Life Blood Centre
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Life since 1978

41 Years in Blood Transfusion

Project 'Life'

A Temple of Humanitarian Services Since - 1978

Life Blood Centre

A Centre for Excellence in Transfusion Medicine

Dr. Spruha Dholakiya
Deputy Medical Director
dymd@999life.org
94280 03827

Dr. Sanjiv Nandani
Medical Director
lbc@999life.org
98253 14831

Joint Executive Trustee
savelife@999life.org

Wrong blood in tube (WBIT) - potential for serious outcomes: Can it be prevented?

WBIT error is caused by the drift from the basics : PATIENT IDENTIFICATION !

What is WBIT ?

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.

Factors Affecting WBIT ?

Human Errors	System Errors
ANXIETY	POOR P & P
FATIGUE	INADEQUATE EDUCATION
DISTRACTIONS	EQUIPMENT/SYSTEM ISSUES
STRESSFUL SITUATIONS	LACK OF STAFF SUPPORT
UNFAMILIARITY WITH TASK	

WBIT

How to prevent ?

Spcimen Collection :

Verify patient identity
Match ID band to specimen labels
Affix labels at bedside

Pretransfusion :

Two separate blood samples
Two witnesses at sample collection
Verify identity, affix labels at bedside

A	ASK Patient to state and spell their first and last names and Date of Birth	GET IT RIGHT THE FIRST TIME	A
B	BEFORE leaving the patient, LABEL the specimens.	GET IT RIGHT FOR EVERY PATIENT	B
C	CONFIRM the sample request form, the specimens and patient ID and detail match	GET IT RIGHT FOR EVERY PROCESS / PROCEDURE	C
D	DECLARATION-Document collector details, signature, date and time of collection on request form	GET IT RIGHT FOR EVERYTIME	D

References:

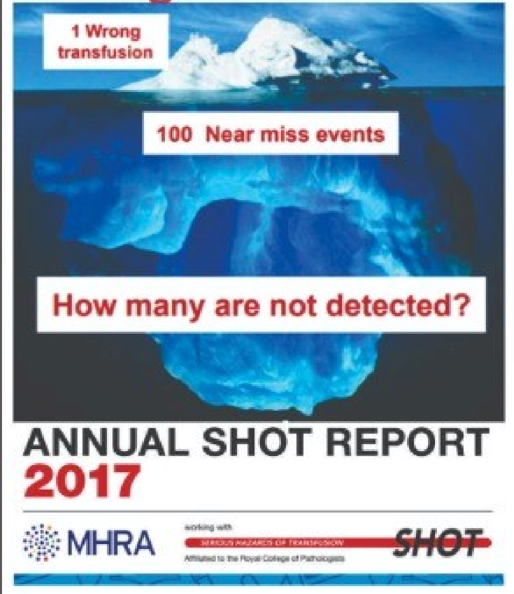
(1) PHB Bolton-Maggs (Ed) D Poles et al. on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group. The 2017 Annual SHOT Report (2018).

(2) BSH Milkins C, Berryman J et al. Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories. Transfus Med 2013;23(1):3-35. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3148.2012.01199.x/full [accessed 21 February 2018].

(3) Valenstein et al. Clin Lab Med 2004; 24:979-996

Serious Hazards Of Transfusion (SHOT) - U.K.

Review of near miss data by SHOT survey (2017) shows that these are the tip of a much larger iceberg.[1] Data for 2016 and 2017 show that although there were only 4 ABO-incompatible red cell transfusions, but 606 were near misses where an ABO-incompatible transfusion would have resulted. Most of these in 2017, 317/342, resulted from wrong blood in tube (WBIT) errors. These will not be detected unless there is a previous record in the transfusion laboratory and demonstrate the importance of the group-check policy[2] In reports of WBIT samples, the majority of institutions (77.4%) had this policy in place and 215 instances of WBIT were detected as a result of this.



The circumstances that lead to detection of a WBIT are mostly fortuitous. There is no quality system that can guarantee detection if a sample is from the wrong patient. If patients are not properly identified there is a risk of transfusion of a component that has not been fully matched, which might be ABO incompatible and cause death.[3]

NAT & X-Ray Irradiated blood units available at Life Blood Centre.