# THE WORLD OF WBITS

**Rachel Moss**

**Transfusion Practitioner**

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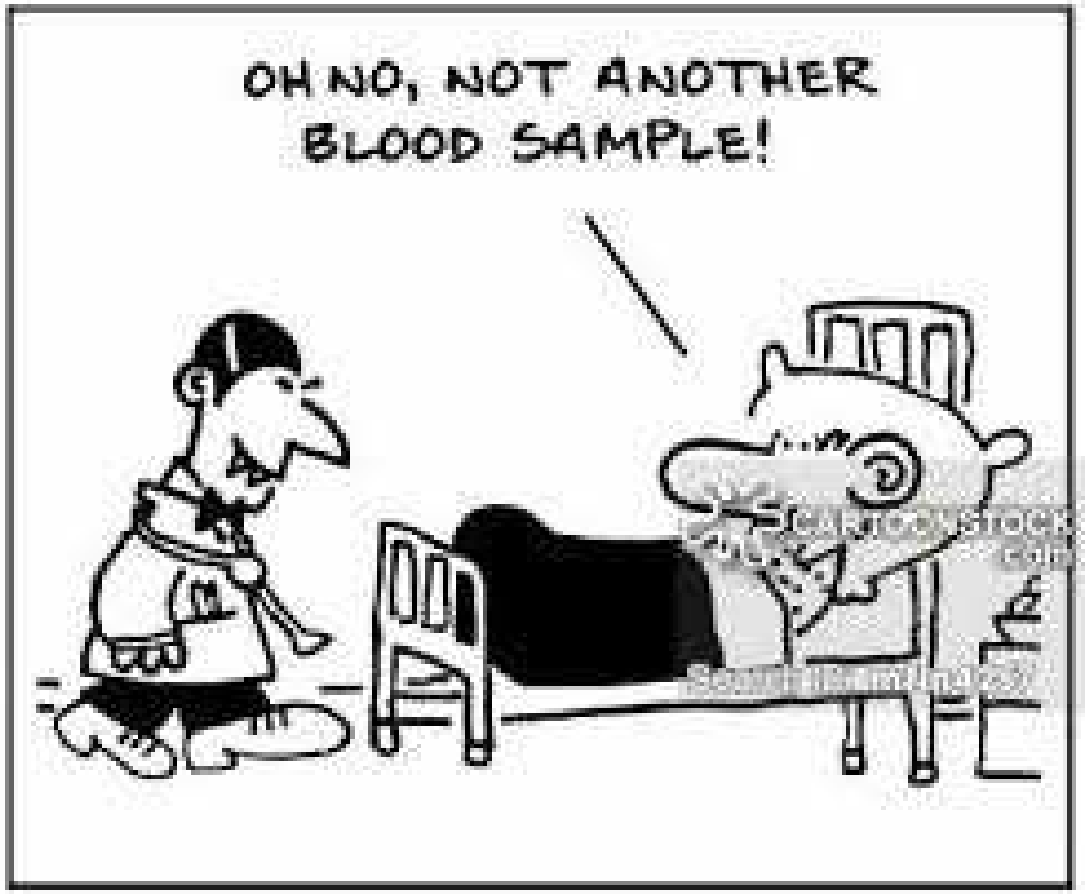
# Why do WBITs happen?

# To err is Human

Many reasons why mistakes happen

- Competing priorities
- System failures
- Human failures
- External pressures
- Management of emergencies
- New ways of doing things / environment
- Human factors

