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Patient Sampling Errors

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Transfusion Practitioners

Importance of sampling labelling

Labelling errors and mismatches between form and sample lead to delays in patient care and research has shown that mislabelled samples are more likely to be wrong blood in tube (WBIT)

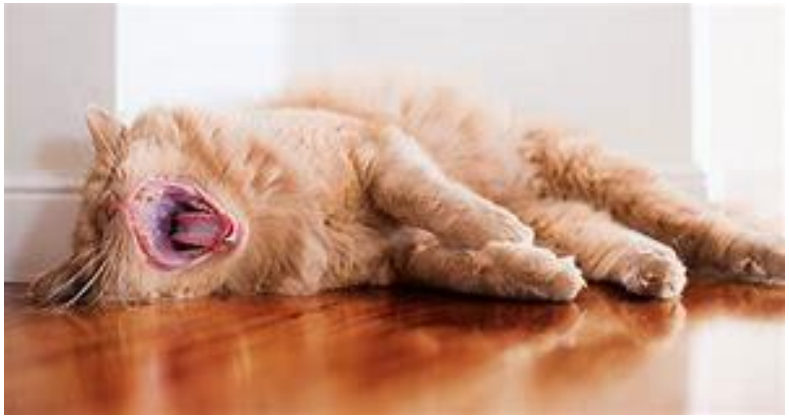
Definition of Wrong Blood In Tube

- Blood taken from the wrong patient and is labelled with the intended patient's details
- Blood is taken from the intended patient but labelled with another patient's details

Many of these errors remain undiscovered because blood isn't required on everyone and many patients are the same blood group anyway but an error can have serious consequences

For midwives this can be detrimental for mum and baby

Boring…not again!



But stick with us…

In the Beginning….

- Group and Save sample at patient's first presentation - blood group B Negative
- No B Neg units in stock so 3 units of O Neg were issued as a suitable alternative. Patient was transfused 2 units
- Sample 2 was taken a month later. The group did not match the historical group on B Neg - now grouped as O Positive
- A repeat sample was requested and the results confirmed the patient was O Positive

Check sample and BSH guidance

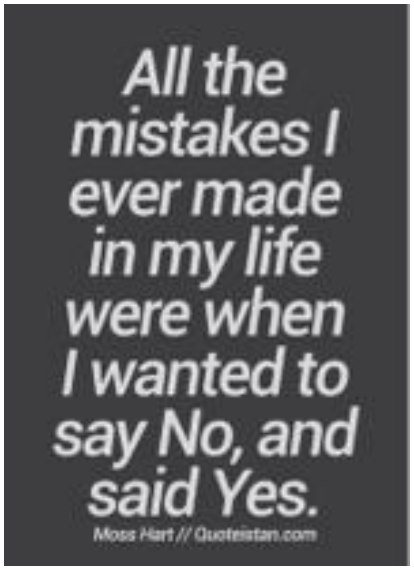
"... unless secure electronic patient ID systems are in place, a second confirmatory blood sample should be requested for confirmation of the ABO group of a first-time patient prior to transfusion, where this does not impede the delivery of urgent blood components"

But it's still happening…..

- Phlebotomist asked to bleed a patient by 2 doctors took 2 EDTA samples
- She handed the unlabelled samples to both doctors
- Doctors aware of the check group policy and labelled the samples independently in the doctor's office
- Blood Bank received 2 samples correctly labelled with appropriate documentation, requesting a x-match
- Both samples grouped as A Positive
- Historical group - O Positive

Does new technology prevent errors ?

- Removing paper in favour of connected and accessible digital information
- Getting people to work in a different ways including using system access cards
- Facilitates patient identification and venepuncture tasks



Apparently not !

- Dr offered to take samples because the nurse was unsuccessful
- Nurse was very grateful and offered to assist Dr by printing the labels and getting the forms ready for them
- Dr was told the patient was in **Bay 2 Bed 4**
- Bloods taken from the patient without checking the ID. Samples given to the nurse to label and dispatch to lab
- The lab found a discrepancy in the chemistry results and the blood bank had to recall the X-matched blood which was now available for collection and transfusion
- The doctor had bled the patient in **Bay 4 Bed 2** !

BSH guidance says…..

“The collection of the blood sample from the patient and the subsequent completion of details on the blood sample tube must be performed as one continuous, uninterrupted event at the patient's (bed)side **involving one patient and one trained, competent and locally designated member of staff**”

British Society for Haematology
Listening • Learning • Leading

Quotes from Incident Reports

The samples were unlabelled and Dr left the ward taking them with her.

