TRAINING UPDATE

Lab Location:	GEC, SGMC & WOMC	**Date Distributed:**	7/29/2021
Department:	Mgmt & QA	**Due Date:**	8/15/2021

DESCRIPTION OF REVISION

Name of procedure:

Document Control AHC.QA05 v15

SOP Format and Content AHC.QA06 v7

Description of change(s):

Note: In preparation for Fort Washington joining the lab system changes are being made to simplify document tracking.

Document Control -

Header: removed specific labs, added All Labs
Section 4: added ML corporate account
Section 5: described ML setup, updated system numbering process, added other document types
Section 9: updated App E
Footer: changed prefix to AHC

SOP Format and Content -

Header: removed specific labs, added All Labs
Section 5: updated system numbering process, added numbering format for forms
Footer: changed prefix to AHC

These revised SOPs will be implemented Aug 10, 2021

Document your compliance with this training update by taking the quiz in the MTS system.

Non-Technical SOP

Title	**Document Control**	
Prepared by	Leslie Barrett	Date: 3/20/2009
Owner	Cynthia Bowman-Gholston	Date: 3/20/2009

Laboratory Approval		
Print Name and Title	**Signature**	**Date**
Refer to the electronic signature page for approval and approval dates.		
Local Issue Date:	Local Effective Date:	

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1. PURPOSE

This procedure outlines the process for document control.

2. SCOPE

The document control system includes all procedures, policies and forms utilized by the Laboratory. It assures that:

1. all copies of policies and procedures are current;
2. personnel have read the policies/procedures relevant to their job activities;
3. all medically related policies/procedures have been authorized by the medical director before implementation;
4. policies and procedures are reviewed periodically by the medical director or designee;
5. discontinued policies/procedures are quarantined in a separate electronic file for the appropriate retention period

3. RESPONSIBILITY

The section supervisor is responsible for keeping the SOP's current and reviewed.

The medical director is responsible for approving all new or revised medically related SOP's. The medical director may delegate signature authority to the appropriate supervisor for periodic review if no changes are made.

In event of a change in directorship of the laboratory, it is the responsibility of the new director to review all medically related procedures within a reasonable period of time, but within one year.

The supervisor must ensure employees review all pertinent procedures:

- prior to completion of the training/competency period
- when revisions are implemented

4. DEFINITIONS

MediaLab – software application for electronic document control system (EDCS); may be referred to as ML

MediaLab Corporate account – multi-site subscription that allows one main site and multiple divisions. The main (corporate) site contains the standard documents that may be shared with one or more divisions. A separate medical director and user list may be created for each division.

'Owner' as described on page 1 in the SOP – Person responsible for drafting or delegating the drafting of initial SOP. Person is responsible for the output of the SOP and ensuring that the SOP is current and reviewed periodically, usually a director, manager or supervisor.

Primary Site Administrator or additional Site Administrators – Person who is responsible for maintaining documents on the system, by processing new, revised, periodic review, and expiring SOPs.

Approver – Person who has been included on one or more document approval routes. Often the 'Owner' as described on page 1 in the SOP. Responsible for reviewing, approving, or rejecting a document.

Designated Reviewers – The owners of documents in the system, usually assigned to supervisor of the section / department. They will receive the recurring review email 90 days in advance of that review being due.

Controlled Copy – Printed copy of a document with a unique copy ID number, which allows it to be tracked and managed. When a controlled copy is created, its location is entered, so that it may later be found if it needs to be replaced.

Uncontrolled Copy – Copy of a document that is not managed through document control. It does not have a unique number or set location and must be shredded by the end of the shift.

Periodic Review - All SOPs must be reviewed and reapproved by the appropriately designated and licensed department director on a periodic basis not to exceed 24 months from the previous review date.

System SOP – A procedure utilized by multiple laboratory sites (specified in SOP header).

Site Specific SOP – A procedure utilized by one laboratory site, specified in SOP header and numbering sequence.

5. PROCEDURE

1. Documents are maintained on the MediaLab system.
   - Designated Document Managers have access rights to edit data/files and create/track approvals.
   - Approvers have the ability to approve, view and print documents.
   - Designated staff has access to read or print only.

