Healthcare Safety Investigation Branch

Wrong Patient Details on Blood Sample:

A Safety II approach to WBIT investigation

HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

I2019/003
Wrong Patient Details on Blood Sample

What HSIB does

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HEALTHCARE SAFETY INVESTIGATION BRANCH

- National safety investigation body for NHS in England since April 2017.
- Conduct thorough, independent, impartial and timely national investigations into clinical incidents
- Engage NHS staff, other medical organisations and patients and/or relatives in the investigation process
- Produce clearly written, thorough and concise reports with well-founded analysis and conclusions that explain the circumstances and causes of clinical incidents without attributing blame
- Make ***safety recommendations and safety observations*** to improve patient safety where appropriate

Reference Event

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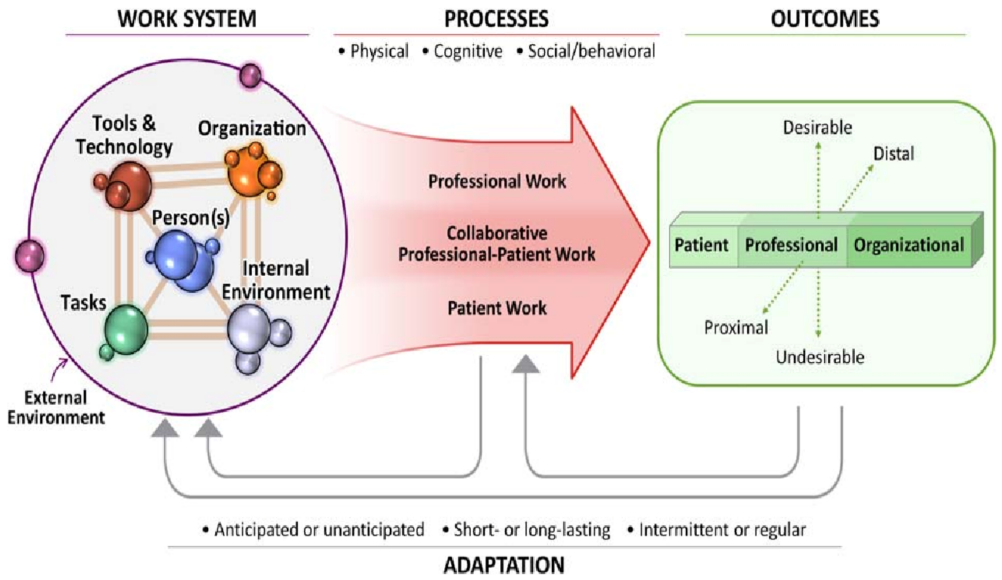
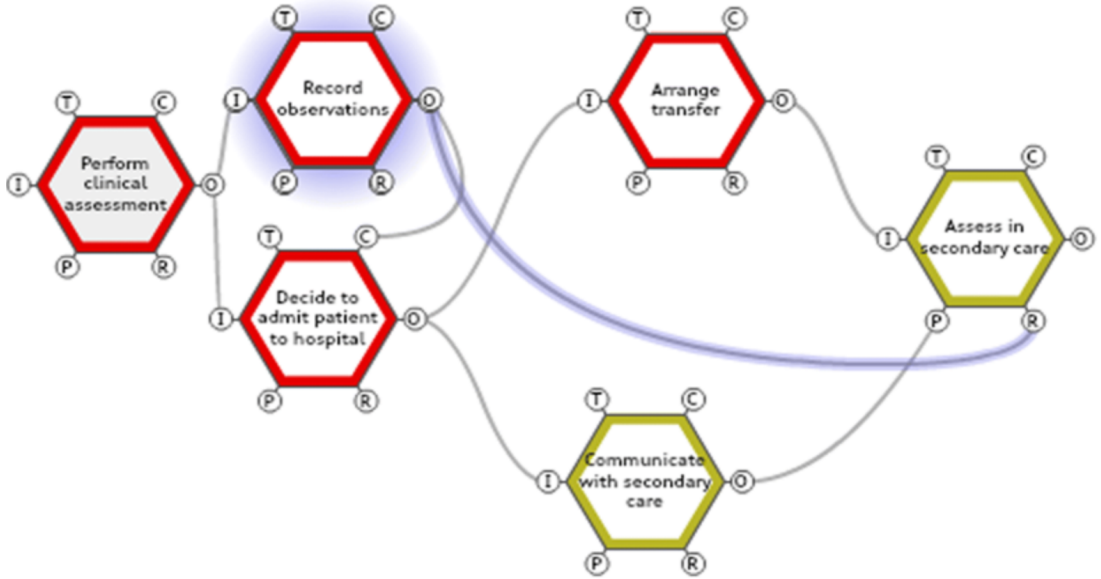
- HSIB received a referral from an NHS Trust in January 2019.
- Concerned about WBIT errors in its maternity unit.
- Most recent:
  - Midwife took blood samples from two patients during the afternoon of 28 November 2018; Patient A and Patient B
  - At 16:00 hours, bloods were requested for Patient A.
  - At 16:47 hours, bloods were requested for Patient B.
  - Both set of samples had been labelled with Patient A's details.
  - Testing by the lab confirmed that only one set of samples belonged to Patient A.

