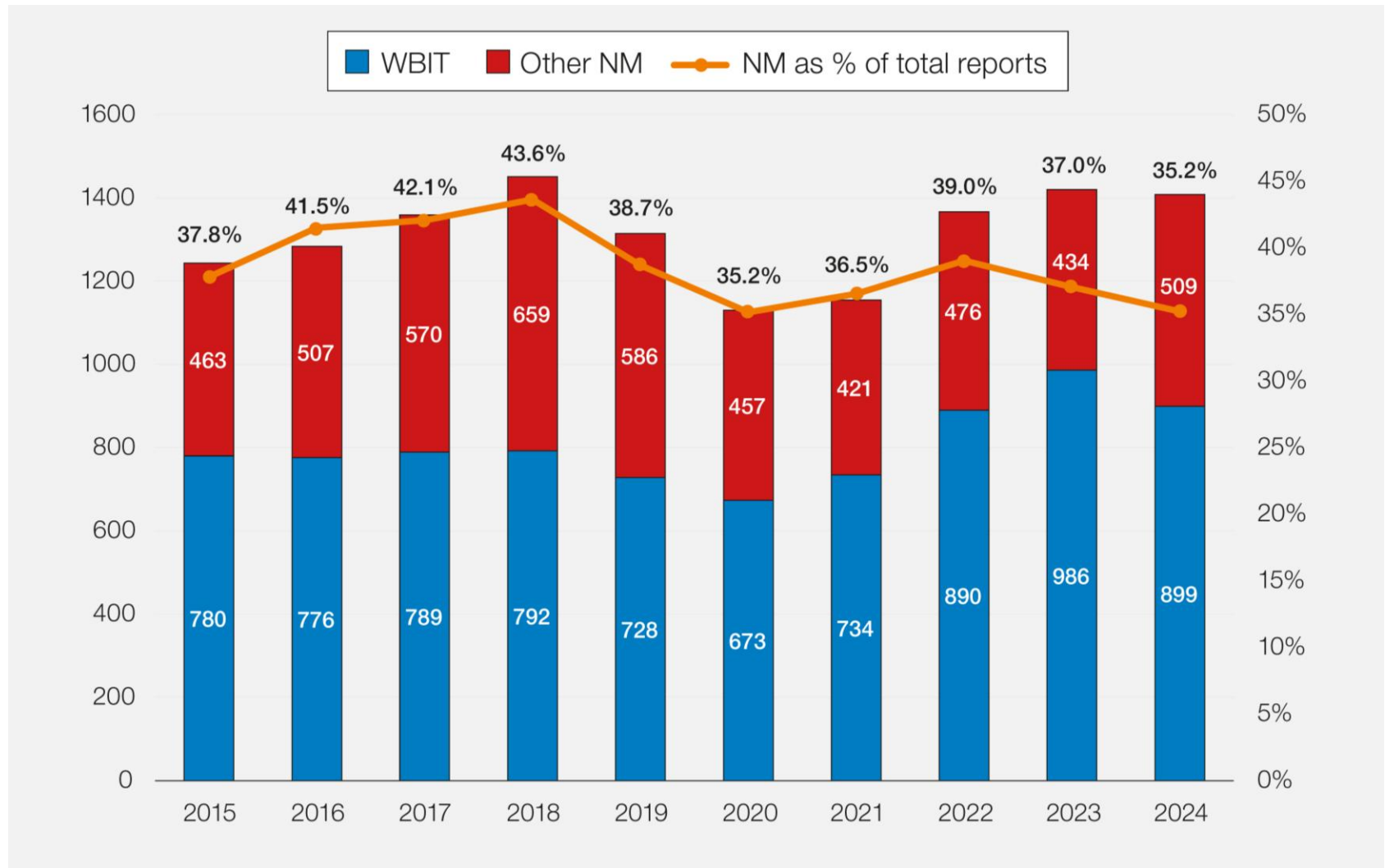


Near Miss (NM)

