Known Defects and Anomalies Addendum for 10.0, Version 1.0

Revision History

Date	Revision	Description	Author
12-10-09	1.0	Throughout VBECS: CR 2,536, CR 2,657, CR 2,658, CR 2,708, CR 2,715 ABO/Rh Confirmation: CR 2,707 Accept Orders: Pending Order List: CR 2,622 Accept Orders: Accept an Order: CR 2,712 and CQ18690 Administrative Data Report : DR 3,539 Audit Trail Report : CR 2,614, CR 2,714 and HD 345870, CR 2,730 Configure Daily QC: CR 2,690, HD 335126, CR 2,696, added HD 249548 to CR 2,385 and CR 2,436 CPRS: DR 3,510 CPRS CQ18494 Added comment See FAQ CPRS TAS Specimen Requirement Problems, CR 2,713 and CQ18690, DR 3,616 CQ 18842 and HD 364290, DR 3,617 and CQ 18841, DR 2,821 Discard or Quarantine: CR 2,706 Enter Daily QC Results: added HD 269544 to CR 2,437. Exception Report: CR 2,642, CR 2,686 Finalize / Print TRW: added HD 332336 and DR 2,084 to DR 1,633 Incoming Shipment: DR 3,542 HD 339722 DR 3,607, DR 3,610 HD 360751, DR 3,605 Invalidate Test Results: CR 2,579, CR 2,674 Issued/Returned Units Report: CR 2,512, CR 2,596 Maintain Minimum Levels: CR 2,599 HD 301562 Modify Units: Pool Units: CR 2,650, CR 2,691 Modify Units (not Pool or Split): CR 2,612, CR 2,656, CR 2,678 Order History Report: CR 2,584 Outgoing Shipment, CR 2,734. Patient History Report: CR 2,610, CR 2,684 Patient Testing: CR 2,576 HD 288163, CR 2,626, CR 2,685 Patient Testing: Pending Task List: CR 2,490 HD 264904 Patient Testing Worklist and Testing Worklist Reports: CR 2,627, CR 2,694 HD 336190, DR 3,556 Patient Updates: CR 2,580, CR 2,711 Post-Transfusion Information: CR 2,550, CR 2,589, CR 2,607, CR 1,655 Print Unit Caution Tag & Transfusion Record Form: CR 2,493, CR 2,624, edited CR 2,454 Reagents: CR 2,528 Transfusion Complications Report: added HD 337715 to CR 2,252 Transfusion Effectiveness Report: CR 2,695, HD 335307 Transfusion Requirements Report: CR 2,581 Unit Antigen Typing: CR 2,646 CR 2,724 HD 353065. Unit History Report: CR 2,545, CR 2,639, CR 2,641, CR 2,643, CR 2,682, CR 2,689, CR 2,716 VBECS Administrator: CR 2,573, CR 2,616 Workload Codes (Division Configuration): CR 2,438, CR 2,700 HD 339277	BBM team

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Date	Revision	Description	Author
		Workload Report to Austin: DR 3,601, CR 2,737	

Introduction

The Known Defects and Anomalies (KDAs) Addendum for 10.0, Version 1.0 consists of system actions that do not meet performance expectations established in VBECS design documents that have been identified after the release of the KDA associated with the release of VBECS 1.4.0.0 to the VistA Document Library (VDL). KDA Addendum for 10.0, Version 1.0 publicizes anomalies identified between VBECS patch releases to our users. When a new VBECS patch and KDA document is released, this document will be rescinded. A new version will begin to supplement that VBECS patch.

Related Manuals and Materials

- *VBECS Known Anomalies and Defects, version 10.0*
- *VistA Blood Establishment Computer Software (VBECS) Installation Guide*
- *VistA Blood Establishment Computer Software (VBECS) Technical Manual-Security Guide*
- *VistA Blood Establishment Computer Software (VBECS) User Guide*

