

# NAP



The Newsletter of the National Association of Phlebotomists February 2013 Volume 13.1

A.G.M. 2013 – April 26th – see back page for details ▶▶

## Phlebotomy Based Sampling Errors

### Part 3 – The Theory Behind Human Error

by Roger Hoke

This third and final part of sampling errors looks at the part we play in producing them. Largely it is because we are human. Much has been published surrounding this and especially by James Reason who introduced his Human Error Theory some years ago. This has been used in industry for many years and is now firmly part of the National Patient Safety Agency (NPSA) Root Cause Analysis Tool Kit which is available on line. Hopefully, when we understand why things go wrong we are able to anticipate errors and implement systems or policies to guard against them.

Wherever possible these systems should have barriers or checkpoints which alert staff where failure is occurring. In phlebotomy, we have a number of these checkpoints such as when we ask the patient to tell us their full name and date of birth – checking these details against the ID band (in-patients) and/or request form and labelling sample tubes.

On the face of it, phlebotomy is quite

straight forward. We check we have the right patient, take the sample and label the tube. The problem is that we are human and we all have momentary *Attention slips or memory lapses*.

In one example, a nurse colleague admitted that she once sent a sample to the lab but had filled in her own name and date of birth on the tube. In another instance, a phlebotomist had correctly identified a patient, taken a sample but unknown to her, a junior doctor had discretely slipped another request form on top of the pile which were on the trolley immediately behind her in a side-room. When she came to label the samples, she was chatting to the patient and automatically copied the details from the added form to the sample tubes. Despite our best efforts, our performance is always subject to *influencing factors*. This can be greater whenever departments are short of staff and the workload increases. We must recognise that at these times the

requirement for vigilance may be even greater.

Whilst it is difficult to eliminate this sort of error, we must endeavour to limit them. It is up to us to recognise that whenever we are checking patients identities or labelling tubes we are performing a 'critical task' on which we need to follow procedure and concentrate. Don't allow colleagues to distract you and don't distract colleagues when they are performing these tasks. We should also forbid anyone to touch the phlebotomist's trolley. If further requests need to be made, they should speak to the phlebotomist personally.

Many hospitals are now using bar code technology as a means of eliminating simple and often avoidable errors. Unfortunately, they can cause errors of their own. In one instance, a phlebotomist had scanned the patient's ID band and the details were sent to the printer buffer or memory. Unfortunately, the phlebotomist was unable to obtain

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## Paediatric Venepuncture Training



**Aim:**  
To provide the underpinning knowledge and basic skills to safely perform phlebotomy on babies and children from 1 year.

- Objectives:**
- Identify the underlying issues in paediatric Phlebotomy. e.g. consent, restraint, distraction and environment
  - Identify correct equipment to suit patient and technique
  - Demonstrate basic techniques for obtaining blood samples
  - Discuss appropriate use of topical analgesia
  - To perform simulated phlebotomy in breakout sessions

**Dates for 2013**

Saturday 9th February 2013	Birmingham Children's Hospital
Saturday 23rd March 2013	Birmingham Children's Hospital
Saturday 20th April 2013	Birmingham Children's Hospital
Saturday 8th June 2013	Birmingham Children's Hospital
Saturday 7th September 2013	Birmingham Children's Hospital
Saturday 9th November 2013	Birmingham Children's Hospital

## Train the Trainer

**Aim**  
To provide an overview of various teaching methods, which can be effectively used to deliver the Phlebotomy Training Programme.

- Objectives:**
- Identify learning styles in individuals
  - Identify various teaching resources
  - Identify and discuss the appropriate use of various teaching tools
  - Identify and discuss the course criteria
  - To be able to formulate a teaching plan and present a five minute lesson
  - To critically assess and evaluate learning has taken place, by measuring candidate achievement against aims and objectives.
  - To be able to assess and record a candidates progress
  - Have individual course accredited by the NAP

**Dates for 2013**

9th & 10 February 2013	Telford, Midlands
21st & 22nd March 2013	Ashford, Middlesex (Near Heathrow)
4th & 5th May 2013	Telford, Midlands
22th & 23rd June 2013	Telford, Midlands
27th & 28th July 2013	Telford, Midlands
14th & 15th September 2013	Telford, Midlands
16th & 17th November 2013	Ashford, Middlesex (Near Heathrow)

## A.G.M. 2013

**Safety  
Safety  
Safety**

is the theme for NAP's 2013 AGM & Conference.

Please join us for the **AGM** at the **Whitehouse Hotel, Telford, TF12NJ** (see [www.whitehousehotels.com](http://www.whitehousehotels.com) for easy travel directions)

on **Fri 26th April** followed by a networking evening, and **Conference** on **Saturday 27th April**

**Speakers**

- DOH representative on Career Pathways Bands 2-5
- Safety Legislation
- Stem Cell Collection
- Phlebotomy where can it lead?
- And more!

Visit exhibitor stands and enjoy the opportunity to meet with like minded professionals!

**Cost:**  
**Friday and Saturday:** £100 inclusive of Dinner and Bed and Breakfast.  
**Saturday only:** £50 for attendance to the conference.

Costs are subsidized, so book early to make use of the 2 day offer as there are limited spaces.

To reserve places on courses or at AGM please email Jacqui Hough on [phlebotomy@btinternet.com](mailto:phlebotomy@btinternet.com) - visit the website [www.phlebotomy.org](http://www.phlebotomy.org) for a booking form or follow the PayPal link (live shortly!)

**Phlebotomy Based Sampling Errors Part 3 – by Roger Hoke . . . . .**

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a sample and marked the form for the doctor to do. She went to her next patient, successfully obtained a sample and printed out labels. Unfortunately, these were for the previous patient that she couldn't bleed and the sample was mislabelled. The phlebotomist hadn't encountered this before and placed her trust in the machine. Even when using automated technology, we still need to be alert and check.

