140

2019

Study Title

Wrong Blood in Tube (WBIT)

Study Description

The goal of this study is to improve our understanding of WBIT risk factors and identifying opportunities to improve safety.
Study questions
Which hospital locations/provider types are most likely to collect a mislabeled (rejected) blood bank sample?
Which hospital locations/provider types are most likely to collect samples with WBIT errors identified during blood bank testing?
What factors in specific hospital locations (e.g. ePPID and ABO second sample requirements, use of centralized printing for sample label generation or pre-printed labels, use of rainbow tubes in the Emergency Department) are associated with higher rates of WBIT errors?
How often are WBIT events identified by provider alerts to the blood bank versus detected in the laboratory by serologic testing?
Among WBIT events detected serologically, what proportion were caught by an ABO second sample versus by due to a discrepancy with the patient's historic type?
Among WBIT events caught by a discrepancy with the ABO second sample, what was the proportion of WBIT events made on the original sample versus on the second ABO sample itself?
What is the most common WBIT type (Wrong patient drawn/intended patient label applied versus intended patient drawn/wrong patient label applied)?

Study Status

Completed

Publication Number

146, 149

Teams

CTS

Study Leaders

Dunbar, Kaufman