Wrong Blood in Tube (WBIT) events can lead to potentially incompatible blood transfusions as well as avoidable delays in care for patients. It is important that all WBITs are recorded on local Quality Management Systems. WBITs are also reportable to SHOT (The definitions and SHOT reporting criteria can be found [here](https://www.shotuk.org/reporting/)). Information gathered on this form could help identify contributing factors to the event and potentially prevent their recurrence. The sections below can be completed either electronically or by hand.

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| **INCIDENT DETAILS** |
| **Local incident number** | Click or tap here to enter text. |
| **MHRA/SHOT incident number** | Click or tap here to enter text. |
| **Patient hospital/NHS/CHI no.** | Click or tap here to enter text. |
| **Date of incident** | Click or tap to enter a date. | **Time of incident (24hrs)** | Click or tap here to enter text. |
| **Urgency of sample** | [ ]  | Routine  |[ ]  Urgent |[ ]  Unknown |
| **Designation of person taking the blood sample** |[ ]  Healthcare support worker  |[ ]  Phlebotomist  |[ ]  ODP  |
|  |[ ]  Registered nurse |[ ]  Locum/agency staff |  |  |
|  |[ ]  Registered midwife |[ ]  Doctor Please state grade Click or tap here to enter text. |
|  |[ ]  Other Please detail Click or tap here to enter text. |
| **Location of patient (where was sample collected)** |[ ]  Inpatient |[ ]  Day case patient |[ ]  Outpatient  |
|  |[ ]  Emergency Dept |[ ]  Delivery Suite |[ ]  Renal unit |
|  |[ ]  Paed /neonatal unit |[ ]  Community setting |[ ]  Theatre |
|  |[ ]  Other Please detail Click or tap here to enter text. |
| **Exact location of incident (for local reference e.g., ward X)** | Click or tap here to enter text. |
| **Sample taken for** |[ ]  Group & Screen (±crossmatch) |[ ]  Antenatal  |[ ]  Other Please detail below |
|  |[ ]  Cord blood testing |[ ]  Neonatal testing |  |  |
| **Select the primary error?** |[ ]  Patient not identified correctly at phlebotomy  |[ ]  Pre-labelled sample tube used  |[ ]  Other Please detail below |
|  |[ ]  Sample not labelled by person taking the blood  |[ ]  Sample not labelled at patient side  |  |  |
| **Select any additional errors?**  |[ ]  Patient not identified correctly at phlebotomy  |[ ]  Pre-labelled sample tube used  |[ ]  Other Please detail below |
|  |[ ]  Sample not labelled by person taking the blood  |[ ]  Sample not labelled at patient side  |  |  |
| **How was the error detected?** |[ ]  By the QMS prior to booking in/testing (Not SHOT reportable) |[ ]  Sampler called Transfusion dept |[ ]  Historical blood group mismatch |
|  |[ ]  At pre-administration check |[ ]  At collection from hospital laboratory |[ ]  Other Please detail below |
| **Please detail ‘Other’**Click or tap here to enter text. |
| **Briefly describe the circumstances leading up to the sample being collected and labelled** *(i.e., working conditions, patient status):*Click or tap here to enter text. |

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| **PATIENT IDENTIFICATION** |
| **When identifying the patient were the following steps carried out?** |
| **Patient asked to state their name and DOB?** |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| **Patient asked to spell their name?** |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| **Patient confirmed details with ID band?**  |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| **Carer/parent confirmed the patient’s/child’s details?**  |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| *Select ‘NA’ if policy does not require an ID band to be worn e.g., home collection, or where unable to confirm own details.* |
| **Compared request form / electronic order against ID band?**  |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| *Select ‘NA’ if policy does not require an ID band to be worn e.g., home collection.* |
| **Was electronic PID device used for patient identification?** |[ ]  Yes  |[ ]  No \* |[ ]  Unsure \* |[ ]  NA  |
| **\*If the answer is ‘no’ or ‘unsure’ to any of the above, give details/rationale and indicate usual practice.**Click or tap here to enter text. |

