Reporting Electronic DDR with MediaLab IQE
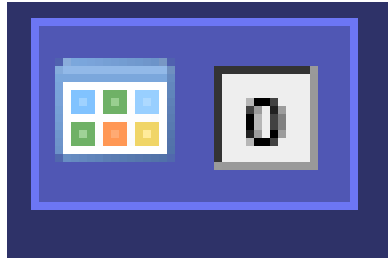
- Sign into MediaLab and use the IQE Icon

- Record a new event

- Select the correct form to complete
  - Blood Bank Occurrence
  - DDR Form

- Click Use Selected Form

Form

Event

Date/Time Incident Occurred

Date and time Discovered *

Problem Identified By *

Department *

- The form number and Event number will automatically populate

- Complete the Data and Time the incident occurred

- Complete the Date and Time Discovered

- The individual completing the forms name will automatically be added by the problem identified by

- Complete the Department that the DDR pertains to (this will automatically assign the supervisor of that department to review)

Patient Medical Record Number

Sample Accession Number (s)

Patient Location: *

Description of Incident

- Complete the Medical Record Number
- Complete the Accession number if necessary
- Complete the Patient Location
- Complete the description of the Incident
- Then Submit

EINSTEIN MEDICAL CENTER LABORATORIES

X EMCP   ☐EMC-EP

MEDIALAB IQE STAFF TRAINING CHECKLIST
ADMINISTRATION DEPARTMENT
Training Checklist

X ORIENTATION & COMPETENCY   ☐ STUDENT TRAINING   ☐RETRAINING

Employee _____   Date of Hire: _____

PROCEDURE/POLICY/TECHNIQUE	CHECK IF NOT APPLICABLE	APPLICABLE POLICY OR PROCEDURE	PERFORMED/ OBSERVED YES/NO	TRAINEE INITIALS	TRAINED BY INITIALS	DATE
Signing into MediaLab		AD02-025	Observed			
Locating the IQE Icon/Drop down tab		AD02-025	Observed			
Record a new event link		AD02-025	Observed			
Selecting Correct Form (BB/ DDR)		AD02-025	Observed			
Completing form		AD02-025	Observed			
Received copy of powerpoint slides		AD02-025	Observed			

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X EMCP □EMC-EP

NAME: _____

COMPETENCY ASSESSMENT
Complete the following table for all testing personnel.

*Assessment Method:

IM – INSTRUMENT MAINTENANCE	WR – WRITTEN ASSESSMENT	SR – SUPERVISOR REVIEW
DO – DIRECT OBSERVATION	PT – PROFICIENCY TESTING (EXTERNAL CAP)	IS – INTERNAL SAMPLE
PS – PROBLEM SOLVING ASSESSMENT	QC – MONITORING QC DOCUMENTATION	

	CHECK IF TEST NOT APPLICABLE	ORIENTATION				6 MONTH COMPETENCY				SECOND 6 MONTH COMPETENCY □ NA			
		ASSESSMENT METHOD*	COMPETENCY VALIDATED? Y/N	VALIDATION DATE	INITIALS	ASSESSMENT METHOD*	COMPETENCY VALIDATED? Y/N	VALIDATION DATE	INITIALS	ASSESSMENT METHOD*	COMPETENCY VALIDATED? Y/N	VALIDATION DATE	INITIALS
• ENTERED DDR/OCCURRENCE		DO/SR											
								NA					

Note: 6-month competency assessment is not applicable.

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ORIENTATION / RETRAINING / COMPETENCY COMPLETION

Date orientation/retraining/competency completed: _____

Satisfactory?   ☐ Yes   ☐ No

Comments

_____

_____

_____

_____

_____

_____

_____

The employee signature below indicates that the employee fully understands and is accountable for all of the procedures/policies/techniques in this form, which are detailed in the Training Manual and is responsible for the proper performance of all the tests and activities defined.

EMPLOYEE SIGNATURE: _____   **DATE:** _____

SUPERVISOR'S SIGNATURE: _____   **DATE:** _____

QA MANAGER/ ADMIN DIRECTOR'S SIGNATURE: _____   **DATE:** _____

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