TRAINING UPDATE

Lab Location:	SGMC and WOMC	**Date Implemented:**	4/3/24
Department:	Blood Bank	**Due Date:**	4/30/24

DESCRIPTION OF PROCEDURE REVISION

Name of procedure:

Documentation Technique Policy

Description of change(s):

AABB cited blood bank for poor documentation technique. We need to follow the attached policy at all times. The three areas that blood bank is struggling with are as follows.

1. When you make an error in documentation, you must place a single line through the error then add the corrected result, date ~~and time~~ of correction, and initials of person correcting.

   DO NOT write over the information that is there or scribble it out.

Correct Documentation	Incorrect Documentation
~~E0666~~ SC 4.3.24 E0668	E0668 ~~E0666~~

2. We must write our dates in the standard format of MM/DD/YY. Please do not write in any other format. This is what our procedure calls for.

Correct Documentation	Incorrect Documentation
4/3/24 04/03/24	3APR24 03/04/24

3. If you add something to a technical record retroactively, you must add the date of addition and reason for late documentation.

   Example: Added 4/3/24. Centrifuge QC performed on day of use, but forgot to initial form.

AHC.QA 3000 Documentation Technique Policy

Copy of version 3.0 (approved and current)

Last Approval or Periodic Review Completed	4/11/2023
Next Periodic Review Needed On or Before	4/11/2025
Effective Date	4/11/2023

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Organization Adventist HealthCare

Approval and Periodic Review Signatures

Type	Description	Date	Version	Performed By	Notes
Approval	Lab Director	4/11/2023	3.0	Nicolas Cacciabeve MD Nicolas Cacciabeve	
Approval	QA Leader approval	4/6/2023	3.0	Cynthia Bowman-Gholston MT(ASCP) (104987)	
Approval	Lab Director	4/13/2021	2.0	Nicolas Cacciabeve	
Approval	QA Leader approval	4/13/2021	2.0	Cynthia Bowman-Gholston	
Approval	QA review	4/5/2021	2.0	Leslie Barrett	
Approval	Lab Director	5/2/2019	1.0	Nicolas Cacciabeve	
Approval	QA Leader approval	5/1/2019	1.0	Cynthia Bowman-Gholston	
Approval	QA review	4/23/2019	1.0	Leslie Barrett	

Version History

Version	Status	Type	Date Added	Date Effective	Date Retired
3.0	Approved and Current	Major revision	4/5/2023	4/11/2023	Indefinite
2.0	Retired	Major revision	4/5/2021	4/19/2021	4/11/2023
1.0	Retired	Initial version	4/23/2019	5/23/2019	4/19/2021

Non-Technical SOP

Title	**Documentation Technique Policy**	
Prepared by	Leslie Barrett	Date: 4/23/2019
Owner	Cynthia Bowman-Gholston	Date: 4/23/2019

Local 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 document sets forth the policy for proper documentation technique related to technical records and is in keeping with regulatory requirements and good laboratory practice.

2. SCOPE

This policy applies to all Laboratory personnel who handle technical records. Hospital personnel are excluded from this policy.

3. RESPONSIBILITY

- The **Laboratory Director** is responsible for the approval of the initial document and any revisions.
- The **Laboratory Director or Designee** is responsible for the recurring review of this document.
- The **Supervisor / Manager** is responsible for
  - Implementing this policy in the department for which he/she is responsible.
  - Ensuring compliance with the policy in the department for which he/she is responsible.
  - Ensuring all employees who handle technical records are trained at new hire and annually thereafter.

- All **Employees who handle technical records** must follow this policy.

4. DEFINITIONS

- **Technical Record:** a clinical laboratory document where the accuracy of the information recorded directly or indirectly affects patient test results and/or patient care. Technical record information includes but is not limited to standard operating procedures, testing data, record of QA/QC activities, workload records, or any other information that has a direct or indirect effect on the quality of patient test results.

5. POLICY

A. Overview

1) Technical records are evidence that work has been performed on a particular date.
2) Documents reflect who did what, when and why as applicable.
3) If no documentation can be produced, there is no evidence that work was performed.

B. General Documentation Requirements

1) There are three types of documentation
   a. Recording information
   b. Voiding information
   c. Changing information
2) Recording, voiding or changing information:
   a. Must be dated with the current date.
   b. If relating to a past event, an entry must:
      (i) Be clearly recognizable as having been made on the current date with a reference to the past date.
      (ii) Include an explanation for any oversight, if applicable trace
3) It is **never** acceptable to back-date an entry on a technical record.
4) All pages of a technical record, including attachments, must be signed/initialed and dated.
5) Documentation must be traceable to the person making, voiding or changing information on the record.
6) The employee/person must identify themselves by signature, initials, code, or other unique identifier.
7) All departments must maintain a list of employees and their unique identifier(s). The department must have a process to ensure it accurately reflects current personnel.

C. Requirements for Recording Information

1) Record information on approved forms.
2) All pages of a technical record must include a name, title, header or type of identification to clearly identify the contents of the record (or information recorded on the document).
3) Record information directly on the technical record.
4) Do not record information on a medium that is not an approved form or technical record.

5) Do not use self-affixing notes or small pieces of paper stapled, paper-clipped or otherwise attached to the technical record. If necessary, create a formal referenced attachment.
6) Use permanent ink (blue or black preferred) that does not smear. Different colored ink is allowed when a second person is marking on a document. Examples include use of red ink when grading training/competency questions or colored ink when reviewing antigrams.
7) Do not use pencil.
8) Avoid highlighters that obscure information if copied or faxed.
9) Write legibly. Numbers and symbols must be clearly decipherable.
10) Use abbreviations that are generally understood or formally defined in a reference table or legend.
11) Make complete entries.
12) Do not use ditto marks to repeat information. The use of arrows is acceptable if it is entirely clear what the arrows mean.
13) When referencing supporting information, include a complete citation so that the reference is retrievable.

D. Requirements for Voiding Information

1) Entries must be voided in a way that does not obscure the original information.
   a. Draw a single horizontal line through the original entry being voided, so that the legibility of the original entry is maintained.
   b. Do not use correction fluid.
   c. Do not use correction tape.
2) The person voiding the information must sign/initial and date the entry.

E. Requirements for Changing Information

1) This is a two-step process, where voiding the original entry is separate from recording the new entry. Entries must not obscure the original information.
   a. Void the original entry by drawing a single horizontal line through the original entry being voided (See Section 5.D, Requirements for Voiding Information).
   b. Enter the new information so it is clear which information it is replacing. Do not obscure any existing or voided information (See Section 5.C, Requirements for Recording Information). Review the changes to ensure they are complete and accurate.
2) Do NOT write over or through original information.
3) Document the reason for the change, if it is not apparent to the reviewer.
4) The person changing the information must sign/initial and date the entry.

6. RELATED DOCUMENTS

None

7. REFERENCES

Quest Diagnostics *Policy for Documentation Technique* (QDNQA707)

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By
		Supersedes SGAHQDNQA707v1.2		
1	4/5/21	Header: changed WAH to WOMC	L Barrett	C Bowman-Gholston
2	4/5/23	Header: changed site to All Laboratories Footer: changed SOP prefix to AHC	D Collier	C Bowman-Gholston

9. ADDENDA AND APPEDNICES

None