**Assignment 2 Assignment #2**

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| **Assignment #2:**   1. **To review the provided documents and records so that the problem can be better understood and defined.** 2. **To define the problem that the laboratory must fix.** 3. **To study the processes that may have failed.**   **Instructions:**  **Document the problem statements on page 2 under Task 4. Submit only page 2 to the facilitator.**  **Completed Task 7 to be submitted to the facilitator by circling the relevant area on the flowchart including the letters a-f (Pages 10-12)** |  |

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| **Task #** | **Task to be performed for homework** | **Reference** | **Location of Reference** | **Helpful Notes** |
| 1 | Read | *Document Review, Records Review, and Photographs* | *Handout 2: RCA Tools 4-18, page 1, 3* |  |
| 2 | Evaluate | * *Urgent List and Result Report Turn-around Time (TAT) Procedure* * *Delay or Failure Notification Procedure* * *Accessioning Resolution Form* from 13 August 2016 * Photograph | Provided with this packet, pages 5 - 9. |  |
| 3 | Document the specific and detailed information you have learned about this problem. | *Problem Statement Table* | Provided with *Preparation for Assignment 1* | Note only the facts; do not include any causes. |
| 4 | Using 1-3 sentences for each event, write a problem statement in the space below. | Facts captured on the *Problem Statement Table* compiled into 1-3 sentences. |  | From your investigation, you see that the reported nonconformity is actually 2 independent events that occurred simultaneously on the same critically acute patient. From the customer’s perception, both events resulted in the same symptom (symptom -the mess left behind each time the problem occurred)– information was not available when the customer needed it to manage their patient.  A problem statement communicates the problem that must be fixed by the laboratory. |
| Gram Stain Problem Statement:  Culture Problem Statement | | | | |
| **RCA Step #1 Define the problem.** You must first understand what happened before attempting to understand the causes. | | | | |
| 5 | Read | *Step 2: Understand the Process* | *Handout 1: RCA Model 4-17, page 3* |  |
| 6 | Review | Provided flowchart documents | Provided with this packet, pages 10 - 12 | Review to understand the process |
| 7 | Locate by **circling the area** in the appropriate flowchart Pages 10-12) the following activities occurred. Place the **task’s corresponding letter** into the appropriate process map to indicate where in the sequence this activity happened.   * 1. LSRC transferred the received request information to the correct fluid request form.   2. Tech AA made the extra slide.   3. Tech AA informed Tech YY that the memo (i.e. delay notification memo) was sent.   4. Tech AA called the urgent cell count results.   5. Tech AA realized the gram stain request could not be fulfilled.   6. LSRC determines the request form is incorrect. | Provided flowchart documents | Provided with this packet, pages 10 - 12 | Circle the relevant area on the flowchart and add in the relevant letter . |

**RCA Step #2: Understand the process** – Root cause analysis must examine problems in the context of the system in which they occurred.

**1.0 Purpose/Applicability:**

**1.1 Purpose:**

To ensure that results are reported timely to optimize patient care and patient outcomes. To define the tests that can be ordered on an URGENT basis and the interval of time between when the sample is received in the laboratory and the results are reported.

**1.2 Scope:**

This procedure is applicable to all sections providing products and services governed by the requirements specified within the CCHL Quality Management System.

1. **2.0 Definitions and Terms:**

**2.1 Routine –** Tests that are collected and batched for efficiency and cost effectiveness. These results are not needed on an immediate basis for diagnosis or treatment

**2.2 TAT (Turn Around Time)** – The interval of time between when a sample is received by the laboratory and the results are reported.

**2.3 Timed –** Tests that are collected at a specified time ±15 minutes and batched for efficiency and cost effectiveness.

**2.4 URGENT Tests** - Test results that are urgently needed for the diagnosis or treatment of the patient. The delay can be life threatening.

**3.0 Responsibilities:**

**3.1 Phlebotomist/Accessioning Clerk -** are responsible for collecting and delivering URGENT samples to the laboratory section as quickly as possible. URGENTs are given priority over all other sample collections.

