Mission Hospital-Whole Blood Administration

Whole blood offers many benefits: reduced volume transfused, simplified transfusion process, and has demonstrated improved outcomes in trauma patients. Whole blood will be available for **EMERGENT** blood administration at Mission Hospital in **September 2025**. Whole blood will not replace current component therapy for routine blood administration (eg. RBCs, FFP, platelets).

Important information to consider:

- **Uncrossmatched Emergency Units:** Whole blood will be issued as uncrossmatched emergency units. It will *not* be crossmatched before dispensing, even if a type and screen has already been completed.
- **Patient Age Eligibility:** Whole blood can be administered to patients 2 years and older.
- **OB Hemorrhage Process Unchanged:** The current OB Hemorrhage process remains the same. Whole blood will **not** be used in these cases.
- **Managing Minor Transfusion Reactions:** Do not stop whole blood administration for mild skin reactions (e.g., flushing) or a temperature increase to greater than 100.4°F (38°C) or 1°C/1.8°F from baseline. This aligns with our current policy for other blood component therapy. However, if the temperature rise is excessive, or if there's other evidence of hemolysis (like hypotension, unexplained lower back pain, or dark red urine), immediately stop the infusion and call the provider and rapid response team**.**
- **Massive Transfusion Protocol (MTP) Integration:** The Massive Transfusion Protocol (MTP) remains unchanged. If a patient received whole blood *before* MTP initiation, transition to component therapy in the **second round** of the MTP algorithm.
- **Consider Calcium:** Administer calcium after the first whole blood unit, as directed by the provider.
- **Whole Blood Unit Limits:** A maximum of 4 units of whole blood can be administered (excluding any pre-hospital administration). For pediatric patients, the maximum is 40 mL/kg.
- **Transition to Component Therapy:** If the patient reaches the maximum whole blood units, or if whole blood is unavailable, switch to component therapy.
- **Documentation Process:** Document whole blood administration using the existing process for emergency released blood products.
- **No Cerner/Bridge Documentation:** Whole blood administration is not documented in Cerner/Bridge.
- **Blood Bank Release & Ordering:** The Blood Bank will release whole blood products upon a verbal order from a Licensed Independent Practitioner (LIP). You must call the Blood Bank when whole blood is ordered.
- **No EMR Order:** No order will be placed in the EMR for whole blood.
- **ED Only: Trauma Bay Refrigerator:** In the Emergency Department only, for any emergency released blood products, always utilize the blood refrigerator in the ED trauma bay first. Remember to complete the "Transfusion Services: Deviation from standard practice" form as per current process.

HUDDLE CARD

Columbia Suicide Severity Rating Scale-Emergency Room

What does the C-SSRS do?

1. Identifies individuals at risk for suicide
2. Determines the severity and immediacy of the risk
3. Determines the level of support needed

When does the C-SSRS need to be completed?

- At the time of triage for patient's who are 12 years and older who presents with a Behavioral Health Complaint
  - If unable to complete due to patient condition, C-SSRS needs to be completed as soon as clinically possible

What to do if someone scores Moderate or High?

1. Immediately notify CNC/Patient Flow Coordinator (bed placement needs to be expedited)
2. Ensure patient is not left alone at any time (keep in direct line of sight)
3. If no bed is readily available, contact security to monitor the patient and secure belongings BEFORE placing patient at the ATC desk to wait for bed assignment

Tracking Board Icons

- These Icons will appear once the provider has completed the Overall Risk Level (ORL) assessment

MISSION HEALTH

Updated:7/21/25

HCA Healthcare®
Center for Clinical Advancement
NC Division

HUDDLE CARD

Columbia Suicide Severity Rating Scale- Inpatient (non-behavioral health)

- **What does the C-SSRS do?**
  1. Identifies individuals at risk for suicide.
  2. Determines the severity and immediacy of the risk.
  3. Determines the level of support needed.
- **When does the C-SSRS need to be completed?**
  - At the time of admission for patient's who are 12 years and older
    - If unable to complete due to patient condition, C-SSRS needs to be completed as soon as clinically possible.
    - The RN can rescreen any time there is a concern of an increase in suicide risk/change in patient condition.
- **What to do if someone scores Low, Moderate, or High?**
  1. Notify the provider immediately. The provider will complete a detailed risk assessment.
  2. Notify unit leadership.
  3. Complete the Suicide Safe Environment Checklist Every Shift and as needed with a Change in Patient Condition.
     - An order and task will fire as a reminder to complete this checklist. This documentation must be completed by the RN.
  4. For a High Risk score: Do not leave the patient unattended.

