<u>Steps to Investigate a Wrong Blood in Tube (WBIT) Incident</u>

The following toolkit will provide you with documents to support your investigation of WBIT incident. You will have already received your AEMS report notification to your email account.

1) **Review your AEMS report noting individuals identified in the incident.**
2) **To review the ordering pattern and information in PowerChart, please refer to Document A to obtain a clear picture of the incident and individuals involved.**
3) **Meet with the individual(s) and use Document B entitled "WBIT Investigation Tool template" to assist in identifying potential trigger points where the process was derailed. This will also assist you in identifying whether electronic equipment or availability of equipment may be an issue.**
4) **Use the poster (Document C) that is available in this package as an educational tool to highlight the issue on your unit. Schedule a time to bring this safety issue up at unit council, team/staff meeting, or imbed this information in a newsletter (ensure anonymity of both patient and staff involved in the WBIT incident). Build a culture of safety by encouraging staff to check in with each other e.g. "Hey Sandy, have you got the right labels for your blood draw?"**
5) **If you would like advice, input or support from Nursing Professional Practice, please contact Deb Karcz at Ext 74700 or at debbie.karcz@lhsc.on.ca If you require the assistance from a laboratory perspective, please contact Kathy Eckert, Blood Transfusion Safety Officer at Ext 55303 or kathleen.eckert@lhsc.on.ca**
6) **Close out your AEMS incident with the information you have obtained.**

This toolkit has recently been created based on previous WBIT investigations and findings in 2009-10. Please feel free to provide feedback to Deb Karcz or Kathleen Eckert on how this toolkit may have assisted you in the investigations or what would have made it easier or more effective for you?

