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| HMC Transfusion Service Staff Meeting 7/21/16 3WH108 | | |
| [http://www.komencolorado.org/kdwp/wp-content/uploads/2014/10/Thank-You.jpg](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&frm=1&source=images&cd=&cad=rja&uact=8&ved=0CAcQjRw&url=http://www.komencolorado.org/thank-you-race-sponsors/&ei=VB63VJbUJMr4yQTd54LQCw&bvm=bv.83640239,d.aWw&psig=AFQjCNGP4nRIWD05M8iVZZERU4GsNU_Feg&ust=1421373380983219) | | *Patients are First* Pillar Goals   * *Focus on Serving the Patient/Family* * *Provide the Highest Quality of Care* * *Become the Employer of Choice* * *Practice Fiscal Responsibility*   Service Culture Guidelines   * *Respect privacy and confidentiality* * *Communicate effectively* * *Conduct myself professionally* * *Be accountable* * *Be committed to my colleagues and to the UW Medicine Health System* |
| Service Culture Guideline | * What is the impact to the team when there is a lack of professionalism? * What would you do if you observed another employee not being professional? | |
| Hospital Update | * HMC budget- 2016 fiscal year completed in June. * Summer Picnic-August 17th, 11am-2pm. August 18th-nights- free for staff * Infection Control – recent outbreak of hospital acquired Acinetobactor at HMC. This strain is resistant to many antibiotics. Infection control wants all areas that potentially go to patient room to make sure proper PPE is being followed. Since TSL deliver blood to patient floors, all staff should follow PPE protocols. | |
| Lab Update | * Document Control – out for UW bid, will take about 4 months. * CAP self-inspection- Expect inspection to happen in July/August. * AABB inspection readiness- application for reassessment has already been submitted. Assessment team to HMC has been assigned, inspection due in Oct-Dec this year. Aubre is working on the standards and matching it to our processes. Staff can prepare by making sure lab does not have old SOPs, forms that are not in use. All forms should be printed from Lilith or the SOP binder in the lab. * Staffing – 2 CLT2, 1 MLS 1, 1 MLS Lead. Interviews for CLT2 positions in process. Hope to have new hires in the next couple weeks. * IH Clinical Trial-testing will be completed 7/27/16. With the trial completion, the Tango Optimo replacement to Tango Infinity will be brought in. * Annual TB screening- kudos to all who have completed their annual screening. Only a few left * Autograft Skin Storage for OR- policy is live. Reminder: product is good for 3days stored in the refrigerator. Autograft skin shelf and quarantine has been created in R6. * Competencies – lot of missing competencies. We need to vigilant about not missing/misplacing competencies. All should be turned in by their due date. MLS staff should also be using the competency tracker to be on track. Nina will be following with staff on their evaluations if competencies are not completed or tracker is not complete. | |
| QA/Blood Utilization | * June utilization data, CT ratio 1.3 * RBC-2 outdate, 4 wasted- cooler * PLTs- 6 outdate * Plasma- 5 wasted- cooler, broken * Cryo- 1 wasted * QA update * OR samples process improvement – there is currently a initiative with OR to reduce the duplicate draws. Patrick is working with IT to develop amalga report that OR staff can look and see if TSCR, ABRH2 has been completed. Both TSL and OR will have access. More to come. * BPDRs- sample testing, QC, issued units with incorrect transfusion record. Few lab errors that have resulted in BPDRs.  1. Wrong blood type- patient had two samples sent to lab. Both were resulted as A neg , patient transfused then with 2 units A neg RBC. Few days later a new sample for TSCR was drawn, tech noticed mixed field with anti-D. Another draw was requested; mixed field seen again. Upon investigation by the lead, the original samples were retested, patient typed as A pos. One explanation was that anti-D was not added to the original testing and the tech had tested both TSCR and ABRH2 at the same time. Policy change has been posted to avoid this error in the future 1508-3. 2. QC- manual reagent qc had AHG lot# recorded as having being qc’d different than actual vial ofAHG in the refrigerator. Discrepancy was not discovered for >24hours. Once discovered all testing was repeated and BPDRs filed on 11units. Change- No preprinted lot#s on the Daily Manual QC sheet, 2nd tech must check bottle against QC sheet to make sure lot# matches. 3. 2 units of RBC requested by OR on same patient. Units sent to OR in fridge, anesthesia removed one unit and upon readback discovered record did not match unit#. TSL was notified; tech investigated and found the records had been switched. Read back process failed. No change at this time, SOP for readback was not followed. | |
| Staff Round Table |  | |