Occasionally, we make what is usually described as a mistake. This can take the form of a **Rule Based Mistake** where a familiar situation arises but the phlebotomist fails to apply the correct solution to the problem. This may either be due to misapplication of a good rule or the application of a bad one (Reason 1993). A Bad Rule is one that cannot be applied to all situations. This can occur where policies and procedures are written by staff whose skill is outdated or experience limited.

Errors can also occur as **Knowledge Based Mistakes**. These occur where the phlebotomist encounters a situation where their training or knowledge fails to provide the correct rule-based solution. Consequently, any on-the-spot decision is made without the specific knowledge required.

An example may be where a phlebotomist is asked to take blood cultures but has never been shown the hospital's procedure. As a result she takes the samples in exactly the same way as she would any other.

Some errors are caused by **Violations**. These are the most serious as they are always intentional. Often these are the frequently performed short-cuts. Sometimes, they can form departmental routine. Everyone knows what they should do but unfortunately an attitude of "We always do it this way" prevails.

Deliberately breaching any rule is a violation.

An example is that everyone within St. Elsewhere's Phlebotomy Department knows that they should prep the skin for 30 seconds and allow it to air dry for a further 30 seconds but no one does. Sometimes there is an element of reasoning behind the actions such as saving time or saving the department money. Current pressure to reduce costs doesn't help. Occasionally, it may be argued that it is better for the patients. If this is believed to be the case, we have a duty to report our findings for the hospital to consider and amend its policy or procedural guidelines.

Although some of these violations are indeed reckless in their nature, with the exception of malicious violations, importantly, harm is never intended.

What can we do then to ensure we practice safely and deliver quality samples time after time? Perhaps a start would be to read all policies and guidelines that are relevant to your role –especially if they have recently been amended. Take ownership of your phlebotomy policy and query any areas which aren't absolutely clear.

Comply with policies and identify the critical checkpoints and beware of influencing factors. Being busy should make you even more vigilant. Remember, in some cases, there are several errors by a number of individuals. It starts with an attention slip, a mistake by someone else, a violation by another and so on. If ever you are in doubt about a sample, report it and re-bleed the patient.

**Guidelines and rules are created by those who foresee the pitfalls to protect those who don't.**

Hoping you all have a very happy and successful 2013.  
Roger Hoke.

## What is the DOH (MSC) doing for Band 2 - 4s ?

### Modernising Scientific Career - Education Plan

There is now an (almost) final draft framework of modules for Apprenticeship, Advanced Apprenticeship, Higher Apprenticeship 4, which will develop staff through from Band 2 to Higher Apprenticeships.

Each apprenticeship will consist of a Technical Certificate (Core plus Themed modules and knowledge based) and a Competence Certificate (functional Category modules and QCF Diploma at relevant level). All qualifications will be underpinned by the Personal Cognitive and Professional framework which is linked to Good Scientific Practice and the Professional skills module.

There will also be awarding body(ies) established to oversee assessment for the Apprenticeship framework.

I have seen draft modules and am excited about the flexibility this scheme of learning will provide professionals whether they are working as a Phlebotomist, MLA, Scientist, HCA or any other role within Healthcare that requires venepuncture skills.

These are interesting times so keep in touch. Shirley Fletcher who is heading this project for the DOH will be speaking at our Phlebotomy Conference on April 26.

Jacqui Hough

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# Life after Train the Trainer

Kirsty Shanley  
Community Phlebotomist

**I have always had an interest in venepuncture. I started performing venepuncture about 10 years ago and immediately enjoyed the variety and skill of the job, I worked hard to perfect my skill.**

I undertook an assessor A1 award about 5 years ago which gave me the opportunity to help assess up to level 3 NVQ Health and Social Care, I would also teach very small groups. It was through this work that I found my passion for teaching began. I was running at least 4 phlebotomy clinics a week and I had seen many old bruises and heard many horror stories from patients in my clinics who had previous bad experiences with venepuncture. I lost count of the number of times I listened to patients telling me they dreaded going for a blood test because the phlebotomist "could never get the vein".

I decided that I would love to train students to perform venepuncture safely and competently. I contacted the National Association of Phlebotomy who were really helpful. I enrolled on the

next available course which ran over two days. It involved a whole day of theory work including teaching methods, how to write lesson plans, how to keep the interest of students and how to assess what your students have learned. The next day we had to give our group a short 5 minute teaching session. I really enjoyed it and I couldn't wait to get started.

Once I had completed the course I got to work straight away on my own lesson plans and power point presentation. I thought hard about what I wanted to teach, how I wanted to teach it and the most exciting and varied ways of teaching it. I finally ended up with a lesson plan for a whole day session. It includes a power point presentation including photographs, group participation and short videos. I finish the theory session with a short quiz to see how much my students have learned. I then have a practical element to the session where we use ACF pads and can use a variety of blood collection equipment to obtain (fake) blood.

I always encourage my students to bring along some of the equipment they use in practice, but I have my own equipment too so we can practice using a variety of different methods. I bring along vacutainer, monovette, needle and syringes, and butterfly needles. I stress the importance of a safe technique and make sure that each student can demonstrate this before they leave.

After each session I ask the students to complete an evaluation form. It is very important that I strive to improve my course each time. I take the comments in to account and make any adjustments I can to improve it.

I have extremely enjoyed my relatively short time as a venepuncture teacher and I still have my passion for venepuncture myself. I find that teaching also improves my own practice and keeps me current with any changing ideas on protocol. I look forward to continuing to improve and find new, fresh ways of teaching venepuncture and passing on my passion to others.