

PURPOSE: To define policy and procedure to ensure accurate laboratory results are reported in a manner that support safe and effect patient care and complies with regulatory and accreditation standards.

PRINCIPLE & CLINICAL SIGNIFICANCE:

POLICIES:

- All results are reviewed for accuracy prior to electronic release in the laboratory information system (LIS)
- Read-back is performed and documented for verbal notification of test results or delay

ROLES	RESPONSIBILITIES	
Transfusion Service Medical Director	 Participates in the development of reports Approves the final format Ensures interpretation, correlation, and effective communication of information Provide direct notification and consultation to clinicians and/or patients for selected cases Provide notification to the patient providers of adverse effects of transfusion including transfusion-transmitted diseases Provide clinical information of adverse effects of transfusion to the patient providers of transfusion to the blood supplier, when applicable 	
TSL Operations Manager	 Develop and update reports as required Ensure accurate and timely reporting of laboratory results by laboratory personnel 	
QA Manager	 Review quality assurance reports associated with result reporting in the laboratory information system (LIS) 	
Transfusion Service Staff	 Review all results and component information are accurate prior to reporting in the LIS Notify caregiver and document notification of First time positive antibody screen Test results with potential to delay transfusion Corrected test results – refer to SOP Sunquest Canceling Orders and Correcting Results 	
TSL Customer	 Provides consultation on the content and format of laboratory reports to ensure reports support patient care needs. 	

SPECIMEN REQUIREMENTS:

NA

REAGENTS/SUPPLIES/EQUIPMENT:

Reagents:	Supplies:	Equipment:
NA	NA	NA

QUALITY CONTROL: NA INSTRUCTIONS: TABLE of CONTENTS Result Review Prior to Reporting in LIS

Caregiver Verbal Notification

Result Review Prior to Reporting in LIS

STEP	ACTION	
	If results are from	Then
1	Manual testing	Enter test results and interpretation in the laboratory information system (LIS)
	Automated testing	Transfer results to the laboratory information system (LIS)
	Review reactions and interpretation for accuracy	
2	If either are	Then
	Inaccurately entered	Correct entry
	Discrepant	Resolve discrepancy
3	Save test results in the LIS	

Caregiver Verbal Notification

STEP		ACTION
1	Request to speak to the RN or physician attending the patient	
2	Ask the attending RN or physician for their first and last name	
3	 Preface the result or information with two patient identifiers First and last name Medical record number (MRN) 	
4	Give them the result or information	
5	Ask them to readback	Readback
	Test result (positive antibody)	Two patient two identifiers and result given

TITLE: Reporting Patient Test Results and Verbal Provider Notification

Number: PC-0099.01

STEP	ACTION	
	Product delay only	Two patient two identifiers
	If notification is for	Then
6	Test result (positive antibody)	Document in LIS as a free text comment under the test: Test result reported. "RDBK"(readback) by xxxRN/MD to Tech ID @ DATE and TIME EXAMPLE: Positive ASCR reported. RDBK by John Smith RN to TR1234 @ 06/08/21 10:30
	Product delay	Document on the component order requisition: Delay reported. "RDBK"(readback) by xxxRN/MD to Tech ID @ DATE and TIME EXAMPLE: Delay communicated. RDBK by John Smith RN to TR1234 @ 06/08/21 10:30

CALCULATIONS/INTERPRETATIONS/RESULTS REPORTING/NORMAL VALUES/CRITICAL VALUES

NA

CALIBRATION:

NA

PROCEDURE NOTES AND LIMITATIONS:

NA

REFERENCES:

AABB Standards for Blood Banks and Transfusion Services, Current Edition

RELATED DOCUMENTS:

NA

APPENDIX:

NA

TITLE: Reporting Patient Test Results and Verbal	Number:
Provider Notification	PC-0099.01

UWMC SOP Approval:			
UWMC CLIA Medical Director			
	Andrew Bryan, MD	Date	
Transfusion Service Manager		Date	
ger and the second s	Nina Sen		
QA Manager		Date	
Transfusion	Tayler Reeves		
Service			
Medical Director		Date	
	Monica Pagano, MD		
UWMC Biennial R	eview:		
		Date	
		Date	