HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

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SUMMARY REPORT

WRONG PATIENT DETAILS ON BLOOD SAMPLE

Healthcare Safety Investigation I2019/003

September 2019 Edition


HSIB
HEALTHCARE SAFETY
INVESTIGATION BRANCH

PROVIDING FEEDBACK AND COMMENT ON HSIB REPORTS

At HSIB we welcome feedback on our investigation reports. The best way to share your views and comments is to email us at **enquiries@hsib.org.uk** We aim to provide a response to all correspondence within five working days.

www.hsib.org.uk/tell-us-what-you-think

ABOUT HSIB

The Healthcare Safety Investigation Branch (HSIB) conducts independent investigations of patient safety concerns in NHS-funded care across England.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations we make aim to improve healthcare systems and processes in order to reduce risk and improve safety.

Our organisation values independence, transparency, objectivity, expertise and learning for improvement.

We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability to individuals.

OUR INDEPENDENCE

We are funded by the Department of Health and Social Care and sponsored by NHS England and NHS Improvement, but we operate independently.

Following recommendations from a parliamentary select committee in August 2018, we expect that a Bill for establishing the Health Service Safety Investigations Body (HSSIB) will be introduced to Parliament soon. The Bill will establish our full statutory independence and enshrine our right to conduct national investigations under protected disclosure. This provision, commonly known as *'safe space'*, enables staff to share their experience of a patient safety incident without fear of reprisal. It does not prevent us from sharing important details with families, regulators or organisations about an incident or to address immediate risks to patient safety.

The Health Service Safety Investigations Bill will also establish our responsibility for NHS maternity investigations that meet specific criteria. Full information about the draft Bill is available on the **Department of Health and Social Care website**.

OUR INVESTIGATIONS

Our team of investigators and analysts have diverse experience working in healthcare and other safety critical industries and are trained in human factors and safety science. We consult widely in England and internationally to ensure that our work is informed by appropriate clinical and other relevant expertise.

We undertake patient safety investigations through two programmes.

NATIONAL INVESTIGATIONS

Our national investigations can encompass any patient safety concern that occurred within NHS-funded care in England after 1 April 2017. We consider the requirement to investigate potential incidents or issues based on wide sources of information including that provided by healthcare organisations and our own research and analysis of NHS patient safety systems.

We decide what to investigate based on the scale of risk and harm, the impact on individuals involved and on public confidence in the healthcare system, as well as the potential for learning to prevent future harm. We welcome information about patient safety concerns from the public, but we do not replace local investigations and cannot investigate on behalf of families, staff, organisations or regulators.

Our investigation reports identify opportunities for relevant organisations with power to make appropriate improvements though:

- *'Safety recommendations'* made with the specific intention of preventing future, similar events.
- *'Safety observations'* with suggested actions for wider learning and improvement.

Our reports also identify actions required during an investigation to immediately improve patient safety. Organisations subject to our safety recommendations are requested to respond to us within 90 days. These responses are published on our **investigation pages**.

Find out more in the **investigations** section.

MATERNITY INVESTIGATIONS

From 1 April 2018, we became responsible for all patient safety investigations of maternity incidents occurring in the NHS which meet criteria for the **Each Baby Counts programme**.

The purpose of this programme is to achieve rapid learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change. For these incidents HSIB's investigation replaces the local investigation, although the trust remains responsible for Duty of Candour and for referring the incident to us.

We work closely with parents and families, healthcare staff and organisations during an investigation. Our reports are provided directly to the families involved and to the trust. The trust is responsible for actioning any safety recommendations we make as a result of these investigations.

We have been operating in all trusts since 1 April 2019. Our longer-term aim is to make safety recommendations to national organisations for system-level improvements in maternity services. These will be based on common themes arising from our trust-level investigations.

Find out more in the **maternity investigations** section.

EXECUTIVE SUMMARY

The reference event

A midwife was working within a maternity triage area. She was the only midwife on duty and was scheduled to work a 12.5-hour shift from 07:45 hours to 20:15 hours. During the afternoon the Midwife collected two blood samples; a sample from Patient A and a sample from Patient B. Both blood samples included a request that the laboratory perform an urgent full blood count[1], liver function tests[2] and a test for C-reactive protein[3].

Records show that the Midwife requested the blood samples for Patients A and B on the Trust's electronic system at 16:00 hours and 16:47 hours respectively. Both samples were collected by a porter and delivered to the Trust's laboratory for testing.

When laboratory staff received the samples they noted that both sets of blood samples had been labelled with Patient A's details, but one set had been sent with Patient B's blood test request form. A test of the blood samples confirmed that only one set of samples belonged to Patient A. Patient B's blood samples had been mislabelled with Patient A's details.

