Quest Diagnostics

# Quest Diagnostics at

# Shady Grove Medical Center and Washington Adventist Hospital

## MEETING

### MINUTES

### 6.3.2015 AND 6.4.2015

**PRESENT:** WAH: 6.3.2015, 0645-0720: STEPHANIE CODINA, MARIA MORRIS, TSEGAYE NEGASH, VANESSA ROBINSON, SHAKIMAH RODNEY
WAH: 6.3.2015, 1655-1745: STEPHANIE CODINA, TARA APPELBAUM, HABIBA LAKO
SGMC: 6.4.2015, 0635-0705: STEPHANIE CODINA, YESHIWAS BELEW, DIPTI PATEL, NAMRATA SHRESTHA, HAMERE TADESSE
SGMC: 6.4.2015, 1440-1515: STEPHANIE CODINA, SARAH DELINGER, HOJAT GOUDARZI

**DISTRIBUTION:** BLOOD BANK STAFF MEMBERS

**MEETING COMMENCED:**

| Item | Discussion | Action | Follow-up |
|---|---|---|---|
| **Minutes** | | | |
| **Forms** | When making copies of forms, ALWAYS pull the master copy from the forms manual and copy that.<br>1. Copies of copies of copies lose integrity and become difficult to read.<br>2. We are implementing new forms and discarding old forms. In some cases, the old forms popped up again after a month or two which suggests people are stashing them in mailboxes, lockers, or drawers. THIS IS INAPPROPRIATE. All forms should be stored in designated areas per regulatory requirements. | None | N/A |
| HDN Case | We recently performed an emergency exchange transfusion on an ~10 lb infant. There were a number of problems with this case (mostly outside of BB). However, there are some things we can improve.<br>1. One complaint that was consistently addressed is that BB staff did not give an adequate estimate of "when" the blood would be available. I realize that we don't always have a perfect estimate, but we can say something like "It will take at least 2 hours." The treating MD stated he would have given IVIG or albumin had he known it would take longer than 20 minutes (remember, they are comparing this to the TAT for | 1. Update SOP to reflect standard hct of 50-55%.<br>2. Update Cerner order to list the following:<br>a. Always order 2 blood volumes.<br>b. Final Hct of unit is 50-55%.<br>c. Product will take at least 2 hours to prepare.<br>d. Consider giving albumin.<br>e. Consider giving IVIG.<br>3. Build new RWB product | Stephanie<br>Josh/Kim<br>Anne |

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| | regular aliquots).<br>2. We did not receive the final hct of the whole blood from the ordering MD. The neonatologists have standardized this so the final hct will ALWAYS be 50-55% and the volume will ALWAYS be 2 blood volumes.<br>3. We had difficulty getting fresh CPDA-1 units for this exchange (and the one that occurred a week later). We have applied for a new product code from ICCBBA for AS-3 RBC with plasma added. Our request has been approved and we received notice that they will assign a code at the end of June. We will build the AS-3 RWB product as soon as we receive the E code. | for AS-3 RBC as soon as E code is received. | |
| Patient Unit Labels | The new patient unit labels have been validated. We will implement the new process at WAH on Monday, June 15 and at SGMC on Tuesday, June 16.<br><br>We reviewed the downtime process:<br>1. If Sunquest is available, print 2 labels. Place one on the downtime form and the other on the unit.<br>2. If Sunquest is down, handwrite patient and unit information on downtime form and label.<br>Downtime forms and labels are in the downtime drawer/cabinet.<br><br>Note: The E code is not on the new label. If you have split apheresis units (>1 unit with the same DIN), look at the VOLUME to determine which label belongs to which bag.<br><br>Notification went out to nursing at both sites. Copies of the notification are posted. | Implement new process on June 15 and 16. | Stephanie and Marie |
| **Reagent Receipt QC** | Reminder that reagent receipt QC must be performed anytime a new lot or new shipment of reagent is placed into use. We are seeing problems with reagents QC'd on the Echo and with antisera.<br>1. People are doing a good job of writing "new lot of reagent" on the Echo QC form, but they are simply filing it in the Echo QC book. They are not going back to the reagent receipt QC to fill in the form. This MUST be done.<br>2. We are receiving a number of shipments of the same lot of antisera. If you QC a bottle with a yellow dot, you are required to perform reagent receipt QC.<br>3. Reagent receipt QC MUST BE DONE even if the form is not pre-filled for you; simply fill out another form and submit if the dot is red, orange, or yellow. | None | N/A |

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| **Tech Cell** | The tech cell on the panel CAN be used for testing and QC. Simply call it "TC" instead of writing a cell number on the form.<br><br>We have had a lot of patients with Fy lately. People are checking the box to indicate a heterozygous positive cell is not available. However, there is one available. It is the TC. | None | N/A |
| **4 Hour Coolers** | The policy that states coolers must be returned within 4 hours instead of 6 hours has been implemented. This change is due to changes in regulatory standards.<br><br>If the patient care area still needs the cooler after 4 hours, you should prepare new units in a new cooler and issue to the floor/OR then request the original cooler be returned. | None | N/A |
| **FIN** | We recently had an incident where a patient was seen in Transcare for cardiac cath on Thursday. The patient has a valid T&S collected and an ETS performed. The patient was discharged and returned on Monday for open heart surgery. The OR questioned whether the patient needed a new T&S because the FIN changed. We initially told them to cut the armband off but later called to say it was OK. Unfortunately, the nurse had already cut the armband off. This delayed surgery.<br><br>Reminder: We DO NOT use FIN for BB. Only name and MRN. The FIN will differ due to the 7-day window for T&S and transfusion. The FIN is NOT printed on the new patient-unit label. | None | N/A |
| **Antigen typing** | 1. If we KNOW a patient is going to need antigen negative units in advance (such as in exchange transfusion), please order from ARC if possible. This is less expensive and will not cause us to use O-neg units for non-O-neg patients.<br>2. The paper order for exchange transfusion IS an order and we can bill off of that.<br>3. If you perform antigen typing in house, perform QC and patient typing all at the same time. I am seeing people perform QC on C, then QC on c, then QC on E, etc. Then they will go back and test the patient for E, then for C, then for….etc. Run the patient and controls for C, c, E, e, and K all at the same time. Then run your units one ag at a time. This will save time, reagents, and resources. | None | N/A |
| **Open Forum** | 1. Techs state the ED is still having difficulty distinguishing between the ABO/Rh and TS tests at WAH.<br>2. Techs state we are receiving multiple orders for the same test (ie ABO/Rh) from the ED at WAH.<br>3. ED and L&D are tubing specimens | 1. Distribute education differentiating ABO/Rh and TS to the ED.<br>2. Give Stephanie examples of duplicate orders (excluding transfuse orders). | Stephanie<br><br>BB Staff Members |

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| | directly to BB at SGMC.<br>4. A large number of specimens are not being received by the front desk at SGMC and are brought directly to the BB. Unfortunately, this is usually during periods where they are busy….and we are busy too, so it is straining BB staff.<br>5. SGMC needs a list of pneumatic tube stations.<br>6. ED at SGMC is not returning yellow form or completing yellow form when receiving blood products via pneumatic tube. | 3. Remind LD and ED nurse leaders that samples should go to processing.<br>4. Remind ED of the process for tubing blood.<br>5. Notify Samson that specimens are not being received.<br>6. Create a post a list of departments/pneumatic tube stations. | Stephanie<br><br>Stephanie<br><br>Stephanie<br><br>Stephanie |

**Meeting adjourned**

**Next meeting the week of July 6**

Stephanie Codina
Recording Secretary