# Case Study 1 - FY1 Medical Ward

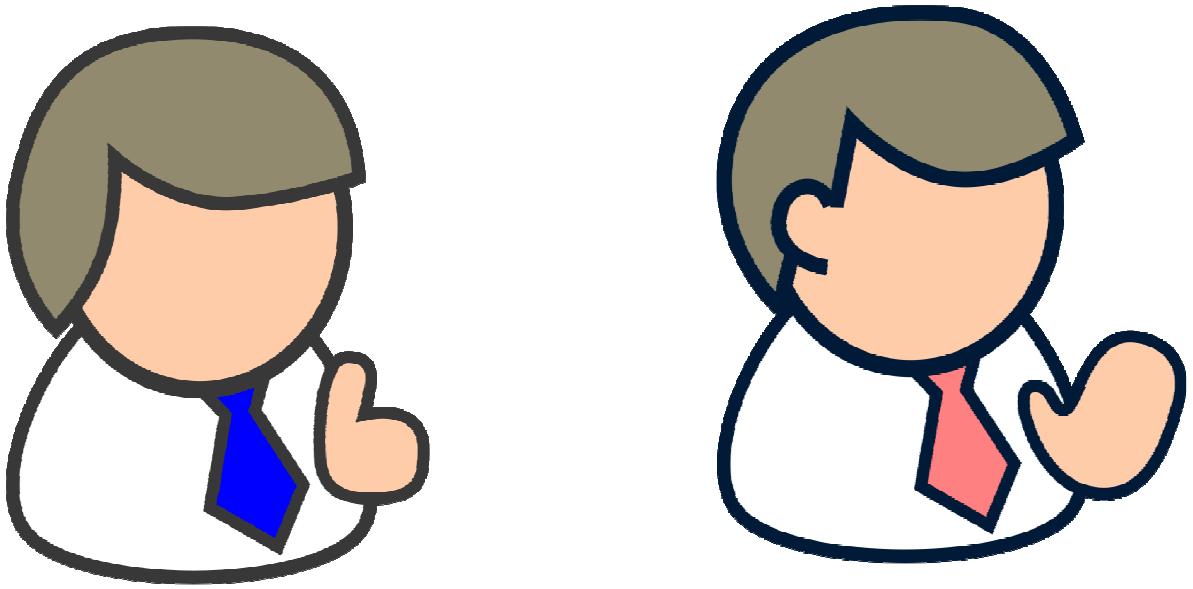


# Contributing Factors to error?

# Case Study 2 – Sister in the CCL

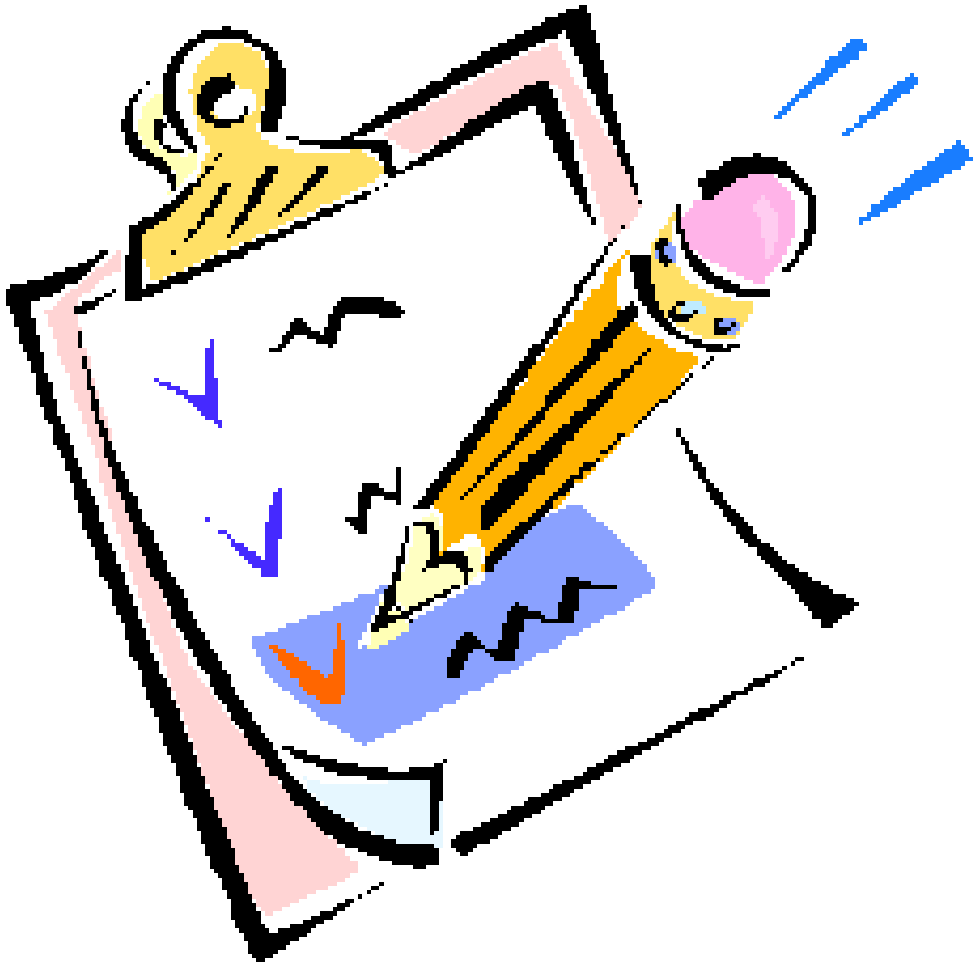
# Contributing Factors to error?