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Through-out VBECS	VBECS cannot send out error messages when a site has configured their VLAN to allow only local addresses.	Low risk/Low impact.	All users	Sites that have a restrictive VLAN must change VBECS to use the local SMTP server.	The VBECS HL7 Libraries have "smtp.va.gov" hardcoded in the classes for emailing out error messages.	CR 2,536	Maintenance TBD
Through-out VBECS	Patient names are truncated or improperly formatted on these reports when a full name exceeds 25 characters: Outgoing Shipment Invoice Cost Accounting Report Unit History Report Exception Report Inappropriate Transfusion Request Report	Low risk/Low impact.	All users	Users are instructed to correct the names on printed copies of reports to be saved.	None.	CR 2,657	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Through-out VBECS	A patient name will be truncated in these screens when one of the name fields (Last, First, or Middle) exceed 22 characters: Blood Unit Details tab Patient Specimen Selector control Patient Order Selector control Patient Order Selector for Report control VBECS will only display the first 25 characters of the name.	Low risk/Low impact.	All users	None available.	The full name is displayed elsewhere on the screens identified or it is provided as read only information and is not used to make decisions for the selected patient.	CR 2,658	Maintenance TBD
Through-out VBECS	An audible alert may not occur when VBECS prevents the user from accessing a selected option or proceeding with a process.	No identified risk/No identified impact.	All users. Varies with the specific affected options, some of which have restricted access.	None required as users cannot proceed until override is satisfied. A visual alert is presented to the user indicating why they may or may not proceed with the process.	Audible alerts are used throughout VBECS as a secondary alert to the user when an override is required.	CR 2,033, CR 1,893, CR 2,045, CR 2,038, CR 2,014, CR 2,017, CR 2,019, CR 2,115, CR 2,193, CR 2,195, CR 2,199, CR 2,708	Maintenance TBD
Through-out VBECS	Outgoing completion messages from VBECS will stay in a status of sending when services are stopped when a message is sending or when an unexpected exception is received from the receiving application.	No identified risk/Low impact.	All users	The messages cannot be resent by a user. Contact product support or create a Remedy ticket. The VBECS team will make the correction.	None.	CR 2,715	Maintenance TBD
ABO/Rh Confirma-tion	Confirmation window buttons are inaccessible when a large batch is processed.	Low risk/Low impact.	All users	Select no more than 40 units in any batch. If a user finds themselves in this position, they need to X out of the confirmation and re enter the unit tests in smaller batches.	Most VA hospitals are low volume transfusion services and will not receive or process unit confirmation batches exceeding the display area.	CR 2,707	1.6.0.0
Accept Orders: Accept an Order	Orders for RBC components pre-fill with an expired specimen UID when an order for RBC is created before an order for TAS is placed.	Low Risk/Low impact.	All users	The expired UID number must be changed to the UID of the new specimen collected. Click on the order for TAS and then click on the RBC order which will allow the UID to be changed.	CPRS should not allow a clinician to order a RBC component without also ordering a type and screen when VBECS does not have a current sample.	CR 2,712 CQ 18690	CPRS v 28
Accept Orders: Pending Order List	VBECS requires more than 15 seconds to print a Pending Order List report.	Low risk/Low impact.	All users	None required.	The amount of time required to generate the report is proportional to the number samples processed by the blood bank.	CR 2,622	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Adminis-trative Data Report	The Administrative Data Report does not contain all of the plasma product types in the final count.	Low risk/Low impact.	All users	Manual calculations must be used to derive the missing data from the number of units received and the total number of units transfused in this category using this report and the division transfusion report.	None.	DR 3,539	Report Tool Upgrade Project Proposal
Audit Trail Report	A record of special typing cost change will appear on the Audit Trail Report for all units received through Incoming Shipment.	No identified risk/No identified impact	Supervisor when blood unit changes have been processed.	None required.	None.	CR 2,714 HD 345870	1.6.0.0
Audit Trail Report	The report does not differentiate reagent types by case size when indicated by a letter only when both have Minimum Reagent Levels have been defined on the same day, eg. K, k or C, c.	No identified risk/No identified impact.	Supervisor	Update the minimum levels on different days and print the report on each day.	None.	CR 2,730	Report Tool Upgrade Project Proposal
Audit Trail Report	The Audit Trail Report will only show the last antigen added to a blood unit through Edit Unit Information.	Low risk/No identified impact	Supervisor when blood unit changes have been processed.	All records of antigens added are properly recorded on the Unit History Report.	Antigens are only added to a unit by using Edit Unit Information if they were omitted when entered in VBECS through Incoming Shipment.	CR 2,614	1.6.0.0
Configure Daily QC	In a VBECS configured for multiple divisions, the lot numbers for testing reagents will not pre-fill day to day when sites are using the same reagent rack designations.	No identified risk/No identified impact	All users performing Daily Reagent QC testing in a multidivision configuration of VBECS.	The sites comprising a multidivision can agree to assign different reagent rack names to prevent overlap. This will allow the reagent lot number to pre-fill with the values from the previous day.	See the FAQ Multidivisional QC Rack Workaround	CR 2,690 HD 335126	Daily Reagent Quality Control Upgrade
Configure Daily QC	Changing the tested with lot number (ex. LISS) does not enable the Enter Daily Reagent QC test grid.	Low risk/Low impact.	All users performing Daily Reagent QC testing.	Change the lot number of the primary reagent as well as the secondary reagent to allow testing of both.	None.	CR 2,696	1.6.0.0
Configure Daily QC	Reverse ABO cell testing results are not displayed on the Testing Worklist Report. Various reagent lot numbers are not displayed including QC kit, Reverse ABO cells, PEG, LISS, or Anti-Human Globulin.	Low risk/Low impact.	All users performing Daily Reagent QC testing. Supervisor who configures and reviews QC output for compliance	Manually record daily reagent QC testing and reagent lot numbers to remain compliant with regulatory requirements.	The incompletely displayed QC lot numbers and results force the blood bank to establish a policy to record results to maintain a complete record for accreditation and regulatory compliance which has been put in place by the sites. Blood bank staff members currently record this manually and have processes and documents to support this activity.	CR 2,385 CR 2,436 HD 249548	1.6.0.0