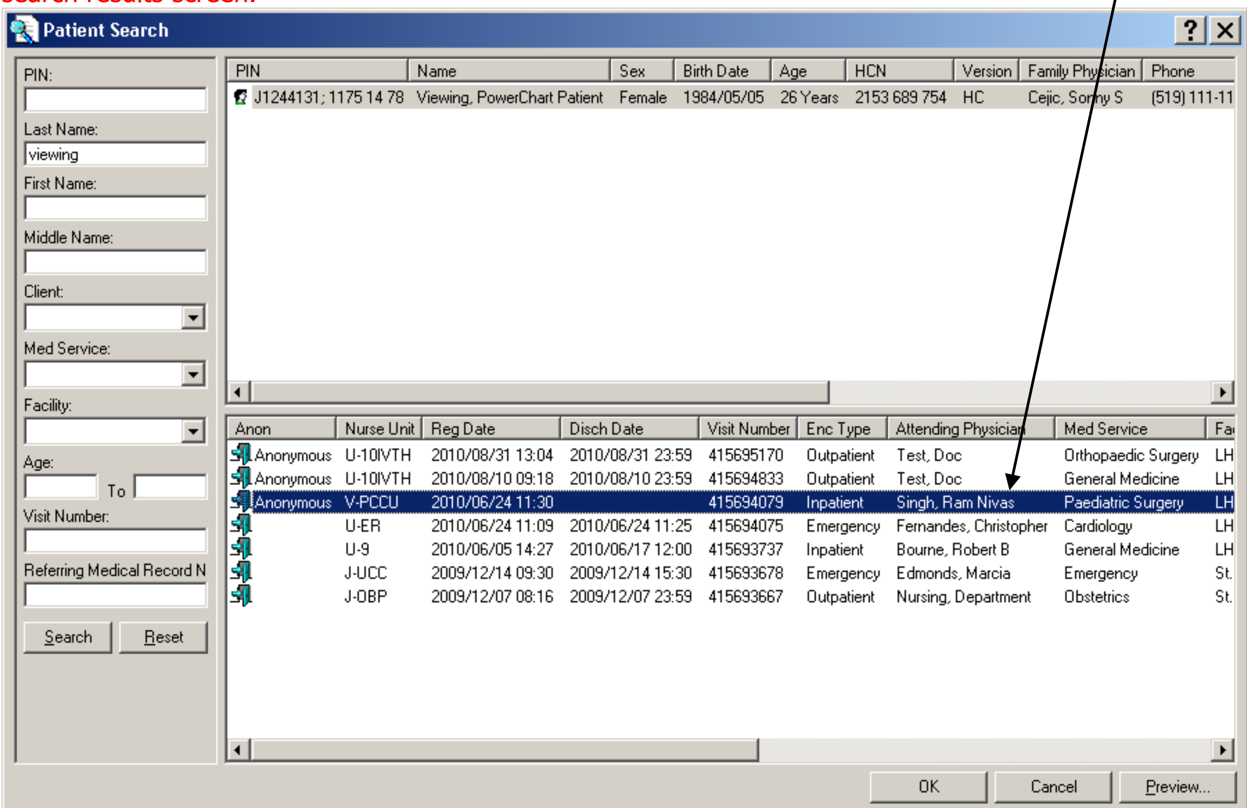
Thank you,

Deb Karcz
Professional Practice Specialist & Nurse Informaticist
Nursing Professional Practice

Kathy Eckert
Transfusion Safety Officer
Blood Transfusion Laboratory

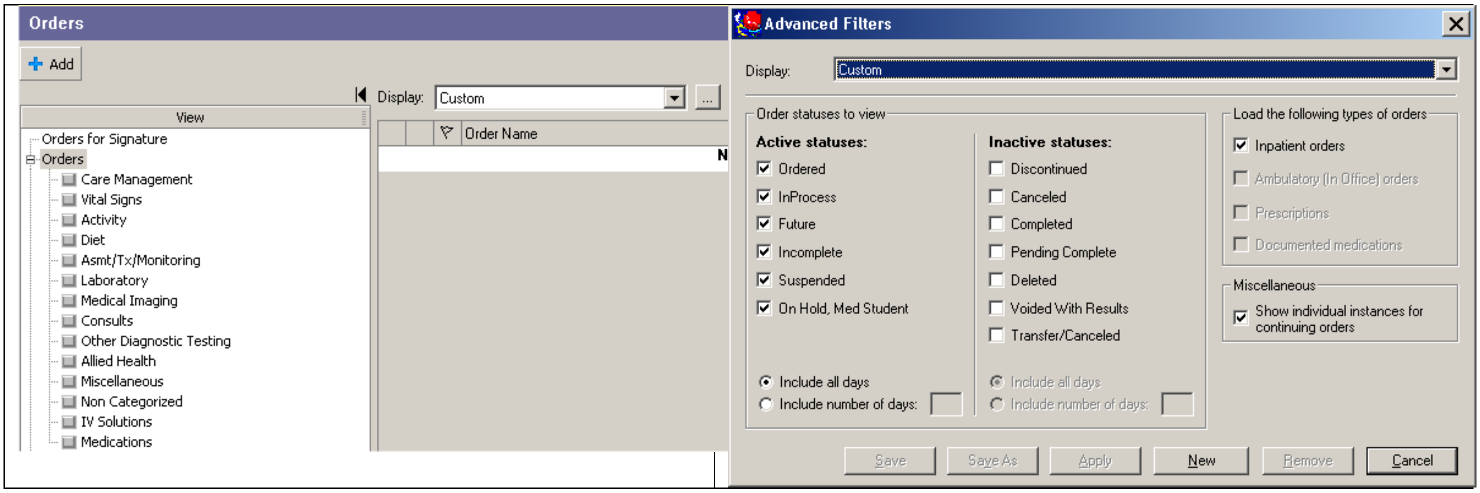
Document A
Steps for WBIT Occurrence Investigation in Cerner's PowerChart

1) When you are investigating a WBIT occurrence in PowerChart sign-in to PowerChart in the usual manner.
2) Open the patient chart either from a current nurse unit location list OR using one of the search options.
   NOTE: If you use the patient search, ensure that you select the correct visit from the encounter pane of the search results screen.



