

A rare case of mistaken identity - Historical blood group saved the situation

Even in today’s advanced world of digital environment, *human error* remains a constant factor in any complicated process. There are at least ten healthcare workers involved in transfusion process from “donor to patient vein.” This chain can be extended also to the persons involved in admission process of the patient. The areas in the hospital where mistakes can occur in patient’s blood group are shown in Figure 1. Carrying out blood group of newly admitted patient and checking the historical records of the patient for the same are of utmost importance.

The AABB standards state that there shall be a process to ensure that the historical records for ABO and Rh type should be reviewed and compared with the current one and any discrepancy noted should be investigated.^[1] Here, we present a case of mistaken identity and how checking of historical blood group saved the situation.

Sarita Sureshchandra Patel - Patient 1 (name changed) was admitted to our institute in February 2019. Her hospital number was xxxx97. Blood center received a sample for blood grouping and was found to be B Rh positive. Historical records for the same hospital number showed blood group as O Rh positive. Fresh sample was collected, and repeat blood group was found to be the same, B Rh positive.

To solve the issue, patient’s old file from the medical records department was checked, and it was realized that she was admitted previously in 2012 and her blood group was reported as O Rh positive. Patient’s address and the telephone number were noted, and she was contacted. To our surprise, she was at home and her name was Sarita Suresh Patel Patient - 2 (name changed) and she was admitted in 2012. She stayed on the same road few blocks away from the Patient 1 address. Her

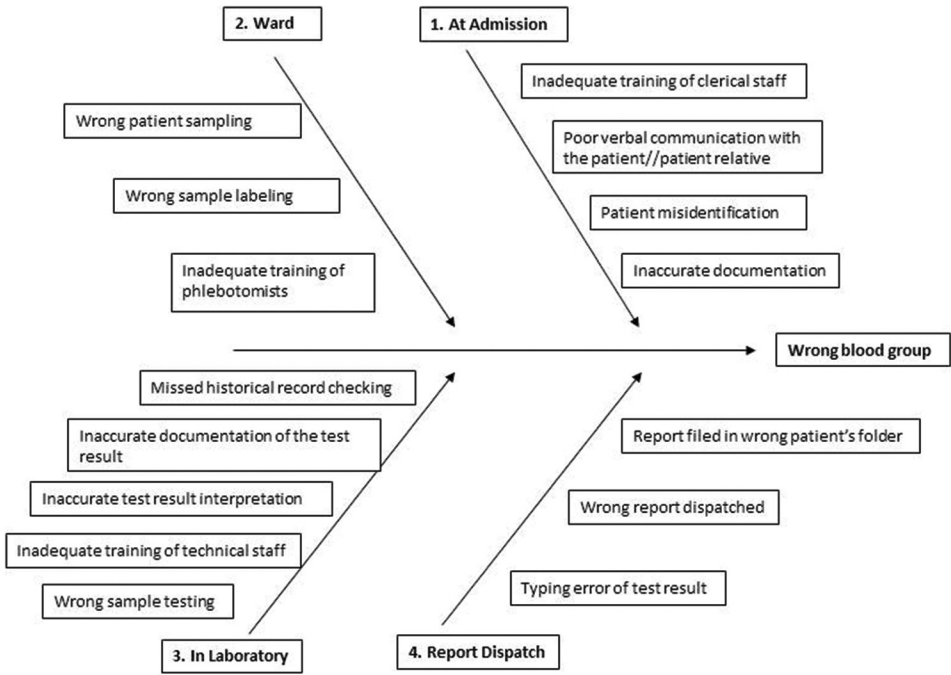


Figure 1: The areas in the hospital where mistakes can occur in patient's blood group

name, surname was same like Patient 1; however, there was minimal difference in middle name. Interestingly, age difference was only 1 year in two patients.

While going through the process, it was realized that at the time of admission, Patient 1 must have been asked about name, age, and address. The old number of Patient 2, who was previously admitted in the hospital, must have been displayed on the screen and was then allotted to Patient 1. Since she was not carrying old hospital number card with her, she did not realize that a new number was allotted to her. Only after finding out the discrepancy in the blood group, the other patient of almost same name, same age, and residing on the same road in the same area was identified. It might have gone undetected if the blood groups would have been same. The patient was requested to get her old hospital number card, and the correction was done. This incident emphasizes the importance of using correct unique identifiers diligently such as not only name, age, sex, and address but also date of birth or Aadhar card number.

Error can be defined as failure in the performance of standard operating procedure (SOP), resulting in unintended and unwanted consequence.^[2] "Near-miss" events reflect the true incidence of transfusion errors. Near-miss events contributed to 38.7% of the reports analyzed by SHOT group in 2019.^[3] Wrong identification of the blood recipients is an important error, leading to transfusion-related complications.

Kromback *et al.*^[4] reported a case of misidentification in two patients with identical first and surnames but different dates of birth; unfortunately, wrong blood was transfused in this case.

This case underlines the importance of checking of historical transfusion records for every new admission in the hospital. The proposed algorithm for proper verification before the blood group is reported is shown in Figure 2.

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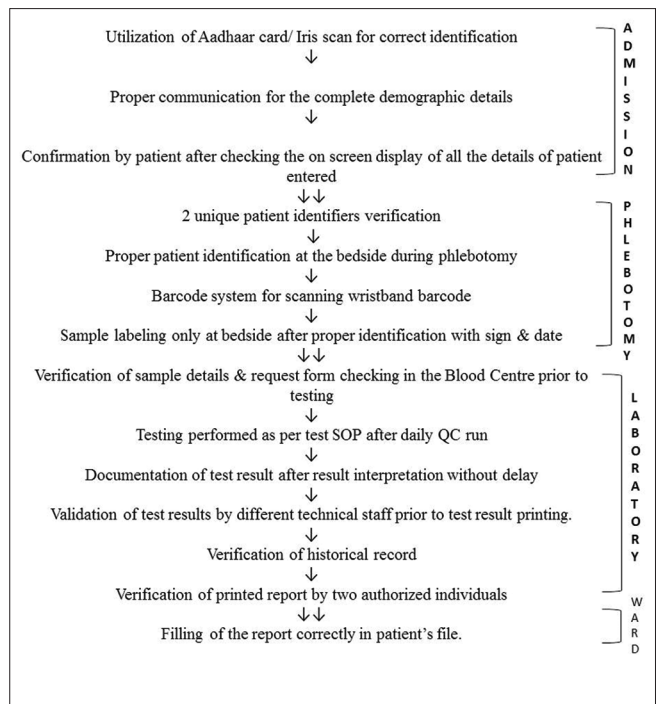


Figure 2: The proposed algorithm for proper verification before the blood group is reported

Conflicts of interest

There are no conflicts of interest.

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