2. The processes for new, revised or periodic review of documents are detailed in attachments A, B and C at the end of this procedure.

3. The MediaLab software is designed to accommodate a corporate account along with one or more divisions.
   a. The original Adventist HealthCare laboratory group (SGMC, WOMC and GEC) is designated as the corporate account.
   b. Fort Washington Medical Center (FWMC) was added as a division in July 2021.
      1) A separate medical director is assigned to this division and all documents shared from corporate must be re-approved. Examples include administrative, safety and quality procedures and policies.
      2) With the exception of medical director, the approval flow mirrors the corporate approval process.

4. Effective July 2021, system SOPs are numbered with the prefix AHC for Adventist HealthCare. If the SOP applies to all laboratory sites, the header will be designated as such (All Laboratories).
   a. This supersedes the prior process using a prefix for Shady Grove Medical Center (SGAH for SOPs transitioned from SS, SGMC for new SOPs added to ML) and all applicable laboratory sites were listed in the SOP header.
   b. Prefix and header changes will be made when an SOP requires revision or during the periodic review process, whichever occurs first.
   c. If a system SOP is only applicable to selected labs, then those lab sites will be listed in the header.

5. Periodic review
   a. Periodic review is documented within ML and displays on the cover sheet for each procedure/policy. Electronic review documentation is performed for all procedures. If the reviewer indicates a revision is needed, this is noted as a comment. Refer to addenda C for process steps.

b. The SOP Review checklist may be used to provide a more structured approach to SOP review, especially useful when staff participates in the review. Documentation will be retained for two years (five years for Blood Bank SOPs).
c. Technical SOP review also includes verification of
   - LIS parameters (units of measure, reference ranges, report comments, etc.). This is accomplished by review of the test code in function MIQ and via a patient report.
   - Electronic test directory (JDOS) information

6. No handwritten changes may be made on any procedure or policy.

7. All changes require revision of entire SOP, including version change and approval. The revision history section includes revision date, a description of the change, name of the reviser and approval.

8. Draft versions are maintained in an electronic file/folder. Hard copy draft versions are labeled 'draft' at the top of the title page.

9. Approved draft versions of procedures may be used to train staff prior to the local effective date.

10. LIS changes or additions must be considered when drafting a new or revised procedure. Refer to the procedure LIS Test Change Request for details.

11. When finalized:
    a. The effective date is added in ML. The effective date should never precede the Medical Director's approval date.
    b. Controlled copies are printed for the procedure manuals at the appropriate laboratory site(s). The location of printed SOPs is captured in ML and maintained on the Document Control Tracking tool. An example is included in addenda E.
    c. The hard copy prior version is removed from the manual and discarded.
    d. The retired electronic version is automatically retired on ML on the same date as effective date of new version.

12. When procedures are discontinued, the electronic version is retired on ML with an appropriate explanation and maintained as archived documents. Access to archived documents is limited by security rights. The hard copy of the retired or obsolete SOP is removed from all manuals and discarded.

13. Any new SOP will be reviewed by the staff. The review documentation is included on the Training Verification form, which also covers training objectives for key elements of the process.

14. Any process revision SOP will be reviewed by the staff. Staff may read either the revised sections as listed or the entire SOP. Revision documentation may be captured on a Training Update form that is attached to the SOP or electronically via MTS. Employees are required to document their review by signature/date on the update form or completion of a quiz in MTS. SOP updates may also be presented during staff meetings/educational sessions and signed at that time.

15. Worksheets and/or forms associated with the SOP must contain a creation/revision date and are listed under Appendices or Related Documents.