Patient asleep and the lights were down

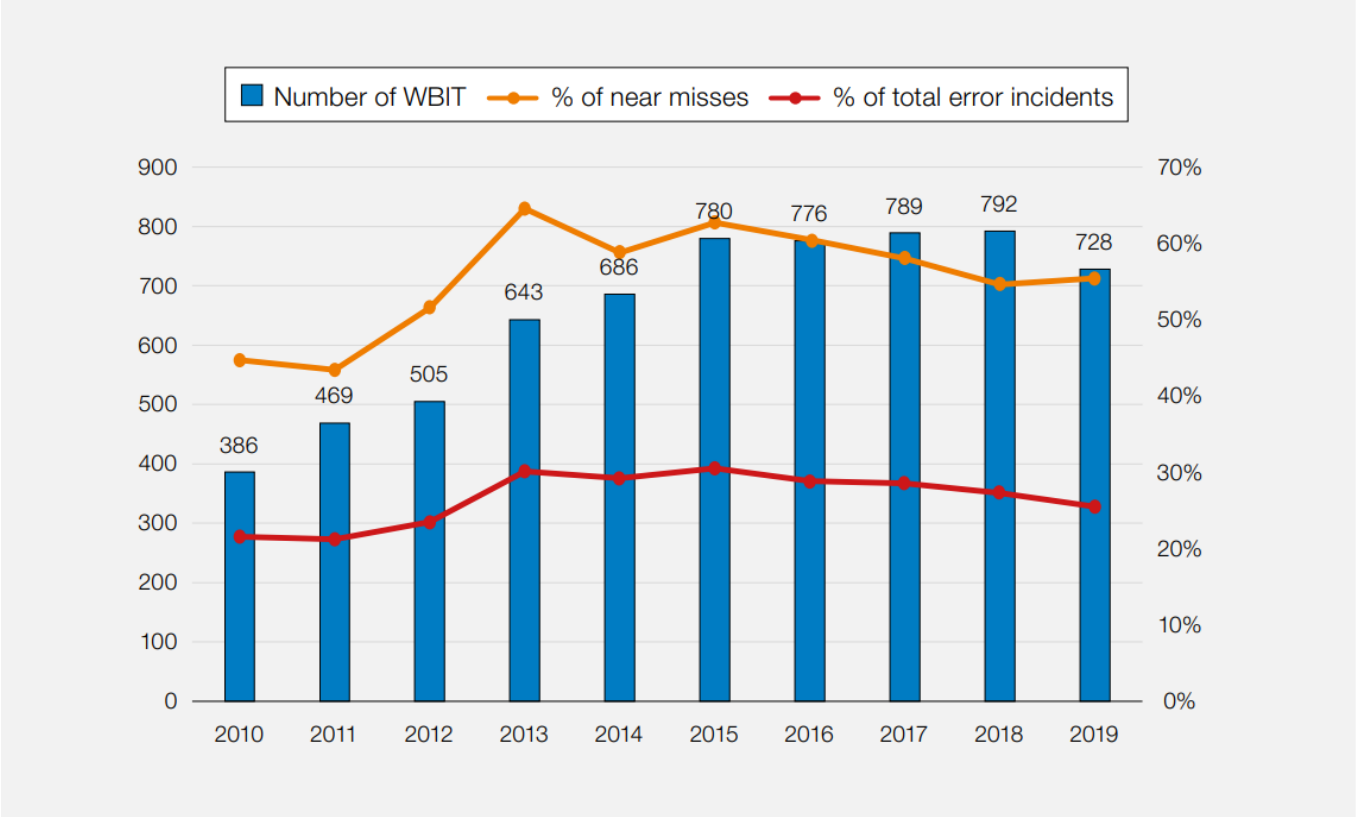
I chased the Doctor down the corridor and asked her to return to the ward to ask her to come and put a label on the blood, as per trust policy.

She took the labels to the patient who had been "nodded to" by the doctor.

