



Quest Diagnostics
At
Shady Grove Medical Center and
Washington Adventist Hospital

BLOOD BANK STAFF MEETING
MINUTES
(03/03/2015)

PRESENT: 3.3.2015 @ 0640-0705 (SGMC) STEPHANIE CODINA, MARY-DALE ABELLANO, HOJAT GOUDARZI, DIPTI PATEL, RONALD ROJAS, ANNE RIENKS, NAMRATA SHRESTHA, HAMERE TADESSE
 3.3.2015 @ 1435-1450 (SGMC) STEPHANIE CODINA, SARAH DELINGER, HABIBA, LAKO
 3.4.2015 @ 0635-0700 (WAH) STEPHANIE CODINA, VANESSA ROBINSON, SHAKIMAH RODNEY
 3.4.2015 @ 1620-1640 (WAH) STEPHANIE CODINA, TARA APPELBAUM

DISTRIBUTION: BLOOD BANK STAFF MEMBERS

MEETING COMMENCED

| Item | Discussion | Action | Follow-up |
|-----------------------|--|--------|-----------|
| Minutes | | | |
| FDA Inspection | <p>The FDA recently inspected the SGMC blood bank. We had a clean inspection with only a few recommendations.</p> <ul style="list-style-type: none"> • We will be changing the PI/Variance form a bit to accommodate recommendations (new copy attached). Some boxes were changed to only require an answer when applicable. Other boxes were removed completely. • Beginning in April, the SGMC form will be blue and WAH will be yellow. | None | None |
| Audits | Nursing seems to be doing a better job with the audits. No major issues were brought up. | None | None |
| Pneumatic Tube | We are currently validating the pneumatic tube for use in blood product transport at SGMC. When implemented, we will use the same process that WAH is using whereby the person who removes the blood from the tube station will sign and return the form. We need to validate cryo. Instructions and forms are at the issue desk. Please work on the validation if you have the opportunity to thaw cryo. | None | None |
| OL Monitor | SGMC will be getting a second OL monitor soon. We will set one up for "unreceived" and the other for "received" samples to hopefully keep samples on one screen. | None | None |
| Printers | <p>We are getting rid of the pink tag. The new printers should arrive any day (they were shipped last week). Once they arrive, we will need to validate before going live. More instructions once they are installed.</p> <ol style="list-style-type: none"> 1. An example of the new tag is attached. 2. We will have a new form for downtime blood administration (see attached). | None | None |

| Item | Discussion | Action | Follow-up |
|--|--|--------|-----------|
| Outside Results | We recently had a hospital call to “demand” that we fax the results of an ARC workup to them. Per our SOP, we will give verbal results. If the lab wants faxed results, they must go through HIS/medical records and send a patient release. They also have the option of sending a patient release to ARC for the results. We will not fax. | None | None |
| Competencies | The BB1 competency is out. BB2 and BB4 will be out soon. Please provide your thoughts about the Immucor competencies. | None | None |
| New T&S Requirement | <p>The non-RBC SOPs are being updated to reflect changes to the T&S requirements:</p> <ul style="list-style-type: none"> • Inpatients = entire hospitalization. You can tell it’s the same hospitalization by the FIN number. • Outpatients = 1 year <p>This will go live as soon as all SOPs are out.</p> <p>Note: OIC will be using a card system to maintain the BB armband for patients. See attached.</p> | None | None |
| Sick Calls | Reminder, per SOP, you must call both the department AND the supervisor when calling off from work. | None | None |
| Open Forum | WAH stated they are not getting the transfuse orders for red cell exchange procedures in a timely manner. Stephanie to follow up. | None | None |
| Meeting adjourned | | | |
| Next meeting week of April 13, 2015 | | | |

Stephanie Codina
Recorder

BB Variance Form

- GEC
- SGMC
- WAH

Occurrence Date: ___ / ___ / ___

Occurrence Location: _____

Patient name: _____ MR# _____

(L Name)

(F Name)