16. Revisions to worksheets and forms adhere to the above document control process.

17. Refer to the specific MediaLab SOPs for detailed instructions on using the application.

18. Additional documents may be processed via the ML system as a means to document approvals and provide an electronic repository. These documents may include but are not limited to:
    a. Validations (equipment, methods, computer software testing, etc.)
    b. Quality assurance reports (safety reviews, assessments, audits, etc.)
    c. Accreditation certificates
    d. Adventist HealthCare policies and SOPs (to capture the required approvals because the AHC policy site does not provide this feature)

6. RELATED DOCUMENTS

- SOP Format and Content
- Retention of Records and Materials
- LIS Test Change Request
- Medical Training Solutions (MTS)
- MediaLab Basic User Functions and Information
- MediaLab Document Management
- SOP Review Checklist – Non-Technical version (AG.F98)
- SOP Review Checklist – Technical version (AG.F99)
- Document Control Tracking tool
- MIQ1 - Maintenance Inquiry, Test Code Lookup

7. REFERENCES

- College of American Pathologists, Laboratory Accreditation Manual, Laboratory General Checklist, current version.
- Standards for blood banks and transfusion services. Bethesda, MD: AABB.

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By
		Supersedes SOP L006.004		
000	3/22/2010	Section 5: item 13 - remove email, add educational sessions Section 7: updated to current version Section 9: App C – add steps 4-6,remove first year process App D – update to job titles only	L. Barrett	C. Bowman
001	4/8/2010	Section 3: removed annual review by staff	L. Barrett	C. Bowman

Version	Date	Reason for Revision	Revised By	Approved By
002	12/20/10	Section 5: item 4 – add checklist requirement, item 14 – add MTS Section 6: update MC version SOPs Section 9: addenda A-C revised	L. Barrett	C. Bowman
003	4/7/2011	Section 3: add definition of annual review (12 months) as being within 12 months from the previous reviewed date. Section 5: add checklist requirement for new SOPs Section 9: addenda A revised, add addenda E and F	L. Barrett	C. Bowman
004	11/1/2012	Page 1: update annual review table to 'Review' Sections 2,3 & 5: update annual to 'periodic' review Section 4: add definition of periodic review Section 9: addenda C & D updated	L. Barrett	C. Bowman
005	11/20/13	Section 4: remove MasterControl terms, add SmartSolve terms Section 5: update to reflect SmartSolve application Section 6: update titles, add forms Section 9: remove forms, update A-D Footer: version # leading zero's dropped due to new EDCS in use as of 10/7/13.	L Barrett	C Bowman-Gholston
6	3/3/14	Section 5 & 9: removed retention of retired hard copy SOPs	L Barrett	C Bowman-Gholston
7	4/3/14	Section 3: remove retention of retired hard copy SOPs Section 5: add tracking for SOP locations Sections 6 & 9: add Document Control Tracking form	L Barrett	C Bowman-Gholston
8	1/19/16	Section 5: Submission of review form optional for new SOP, specify LIS and JDOS technical review process Section 6: Add MIQ Section 9: update App D (list titles without names)	L Barrett	C Bowman-Gholston
9	4/25/16	Section 5: specify electronic review if revision needed (item 5) Section 9: update App C to add review if revision is required	L Barrett	C Bowman-Gholston
10	6/14/16	Header: add WAH and GEC Section 4: add System and Site Specific SOP Section 5: add explanation of system SOP process Section 9: update App A and B	L Barrett	C Bowman-Gholston
11	3/30/18	Section 4: change recurring review email to 90 day advance notice Addendum C: specify SOP review list is 90 days before due date	L Barrett	C Bowman-Gholston

Version	Date	Reason for Revision	Revised By	Approved By
12	2/22/19	Header: update parent company Section 4: added MediaLab and associated terms Section 5: added ML transition process, change review checklist to optional Section 6: added ML SOP Section 9: updated all to match ML processes	L Barrett	C Bowman-Gholston
13	4/9/20	Header: changed WAH to WOMC Section 2 & 3: specify medical director approval required for medically related Section 4: removed SmartSolve Section 5: deleted transition from SmartSolve Section 6: deleted SmartSolve SOP Section 9: updated to reflect med. director approval not required for administrative SOPs	L Barrett	C Bowman-Gholston
14	7/20/21	Header: removed specific labs, added All Labs Section 4: added ML corporate account Section 5: described ML setup, updated system numbering process, added other document types Footer: changed prefix to AHC Section 9: updated App E	L Barrett	C Bowman-Gholston

9. ADDENDA AND APPENDICES

A. New Procedure/Policy Process
B. Revised Procedure/Policy Process
C. Periodic (Recurring) Review Process
D. Approval Routes
E. Example of Document Control Tracking tool

