Name of Policy: Organizational Issues: Design, Implementation and Review of Quality Plan **Policy Number**: 3364-108-101 **Approving Officer**: Senior Hospital Administrator Director, Blood Transfusion Service **Responsible Agent**: Blood Transfusion Service Supervisor Administrative Director, Lab **Scope**: University of Toledo Medical Center Pathology/Laboratory – Blood Bank	UTOLEDO HEALTH **Effective date:** 03/7/2025 **Original effective date**: 06/1996
Key words: Quality Plan, Quality, Organization, Laboratory, Transfusion	

☐	New policy proposal	☐	Minor/technical revision of existing policy
☐	Major revision of existing policy	X	Reaffirmation of existing policy

(A) Policy Statement

The University of Toledo Medical Center Blood Transfusion Service is committed to a program to maintain and improve quality of service in providing a safe, adequate and timely supply of blood and blood products for UTMC patients. Responsibility for necessary monitoring and evaluation activities lies with the Director of the Clinical Laboratories, who may in turn, delegate responsibilities to division directors, coordinators, and supervisors.

(B) Purpose of Policy

To define responsibility, process, and authority for the implementation of activities necessary for review, monitoring and evaluation of quality goals, objectives and policies.

(C) Procedure

(1) The Medical Director of the Transfusion Service has responsibility and approval authority for all medical and technical policies, processes, and procedures, and for the consultative and support services that relate to the care and safety of transfusion recipients.

(2) The Director of Clinical Laboratories, the Lab Clinical Manager or designee and the Laboratory CQI Coordinator is responsible for the Pathology Quality Plan as stated in the Pathology Quality Assessment, Monitoring and Evaluation Plan. According to the Pathology Quality Plan, system checks will include, but are not limited to, tracking of missed venipunctures, specimen collection variances, mishandled or misdirected specimens, corrected reports, missing reports, STAT utilization and turnaround time, proficiency test results and occurrence reports. The responsible parties will also approve, implement and monitor corrective actions and follow-up measures.

(3) The Core Lab Manager (or Blood Transfusion Service supervisor) and Medical Director (or designee) monitor and evaluate activities specific to the division. System checks and self assessments include surveillance of the variance logs and reports, Blood Release forms, Transfusion Orders, Special Studies, Investigation of Adverse Reaction to Blood Transfusion reports and transfusion record audits. Corrective actions and follow-up measures will be approved and implemented by the Blood Transfusion Service (BTS) Medical Director or Core Lab Manager (or BTS supervisor).

(4) Lab Utilization Review Committee monitors and evaluates the use, administration, distribution and handling of blood and blood components using data provided by the Blood Transfusion Service Medical Director and supervisor and director of Perfusion Services. Included is appropriate blood usage, prospective review, wastage, crossmatch:transfusion ratio, intraoperative blood salvage, directed donor/autologous transfusions, adverse reactions, and usage of uncrossmatched blood. The committee also assures biennial review of Blood Transfusion Service policies and procedures and periodically reviews nursing and hospital policies regarding blood transfusion. Physician members of the committee perform peer review of selected transfusions failing to meet initial screening criteria. The committee periodically reviews and recommends revision of appropriate transfusion indications criteria. The Lab Utilization Review Committee reports findings and recommendations to the Hospital Quality and Patient Safety Counsel which includes Hospital Administration.

(D) References

(1) AABB Quality Program Quality Plan Manual and Self-Assessment Manual, 1994.
(2) AABB Standards for Blood Banks and Transfusion Services, current edition.

Approved by: /s/ _____ Lauren Stanoszek, M.D. Assistant Professor Director, Blood Transfusion Service 03/1/2025 _____ Date /s/ _____ Russell Smith Pharm D, MBA, BCPS, CPEL, FACHE Senior Hospital Administrator 03/7/2025 _____ Date *Review/Revision Completed by:* Danielle Weilnau MLS(ASCP)^{CM}	**Policies Superseded by This Policy: None** Initial effective date: 06/1996 All Review/Revision Dates: 1/05 1/2008 6/9/2008 3/22/2011 3/01/2013 3/2/2015 03/01/2017 03/01/2019 03/01/2021 03/20/2023 03/7/2025 Next review date: 03/7/2028