HUDDLE CARD

Interpreter Use for Persons who are Deaf or Hard-of-Hearing: In-person is best

All staff are responsible for obtaining a qualified interpreter when needed to effectively communicate

- AMN Language Services (Stratus) is available for immediate needs for a patient who requires a sign language interpreter, but **an in-person interpreter is most preferred by persons with impairment** and should be contacted right away.
  - Video Remote Interpreting (VRI) is accessible 24x7x365 in facilities through the AMN Language Services app on equipment such as facility iPads or AMN language services stands located in your department.
  - Please utilize an iPad stand/AMN language services stand when using VRI for a sign language interpreter.
  - iMobile Devices are **not** suitable for a sign language interpreter.
- **For an In-Person interpreter, please call WIN – Western North Carolina Interpreter Network at (828)274-0950. They are available 24/7.**
  - If prompted to leave a message, please provide a contact name and number.
  - WIN can also be emailed @ WIN@mywcms.org for non-urgent requests, such as setting up an interpreter ahead of time for a scheduled procedure

MISSION HEALTH

Updated: 7/28/25

HCA Healthcare®
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NC Division

HUDDLE CARD

2025 i-Stat ACT & Crea Quality Controls

What is the purpose of Quality Control?

- Detect, reduce, and correct deficiencies in the testing process prior to the release of patient results.
- Improve the quality of the results reported.
- Safeguard the accuracy and reliability of test results.
- Ensure the early detection of results or measurement errors and procedures to rectify them.

***When a Level of QC fails, QC must be repeated.
Patients cannot be tested until that level of QC Passes.

MISSION HEALTH

Updated: 7/24/25

HUDDLE CARD

Tips for Troubleshooting i-Stat QC Failures:

TROUBLESHOOTING OUT-OF-RANGE CONTROL OR CALIBRATION VERIFICATION RESULTS ON CARTRIDGES

Troubleshooting

Verify that the following conditions are met and then repeat the test:

- The correct expected values insert is being used and the correct cartridge type and lot number listing is being used.
- Expiration date printed on cartridge pouch and control ampule or vial have not been exceeded.
- Room temperature expiration date for cartridge and control have not been exceeded.
- Cartridge and control have been stored correctly.
- The control has been handled correctly–see the directions for use.
- The analyzer being used passes the Electronic Simulator test.

If the results are still out of range despite meeting the above criteria, repeat the test using a new box of control solutions and/or cartridges. If the results are still out of range, refer to Support Services information in the Technical Bulletins section.

Please contact the Point of Care Coordinator, Lexie Brindle, for help if there are repeated QC failures after troubleshooting has been performed.
Office: 828-213-5196, Cell: 828-203-5707

MISSION HEALTH

Updated: 7/24/25

What a Patient with Sickle Cell Wants You to Know

Sickle cell disease (SCD) is a genetic disorder causing the abnormal production of red blood cells (RBCs) in a sickled in shape. SCD causes painful crises, chronic disability, end-organ damage, and a shortened life expectancy. SCD is most common in the African American population.

Initial care

When a sickle cell patient presents to the emergency room or is a direct admit from a clinic, these initial steps will help to stabilize the patient, with a main goal of maintaining adequate tissue perfusion:

- Apply supplemental oxygen
- Administer pain medications within 30 minutes
- Infuse IV fluids and/or blood products
- Place patient on continuous monitoring

Once stable, the patient may need to be transferred to a higher level of care.

Pain management

Sickle cell patients have been living with severe or debilitating pain for most of their lives, beginning around 6 months of age. Pain may range in severity from mild to debilitating and may last for days in acute crises. Differentiating pain levels from prior crises can help to determine if other complications are occurring.

Pain is whatever the patient says it is. Do not make assumptions based off patient's facial expression or behaviors. It is imperative you treat the pain the patient sates they have. When performing an admission history, ensure you are asking the patient what pain medications or regimen work best to relieve their pain.

Compassionate care

Compassionate care may look like many different things depending on the patient you are caring for, but the mainstay is understanding the patient's perspective and providing support without judgement. Active listening is one of the best ways to build trust and allow the patient to express their concerns, beliefs, and/or needs. You can provide active listening through:

- Maintaining eye contact
- Avoid interrupting the patient
- Paraphrase to confirm understanding or seek clarification

- ‘Do you mean… when you say…’
- ‘I want to be sure I understand what you mean when you said…’

- Use silence to allow the patient time to reflect and express themselves

Active listening combined with nonverbal communication can positively impact the patient’s perception of not only the nurse, but the whole care team. Nonverbal communication is not only touch or eye contact, but having open body language and taking the time to sit down and be at eye level with the patient while actively listening.

Asking the patient ‘What do you need’ or ‘What can I do for you in this moment’ are small acts that show you realize the patient may be suffering, that you care, and that you have the time or are willing to make the time to comfort and be with them in their time of need.

For sickle cell patients in particular, the follow are terms that should be avoided:

- Frequent flier: this is a derogatory term and may imply the patient is drug seeking
  - Instead, use neutral language when referring to hospitalizations, e.g. high healthcare utilization
- Sickler: may be considered a disparaging term to call a patient
  - Associated with reduced treatment or distrust of patient’s pain
- Pain crises: referring to all pain as ‘pain crises’ undermines the patient’s ability to differentiate acute pain from a crisis
  - Pain should be referred to as ‘painful episodes’ or ‘acute pain episodes’

Sickle cell crises

Below are major complications that typically require hospitalization and may occur across the lifespan.