A. New Procedure/Policy Process

	New Procedure	Who
1.	Draft written (electronic)	Owner/supervisor
2.	Draft content reviewed by technical expert, QA, LIS (if appropriate)	
3.	Training document written, email to QA team	Owner/supervisor
4.	Draft SOP reviewed by Medical Director, if appropriate	
5.	Revisions made if indicated	Owner/supervisor
6.	Final SOP emailed to Site Administrator	Owner/supervisor
7.	Load onto MediaLab (ML) and start approval process	Site Administrator
8.	SOP approved by Owner and Medical Director via ML Note: Medical Director approval not required for administrative SOP	
9.	*Email electronic copy of approved DRAFT to Owner/supr for training*	Site Administrator
10.	Print approved DRAFT and Training document for training process	Owner/supervisor
11.	Training performed	Owner/supervisor
12.	Add effective date to implement sop (date specified by Owner/supvr)	Site Administrator
13.	Email notification sent via ML, as designated by system	N/A
14.	Controlled copies printed for appropriate manuals	QA/designee
15.	Table of Contents updated / printed	QA/designee
16.	Competency written for 6 month/annual	Owner/supervisor
17.	Training documents signed by supervisor, given to QA	Owner/supervisor
18.	Recorded on Training spreadsheet and filed	QA/designee

B. Revised Procedure/Policy Process

	Revised SOP	Who
1.	Owner requests e-copy of SOP /document	Site Administrator
2.	Revision made to existing document, revision box completed	Owner/supervisor
3.	SOP Review Checklist completed, as needed	Owner/supervisor
4.	Revision content reviewed by technical expert, QA, LIS (if appropriate)	Owner/supervisor
5.	Revisions made if indicated	Owner/supervisor
6.	Training update written	Owner/supervisor
7.	Review existing training and competency documents for possible revision	Owner or QA
8.	Final SOP emailed to Document Manager	Owner/supervisor
9.	Load onto ML, and start approval process	Site Administrator
10.	SOP approved by Owner and Medical Director via ML Note: Medical Director approval not required for administrative SOP	
11.	*Email electronic copy of approved DRAFT to Owner/supr for training*	Site Administrator
12.	Training update and approved DRAFT SOP placed onto MTS or a binder, staff notified of due date and planned implementation date. Completion of training update to be monitored by Owner/supvr	Owner/supervisor
13.	a. Add effective date to implement SOP (date specified by Owner/supvr) b. Previous version automatically retires on ML	Site Administrator
14.	Email notification sent via ML	N/A
15.	Controlled copies printed for appropriate manuals	QA/designee
16.	Previous version removed from all manuals and discarded	QA/designee

C. Periodic (Recurring) Review Process

	BB, Field Ops and IT/LIS	Who
1.	Email notice sent via ML to document Owner for BB, Field Ops and IT/LIS	Designated reviewer
2.	Review SOP in ML, approve current version or indicate revision needed	Designated reviewer
3.	If no revision required, Print cover page and insert into manual	QA/designee
4.	**If revision required**, follow process above for **Revised SOP**	Owner/supervisor

	Core, Micro, General Lab, QA, Safety sections	Who
5.	Email a list of SOPs that are due for review each month (90 days before due date).	Site Administrator
6.	Review each listed SOP and complete SOP Review Checklist	Owner/supervisor
7.	Determine which require revision and which do not. Email that info back to Site Administrator	Owner/supervisor
8.	Launch Recurring Review in ML. If a revision is required, indicate as such	Site Administrator
9.	Review approved by Designated Reviewer via ML	Designated reviewer
10.	If no revision required, Print cover page and insert into manual	QA/designee
11.	**If revision required**, follow process above for **Revised SOP**	Owner/supervisor

D. Approval Routes

New/Revised (SOPs, Policies) Approval

Department	LEVEL 1	LEVEL 2	LEVEL 3
Blood Bank	QA Review	BB Manager Approval	Medical Director Approval
Core Lab	QA Review	Technical Manager Approval	Medical Director Approval
Microbiology	QA Review	Director of Hospital Micro Approval	Medical Director Approval
General Lab Policy, Safety	QA Review	Lab Ops Director Approval	Medical Director Approval
Administrative and HR	QA Review	Lab Ops Director Approval	
IT and LIS	QA Review	LIS Manager Approval	Medical Director Approval
Phleb, Processing, Customer Support	QA Review	Manager/Supervisor Approval	Medical Director Approval
Quality Assurance	QA Review	QA Specialist Approval	Medical Director Approval