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| **SAMPLE LABELLING** |
| **When preparing for sample collection and labelling:** |
| **How was the sample labelled?** | [ ]  | Handwritten |[ ]  Label printed electronically |
| **Was the sample prelabelled with the patient’s details?**  |[ ]  Yes \* |[ ]  No  |[ ]  Unsure \* |
| **Was the sample label pre-printed?**  |[ ]  Yes \* |[ ]  No  |[ ]  Unsure \* |[ ]  NA |
| *NA if handwritten* |
| **\*Where selecting starred questions to any of the above, give details / rationale and indicate your usual practice:**Click or tap here to enter text. |
| **Was more than one person involved in collecting or labelling the samples?** |[ ]  Yes  |[ ]  No  |[ ]  Unsure  |
| **If yes, how many people and describe the process:**Click or tap here to enter text. |
| **Was the sample labelled away from the patient side?**  |[ ]  Yes  |[ ]  No  |[ ]  Unsure  |
| **If yes, when, and where were they labelled?** Click or tap here to enter text. |
| **If yes, is this usual practice in the work area?** |[ ]  Yes  |[ ]  No  |[ ]  Unsure  |
| **Where an electronic system has been used:** |
| **Can labels be printed remotely?** ***(Where systems allow labels to be printed remotely, there could be potential mix-ups with another patient’s labels and/or wrongly picked up by a staff member)***  |[ ]  Yes  |[ ]  No  |
| **Does it allow the patient to be selected from a list or drop-down menu?** |[ ]  Yes  |[ ]  No  |
| **Explain process further, where required:**Click or tap here to enter text. |

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| **BARRIERS / CONTRIBUTING FACTORS** |
| **Tick those that may have contributed to this error. NB this is NOT an exhaustive list, explain further below if required.**  |
| **Patient factors** e.g., language barrier, unconscious, special precautions, noncompliant |[ ]
| **Environment** e.g., lighting, no surface to label at patient’s side |[ ]
| **Distraction** e.g., multitasking, being interrupted |[ ]
| **Staffing** e.g., staff breaks, sick leave, patient to staff ratio |[ ]
| **Pressure** e.g., urgency, workload, stress, time pressures, rushing to finish task |[ ]
| **Staff communication** e.g., handover |[ ]
| **Equipment** e.g., insufficient blood collection trolleys, lack of collection equipment, insufficient scanners available to scan patient ID; scanners not working |[ ]
| **IT** e.g., lack of computers, printer not working, delay or difficulty in printing specimen labels |[ ]
| **Knowledge** e.g., unfamiliar with specimen collection, unfamiliar with printing specimen labels |[ ]
| **Education / training / competency assessments and updates** e.g., not trained or assessed in specimen collection, not trained, or assessed in using printed specimen labels, training incorrect |[ ]
| **Time** e.g., night shift, overtime |[ ]
| **Fatigue** e.g., overtime, no break |[ ]
| **Culture** e.g., workarounds or shortcuts in place |[ ]
| **Policies and SOPs** e.g., unclear, difficult to follow or outdated SOPs and policies |[ ]
| **Detail additional factors if required**Click or tap here to enter text. |

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| **WBIT FURTHER DETAILS** |
| Was the intended patient bled? |[ ]  Yes |[ ]  No |
| **Where ABO D group of the sample has been identified:** |
| Group of the patient who could have been transfused? |[ ]  A |[ ]  B |[ ]  AB |[ ]  O |
|  |[ ]  D-Negative |[ ]  D-Positive |
| Group of the component that could have been transfused? |[ ]  A |[ ]  B |[ ]  AB |[ ]  O |
|  |[ ]  D-Negative |[ ]  D-Positive |
| Could this have led to a potentially ABO incompatible transfusion? |[ ]  Yes |[ ]  No |
| Is the patient group complex due to transplant? |[ ]  Yes |[ ]  No |
| Does your organisation follow the ‘two-sample rule’ when issuing group specific units? |[ ]  Yes |[ ]  No |

**TRANSFUSION TEAM TO COMPLETE:**

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| **OPPORTUNITIES FOR IMPROVEMENT** |
| **Have improvements / actions been identified from this error? Have barriers and contributing factors from above been addressed?**Click or tap here to enter text. |
| **How are the improvements / actions being shared** **across the organisation?** E.g., sharing with practice development nurses, discussing at governance committees Click or tap here to enter text. |
| **Are there any future improvements you feel are important to consider in relation to this event or other similar events and how they are managed and prevented?** E.g., working towards new system, improving training packageClick or tap here to enter text. |

*Note: Adapted from the South Australian (SA) BloodSafe tool with permission from SA Health*

If you have any feedback regarding this form, please email SHOT at shot@nhsbt.nhs.uk.