# Case Study 3 – The 2 Johns



# Contributing Factors to error?

# Case Study 4 - The List

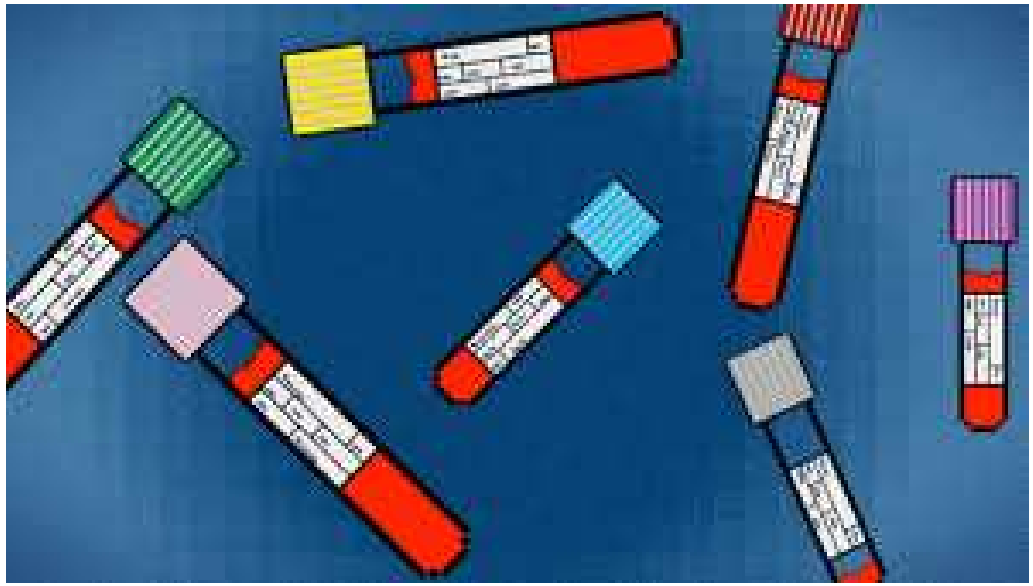


# Contributing Factors to error?

# Case Study 5 - Next Patient Please

# Contributing Factors to error?

# Case Study 6 - Mix It Up



# Do people know what to do?

# Let’s ask them!

Thinking about taking blood transfusion samples from patients, please rate the following statements in order (*1 being most important, 5 being the least important)*