New/Revised FORMS Approval

Department	LEVEL 1	LEVEL 2
Forms	Section Manager/Supervisor	Medical Director Approval

Validations Approval

Department	LEVEL 1	LEVEL 2
Validation Blood Bank	BB Manager Approval	Medical Director Approval
Validation Automated Chemistry	Technical Manager Approval	Medical Director Approval
Validation Core Lab	Technical Manager Approval	Medical Director Approval

Recurring Review

Department	LEVEL 1	LEVEL 2
Blood Bank	BB Manager Approval	Medical Director Approval
Core Lab	QA Review	Technical Manager Approval
Microbiology	QA Review	Director of Hospital Micro
General Lab Policy, Safety	QA Review	Lab Ops Director Approval
IT and LIS	LIS Manager Approval	
Phleb, Processing, Customer Support	Manager/Supervisor Approval	
Quality Assurance	QA Review	QA Specialist Approval

FORMS Recurring Review

Department	LEVEL 1
Forms	Section Manager/Supervisor

E. Example Document Control Tracking

		Printed							
Procedure Name	**Shared SOP #**	**S**	**W**	**G**	**F**	**SGMC Manual**	**WOMC Manual**	**GEC Manual**	**FWMC Manual**
Ergonomics Program	SGAH.SA04.4	P	P	P	P	Safety 1	Safety	Safety	Safety
Monthly Safety Audit	SGAH.SA06.3	P	P	P	P	Safety 1	Safety	Safety	Safety
Biohazardous Waste Management	SGAH.SA07.2	P	P	P	P	Safety 1	Safety	Safety	Safety
Routine Decontamination Procedure	SGAH.SA08.2	P	P	P	P	Safety 1	Safety	Safety	Safety
Disaster and Emergency Preparedness	SGAH.SA09.3	P	P	P	P	Safety 1	Safety	Safety	Safety
Electrical Safety	SGAH.SA10.4	P	P	P	P	Safety 1	Safety	Safety	Safety
Evacuation Plan	SGAH.SA11.4	P	P	P	P	Safety 1	Safety	Safety	Safety
Fire Emergency Plan	SGAH.SA12.3	P	P	P	P	Safety 1	Safety	Safety	Safety
Occupational Noise	SGAH.SA15.3	P	P	P	P	Safety 2	Safety	Safety	Safety
Personal Protective Equipment (PPE) Usage	SGAH.SA16.3	P	P	P	P	Safety 2	Safety	Safety	Safety
Specimen Containers	SGAH.SA18.3	P	P	P	P	Safety 2	Safety	Safety	Safety
Tuberculosis Prevention Program	SGAH.SA19.3	P	P	P	P	Safety 2	Safety	Safety	Safety
Waste Minimization	SGAH.SA21.3	P	P	P	P	Safety 2	Safety	Safety	Safety
Incident Reporting and Post Exposure Prophylaxis	SGAH.SA930.2	P	P	P	P	Safety 2	Safety	Safety	Safety
Bloodborne Pathogens Exposure Control Plan	SGMC.SA931.2	P	P	P	P	Safety 1	Safety	Safety	Safety
Chemical Hygiene Plan	SGMC.SA932.2	P	P	P	P	Safety 1	Safety	Safety	Safety
COVID-19 Employee Exposure and Screening	SGMC.SA933.2	P	P	P	P	Safety 2	Safety	Safety	Safety

Non-Technical SOP

Title	**SOP Format and Content**	
Prepared by	Leslie Barrett	Date: 3/20/2009
Owner	Cynthia Bowman-Gholston	Date: 3/20/2009

Laboratory Approval		
Print Name and Title	**Signature**	**Date**
Refer to the electronic signature page for approval and approval dates.		
Local Issue Date:	Local Effective Date:	

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1. PURPOSE

The College of American Pathologists (CAP) guidelines dictate that technical standard operating procedures (SOP's) be written in substantial compliance and meet the intent of the Clinical Laboratory Standards Institute (CLSI) QMS02- A6.