Accession #: _____ Test Code: _____ Patient location: _____

A. Description of Variance (specify the incident). Check the appropriate box below.

| | | | |
|--|--|---|--|
| Patient Identification Error | | Specimen | Issuing |
| <input type="checkbox"/> Incorrect patient drawn by lab | <input type="checkbox"/> Incorrect patient drawn by nursing | <input type="checkbox"/> Not labeled with blood bank label | <input type="checkbox"/> Issued unit did not meet transfusion requirement |
| <input type="checkbox"/> Patient not banded with blood bank armband | <input type="checkbox"/> Armband information incomplete or incorrect | <input type="checkbox"/> Not labeled | <input type="checkbox"/> Wrong product issued |
| <input type="checkbox"/> Blood bank armband removed | <input type="checkbox"/> Patient's Current ABO/Rh does not match patient's historical ABO/Rh | <input type="checkbox"/> Double labeled (label beneath BB label) | <input type="checkbox"/> Autologous or directed products not issued when available |
| <input type="checkbox"/> Admitting Department error in patient identification or MRN merge | <input type="checkbox"/> Wrong blood in tube | <input type="checkbox"/> Misspelled name and/or incorrect MRN | <input type="checkbox"/> Product returned outside of acceptable temperature range |
| <input type="checkbox"/> | | <input type="checkbox"/> Label missing one or more required pieces of information (name, MRN, collector's initials, time or date of collection) | <input type="checkbox"/> ABO confirmation not completed prior to product issue |
| Ordering | | Maintenance/Temperature/QC | Procedural Error |
| <input type="checkbox"/> Test or blood product ordered on wrong patient (computer entry) | <input type="checkbox"/> Blood product requested on incorrect patient (transfusion request) | <input type="checkbox"/> Duplicate specimen | <input type="checkbox"/> Failure to follow SOP |
| <input type="checkbox"/> Incorrect BB number on request form | | <input type="checkbox"/> Specimen collected on patient at incorrect time (TS drawn with current TS on file, Fetal Screen collected prior to delivery) | <input type="checkbox"/> Unclear SOP |
| | | <input type="checkbox"/> Collected in wrong tube type | <input type="checkbox"/> No procedure available |
| | | <input type="checkbox"/> Missing specimen (i.e. cord blood) | <input type="checkbox"/> Tech misunderstood SOP |
| Testing | | | Supplier Error |
| <input type="checkbox"/> Corrected report due to erroneous result | <input type="checkbox"/> Clerical (computer data entry error) | <input type="checkbox"/> Temp out of range; no corrective documentation | <input type="checkbox"/> Mfg recall (excludes blood products) |
| Blood Product | | <input type="checkbox"/> Temp not recorded | <input type="checkbox"/> Incorrect or unfilled order |
| <input type="checkbox"/> Incorrect label | <input type="checkbox"/> Extended expiration date | <input type="checkbox"/> QC not documented | Quality Concern / Complaint |
| <input type="checkbox"/> Wasted Product | | <input type="checkbox"/> QC failure, no corrective action | <input type="checkbox"/> Tech Quality Concern (Document on back) |
| | | | <input type="checkbox"/> Customer Complaint (Document on back) |

Comments (use space on back of this form)

If this is an RQI (See reverse), reported to: _____ Date: _____ RQI # _____

If this is FDA reportable (See procedure), reported to: _____ Date: _____ FDA # _____

Notified: _____ (date/time) _____ by: _____ (Tech Code)

B. Supervisor Action and Recommendation: (document all follow-up actions taken on reverse) (Tracking) Tech code: _____
 No lab involvement (✓) _____

C. Level of Severity
 No patient impact Minor impact Major impact

D. Follow-Up: Hospital Incident Report # _____ Date: _____

E. Signatures (Sign/Initial and date)

Supervisor: _____ Medical Director: _____ QA Specialist: _____ Admin. Director: _____

Label Output:

The output label will be as shown in the following graphic. There will no barcodes on this label.

| | |
|---------------------------|-----------------------|
| Patient Name | Donor ID/ Unit Number |
| Medical Record Number | Expiration Date/Time |
| Blood Bank Armband Number | Volume |
| Date of Birth | |
| ABO/Rh | ABO/Rh |
| Crossmatch Results | Unit Attributes |

There will be field headings on the label next to the data fields that are stripped from the incoming data stream. Based on the sample data on the previous page, the label will look like the following.

| | |
|------------------------|------------------------------|
| Name: SUNQUEST,APPLE | Donor ID: W2004 14 100929 00 |
| MRN: 159753 | Exp Date: 10/31/2012 2359 |
| BB#: 1235689 | Volume: 335 ml |
| DOB: 01/10/1953 | |
| ABO/Rh: O-NEG | ABO/Rh: O-NEG |
| | E Neg Kell Neg HgB S neg |
| Crossmatch: COMPATIBLE | CMVN++ |

Place patient/unit label here or complete the following:

| |
|--|
| |
|--|

Patient Information

| |
|---|
| Name |
| Medical record number |
| Blood bank number |
| Date of birth |
| ABO/Rh |
| Crossmatch Results <input type="checkbox"/> Compatible <input type="checkbox"/> N/A <input type="checkbox"/> Least Incompatible |

Unit Information

| | | | |
|---------------------|----------------------|--|------------|
| Donor ID | Expiration date/time | ABO/Rh | Attributes |
| Date/Time of issue: | Issued to: | Visual inspection: <input type="checkbox"/> Acceptable <input type="checkbox"/> Not acceptable | |

We certify that before starting the blood transfusion, we have checked the following:

- 1. Verify the provider order for transfusion.
- 2. Verify the consent for transfusion.
- 3. Compare the patient's last and first name and medical record number on the blood bank and hospital armbands. Ensure they match exactly.
- 4. Compare the patient's last and first name and medical record number on the hospital armband and patient/unit label. Ensure they match exactly.
- 5. Compare the blood bank number on the patient's blood bank armband and the patient/unit label. Ensure the number matches exactly.
- 6. Compare the donor identification number (unit number) on the blood product label and the patient/unit label. Ensure the number matches exactly.
- 7. Compare the expiration date (and time if applicable) on the blood product label and the patient/unit label. Ensure it matches exactly and has not been exceeded.
- 8. If the provider ordered attributes for the blood product, verify that the blood product contains the ordered attributes (CMV-negative, irradiated, HbS-negative, HLA-matched).

