Heme April Department Meeting
Tuesday, April 30th, 2013

Attending: Vicky Douglas, Patty Isbill, Carolyn Wade, Bruce Reese, Kathy Stanley, Evan Evans.

1. Weekend Start Times/Staffing:
   To make scheduling more consistent, we are going to make all weekend start times 0600. Also – on Saturdays, if Nancy or Anita are scheduled for Coag, it might be better to have them work UA and help in Lab Processing, allowing a send-out trained tech to cover Coag, so they can also do diffs and send-outs.
   Also – Kathy will ask Robyne about the resource Phleb on Saturdays – there have been several recently were the resource person has gone to the floor, so the department has to cover OP fully. On next schedule – on weekdays there will be a registration clerk and the resource person out front at 0600. Once morning pickup is done, a second C&D person will go out front. There may be times form 0600 until pickup completion that the department scheduled will be called, but afterwards they will call phlebs from the floors to cover.

2. Night-Days shift handoff issues:
   An adjustment is needed as we have more blood being collected earlier and then waiting until dayshift arrives to test. Heme's recommendation is that the tracking list for night be printed at 0545 and nights will be responsible for completing any test < 0.5 hours at that time. I will talk to Chemistry at their department meeting and talk to Carol and we will finalize a change.
   Regarding the tracking list - instead of doing a print screen, please select "All Files" from the bottom keys – this will allow you to print out a tracking list that includes the time it was printed. I know the print is small, but it is a little cleaner then the print screen and shows the print time.
   Also show common courtesy/respect for each other – if a tech indicates they want to stay and finish a particular run or patient, let them – use the time to check e-mail or find monthly maintenance to do. Conversely – if there is a patient or instrument issue, explain it to the next shift and write it on the shift handoff form

3. Troubleshooting logs:
   Remember that if you get an unusual alarm or error on an instrument to write it and your solution in that instruments troubleshooting log. Too often a recurrent problem gets overlooked because it's not written down and so we have no idea of its frequency and rarely does the same tech work the same bench on consecutive days, so it's harder to spot a pattern. A problem can linger instead of being resolved, because no one realizes it has been happening because there is no record of it.

4. Elevated ED Coags:
   Scenario: an ED patient has a PT of 25.3 (INR 2.8) and a PTT of > 180. A PTT that high is usually the result of heparin. You can run a Factor Xa on the patient and see if the patient has any heparin in the specimen. You should call the ED to see if the results are probable and if the patient has a heparin line. It would be very rare if a patient came into the ED on heparin (unless they came from another facility), and only a very high level of heparin (resulting from contamination not drip) would cause an elevated PT also (unless the patient is on Coumadin). Low molecular weight heparin does not cause any PT elevation and would not cause the PTT to be elevated to > 180. In any situation, if you have results that you question the validity of, you should ask for a re-draw to verify and hold the original results.

5. UA pass-through (OP urines):
   We are trying to work out a way to make sure UA is aware of urines in the out-patient pass-through. We are looking at a sensor that would light up in C&D and UA when there is a specimen in the pass-through. We are also going to look at a different system, a drawer that would 'push' the specimen into C&D. With MobiLab the UA label will appear with the blood draw labels, it has been brought up by C&D that they could ask the patient if they have provided a specimen and then they would look for the specimen and bring it and the label to UA. We are still trying to find the best solution.

6. Competency:
   I should have the problem solving quiz available in MTS by the end of this week. I will also try to make sure everyone has a printout of their updated competency sheets during this month so they know where they are.
   Semen motility – Cap requires a semi-annual review – I will assign the MTS version for the first one and we will use a completed survey for the second one – it will be in HealthStream.
   For diffs and urine micro competencies – I will scan the images in and create an MTS quiz for them for later this year (I want to get 2 of set in for the quiz.

7. Kathy's section:
   Confidentiality: a reminder that HIPAA violations can be fireable. A (non-lab) registration clerk mentioned to a friend that a mutual acquaintance was in the hospital. That person's family was not happy that that information was given out and lead to that clerk being fired. We see many patient names and it's better to not even connect them as people you know unless you are aware of their condition from them or their family.
   Professionalism: Be careful of what you way to patients – always keep the conversation professional and non-opinionated. A non-lab example – a patient was upset with a wait and when dealing with the person taking care of them demanded to talk to a supervisor, the employee responded that there was no one they could talk to thanks to Obamacare. The patient complained to administration and the employee was let go. No matter how you might be baited, do not rise to the challenge, keep calm and professional.