**Wrong Blood in Tube (WBIT) events**

Wrong blood in tube (WBIT) errors, where the blood in the tube is not that of the patient identified on the label, may lead to catastrophic outcomes, such as death from ABO-incompatible red cell transfusion.

A Wrong Blood in Tube (WBIT) event can be defined as either:

* blood that is taken from the wrong patient and labelled with the intended patient’s details; OR
* blood that is taken from the intended patient but labelled with another patient’s details.

A WBIT can:

* go undetected and result in incompatible blood being transfused, which can be fatal
* have serious consequences for more than one patient
* impact other blood specimens collected with potential for incorrect results to lead to lack of, inappropriate or unnecessary care (e.g. investigation / management / treatment).

**Wrong Blood in Tube (WBIT) reporting**

Given the potentially serious outcomes listed above, it is important that all WBIT events be recorded on the Safety Learning System. The next page provides a standardised approach to logging all incorrectly labelled specimen incidents on SLS.

**Wrong Blood in Tube (WBIT) investigation and reflection**

In relation to any specimen labelling issues reported, the BloodSafe Program seeks, and values input from reporters and/or managers in providing further details to better understand the circumstances and improve patient safety. Labelling errors may often reflect greater system issues, and we seek to understand and improve these wherever possible.

The form on pages 3-5 has been developed by the SA BloodSafe program & is endorsed by Safety and Quality, SA Health. Its use is recommended to gain an understanding of circumstances that may contribute to Wrong Blood in Tube (WBIT) or other near miss events, determine root causes to improve patient safety and help you identify any gaps in your knowledge or practice. If you are given this form in relation to an incident you have reported and/or been involved in, please complete it and return it to your local BloodSafe nurse.

If you are from another clinical area and interested in following up non-transfusion related WBITs, please feel free to use/adapt the contents of the form applicable to your local setting with a reference as follows:

“The *contents/form/materials (as appropriate)* were originally developed by the SA BloodSafe Program and have been adapted for local use (with permission of the SA Department for Health and Wellbeing)”.

# Logging wrong blood in tube and other specimen labelling incidents

**Principle:**

To ensure a standard approach to logging all incorrectly labelled specimen incidents on SLS including wrong blood in tubes (WBIT), for transfusion & non-transfusion blood samples and other specimens.



|  |  |  |
| --- | --- | --- |
| Incident Details | | |
|  | SLS Number |  |
|  | Date of incident |  |
|  | Location  (area of incident) |  |
| 1 | **Designation** of collector | Phlebotomist  RN / RM  EN  Intern  RMO  Registrar  Consultant/GP Other: (indicate)…………………………………………….. |
| 2 | **Location of patient** where the specimen was collected | Ward inpatient  Day patient  Outpatient  Emergency  Delivery suite  NNU  Operating Theatre Other Dept: |
| 3 | **Type of Specimen** | Group and Screen  Antenatal  Neonatal blood group  Cord blood  Cord blood multiple birth (No:\_\_\_\_) |
| 4 | **Briefly describe the circumstances** leading up to the specimen being collected and labelled (i.e. working conditions, patient status): | |
|  | **PATIENT IDENTIFICATION** | |
| 5 | **When identifying the patient** did you:   * Ask the patient to **state** their full name and DOB?  Yes  No  unsure * Ask the patient to **spell** their full name?  Yes  No  unsure * **Confirm** the patient details with the ID band?  Yes  No  unsure  NA * **Confirm the child’s / patients details with carer/parent?**  Yes  No  unsure  NA   *Select ‘NA’ (not applicable), if policy does not require an ID band*  *to be worn e.g. Pathology Centre or home collection.*   * **Compare** the details on request form against the ID band?  Yes  No  unsure  NA   *Select ‘NA’ (not applicable), if hospital policy does not require*  *wrist band to be worn e.g. Pathology Centre or home collection*.  If you answered ‘no’ or ‘unsure’ to any of the above, please give details/rationale and indicate your usual practice. | |
|  | **SPECIMEN LABELLING** | |
| 6 | **When preparing** for specimen collection and labelling:   * Was the request form at the patient’s side?  Yes  No  unsure * Were the specimen tubes left UNLABELLED until  Yes  No  unsure   immediately after collection?   * Were specimen labels with patient ID taken to patient’s side?  Yes  No  unsure   Not applicable  (tubes were to be hand labelled)  If you answered ‘no’ or ‘unsure’ to any of the above please give details/rationale and indicate your usual practice:  Was anyone else involved in collecting or labelling the specimens?  Yes  No  unsure  If yes, how many people and describe the process:  *(please use additional page if necessary)* | |
| 7 | **Labelling process:**   * Were the tubes labelled immediately AFTER collection  Yes  No  unsure   BEFORE leaving the patient’s side?    If no, **when** and **where** were they labelled? Click here to enter text.  If no, is this usual practice in the work area?  Yes  No  unsure  Click here to enter text.   * Did you check that the details on the patient’s  Yes  No  unsure   ID band matched those on the specimen?  Not applicable  *Select ‘NA’ if policy does not require an ID band*  *to be worn e.g. Pathology Centre or home collection.*         * Did you check that the patient details on the  Yes  No  unsure   specimen matched those on the request form?    If you answered ‘no’ or ‘unsure’ to any of the above please give details/rationale:   * How was the specimen tube labelled?   Hospital addressograph labels  Pathology (EPLIS) specimen labels, printed with patient’s ID  Handwritten  Unsure  Other (comment): Click here to enter text. | |
|  | **BARRIERS/CONTRIBUTING FACTORS** | |
| 8 | **Please check/circle barriers** that may have prevented the correct procedure being followed in this case:  **Patient factors** e.g. language barrier, unconscious, special precautions, noncompliant  **Environment** e.g. lighting, no surface to label at patient’s side  **Distraction** e.g. multitasking, being interrupted  **Staffing** e.g. staff breaks, sick leave, patient to staff ratio  **Pressure** e.g. urgency, workload, stress, time pressures  **Staff communication**  **Equipment** e.g. insufficient blood collection trolleys, lack of collection equipment  **IT** e.g. lack of computers, printer not working, delay or difficulty in printing specimen labels  **Knowledge** e.g. unfamiliar with specimen collection, unfamiliar with printing specimen labels  **Education / training** e.g. not trained in specimen collection, not trained in using printed specimen labels  **Time** e.g. night shift, overtime  **Fatigue** e.g. overtime, no break  **Culture** e.g. local processes used to “streamline” or shortcut  Please provide further details and use the end of this page if more room is needed. | |
|  | **OPPORTUNITY FOR IMPROVEMEMT** | |
| 9 | **Will this event change** the way you identify patients in future?  Yes  No  unsure    **Will this change** the way you collect and label specimens?  Yes  No  unsure | |
| 10 | **Is there any other information** that you feel is important to consider in relation to this event or other similar events and how they are managed and prevented? Please use the end of this page if more room is needed. | |
| 11 | **What kind of education/information** have you received in relation to specimen collection and labelling?  Tick all that apply:  University  Simulation  eLearning  Ward in service  Colleague  Transfusion safety in-service/seminar  Phlebotomy course  Lanyard card  No education received  Other | |
|  | **On completion of this form**  **Please return it to: By:** | |
|  | ***For OFFICE USE ONLY***  ***Actions for the investigators for this Document:***  *Added to SLS report Date: Initial:*  *Emailed to line manager of person completing report Date: Initial:*  *Emailed to hospital BloodSafe transfusion nurse Date: Initial:*  *Emailed to hospital PBM/transfusion committee chair (BloodSafe nurse action) Date: Initial:* | |