Signature: _____ Signature: _____

Note: Contact blood bank if the transfusion will not begin immediately.

Date and Time transfusion started: _____
 Date and Time transfusion completed: _____
(TRANSFUSE WITHIN 4 HOURS OF DISPENSE TIME)
 Volume transfused: _____

| |
|---|
| Type of blood product: <input type="checkbox"/> red cells <input type="checkbox"/> plasma <input type="checkbox"/> platelets <input type="checkbox"/> cryoprecipitate <input type="checkbox"/> whole blood |
|---|

Transfusion Reaction? No Yes If yes, stop transfusion, see back of sheet

| | Time | B/P | HR | Resp | Temp | Initials |
|----------|------|-----|----|------|------|----------|
| Pre-txn | | | | | | |
| 15 min | | | | | | |
| 60 min | | | | | | |
| 2 hrs | | | | | | |
| 3 hrs | | | | | | |
| Txn Stop | | | | | | |

Reminder: Give patient "Notice to Patients Receiving Blood Transfusion" form if discharged within 12 hours of transfusion.



W520300

Downtime Blood Administration

520-300 (2/15)

Patient Identification

DOWNTIME BLOOD TRANSFUSION REACTION REPORT

Fax both sides of this form to blood bank.

Procedure:

1. Clamp off blood immediately; disconnect blood tubing, all extension tubing and saline. Keep vein open using new saline and transfusion tubing.
2. Check for agreement of all identifying names and numbers on patient armbands, blood product label, patient/unit label, and electronic medical record. Document below.
3. Notify attending physician immediately, or house physician if warranted to manage patient symptoms.
4. Phone Blood Bank. A phlebotomist will be sent to draw post-reaction specimen(s), if indicated.
5. Monitor vital signs every 15 min x 3, then every 30 min x 2, then hourly x 2, continue as needed. Record on frequent monitoring record and document pertinent information on nursing flowsheet.
6. Return blood container and transfusion tubing to the Blood Bank immediately. Fax a copy of this form to Blood Bank or photocopy both sides of this form and send to Blood Bank immediately.
7. Maintain hourly I & O until further orders are obtained.

Clerical Check

1. Compare the patient's last and first name and medical record number on the blood bank and hospital armbands. Ensure they match exactly.
2. Compare the patient's last and first name and medical record number on the hospital armband and patient/unit label. Ensure they match exactly.
3. Compare the blood bank number on the patient's blood bank armband and the patient/unit label. Ensure the number matches exactly.
4. Compare the donor identification number (unit number) on the blood product label and the patient/unit label. Ensure the number matches exactly.
5. Compare the expiration date (and time if applicable) on the blood product label and the patient/unit label. Ensure it matches exactly and has not been exceeded.
6. If the provider ordered attributes for the blood product, verify that the blood product contains the ordered attributes (CMV-negative, irradiated, Hbs-negative, HLA-matched).

Clinical Diagnosis prior to transfusion:

History of pregnancy or abortion? _____ When? _____
History of previous transfusions? _____ When? _____
History of previous reactions? _____ When? _____
Medications at the time of transfusion (list) _____

Time Reaction First Noted _____ AM/PM
Time Blood Discontinued _____ AM/PM
Volume Transfused (approx.) _____ mL

PLEASE CHECK THOSE THAT APPLY

- | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------|--|-------------------------------------|-----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|---|---|-----------------------------------|------------------------------------|--|-----------------------------------|---|------------------------------------|--------------------------------|---|---|-----------------------------------|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Pulse | <input type="checkbox"/> ↓ B/P | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rash | <input type="checkbox"/> Coma | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Headache | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Hemoglobinuria | <input type="checkbox"/> Hemolysis | | | | | | | |
| <input type="checkbox"/> ↓ Pulse | <input type="checkbox"/> ↑ B/P | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rash | <input type="checkbox"/> Coma | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Headache | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Hemoglobinuria | <input type="checkbox"/> Hemolysis | | | | | | | |
| <input type="checkbox"/> Delirium | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> Petechiae | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Flushing | <input type="checkbox"/> Pruritus | <input type="checkbox"/> Hives | <input type="checkbox"/> ↓ Urine Output | <input type="checkbox"/> Heat/Pain at IV Site | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Petechiae | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> Delirium | <input type="checkbox"/> Flushing | <input type="checkbox"/> Pruritus | <input type="checkbox"/> Hives | <input type="checkbox"/> ↓ Urine Output | <input type="checkbox"/> Heat/Pain at IV Site | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Petechiae | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> Delirium |

Other comments (Specific)

Signature: _____
Signature: _____

Patient Identification

Adventist HealthCare
Washington Adventist Hospital

Downtime Blood Administration

520-300

W520300