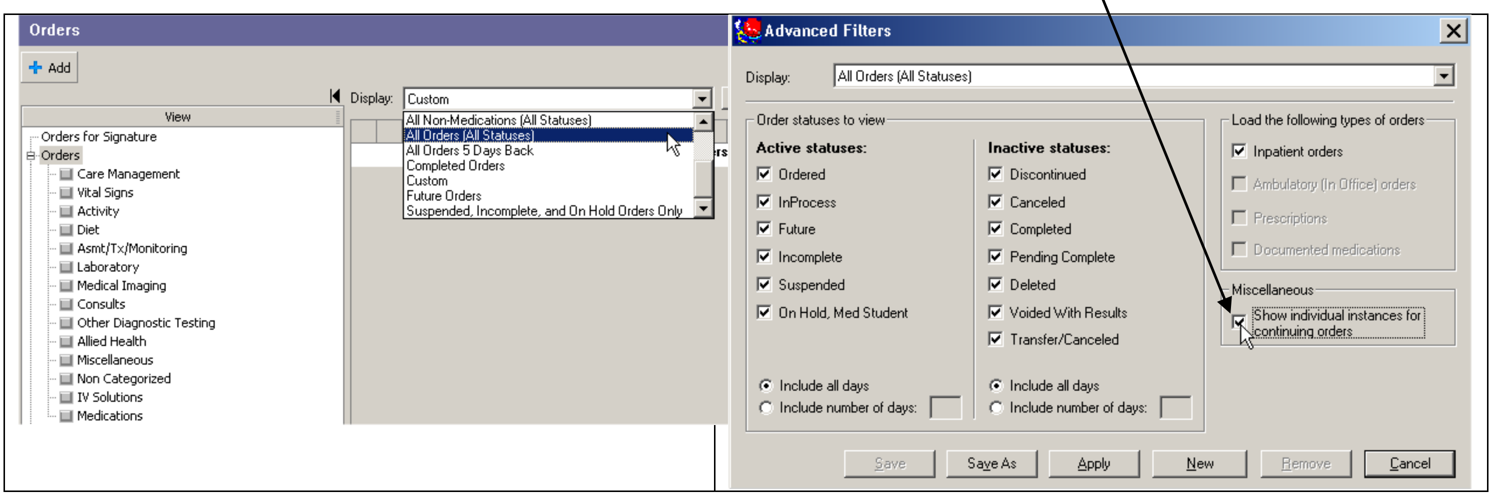
3) Once the patient chart is open, navigate to the "Orders" component on the Table of Contents.

4) The default view for the Orders screen is called "Custom". In this view, you only see active orders (Orders not cancelled/completed).

