LAB Dept MEETING – Huddles

Date of Meeting: April 6, 2021

Attendees: Juanita Fernandez, Juliet Garlejo, Marietes Gonzalez, Yetunde Kosoko, Raquel Lecaro, Melanie Magee, Lourdes Maniago, Mariela Mora, Sumera Nazir, Myrna Ocob, Erica Torres, Michelle Trammell, Patricia Chea, Marissa Calilung, Theda

Торіс	Details	Action Item, responsible person, date due, or informational only
SAFETY TIP	This red biohazard bin is full up to the brim. Don't let waste go up that high, must be only up to 75% full.	Informational
KUDOS	3 rd and 4 th Quarter Perfect Attendance EMPLOYEE Erica Torres Lourdes Q. Maniago Nancy Khalil Fahiem Khalil Raquel A Lecaro Sumera Nazir Yetunde Folashade Kosoko	

Lob Wook to may		
Lab Week- to move week of April 26 due	*********	ALL STAFF
to CAP inspection.	GET READY!!!!!	
	2021 Lab Week April 19th-23rd	
	Themes /Games/Food this year are:	
	Monday- Music Monday Tuesday- Tie Dye (Favorite band T-shirt)	
	Guess that kazoo song/Cinnabon Hip-pea in a cup/B-fast Burritos	
	Wednesday- Silly Hat/Hair day Thursday- 80's Day Most creative and silliest wins prize/ 80's Trivia/Totally Tubular Sandwiches (WEAR YOUR LAB SWEATSHIRT) Pizza	
	Friday- The lab is a Zoo!! Day	
	Hungry Hungry Hippo Face off/Bucket O' Fun	
	•	
COBAS testing alert.	 .COBAS LIAT Technical Bulletin Any unusual error messages such as "Thermal runaway" – stop testing and report to manager Any unusually high invalid result- stop testing and report to manager Any increase in Flu B positive result- stop testing and report to manager See technical bulletin attached and on the hood 	CLS
	•	
Cerner Comments	Dear CLS	CLS
can now be read by members.	In our response to the 21 st Century Cures Act, all comments in Cerner are now visible to our members.	
	Make sure to follow policy in writing comments.	
	Any additional information that is outside the policy or canned comments- use Cerner Order NOTES or Result NOTES.	
	Example, if you want to document that you called Pharmacy twice and no response- document that under NOTES.	

I		
Chino will fax	Mar/6/2021 10:18:01 PM KP Bacteriology->9512516722 1/1 2021-03-06 22:09 KP Bacteriology 9097036030 >> 9512516722 P 1/1	Phlebotomist
this document-	Medical Care Program RRL-Chino Hills California Division – South Record	
give to SPA	BACTERIOLOGY SPECIMEN PROBLEM FORM	
Phlebotomist	To: SUPERVISOR Facility: Moreno Valley Area	
T mebotomist	From: RRL-CH BACTERIOLOGY DEPT. Phone: (Tie Line) 8-263-6056 FAX: (Tie Line) 8-263-6035	
Phleb to perform	Patient Name Will Provide Patient Name Will Pati	
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ionn, men me.	Clotted Blood [specify: SST Non-SST Spun Unspun] BD E-Swab	
Do not ignore the	Universal Transport Media CT/GC Transporter Stool [Specify: BD Vacutainer (gray top)	
fax machine or	Platod media (specify:] Other (specify:] Yest(s) Ordered:	
leave in manager	ACCESSIONING ERROR ADDITIONAL INFORMATION UNABLE TO PERFORM TEST	
mailbox.	Wrong Gender REQUIRED PLEASE RESUBMIT	
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away	Barcode of specimen; not accessioned Please specify source/body site: Incorrect media	
away	No barcode on specimen [NBC]	
	Accessioned for wrong performing Facility [WPF] Incomplete accessioning Lab accident/Lab error	
	Delete [Reason: [describe:]	
	PLEASE RESPOND WITHIN <12 years ≥12 years 49-HOURS ! Other: WOULD YOU LIKE OTHERWISE, SPECIMEN WILL TO ORDER No Specimen received	
	OTHERWISE, SPECIMEN WILL TO ORDER Other: Other:	
	(ANCILLARY SERVICES DEPARTMENT USE ONLY) Ordering facility called Date/Time:	
	Problem Form faxed to ordering facility Specimen(s) returned per request Specimen(e) discorded	
	rest(s) performed Test(s) deleted Specimen on hold	
	Resolution:	
	Page 1 of 1 Version No: 02	
UBT		

This concludes the Minutes of the _April 6, 2021_____ Lab Staff Meeting.