2. SCOPE

This SOP applies to all departments within the Laboratory.

3. RESPONSIBILITY

Each process owner is responsible for utilizing the proper SOP format.
The medical director is responsible for approving all medically related new or revised SOPs. Administrative SOPs do not require medical director approval; these are approved by the Laboratory Operations Director

4. DEFINITIONS

Technical SOP format – approved format for assay / test procedures

Non-technical SOP format – approved format for all non-assay procedures and policies. Exception: Blood Bank assay procedures utilize a modified non-technical format with additional sections added (specimen requirements, reagents, quality control, etc.).

Process owner (indicated as 'owner' on page 1 of each SOP) – Person responsible for drafting or delegating the drafting of initial SOP. Person is responsible for the output of the SOP and ensuring that the SOP is current and periodically reviewed. Process owner is usually a director, manager or supervisor.

Periodic Review - All technical and non-technical SOPs must be reviewed and reapproved by the appropriately designated and licensed department director on a periodic basis not to exceed 24 months from the previous reviewed date.

EDCS – electronic document control system

MediaLab – software application for electronic document control system (EDCS); may be referred to as ML

System SOP – A procedure utilized by multiple laboratory sites.

Site Specific SOP – A procedure utilized by one laboratory site, specified in SOP header and numbering sequence.

5. PROCEDURE

1. SOP's are written in substantial compliance with CLSI guidelines and will utilize the Quest Diagnostics formats/templates and follow the Technical SOP Instructions.

2. Each Technical SOP should contain the following elements if appropriate:

    a) TITLE PAGE WITH APPROVALS (reference to electronic signatures) and TABLE OF CONTENTS
    b) TEST INFORMATION
    c) PRINCIPLE
    d) SPECIMEN COLLECTION
    e) REAGENTS OR MEDIA – SPECIAL SUPPLIES AND EQUIPMENT
    f) CALIBRATION
    g) QUALITY CONTROL
    h) EQUIPMENT AND SUPPLIES
    i) PROCEDURE
    j) CALCULATIONS
    k) REPORTING RESULTS AND REPEAT CRITERIA
    l) EXPECTED VALUES
    m) CLINICAL SIGNIFICANCE
    n) PROCEDURE NOTES
    o) LIMITATIONS OF METHODS
    p) SAFETY
    q) RELATED DOCUMENTS
    r) REFERENCES

s) REVISION HISTORY
t) APPENDICES

3. Each Non-technical SOP contains the following elements:
   a) TITLE PAGE WITH APPROVAL (reference to electronic signatures) and TABLE OF CONTENTS
   b) PURPOSE
   c) SCOPE RESPONSIBILITY
   d) DEFINITIONS
   e) PROCEDURE
   f) RELATED DOCUMENTS
   g) REFERENCES
   h) REVISION HISTORY
   i) ADDENDA AND APPENDICES
   j) Additional element sections may be added as necessary

4. SOP templates reflect required content. No major section heading may be deleted. If a section or subsection is not applicable to the procedure/policy, enter N/A.

5. Each SOP must indicate the author (prepared by) and date prepared or drafted.

6. The local effective date may not be prior to the Medical Director's approval date and is assigned at the completion of the EDCS approval process.

7. Effective July 2021, system SOPs that apply to all sites are designated as such in the header (All Laboratories). ~~contain all applicable laboratory sites in the header.~~
   a. If a system SOP is only applicable to selected labs, then those lab sites will be listed in the header.
   b. Header changes will be made when an SOP requires revision or during the periodic review process, whichever occurs first.

   Historical notes:
   - On August 25, 2019 Washington Adventist Hospital relocated and the facility name became White Oak Medical Center (WOMC). SOPs and other documents that contain site names were updated when due for periodic review or content revision.
   - In July 2021, Fort Washington Medical Center (FWMC) joined the system.
   - Refer to the *Document Control* procedure for a description of the MediaLab corporate account vs. a site designated as a division.