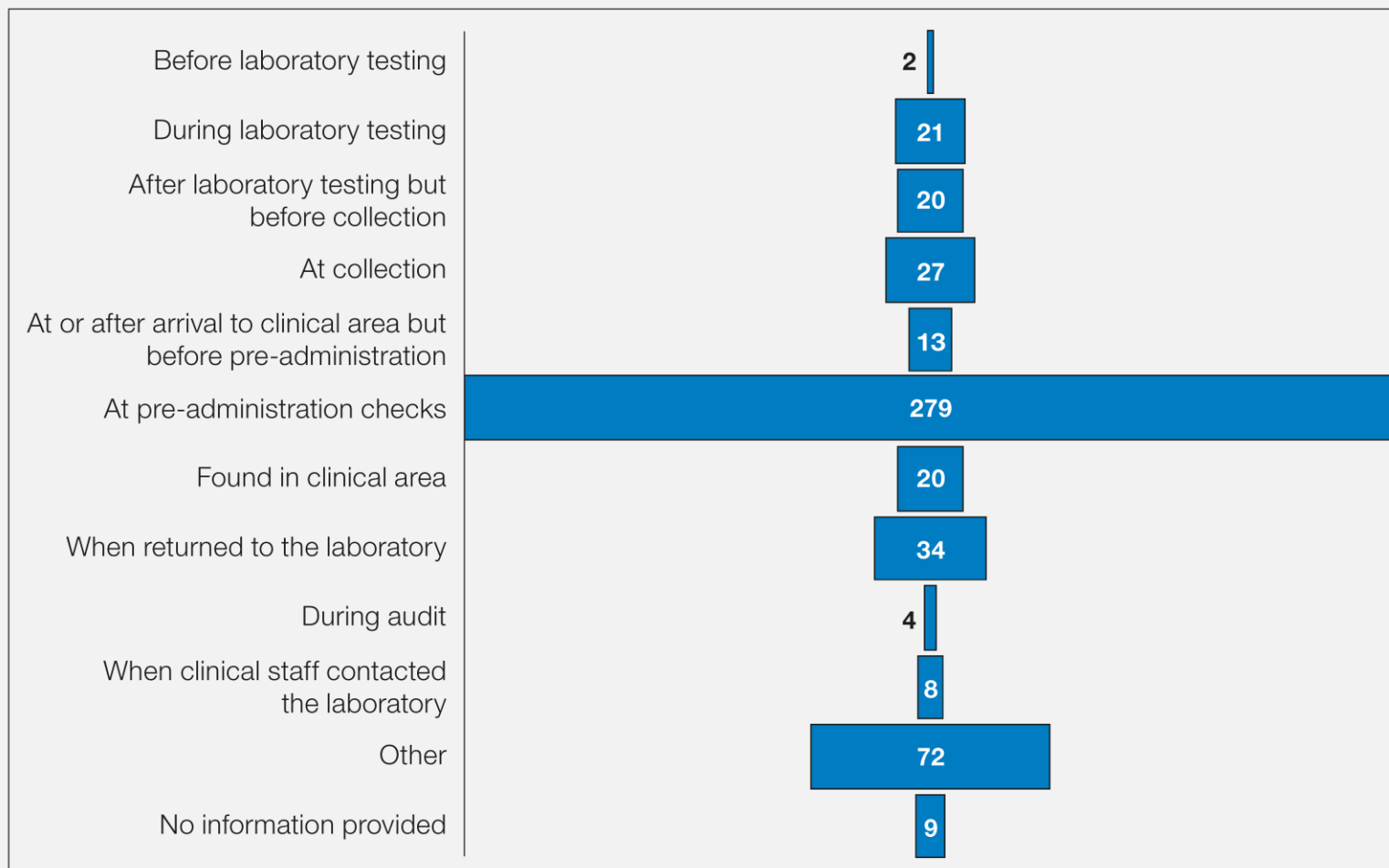
FIGURES FROM THE ANNUAL SHOT REPORTS 2020-2024

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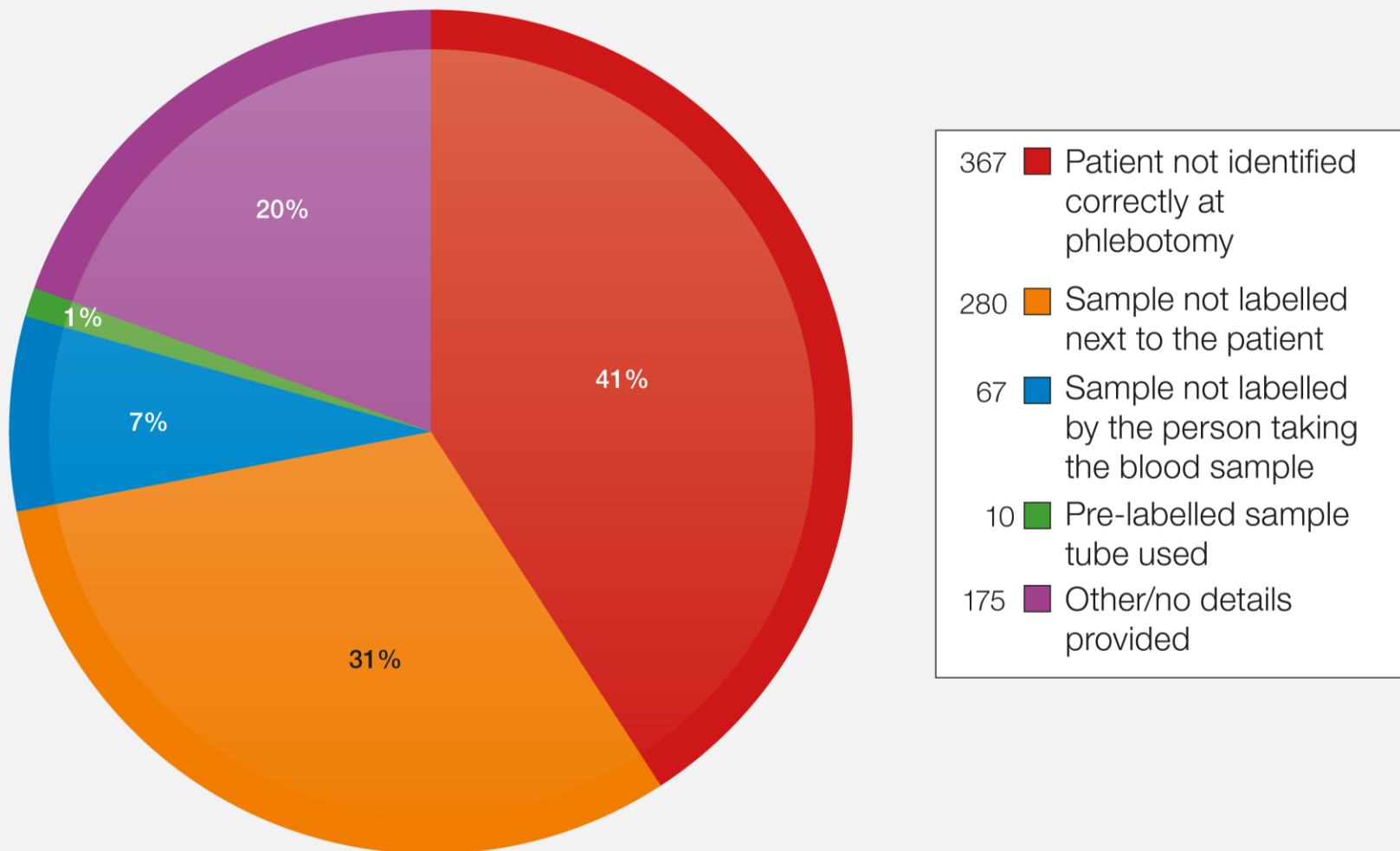
A decade of NM (other) and WBIT reports (2015-2024)



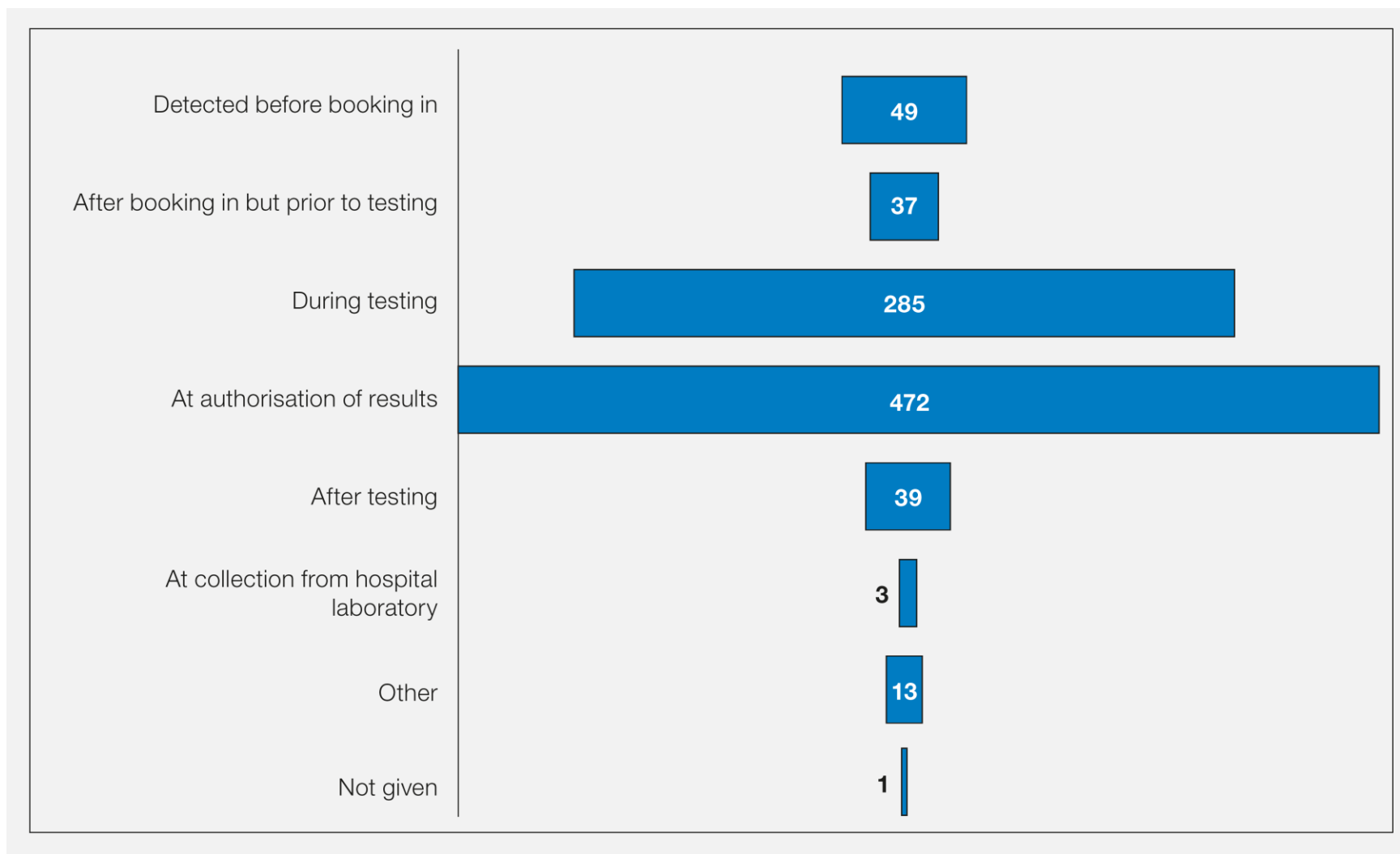
Point in the process where the error was detected in NM events, excluding NM-WBIT reported in 2024 (n=509)