Prepared by: __Patricia Chea, Marissa Calilung____ Date: __6/2/2021_____

Laboratory Care Delivery System - 03/17/21

Technical Bulletin

Laboratory Care Delivery System

SPORADIC FALSE POSITIVE RAPID MOLECULAR FLUVID RESULTS

Roche recently identified some sporadic false positive results associated with their cobas Liat SARS-CoV-2 + Influenza A/B molecular multiplex test (SARS COV-2 (COVID-19), INFLUENZA A + B, MULTIPLEX NAA [87636A]), particularly for the Influenza B target. They proactively reported these events to the FDA and are conducting an in-depth investigation to fully understand the cause and to determine next steps.

According to the FDA, the false positive results may be related to two issues observed by Roche:

- Roche identified that the assay tubes may sporadically leak, causing an obstructed optical path in the Liat
 analyzer, producing abnormal PCR growth curves. This could lead to invalid or erroneous positive results,
 particularly for the Flu B test. If a tube leak occurs, later testing runs may have an increased likelihood of false
 positive Flu B results.
- Roche determined that abnormal PCR cycling in the reaction tubes may also produce abnormal PCR growth curves, leading to erroneous results. The issue is sporadic and may be caused by multiple factors happening at the same time, such as hardware positioning, volume movement, and curve interpretation. This issue may cause false positive results for multiple analytes (Influenza A, Influenza B and/or SARS-CoV-2) in a single testing run.

The FDA recommends users of the cobas SARS-CoV-2 & Influenza A/B Nucleic Acid Test for use on the cobas Liat System:

- Monitor for unexpected clusters of positive Flu B results, as this may indicate the cobas Liat System has
 experienced a tube leak.
- Repeat tests when two or three analytes are positive. Different results on the repeat test may indicate abnormal PCR cycling.
- Stop using the cobas Liat System and contact Roche if you suspect either of these two issues has occurred.

In addition to following the FDA recommendations above, the LCDS will send repeatedly multi-analyte positive results to the RRL for confirmation testing by way of the following assay: SARS-COV-2 (COVID-19), INFLUENZA A, INFLUENZA B, MULTIPLEX NAA, HIGH THROUGHPUT [258971].

QUESTIONS?

- Client Service Center: 1-888-4LAB NFO, or tie line 8-397-7077
- Jonathan C. Gullett, MD, Physician Director of Microbiology, jonathan.c.gullett@kp.org
- Ken Van Horn, PhD, D(ABMM), Technical Director of Microbiology, <u>ken.van-horn@kp.org</u>
- Tam Van, PhD, D(ABMM); Technical Director of Microbiology, <u>tam.t.van@kp.org</u>

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Laboratory Care Delivery System - 03/23/2021

Technical Bulletin

Laboratory Care Delivery System

CHANGES TO RAPID RESPIRATORY SYNCYTIAL VIRUS (RSV) TESTING

Effective Wednesday, March 31, 2021, the Laboratory Care Delivery System will make the following changes to rapid RSV testing:

- RAPID INFLUENZA A/B AND RSV, PCR [87631C] will be discontinued temporarily due to vendor supply issues.
- Instead, RSV ANTIGEN SCREEN [87807A] will be performed using the BD Veritor antigen detection system at local Medical Center Laboratories.

There will be no changes to the RAPID INFLUENZA A/B, PCR [87502A] or SARS COV-2 (COVID-19), INFLUENZA A + B, MULTIPLEX NAA [87636A] orderables. Select MOBs and EDs that are already using the BD Veritor for point-of-care RSV (RSV ANTIGEN, NASAL SWAB, IMMUNOASSAY, POCT [87807D]) and/or influenza (INFLUENZA VIRUS ANTIGEN (A, B), NASAL SWAB, POCT [87804D]) testing can continue to do so.

