REDUCING BLOOD WASTE

WITHOUT CUTTING CORNERS ON SAFETY

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Implementation depends on institutional policy, medical director approval, and regulatory requirements; examples reflect real-world operational workflows. We'd like to highlight that not every solution will work in every hospital environment but the point is to **enable attendees to think outside of the box and even if blood wastage is already low, think critically if it could be better.**

1 MEASURE WASTE AS A PERFORMANCE INDICATOR

Track Wastage as a % of Issue (WAPI) monthly so you can trend performance and benchmark improvement.

Bucket every discard into a small number of actionable categories...

* Temperature excursion/ uncontrolled environment

* "Issued but not transfused" (canceled procedure, patient status change)

* Clerical/process errors

Target the top driver first.

2 STANDARDIZE RETURN-TO-STOCK & DECISION AUTHORITY

Returned blood that sits while people **debate** "can we take it back?" **is a major hidden waste driver.**

* **Write Clear Return Criteria**
* **Create a Rapid Triage Path**
  * Immediate Accept
  * Hold for Review
  * Discord
* **Hardwire Ownership:** Define exactly who has authority to accept returns after hours (on-call vs charge vs blood bank lead).
  * **Close the loop:** feed discard reasons back to the unit/area as a process improvement opportunity, not a blame message.

3 RIGHT-SIZE TRAUMA & MTP ACTIVATION

* If your data show many ED activations don't progress to full MTP, start with a **smaller "starter release"** (trauma cooler) and escalate only when objective criteria are met.
* **Escalation triggers** should be objective: ongoing hemorrhage, hemodynamic instability, provider activation, OR transfer, etc.
* Keep **full MTP immediate** for true bleeders (often depends on local patterns in OR/inpatient settings).
* Pair with a tight return process (see #2) so "false activations" don't become automatic waste.

4 MAKE INTER-FACILITY "REDISTRIBUTION" NORMAL

* Set a **near-expiry threshold**
* Track transfers as a positive metric (**"units saved"**) so it's seen as stewardhsip, not extra work.
* Use a simple decision rule:
  * **High-use sites** receive near-expiry units first
  * **Low-use sites** hold fresher units

* **Standardize** packaging/transport/chain-of-custody so the process is routine and auditable.

* **Focus on near-expiry migratin instead of expiration.**

5 REDUCE OUTDATING BY "TYPING WHAT YOU ALREADY HAVE" INSTEAD OF PRE-ORDERING EXTRA ANTIGEN-NEGATIVE UNITS

* Build workflow to use updated antisera to rapidly **antigen type units** already in inventory when clinically appropriate.
* Reserve special orders for when they truly add value (rare antigens, complex patients, urgent needs when in-house typing isn't fast enough).
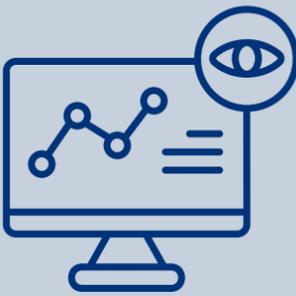
This reduces:
* Units sitting "just in case"
* Courier/send-out costs
* The chance specialty units expire unused

* If you have a regional network, you can often locate antigen-negative units across sites instead of ordering duplicates.

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CROSSMATCH STEWARDSHIP (MSBOS + C:T RATIO) TO STOP TYING UP UNITS "JUST IN CASE"

MONITOR C:T RATIO

- Monitor Crossmatch-to-Transfusions (C:T) ratio by service line and procedure type (goal commonly ≤2:1)

BUILD ORDERING NUDGES

- Type & Screen only for low-likelihood procedures
- Crossmatch only when criteria are met (history, anemia, high-risk case)

SHARE MONTHLY DASHBOARDS

- Share monthly dashboards with OR leadership so stewardship becomes a shared accountability

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USE THE RIGHT PRODUCT FORM FOR THE CLINICAL CONTEXT

Cold-Stored Platelets (CSP)

* For trauma/active bleeding workflows, CSP can be a strong fit because it's aimed at **hemostatic function** rather than prophylaxis.

* Operationally, it can **reduce "panic ordering"** and protect conventional platelet inventory when bleeding cases arrive unexpectedly.

* **Guardrail**: define **indications** (bleeding/trauma) and preserve conventional platelets for prophylactic use per medical director.

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HARDWIRE MTP INVENTORY TO MINIMIZE WASTE

Build an MTP plan that balances readiness with waste risk and review it quarterly using real activation/usage data.

- Use an escalation/de-escalation decision tree:
  - When to move from starter release → full MTP
  - When to stop components as patient status stabilizes.

  - Reduce **"thaw-and-pray"** by only thawing additional units when objective triggers are met.

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CONVERT "EXPIRING RISK" INTO "READY INVENTORY WITH LONGER-LIFE HEMOSTATIC OPTIONS (IFC / PR-CYRO)

- **Pathogen-Reduced Cryoprecipitated Fibrinogen Complex (IFC)**
  - If your institution uses IFC, it can reduce waste and improve readiness by shifting fibrinogen support toward a product with operational advantages compared with traditional cryo workflows.
  - Position it as patient safety + readiness first, with waste reduction as a measurable operational benefit.
  - <u>**Guardrail**</u>: Align with your hemorrhage protocol and transfusion committee guidance.

Follow the link below to see how MaxQ is helping blood centers and hospital blood banks reduce blood wastage and increase efficiency.