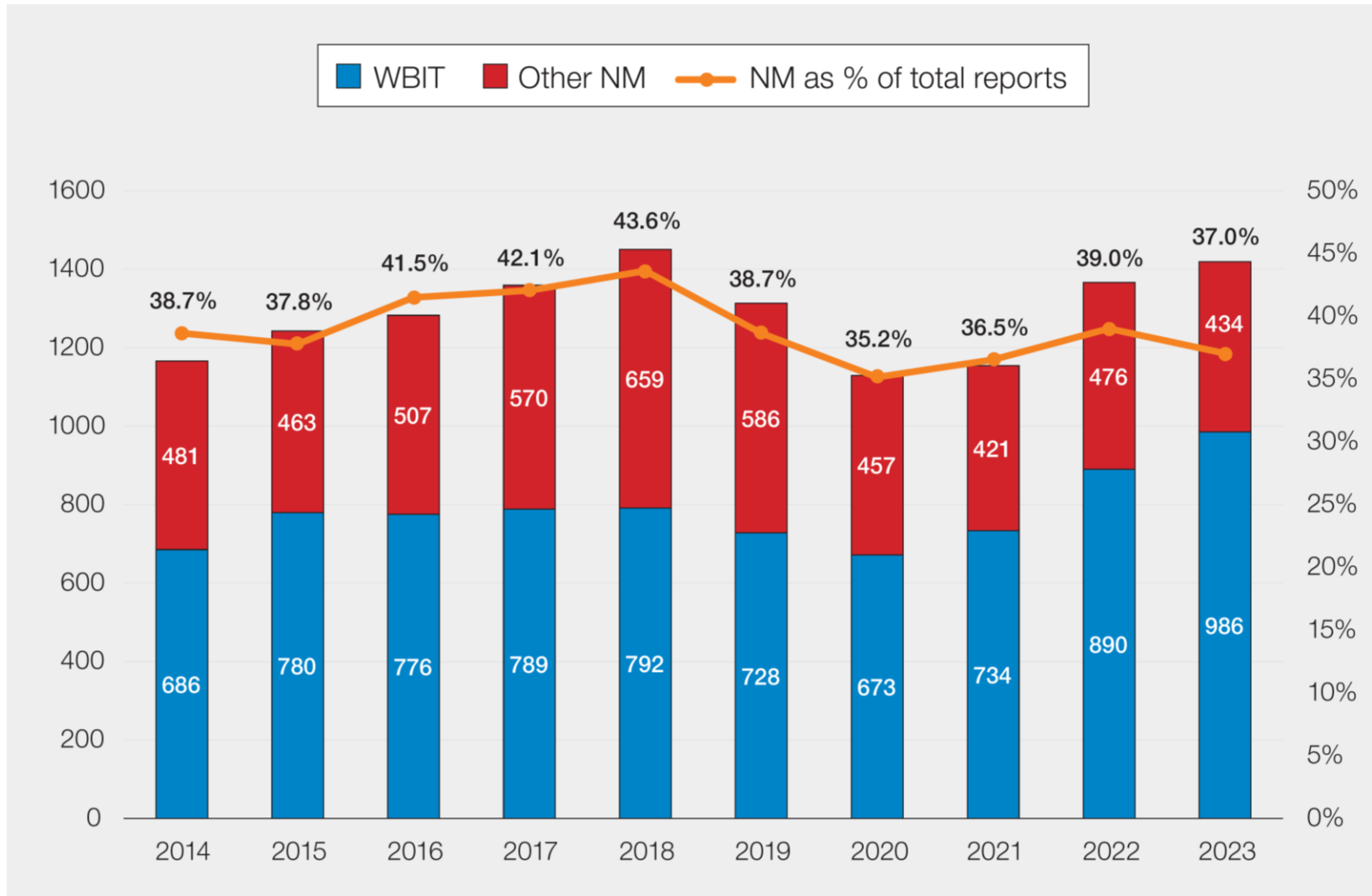
Primary errors leading to WBIT in 2024 (n=899)



Point in the process where the error was detected in WBIT reported in 2024 (n=899)

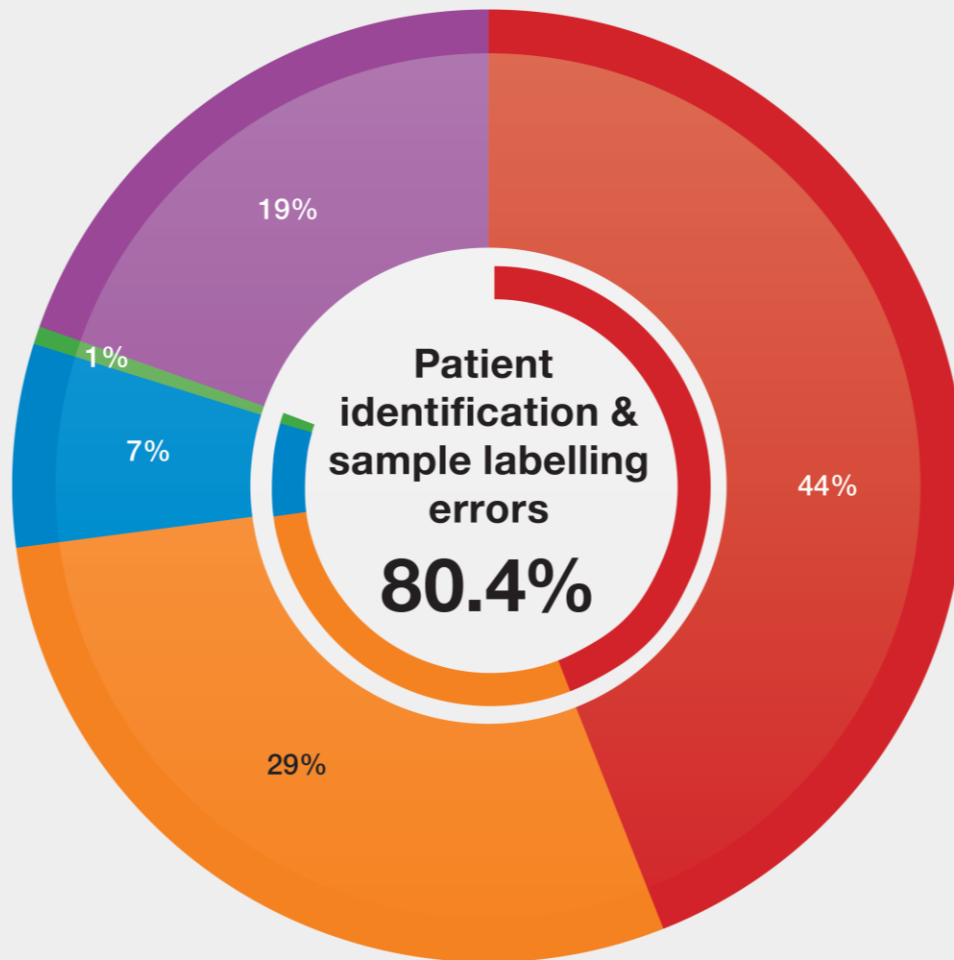


A decade of near miss and WBIT reports 2014-2023



NM=near miss; WBIT=wrong blood in tube

Primary errors leading to WBIT in 2023 (n=986)

