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|  | **Inpatient Phlebotomy Scope of Service and General Information**  **#IPP2** | **Dept:** | **Inpatient Phlebotomy 324305** |
| **Effective Date:** | **2/17/2011** |
| **Revised Date:** | **March 2019** |
| **Contact:** | **Laurie Watson** |
| **Name & Title: Greg Pomper, MD Medical Director** | | **Date:** |  |
| **Signature:** | | | |

1. **General Procedure Statement:**  To give guidelines to staff concerning the scope of services for the Medical Center
   1. **Purpose:** This procedure is to serve as a guide for trained personnel in the Inpatient Phlebotomy Department to perform the services described herein. These guidelines should be used in conjunction with proper training and only by qualified Phlebotomists.
   2. **Responsible Department/Scope:** 
      1. Procedure owner/Implementer: Inpatient Phlebotomy
      2. Procedure prepared by: Laurie Watson MT(ASCP)
      3. Who performs procedure: Inpatient Phlebotomy staff

1. **Procedure:** The Role of the Phlebotomist
   1. Inpatient Phlebotomy provides the following services for the Medical Center 24 hours a day, 7 days a week.
   2. The Role of the Phlebotomist
      1. The collection of the blood sample is an important pre-analytical step for the test to be performed in the laboratory. The accuracy of the result is as dependent on this step as the actual testing and reporting.
      2. The phlebotomists take care to follow universal precautions and provide for the safety of the patient by assuring proper identification of patients, selection and preparation of the appropriate site, perform skin penetrations with as little trauma as possible, obtaining appropriate samples for test requested, caring for the site, and leaving the patient with a positive impression.
      3. Phlebotomists maintain a professional image in their manner of dress and behavior. Their role is as much ambassador for the laboratory as it is as blood collector. They respect the privacy and confidentiality of the patients.
      4. Phlebotomists approach their patients in a calm reassuring manner and introduce themselves. Respect and courtesy is extended to all patients, their friends, and family.
      5. Phlebotomists are prepared to care for patients who experience adverse reactions from the phlebotomy procedure.
      6. The phlebotomist promptly sends specimens to the laboratories.
      7. Any uncollected sample should be communicated to the nurse or provider and documented in the patient’s EMR. A signature is obtained from the nurse to document the communication. The slips are retained for 2 years.
      8. The phlebotomists work as a team. They help their co-workers complete tasks on time. Each member of the team treats everyone with respect and courtesy.
2. Patient Feedback
   1. Phlebotomists may get patient feedback through the Press Gainey Survey and Wow Cards.
      1. Results of this survey and staff members mentions are maintained by the Patient and Family Relations office and electronically on the Press Ganey Website.
      2. Monthly emails are sent out with survey results and staff members that are mentioned.
      3. Staff that are mentioned in a positive way receive a “WOW” certificate.
   2. Patient concerns brought to the phlebotomist’s attention are forwarded to the manager or supervisor by phone call, email, or direct conversation. Documentation will be made as appropriate by the manager.
3. Feedback to Phlebotomists on issues relating to specimen quality and safety
   1. Received verbally (phone or meeting), written (interoffice mail, meeting) and/or electronic (e-mail, RL6 patient safety reporting software)concerning specimen quality
   2. The shift Coordinator or Manager will research the concern, and meet with the employee to discuss future actions to avoid a recurrence of the event
   3. The meeting is documented in the RL6 software and on the RL6.xlsx spreadsheet in the Inpatient Phlebotomy Coordinators shared folder (G: Lab\_Shared->Inpatient Phlebotomy Coordinators)
   4. Generic reminders related to specimen quality are shared via email and staff meetings.
4. Employee Feedback
   1. Employees provide feedback when lab/quality/safety concerns arise.
   2. The Manager determines the level of action regarding the method of following up
      1. Risk Management
      2. Infection Prevention
      3. Administration
   3. There is a CAP sign regarding the reporting of quality concerns posted in the main lab.
5. Error Discovery and Reporting
   1. On the occasion that an error is discovered and a report needs to be corrected, corrections will be called to the appropriate caregivers. The result will flag in the laboratory information system that it is a corrected report. The corrected result must have the name of the person, date and time of the call appended to the corrected results as well as the reason code for the correction. I
   2. If a credit results from that error, complete the credit form and send it to the Billing Office
   3. Notify the section manager of any incorrect result that is reported.
   4. Deviations in Standing Operating Procedures that result in adverse patient outcomes require a CAPA (Corrective Action/Preventive Action).
6. Feedback from Vendors and Manufacturers
   1. Is received electronically and responded to via the ECRI alert system.
   2. Technical recalls are referred to the specific lab and Lab Director.
7. Provider Feedback is provided by a quarterly survey that is distributed by the Medical Director.
8. Personnel requirements include a minimum of a High School Diploma and the following:
   1. Phlebotomy Tech I-entry level with ASCP certification eligibility within 1year
   2. Phlebotomy Tech II-ASCP Certification and basic experience
   3. Phlebotomy Tech III-ASCP Certification and at least 2 years with the department
   4. Phlebotomy Coordinator-ASCP Certification, at least 5 years with the department, and strong leadership skills.

The Management Tier for Inpatient Phlebotomy

Medical Director

Lab Administration

Manager

Phlebotomy Coordinator

Phlebotomy Technician III

Phlebotomy Technician II

Phlebotomy Technician I

1. **Review/Revision/Implementation:**

All procedures must be reviewed at least every 2 years.

* All new procedures and procedures that have major revisions must be signed by the CLIA Laboratory Medical Director.

* All reviewed procedures and procedures with minor revisions can be signed by the designated section manager.

1. **Related Procedures: Pathology Event Documentation; Pathology Customer Satisfaction Survey; Pathology QA/QA /QM Management; Product Recall and Alert Notifications (ECRI); CAPA; Reporting Quality Issues; Event Documentation; Environmental Health and Safety Training; Reporting Quality Issues; CAP Accreditation**
2. **References: GEN.20325, GEN.20330, GEN.20335, GEN.20340, GEN.20374, GEN.40499**
3. **Attachments:** **N/A**
4. **Revised/Reviewed Dates and Signatures:**

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| Review Date: | Revision Date: | Reason: | Signature: |
|  | 3/6/2017 | Reformatted to standard Medical Center template. | Laurie Watson, MT (ASCP) |
|  | 3/5/2019 | Revised signature page | Laurie Watson, MT (ASCP) |
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