**

Shady Grove and White Oak Medical Centers

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| **Blood Bank Team Meeting** **Minutes**  **February 6, 2024** |

**Present:**

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| √ | Mary-Dale Abellano |  | Bilen Gebresenbet | √ | Larissa Kukapa |
| √ | Kelvin Addo | √ | Isaias Gebreweldi | √ | George Li |
|  | Malak Antar | √ | Hojat Goudarzi | √ | Arlene Mencias |
| √ | Lesley Crowder |  | Natasha Hall |  | Tsegaye Negash |
|  | Bech Ebini | √ | Chizobam Igweh |  | Boris Njeambosay |
|  | Uchama Eni | √ | Jessica Jenkins | √ | Rocio Vergara Torres |

**Distribution:** Blood Bank Team

**Meeting commenced:** 0630 and 1600 via TEAMS

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| **ITEM** | **DISCUSSION** | **ACTION** | **FOLLOW UP** |
| **Neonatal Exchange Transfusions** | **When blood bank is notified of a possible neonatal exchange transfusion, what do we need to know immediately?**  MRN of baby and mom  Does mom have clinically significant antibodies?  **If notified, please order blood in immediately.**  Red cells should be fresh <7 days old  Antigen negative for mom’s corresponding antibodies  Meet all other neonatal criteria  **Why do we order blood that is <7 days old?**  Potassium is an intracellular electrolyte. As blood sits, the potassium leaks out of the cells into the red cell bag. The potassium leak is pretty consistent for the first week of storage, but it jumps up on day 7. We need to minimize the amount of potassium that we transfer to the baby, since we are giving such a large volume of red cells.  **Why are exchange transfusions done?**  If baby’s red cells are being destroyed, there are two risks:   1. Before birth (in utero) the bigger risk is anemia. Mom’s system will remove the bilirubin, but it is difficult to transfuse prior to birth. 2. After birth the bigger risk is bilirubinemia. We can easily transfuse the baby to increase the hemoglobin, but it is difficult to remove bilirubin. The first treatment is generally putting the baby under a bili light. Bilirubin is light labile and will break down. However, if the bili continues to rise they need to remove it to prevent negative effects such as brain damage.   During an exchange transfusion, they will remove the baby’s blood volume twice and replace with new blood. This will remove toxins, antibodies, and bilirubin while replacing the cells with antigen-negative cells (in some cases) to prevent further destruction.  **When we get the blood in house:**   1. Sterile dock tubing to the bag to pull off a sample for hematocrit and send to hemo for testing. 2. Crossmatch unit to mom’s or baby’s specimen per policy. 3. Calculate the volume of plasma once hematocrit returned.   **When the order for reconstituted whole blood is received:**   1. Thaw plasma and create aliquots based upon your calculated volumes. 2. Sterile dock plasma aliquots to red cell back and combine. 3. Mix well and obtain another hematocrit to verify it is within acceptable limits. 4. Reconstitute whole blood in the computer. Document volume and ABO/Rh of plasma added on the label. 5. Irradiate. 6. Notify unit it is ready. 7. Prepare a waste bag   **Preparing RWB in Blood Component Prep:**   1. Use the function R + the E code of the red cell 2. Scan the plasma aliquot first 3. Scan the red cell unit second 4. Enter the information as required to complete the component prep   If the volume required more than one unit of RWB, issue all in a cooler. They will need at one time.  We will do competency on this process in 2024. Please ensure you read the SOP and are familiar with the process.  Please send Stephanie edits to the SOP as soon as possible. | Informational | None |
| T&S Hold | ED is seeing more patients then they can manage. In addition, ED routinely houses patients that need to be admitted but no bed is available. They are looking at improving throughput. One project involves us.  If a stable patient is referred to ED for transfusion or if they note a patient needs transfusion and is stable during exam, they are going to refer that patient to OIC for transfusion. The patient will be discharged from ED and given an appointment with OIC that may be the same day or a different day.  When this occurs, we need to run the T&S and issue units on the OIC FIN number.   * ED will draw the T&S for us using the order “TS HOLD.” * We will perform testing on downtime but do not enter into the LIS. * When the patient is admitted to OIC, they will place T&S and transfuse orders. * We will enter the results of downtime testing into the OIC order (note it must be the OIC order and not the ED order) and order the retype if needed. * We will issue blood on the OIC order. | Informational | None |
| Competency | I will be issuing the competency forms to all staff for 2024. We will do one assessment per month. Please do not work on getting signed off until a particular test system is assigned. In February, we will do manual testing with the Antibody Titer. In addition, I have assigned Cont Ed programs that will be due at the end of each even month in 2024. Instructions for accessing the Cont Ed programs is in your mailbox. | Informational | None |