Blood Bank Huddle Notes

01/16/2024

Please make sure you sign online at the MTS site.

- **QUALITY -** ***each one of these events represents a deviation from protocol and consequently a risk to our patients. Patient safety and quality are still the standards for the Troy Blood Bank.***
  - **Quality Events**
    - Sickle patient with historical documentation for the SICC, SICK, SICE codes. The tech antigen typed the patient for C, E, K and the patient was found to be C pos, but the tech did not remove the SICC code. The patient had an anti-E identified at HFH, but the SICE code was not removed either.
    - Tech documented an anti-Kell on a patient when patient really had an anti-E.
    - RhIG action added to the TS order, not the RhIG Eval.
    - Wrong QC rack selected.
    - Patient is a BMT recipient with an ABO discrepancy that requires override. The tech did not have override, so she needed to do ISXM due to the ABO discrepancy. She only did gel XM for both units. This was discovered when the units were being issued by the following shift- the ISXM had to be performed at the time of issue.
    - Patient has a history of DPASS but one of the units was 1+ incompatible. The tech did not result the XM in SoftBank- instead it was cancelled. The tech did do Panel A, but she did not complete the rule outs for additional antibodies. The tech did not result a TWTI on the patient due to the incompatible XM.
    - Unit was issued without adding HGBS and antigen test results in SoftBank.
    - RN came down with request form for platelet. Tech issued RBCs.
    - Incorrect comment added to QC in the computer.
    - NEXM was not added to new antibody patient.
    - Unit of RBC was out of temperature because the tech was delayed in taking the temp of the unit.
    - Tech failed to document comment in Temp Trak.
    - Delay comment missing.
    - Mom of baby had a positive antibody screen (TWTI). Tech that worked up baby forgot to add the maternal antibody flag in both Soft and Epic.

- **EDUCATION**
  - **Processes/procedures**
    - **Samples from Lenox**
      - When a TS or RHGAN is received from Lenox, follow Troy's testing protocol.
      - Document Rhig candidacy.
      - Treat the sample as you would treat a "NOB" sample.
    - **Exchange Transfusion**
      - When an exchange transfusion is requested by the caregiver, they will need to communicate how many units they would like available to transfusion.
        - If the patient has unexpected antibodies, follow the procedure for crossmatching RBCs on a patient with antibodies.
        - There is not a "exchange transfusion" order in SoftBank or Epic. The provider will need to order a transfusion order and a product order with the desired number of units.
      - **Providing a STAT Cooler for Neonate or Infant Transfusions**
        - For urgent transfusions when a request for STAT blood in a cooler is made, an entire RBC unit and an empty, 60-cc pre-filtered syringes should be

issued in the neonatal blood cooler. Syringes shall remain in their sterile packaging when issued in the cooler until needed for transfusion.

- The caregivers will pull off the required volume into the syringes and the remainder of the unit will be discarded upon return to the Blood Bank.
- Red Blood Cells (RBC) transfused to neonates should be type O Negative.
- All RBCs must be CMV seronegative.
- All RBCs must be hemoglobin S (Sickle Cell) negative.
- All RBCs must be irradiated.
- The RBC unit should be "fresh" with an expiration date greater than 10 days from date of issue.
- For neonates (less than 4 months of age) the post-issue crossmatch may be canceled if there are no maternal / neonatal antibodies (if group O RBCs were issued). This applies even if the neonatal ABORh was interpreted as GND (group not determined).
    - If maternal or neonatal antibodies are present, then serologic post-issue crossmatches should be performed on the neonatal sample.
- Once Blood Bank receives notification of the need for emergent RBCs on an infant, neonate, or unborn / soon-to-be-delivered baby, obtain the mother's patient identification.
    - If clinically significant maternal antibodies are present, notify the patient's physician immediately. It is the physician's decision whether to take a product that is not yet antigen tested or wait for antigen testing.
- After the cooler is returned, determine whether the RBC was entered by visually inspecting both ports. If necessary, call the caregivers to make this determination.
    - If the unit was entered, discard the remainder of the unit. Refer to Transfusion Medicine policy, Blood Products - Quarantine or Discard.
    - If the unit was not entered, perform a visual inspection and place the unit in the appropriate status. Refer to Transfusion Medicine policy, Return of Blood Products from Issue.
    - Regardless of whether any of the product was transfused, the unit will be recovered (i.e. issued and returned) in the Blood Bank computer.

❖ **REMINDERS**

- If you spill blood/plasma on paperwork that needs to be reviewed by another individual, please make a copy of the sheet or place in a page protector.
- HLA matched platelets do NOT automatically come irradiated. Make sure to request IRRADIATION when ordering for HLA matched.
- If you are in a patient's chart and notice that they are discharged but there is blood setup on the patient, please release the units back into inventory.
- Please continue to participate in the weekly review quizzes. If you would ever like a reset on a quiz, just let me know. These are not meant to stress you out! They are designed to help you remember those pesky items we keep forgetting.