**BBBP 1.0-General Policies for Blood, Blood Products and Tissue**

1. All blood, blood products and tissues received by the Blood Bank will be entered into the hospital computer system.
2. The blood provider to Memorial Hospital is Central Illinois Community Blood Center (CICBC) dba Mississippi Valley Regional Blood Center (MVRBC).
   1. Tissues are ordered by the operating room at the request of the individual physician. Blood Bank is only the storage facility.
3. Red blood cell and platelet pheresis products are leuko-reduced.
4. CMV negative vs. CMV safe blood and blood products
   1. Leukoreduced cellular products are considered CMV safe.
   2. CMV seronegative products may be indicated for, but are not limited to:
      1. Transfusion of premature or low birth weight neonates
      2. Intrauterine transfusion
      3. CMV negative bone-marrow or stem cell recipient
      4. Pregnant women who are to be transfused before delivery. (NOTE: CMV negative products are not needed after delivery of infant)
5. Irradiated blood and blood products are indicated for use in patients that are at risk of transfusion associated graft versus host disease (TA-GVHD).
   1. Only cellular products require irradiation.
   2. Indications for use include, but are not limited to:
      1. Transfusion of products from biologic relatives
      2. HLA-compatible platelet pheresis
      3. Bone marrow or stem cell transplant patients
      4. Intrauterine transfusion
      5. Patients with hematologic or B cell malignancies
      6. Transfusion of premature or low birth weight neonates
      7. Patients ever receiving treatment with Fludarabine
6. Blood products negative for Hemoglobin S may be indicated for, but are not limited to:
   1. Intrauterine transfusion
   2. Neonatal exchange transfusion
   3. Patients with sickle cell disease or sickle cell trait
7. Complete an orange card for any special need units “saved” for a specific patient.
   1. Indicate charges to be entered at time of use
   2. Remove orange card when no longer needed for patient.
8. Patient testing requirements
   1. Patients requiring red blood cell transfusion must have:
      1. ABO/Rh performed on two independent specimens
      2. Antibody screen/identification performed within the previous three (3) days
      3. Crossmatches performed on current in-date specimen
   2. Patients requiring plasma product (thawed plasma, cryoprecipitate or platelet pheresis) transfusion must have:
      1. ABO/Rh performed on two independent specimens
      2. ABO/Rh performed in the past 14 days
9. Autologous and/or directed donor units
   1. Memorial Hospital transfusion service does not accept autologous or directed blood products for transfusion.
10. Blood filters/infusion sets will be obtained by the nursing department.

References:

* 1. Standards for Blood Banks and Transfusion Services, AABB, Current edition, Bethesda, MD.
  2. Circular of Information, Rev. 12/09.
  3. Guidelines for Ordering Blood Products, CICBC, 2/10.

**PROCEDURE AND FORM CHANGE CONTROL**

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| Title: General Policies for Blood, Blood Products and Tissue | | | | | | | | | | |
| Written | | **Validated** | | **Path Review** | | **Review** | | **Effective** | | **Reason for Revision** |
| Date | **By** | **Date** | **By** | **Date** | **By** | **Date** | **By** | **Date** | **By** |
| **10/12/10** | **PAB** | **12/5/10** | **KMS** | **12/10/10** | **JAP** |  |  | **12/14/10** | **PAB** |  |
| **Revised** |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | **4/18/11** | **PAB** |  |  |  |
| **7/6/11** | **PAB** |  |  | **8/14/11** | **ESB** |  |  | **8/9/11** | **PAB** | **Removed reference to ARC and Rhogam** |
|  |  |  |  |  |  | **3/21/12** | **PAB** |  |  |  |
| **4/26/13** | **PAB** |  |  | **5/15/13** | **ESB** |  |  | **6/1/13** | **PAB** | **Remove autologous/directed products** |
| **7/23/13** | **PAB** |  |  | **7/25/13** | **ESB** |  |  | **7/25/13** | **PAB** | **Included orange charge card** |
| **1/21/15** | **JLH** |  |  |  |  |  |  | **1/21/15** | **JLH** | **Included CMV neg products for pregnant women, removed references to coag factors, changed plasma product requirements to 14 days.** |
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Location of any copy(s) of the procedure:

**Out of use:**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**