Western Sussex Hospitals
NHS Foundation Trust

INTEGRATED PATHOLOGY SERVICE
BLOOD TRANSFUSION DOCUMENT

Investigation Of a Wrong Blood in Tube Incident Form

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Wrong Blood in Tube Incident Investigation

Information: Full name & Job role: Contact details: Name of line manager:	Date of incident: Today's date: Form completed by:
Take copies of: Request form, Sample label & Complete Table 1	
Description of Incident: It is important to try and establish how the incident occurred to reduce the chance of it happening again. **List 2** (below) are situations that are known to contribute to errors. They are not excuses (we expect you to get things right) but may help you to identify contributory factors. It is important that we learn why the error was made so we can try to reduce the chance compromising Patient Safety in the future. Can you recall and describe the situation that led to the error? If you cannot recall the specific incident please think about what may have contributed to you making the error.	
How it happened: Below is the agreed safe process. If the answer to any question is 'No' please recall the specific incident and explain why the process wasn't followed. If you cannot recall the specific incident, please think about occasions where you might not follow it and the reasons.	
Was the sample bottle pre-labelled?	
Did you ask the patient to state their full name & DoB?	
Did you check the wrist band?	
Did you use any other items to confirm patient I.D? E.g. notes/name board	
Did you complete the request form before venepuncture?	
Did you check the request form against the wristband?	
Did you label the sample yourself?	
Was the sample labelled at the bedside?	

Do you hold an in-date venepuncture competency? You are advised you should now not take Blood Transfusion samples until re-training and re-assessment	
Do you have any other questions/comments specific to this case or more generally about blood transfusion?	

Table 1: Sample Table Check previous history and any subsequent samples

Date	Sample Number	Blood Group

SAMPLE IN QUESTION

List 2 – Possible contributing factors to 'wrong blood in tube incident'

Norms
That's the way things are done round here. Unwritten rules followed or tolerated by the majority of staff. E.g. T*he 'error' is normal practice (E.g. when it gets busy no-one labels at the bedside)*

Distraction
Being interrupted whilst completing a task (anything that takes your mind off the job at hand) E.g. *I was following the process but put the sample down to answer a complicated enquiry.*
The patient asked me a question so I missed out checking their wrist band.

Complacency
As we become more proficient at something 'overconfidence' can creep in. If we have done a task before with no adverse consequences we think that it is OK to repeat. *E.g. I've taken hundreds of samples this way and nothing has happed before.*

Lack of knowledge
Not knowing a SOP or process. *E.g No-one told me that I had to check the form against the wristband.*

Lack of resources
Were the correct equipment/forms available? E*.g There weren't any request forms to hand so I filled it in later on.*

Lack of assertiveness
Not speaking up when things do not seem right. *E.g. I hadn't taken the sample but the Consultant told me to label it.*

Pressure
Pressure to be on time (or make quick decisions) is ever-present. Some stress is caused by self-pressure as opposed to external influences. *E.g. .I had 4 other patients to bleed and i was due to go on lunch soon.*

Lack of communication
What has been done – what needs to be done. Do you have suggestions to stop this happening again?

Lack of team work
Does everyone understand their role – what, who and how a job is to be done? E.g. *I am always asked to take samples for the Doctors even though I have so much else to be doing.*

Fatigue
More than tiredness – impairs judgement and is hard to recognise yourself. E.g. *It was right at the end of a busy 12+ hour shift.*

Stress
The subconscious response to the demands placed upon us. It can stop us looking rationally at a problem. E.g. *I don't have time to talk to the patients and that is what will happen if I label at the bedside.*

Lack of awareness
Reduced alertness and vigilance and failing to see possible consequences. Not recognising the impact your practice has on others. *E.g. At least the error was caught so I don't need to worry.*

Table 3: Read the following statements to the member of staff

The member of staff should be informed that:	✓
Incorrect blood transfusion can cause serious patient harm or death	
An ABO incompatible transfusion is regarded as a 'never event'	
This incident will be reported nationally to the Serious Hazards of Transfusion (SHOT)	
The request form responsibility boxes have been signed by the sample taker indicating they have followed Trust Procedure	
(For medical staff) You are required to make an appointment with the Haematology Consultant to discuss the incident	
You are advised you should no longer take samples for Blood Transfusion until you have been re-trained and assessed	
Your direct manager and the Chair of the Trust Transfusion Committee will also be informed of the incident	

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Table 4: Actions for the Investigator:		
To complete:	✓ or **X**	If **X** (not done) please give explanation for your decision
DATIX reference		
SHOT Report		
Email to Phlebotomy trainer		
Email to Haematology Consultant		
Email to Line manager		
Email HTC Chair & Laboratory Manager		

Signature …… Date……