**3.2 Clinical Laboratory Technologist and Clinical Laboratory Technician -** are responsible for analyzing URGENTs as quickly as possible. URGENTs are given priority over all other tests. The reporting analyst is responsible for notifying the ward and documenting the notification.

**4.0 Procedure:**

4.1 Phone the ward (inpatients) or ordering physician (outpatients) immediately with the released result.

4.2 Instruct the receiver to read-back the results to verify correctness.

4.3 Document on the report and in the appropriate log book who received/read-back the results, date/time results were given/ your initials.

4.4 Handle all critical results ordered on an URGENT basis according to the Critical Results Procedure.

**5.0 Notes**

5.1 TAT for Tests in the Clinical Laboratory:

1. **5.1.1. URGENT –** One hour or less from when the sample was received in the laboratory.
2. **5.1.2 Routine** – Four hours from when the sample was received or as scheduled for the next run.
3. **5.1.3 Timed–** Two hours or less from when the sample was received in the laboratory.

**6.0 Related Documents:**

6.1 Critical Results Procedure

6.2 Inpatient Report Release Procedure

6.3 Outpatient Report Release Process

6.4 Release of Laboratory Test Results to a Patient Procedure

**7.0 References:** CAP Checklist

**8.0 Appendices:** Appendix A: URGENT List of Tests

Appendix A: **URGENT List of Tests**

**Chemistry Tests Available on an URGENT Basis**

|  |  |
| --- | --- |
| ALT  Albumin  Alk Phos  Ammonia  Amylase  AST  Bili, Total and Direct  BUN  Calcium  Chloride  Cholesterol  CO2  CK  Creatinine  CRP | CSF Glucose  CSF TP  GGT  Glucose  HDL  HCG  Lactic Acid  LDH  LDL  Lipase  Magnesium  Phosphorus  Potassium  Sodium  Total Protein  Triglyceride  Uric Acid  Urinalysis |

**Hematology Tests Available on an URGENT Basis**

|  |  |
| --- | --- |
| APTT  CBC  D-Dimer  Differential  FDP | Fibrinogen  Hemoglobin  Platelet Count  PT  Retic |

**Microbiology Tests Available on an URGENT Basis**

|  |  |
| --- | --- |
| Fluid Cell Count  Gram Stain  India Ink  Rapid HIV | Rapid Malaria  Rotavirus  Wet Mount |

**Transfusion Services Tests Available on an URGENT Basis**

|  |  |
| --- | --- |
| Cryo\*\*  FFP\*\*  Platelets\*\* | Type and Screen  Type and Crossmatch for Packed Red Blood Cells\*\* |
| \*\*The one-hour TAT applies only if the product is available in the laboratory and there are no complications such as an unexpected antibody. In those cases, blood products may need to be brought from BloodSource or a sample of blood sent to BloodSource for further studies. The nursing unit will be contacted as soon as possible and notified of the delay and options available. If necessary, the Pathologist may need to be consulted for the best course of action to meet the patient care needs. The Pathologist may need to speak to the ordering physician to discuss how to accommodate the needs of the patient. | |

**1.0 Purpose/Applicability:**

**1.1 Purpose:**

To establish a communication process with the physician and hospital management regarding delays or failures to provide laboratory services.

**1.2 Scope:**

This procedure is applicable to all sections providing products and services governed by the requirements specified within the CCHL Quality Management System.

**2.0 Definitions and Terms:**

**2.1 Delay -** Whenever there is anticipated delay in TAT of laboratory services.

**2.1 Failure** Whenever the laboratory is unable to provide examination testing.

**2.2 TAT (Turn Around Time)** – The interval of time between when a sample is received by the laboratory and the results are reported.

**3.0 Responsibilities:**

**3.1 Clinical Laboratory Technologist and Clinical Laboratory Technician –** are responsible toinform the Section Supervisor whenever there are inadequate resources to perform a test (e.g. instrument breakdown, reagents out of stock, reagent recall).