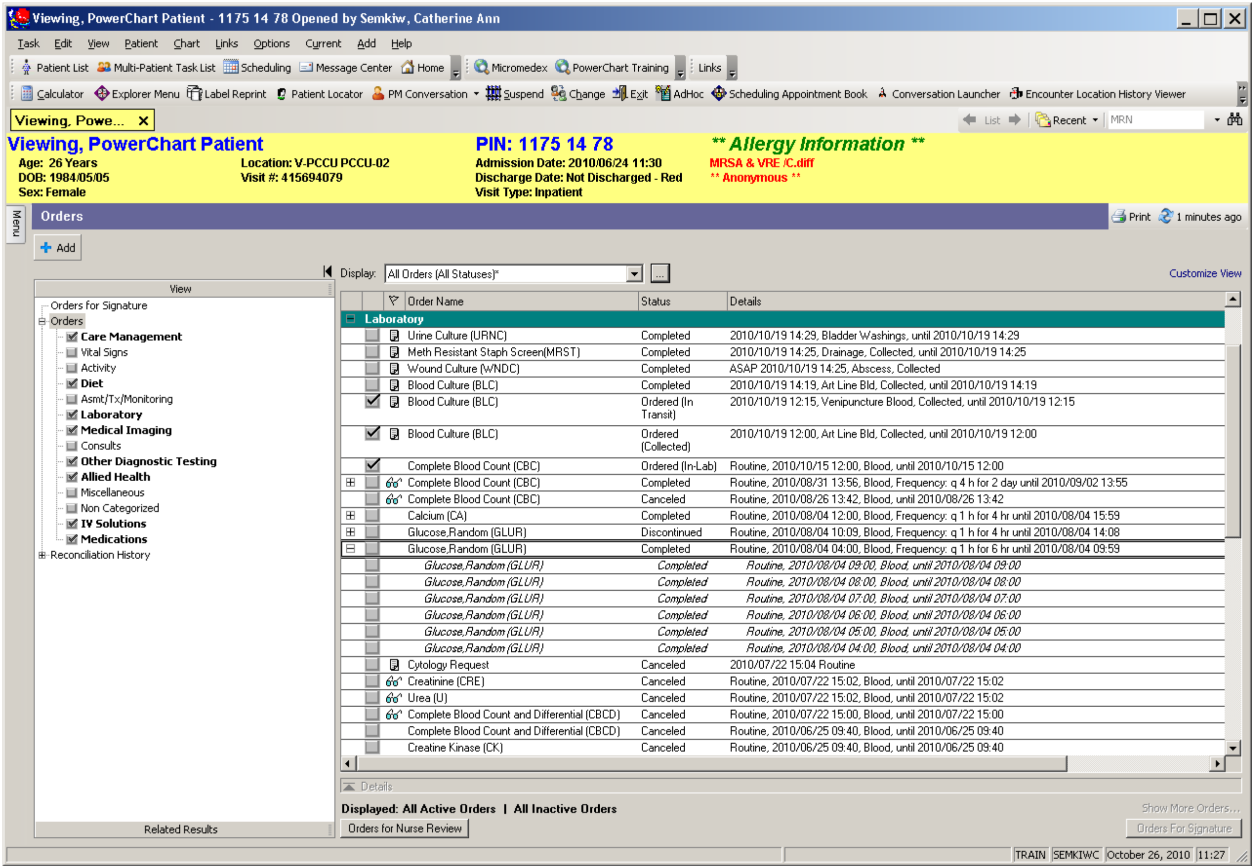


5) Since you will most likely be investigating an order/bloodwork that has been completed, you must change your view in order to display the completed order. To do this, click the drop-menu beside "Display" and select "All Orders (All Statuses). Once this view is selected, click on the ellipsis button to the right of the view. The Advanced Filters screen will display to validate that all available criteria has been selected.
NOTE: You must click in the box under Miscellaneous to "Show individual instances for continuing orders" in order to see each individual order that was placed using a frequency ie. Daily for 3 days.

6) Click <Apply> to return to the Orders screen.