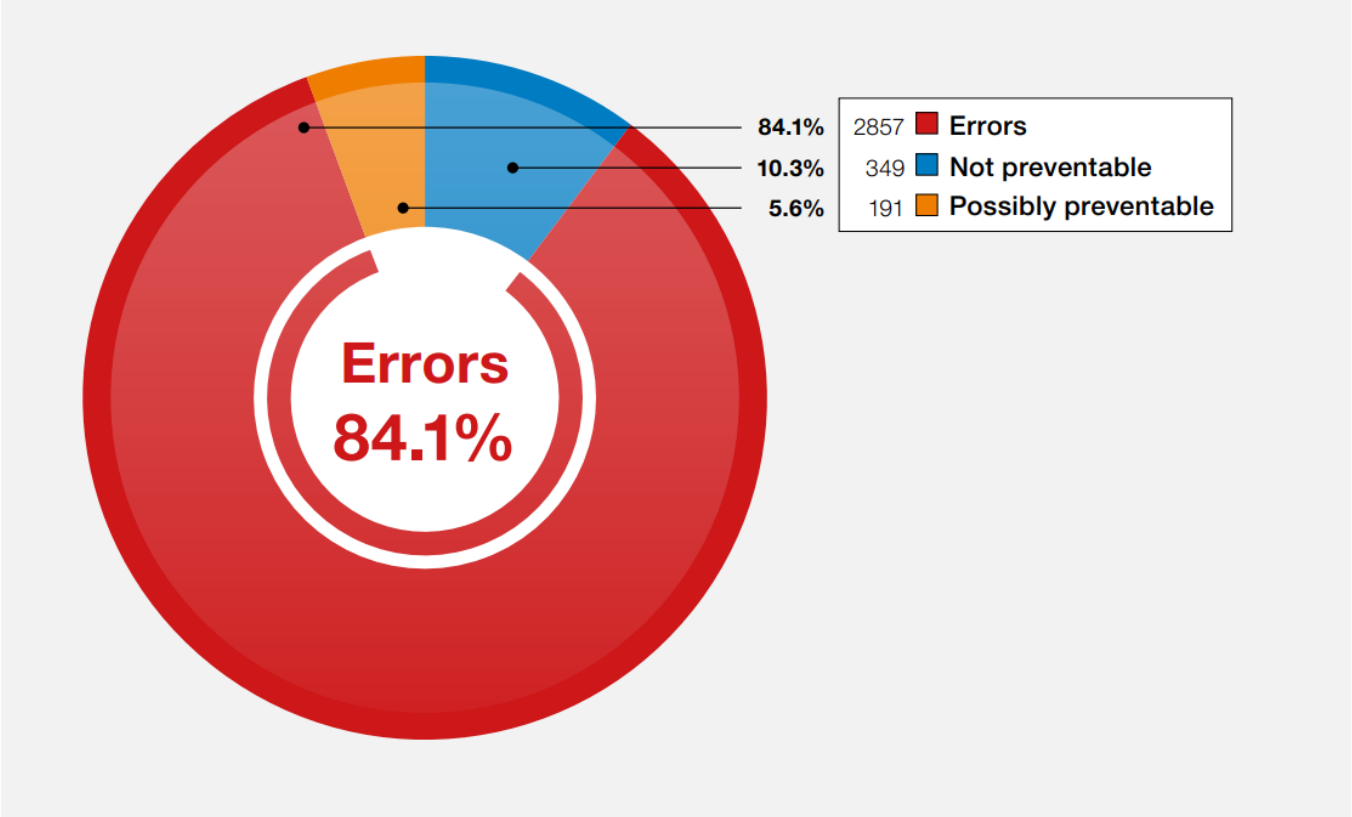
The shift was not that busy but i was trying to be efficient

I was informed by the patient his wristband was on the side bar of his bed

WBITs reported to SHOT(Serious Hazards of Transfusion)

