

WRONG BLOOD IN TUBE

WE'RE ONLY HUMAN AFTER ALL



Looking at errors from a Human Factors perspective

Ruth O'Donnell

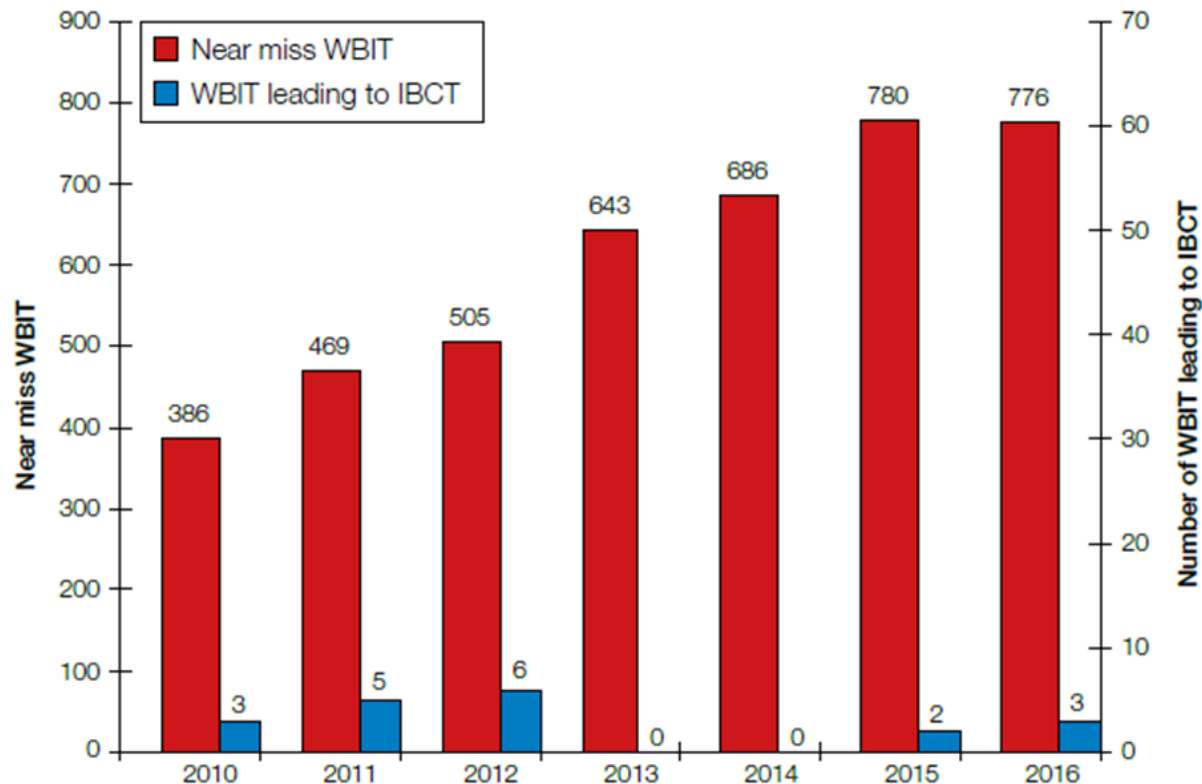
Transfusion Practitioner WSHT

Wrong Blood In Tube (WBIT) Errors

- ▣ Sample isn't from the patient it's labelled for
- ▣ Consequences may be **catastrophic**
- ▣ Correct patient ID **doesn't only effect transfusion**

SHOT Data

- ▣ ~1 in 100 WBITs → wrong transfusion
- ▣ WBIT near miss incidents increasing



If WBIT Is Detected

- ▣ Ensure patient safety
- ▣ Significant time & effort to investigate
- ▣ Patients & staff lose confidence in the system