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
CPRS	CPRS forces the collection of a Type and Screen specimen for non-red cell components when VBECS has the component class configured as specimen not required.	Low risk/Low impact.	All users	None available.	Local Blood Bank policy must determine management of the ordering and specimen ordering and specimen collection process. See FAQ CPRS TAS Specimen Requirement Problems.	CQ 18494 DR 3,510	CPRS v 28 coordinated work.
CPRS	CPRS does not require a Type and Screen order when a RBC order is placed and VBECS does not have a current specimen.	Low risk/Low impact.	All users	Notify clinicians that a Type and Screen is required so that it can be ordered in CPRS.	None.	CR 2,713 CQ18690	CPRS v 28
CPRS	Users with OREMAS does not include urgency of “STAT”	No risk/No impact.	All users with OREMAS key	None available.	None.	DR 3,616 CQ 18842 HD 364290	CPRS TBD
CPRS	Ordering the diagnostic test after selecting the Urgency changes Urgency to Routine.	No risk/No impact.	All CPRS users	Indicate the urgency after selecting all blood component and diagnostic test orders.	The urgency applies to the overall order, not just the component portion of the order. The user should process the order completing the section for blood component orders, then the diagnostic test orders and finally the information that applies to all of the order as indicated by the divisions of the window.	DR 3,617 CQ 18841	CPRS TBD
CPRS	Require information regarding pregnancy and previous transfusion in the order dialog.	No risk/No impact	All users	Enter any additional information in the order comments area.	This is an enhancement request to the CPRS order dialog.	DR 2,821	CPRS TBD
Discard or Quaran-tine	When a large batch of units is processed, the confirmation window displays with inaccessible buttons prohibiting the user from processing the confirmation.	Low/Low impact	All users	Select no more than 40 units in any batch. If a user finds themselves in this position, left click on the message box where the list of units are displayed and hit the enter key to proceed.	Most VA hospitals are low volume transfusion services and will not receive or process unit confirmation batches exceeding the display area.	CR 2,706	1.6.0.0
Enter Daily QC Results	Line items may display in a different order on a display and report after a change to the configuration.	No identified risk/ Low impact.	All users in full service divisions.	None required.	Explanation of VBECS behavior. Re organization of the same line items.	CR 2,437 HD 269544	Daily Reagent Quality Control Upgrade
Exception Report	The Exception Report type Antigen Testing Phase Change does not display test interpretations.	No identified risk/ No identified impact.	Supervisor responsible for report review	None required.	The Testing Worklist Report is identified as one of the reports requiring supervisor review. The supervisor reviews the test results as part of their investigation.	CR 2,642	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Exception Report	The exception type “Previously recorded results invalidated” displays an incorrect time for the "Date/time results invalidated."	No identified risk/ Low impact.	All users	None required.	The time displayed in the "Date/time results invalidated" field is the time the results were entered.	CR 2,686	Report Tool Upgrade Project Proposal
Finalize/ Print TRW	A finalized Transfusion Reaction Workup cannot be corrected once it has been finalized.	No identified risk/ No identified impact.	Supervisor	None available.	Users are cautioned to double check the workup before finalizing. Report is printed for medical director signature and charting. Printed report can be updated manually if required.	DR 1,633 DR 2,084 HD 332336	Maintenance TBD
Incoming Shipment	When an ISBT 128 expiration date barcode does not include a time, including 2359, the barcode cannot be interpreted.	Low risk/Low Impact	All Users	Manually type in the expiration date and time of the blood unit per the eyereadable expiration date information.	This is also the case in the VistA 5.2 Blood Bank option.	DR 3,610 HD 360751	Maintenance TBD
Incoming Shipment	When a blood unit is received after being shipped out of the facility, it appears that the user can indicate special testing information. The user may not realize their entries were not saved as described in the verification message.	Low risk/Low impact.	All Users only when a user reenters a blood unit into inventory.	Add or remove information on the unit’s record (special testing, antigen typing and restricted-to patient) using Edit Unit Information.	As the blood unit record was previously defined and is now being revitalized by the new receipt of the unit, the user may only change the blood unit record’s information in Edit Unit Information. When any attempted changes are related to the evaluation of a patient requirement during Select Unit and Issue Unit, missing antigen negative or special testing information alerts appear notifying the user that the blood unit record is not correct.	DR 3,605 DR 3,607	1.6.0.0
Incoming Shipment	A unit does not lose its patient restriction when it is shipped out of the facility. Subsequently the unit cannot be restricted to another patient when the units is received again through Incoming Shipment.	Low risk/No impact at a Full Service Facility Type. Low Risk/High Impact at a Transfusion Only Facility Type.	All users	Enter the unit as restricted during Incoming Shipment. Immediately edit the “restricted-to” patient using Edit Unit Information option.	In a Full Service Facility type, only units with an Autologous and Directed donation types are restricted. These units should correctly remain “restricted-to” the selected patient. Normally these units are not changed to another patient. When a directed donation is released in VBECS, the donation type changes from D (Directed) to V (Voluntary Allogeneic). In a Transfusion Only Facility Type, all units, including those with a donation type of “V”. Units are re-used for different patients. The units are being shipped between the blood center and the VA facility for different patients possible transfusion support. An Enhanced Technologist is required to reassign the restricted unit to a patient.	DR 3,542 HD 339722	1.6.0.0

