“Patient identification errors in pre-transfusion blood sampling (‘wrong blood in tube’) are a persistent area of risk. These errors can potentially result in life-threatening complications.”

Oldham (2014).

Reference:
Oldham, J. (2014) Blood transfusion sampling and a greater role for error recovery. British Journal of Nursing. 23(8), Supplement, p.S28-S34.

Abstract:
Introduction: Patient identification errors in pre-transfusion blood sampling (‘wrong blood in tube’) are a persistent area of risk. These errors can potentially result in life-threatening complications. Current measures to address root causes of incidents and near misses have not resolved this problem and there is a need to look afresh at this issue.

Project purpose: This narrative review of the literature is part of a wider system-improvement project designed to explore and seek a better understanding of the factors that contribute to transfusion sampling error as a prerequisite to examining current and potential approaches to error reduction.

Search strategy: A broad search of the literature was undertaken to identify themes relating to this phenomenon.

Key discoveries: Two key themes emerged from the literature. Firstly, despite multi-faceted causes of error, the consistent element is the ever-present potential for human error. Secondly, current focus on error prevention could potentially be augmented with greater attention to error recovery.

Conclusions: Exploring ways in which clinical staff taking samples might learn how to better identify their own errors is proposed to add to current safety initiatives. Other intravenous and vascular access resources that may be of interest (External links – IVTEAM has no responsibility for content).

- Guide for intravenous chemotherapy and associated vascular access devices from Macmillan.
- CancerUK IV chemotherapy information.