Worryingly

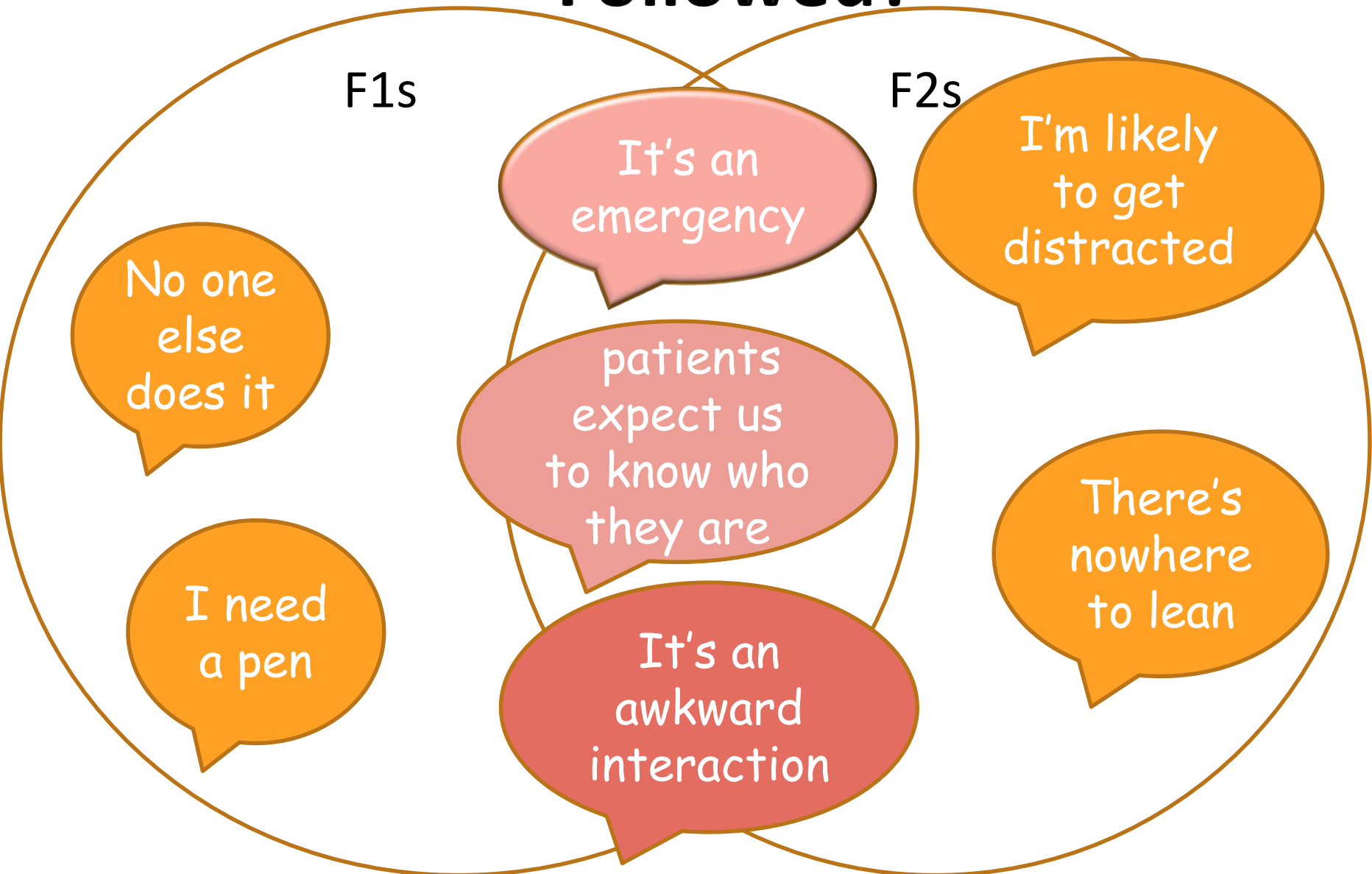
- ▣ Undetectable WBITS
 - Only 1 sample received
 - 2 samples have the same group ~ 30%

- ▣ ‘junior Drs appear to lack knowledge about the potential for error, a situation reinforced by a culture that openly accepts doctors not following protocols’
(Jeffcott, 2010).

The Dirty Dozen (Dupont 1993)

- ▣ Lack of Awareness
- ▣ Lack of Assertiveness
- ▣ Lack of Resources
- ▣ Lack of Knowledge
- ▣ Lack of Communication
- ▣ Lack of Teamwork
- ▣ Fatigue
- ▣ Distraction
- ▣ Norms
- ▣ Pressure
- ▣ Stress
- ▣ Complacency

Why Isn't Sampling Procedure Followed?



The Dirty Dozen (Dupont 1993)


- ▣ Lack of Awareness
- ▣ Lack of Assertiveness
- ▣ Lack of Resources
- ▣ Lack of Knowledge
- ▣ Lack of Communication
- ▣ Lack of Teamwork
- ▣ Fatigue
- ▣ Distraction
- ▣ Norms
- ▣ Pressure
- ▣ Stress
- ▣ Complacency



"It's an emergency"



"patients expect us to know who they are"



"It's an awkward interaction"

What Have We Done To Improve?