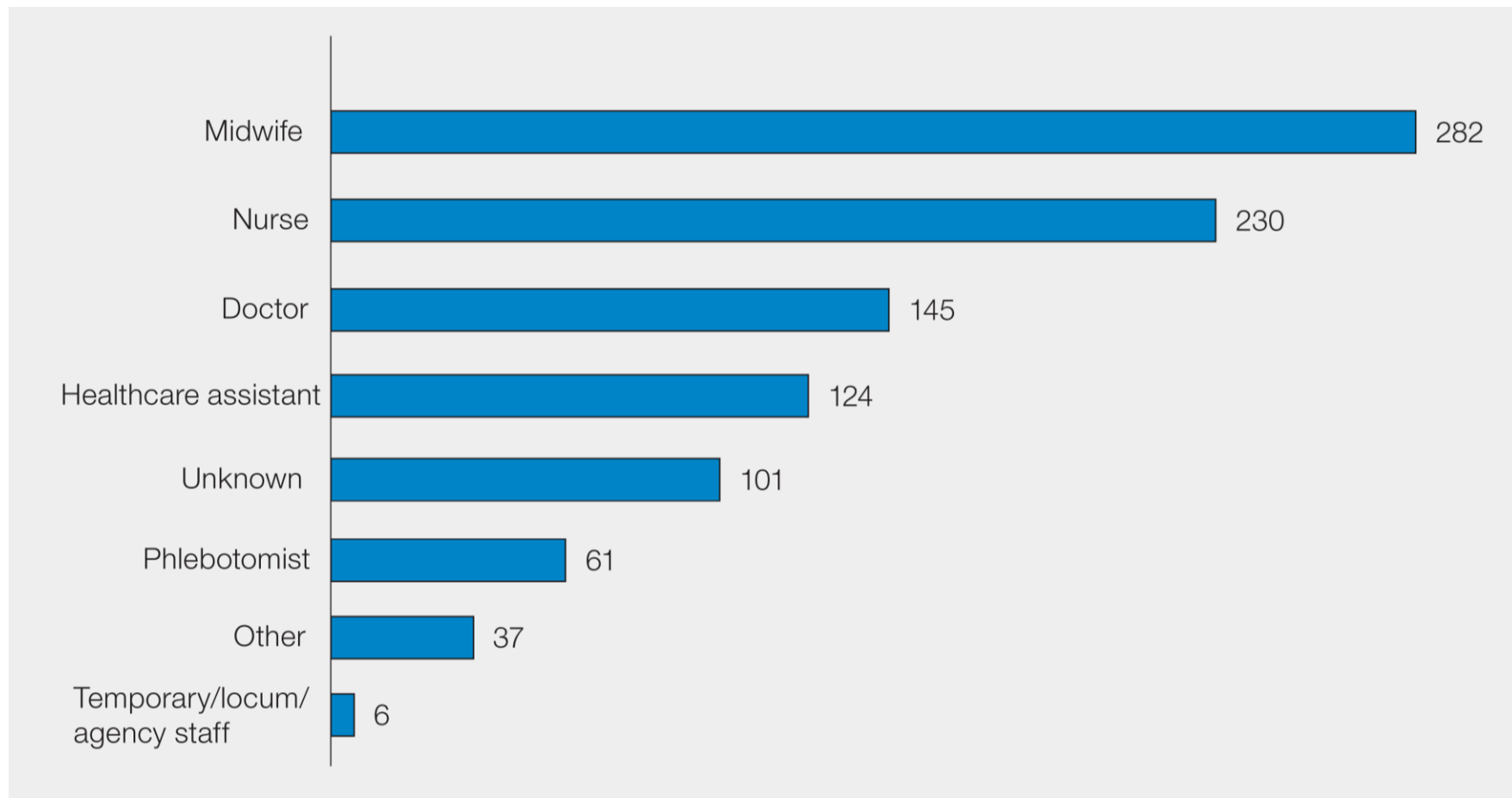


- 434 ■ Patient not identified correctly at phlebotomy
- 285 ■ Sample not labelled next to the patient
- 68 ■ Sample not labelled by the person taking the blood sample
- 6 ■ Pre-labelled sample tube used
- 193 ■ Other/no details provided

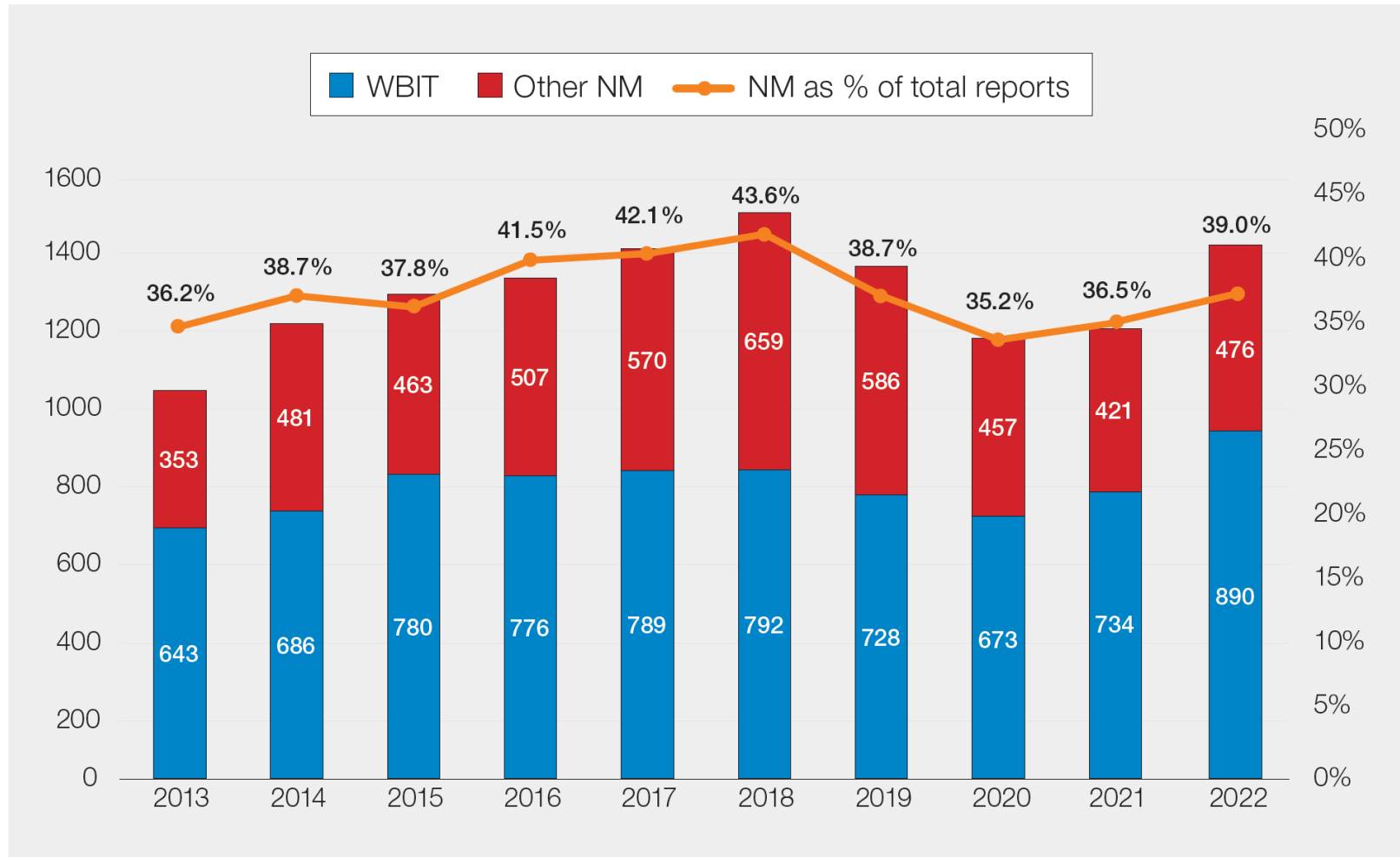
Point in the process where the error was detected in WBIT reported in 2023 (n=986)



Numbers of different healthcare professionals who took blood samples resulting in WBIT in 2023 (n=986)

