**Blood Bank Staff Meeting – 5.25.23**

1. **IQEs/FDA Reportable Events**
	1. FDA reportable event:
		1. The wrong unit went to the patient due to the tech scanning the barcode on the transfusion tag instead of hand typing MRN using yellow slip.
		2. Discussed at the last meeting as this was previously observed with other techs and it was identified to cause this exact same error.
			1. Why is scanning a MRN from the transfusion tag a problem?
				1. When you scan MRN of the transfusion tag, the unit scanned after it will be crossmatched to that same patient and therefore the system will not recognize that the blood being issued to the patient on your screen is the same patient the runner is picking up blood for.
			2. Well, you would catch it when you match the yellow slip with the unit.

No, that is where we failed, and a wrong unit got issued.

Yes, it is in our policy to match the unit with LIS and the yellow slip.

* + - 1. What happens if you type the wrong MRN than what appears on the yellow slip? Wouldn’t that cause a problem?
				1. If you type in incorrect MRN than what appears on yellow slip, when unit is scanned, the system will prompt you and say the unit is NOT crossmatched to the patient on your screen.
	1. IQE:
		1. Reagent QC not appropriately documented in LIS.
			1. “REAGENTQC” template changed. Review updated policy.
			2. Missed temperature recording. Chart temperature okay.
			3. QC on new lot of saline not performed.
				1. DO NOT put in use any new lot until the previous lot is completely used or discarded.
				2. DO NOT bring the new lot out and have it on standby.
				3. READ signs posted in storeroom.

Lot in use should all be moved to the right and placed under the appropriate sign.

Lot NOT in use should all be kept to the left and placed under the appropriate sign.

1. **Change in shifts:**
	1. PLEASE communicate all details to the following shift.
		1. Platelet inventory, Transplants, Exsanguinations, Trauma, Antibody Workups, Pending specimens and or blood orders.
		2. Complete end of shift report.
		3. Do not leave assuming next shift will figure things out on their own.
2. **Requesting 2ABO/Rh:**
	1. DO NOT request a confirmatory specimen when calling to request a T/S.
		1. Nurses will draw T/S and a confirmatory specimen at the same time, and you will end up rejecting it.
		2. We should be requesting a confirmatory specimen once T/S specimen is received in the lab.
		3. A serious error will occur if the policy is NOT followed.
3. **EP Forms:**
	1. Whether or not the patient has an active T&S, you must fill out the EP form every time an EP is activated.
4. **Mixed Field Reaction:**
	1. Watch the video if you have not already done so. See my email from 5.4.23.
	2. If you still need help in identifying, please notify me immediately so I can schedule a time for you to learn. If I do not hear from you, I will assume that you understand and are able to identify mixed field.
5. **Important Dates:**
	1. ***June 15th – August 11th***: Employees will be able to complete their self-evaluations.
	2. ***October 9th***: Annual Mandatory and Required Education due on MyJeffHub.
		1. You will be suspended if not completed on time.
6. **New Employee:**
	1. Yizet Garcia, starts 6/5/23