Organisation name Site or unit		POLICY **Blood bank quality system**	
Document ID	BLD-POL-001	**Version**	1.0
Status	Blank form, to adapt	**Issue date**	
Review date		**Replaces**	
Owner		**Approved by**	
Signature			

Standards › Standard 5 › Policies

Policy · BLD-POL-001 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 5.8

At a glance

- The blood bank has a written quality system for procedures, equipment, audit and training.
- Each procedure has an owner and a review date.
- Equipment is checked and calibrated on schedule.
- The quality system is audited each year and reported to the governing body.
- Stop and get help straight away if: a procedure is in use with no owner or past its review date, or an audit finding is open past its due date.

1. Purpose

To make sure the blood bank works the same way every day, and that its quality is checked (5.8).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility

When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

A blood bank without a quality system depends on the memory of its people. A written system covering procedures, equipment, audit and training keeps the service the same from one shift to the next.

5. Responsibilities

Role	Responsibility	Competence
Blood bank director	Owns the quality system	Clinician
Quality manager	Runs the audit and training plan	Quality

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Write.

- Keep the procedures, equipment list and training plan written and current.

Key point: Written, owned, dated.

Step 2. Audit.

- Audit each procedure each year against its written standard (BLD-FRM-004 for the emergency release audit, and others as set).

Key point: Audit finds the gap before the patient does.

Step 3. Act.

- Close each finding by its due date and report the status to the governing body.

Key point: Findings close.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Procedures in date	100%	Quarterly	Quality manager	Escalate to governing body
Audit findings closed by due date	At least 90%	Quarterly	Quality manager	Escalate to governing body

14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility's records policy, in years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
STF-SOP-001	Staff credential verification and recheck	Staff
GOV-PLN-002	Quality improvement plan	Plan

17. Evidence

Reference	Note
E-009	Based on ISO 15189:2022 for medical laboratories.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

19. References

Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)

Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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