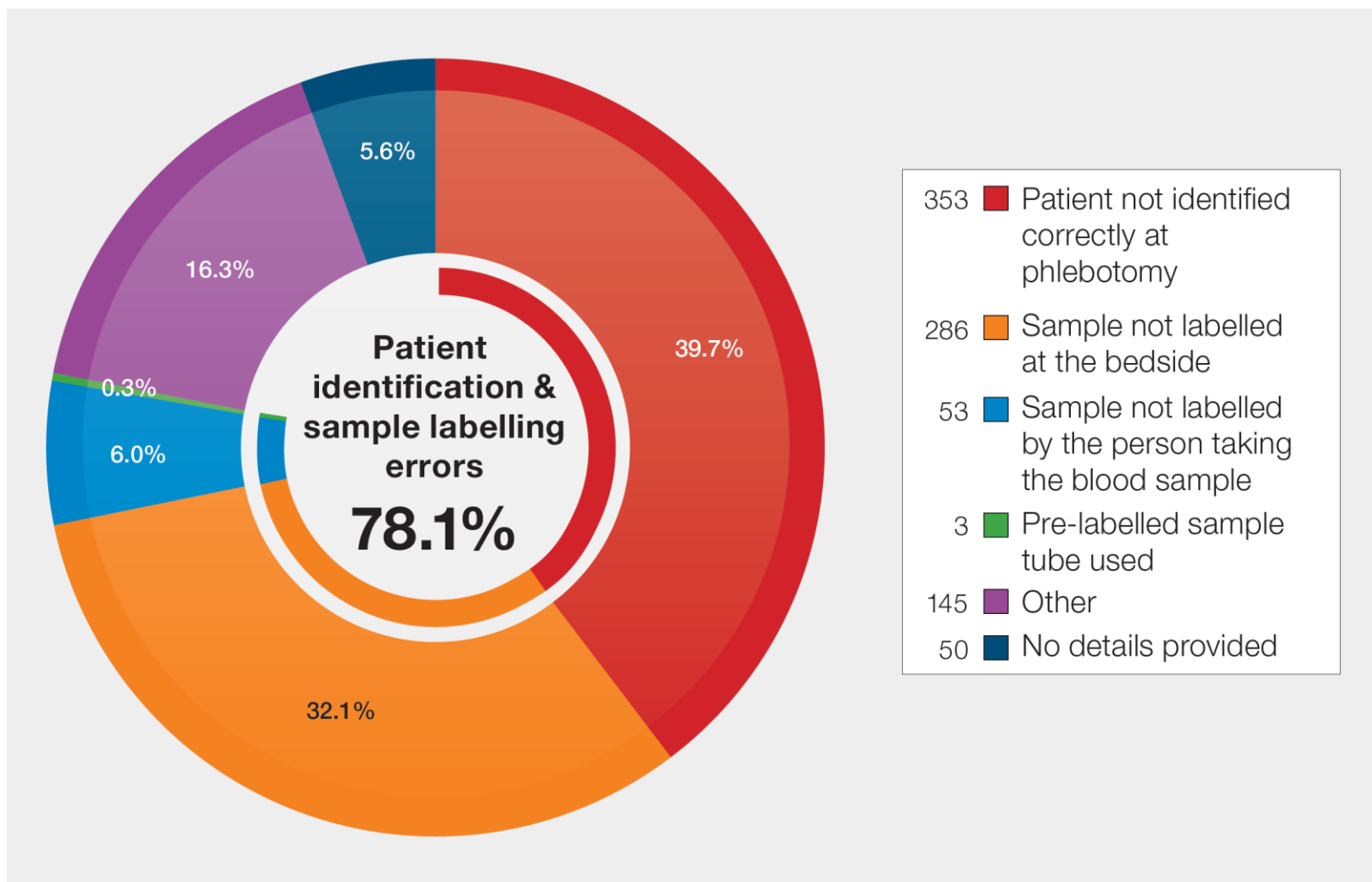


A decade of near miss and WBIT reports 2013-2022

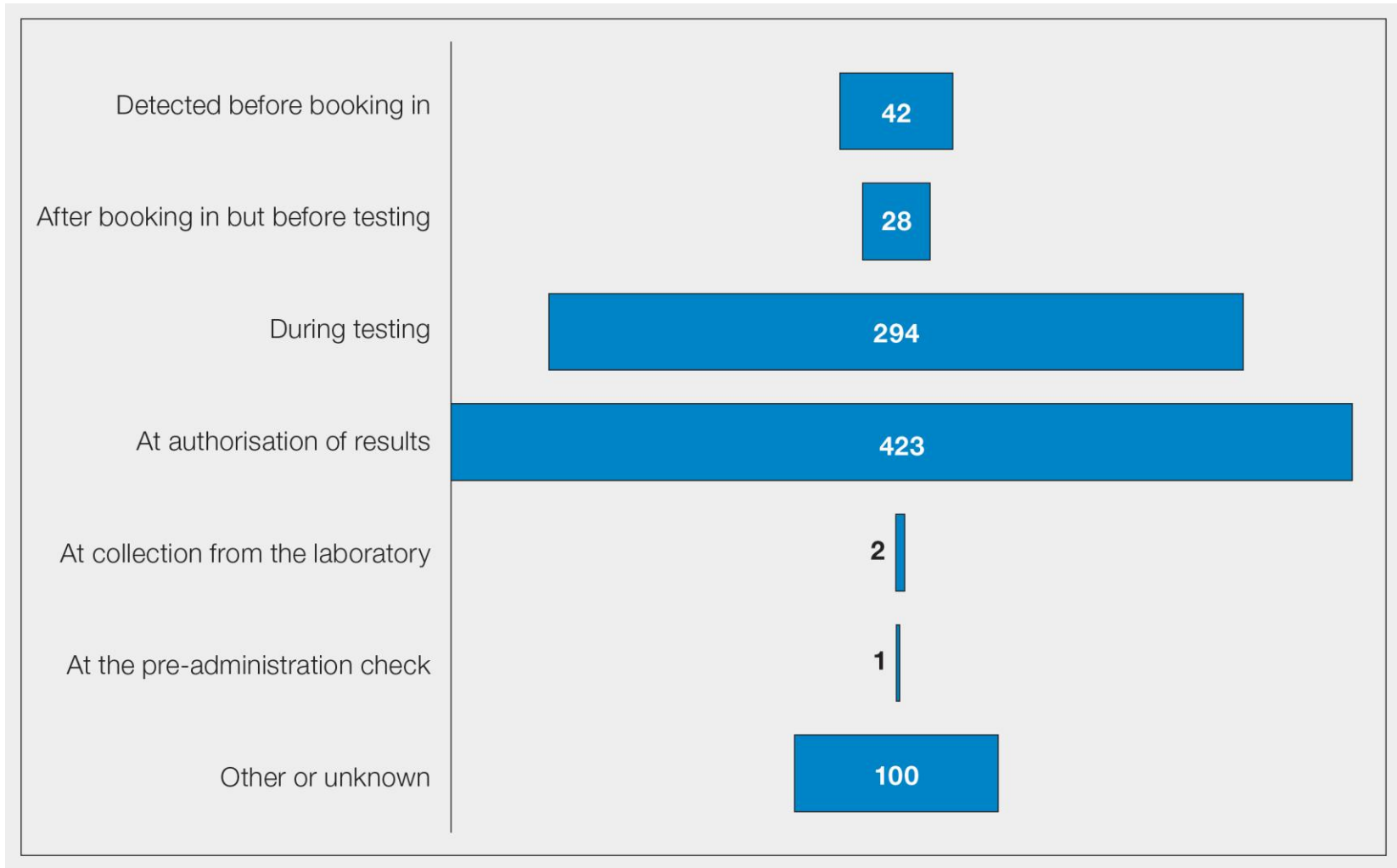


WBIT=wrong blood in tube; NM=near miss

