## Patient receives wrong blood type

The mix-up is the second high-profile incident at Sarasota Memorial this year

## **BRIAN HAAS**

Herald Staff Writer

SARASOTA — A Sarasota Memorial Hospital patient was given the wrong blood type in late June, a hospital

official revealed Friday night.

Lyn Cassan, marketing director for the hospital, said that a "critically ill" patient in late June was infused with the incorrect blood. She declined to say if the patient survived the transfusion.

Cassan said the hospital is in the middle of an internal investigation to find the "root cause" of the mistake. Preliminary results were not available Friday. Cassan said that the hospital also notified the Agency for Health Care Administration — which governs hospitals — and Sarasota Memorial Hospital's two accrediting agencies about the mistake. The National Institute of Health says that being

transfused with the incorrect blood type can lead to kidney failure or death.

This mistake came shortly before a July 1 deadline set by the Joint Commission on Accreditation of Healthcare Organizations for new standards to avert medical errors. The standards include more checks and verifications

BRADENTON HERALD

Bradestoe, FL

Saturday Circulation - 37,350 Daily

**JULY 17, 2004** 

are to ensure that hospitals have the correct patient, that they are performing the correct procedure and that they are performing the procedure on the correct body part or limb.

The procedural mistake is the second high-profile incident at the hospital this year. In March, the hospital revealed that a heart catheterization was performed on the wrong patient. The hospital revealed that no one compared the patient's ID bracelet to the patient's chart. Hospital officials at the time said the patient was not harmed in the surgery.

Cassan acknowledged that the two significant medical errors in the course of a few months does not look good.

"Everyone's concerned about the timing," Cassan said. "I think the hospital has continued to be very vigilant about any mistake. I think the important thing is to see what happened in our process so it doesn't happen again."

Cassan said that more information about the bad blood transfusion should be available Monday. She was unaware of any lawsuits resulting from the mistake.

Brian Haas, public safety reporter, can be reached at 748-0411, ext. 7024, or at bhaas@bradenton herald.com.