9.0 Troubleshooting

9.1 RN will call BB if he/she cannot determine why unit cannot be scanned into BPAM.

9.2 CLS will follow the steps described below to troubleshoot if error originates from Millennium.

9.2.1 Did the product dispensed exceed the maximum products in the Prepare Order?

9.2.1.1 Check PPI, Prepare Order & Pick-up slip.

9.2.1.2 Was the appropriate pick-up slip used to dispense unit?
NOTE: The appropriate pick-up slip is the KPHC 'Transfuse' Pick-up. Reprinted pick-up slip, manual pink slip, blank pick-up slip are not acceptable for routine transfusion.

9.2.1.3 **FIX:** Return product and request for new Prepare Order.

9.2.2 Was the correct product type or Ecode dispensed?

9.2.2.1 Verify with RN that dispensed unit is the correct component needed.

9.2.2.2 Verify that the Ecode dispensed matches the unit face label.

9.2.2.3 Match the 'Transfuse' Pick-up slip with the unit and Prepare Order.

9.2.2.4 **FIX:** Return product to inventory and Dispense the correct product per SOP.

9.2.3 Was unit dispensed in CM (Cerner Millennium)?

9.2.3.1 Check Product HX for status. The unit active status should be 'Dispensed'.

9.2.3.2 **FIX:** Dispense the product in CM per SOP.

9.2.4 Was the DEVICE correct?

9.2.4.1 Check Product HX for status. The unit active status should be 'Dispensed'.

9.2.4.2 Check the DEVICE. DEVICE: SFO BPAM (inpatient) or SFO Ambulatory (outpatient).

9.2.4.3 **FIX:** Return product and Dispense in CM per SOP. Default DEVICE: SFO BPAM (IP) or SFO Ambulatory (OP)

9.2.5 Was unit dispensed using the correct encounter?

9.2.5.1 Check Complete Product HX for 'dispensed to' Location.

9.2.5.2 **FIX:** Return product and Dispense using the current encounter.

9.2.6 Was Dispense linked to a Prepare Order Acc#?

9.2.6.1 Check Product HX for Prepare Order Acc#.

9.2.6.2 Emergency Release, MTP and SX do not have Prepare Order – MD need to place Transfuse Order after emergency or after SX.

9.2.6.3   **FIX:** Return product and Dispense in CM. Scan the correct Prepare Order Acc# then Unit#.

9.2.7   Was the correct Prepare Order Acc# used?

      9.2.7.1   **NOTE:** Prepare Order from Inf Ctr/Onc **cannot** be used for ER or inpatient.

      9.2.7.2   **NOTE:** ER/Inpatient MD need to place a new Transfuse Order to get a new Prepare Order Acc#.

      9.2.7.3   Check ORV and Product HX. **NOTE:** Make sure the Acc# used is not one that was ordered by a CLS.

      9.2.7.4   **FIX:** Return product and Dispense in CM. Scan the correct Prepare Order Acc# then Unit#.

9.2.8   Was unit scanned into inventory at receipt?

      9.2.8.1   Check Product HX for bolded barcode.

      9.2.8.2   Crossmatch and Dispense another unit if possible.

      9.2.8.3   **FIX:**

          9.2.8.3.1   Return problem unit to inventory.

          9.2.8.3.2   Correct Inventory to change DIN to e.g. zzSFO19EntEr1 with Prod Comment of original DIN.

          9.2.8.3.3   Final Dispose unit - Reason: ErrorCorrection and Method: Corrected.

          9.2.8.3.4   Rereceive with <u>Prod Comment</u> of original receipt date, receipt CLS and the changed DIN.

          9.2.8.3.5   Confirm unit ABORh. Recrossmatch and Dispense if needed.

9.2.9   Was unit previously dispensed to the same patient? (exclude OP, emergency, MTP or SX)?

      9.2.9.1   If unit was previously scanned into BPAM for the same patient, then it cannot be scanned again into BPAM. RN can bypass BPAM and use

Downtime protocol i.e. manual bedside check and manual documentation to transfuse unit.

9.2.9.2   If unit was not previously dispensed to the same patient and is not a Special unit or short dated, return unit and dispense another unit.

