1. Yellow slips
	* Please make sure you and the runner, both are signing the yellow slip. Do not leave it blank.
2. Override reasons
	* When overriding exceptions, please pick the best appropriate choice from the drop-down menu. DO NOT choose supervisor or pathologist approved for all the exception.
	* If appropriate reason does not exist, choose the one that fits the best and add a comment.
3. Trauma Pager
	* Blood Bank now has 2 trauma pagers.
		1. Due to several alerts being missed in past 2-3 months, we have requested a second pager as a backup.
		2. Per help desk, if the pager is kept too close to the computer, interference may occur, and alerts may not come through. Therefore, please do not place pager close to the computer.
		3. New pager is kept by the blood order bin. Please do not move it from there. It is kept there since there are no computers there to create an interference with the trauma alert.
		4. If you notice that one or both pagers are missing an alert, please NOTIFY ME IMMEDIATELY.
4. Kudos
	* Thank you all for working hard on the new process put in place to remove all the blood products that are assigned but not used within 24 hours. This has helped us a lot in reducing wastage. I appreciate all your hard work with this. Thank you!!
5. Jeff email
	* If you have not switched to your Jefferson email yet, please do so. If you’re having issuing converting it, please let me know ASAP and I can help you or you may call help desk.
6. Jeff ID badge
	* For Jefferson ID badge, you MUST submit your photo and driver’s license to photoID@jefferson.edu by May 16th. If not completed by then, you will experience issues with your paycheck. This information was confirmed with HR by laboratory management.
7. Wasted products
	* Assign when thawing
		1. Please assign all the product when modifying them. Before saving under modification, you MUST right click on the product and click “Assign to Patient” option.
			1. This helps us track the patient information when units are sitting on the shelf and does not get picked up, especially when orders get filled accidently.
			2. When units are wasted, if products were never assigned, we will not be able to find out who it was thawed for.
	* PSN if wasted
		1. When wasting a product due to below reasons, you MUST file PSN/On point event.
			1. No consent.
			2. Floor did not pick it up on time
			3. Nurse returned it after 30 min.
			4. Return temperature too high.
8. FDA reportable events

These events are being shared so that we can avoid the same mistakes from happening again.

* + **Unlabeled trauma blood went to floor**
		1. *Exsanguination protocol was activated on a trauma patient who had been assigned a medical record number. As per policy, tech should have labeled all the blood products with patient’s chart label before issuing them to the OR in a cooler. However, tech missed to label 4 units of FFP with patient information for the identification. Nurse in the OR noted that patient information was missing on 4 FFPs and brought the cooler back to the Blood Bank. All unlabeled units were returned to the blood bank. No harm to the patient was done. Patient did not need any FFP and therefore additional products were not issued.*
	+ **Cryo. issued without a valid T&S at EMCP**
		1. *A request for Cryoprecipitate was received. Per policy, the tech looked up to see if the patient had a valid type and screen available. Tech saw a type and screen completed within 3 days and issued a unit of cryoprecipitate to the patient. The tech did not notice that the type and screen was completed at a sister hospital and no valid type and screen was available for the current admission. This action resulted in Blood Product Deviation.*
	+ **Plasma issued without a valid T&S**
		1. *The blood bank received an order for Fresh Frozen Plasma (FFP). Per policy, the tech needs to look for a type and screen (T/S), collected during the current admission, before preparing the FFP. The tech receiving the order thawed the product based on a historical type (not a current type). The product was issued based on a historical type and not a current, valid type. When another tech was preparing a second unit for the patient, the error was discovered. The patient’s floor was called, and the product was returned to the blood bank. Transfusion was not initiated, so there was no harm to the patient.*
	+ **Unlabeled trauma blood left in a cooler in trauma bay**
		1. *The tech responded to a trauma alert with multiple units of Red Blood Cells (RBCs) in a cooler. One unit of RBCs was requested by the physician in the Trauma Bay. Per policy, the tech appropriately labeled the unit with proper patient identification label and an emergency dispense form with the unit number. Once the unit was handed over, the physician requested that the tech leave the cooler with the additional units of RBCs in the trauma bay. The tech updated the emergency dispense form to include additional units of RBCs that were in the cooler but did not label each of those units with patient identification label. The tech returned to the blood bank. One of the unlabeled units left in the Trauma Bay was transfused to the patient, and rest were returned to the blood bank. The unit transfused was O pos and was found to be compatible with the patient’s blood type. No harm was done to the patient.*