- ▣ Procedure
- ▣ Competency
- ▣ Education
- ▣ Request form
- ▣ Improved investigation
- ▣ 2 sample rule

- Have you discussed any proposed transfusion with the patient and obtained informed consent? Yes / No

I confirm that I have:-

Signature

Asked the patient to state full name & date of birth

Checked the patient details match the wristband

Checked the wristband matches the request form

Labelled the sample next to the patient immediately after venepuncture

Taken only 1 transfusion sample in this venepuncture

Signed the sample tube

- I take responsibility for sampling procedure accuracy

Signed..... Print Name

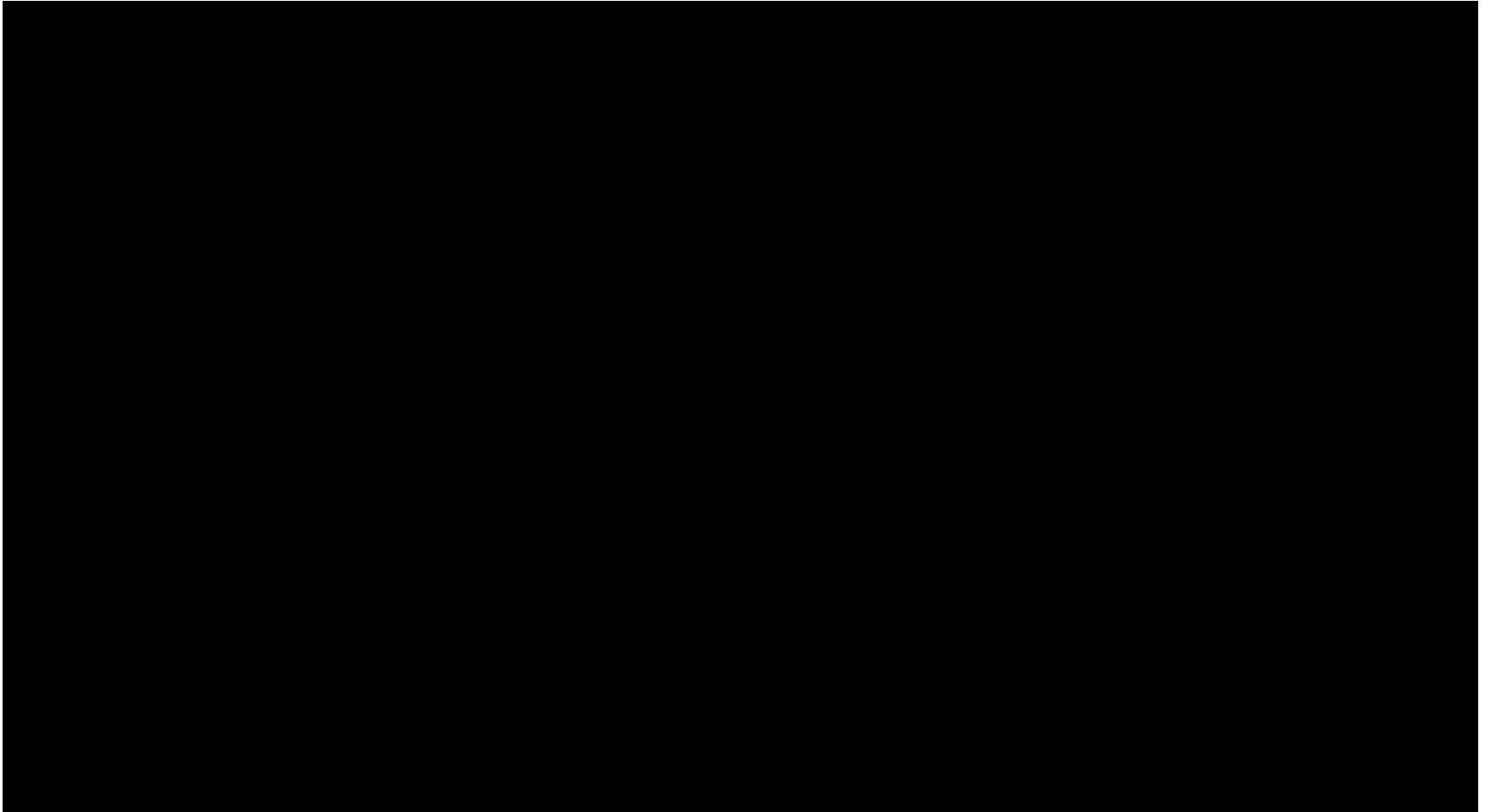
GMC/NMC Stamp / PIN.....

Date/...../..... Time:.....

2 Sample Rule Case

- ▣ 2 samples sent to the lab timed at 10:00hrs & 10:30hr – they both arrived at the same time
- ▣ 2 unit x match
- ▣ They both grouped as A pos
- ▣ Previously the patient was O pos

How did this Happen?



Do We Have Anything To Combat Cultural Norms?



Extraordinary people –
with passion and
courage to call out poor
practice.

The Way Forward....

- ▣ Standardise request forms?
- ▣ IT solutions
- ▣ Design a system that makes it easier to do the right thing