Irish Blood Transfusion Service
Seirbhís Fuilaistriúcháin na hÉireann

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Review

Review: IBTS DOC REVIEW AND APPROVAL

Level	Owner Role	Actor	Sign-off By
1	DOCUMENT CONTROLLER	BECKY WHITE	BECKY WHITE
2	HAEMOVIGILANCE WRITER	CAROLINE CASEY	CAROLINE CASEY
3	HAEMOVIGILANCE REVIEWER	JOANNE SCANLON	JOANNE SCANLON
4	NATIONAL MEDICAL DIRECTOR	TOR HERVIG	TOR HERVIG
5	QUALITY ASSURANCE REVIEWER IBTS	BERNADETTE CASEY	BERNADETTE CASEY

Change Orders

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Change Orders - Incorporated

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TITLE: NATIONAL HAEMOVIGILANCE OFFICE GUIDANCE ON REPORTING WRONG BLOOD IN TUBE

Change Description:
Revise IBTS/HV/GDE/0001 to change ref to BT0471 and BT0472 to Near Miss Notification and Confirmation forms.

Reason for Change:
Forms are changed need to update to latest version

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Referenced Documents:
N/A

SmartTrain Roles

HV CO NBC	HV HVO NBC

Training Type

Staff trained in previous version	**New staff**
Read only	Procedural training

SmartSolve Document Category

Category	**Mobile**	**Cryobiology**	**Website**	**GDP**
Yes / No	No	No	Yes	No

National Haemovigilance Office

Guidance on

Reporting

Wrong Blood in Tube

Introduction

This purpose of this document is to provide HVOs and other hospital reporters with information on completing the **WRONG BLOOD IN TUBE (CLINICAL NEAR MISS) REPORT FORM (WBIT REPORT FORM).**

The editable report form is available from:
https://healthprofessionals.giveblood.ie/clinical-services/reporting-to-nho/wrong-blood-in-tube-clinical-near-miss-form.pdf

We hope this guidance document will assist you in completing the report forms. However, if difficulties are encountered while completing the form, do not hesitate to contact the NHO for assistance.

1. Completing the report form

This section is designed to aid hospital staff when submitting WBIT reports to the NHO. This report form is for collection of clinical near miss reports on WBIT. If the patient ***has been transfused*** please complete:

- Initial Report form - HV form 1 to report the event

  This editable form can be found on the NHO web pages:

  https://healthprofessionals.giveblood.ie/clinical-services/reporting-to-nho/initial-report-form-1-.pdf

WRONG BLOOD IN TUBE (CLINICAL NEAR MISS) REPORT FORM (WBIT REPORT FORM)

This form can also be found on the NHO web pages: http://www.giveblood.ie/Clinical_Services/Haemovigilance/Reporting_to_the_NHO/

- It is essential that **all relevant sections** are completed fully. If Not *Applicable,* write *N/A* in the relevant section. Omissions in form filling causes delay and information may be misinterpreted.
- The form should be completed and returned to the NHO as soon as possible after the occurrence of the event.

The following information is required when completing the WBIT report form

- Hospital name
- Unique Incident number is assigned by the reporting facility which we define as a numeric or alphanumeric identification code which is exclusive to that particular report. For many reporting establishments this can be a serial number, nonconformance number or similar identification. Please do not use the patient's medical record number or board number
- Age should be reported to the most appropriate denominator e.g. 46 years for an adult, or 8 months for a child, or 3 days for a neonate.

It is not required to calculate the patient's age in years months and days

Date and time error was discovered and date and time error occurred.

Nature of Incident

Wrong blood in tube' (WBIT) may be defined as events where:

1. Blood sample is taken from the wrong patient and labelled with the intended patient's details ('miscollected').
2. Blood sample is taken from the intended patient, but labelled with another patient's details (in other schemes 'mislabelled',)

Please note where a mismatch between the paperwork request form and specimen is not identified on receipt in the Hospital Blood bank *and*/*or* the patient has a previous history on the Laboratory Information system, the invalid sample is not identified, and subsequently processed – this now becomes a mandatory Near Miss SAE and should be reported accordingly:

Attachment 1: Near Miss Notification Form	HOSPITAL BLOOD BANK : NOTIFICATION OF A NEAR MISS SAE TO THE NATIONAL HAEMOVIGILANCE OFFICE
Attachment 2: Near Miss Confirmation Form	HOSPITAL BLOOD BANK : CONFIRMATION OF A NEAR MISS SAE TO THE NATIONAL HAEMOVIGILANCE OFFICE

These editable report forms are also available from: https://healthprofessionals.giveblood.ie/clinical-services/reporting-to-nho/near-miss-notification-form-copy-1.pdf and https://healthprofessionals.giveblood.ie/clinical-services/reporting-to-nho/near-miss-confirmation-form.pdf

Questions 3 and 4 ask for the blood group of the patient and the group of the component/s that could have been transfused.

Questions 5 and 6 ask if electronic systems are in use in your facility and if they were in use at the time of the event.

1.2 Discovery information (questions 7-11)

This section seeks details surrounding the *Discovery* of the error, it asks where, what, when and how the error was discovered in addition to who was involved in the discovery. Question 7 asks you to select from a list of specific descriptors, each of which is further broken down and which best describes what was discovered. Question 10 asks you to select at what step of the work process the error was discovered. Question 11 asks you to describe in free-text how the error was discovered e.g. errors can be discovered through routine haemovigilance audit, routine cross-checking of laboratory work on call.

1.3. Occurrence information (questions 12-17)

This section asks the reporter for details surrounding the actual O*ccurrence.* It looks at where and how the error occurred and who was involved.

