Release Notes RTI 3472/22
Patient Safety and Quality Improvement Service

Right to Information application 3472/22

Babies not tagged correctly or given to wrong parent

Date range: 01/04/2021 – 30/04/2022

Purpose of report

Provide applicant of RTI 3472/22 details of RiskMan incidents between 01/04/2021-30/4/2022 as detailed in the Request for documents Terms of application:

Information from RiskMan of incidents between 01/04/2021 – 30/04/2022 for:

1. Babies tagged incorrectly
2. Babies given to the wrong parent

Please provide the following fields:

- HHS
- Date of incident
- Details
- Summary

Important notes in considering the data

- The data presented is information directly reported by frontline clinicians

Data source

- Data was retrieved from the RiskMan Clinical Incident database for all Hospital and Health Services.
- RiskMan is designed to enable reporting, investigation and management of clinical incidents and consumer feedback reported/received by Hospital and Health Service (HHS) staff.
- All data presented for the current RTI 3472/22 was extracted from RiskMan and has been self-reported by Hospital and Health Service staff.
- The data for RTI 3472/22 is current in RiskMan as at 27/6/2022.

Search Criteria and Methodology

- RiskMan data was extracted based on search criteria and checked by Systems team, Patient Safety and Quality Improvement Service (PSQIS).
- Clinician and patient details were deidentified from records meeting criteria.

Date of incident	1/4/2021-30/4/2022
Harm	All
Hospital and Health Service	All
Subject affected	Patient/Client
Patient affected type	All
Classification	1. Patient Flow\Discharge to wrong parents 2. Patient Identification

Search Results

Statistical Data

1. Babies tagged incorrectly
   - All three mislabels were detected when staff undertook the required checking of the labels (i.e. review of the three identifiers – see below) and in each of the three instances the labels were amended when identified. None of these three instances resulted in harm.

2. Babies given to the wrong parent
   - Zero records were located

Interpretation notes

Each year, approximately 60,000 women give birth in Queensland.

Queensland Health is proud of the high quality of its work performed by its maternity services, which ranks very well when compared with maternal and neonatal outcomes in countries such as the United States and the United Kingdom.

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

The National Safety and Quality Health Service Standards requires Health Services to:

a. define approved identifiers for patients according to best-practice guidelines
b. requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated

Incident Date	Hospital and Health Service	Summary	Details
4/04/2021	TOWNSVILLE	Written ID tags incorrect UR number	Midwife had written the wrong UR number on ID tags and placed on the baby. Checked ID tags by myself leaving OT however was same as admitting form. Upon performing a blood gas the patient name associated with the entered number was not the same name as this above patient. Midwife had identified that this was incorrect and has written in the patient note and informed the NICU ward clerk. However bedside nurse was unaware.
16/04/2021	METRO NORTH	Baby had mums id labels on	Nurses this am completing medication round, upon checking baby ID found that the UR number was incorrect. Upon further investigation it was found that the patient's mother's ID labels had been printed and attached to baby.
29/04/2021	TOWNSVILLE	Incident closed: wrong ID tag on patient x 1	During medication administration with RN XXXXXX and myself, we came across the wrong ID band on baby XXXXXX Tag was removed and replaced with right tag