Quest Diagnostics

Quest Diagnostics Nichols Chantilly
At
Shady Grove Adventist Hospital and
Washington Adventist Hospital

BLOOD BANK STAFF MEETING

MINUTES

(09/09/2014)

PRESENT: 9.9.2014 @ 0640-0710 (SGAH) STEPHANIE CODINA, HOJAT GOUDARZI, MARIA MORRIS, YVONNE NGWA, ANNE RIENKS, HAMERE TADESSE
9.9.2014 @ 1430-1500 (SGAH) STEPHANIE CODINA, SARAH DELINGER, GABRIEL NJIKA
9.10.2014 @ 0640-0710 (WAH) STEPHANIE CODINA, MARY-DALE ABELLANO, SHAKIMAH RODNEY
9.10.2014 @ 1510-1525 (WAH) STEPHANIE CODINA, HABIBA LAKO

DISTRIBUTION: BLOOD BANK STAFF MEMBERS

MEETING COMMENCED

Item	Discussion	Action	Follow-up
Minutes			

Transfuse Orders	We are seeing a number of duplicate transfuse orders.
	 1. When a provider places a transfuse order in Cerner, Cerner actually generates two orders: A blood bank transfuse order and a nursing blood administration order.
	 2. The blood bank order moves to a "complete" status as soon as units are allocated.
	 3. If the patient is moved to a new location (Ex= ED to the floor), all open orders will be cancelled.
	    a. The nursing blood administration order will cancel.
	    b. The blood bank order will remain open, because it shows "completed" once the unit is allocated.
	 4. The new provider will place new orders when the patient is received.
	    a. These orders will show as duplicates for BB, because our original order didn't cancel.
	    b. This will be the only open order for nursing.
	
	 There is a high-level workgroup looking at this issue as it affects more than BB. I will let you know if I hear anything new.
	
	 Please go to lab inquiry and leave me a printout if you receive what looks like several duplicate transfuse orders for a patient. I need examples!
		None	None

Plasma/Platelet Orders	We have capped the plasma and platelet orders at 2 units. However, providers are getting around this by typing a comment such as "transfuse 4 units" in the physician instructions. When you encounter these, 1. Thaw and allocate all 4 units if the patient is bleeding profusely or undergoing plasma exchange. 2. Thaw and allocate only 2 units in other situations. 3. Refer providers to the hospital policy if they have issues. Cerner is considering adding a verbal comment to the orders, but won't review until the end of September. Please print these orders for me. I need examples!	None	None
Ordered by OR	Reminder…..If we take a telephone/verbal order for products from OR, the BB staff member MUST place the transfuse order and document the indications. 1. You cannot just add red cells to a T&S, we must have a transfuse order. 2. "Ordered by OR" is a comment and not an indication. Please use the indications that are on the clipboard.	None	None
Attributes	We are seeing many cases where the providers are not ordering transfusion attributes when a patient needs them. We honor the attributes if they are in the patient's BAD file regardless of whether the physician actually orders them.	None	None
Future Orders	We are seeing a lot of transfuse orders being placed for the future. Example: MD placed an order on 9.4.14 for platelet transfusion on 9.15.14. Right now, there is not a process to deal with this type of order. I have reported this issue to the Cerner team and will let you know if I hear something. Please print these orders for me. I need examples!	None	None
ETS/CHOLD	Please continue to leave examples of incorrect MMRNs in the CHOLD and duplicate entry fields for the ETS. The Cerner team is still asking for more examples.	None	None
New Antisera	The new monoclonal antisera can be used at SGAH. We continue to validate at WAH. Anti-s will be done by the end of the week at both locations.	None	None
Echo Upgrade	Immucor is going to upgrade the Echo software at WAH on Friday and SGAH next week. Problem: They are seeing false positive results on antigen typing when fibrin is present. Solution: They are decreasing the range for a positive result and increasing the range for a NTD result. We will see more NTDs reported for weak results.	None	None
5S	5S reminder…..Everything has a place and everything should be in its place. Please DO NOT relocate supplies or reagents!	None	None
Supplies	We no longer have Luke, so please pay attention and look for BB supplies in the lab at least once per shift. On Monday morning I found a box of Immucor reagents in the refrigerator room that had been delivered on Friday. The box was clearly marked, 'Open Immediately—Contents Require Refrigeration."	None	None

Shift Change	I am getting a lot of complaints about shift change. I think it is important to note that we are working short on EVERY shift. People are doing the best they can to keep up with the workload, but it is unrealistic to think there will be no work to pass on at change of shift. Incoming shifts: Ask what you can do to help as soon as you arrive. Take over work without complaining or criticizing. Slow shifts: If you have time for extra tasks on your shift, try to get some of the QC/PM assignments done. You can help with QC that is not assigned to you…..especially with audits! Take it upon yourself to be proactive and help someone else out! We have to realize that we are all one team. We need to work together instead of against each other!	None	None
Open Forum	Reminder: The person who reviews the surgery schedule is responsible for 1. Ordering a TRRC on every patient who is scheduled for open heart surgery; use the indication "Pre-op cardiac surgery protocol." 2. Crossmatching 2 units to every patient who is scheduled for open heart surgery. 3. Order a retype for any patient who needs a retype and has a T&S ordered.	None	None
Fire Drill	We conducted fire drills for all staff members in attendance. 1. Know where the fire pulls are 2. Know where the fire extinguishers are 3. Know the number you call to report a fire (SGAH 4444 and WAH 5555) 4. Know where to meet if you have to evacuate For code pink at WAH 1. Lab is responsible for guarding the door outside the lab 2. Don't let anyone in or out during the code pink 3. Inspect all bags, backpacks, suitcases for babies	None	None
Meeting adjourned			
Next meeting week of October 6, 2014			

Stephanie Codina
Recorder