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Wrong Number On Tube

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Abstract: ***'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. Blood sampling from patients, whether in hospital or in the community, is a regular and important part of healthcare. Nevertheless, as with all interventions, it is not without risk. Correctly linking the blood sample to the patient from whom it was taken is fundamental. If the sample in the tube does not belong to the patient whose name is on the tube, and this is not detected, then many different consequences may follow.***

I. INTRODUCTION

Transfusion safety entails an entire vein-to-vein chain of events from adequate sample labelling, pretransfusion compatibility testing, suitable component issue to right blood administration to the patient.[1] Sample collection, handling/transport and completeness of the requisition form constitute important pre-analytical variables for quality assurance in Blood Transfusion Services.[2]

II. CASE REPORT

We have received sample of 1 male patient in AIIMS Bhopal blood bank who was admitted in Oncosurgery ward, which on blood grouping we got to know its A RhD positive. But the previous transfusion history of the patient revealed its a B RhD positive. On the telephonic conversation with on duty SR in oncosurgery ward, we communicated the same thing to them. We didn't proceed for cross match untill the blood group gets cleared. Hence, we demanded new fresh samples of patient and JR of our department went to Oncosurgery ward for collection of blood samples personally. After collection of samples, we did the blood grouping personally and with help of 2 other technicians to review the result. Result revealed B RhD positive which relates with the same blood group transfused in transfusion history. After communication with on duty SR in oncosurgery ward we arrived to result that there was sample change during the sample collection and sample of patient was handed to relative of another patient.

III. DISCUSSION

The UK SHOT scheme defines 'wrong blood in tube' (WBIT) (SHOT, 2012) as events where:

- ✓ Blood is taken from the wrong patient and is labelled with the intended patient's details (in other schemes 'miscollected').
- ✓ Blood is taken from the intended patient, but labelled with another patient's details (in other schemes 'mislabelled', but the term 'mislabelled' could include missing core identifiers or other errors which are not WBIT in SHOT).

The International Society for Blood Transfusion (ISBT) and International Haemovigilance Network (IHN) both use the term 'wrong name on tube' (WNOT), a definition restricted to samples for transfusion and includes 'all cases where a blood sample submitted for blood group determination, irregular antibody screen and/or compatibility testing was labelled with the identification details (ID) of another patient'. This is a problem which is ubiquitous and serious. It includes all events:

- ✓ Even if the error was detected by routine checks such as repeat blood group determination;
- ✓ Even if the error did not lead to an incorrect transfusion (for whatever reason);

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✓ Even if the patient sampled was not (imminently) scheduled for transfusion.'

WNOT may include ABO-incompatible transfusion or other instances where the patient received an incorrect blood component, as well as near miss incidents.

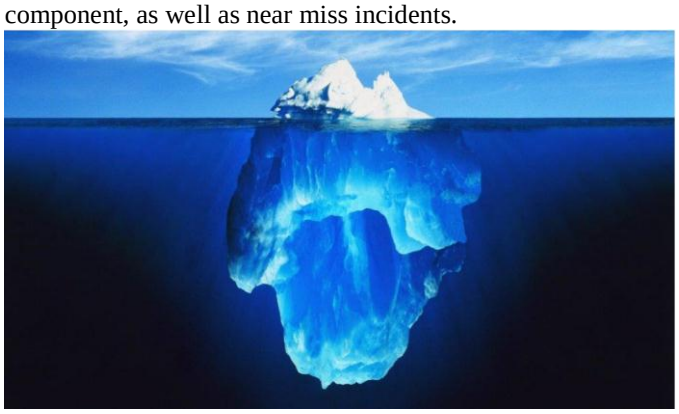

Figure 1

IV. CONCLUSION

The transfusion history mentioned in the form is very important as per the blood bank point of view. Sometimes it prevents serious transfusion related events if it is properly filled. In our case it was the same which helped us to have a doubt for the blood grouping. The main aim of this study was to evaluate the causes and sources of rejection of blood samples and blood component requisition forms for intended recipients at the Reception of Department of Transfusion Medicine & Blood Bank. Timely detection and feedback to the clinicians about inadequate/inappropriate samples/forms prevented serious transfusion related events.

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