



e-Network Forum

CALIFORNIA BLOOD BANK SOCIETY

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Managing Emergency Blood Needs in Hospitals Whose Lab is Not Staffed during the Graveyard Shift

You may recall that an e-Network member was aware that a small hospital might soon be opening, but that will NOT be staffing the laboratory for the 3rd (midnight to 8 am) shift. However, in spite of the lack of 3rd shift laboratory staffing, it is anticipated that during the 3rd shift there will be an occasional visit/drop off of a victim of the knife and gun club. This member wanted to know if any other facilities employ a similar staffing situation, and if so, what procedures are being followed for issuing blood when laboratory staff are not available to issue blood products? The inquiring member says that she is concerned about safe transfusion in the absence of laboratory personnel.

To which the following comments and advice were submitted:

1. One member commented that there might be **a few options** available, including the following:
 - Developing an "on call" system using the staff of the other two shifts
 - Developing a cooperative networking effort with other area hospitals, provided legal hurdles could be overcome.
 - The pooling of scarce resources during "off shifts" may be cost effective
 - Employ pathology or hematology fellows or attendings to take on the episodic responsibility.
 - Divert trauma cases away from the hospital during unstaffed shifts
2. A second member commented that in his opinion, **a hospital that has no around the clock laboratory staff has no business treating critically ill patients, much less trauma patients who might in some instances need immediate transfusion.** This member says that if the new hospital's administration insists on no laboratory staff for the third shift, he assumes the administration is of the opinion that the hospital will not be treating critically ill patients who need round-the-clock access to laboratory information. Thus, patients who are dropped off should **immediately be rerouted** to a suitably equipped acute care hospital. This member cannot imagine having access to a refrigerator with group O Rh Negative red cells but no access to laboratory testing as being an appropriate mix of services.
3. A third member commented that although he has no such experience with this type of staffing situation, he does have **two suggestions**:
 - First, a supply of group **O Rh positive red cells** could be kept on hand for emergency use; in wartime on the battlefield, this was the safest way to transfuse someone until transported to a MASH unit.
 - Second, it would seem they could have someone on call or a back-up arrangement with another hospital in the vicinity, or as close as possible.

Editor's Note: Many blood bankers might feel more comfortable with maintaining a supply of Group **O Rh negative** red cells, rather than group O Rh positive red cells, since some of the victims needing transfusion might be girls or women of childbearing age.

4. A fourth member stated that 15 years ago she encountered a similar situation and felt then, as she does now, that it is **unacceptable** to have an emergency room where trauma cases are expected and not have an on-site laboratory professional. The solution, of course, was to staff the third shift and to move some activities currently being done on day or evening shift to that shift. Also, this member wondered how early does the laboratory begin testing "day" shift samples? It may be possible to improve customer services and laboratory coverage by bringing in the day shift earlier. **As an alternative**, this member proposed the development of an "on-call" system, with uncrossmatched Group O blood in the emergency room (She thinks 6 units are the minimum). The best safeguard to ensure that the laboratory person is notified is to alarm the refrigerator door with an automatic call to the "on-call" person when the door is opened.
5. And a fifth member commented that she has worked in a rural setting before transferring to the big city and seen this type of staffing before. This staffing situation has been **handled in two ways**:

- Rotating on-call staff who live within 30 minutes of the hospital. Call frequency was once or twice for a 3-5 day period. Of course, using "infrequent workers" has its pitfalls.
- The House supervisor (RN) had keys to all areas. She frequently had pharmacy needs and laboratory needs to fulfill.

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6. Similar to another responder, this sixth member also worked in a rural setting that had "on-call" staffing from 11 pm until 6 am. They had a 24-hour emergency room, but unlike a major trauma center, most of the incoming patients did not require immediate transfusion. The requirement was to be within 15-20 minutes of the hospital when on call. When the ER received word of trauma or critical patients coming by ambulance, the on-call laboratory, respiratory therapy and x-ray personnel were called (if not already in house) and the ambulance ETA was given. More often than not, the member was able to be in the ER to draw blood samples as the patient was being wheeled in. They also had EMTs and RNs with advanced life support certification who were also qualified (by the lab) to draw blood samples. They did have their share of major traumas because they were located on an interstate at the bottom of a mountain pass. We also had walk-ins. **Rarely did they need to release uncrossmatched blood on the night shift.** Procedures were in place, whether a laboratorian was present.

It may surprise laboratorians who are used to having 24-hour staffing, but **on-call systems do work without jeopardizing patient care.** Yes, this member occasionally pulled all-nighters or slept on a cot in between hourly glucoses for a critical diabetic. Unlike larger hospitals, all the technologists were essentially generalists (able to handle any and every situation) because of our setting even though their primary role in the lab may have been a specialty.

Please submit comments to the [e-Network Forum](#).

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Posted: April 9, 2001

Addenda: April 10, 2001

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