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Invalidate Test Results	VBECS does not display the expected confirmation message to the user informing them that the test was added back to the Pending Task List.	No identified risk/No identified impact.	All users	None required.	None. The inactivated test is added to the Pending Task List as indicated by the user.	CR 2,579	Testing Grids
Invalidate Test Results	A VBECS system error occurs when a user tries to invalidate a patient's crossmatch test in a Transfusion Only facility type.	Low risk/Low impact.	All users at TO facilities.	Release the blood unit from patient assignment and inactivate unit using the Edit Unit Information option. Re-enter the unit using Incoming Shipment, then select the unit and enter the correct crossmatch results.	The error does not occur in Full Service Facility Types.	CR 2,674	Maintenance TBD
Issued/ Returned Units Report	Report title does not print when requested using the report scheduler.	No identified risk/ No identified impact.	All users	Do not use the report scheduler to print the Issued/Returned Report.	The report title prints when the report is printed on demand rather than queued.	CR 2,512	Report Tool Upgrade Project Proposal
Issued/ Returned Units Report	If a unit is issued to a patient and returned and then re-issued to the same patient, duplicate issue records will display on the Issued/Returned Units Report.	No identified risk/ No identified impact.	All users	None required.	The report displays the correct issue information with a time and date stamp. A user can easily determine the last issue event.	CR 2,596	Report Tool Upgrade Project Proposal
Maintain Minimum Levels	Multiple shipments of the same lot number of a reagent type can cause a discrepancy in the total number available displayed on the Reagent Inventory Report and what is in inventory.	No identified risk/ No identified impact	All users	Refer to the most recent entry of a reagent for the number of vials available when the shipment was received.	VBECS can only display the data entered and does not manage inventory.	CR 2,599 HD 301562	Daily Reagent Quality Control Upgrade
Modify Units (not Pool or Split)	When volume reducing a product that has been previously manipulated may display no target or an incorrect target.	Low risk/No identified impact	All users	Do not volume reduce a previously altered unit.	It is highly unlikely that a volume reduced unit will be volume reduced again. ICCBBA attribute form E (altered) may be incorrect in the unit record if processed by the modification: Volume Reduced.	CR 2,612	Type III Blood Product Table Update
Modify Units (not Pool or Split)	A VBECS system error occurs when a user assigns a frozen unit to a patient and then modifies the unit to thawed. The user is asked if they want to continue the patient assignment to the thawed product. Clicking yes creates a duplicate assignment on the unit and causes the system error.	Low risk/No identified impact	All users	Remove one of the assignments by using the Release Unit(s) from Patient Assignment option to allow issue of the pooled unit.	A user can assign the frozen unit to a patient after the modification to thawed takes place which is normal practice. This is related to the duplicate assignment error noted in CR 2,650.	CR 2,656	Type III Blood Product Table Update

