1. Everyone should be done with both MTS and paper competencies. Please get these done THIS WEEK if you have not completed them. See me if you are having issues or need reset.
2. Review the readback process with staff. We are missing too many things on readback.
   1. The purpose of readback is to compare the blood product label to the request form to ensure we are giving the right product to the right patient.
   2. DO NOT use the pink form during readback.
   3. The BB staff member reads from the request form and blood product label while the pickup person reads from the blood administration label.
   4. YOU MUST READ ATTRIBUTES, BLOOD TYPE, PRODUCT REQUESTED, and EXPIRATION DATE!!!!! This is what we are missing
3. Review the history check process with staff. Many staff members missed duplicate patient information and designated units on competency. YOU MUST CHECK FOR THIS EVERY TIME YOU DO A HISTORY CHECK! Also reviewed an example of a history check where information was not reviewed properly.
4. Sunquest validation is going well. I am hoping validation will be complete this week, so I can start updating procedures. I will add the MTS quizzes as I update the SOPs. Please DO NOT attempt the quizzes until you have been trained. A few things to expect with the upgrade:
   1. All unit information must be barcoded into the LIS. You cannot type information or the products will not work.
   2. We will no longer be able to branch from BOP to BCP. You will need to BCP a unit THEN allocate to the patient. This is because we turned blood label check on. Units return to a non-available state until the label check is performed. This will generate a QA failure for the patient, because you have allocated units that are not in available status.
   3. Blood label check will be automated for all products except irradiated red cells and reconstituted whole blood. This means we can get rid of the thawed plasma log and each person will be able to do their own label checks.
   4. There will be changes will aliquoted products (A codes instead of E codes).
   5. Auto and directed units can be scanned into the system like other units.
   6. Archived information will go away at some point during 2014 (it won’t be with the upgrade, but we can start working on the project as soon as the upgrade is complete).
5. Pharmacy will take over RhIG at WAH on Wednesday, May 21. I am finalizing plans for changeover now and will provide more detailed information as it becomes available.
6. Dr. Cacciabeve, Dr. Massimiano (Cardiac Surgery), Dr. Underwood (Anesthesia), and Stephanie met to discuss platelet management for cardiac surgery.
   1. Blood bank staff members will ensure we have 2 total platelets in house for all scheduled cardiac surgery cases. As soon as we issue a platelet, we will order a replacement in for inventory.
   2. We will hold platelets for high risk cases.
      1. High risk cases are those that are more likely to require platelet transfusion such as those with known platelet defect (ie von Willibrands), drug induced platelet defect (ie Plavix), a redo case, those that will be on the pump for a long time.
      2. Only the surgeon and anesthesiologist can identify a high-risk patient (not the PA or nurse practitioner before surgery).
      3. The circulating nurse will notify blood bank when a high-risk patient has been identified.
         1. Initially, this will be telephone notification using the verbal order log.
         2. After June 21, we will have an electronic notification similar to the ETS order. The order will be called “high risk cardiac surgery” and will come to BB. We will need to acknowledge the order to let OR know we are aware of the case.
      4. When a high-risk patient has been identified, BB will ensure 2 platelets are allocated to the patient. This is in addition to the 2 platelets we keep in inventory.
         1. We will be responsible for notifying OR immediately if we don’t have platelets for the patient.
         2. If we have a competing order, we need to call OR and speak to them BEFORE giving the platelets out. This may require the pathologist to triage the patients and decide which gets the platelets.
   3. We will have an SOP outlining this process. This is being added to the hospital policy now.
7. Review examples of rejected Transfusion Order forms.
   1. Dr. Cacciabeve does NOT want us to reject orders that definitely meet indications even if the ordering provider does not check the indication. Examples = platelet count <15K, Hb <7, etc.
   2. Acute hemorrhage does not require signs/symptoms or increased risk even when the hb is between 7-10
   3. Pt on Plavix and undergoing invasive procedure meets requirements for “platelet dysfunction and pre-op”
   4. If the provider gives us signs and symptoms and we can clearly see the hb is between 7-10, we don’t need to require them to check the box
8. Entering ARC Reference Lab results: If you have a panagglutinin AND a reactive eluate, enter WAA as the AbID.