Identification errors and double check procedures

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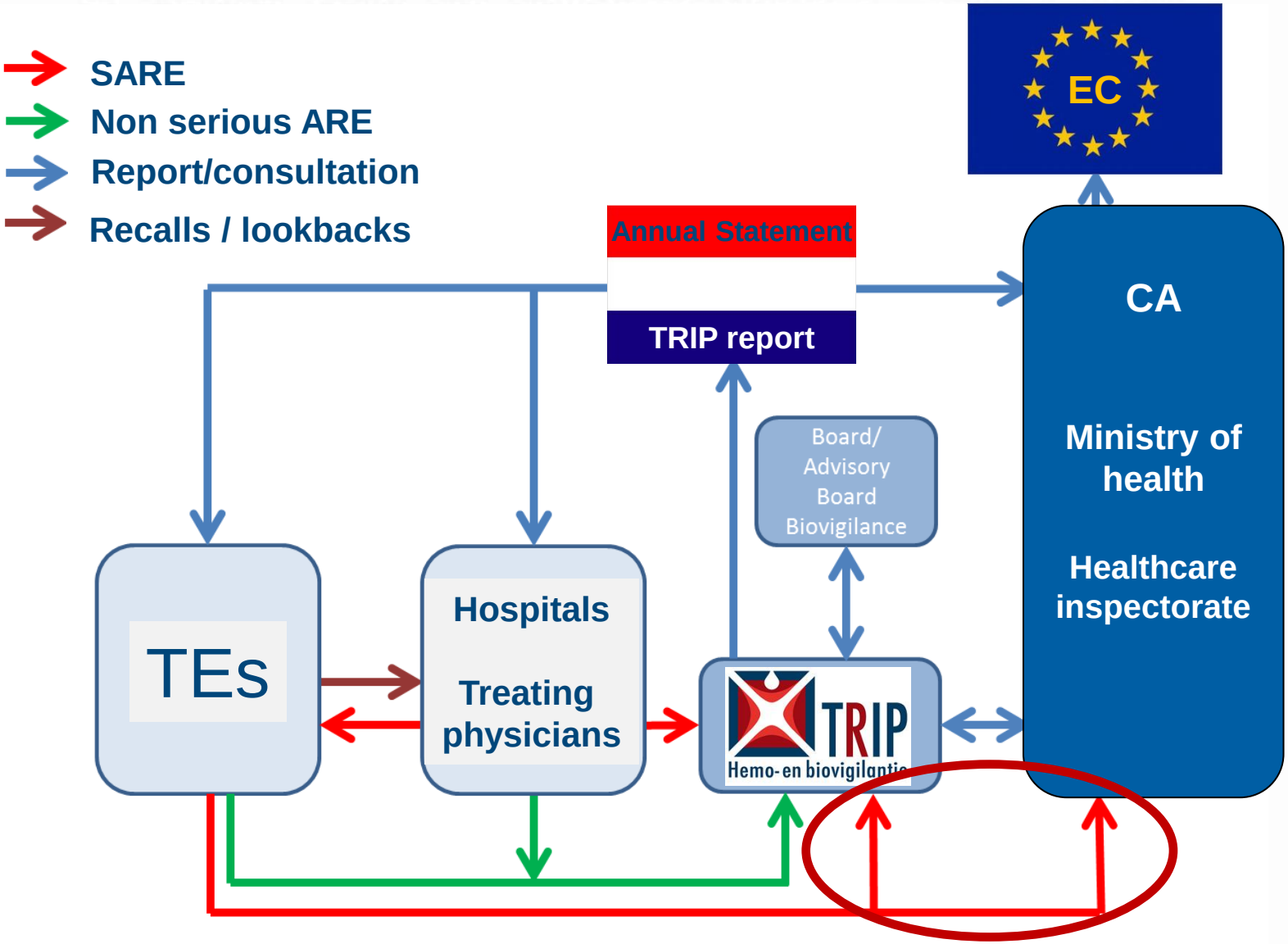
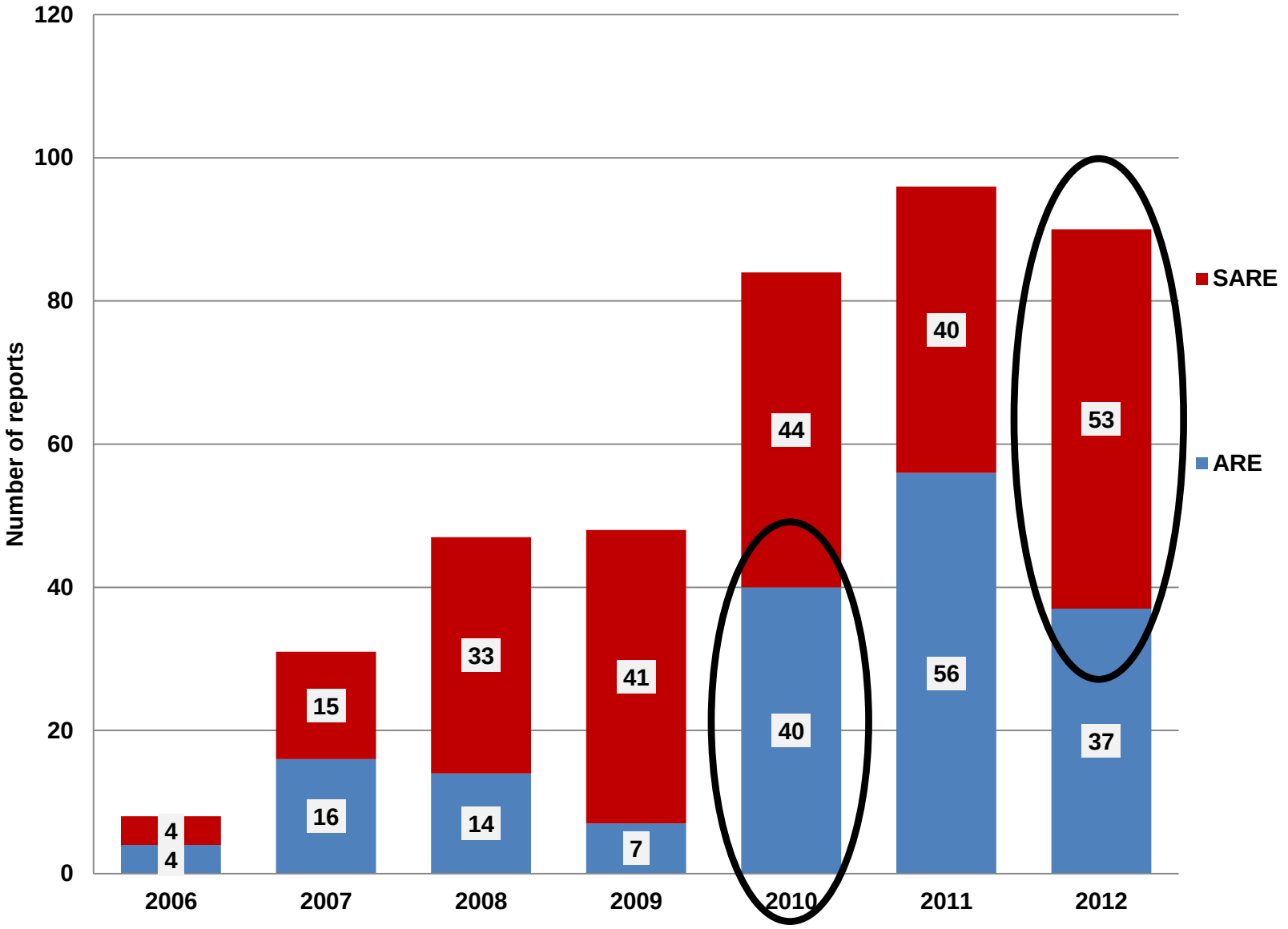
TRIP National hemovigilance and biovigilance office