Question 12 asks you to select the step in the work process where the error *first* occurred e.g. the first site of error.

Questions 13 ask where the error occurred and if there were any additional areas where a further error occurred.

Question 14 asks about the staff involved in the error. Multiple selections can be made here

Question 15 asks if the error was detected by a planned check step in the work process.

Question 16 and 17 are self- explanatory

1.4 Cause of error (Question 18)

The data you provide us with in question 18 is particularly important as this data may be used by the NHO to carry out a root causes analysis (RCA). An accurate RCA can only be carried out if all the details of *how and why* the error occurred (including contributory factors) are included. Contributory factors can be described as circumstances surrounding the event that you feel contributed to the error. Examples of contributory factors could include; short staffing, busy workload, lack of clear SOPs in place or lack of support from management for providing haemovigilance education & training. Providing a detailed

account of *what occurred* without details of *why* the error occurred will not enable a RCA to be carried out. RCA allows us to learn from error enabling improvements to be made, preventing future recurrence and improving the overall safety of transfusion.

Question 18 also asks you to select the cause / causes of the error from a list of human & system failures. Many events involve both human and system failures therefore multiple selections can be made here. If the cause of error does not appear on the list then 'other' should be selected and a brief explanation should be given.

The NHO has adopted the categorisation for human and system failures from the medical event reporting system for transfusion medicine (Mers-TM) these are outlined as follows;

Human Failure

- ***Verification:*** Errors which occur following incomplete assessment of a situation including related conditions of the patient / donor and materials to be used before beginning a task. Examples would be failure to obtain positive patient ID at the bedside, failure to verify most recent test results prior to prescribing and failure to verify current results against historical results where applicable.
- ***Knowledge:*** An error occurs when the individual is unable to apply their existing knowledge to a novel situation .examples would be a trained Medical Scientist who is unable to solve a complex antibody issue, or a trained nurse who fails to take into account the patient's blood group prior to commencing a transfusion.
- ***Co-ordination /Communication:*** An error occurs due to a lack of communication or co-ordination within a team for example where an intention to cancel a prescription is not communicated resulting in the patient receiving an inappropriate transfusion.
- ***Intervention:*** When error occurs due to faulty task planning and/or execution resulting in selection of the wrong rule or procedure. For example failing to adhere to policies / procedures correctly, or at all.
- ***Monitoring:*** Errors occur where there is a failure to monitor a process or patient status. Examples include; failure to monitor rate of transfusion leading to patient being transfused too quickly / slowly or a trained Medical Scientist operating an automated instrument and not realising that the pipette dispensing the reagent is clogged.

- ***Slip:*** Errors occur where there is a failure in the performance of highly developed skills for example e.g. computer entry error or simple mind slip leading to failure to complete a task.
- ***Trip:*** Failures in whole body movement, for example dropping a blood bag which splits and is wasted.
- ***Patient Related***: Errors which occur directly as a result of actions or characteristics of patients, and which are not within the control of the health care team. Examples include; where a patient gives wrong information about their patient details or where patients remove their own ID band.
- ***Unclassifiable:*** Errors which arise and cannot be classified in any of the current categories.

System Failures

- ***Design:*** Errors which arise due to inadequate design of equipment, software or materials e.g. design of workspace, software packages, or label design.
- ***Materials:*** Errors which arise due to deficits in materials e.g. defects in label adhesive, or ink smears on pre-printed labels or forms.
- ***Construction:*** Errors which occur following poor construction e.g. incorrect set-up of blood pumps / laboratory equipment or installation of equipment in an inaccessible area.
- ***Management Priorities:*** Errors which occur as result of organisational management prioritisation of other issues over safety e.g. decisions on staffing levels, limited or absent phlebotomy services, no provision for medical record numbers out of hours (Lundy et al)
- ***Policies and procedures;*** Errors which occur due to unclear / outdated or absent SOPs. Policies / procedures should be current, understandable well-presented and accessible to all staff.
- ***Culture***: Errors which arise from a collective approach to safety and risk. Groups may establish their own modes of function as opposed to following prescribed methods e.g. Not paging a manager / doctor out of hours to review a result /decision, as it is not usual practice.

1.5 Post Event Review (Questions 19-22)

Question 19-20 relates to action taken following the event. Details on any follow-up corrective and preventative action taken should be included here.

Question 21-22 relates the event review at hospital level

2. The Role of the NHO

2.1 On receipt of a WBIT report form

- On receipt of the *report* the NHO will review the information and enter this information in the haemovigilance database.
- A unique number, e.g. HV sequence number/year, i.e. HV/CNM/001/19 is assigned to the case.
- The HVO in the NHO may request further information.
- Following review, cases are closed and are accepted or not progressed.
- The HVO will send a letter confirming "close-out" of the report. This letter will inform the reporting hospital/HVO of the final disposition of the report.

2.2 Reports which are not progressed

Reports not meeting the criteria for reporting will not be progressed. This can occur following review of the report or following withdrawal of the report by the reporting facility. A letter informing the reporting hospital / HVO of this is sent by the NHO

3. References

Kaplan, H., Callum, J., Fastman, B. and Merkley, L. (2002). The medical event reporting system for transfusion medicine: Will it help get the right blood to the right patient? *Transfusion Medicine Reviews*, 16(2), pp.86-102.

Lundy D., Laspina S., Kaplan H, Rabin-Fastman, B. and Lawlor, E. (2007) Seven Hundred and Fifty-Nine (759) Chances to Learn a 3-year pilot project to analyse transfusion-related-near-miss events in the Republic of Ireland. Vox Sanguinis. 92(3), 233-41.