a) The patient must be comfortable before the blood sample is taken

b) The patient must be positively identified before taking the blood sample

c) The patient must understand the reason for the blood sample being taken

d) The patient details on the request form must be correct

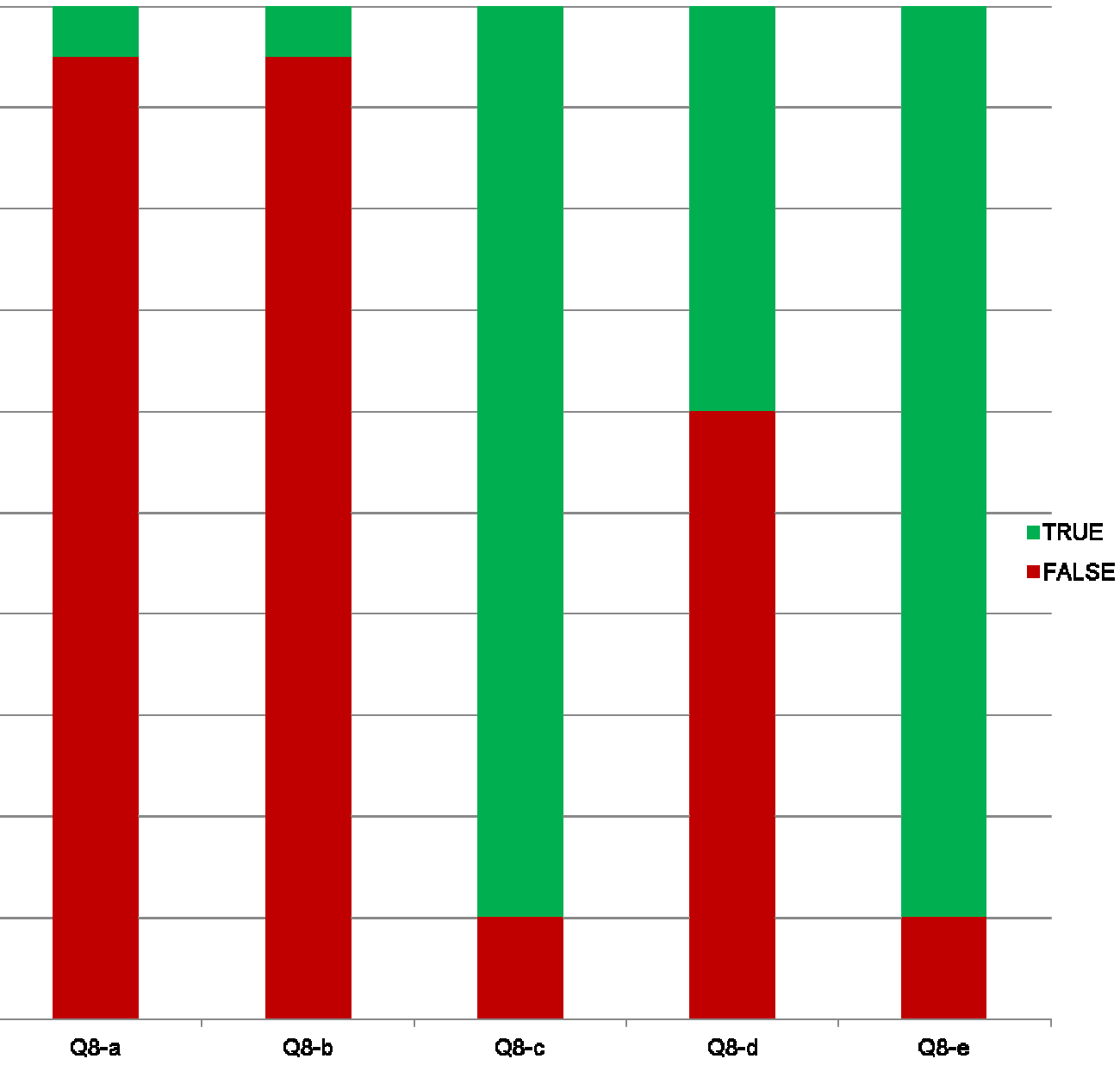
e) The patient must be wearing a wristband

# Results

| | | |
|---|---|---|
| 1 | b) The patient must be positively identified before taking the blood sample | **60% rated this as the most important** (30% said D, 10% said C) |
| 2 | d) The patient details on the request form must be correct | **50% rated this as the 2nd most important** (30% said E, 20% said D) |
| 3 | e) The patient must be wearing a wristband | **45% rated this as number 3** (20% said B, 20% said C, 5% said A) |
| 4 | c) The patient must understand the reason for the blood sample being taken | **65% rated this as number 4** (15% said E, 10% said A) |
| 5 | a) The patient must be comfortable before the blood sample is taken | **85% rated this as number 5 (10% said E, 5% said C)** |

# True or False?

| | | |
|---|---|---|
| **a)** The blood sample bottle can be labelled away from the patient so long as it is labelled from the request form and not the patient notes | TRUE | FALSE |
| **b)** If the information written on the sample bottle matches the Cerner printed wristband, the information on the request form doesn't have to match up | TRUE | FALSE |
| **c)** If a Cerner sample label is printed for blood transfusion samples it must not be used and the sample must be handwritten | TRUE | FALSE |
| **d)** If there is no wristband in place the blood sample can still be taken providing the patient can state their name and date of birth | TRUE | FALSE |
| **e)** The sample bottle should be labelled after the blood sample has been taken from the patient not before | TRUE | FALSE |