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Modify Units (not Pool or Split)	VBECS does not present product code 10191 when Cryoprecipitate product code 10100 is thawed.	No identified risk/No identified impact	All users	The user is instructed to select one of other correct product codes presented by VBECS.	None.	CR 2,678	1.6.0.0
Modify Units: Pool Units	A pooled unit will become assigned to a patient twice when a user chooses to add or remove units from a pooled unit.	Low risk/Low impact.	All users in a division where pooling modification has been enabled.	Remove one of the assignments by using the Release Unit(s) from Patient Assignment option to allow issue of the pooled unit.	A VBECS system error occurs when a user attempts to issue this unit with duplicate assignment.	CR 2,650	Type III Blood Product Table Update
Modify Units: Pool Units	A target product code is not available when units with product code E2817 are pooled.	Low risk/Low impact.	All users in a division where pooling modification has been enabled.	Document the POOL of units off-line. Enter the pooled unit through Incoming Shipment.	None.	CR 2,691	1.6.0.0
Modify Units: Pool Units	VBECS presents an incorrect product code (E3586) when pooling units with product code E3667.	Low risk/Low impact.	All users in a division where pooling modification has been enabled.	Users are instructed to select the other product code presented (E3685) which is correct.	None.	CR 2,691	1.6.0.0
Order History Report	Order History Report does not work with the report scheduler.	No identified risk/ No identified impact.	All users	Users must run the report when needed.	The report is available for on demand printing.	CR 2,584	Report Tool Upgrade Project Proposal
Outgoing Shipment	The outgoing shipping invoice is missing required information regarding a blood unit's CMV Negative status, biohazardous, and autologous unit testing status. When assigned, the patient first name and ID are not printed on the outgoing shipment document to maintain patient privacy.	No identified risk/No identified impact.	All Users	Handwrite pertinent information on the VBECS invoice, if used to ship the blood products.	None.	CR 2,734	Report Tool Upgrade Project Proposal
Patient History Report	The 2nd digit of the minutes under the Date Processed column of the Demographics section is difficult to read when a 30 character patient name is displayed.	No identified risk/No identified impact.	All users	None required.	None.	CR 2,610	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient History Report	The exception for antigen typing testing phase changes does not appear on the Patient History Report.	Low risk/Low impact.	All users	Users are directed to review the Exception Report for this information.	The Exception report is identified as one of the reports requiring supervisory review. The impact to the antigen typing result is investigated and addressed at that time not as a result from an entry on the unit or history report.	CR 2,684	Report Tool Upgrade Project Proposal
Patient Testing	When a user saves patient ABO and Rh results separately with ABO saved first and Rh later the Pending Task List (PTL) will not allow this patient to be ABO/Rh tested in the future. When the next specimen is tested, VBECS will display an error message that there is an ABO/Rh discrepancy, even though no discrepancy exists in the patient's historic test results.	Low risk/Low impact.	All users	If the problem occurs, the user is instructed to invalidate the ABO/Rh test that was saved as separate ABO and Rh. After invalidation and adding the test back to the pending task list, the user can now enter both the ABO and Rh and save them.	The ABO and Rh test are traditionally saved simultaneously.	CR 2,576 HD 288163	1.6.0.0
Patient Testing	A user is allowed to enter more than 50 characters in the Off-Site Location field when entering antibody ID results without a message from VBECS that only the first 50 characters will be saved.	Very Low risk/Very Low impact.	All users	Do not exceed 50 characters for the name of the off-site testing location.	None.	CR 2,626	Testing Grids