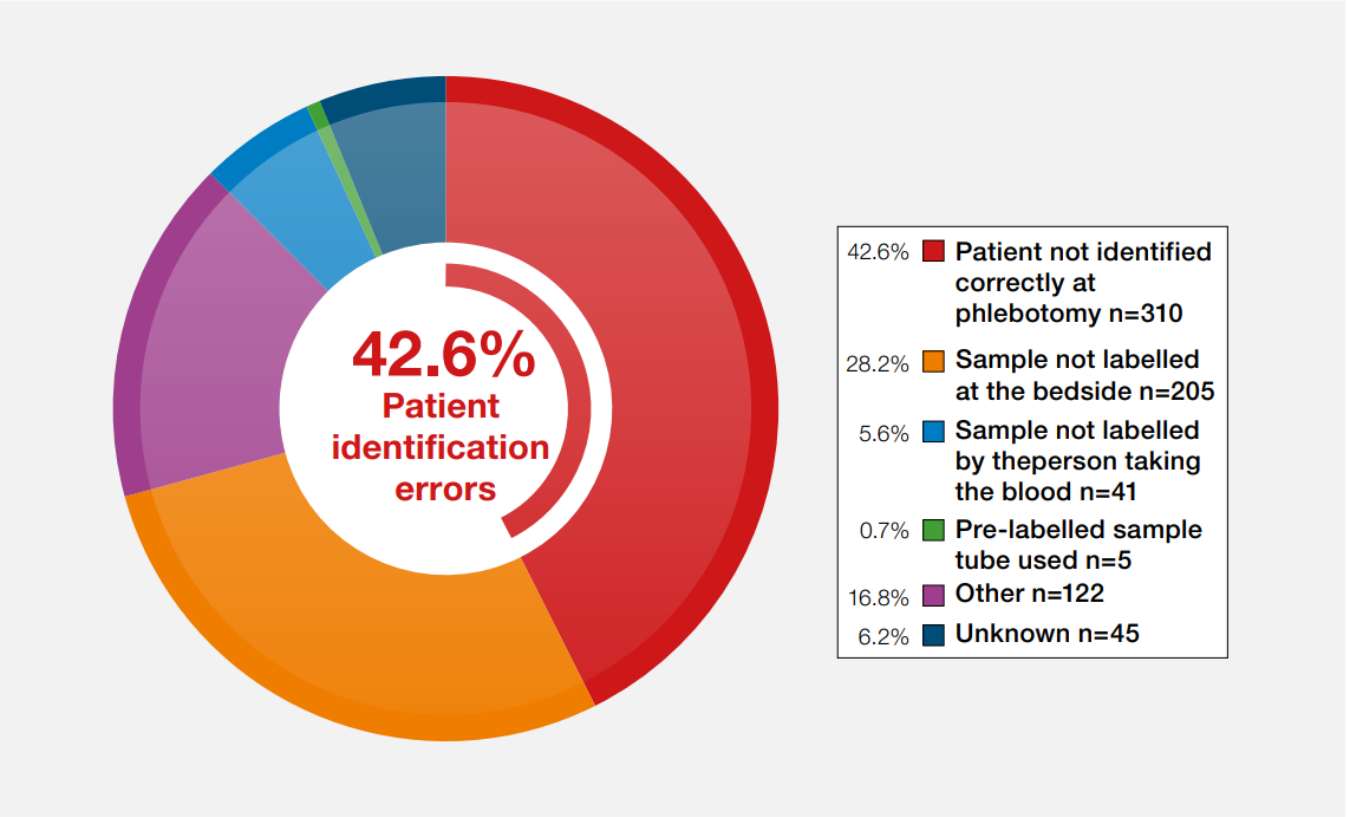


Most SHOT reports are preventable errors (2857/3397 in the most recent report)



SHOT Serious Hazards of Transfusion

Causes of WBIT (728/2857 errors) as stated by reporters



What are the causes of sampling errors?

- Work arounds become accepted practice
- Familiarity with patients leads to patient's ID being assumed
- Multi-tasking
- Distractions
- Staff rotation i.e., rotational midwife
- Stress and emotional demands
- Interruptions
- Workload and staff to patient ratio
- Urgent situations
- Lack of training in good practice – it’s a one-person task and not a team effort


THINK OUTSIDE THE BOX

Definition of PPI (Positive Patient Identification)

Guess what? There isn't one

WHO states a primary responsibility of health-care workers is to check the identity of patients and match the correct patients with the correct care (e.g., laboratory results, specimens, procedures) before that care is administered

How do we do this?

Wherever possible, patients for blood sampling or transfusion should be asked to state their full name and date of birth and this must exactly match documentation and the details on the identification band

What are the barriers to this ?

1. Patient ID is not routinely performed correctly

Is the trust policy on the requirements for patient ID robust enough e.g. community midwives and their women without wristbands

2. Workarounds become accepted practice

Is this because of the environment ?

3. Is the SOP good enough ?

Does it work in YOUR area e.g., community midwives and hospital midwives will require different SOPs

Any SOP should be tested by individual areas to check that it works in that area and any deviations agreed

4.Technological solutions – is this the answer?

They can fail to consider the reality of clinical care settings

Observations from our experience

1. We don’t focus on the consequences and potential harm of any wrong blood sample
2. Understanding the cause of the errors is focused on the individual and not the systems and process
3. Human factors play a role in WBIT (SHOT)
4. Incident feedback is not always received by the relevant staff
5. Sample collection primarily focusses on the venepuncture technique and less so on patient identification and sample labelling
6. If the documentation e.g. request card isn't there at the beginning you are more likely to make an error
7. Samples labelled away from the patient lead to errors
8. Senior management often don’t appreciate the consequences of WBITs and are more focused on the Never Event – ABO incompatible transfusion

Think 10!

It takes 10 seconds to positively identify your patient

It takes 10 seconds to check that the sample and request documentation match

It takes 10 minutes to rebleed your patient if the sample is rejected

However...

It takes only 10 mls of the wrong blood to potentially harm your patient

Recommendations

- Venepuncture/cannulation courses should include more emphasis on the patient identification steps
- Feedback findings about sampling errors to the right people
- Go back and look at your process. Is there an SOP on sampling – is it fit for purpose? Do you need one?
- Are you involving your patient in the process?
- View the SHOT sampling video or your own Trust may have one
- Audit your sampling errors. Are they area specific e.g. community or ward

Practise Purrfect Patient Identification (PPPID) every time