EQUIPMENT FAILURE/MALFUNCTION REPORT

Hospital Transfusion Service: _____

Equipment that failed (✓) : Blood Bank _____ Recorder _____ Alarm _____

Type of Failure/Malfunction: _____

Action Taken: _____

Expected Time of Repair: _____

1) If blood products were stored outside of their acceptable range: N/A ☐

a) What was the "peak" unacceptable temperature? _____ ° C

b) How long did the temperature excursion last? _____ minutes

Product Category	Storage Range
Red Blood Cells	1 - 6° C
Platelets	20 - 24° C
Frozen products	-18° C or colder

2) If blood products were moved to temporary storage: N/A ☐

a) Who placed the units in temporary storage? _____ When? Date: _____ Time: _____

b) ***Initiate MEDIC form # TSI3.D*** *to document temperatures while in temporary storage.*

3) ***NOTIFY MEDIC BY PHONE IMMEDIATELY. (865) 521-2640***

Reported to: _____ at MEDIC on Date: _____ Time: _____ By: _____ at Hospital.

4) ***FAX THIS COMPLETED REPORT to (865) 521-2647***. Attach documentation of the temperature excursion. This could be a photo/copy of the recorder chart or printout from an electronic monitoring system.

<u>UNIT NUMBERS</u> OF RED BLOOD CELLS PLACED IN TEMPORARY STORAGE:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDIC Hospital Services staff:

Forward for prompt review. MEDIC will not receive returns from this facility without approval from Quality.

MEDIC Supervisor Review By: _____ Date: _____

MEDIC Quality Review By: _____ Date: _____

MEDIC Regional Blood Center
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