Patient Testing	A VBECS system error occurs when a user tries to save a result of “H” (hemolysis) in the Patient Antigen Typing testing grids.	No identified risk/ No identified impact.	All users	Users are instructed not to enter “H” in the Patient Antigen Typing test grids. Any attempt to save a result of “H” will cause a system error and clear the testing grid of that result when the user re-enters VBECS.	The key for acceptable entries in the testing grid does not include “H” but it is permitted to enter until saving.	CR 2,685	Testing Grids
Patient Testing: Pending Task List	A system error occurs when the search option “Results Corrected” is used.	No identified risk/ No identified impact.	All users	None required.	There are other fields available for use that will present the orders associated for a single patient. Field sites report that they require entry of the patient full SSN or specimen UID to select an order for processing.	CR 2,490 HD 264904	Testing Grids
Patient Testing Worklist and Testing Worklist Reports	The Testing Worklist Report only displays the first 218 characters entered in the ABID results comment field.	No identified risk/ No identified impact.	Supervisor responsible for report review	The full comment is viewable in the Patient History Report.	Users are limited to entering 255 characters in the ABID results comment field.	CR 2,627	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient Testing Worklist and Testing Worklist Reports	The Testing Worklist Report does not display the last name of the tester if their user name includes a site abbreviation [e.g. First Name, Middle Initial, (Division Abbreviation Last Name)].	No identified risk/ No identified impact.	All users	There is enough of the user name present on the report to identify the individual that performed the testing.	The VBECS report-generating tool is displaying the first, middle, and division abbreviation, for the users that have a division abbreviation included in their user name.	CR 2,694 HD 336190	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The Rack QC Testing Worklist Report section of the Testing Worklist Report only displays the testing tech and not the identity of the logged in tech that entered the results.	Low risk/Low impact.	Supervisor responsible for report review	Maintain the original testing records for the QC that was performed offline with the testing tech information. Do not change the testing tech name when entering results in VBECS so that the logged in tech that enters the results is included on the Testing Worklist report.	Local policy dictates the storage of downtime records. Storage of the original work in addition to the computer entry is customary.	DR 3,556	Report Tool Upgrade Project Proposal
Patient Updates	The last update date time is updated on all Patient Updates displayed each time a new update is viewed.	Low risk/Low impact.	All users	None required.	None.	CR 2,711	Maintenance TBD
Patient Updates	Patient updates display in VBECS for active patients when the data change is unrelated to VBECS data.	No identified risk/ No identified impact.	All users	None Available.	The changing demographics do not affect VBECS or the patient identity so the update will not reflect any changes.	CR 2,580	Maintenance TBD
Post – Transfu-sion Informa-tion	The OK button is enabled on the Post Transfusion Information window when a Traditional Supervisor or above selects a unit that was marked transfused.	No identified risk/Low impact.	Traditional Supervisor and above.	None required.	The OK button should only be enabled after a change has been made to saved information.	CR 2,550	Maintenance TBD
Post – Transfu-sion Informa-tion	Removing a unit's final status of presumed transfused to enter post transfusion data in Post-Transfusion Information will results in a duplicate display in the CPRS Blood Bank Report.	No identified risk/ No identified impact.	All users	None required.	This issue is due to incorrectly invalidating the transfused unit. User can add post-transfusion information in the Enter Post Transfusion Information option.	CR 2,589	Maintenance TBD
Post – Transfu-sion Informa-tion	VBECS allows the user to set a transfused volume to an amount greater than the default average volume associated with the product code in Blood Products.	No identified risk/ No identified impact.	All users	None required.	This may actually be a benefit as an accurate transfused volume may be entered. The default product volume is an average, not the maximum.	CR 1,655 CR 2,607	VBECS BCE Interface Project