8. Each SOP must contain an assigned SOP number with a specific format.
   a) Effective July 2021, the prefix for a system SOP is AHC. This supersedes the prior process using a prefix for Shady Grove Medical Center (SGAH for SOPs transitioned from the prior EDCS, SGMC for new SOPs added to ML)
   b) Prefix for site specific SOP indicates the specific Laboratory site (GEC, SGMC, WOMC [formerly WAH] or FWMC) and may include the site in SOP title.
   c) Prefix changes will be made when an SOP requires revision or during the periodic review process, whichever occurs first.

d) Prefix is followed by a code to indicate Laboratory section

Code	Section	Code	Section
BB	Blood Bank	S	Processing
C	Chemistry	CS	Client Service
G	Coagulation	OP	Outpatient Lab
H	Hematology	P	Phlebotomy
I	Immunology	L	General Lab Policy
M	Microbiology	LIS	LIS
U	Urinalysis	IT	Information Technology
POC	POCT	QA	Quality Assurance
HG	Hematology/Coag	SA	Safety

e) Number portion is assigned by ML system (user-controlled configuration)
f) Version number for a new procedure is 1. Version increases to 2, 3, etc. with each revision.

9. A confidentiality statement (CONFIDENTIAL: Authorized for internal use only) is to be included in each SOP.

10. Worksheets and/or forms must contain a title and creation/revision date. These may be listed under Appendices or Related Documents. The numbering format for forms:
    - AG.Fxxx.v (xxx = number assigned by ML; .v = version number)
    - AG.FWxxx.v is utilized for Fort Washington specific forms

6. RELATED DOCUMENTS

- Document Control, QA procedure
- MediaLab Basic User Functions and Information, QA procedure
- MediaLab Document Management, QA procedure
- Technical SOP template (AG.F443)
- Nontechnical SOP template (AG.F444)

7. REFERENCES

Clinical and Laboratory Standards Institute (CLSI), *Quality Management Systems: Development and Management of Laboratory Documents: Approved Guideline—Sixth Edition*. CLSI document QMS02-A6

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By
		Supersedes SOP L006.004		
000	11/1/2012	Page 1: update annual review table to 'Review' Section 4: add definition of periodic review Section 6: add MC SOPs	L Barrett	C Bowman

Version	Date	Reason for Revision	Revised By	Approved By
		Section 9: Page 1 of SOP templates revised, local information inserted into Instruction for Preparation of SOPs		
001	11/28/14	Section 1: update CLSI document number Section 4: add SmartSolve & EDCS, remove MC Section 5: update to reflect SS process Section 6: replace MC with SS SOPs Section 7: update CLSI title and number Section 9: update instructions to reflect SS process, update templates Footer: version # leading zero's dropped due to new EDCS in use as of 10/7/13	L Barrett	C Bowman-Gholston
2	6/24/16	Section 4: add System and Site Specific SOP Section 5: add detail for SOP headers, update prefix numbering format Section 9: update addendum A and appendix B	L Barrett	C Bowman-Gholston
3	7/13/18	Section 4: add exception for BB format Section 5: include adding other elements in non-technical format	L Barrett	C Bowman-Gholston
4	5/7/19	Header: update parent facility Section 4: add MediaLab Section 5: add note for WOMC, edit format & numbering to match Media Lab Section 6: delete NQA documents, move SOP templates from section 9 Section 9: remove corporate & BPT references in App A, add instructions for nontech. SOP	L Barrett	C Bowman-Gholston
5	4/9/20	Header: change WAH to WOMC Section 3: specify approval requirements for medically related vs. administrative SOPs Section 4: delete SmartSolve Section 6: delete SmartSolve SOPs, add ML management SOP	L Barrett	C Bowman-Gholston
6	7/23/21	Header: removed specific labs, added All Labs Section 5: updated system numbering process; added numbering format for forms Footer: changed prefix to AHC	L Barrett	C Bowman-Gholston

9. ADDENDA AND APPENDICES

A. Instructions for Preparing Technical SOPs
B. Instruction for Preparing Nontechnical SOPs

Note:

The appendices were not included for the training update review because the content did NOT change. They can be viewed in the current existing SOP as needed.