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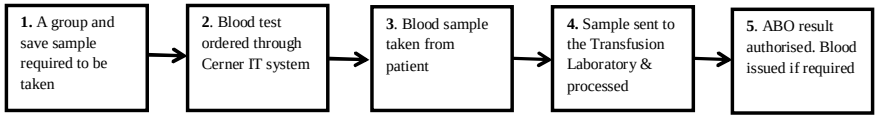
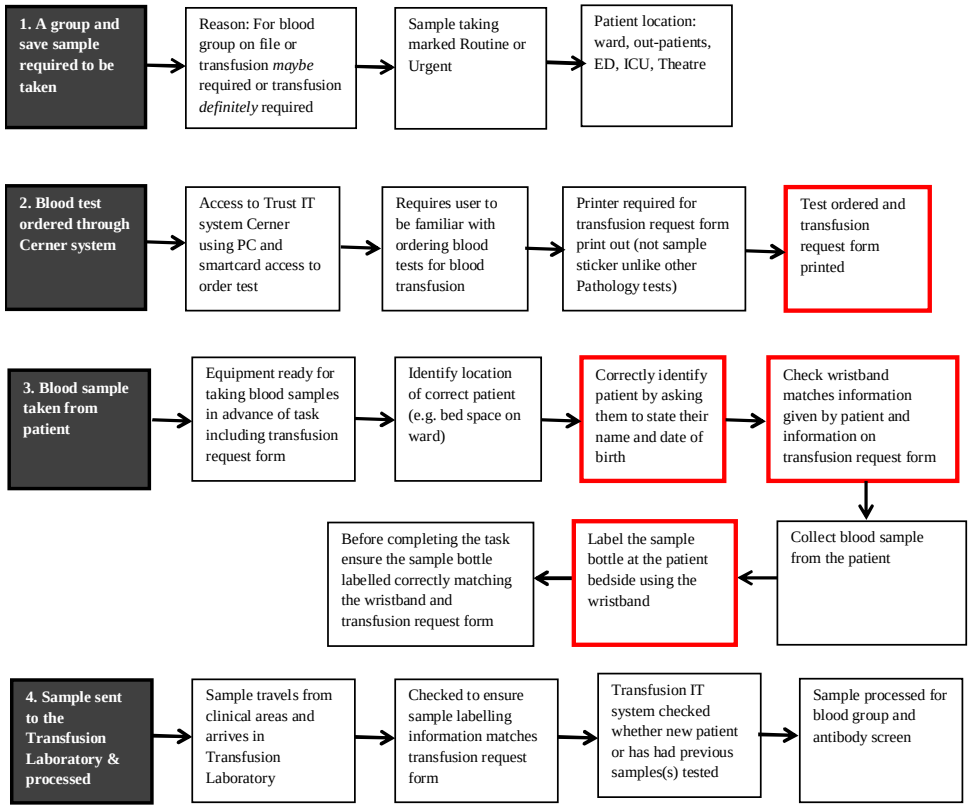
# Process Map

**OVERVIEW OF PRE-TRANSFUSION SAMPLE TAKING PROCESS**




**DETAILS OF PRE-TRANSFUSION SAMPLE TAKING PROCESS**

***Critical points highlighted in red boxes***



# WBIT Studies

- 2004 Murphy et al WBIT survey (UK) : rate varies from 1 in 1303 to 1 in 3448
- 2011 Ansari & Szallasi reviewed 5 years WBITs (USA): rate in 1 in 2283
- 2010 VIMA WBITs in ED using FMEA process and made 40 recommendations for improvement

# Human Factors

‘Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.”

