering care.

- Conduct random observation audits checking the use of two patient identifiers.

For more information on this Safer Practice Notice, please contact:

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Related Documents

Health PEI – Client Identification Policy
Health PEI Patient Safety & Environmental Incident Reporting & Management Policy
Facility Specific Administration of Blood Product Policy

References

Canadian Patient Safety Institute (CPSI). (2015). *Never Events for Hospital Care in Canada* . Retrieved from https://www.patientsafetyinstitute.ca/en/toolsResources/NeverEvents/Pages/default.aspx

Health Standards Organization (HSO) (2024). HSO Required Organizational Practices: 2024 Handbook.

Namikawa A, S. Y. (2018). A case of ABO-incompatible blood transfusion treated by plasma exchange therapy and continuous hemodiafiltration. *CEN Case Report*, May;7(1):114-120.

Safer Practice Notices are issued by the Health PEI Quality and Patient Safety Division to communicate recommended changes as a result of events that have been reported and investigated through the Provincial Safety Management System (PSMS).

Safer Practice Notices can be found at: https://src.healthpei.ca/safer-practice-notices