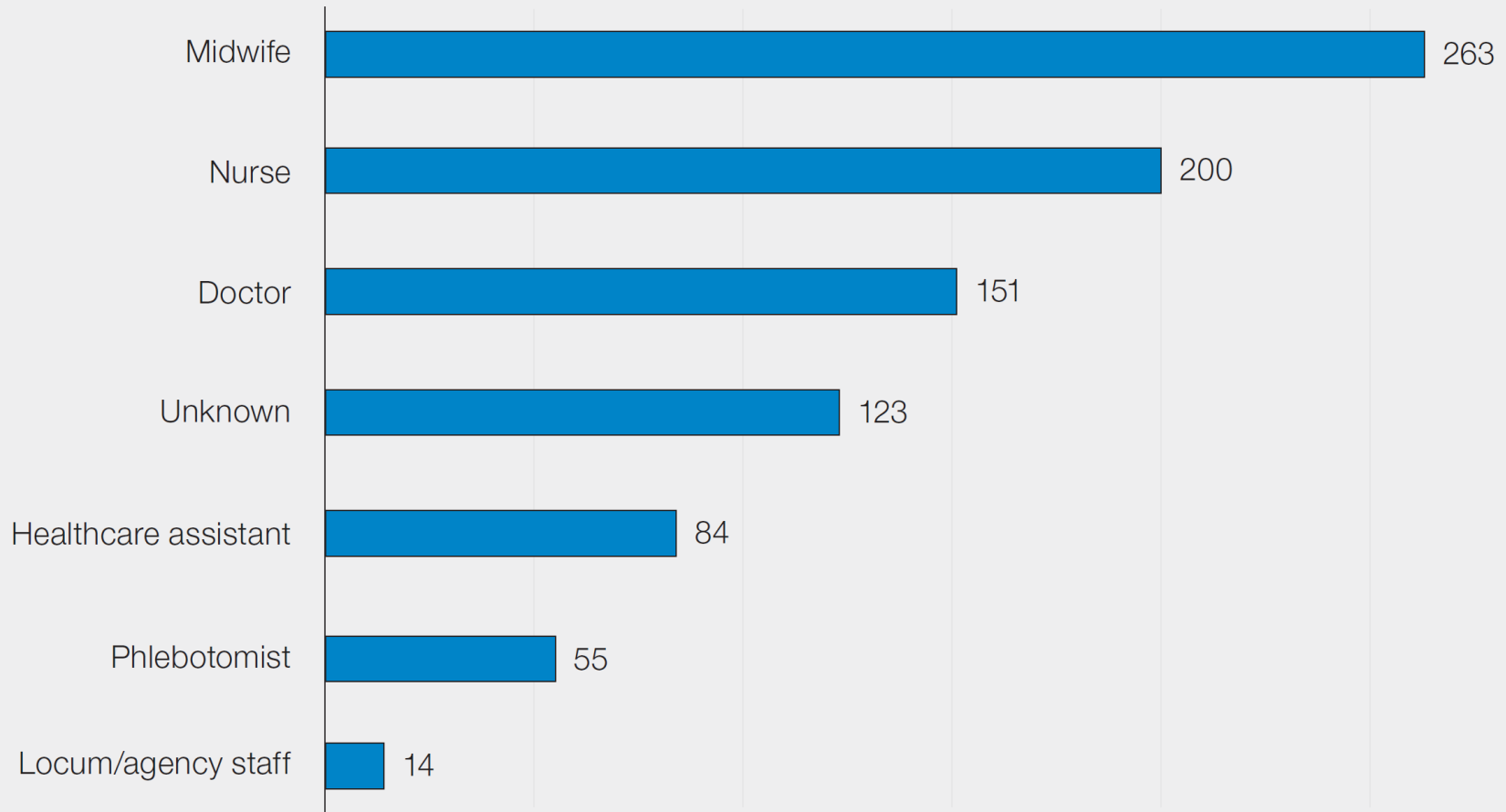
Primary errors leading to WBIT in 2022 (n=890)



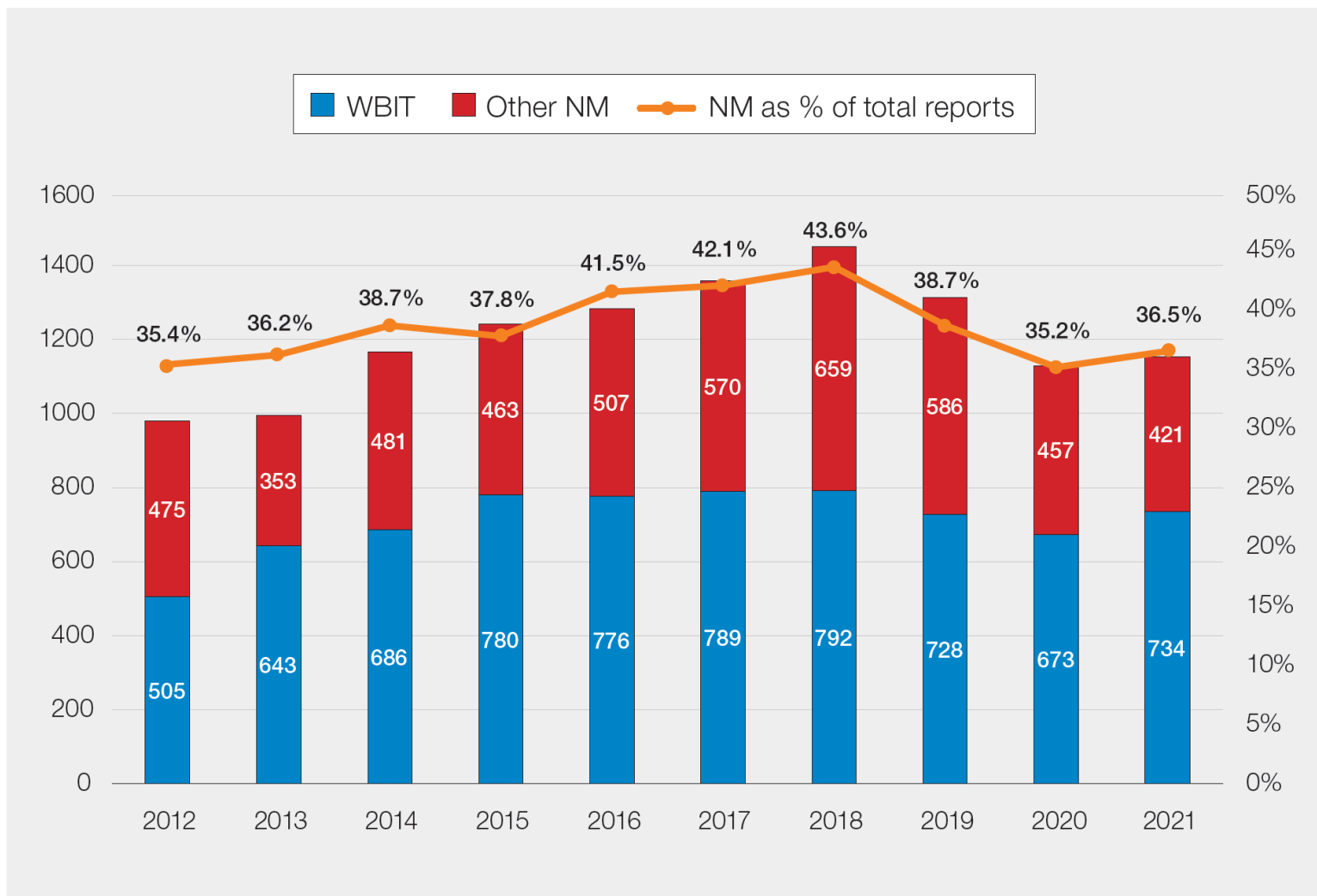
Point in the process where the error was detected in 2022 (n=890)