**3.2 Section Supervisor** - is responsible to inform the Technical Supervisor whenever there are inadequate resources to perform a test.

**3.3 Technical Supervisor –** is responsible for communicating testing delays or failure with the physicians and hospital management.

1. **Procedure:**

4.1 Document the notification in the section’s communication log.

4.2 Whenever the laboratory is unable to provide any test or there is anticipated delay in TAT, communicate to the customers about the situation

4.3 Mobilize the resources needed for the service to return to normal as soon as possible.

4.4 Communicate with the customer when service returns to normal.

**5.0 Related Documents:**

N/A

1. **References:**

N/A

**Accessioning Resolution Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Patient’s Name** | | **Test / # of Specimens** | | | **Location** | **Problem** | | | | | | | | | | | | | | | | | | | | | | | **Action Taken** | | | | | | | | **Initials**  **Date/ Time** | |
| Dontana Silue | | Gram, cult, cell count/ 1 sterile | | | Men’s Med Surg | **1** | | **2** | | **3** | **4** | **5** | **6** | **7** | | **8** | | **9** | | **10** | | | **11** | | | **12** | | **13** | **A** | | **B** | **C** | **D** | **E** | **F** | **G** | JJ  13 Aug 2016 /0900 | |
| Called Marie 13/8/16 @ 0900; no fluid requests on ward | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1 red, 1 purple | | | ED | **1** | | **2** | | **3** | **4** | **5** | **6** | **7** | | **8** | | **9** | | **10** | | | **11** | | | **12** | | **13** | **A** | | **B** | **C** | **D** | **E** | **F** | **G** | JJ  13 Aug 2016 / 1155 | |
| Called Stanley 13/8/16 @ 1150; not sure who patient was | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alicia Ketema | | Gram,  cell count/ 1 sterile | | | Peds | **1** | | **2** | | **3** | **4** | **5** | **6** | **7** | | **8** | | **9** | | **10** | | | **11** | | | **12** | | **13** | **A** | | **B** | **C** | **D** | **E** | **F** | **G** | LSRC  13 Aug 2016/ 1330 | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kereng Soro | | PT, PTT/ 1 blue | | | Men’s Med Surg | **1** | | **2** | | **3** | **4** | **5** | **6** | **7** | | **8** | | **9** | | **10** | | | **11** | | | **12** | | **13** | **A** | | **B** | **C** | **D** | **E** | **F** | **G** | LSRC  13 Aug 2016  1650 | |
| Called Marie 13/8/2016 @ 1645 to reject | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rowland Lewis | | CD4 / 1 red | | | Men’s Med Surg | **1** | | **2** | | **3** | **4** | **5** | **6** | **7** | | **8** | | **9** | | **10** | | | **11** | | | **12** | | **13** | **A** | | **B** | **C** | **D** | **E** | **F** | **G** | STU  14 Aug 2016  0720 | |
| Called Clara 14/8/2016 @ 0720, will redraw with noon Hb order | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Problems Encountered** | | | | | **Action Taken** | | | | | | | | | |  | |  | |  | |  |  | |  |  | |  | |  |  | | | | | | | |  | |
| **1** | Unlabeled specimen | **8** | | Insufficient quantity | | | **A** | | Phone < 5 min to resolve | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **2** | Unlabeled form | **9** | | Received broken | | | **B** | | Phone > 5 min to resolve | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **3** | No specimen received | **10** | | Wrong tube/ specimen & form differ | | | **C** | | Passed on to laboratory section to further resolution | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **4** | No form received | **11** | | Name on specimen and form differ | | | **D** | | Made out form | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **5** | No test on form | **12** | | Received empty | | | **E** | | Held a reception for 1 week | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **6** | No location on form | **13** | | Specimen leaked in transit | | | **F** | | Discarded immediately | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | |
| **7** | No ordering clinician | |  | |  | | **G** | | Other | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Recp-Rej-F001; v3  02/05/2014 | |