Investigation Models





Systems Engineering Initiative for Patient Safety (SEIPS)

- Most errors and inefficiencies in patient care arise not from the solitary actions of individuals but from conflicting, incomplete, or sub-optimal systems of which they are a part and with which they interact.
- Holden et al (2013)

Functional Resonance Analysis Method (FRAM)

- 'Resonance' arises from the variability of everyday performance.
- Identifies functional variability and resonance, and helps to identify unwanted variability
- Hollnagel (2012)

See: Pickup et al. (2017). Blood sampling - Two sides to the story

Reference Event

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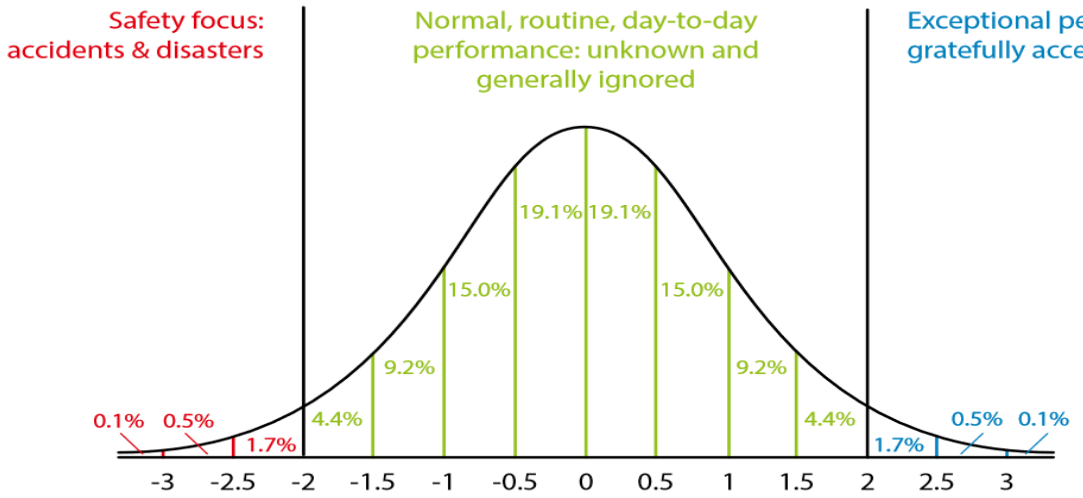
- Reference Trust couldn't understand why regular training had not eliminated the WBIT errors completely.
- However;
  - SHOT data suggests majority of WBIT errors reported by trained staff.
  - The impact of training on staff practice was not audited.
  - The investigation found blood sampling policy was not routinely followed in line with training.
  - Staff had to make adaptions to account for the challenges they faced in their environment.
- The investigation considered the wider challenges impacting on WBIT errors occurring.

Approach



Safety II

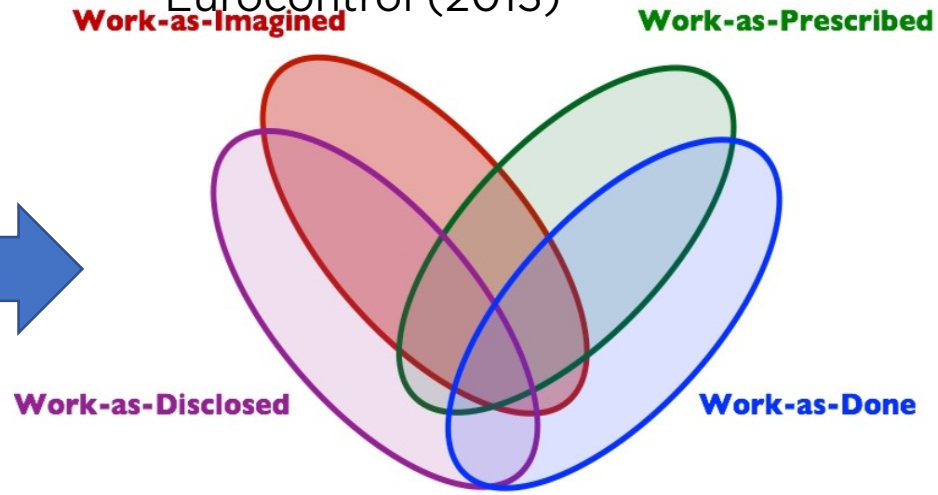
Safety II seeks to understand how normal or routine performance that accounts for the majority of clinical interactions usually results in things going right.

Eurocontrol (2013)

Varieties of Human Work

How we think work is carried out.
How we prescribe work is carried out.
What staff are willing to tell us about how work is done.
How work is actually done on the front line.

Shorrock (2016)



Findings

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The investigation highlighted challenges faced by staff in carrying out blood sampling. Examples include:

- Staffing: Only one midwife in triage vs two that were required
- Fatigue: Errors occurred in hour 31 of 34 hour; 3 day shift rotation
- Physical Environment: Distances the midwife travelled during a shift
- Equipment: Lack of IT support
- Labelling at the bedside: Psychological challenges

There was a gap between ‘Work as Imagined’ and ‘Work as Done’.

Staff routinely adapted to challenges ensure blood sampling went well.

Recommendation and Observations

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Recommendations

It is recommended that NHS X support the adoption and ongoing utilisation of electronic identification, blood sample collection and labelling systems in NHS trusts. .

Observations

HSIB acknowledges the work of SHOT in seeking to introduce and evaluate system level considerations in transfusion incident reporting. Wider NHS incident reporting may benefit from a similar approach in encouraging staff to identify and report system level factors influencing clinical incidents.

NHS organisations may benefit from the input of suitably qualified and experienced human factors specialists in developing, evaluating and reviewing services in addition to the positive role identified for patient safety specialists as outlined in the NHS patient safety strategy.

Highlights learning points for local trusts that may help in addressing WBIT errors.

Report

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26 September 2019

Available via: www.hsib.org.uk