TRIP Biovigilance since August 2006

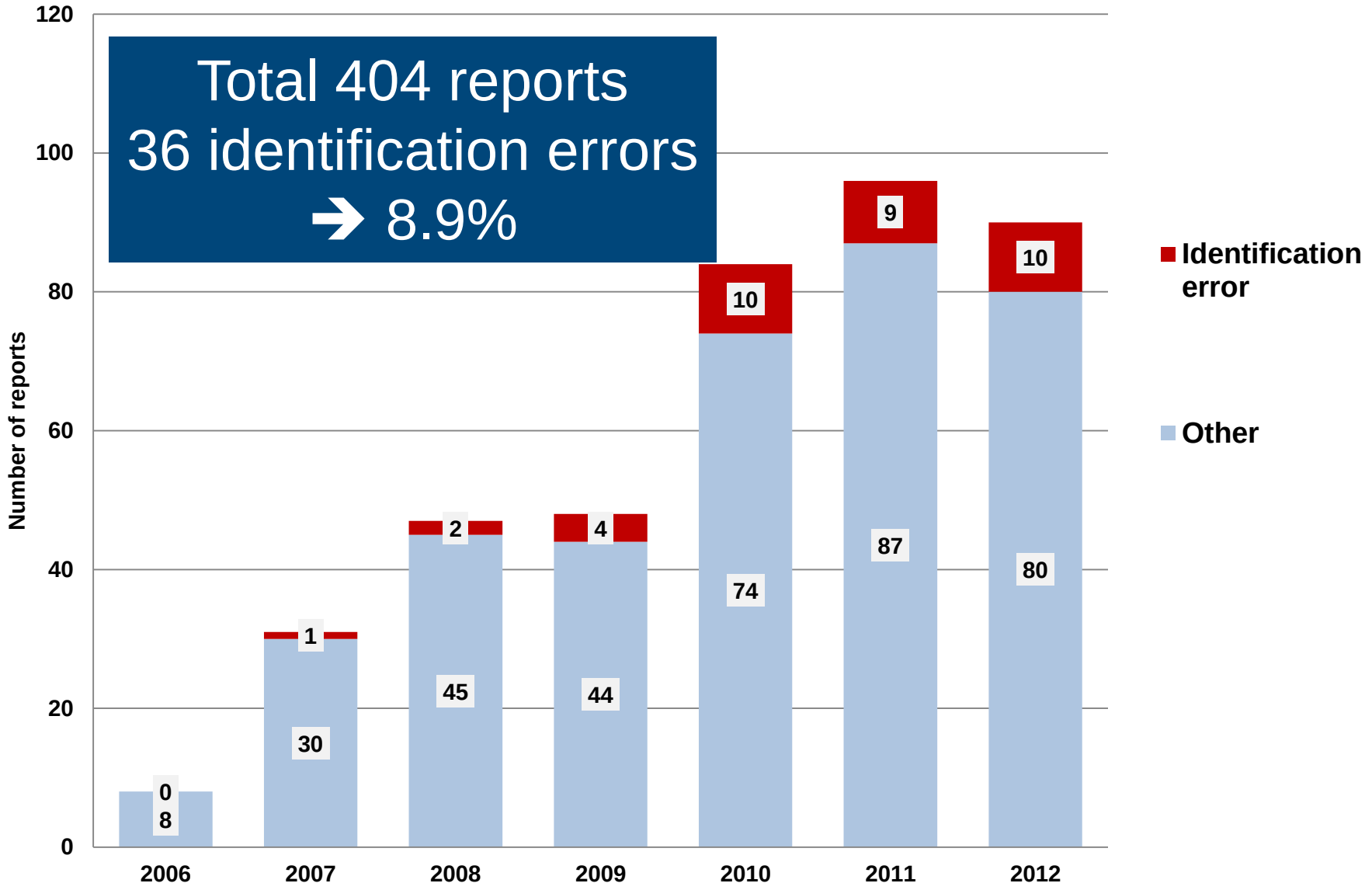
Flowchard of reporting



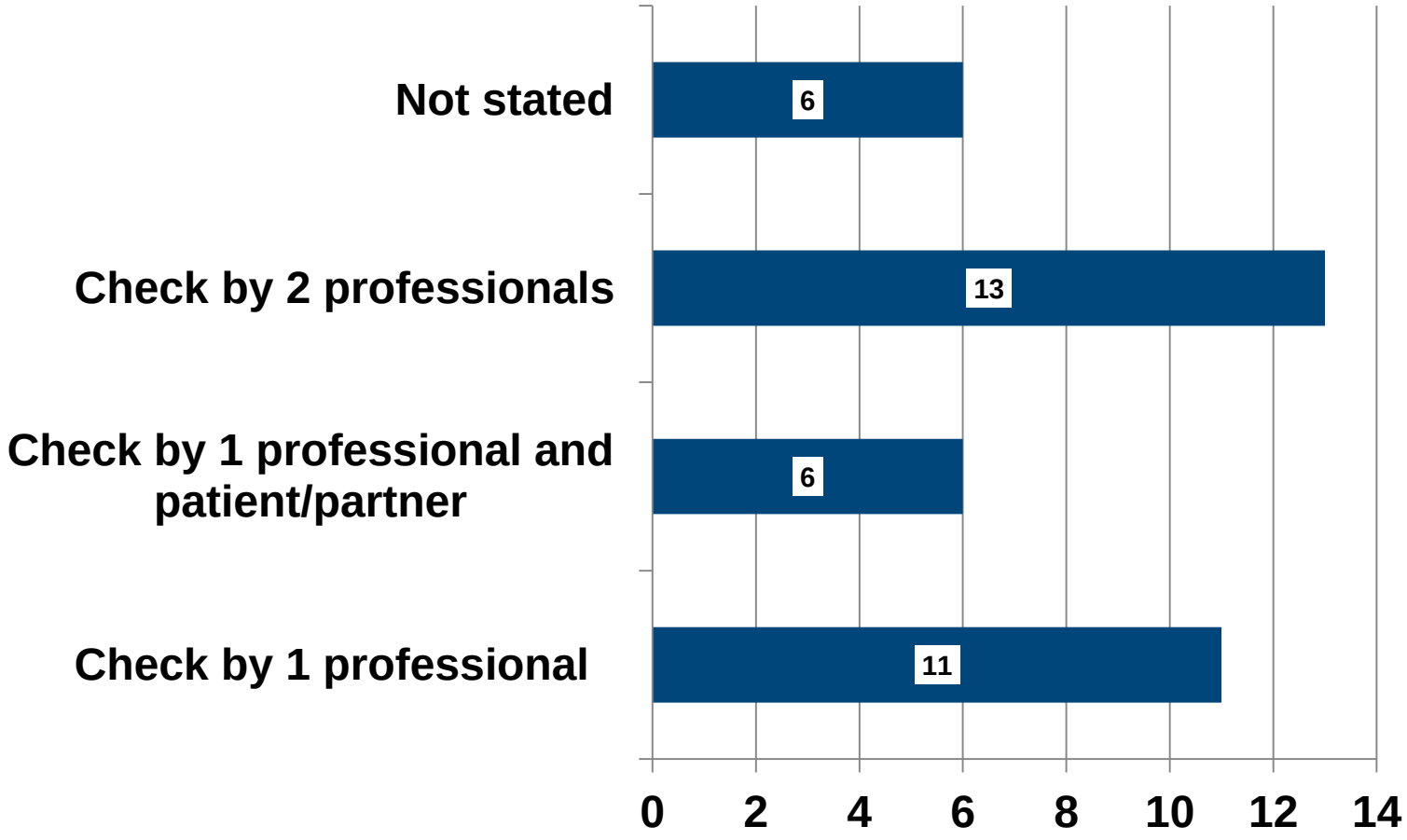
Reports 2006-2012



Reports of identification errors 2006-2012



Reports of identification error according check procedure



Reports of identication errors by category of event

Persons performing check	Incorrect tissues or cells transplanted	Loss of tissues or cells	Near miss	Minor consequences	Total number of reports
2 professionals	2	3	6	2	13
1 professional and patient/partner	1	2	3	0	6
1 professional	4	6	0	1	11
Not stated	1	2	1	2	6
Total	8	13	10	5	36

Overview of reports concerning identification errors

Category event	Type of tissues or cells	Number of reports
Incorrect product transplanted	Embryos	2
	Donor semen	1
	Partner semen	2
	Donor semen	1
	Embryo	1
	Donor skin	1
	Chondrocytes	1
Loss of tissues or cells	Embryos	6
	Partner semen	4
	Oocytes	3
Near miss	Partner semen	6
	Donor semen	1
	Embryos	2
Minor consequences	Embryos	2
	PBSC	1
	Cornea	1
	Tendon	1

Case 1

CMV positive donor semen selected and inseminated in CMV negative recipient

Detected during administration

Investigation:
Donor code shows one number different
Missed by two employees

Recipient:
No pregnancy, CMV serology: no conversion

Case 2

Wrong patient file used for thawing embryo. Embryo lost.

Single check of electronic patient number. 2 patients with same name.

Embryo not transferred

Less chance of pregnancy

Protocol changed, double check procedure

Conclusions

Worst outcome:

- Transplantation of incorrect tissues or cells
- Loss of tissues and cells

Majority of these outcomes occurred when identification was performed by only one person

When checks are performed by two professionals the majority of cases resulted in near miss

Double check system is essential to prevent misidentification and adverse outcomes

Recommendations

2010:
The identification of recipients and donors of tissues or cells is not always carried out completely and according to protocol as was demonstrated by nine reports of adverse events due to identification errors

2012:
By performing identification double check procedures by two employees the number of errors and subsequent adverse outcomes can be reduced

Extra attention is needed for identification based on numerical codes of products or date of birth for spotting of small discrepancies

Thank you for your attention

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