*Ken Catchpole; CHFG*

# SHEEP

| S | H | E | E | P |
|---|---|---|---|---|
| Systems | Human interaction | Equipment | Environment | Personal |
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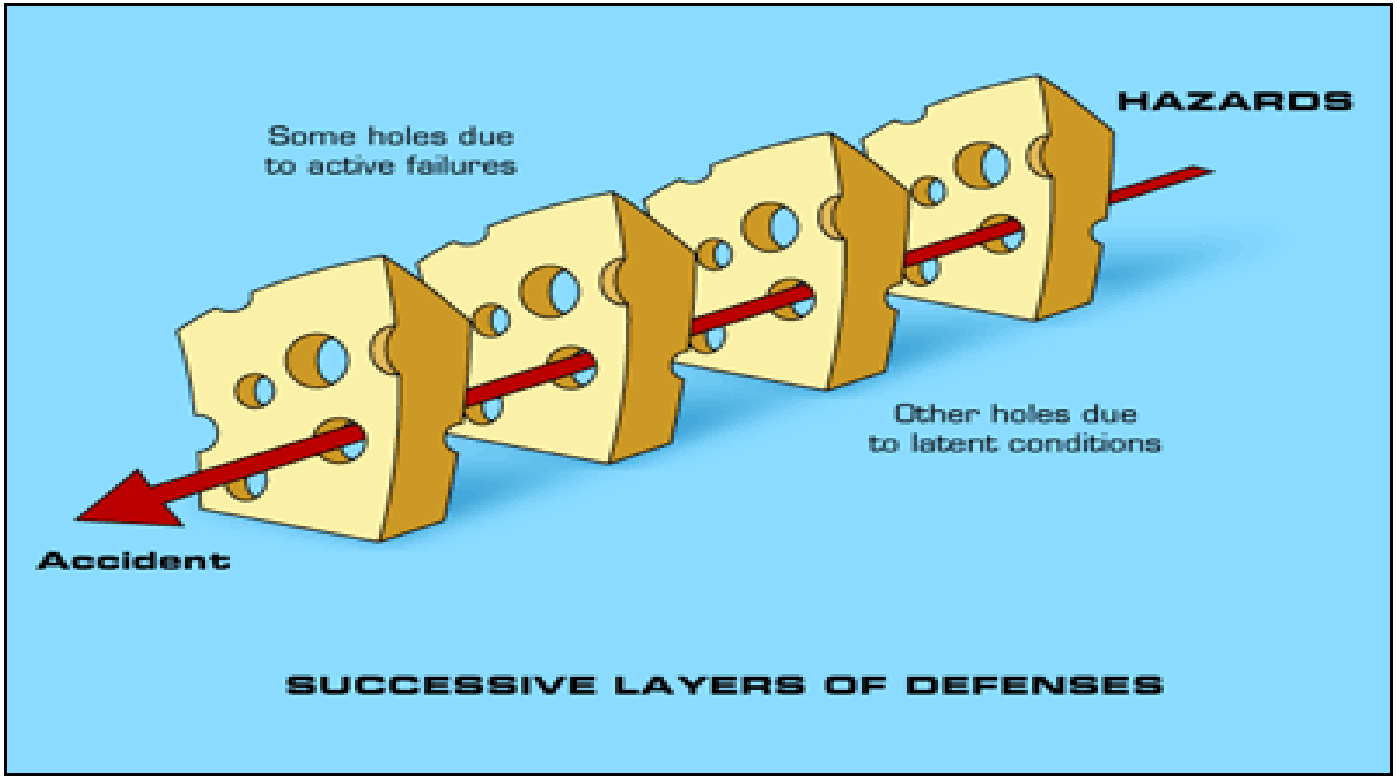
# SHEEP

| S | H | E | E | P |
|---|---|---|---|---|
| **Systems** | **Human interaction** | **Equipment** | **Environment** | **Personal** |
| Culture | Team dynamics | Equipment failures | Location | External influences |
| T systems | Conflict | Lack of consumables | Interruptions | Problems based on who you are |
| nformation flow | Leadership | User issues | physical | Pathology / physiology |
| Organisation flow | Behaviours of others | Non consumables (analysers, monitors) | Safety | Attitudes, behaviour, emotion |
| mprovement models | Communication | | Ergonomics | |