The national investigation

The Healthcare Safety Investigation Branch (HSIB) received a referral from an NHS trust that highlighted wrong blood in tube (WBIT) incidents that had occurred in the Trust's maternity unit.

WBIT incidents can occur when blood samples are taken from patients and are either miscollected (blood is taken from the wrong patient but labelled with the correct patient details) or mislabelled (blood is taken from the intended patient but labelled with the incorrect patient details) (Serious Hazards of Transfusion, 2018).

The Trust had 16 WBIT incidents in its maternity unit in 2017. In response to this the Trust had rolled out a comprehensive training package for staff. All staff had subsequently been retrained in blood sample collection. However, in 2018 the Trust had a further four WBIT incidents in the maternity unit.

HSIB commenced a scoping investigation. The scoping investigation focused on the most recent WBIT incident reported by the Trust. The investigation also evaluated information available to it on the other reported WBIT incidents in 2018 and carried out observations in a range of clinical areas within the maternity unit.

The findings were considered against HSIB's investigation criteria, and a decision was made to progress to a national investigation.

The investigation utilised a safety science approach to consider staff perspectives on blood sampling and labelling practice. The HSIB investigation aimed to highlight a range of local and national factors that may contribute to WBIT incidents occurring in acute hospitals.

Findings

- *'Work as done'* (what actually happens in the workplace) in blood sampling and labelling practice by clinical staff within health services may vary from *'work as imagined'* by policy makers (assumptions about how it is done).
- Staff are required to adapt their practice in blood sampling and labelling to account for the individual environments and circumstances in which they work.
- There is a risk that current systems that use labels and handwriting on blood samples are open to error induced by work environments.
- Current evidence supports that electronic systems can reduce WBIT incidents and improve efficiencies in blood sampling and labelling practice.
- A lack of suitably qualified staff increases workload, fatigue and the range of distractions in carrying out blood sampling.
- Longer shift patterns may negatively impact on patient safety and make it more likely that WBIT incidents will occur.
- The design of work environments can contribute to staff fatigue and impact on staff's ability to follow end-to-end processes effectively.
- Training is only one of multiple strategies required to address WBIT incidents occurring.

[1] A blood test that can be used to evaluate overall health and detect a wide range of disorders.
[2] Blood tests that provide information about the health of a patient's liver.
[3] A blood test that checks for inflammation in the body.

- Current incident investigations do not always address system-level factors influencing WBIT incidents or seek to understand why blood sampling usually goes right.

- Safety science and human factors methodologies can assist in understanding *'work as done'* and help to identify the necessary adaptations made by staff in local clinical environments.

Local learning for NHS trusts

The HSIB investigation identified local learning that may assist NHS trusts when considering how their own local blood sampling and labelling practices operate:

- Trusts can seek to understand *'work as done'* by staff and take a safety science approach when developing blood sampling and labelling policies.

- Trusts can aim to incorporate human factors thinking and awareness within incident reporting and investigation.

- Trusts should be aware of the increased risk of WBIT incidents occurring where there may be staff shortages and staff fatigue.

- Trusts can ensure that local policies and training on blood sampling account for the challenges posed by different working environments.

- Trusts can aim to understand the range of distractions staff face in different working environments and the compromises staff may have to make to deliver patient care.

- Trusts can optimise the availability, accessibility and usability of appropriate equipment used in blood sampling and labelling (for example: computer terminals, printers, bedside tables, sampling equipment, and that equipment is maintained).

HSIB MAKES THE FOLLOWING SAFETY RECOMMENDATION

Recommendation 2019/46:
It is recommended that NHSX should take steps to ensure the adoption and ongoing use of electronic systems for identification, blood sample collection and labelling.

HSIB MAKES THE FOLLOWING SAFETY OBSERVATIONS

HSIB acknowledges the work of the Serious Hazards of Transfusion scheme in seeking to introduce and evaluate system-level considerations in transfusion incident reporting. Wider NHS incident reporting may benefit from a similar approach that encourages staff to identify and report system-level factors that influence 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.

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FURTHER INFORMATION

More information about HSIB – including its team, investigations and history – is available at **www.hsib.org.uk**

If you would like to request an investigation then please read our **guidance** before submitting a safety awareness form.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

CONTACT US

If you would like a response to a query or concern please contact us via email using **enquiries@hsib.org.uk**

We monitor this inbox during normal office hours - Monday to Fridays (not bank holidays) from 0900hrs to 1700hrs. We aim to respond to enquiries within five working days.

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