	TEST IN	FORMATION	
KPHC Order Display Name [Code]	RSV ANTIGEN SCREEN [87807A]		
KRMS Procedure Name [Code]	RSV SCREEN [8649677]		
Test Location	Medical Center Laboratories		
CPT Code(s)	87807		
Specimen Requirement	Nasopharyngeal swab in UVT/UTM		
Transport Temperature	Refrigerated (2-8°C)		
Stability	72 hrs		
Special Instructions	This test is intended for <i>in vitro</i> diagnostic use to aid in the diagnosis of RSV infections in infants and pediatric patients under the age of 20 years.		
	Display Name	CID	Base Name
KPHC Result Components	RSV AG	12121039	RSVAG

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Technical Bulletin

Laboratory Care Delivery System

BLOOD CULTURE CONTAMINATION REPORT CHANGES

The Laboratory Care Delivery System is pleased to announce that monthly Blood Culture Contamination Reports have been revised to include a more accurate count of true contaminants and will now be more readily available electronically. Reports should be available within the first week of each month and posted on <u>SharePoint</u>, where current reports are located. January and February 2021 reports have already been posted.

Specific existing changes include:

- The Contamination report, which is derived from iLab data, resides in SharePoint, and published each month.
- Revision of the previous acceptable contamination rate from existing (<2%) to microbiology standard (<3%)
- More accurate capture of contaminant organisms / events
- More accurate capture of draw location and collecting individual (where available)

Additional changes to soon follow:

- Procedure for report to be posted on SharePoint
- Electronic form for Med Center documentation/review available, and relevant corrective actions that need to be taken

There will be only minimal changes to the actual structure of the report.

QUESTIONS?

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TP-01255 03/25/21

URGENT MEDICAL DEVICE CORRECTION

cobas[®] SARS-CoV-2 & Influenza A/B Assay for Use Under Emergency Use Authorization – Potential for Invalid or False Positive Results

This Urgent Medical Device Correction (UMDC) only affects customers using:

Product	Analyzer	Catalog Number
cobas® Liat® analyzer	All serial ID numbers	07341920190
cobas SARS-CoV-2 & Influenza A/B assay	cobas Liat	09211101190

Issue

Recently, Roche discovered and proactively shared an issue with the FDA regarding invalid or false positive results for one or more targets (SARS-CoV-2/Influenza A/Influenza B) using the **cobas** SARS-CoV-2 & Influenza A/B assay for use under emergency use authorization on the **cobas** Liat analyzer. A review of customer-provided data associated with the reported invalid or false positive results showed abnormal PCR growth curves.

Actions Required

- Inform any operators that use the cobas Liat analyzer and/or cobas SARS-CoV-2 & Influenza A/B test of the
 potential hazards associated with this issue and provide a copy of this UMDC as appropriate.
- If you observe an increase in Influenza B positive results that does not match community infection rates, stop testing on the **cobas** Liat analyzer and contact the Roche Support Network Customer Support Center at 1-800-800-5973 to determine if a tube leak or other issue has occurred.
- If you observe dual- and/or triple-positive results for a particular sample, retest the sample with the cobas SARS-CoV-2 & Influenza A/B test for use with the cobas Liat analyzer using a different cobas Liat analyzer. If you do not have an additional analyzer or if results on the second analyzer disagree with the results from the first analyzer, stop testing on the affected analyzer and contact the Roche Support Network Customer Support Center at 1-800-800-5973.
- Monitor your invalid result rates. If there is a sudden increase or if invalid results are observed repeatedly
 on a specific **cobas** Liat analyzer, stop testing on the analyzer and contact the Roche Support Network
 Customer Support Center at 1-800-800-5973.
- If the "Thermal runaway (disable)" message appears (as described later in this UMDC) on your cobas Liat analyzer running software version 3.3.0, stop testing on the analyzer and contact the Roche Support Network Customer Support Center at 1-800-800-5973.
- For handling previous positive results generated with the cobas SARS-CoV-2 & Influenza A/B test for use on the cobas Liat analyzer, follow your laboratory's standard operating procedures to investigate the potential for false positive results.
- Complete all sections of the enclosed faxback form (TP-01256) and fax it to 1-866-503-1216 or email it to roche6136@stericycle.com by April 8, 2021.
- · File this Urgent Medical Device Correction (UMDC) for future reference.

over...

🗹 cobas Liat

Roche Diagnostics Corporation

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