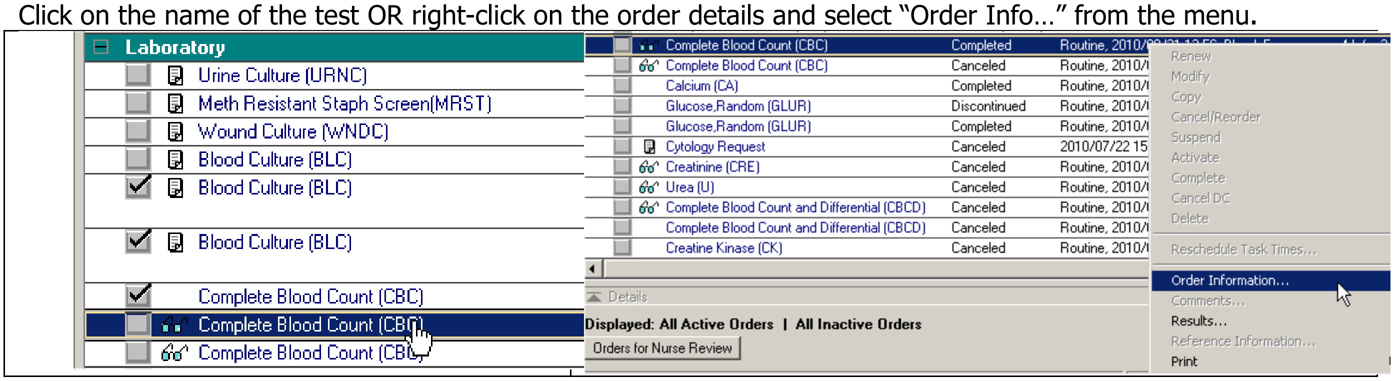


7) The Orders screen will display to show all orders for that patient visit. The "+" sign indicates a frequency order. You must click the "+" sign to show each individual order instance.

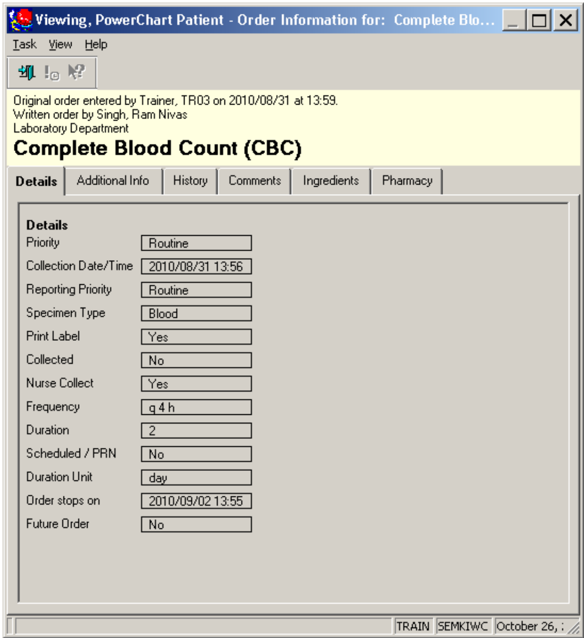


8) Scroll through the list of orders to find the order you wish to investigate.

9) Click on the name of the test OR right-click on the order details and select “Order Info…” from the menu.

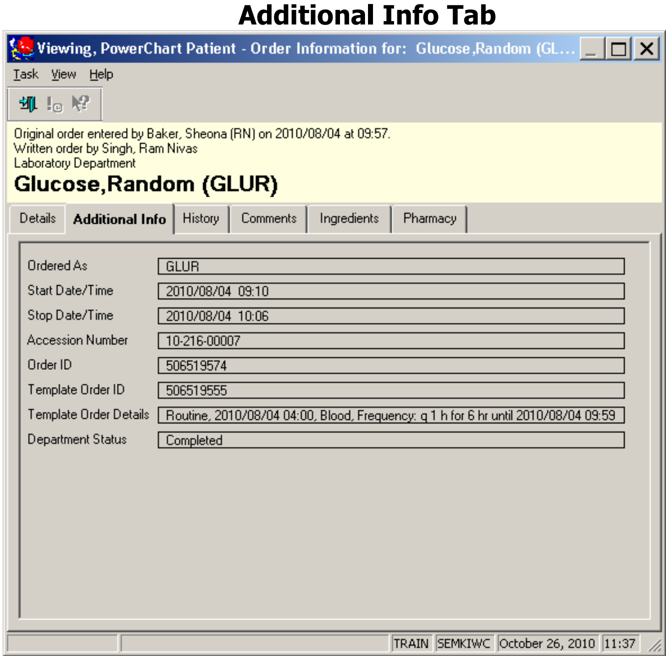


10) The Order Information window will appear.



11) Each tab provides different information about the order. The 2 tabs that provide all of the information you should need are the Additional Info and History Tabs.

