

Quest Diagnostics at SGMC

Core Lab Meeting

MINUTES

1/11/18

PRESENT: TECHNICAL STAFF

DISTRIBUTION: SGMC TECHNICAL STAFF

MEETING COMMENCED: 0715, 1600

Item	Discussion	Action	Follow-up
Minutes			
Overtime	Scheduler and Supervisor must know when swapping schedules. This is to ensure no OT is incurred. Clock in and out timely Document reasons for staying over. Lunch must be taken timely	Supervisor to closely monitor schedule and OT.	JN
Unlabeled Reagents and QC	This applies to both SGMC and GEC	ALL opened reagents and QC MUST be labeled. Reminded staff the consequences of not doing so.	All Staff
Full Accountability	Gap in bench coverage.	All techs are expected to communicate with GL or TIC when leaving their designated coverage area. This is in the policy and must be followed.	All staff
Metrics	Throughput complaints from ER and other areas of the hospital. Rob sends report daily on troponin TAT. (staff shown) Issues identified: Communication failure No order in LIS Separate accession numbers New staff ER not using LIS labels	Team: Supervisor and GL to ensure TATs are met at all times. <ul style="list-style-type: none"> • check in with accessioning often • coordinate AM and lunch breaks • pay attention to the OL monitor; it is everyone's responsibility • avoid unnecessary breaks and conversations • everyone must report to the bench ON TIME • covering the bench does not mean just loading the samples; calling results and etc. must also be done 	All staff
	Pull QA report after each shift. <ul style="list-style-type: none"> • Run QC at GEC and SG per schedule. • When calling results for OP, document call on the log and not on the patient report 	Quite a few deltas are found each day by GL on their QA reviews without comments.	All staff

Item	Discussion	Action	Follow-up
Secondary Labeling	<p>We are seeing a lot of cases where name is tore off from the bottom of the CBC label (containing patient identifiers), but the tube is missing the 2 tech codes. This is creating problems for people trying to follow the procedure.</p> <p>Example:</p> <ul style="list-style-type: none"> • KBT sent to hematology • patient does not have blood type on file • tube brought to BB for ABO/Rh typing • tube has no patient name/MRN on primary label and no tech codes on secondary label <p>How does BB reject if Heme accepted? This is a lab labeling error</p>	<p>Follow secondary labelling procedure.</p> <p>Techs mentioned we still see many samples labeled improperly by nursing. Advised staff to submit a QV so we can forward it to their respective educators and nurse managers for training.</p> <p>Techs mentioned some accessioners put the add-on label on patient's sample/tube top. If accessioners are looking and adding test to the sample, why can't they verify, label and initial the tube?</p>	<p>All staff</p> <p>Julie to verify with Samson and/or Stephanie.</p>
MTS	<p>New assignments have been assigned.</p>	<p>Sign in at least once a week to check SOP updates and some competencies. Most SOP revision/ updates are communicated on MTS so it is imperative that we log in timely.</p>	<p>All staff</p>
Calling Critical Result	<p>Call nurses directly for inpatients using vocera. We still need to call the ER front desk to reach their nurses.</p>	<p>Discussed how to call inpatient nurses. Some nurses are taking calls on the vocera and some want to be called on the landline. When vocera calls are redirected to charge RNs, some of them refuse to take critical results. Advised techs to write a QV so it can be addressed accordingly.</p>	<p>All staff</p>
Tracked Chemistry Specimens	<p>Processing requested chemistry samples be stored in the refrigerator after tracking and not in accessioning area.</p>	<p>Techs agreed they are going to store the racks in refrigerator once tracking is done.</p>	
Reporting to bench on time	<p>Some techs not reporting on the bench on time.</p>	<p>When clocked in, please report on the bench right away and take over so outgoing techs can complete their tasks timely.</p>	<p>All staff</p>
Delay in Patient Testing	<p>RL received from nursing about a phosphorus sample received at 0520 and was resulted at 1512; the result was critical.</p>	<p>Instruments down. Bench tech was busy troubleshooting. Other techs helped but no one pulled the pending list. Sample was not found until all specimens were tracked.</p> <p>Reminded staff to include pulling pending logs when helping other benches. Ensure all samples are accounted for and processed timely.</p>	<p>All staff</p>
Meeting adjourned	<p>0730,1615</p>		
Next meeting	<p>February 2018</p>		

Julie Negado
Recording Secretary