Numbers of different healthcare professionals who took blood samples in 2022



A decade of near miss and WBIT reports 2012-2021



WBIT=wrong blood in tube; NM=near miss

The sample circle

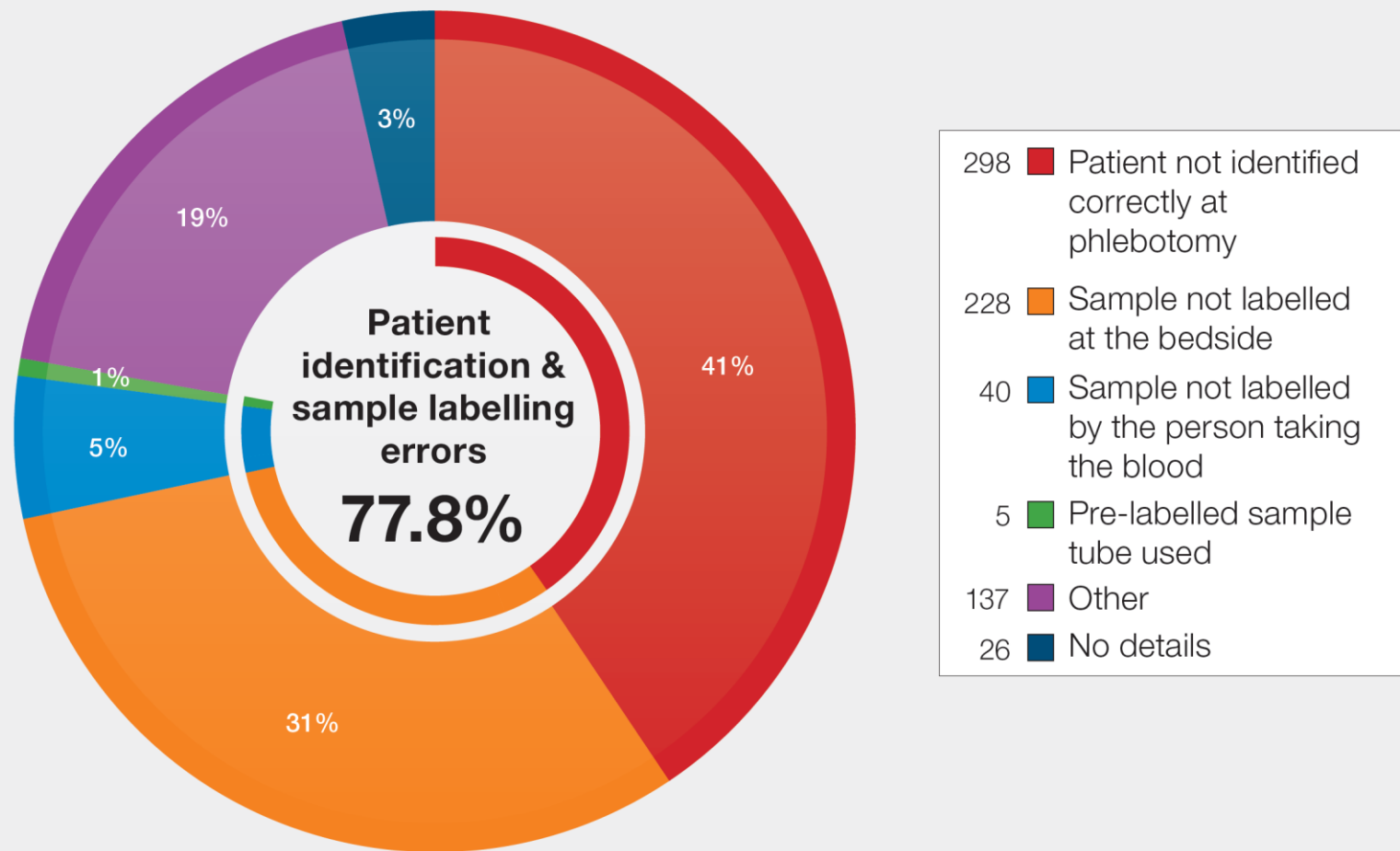


All samples must be labelled at the patient side
using positive patient identification.

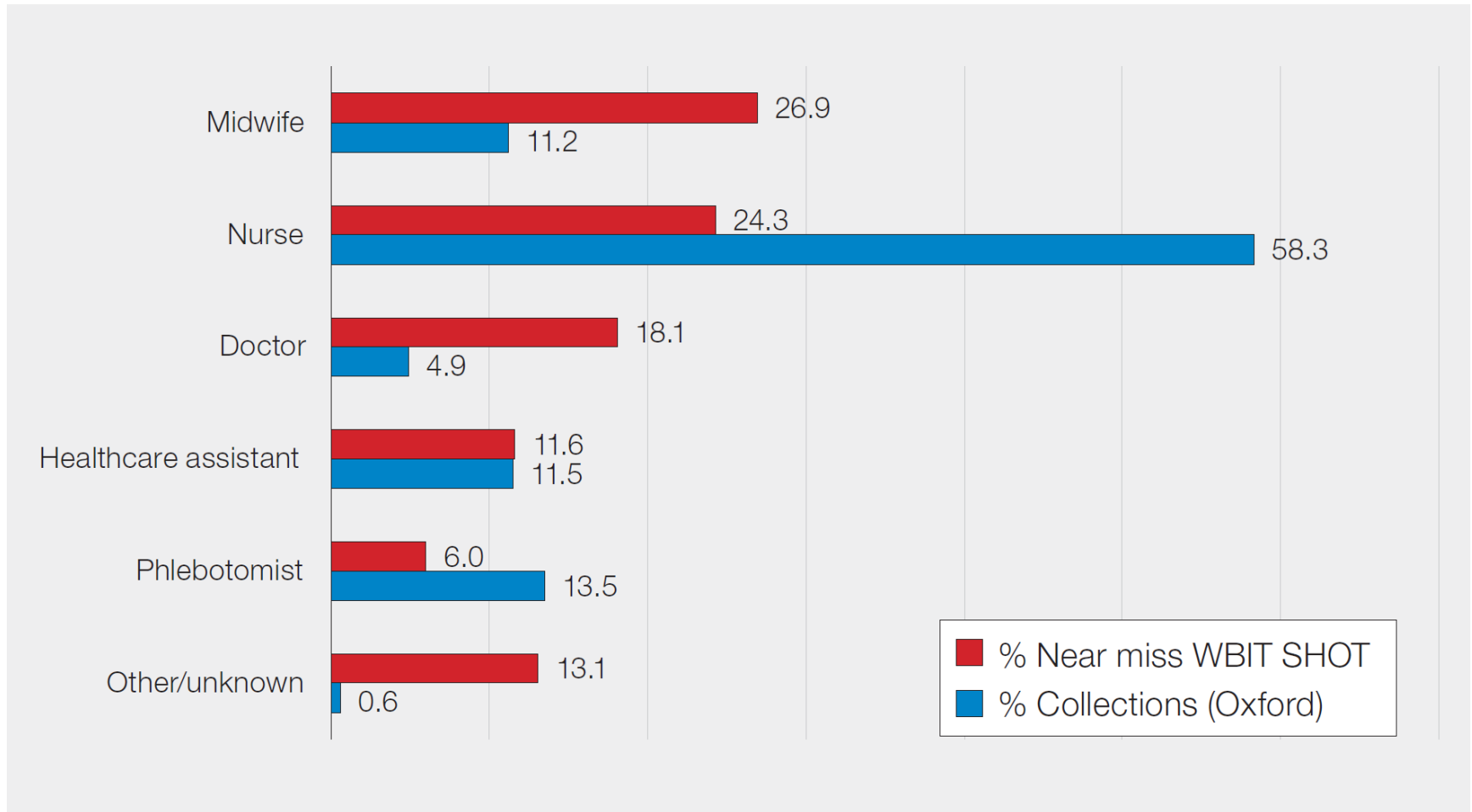
Unlabelled blood samples **MUST NOT** leave the **SAMPLE CIRCLE**.

Unlabelled blood samples outside the circle should be disposed of.