Additional Info Tab



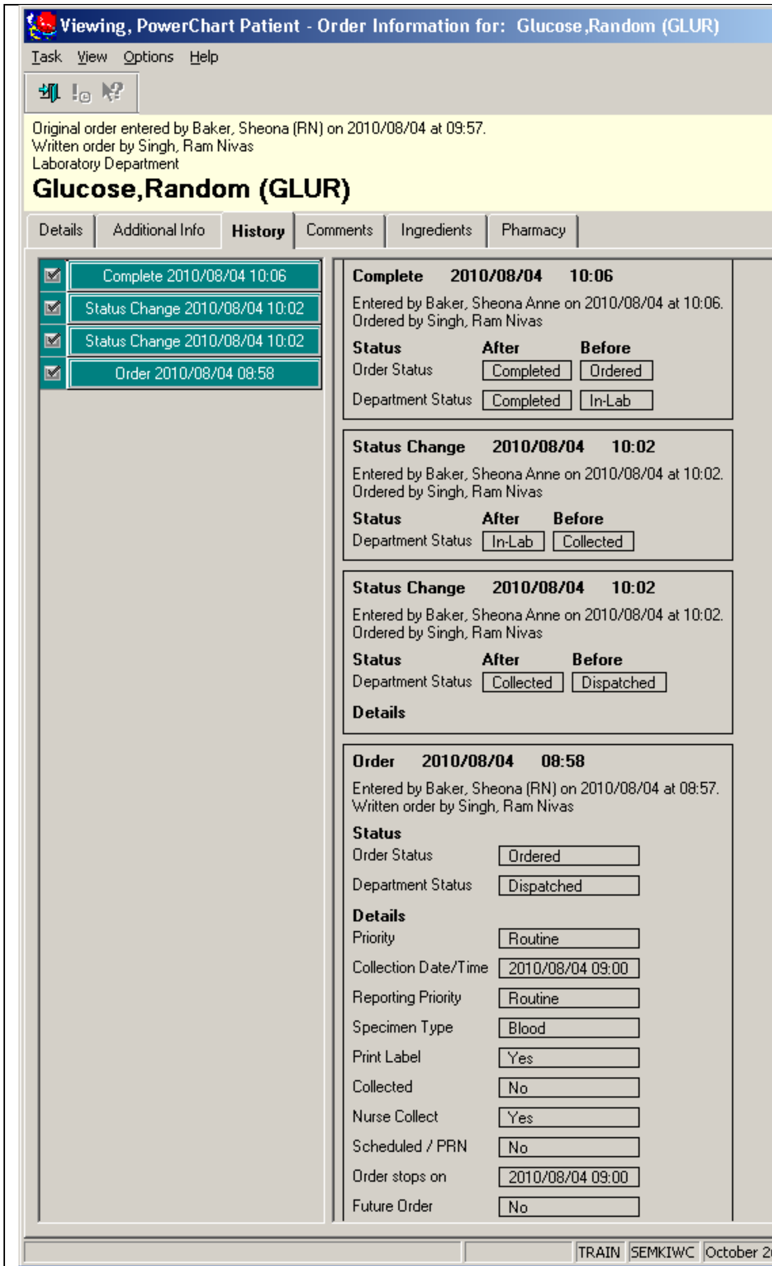
<u>Displays information about the order including:</u>
Ordered As - The name used to order the test
Start/Stop Date/Time for the order
Accession Number - Lab Tracking Number
Order ID – the database tracking number
Template ID – this appears if the order was placed using a frequency. This is the database tracking number for the frequency order.
Template Order Details – these are the order details completed when the order was placed as a frequency order.
Department Status – this is the current lab status for the order. time the ordering person

History Tab

This window displays information in reverse order, showing the first actions for the order at the bottom.

Scroll down the window to begin viewing the details for the order.

Order
Shows you the name of the person who entered the order, the date/time they actually click the "Sign" button and the physician it was attributed to.



