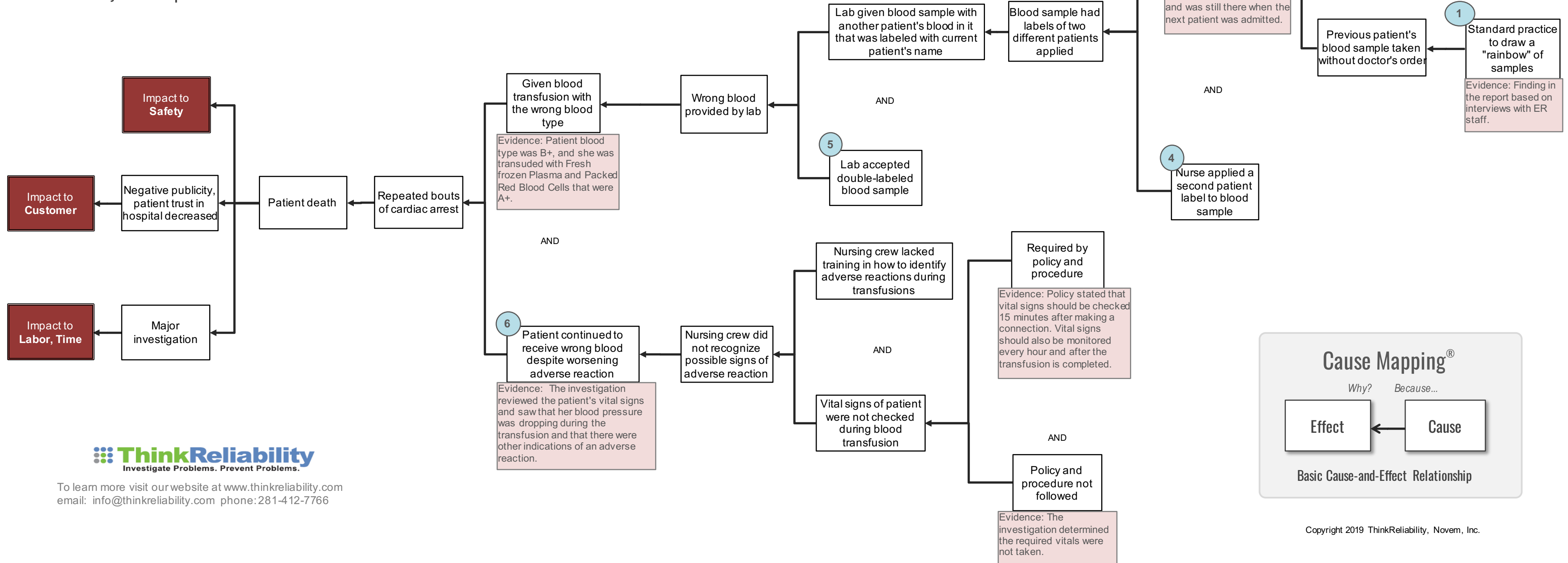
Deadly Blood Transfusion Error

On Dec. 3, 2018, a 75-year-old woman sought emergency care at Baylor St. Luke's Medical Center in Houston where her treatment included blood transfusions. She was given the wrong blood and died the next day after repeated cardiac arrests. The investigation into the error determined that a label with the patient's name was applied to a blood sample from a different patient who had previously been in the same room. This mislabeled sample was sent to the lab. The earlier patient had a different blood type from the current patient, which resulted in the patient being given two different transfusions of the wrong type of blood.

Outline			
	What	Problem(s)	Patient death
	When	Date	December 3, 2018
		Time	12:50 PM
		Different, unusual, unique	Blood sample was left in ER room after patient was discharged
	Where	Facility, site	Baylor St. Luke's Medical Center in Houston
		Unit, area, equipment	Emergency Room
		Task being performed	Patient treated with blood transfusion
	Impact to each GOAL		
		Safety	Patient death
		Customer	Negative publicity, patient trust in hospital decreased
		Labor, Time	Major investigation
		Frequency	First patient death, but regulators identified 122 incidents of blood labeling errors during September 2018 to January 2019

Missed Opportunities

Reviewing the Cause Map shows that this mistake was not the result of a single error. There were at least six missed opportunities where this error could have either been prevented or caught significantly earlier.



Copyright 2019 ThinkReliability, Novem, Inc.