Primary errors leading to WBIT in 2021 (n=734)

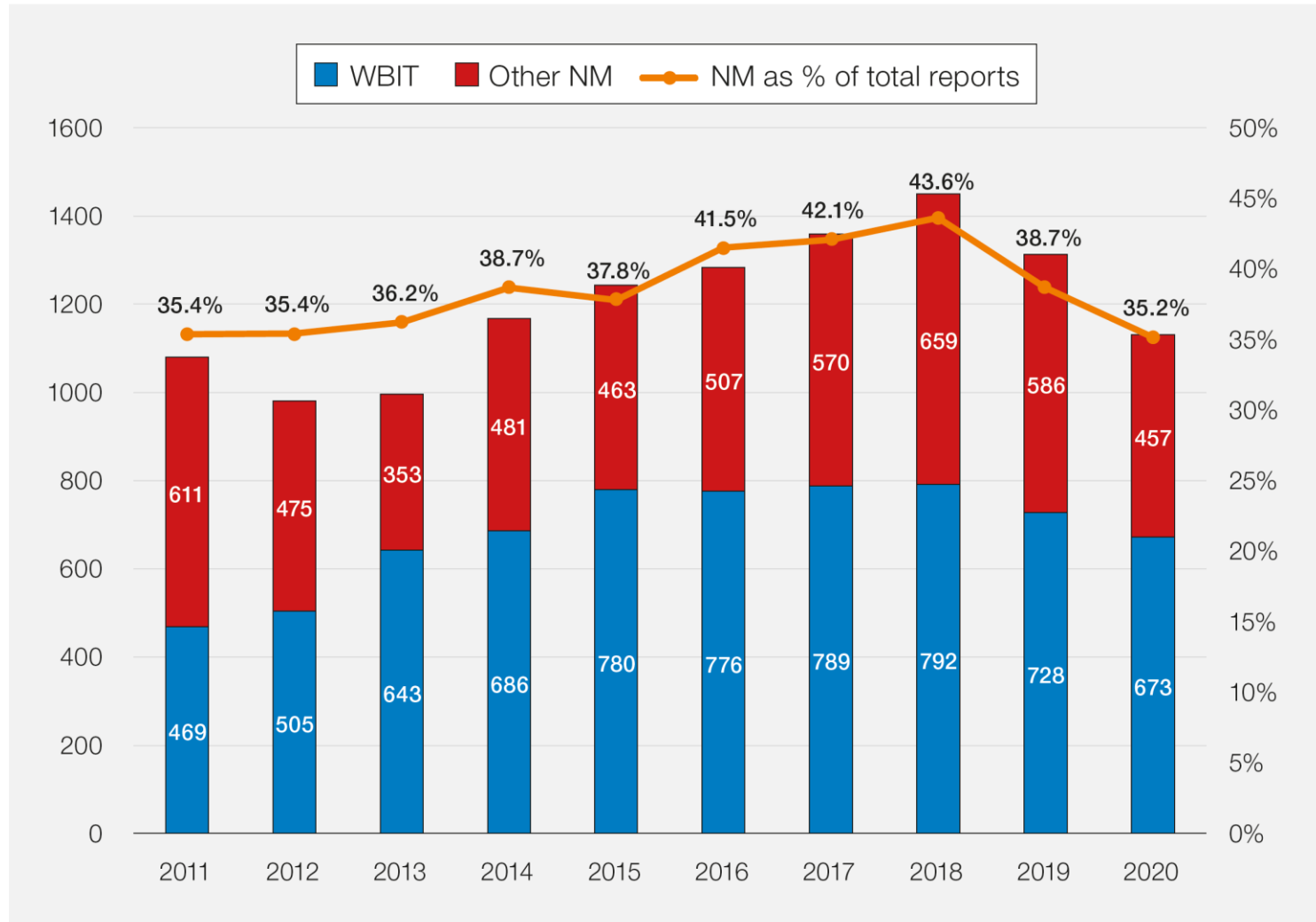


Percentage of different healthcare professionals who took blood samples in 2021



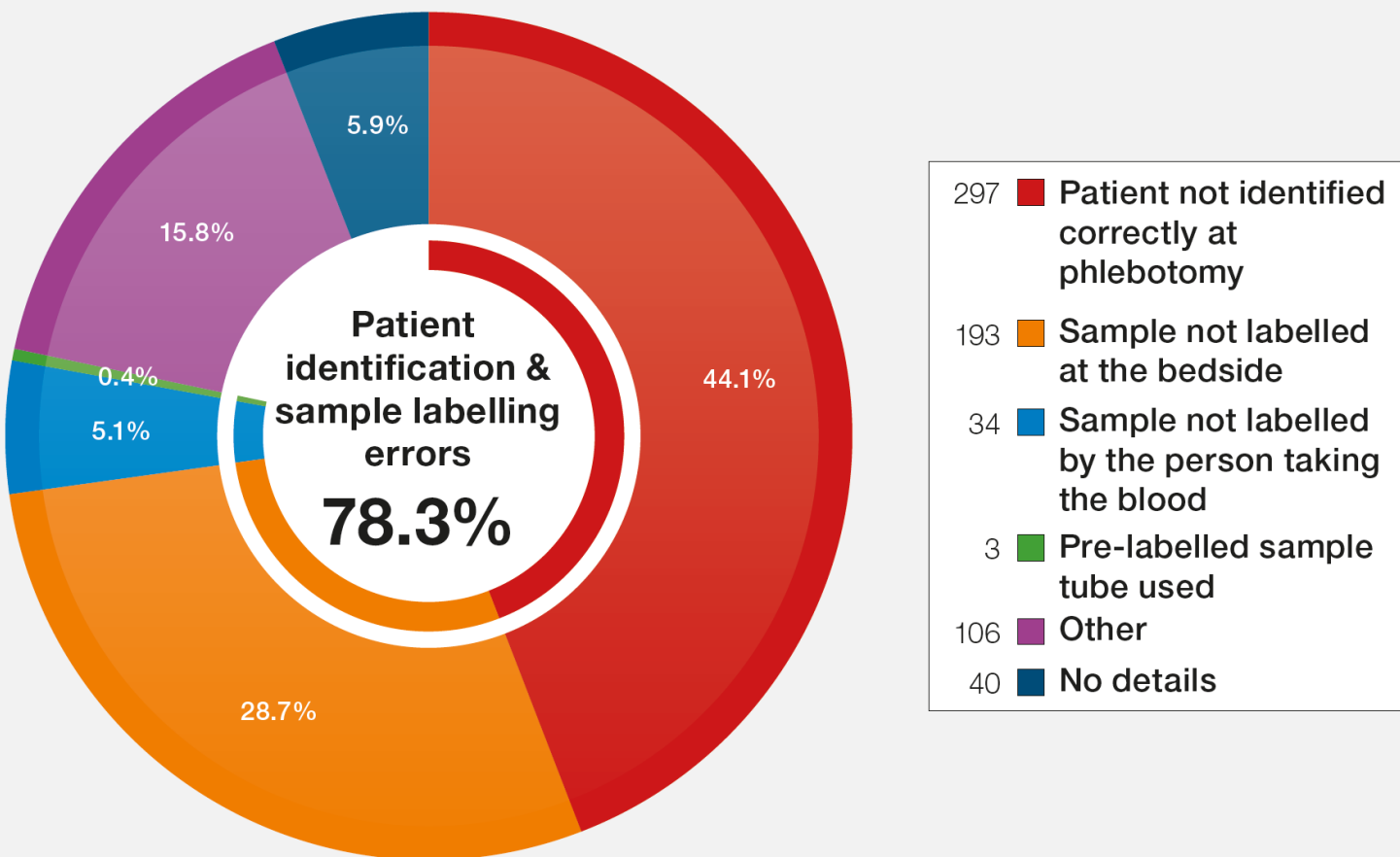
WBIT=wrong blood in tube

A decade of near miss and WBIT reports 2011-2020



WBIT= wrong blood in tube; NM= near miss

Primary errors leading to WBIT in 2020 (n=673)



Point in the process where the error was detected in 2020 (n=673)