It shows you the status of the order for PowerChart and for the lab.

It shows you all of the details that were completed when the order was signed.

Status Change

Each time action is taken against the order, you will see a Status Change, along with the name of the staff who changed the status.

In this example, the status changed from Dispatched (meaning a label has printed) to "Collected" and then to "In-Lab". This means a collected sample has arrived in the Specimen Receiving area and has been logged in using the collectors user name and has been routed to the appropriate lab for processing.
NOTE: You cannot see the name of the collector in PowerChart.

Once the sample has processed, the status changes to complete for both PowerChart and the Lab.

Investigation of WBIT Occurrences

Date of Occurrence:

How was occurrence discovered?

Date of Interview:

Location:

By BTL: ☐ **By patient care area:** ☐

History:

Additional Info:

Major Steps in the Process of Specimen Collection		Additional information on each step	Investigation Notes
1. Order tests in PowerChart / print labels	a.	Who is responsible for putting the order in PowerChart?	
	b.	How often would someone leave their log-in active when they leave the computer? Have you used someone else's logged-in session to order tests?	
	c.	If a unit clerk inputs the order, does an RN consistently do a "Nurse Review" of the order	
	d.	Where is the computer(s) located?	
	e	Where is the label printer(s) located?	
	f	In your opinion, in what % of cases is this the 1^{st} step of the process.	
2. Take labels to the bedside	a.	Who takes the labels off the label printer?	
	b.	Where are they put if specimens are not drawn immediately?	
	c.	Is it consistent with the workflow to bring labels to the bedside?	
	d.	What are the reasons why labels may not be taken to the bedside?	
3. Compare to patient armband	a.	Are patients armbanded?	
	b.	Is it common practice to compare label to armband?	
	c.	What are the reasons why armband is not used to compare to labels?	

	d.	How frequently would you be interrupted either when inputting the order or in the process of drawing the blood and labeling it?	
	e	Do you have any recommendations as to how this could be avoided?	
4. Take specimens	a.	Is it generally the patient's RN who takes blood specimens?	
	b.	Where are the phlebotomy supplies located?	
	c.	Is a cart, tray or basket used that can be brought to the patient's side?	
	d.	How do you dispose of sharps, if a sharps container is not brought into the room?	
	e	Do you routinely take extra tubes of blood in anticipation of future orders? If yes, where do you store them and how are they labeled?	
5. Label at bedside	a.	What work surface is used to place tubes and labels when drawing specimens?	
	b.	Are there any reasons why a specimen could not be labeled at the bedside?	
6. Print username, date/time on label (and sign – BTL specimens only)	a.	Can the completion of the label be done at the bedside?	
	b.	If no, why?	
7. Send specimen to BTL	a.	Who packages up the specimens to be sent to BTL?	
	b.	Are specimens sent by pneumatic tube or by porter?	

Coordinator:

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Participants:

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Additional Notes:

1.

Posted March 2011

2.

3.

4.

5.

Action Items or Recommendations:

1.

2.

3.

4.

Does your label match your patient?

You know your patient…

Misidentified patients can result in your patient receiving incorrect treatment

BUT…

Do you know your labels?

Mislabeled specimens can result in another patient receiving incorrect treatment

7 Steps to Successful Specimen Labeling

1. **Order test** in PowerChart
2. Take **labels** to **bedside**
3. **Compare** labels to patient arm (ID) band
   - when possible include patient in the identification process by asking them to confirm the spelling of their last name their date of birth
   - avoid questions that require a Yes/No answer (ie Are you John Smith?)
4. **Collect** specimen(s)
5. **Label** specimen(s) at **bedside**
6. **Complete** label - e.g. signature, user name, collection date
7. Place specimen(s) in designated biohazard transport bag, place requisition or collection label in separate pouch and send to lab

For additional information on specimen collection, view the on-line [Specimen Collection Guide]

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Authorized by: WBIT committee / Glen Kearns

Posted March 2011