Adventist HealthCare

Shady Grove and White Oak Medical Centers

BLOOD BANK TEAM MEETING

MINUTES

APRIL 2, 2024

PRESENT:

√	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	√	HENRY NVULE
				√	ROCIO VERGARA TORRES

DISTRIBUTION: BLOOD BANK TEAM

MEETING COMMENCED: 0630 AND 1600 VIA TEAMS

ITEM	DISCUSSION	ACTION	FOLLOW UP
TRANSFUSION REACTIONS	I have been seeing a lot of transfusion reactions coming through that do not have results entered. Reminder that the person performing the transfusion reaction workup should be entering the testing parts: • ABO/Rh • DAT • Clerical check • Hemolysis check • Visual inspection The only thing that should be pending is the pathologist's interpretation. Also, reminder that each form needs the Sunquest label in the upper, right corner. We test ALL units that have been transfused within the previous 12 hours.	Informational	None
ANTIGRAMS	Please ensure that you are placing an antigram in the binder when receiving reagent red cell panel or screening cells. Also, please DO NOT remove antigrams from the binder. Several have gone missing in recent months.	Informational	None
BINDERS AND LABELING	Binder colors and labeling of refrigerator shelves, etc is regulated within Quest. Please do not change a binder or relabel without checking with me. We need to keep our binder in the same color.	Informational	None
Reagent Receipt QC	We perform Reagent Receipt QC on every new lot and new shipment of reagent. When you are receiving reagent, you need to look at the logbook to see if we've received other shipments of the same lot. If we do, you must segregate the lots.	Informational	None

- New shipments of a previously received lot get a yellow circle instead of a red circle.
- Rubberband or somehow segregate the 2+ shipments. This can also be done by writing the date received on the yellow dot sticker.

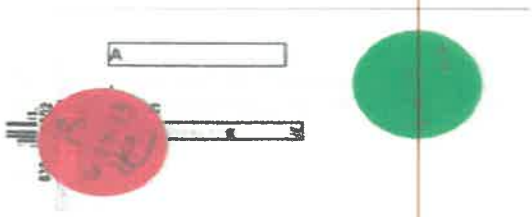
Reagent receipt QC must be performed on each shipment and documented.

When the green circle label is added to show that a new shipment has been QC'd, the green circle goes directly on top of the red or yellow circle sticker. The stickers are supposed to be placed next to the lot and expiration date of the reagent.

Case Study:
We received multiple shipments of the same lot of AHG.

11-10-22	1	703025	02-22-24	S	07/19	N/A
[illegible]	1	703026	02-23-25	S	07/19	N/A
6-15-23	1	703026	2-23-25	S	7-19	N/A
6-23-23	2	703026	2-23-25	S	07-19	N/A
12/29/23	2	703026	2/23/25	S	07/19	N/A
5/12-1	2	703026	2/23/25	S	7/19	N/A

The incorrect color of circle sticker was placed on the reagent. Note the dates.



The tech placed a green circle sticker on this even though the QC date occurred before the shipment was received.

As a result, no reagent receipt QC was performed per procedure.

See procedure examples:

> Place a red, circle sticker on each package of reagent received and store the supplies/reagents in the designated location. In addition to the red circle, place a yellow circle on subsequent shipments of any reagent that contains the same lot number. This will help to differentiate different shipments of the same lot o reagent that require reagent receipt QC.
>
> Note: It is very helpful to segregate new lot and new shipments of reagent fron the current, in-use lots of the same reagent in some fashion. This can be accomplished by placing a rubber-band around packages of different lot numbers of reagent or physically separating reagents (though not always possible given space constraints).

> Place a green, circle sticker on each box of reagent that will be placed into use following acceptable performance of quality control testing. Place the green sticker directly on top of the red sticker that was placed upon receipt.

Also, when bringing in new reagents, reagents that go together must be written on the same reagent receipt QC form. This includes, Pos and Neg Capture QC, A1 and B cells, Screen cells 1, 2, & 3. This is

