1. Purpose

A 'Wrong blood in tube' (WBIT) error, is where a patient sample or specimen within the container (e.g. blood within the sample tube) is not that of the patient identified on the label. This may lead to avoidable patient harm or near miss events.

The Blood Sciences department of RUH Bath Pathology, consists of the sub-disciplines Biochemistry, Haematology, Blood Transfusion, Microbiology and Immunology. The Blood Sciences department is committed to providing the highest quality of patient care, through the provision of accurate laboratory examination results to the correct patient.

This policy states how the department of Blood Sciences is committed to ensuring patient safety by acting on incorrect patient results as a consequence of WBIT events external to Pathology and within the Hospital. This supplements the Pathology Quality Policy (Pathology QMS ref: POL/COMM/20) and is therefore being implemented as an integral part of the Pathology Quality Management System (QMS) and as a Trust policy.

2. Policy

Upon discovery of a WBIT incident, the Blood Sciences department must ensure that:

1. The details of the reporter of the incident (where possible, when the laboratory is notified by the responsible ward) are recorded, alongside details of the affected patient(s) where possible (name, hospital number, DOB and laboratory request number/s; as a minimum).

2. A Trust incident (Datix) will be raised for the attention and responsibility of the sample collection location, this must explain the details of the WBIT. A Datix enables investigation, corrective and preventative action by the ward responsible.

3. A WBIT non-conformance (CAPA – Corrective and Preventive Action) will be raised using the laboratory QMS software (Q-Pulse), the Datix reference number will be included in this record for traceability.

4. There may be other samples affected. These shall be subject to investigation before processing or releasing results (check date and times of sample collection). There will be cross-discipline communication as soon as an incident is noticed, so that other disciplines can commence their sample rejection processes.

5. Results will be removed from the Laboratory Information Systems (LIMS) and amended reports will contain explanatory comments stating the reason for removal of results. Clinical teams will be informed as appropriate.

The trending of WBIT incidents are monitored and presented at Pathology Clinical Governance and Risk Management meetings by the Quality Manager, they may be escalated further as required. These reports are used for safety and quality improvement purposes.

NOTE 1: Where the source of the WBIT relates to Primary Care or non-RUH Trust facilities, results will be removed from the LIMS and amended reports issued, as in step 5 above. These incidents are trended by raising an external incident CAPA only (Trust Datix will not be raised). The Quality Manager, Chief BMS or Duty Clinical Biochemist as appropriate will contact request locations to prompt local investigation and request details for completing the laboratory CAPA record.

NOTE 2: Local laboratory department SOP's should be used for the exact process of managing WBIT associated erroneous results and alerts held with various laboratory systems.