**Morning Meeting Attendees:** Ariel, Vaness, Ben, Crystal, Deann, Christine, Anel, Kate, Alyssa, Mariah (student)

**Afternoon Meeting Attendees**:

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| **Agenda Item** | **Discussion** |
| **Staffing and schedule-**  | * New hires
	+ Night shift offer out pending acceptance
	+ New employee starting is night shift
* Night shift coverage
* Evening shift is fully staffed
* One opening on day shift
* Pushing schedules to the shifts and coordinating with Ryan so that there are no problems
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| **Cleaning**  | Reminder from housekeeping to keep the area picked up to allow them to complete their cleaning duties* Clean up after potlucks so Jolly (house keeper) can do her cleaning
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| **Marnie Thomas role transition plan** | * Going away from Tx coordinator to Nurse development on May 8th
* No longer the person to call about issues.
	+ These will be handled internally or with the affected units
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| **DARA Carryover** | * We are good about known DARA go to Manual bench
* New SCCA patients that are already on DARA are giving us problems.
	+ If it says multiple myeloma, send to manual bench or interpret subsequent positive reactions with caution (they may be false)
	+ NOTE: pre-DARA may mean pre dose administration not pre-starting DARA therapy
* FYI: Will not go live with Infinity unless HMC can validate theirs.
	+ Germany is able to replicate the missed reactions between Tango and Infinity, it may be related to how the machines pipette
 |
| **ARC Antigen Negative Reports** | * Antigen Neg reports come in an envelope addressed to management. The envelope is NOT for management. Open it, review it, move units to appropriate locations (for patient or antigen negative inventory), and file
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| **Units returned from Issue** | Units returned from issue must have the temperature checked for acceptability prior to returning to inventory when not stored in monitored storage* Check the temperature **when it arrives**. It may come into acceptable temperature while in quarantine awaiting approval.
* Floor asked for two units, received two units, and later called requesting a refrigerator for second unit. Tech refused. Tech was correct. Have them return the unit so we can check the temperature and return to inventory or quarantine (as appropriate).
* Looking at alternative thermometers
	+ The Fluke is meant for liquid so not the best for the task
	+ Temperature stickers that are placed on the unit are not cost effective for the volume that we issue
	+ Please let Deann know if you know of a good thermometer from working elsewhere
* Should we have a protocol for deferred tube?
* Tubes sometimes sit at tube station for 5+ minutes waiting to leave
	+ Our location is not on the main tube line, tubes take a very inefficient route
	+ Management will check tube station delivery times
	+ Construction is required to give our tubes direct routes. Management will check with DSB
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| **TRRX – itching and hives only** | * If patient’s physician deem it is nothing other than itching and hives, the transfusion may be restarted and we will not receive the bag
* We are not responsible for determining TRRX, refer questions to the LMR or the nursing policies
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| **Managing Thawed Plasma Inventory** | * Working to educate clinicians that they don’t need plasma on the floor. Most plasma orders are not transfused.
	+ Try to convince OR to keep plasma with us or get the refrigerator back after the case is over (or just the plasma)
 |
| **Quality**  | BDPRs and other event review * Issuing in SQ – You are accountable for following the procedure. All shifts, regardless of staffing, must issue first and perform the clerical check second.
	+ The number of events increased from last month
	+ Issue in SQ **before** handing off for clerical check, don’t forget to hit cancel. It will time out and issue will not be complete
	+ You can allocate and **store in monitored storage**, it is ok for someone else to issue.
		- If you are too busy to issue, hand the transfusion record to someone else for them to locate unit **and issue**.
* Wrong component issued
* Review QA failure before saving test results
	+ Watch out for testing with NTD
		- Reverse type was reported as ND on an adult
		- Rh control is required for an NTD that is testing as ABPos front type
* In-use vs not in-use reagents
	+ In-use reagents are in the refrigerator nearest the manual benches
	+ Not in use reagents are in the further away refrigerator
* What to do if QC is missed
	+ Check reagent and instrument QC/maintenance at beginning of shift to verify everything is current and correct
	+ If QC is missed:
		- Review and repeat ALL testing. They need the original testing and repeat testing results together
		- Call Christine (it is ok if she is at home) for help and guidance
* New tables categorizing the kinds of BPD events.
	+ Current rate will lead to fewer annual events than last year but still over the desired level of events for our work type and volume
	+ We transfuse 0.19% of the components issued nationally but we report 3.29% of the BPDs reported to the FDA nationally
* Management is meeting with SCCA to streamline processes
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| **Safety** | * Leak repair and door lock issues have been repaired. Please report any additional issues to OPS & Maint as well as TSL leadership
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| **Training** | * SOP revision implementation 5/1 - Specimen Acceptability and Order Receipt
	+ Complete training by 5/12, these revisions need to be implemented
	+ There are summaries of the changes which also address common mistakes
		- CRITICAL STEP: you **must** use the original sample collection date and time when converting BBHOLD to TXM. Units have been issued on an expired crossmatch because the default date and time were used
* TBD
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| **Preventing wastage of washed/RV products** | The TSL MDs can be contacted to work with the nurse to ensure administration occurs product outdate and/or outdates can be extended as necessary.* Working to revise nursing policy that they have to start the transfusion before the unit expires instead of complete transfusion before it expires
* Refer nurse to TSL MD if they need counselling

To help RN planning: provide the expiration time of RV and washed platelets. When shift hand-offs occur, RNs may not tell the next shift that platelets are being processed.  |