9.2.9.3   If problem recurs, suggests that RN bypass BPAM and use Downtime protocol then contact KPHC IT.

9.2.10   Has the **correct** 'Transfuse' order been released?

9.2.10.1   Ask RN to check KPHC. **NOTE:** 'Transfuse' pick-up can be 'reprinted' even if the order has not been released.

9.2.11   Notify RILIS Coordinator if unable to determine problem.

BPAM
Troubleshooting when unit Info does not populate KPHC

Product returned to Blood Bank for further investigation

↓

Did the product dispensed exceed the maximum products in the Prepare Order? Check PPI, Prepare Order & Pick-up slip

— yes → **Return product and request for new Prepare Order**

The appropriate pick-up slip is the KPHC 'Transfuse' Pick-up. Reprinted pick-up slip, manual pink slip, blank pick-up slip are not acceptable for routine transfusion

↓ no

Was the correct product type dispensed? Match Transfuse Pick-up with unit and Prepare Order

— no → **Return product and Dispense the correct product per SOP**

↓ yes

Was unit dispensed in CM? Was the DEVICE correct? Check Product HX for status and DEVICE

— no → **Dispense the product in CM per SOP DEVICE: SFO BPAM (IP) or SFO Ambulatory (OP)**

PathNet BB Transfusion: Product History Review

↓ yes

Was unit dispensed using the correct encounter? Check Complete Product HX for Location

— no → **Return product and Dispense in CM using the current encounter**

↓ yes

Check Product HX if Dispense was linked to Prepare Order Acc#

— no → **Return product and Dispense in CM – Scan the correct Prepare Order Acc# then Unit#**

Emergency Release, MTP and SX do not have Prepare Order – MD need to place Transfuse Order after emergency or after SX

↓ yes

Was the correct Prepare Order Acc# used? Prepare Order placed by a CLS or from Inf Ctr/Onc cannot be used for ER or inpatient Check ORV and Product HX

— no → **Return product and Dispense in CM – Scan the correct Prepare Order Acc# then Unit#**

ER/Inpatient MD need to place a new Transfuse Order to get a new Prepare Order Acc#

↓ yes

Was unit scanned into inventory at receipt? Check Product HX for bolded barcode

— no → **Crossmatch and Dispense another unit if possible Return problem unit to inventory -> Correct Inventory to change DIN to e.g. zzSFO19EntEr1 with Prod Cmnt of original DIN -> Final Dispose unit - Reason: ErrorCorrection and Method: Corrected -> Rereceive with Prod Cmnt of original receipt date and CLS and the changed DIN -> Confirm unit ABORh -> Recrossmatch and Dispense if needed**

KPSF RILIS BPAM Workflow_3.20.2018

↓ yes

Was unit previously dispensed to the same patient? (exclude OP, emergency, MTP or SX)?
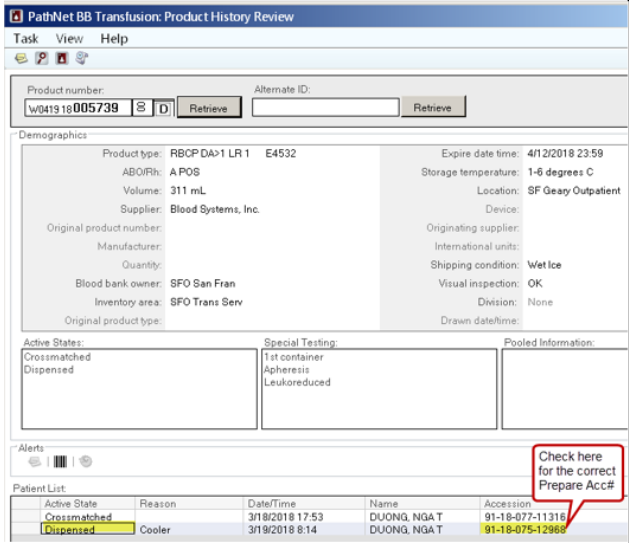
— yes → **If unit was previously scanned into BPAM for the same patient, then it cannot be scanned again into BPAM. RN can bypass BPAM and use downtime protocol i.e. manual bedside check and manual documentation to transfuse unit.**

— no → **Return unit and Dispense another unit – if problem recurs, tell RN to bypass BPAM and use downtime protocol then contact KPHC IT**

Notify RILIS Coordinator if unable to figure out problem