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Print Unit Caution Tag & Transfu-sion Record Form	When a caution tag or Blood Transfusion Record Form (BTRF) is printed when completing the first instance of ABO/Rh testing for a patient, the caution tag and BTRF will print the blood type as NR (no record).	Low risk/Low impact.	All users	Re-print the caution tag and BTRF after patient testing is saved to show the blood type on the caution tag and BTRF.	VBECS prints the caution tag and BTRF before saving patient testing, which is why the forms print with NR as the blood type.	CR 2,493	1.6.0.0
Print Unit Caution Tag & Transfu-sion Record Form	VBECS can only print ten blank caution tags per request. A user request for more than ten blank caution tags will result in only ten tags printed.	No identified risk/ No identified impact.	All users	Perform several requests for ten blank caution tags to fulfill the quota if more than ten caution tags are required.	None.	CR 2,624	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	Patient name may exceed the allotted space when it is 30 characters in length.	Low risk/Low impact.	All users	The user would complete backup forms and caution tags for all units associated with this patient.	This is considered low impact as the likelihood of a patient having a name that is 30 characters long is small.	CR 2,454	1.6.0.0
Reagents	A system error occurs when sorting reagents by invoice if the invoice contains any non-numeric characters	No identified risk/ No identified impact.	All Users	Do not enter non-numeric characters for the invoice number.	None.	CR 2,528	Daily Reagent Quality Control Upgrade
Transfu-sion Complica-tions Report	Transfusion Complications Report has a system error if a numeric threshold value is defined and there is a text result.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	The user will have to request the report without the date of the implicated text test result (e.g., “Canc” for an expected numeric result). VistA tests for the date of the text result can be viewed in VistA.	The user may screen the test in question using VistA. This report is used as a look back tool, not a pretransfusion assessment.	CR 2,252 HD 337715	Report Tool Upgrade Project Proposal
Transfus-ion Effective-ness Report	A VBECS system error occurs when a user requests a Transfusion Effectiveness Report and the response time from VistA exceeds the configured timeout in VBECS.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	A VBECS Server Administrator can change the VistALink time out set in the VBECS.exe.config file. This workaround is detailed in Remedy ticket HD 335307 which resolves the system error.	None.	CR 2,695 HD 335307	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Transfu-sion Require-ments Report	The partial Patient Transfusion Requirements Report does not display the special instructions or transfusion requirements unless they were entered within the date range specified for the report.	Low risk /Low impact.	All users can print the report but a Supervisor would be responsible for review.	To create a report with all patients' special instructions and transfusion requirements, print a partial report with the date range from VBECS implementation through the current date.	The user must request the report using the workaround to view the special instructions and transfusion requirements to ensure a complete report.	CR 2,581	Report Tool Upgrade Project Proposal
Unit Antigen Typing	The test set up is very specific to reproduce the problem: 1. Weak D testing of an Rh negative unit is performed with one or more additional unit antigen tests in the same testing episode. (Example: Weak D and K typings). 2. Enter an invalid result or interpretation into the Weak D grid in any combination that causes an Error icon alert. The OK button is correctly disabled and does not allow saving of this test. 3. When the technologist switches to another antigen testing tab and enters a valid result for another antigen test, the OK button is enabled for this tab. The technologist saves the result (Example: K antigen). 4. When the user returns to the Weak D tab in the same testing session, the error icon alerts the user of the invalid test. However, the OK button incorrectly remains enabled and will allow the user to save the invalid weak D results. 5. If the invalid Weak D result is saved, VBECS does not update/change the unit blood type or quarantine the unit of blood.	Moderate risk /Very Low impact.	All users	Perform Weak D antigen typing as a single test and not in combination with other antigen tests in the same testing episode.	• Throughout VBECS, the appearance of the Error icon is designed to warn the user that the entered results cannot be saved. • No other unit or patient antigen typing tests have been identified with this problem. • The blood supplier is required to test any unit that will be labeled *Rh negative* for Weak D before it can be released for shipment. Therefore, customer antigen testing is not expected to detect a Weak D antigen on a blood unit. • The Rh negative unit is treated per the face label and original ABO/Rh Confirmation results by VBECS. • It is unlikely the user will perform a Weak D test on a blood unit unless the patient has Anti-D. In that case, a complete crossmatch is also required to confirm compatibility.	CR 2,724 HD 353065	1.6.0.0
Unit Antigen Typing	When a user applies a sort order when selecting units for antigen typing that order is not inherited by the testing grid.	No identified risk/ No identified impact.	All users	Organize physical tests materials according to the order of units presented on the testing grid.	The units sort order is based on the last update date/time which is not displayed to the user.	CR 2,646	Testing Grids
Unit History Report	The last digit of the minute printed for the Date Processed field is difficult to read.	No identified risk/ No identified impact.	All users	None available.	None	CR 2,545	Report Tool Upgrade Project Proposal
Unit History Report	Unit Tests section of the Unit History Report incorrectly displays the QC results for unit antigen typing. The control cells display the unit test result not their own results.	No identified risk/ No identified impact.	All users	View or print the Testing Worklist Report, Miscellaneous Reagent QC section where the correct antigen typing QC results are displayed.	None	CR 2,639	Report Tool Upgrade Project Proposal