# Swiss Cheese

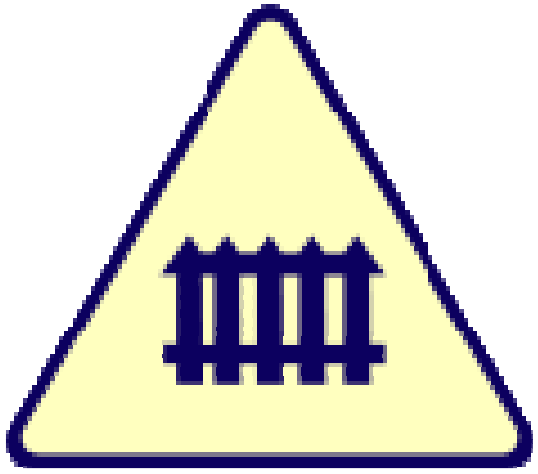



James Reason
1990

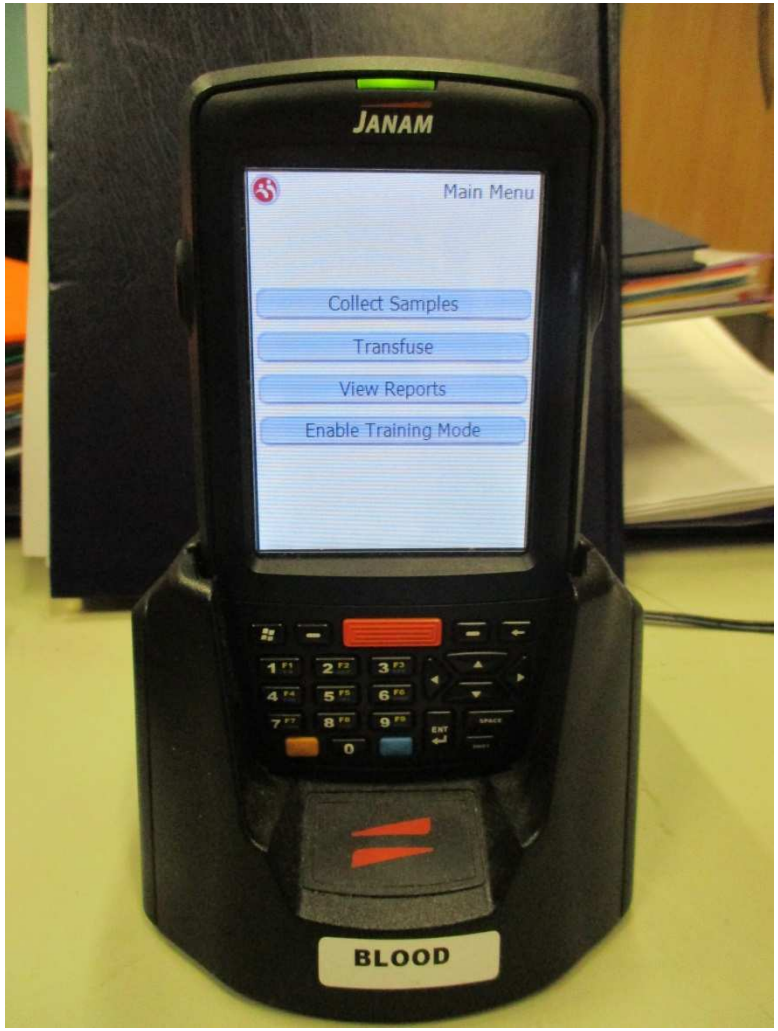
*When a combination of latent conditions and active errors causes all levels of defences to be breached a patient safety incident occurs*

# Barriers

- Swiss cheese shows we need barriers to prevent the continuum of the error
- BUT there is always a risk we add more barriers to prevent errors, make it a more complex system and people take short cuts and work-arounds
- Balance of complete safety versus pragmatic “real world”



# Barrier


JANAM
Main Menu
Collect Samples
Transfuse
View Reports
Enable Training Mode
BLOOD

NHS
Blood and Transplant

# Taking a blood sample for pre-transfusion compatibility testing

## REMEMBER:

### Positive patient identification

- The request form should be completed *before* you approach the patient
- Ask the patient to state their full name and date of birth
- Check the information given matches exactly the details on the patients ID band and request form
- In-patients must be wearing an ID band

### Sample Labelling

- Never pre label sample tubes
- Sample tubes should be hand written* by the person taking the sample before leaving the patients side
- Details on the sample tube should include surname and first name, date of birth and unique identification number eg hospital number or NHS number
- Only take samples from one patient at a time

BETTER BLOOD TRANSFUSION TEAM

**For further information please refer to your Hospital Transfusion Policy*

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version2 August 2012

# The End