	because you cannot interpret QC without looking at the results of each subpart. D. Expiration date E. Lot number of kit (for A_1B cells, Capture R controls, and sickle contro only) *Note: All parts of a kit should be on the same QC sheet. F. Expiration date of kit (for A_1B cells, Capture R controls, and sickle controls only)		
Reagent Expiration and Quality Control	Reminder: When performing quality control, we discard reagents at least 24 hours BEFORE the expiration. This is because we do QC after midnight. If we QC a reagent on 3/31 that expires on 4/1, there is a possibility that reagent will get used after expiration and before QC is run again. B. Discard expired reagents and any reagent that will expire within 24 hours of quality control. a. Be sure to discard all remaining bottles from the reagent refrigerator also. b. DAT positive and indicator cells that will be used on the Galileo Echo can be excluded from this rule. The Echo will not accept reagents that have exceeded their expiration.	Informational	None
Temperature Charts and Alarms	If a refrigerator alarms, you MUST take and document the internal temperature. You must also move the blood products if the temperature of the refrigerator exceeds the acceptable range of 2-6C. Document the internal temperatures on a manual form or on the temperature chart with date/time and the reason for activation. DO NOT hold refrigerator doors open long enough for the temperature to go out of range. You must monitor the temperature and close the door when the temperature gets to about 5C.	Informational	None
Documentation Technique	AABB cited blood bank for poor documentation technique. Specifically, staff need to follow procedure when correcting errors. • Place a single line through the error. • Add date/time of correction. • Add initials or tech code. DO NOT overwrite errors. Also, reminder, that you must add the date and reason when adding retroactive information to a QC/Maintenance form.	Informational	None
Billing	Reminder that you cannot change billing in Sunquest once it has been saved. The billing may update in Sunquest, but it is only transmitted to Cerner once. Special functions are needed to force it to cross again.	Informational	None
Case Study	We reviewed an ABO discrepancy case study. Details are attached.	Informational	None
To Do List	1. Complete training on refrigerator/freezer/platelet rotator alarm checks before April 30, 2024. 2. Complete the 2nd course with Versiti (ABO Discrepancy) and turn in your certificate before April 30, 2024. 3. Complete Empower training. Note Empower is now accessed via Employee Self Service and Learning. 4. Competency—Complete RWB/Irradiation during the week in which you work nights at SGMC. Due May 30, 2024. Please	Informational	None

	ensure that you enter a thawed plasma and an AS-3 or CPDA-1 red cell into the TEST system in preparation for the competency.		
Runners	I received a complaint that the regular Runner's couriers that are scheduled to transport specimens from FWMC→WOMC→SGMC are refusing to take things like envelopes, reagents, and coolers unless we call in a separate ticket. I spoke with Runners and this is not true. Please contact me if you run into issues.	Informational	None

Case Study:

Patient is a 79 yo male with history of bladder/kidney cancer; receiving immunotherapy with Keytruda; has history of anemia requiring blood transfusion. Seen in ED on 3/6/24. Patient's current H/H is 6.2/19.1. Provider writes orders to transfuse 1 RBC.

ABO Retype received in blood bank.

Initial results:

Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
?	0	3+	1+	3+	NTD

Patient has a history of being O-positive:

1/17/24 T&S reported as O-positive

1/17/24 ABO Retype reported as O-positive

3/6/24 T&S reported as O-positive

Patient was transfused 2u O-pos RBC in January

ABO discrepancy workup initiated. Results as follows:

	Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
Repeat ABO	4+ MF	0	4+	0	4+	A-Pos, but does not match Hx ABO
Extended Inc @ RT	4+	0	4+	1+	4+	NTD
Extended Inc @ 1-6C	4+	0	4+	3+	4+	NTD

Tech asked for a new ABO Retype and pulled the CBC for testing.

	Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
New Retype	4+ MF	0	4+	0	4+	? A pos
CBC	4+ MF	0	4+	0	4+	? A pos

A1 subtyping performed to rule out A subgroup. A1 typing is positive.

Patient history obtained. Patient received 2u A-pos RBCs at MedStar in February. They show patient is A-positive.

QUESTION: Why are we seeing a mixed field result with Anti-A?

Answer: Patient is likely A-pos. The MF result is due to the 2 O-pos units we gave him in January.

So, how did we report out O-positive on three different specimens?

Pulled T&S from 3/6/24. Results are as follows:

	Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
T&S on Echo	?	0	3+	1+	3+	NTD
ABO Reported in LIS	0	0	4+	3+	3+	O Pos

Repeat testing by another tech yielded the following results:

	Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
Manual Repeat	4+	0	4+	0	4+	A Pos

QUESTION: What could explain the discrepancy between the ABO reported in the LIS and the repeat results?

ANSWER: The tech did not run all cells when performing the repeat ABO. He admits he only did the backtype, based on historical results and patient age. This is considered falsification of results.

Testing from January was also pulled. The following were reported in the LIS:

	Anti-A	Anti-B	Anti-D	A1 Cell	B Cell	Interpretation
T&S Echo	0	0	3+	1+	2+	NTD but reported as O-pos
Retype	0	0	4+	2+	3+	Reported as O-pos

QUESTION: What is wrong with reporting the Echo results the way we did?

ANSWER: Results of the A1 cell did not meet our testing requirement of strength $\geq$2+. An ABO discrepancy workup should have been performed. This is a failure to follow procedure.

QUESTION: Why wasn't this picked upon retype?

ANSWER: We accept the IS results for retype if they match the initial testing results.

QUESTION: What is the most likely reason for all of the results?

ANSWER:

Patient likely has 2 different ABO discrepancies demonstrating.

- **Weak forward group due to cancer treatment**
- **Extra reactivity in the reverse type due to a cold antibody**

LESSON LEARNED:

Always follow blood bank procedures and test both forward and reverse cells with each step of an ABO discrepancy.

Note:

We should not be testing ABO retypes on the Echo. We perform ABO retype testing in manual tube to save time and lower cost.