Vaso-occlusive	• Severe ischemic pain occuring from blocked blood vessels and inadequate blood supply to organs
Aplastic	• Cessation of RBC production causing severely low hemoglobin levels • Typically caused by viral illness
Acute chest syndrome	• From occlusion of small blood vessels in the lungs • Respiratory distress, hypoxia, fever, and changes on x-ray
Splenic sequestration	• Sudden spleen enlargement from trapped RBCs • May have abdominal pain/distension, fatigue, pallor
Stroke	• Confusion or altered mental status, one-sided weakness/neglect, facial drooping, slurred speech • Initiate stroke protocol within your facility

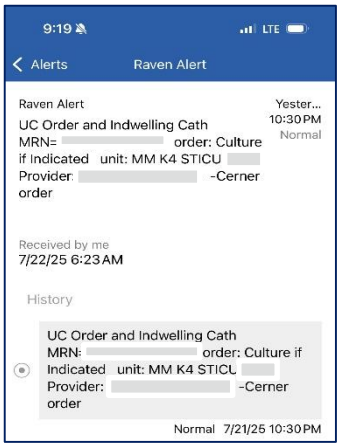
HUDDLE CARD

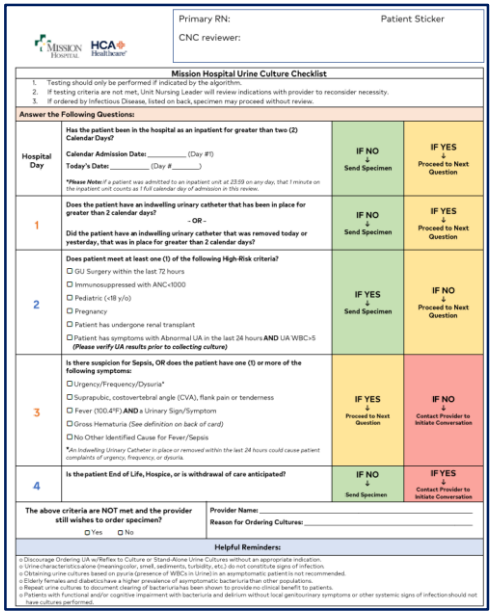
Mission Hospital: Culture Pause Process

Go-Live 8/11/25

Mission Hospital will implement a new Culture Pause Process for CDiff testing and Urine/Blood Cultures.

- Why:
  - Improve clinical care, with fewer false-positive test results and less over diagnosis.
  - More appropriate antibiotic use, resulting in fewer adverse effects and shorter hospital stays.
- The process:
  - When a CDiff Test, a Urine, or a Blood Culture is ordered meeting criteria a RAVEN alert will fire to the CNC/Charge Nurse I-Mobile.
  - The primary nurse and the CNC/Charge Nurse will complete the appropriate checklist **PRIOR** to collecting the specimen.
  - If criteria not met, CNC/Charge Nurse will initiate conversation with physician to inform which criteria are not met.





Scan the QR Code to complete the required HealthStream module

Clinical Updates

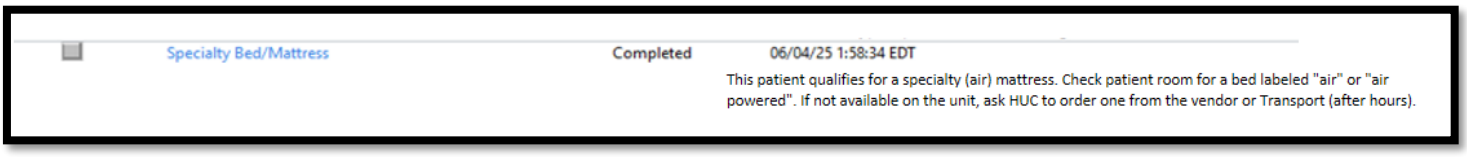
Reminder-TNKase (tenecteplase) 50mg packaging has changed

- The package will no longer contain the 10ml syringe used for reconstituting the 50mg vial. The nurse will need to obtain the syringe from their supply are in order to prepare the medication.

	TNKase (tenecteplase) 50mg	
	New **NDC 50242-176-01**	**Superseded** **NDC 50242-120-47**
Carton contents	• One vial TNKase 50 mg • One vial Sterile Water for Injection 10 mL • Full Prescribing Information • **No syringe**	• One vial TNKase 50 mg • One vial Sterile Water for Injection 10 mL • Full Prescribing Information • One 10mL syringe
		

Order comment for Specialty Bed/Mattress Update: Go-live 7/28/25

- Order Comment Current state – “Contact vendor to obtain Specialty Bed (generated from specialty bed screening form)”
- Order Comment Future state – “This patient qualifies for a specialty (air) mattress. Check patient room for a bed labeled "air" or "air powered". If not available on the unit, ask HUC to order one from the vendor or Transport (after hours).



- Reminder-Do not Delay Transfers while waiting on a specialty bed or mattress