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Unit History Report	Antigen typing comments for QC do not appear on the Unit History Report. The testing comments entered for a unit appear for the positive and negative controls instead.	No identified risk/ No identified impact.	All users	Testing comments for the antigen typing QC can be viewed as entered on the Testing Worklist Report, Miscellaneous Reagent QC section.	None.	CR 2,641	Report Tool Upgrade Project Proposal
Unit History Report	The Antigen Testing Phase Change Exception does not appear on the Unit History Report.	No identified risk/ No identified impact.	All users	The Antigen Testing Phase Change Exception appears on the Exception Report which should be reviewed daily by the supervisor.	None	CR 2,643	Report Tool Upgrade Project Proposal
Unit History Report	The exception detail captured for the exception type Previously Recorded Results Invalidated do not appear on the Unit History Report.	Low risk/Low impact.	All users	View the Exception Details on the Exception Report for this information for the date the exception was generated.	The Exception report is identified as one of the reports requiring supervisory review. The impact to the antigen typing result is investigated and addressed at that time not as a result from an entry on the Unit History Report.	CR 2,682	Report Tool Upgrade Project Proposal
Unit History Report	The exception details captured for Antigen Testing Phase Change do not appear on the Unit History Report.	Low risk/Low impact.	All users	View the Exception Details on the Exception Report for this information for the date the exception was generated.	The Exception report is identified as one of the reports requiring supervisory review. The impact to the antigen typing result is investigated and addressed at that time not as a result from an entry on the Unit History Report.	CR 2,689	Report Tool Upgrade Project Proposal
Unit History Report	The Crossmatch Tests section of the Unit History Report will display testing without interpretations if the unit selected was tested in a batch of units and results were not entered.	No identified risk/ No identified impact.	All users	Enter crossmatch testing results for all units selected for crossmatch.	The Unit History Report correctly displays crossmatch results when the testing is complete or if the testing fields for the unit are left blank and not edited during testing.	CR 2,716	Report Tool Upgrade Project Proposal
VBECS Adminis-trator	System Administrator can save the Patient Update and Patient Merge tabs for the VBECS Interface without entering a value in the Facility ID field. Failure to enter a facility ID will prevent patient updates and merge alerts from being processed.	Low risk/Low impact.	System Administrator	Enter the facility ID in the Facility ID field on the Patient Update and Patient Merge tabs of VBECS Administrator.	VBECS System Administrator is instructed to enter the facility ID in the Facility ID field in the VBECS Technical Manual-Security Guide when VBECS is configured for use.	CR 2,573	Maintenance TBD
VBECS Adminis-trator	A system error occurs in the VBECS Administrator when the system administrator edits a user of VBECS and minimizes the VBECS Administrator window.	No identified risk/No identified impact	System Administrator	Restart VBECS Administrator.	None.	CR 2,616	Maintenance TBD
Workload Codes (Division Configu-ration)	LMIP/NLT associated CPT codes are not changed by checking or unchecking the boxes.	No identified risk/ No identified impact.	Administrator	Adjust the LMIP/NLT code to CPT code associations in VistA Lab.	This has been identified as a training issue.	CR 2,438	Maintenance TBD

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Workload Codes (Division Configu-ration)	Changes to workload weight in VistA does not update the VBECS database with the workload multiplier for associated LMIP/NLT codes , transmitting incorrect workload data back to VistA.	No identified risk /Low impact.	Administrator	Verify the correct workload weight is set in VistA. Inactivate the LMIP/NLT associated with the VBECS workload process. Then select the workload process and associate it with the same LMIP/NLT code. VBECS is updated and will use the new weight.	Changes to workload weight do not update previously accrued workload date saved in the VBECS database.	CR 2,700 HD 339277	Maintenance TBD
Workload Report to Austin	The method portion of a LMIP number (four numbers to the right of the decimal) is not returned in the national report.	None/None	None	None Available.	Assign NLT code 93960 VBECS Other to all non billable VBECS processes.	DR 3,601 CR 2,737	TBD may be a LR patch or VBECS patch.

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number), HD (Remedy Help Desk Ticket Number), CQ (CPRS ClearQuest Tracking System Number)