DIAGNOSTIC SERVICES OF MANITOBA / SERVICES DE DIAGNOSTIC DU MANITOBA	Equipment Malfunction and Corrective Action Record: Storage Equipment and Plasma Thawer	Document # F160-QCFORM-15
		Version # 01
	Approved by:  Effective Date: 31-MAR-2011	Source Document: Manitoba Transfusion Quality Manual for Blood Banks

Equipment_____

Model #_____ Serial # _____ Location: _____

Date: _____ Time: _____ Reported by: _____

Part A: Equipment Malfunction Identification and Actions

If this is a satellite refrigerator, did the nursing unit call you? □ Yes □ No

State Problem	**Temperatures**		
	Chart	Digital Controller (Internal Thermometer)	Independent Thermometer
□ Refrigerator alarm triggered. Temperature at time of alarm			
□ Freezer alarm triggered. Temperature at time of alarm			
□ Platelet Incubator alarm triggered. Temperature at time of alarm			
□ Room alarm triggered. Temperature at time of alarm			
□ Plasma thawer outside of 30-37°C range. Temperature at time of alarm			
□ Malfunction of Continuous Recording Graph only ▪ Document temperatures every four hours until resolved			
□ Other			
If applicable: Length of time out of acceptable range _____ Remote Alarm Activated: □ Yes □ No			

Cause of alarm: □ Door ajar □ Other (Specify):_____

Describe action(s) taken. Include temperatures taken at 10 or 15 minute intervals:

Action	Time	Tech	**Temperatures**		
			Chart	Digital Controller Internal Thermometer	Independent Thermometer

Was problem resolved? □ Yes □ No

If No:

Document on refrigerator as "STOP Service required" as per policy 100-10-07 Appendix 4

Proceed to Part B.

Part B: □ **Malfunction (specify)** _____

Interim Corrective Actions

Relocation to on site alternate storage: □ No □ **If Yes = Complete Chart below:**

Location Details	**Alternate Storage Equipment Name**	**Model#**	**Serial #**	**Location**
Date (dd/mmm/yy)	Time Product Removed	Relocation Completion Time	Product Type(s)	Signature

Alternate storage temperature monitoring implemented (check all that apply)

□ 4 hour check required (No continuous chart recorder available – use alternative Storage Temperature Record Form)	□ Continuous monitoring available (4 hour not required)
□ Daily temperature Record	□ Capacity for alarm activation and monitoring (required to meet back-up criteria.

If No:
Inter-facility transfer activated (policy *Inter-facility Shipping of Blood, Blood Components and Derivatives*) □ Yes

Site: _____

Inter-facility documentation completed □ Yes

Attach all supporting interim corrective action documents.

Part C: Equipment Return to Service

Validation Performed as per policy *Validation of Blood, Blood Components and Derivatives temperature monitored storage equipment* and applicable form for documentation □ Yes

Placement of Product in equipment Date: _____ Initials: _____

Attach all supporting return to service documents.

Part D: Supervisory Review

Was the service company or maintenance called? □ Yes □ No

Was the problem resolved? □ Yes □ No

Corrective action taken: _____

Maintenance documents attached to report? □ Yes □ No

Reviewed by (signature/date): _____