

**Step**

**What  
happens?**

**Who is  
responsible?**

**Procedures  
needed?**

# Pitfalls



**Input**



**Output**

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**Outcome**

**Specimen**

**Personnel**

**Reagents**

**Equipment**

**Supplies**

**Infrastructure**

**Document & Information  
Record  
System**

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**Policies &  
Procedures**

**Improved  
Health for  
All**

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**PRE-ANALYTICAL**

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**ANALYTICAL**

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**POST-ANALYTICAL**

# **Beginning “Step” cards**



**Order placed**

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**Patient  
presents to  
laboratory**

**Requisition  
completed &  
reviewed by  
laboratory staff**

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**Specimen type  
determined for  
collection**

**Specimen  
collected**

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**Specimen  
logged**

**Specimen  
accepted or  
rejected**

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**Specimen  
assigned  
according to  
test request/s**

**Routine quality  
checks  
completed**

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**Specimen  
analyzed**

**Test results  
analyzed**

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**Test results  
recorded**

**Test results  
communicated/  
reported**

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**Documents and  
records  
maintained,  
filed & stored**

**Beginning  
“What happens?”  
cards**



**Clinician  
determines  
need**

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**Laboratorian  
interacts with  
patient**

# **Requisition reviewed for proper information**

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**Note specific test  
requested and  
determine what  
type of sample is  
needed**

**Blood drawn from  
patient;  
Sputum, urine, stool,  
or other specimen is  
collected**

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**Appropriate  
information  
recorded in  
specimen log**

# **Specimen accepted or rejected based on meeting acceptance criteria**

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**Requests reviewed for**

- **Testing priority – STAT versus routine**
- **If multiple tests to be done, sequential workstations versus aliquoting**
- **Centrifugation required**
- **Send out versus in-house testing**

**Prior to testing,  
determine if proper  
routine QC, reagent  
validation, equipment  
maintenance and  
calibration completed**

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**Run analysis on  
specimen**

**Review test results for accuracy, legibility, & validity;**  
**Cross-checking;**  
**Assure proper quality monitoring**

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**Transfer test results into logbook;**  
**Record results accurately**

**Notify Clinician of results  
via written report;  
Verbal reporting if  
necessary;  
Critical Values reporting;  
Assure that referral  
specimens are properly  
tracked**

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**File & store results in  
a retrievable fashion;  
Transfer files to long  
term storage;  
Dispose of files at an  
appropriate time**

**Beginning  
“Who is  
responsible?”  
cards**



**Clinician**

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**Patient /  
Laboratorian**

**Clinician,  
Clerk, or  
Laboratorian**

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**Laboratorian**

**Blood: Clinician or  
Laboratorian**

**Non-blood specimens:  
Clinician or Patient**

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**Laboratorian**

**Laboratorian**

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**Laboratorian**

**Laboratorian**

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**Laboratorian**

**Laboratorian,  
Supervisor**

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**Laboratorian,  
Clerk**

**Laboratorian,  
Nurse**

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**Laboratorian**

**Beginning  
“Procedures  
needed”  
cards**



**Ordering  
protocols**

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**Customer  
Service**

# **Criteria for specimen acceptability**

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**Specimen  
requirements for  
(venous) blood  
collection;**

**SOP for each analyte**

**Phlebotomy key  
competencies;**

**Phlebotomy  
training checklist**

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**Specimen  
management**

**Specimen  
management;**

**Criteria for specimen  
acceptability**

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**Guidelines for STAT testing;**

**Guidelines for multiple test  
from one sample;**

**Specific SOPs for each  
analyte;**

**SOP for send outs**

**(specimens referred to other  
facilities for testing)**

**SOP for each analyte;  
Guidelines for quality  
checks of all log/charts  
for each analyzer or  
test**

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**Specific SOP  
for each  
analyte**

**Specific SOP  
for each  
analyte**

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**Test Reporting  
SOP;**

**Specimen  
Management**

**Specimen  
management;**

**Client satisfaction  
guidelines**

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**SOP for document &  
record management  
(Including Document  
& Record Retention)**

# **Beginning “Pitfalls” cards**



- **Unauthorized person ordering**
  - **Inappropriate order**
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- **Lack of timely service**
- **Interaction not client friendly**

- **Incomplete patient data**
- **Incomplete clinical history**
- **Clerical errors**

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- **Not checking or following specimen requirements**
  - **Inadequate communication to patients regarding specimen self-collection**

- **Blood - Wrong tube, incorrect amount of blood,**
  - **Injury**
  - **Non-blood specimens – incorrect specimen or incorrect collection procedure; improper labeling**
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- **Clerical errors**
- **Inadequate information**

- **Unsatisfactory specimen**
- **Specimens with hazardous handling conditions**
- **Inadequately labeled specimen**

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- **Processing not performed in a timely fashion as ordered**
  - **Missing some tests on a requisition with multiple tests requested**
  - **Centrifuge not performed in a timely manner**
  - **Send out tests not referred in a timely matter or transported inappropriately**

- **QC not done or out of control,**
  - **Inadequate troubleshooting or follow up of QC**
  - **Improper calibration**
  - **Inadequate equipment maintenance**
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- **Not following SOP**
- **Taking shortcuts**

- **Release of test results without validation or interpretation**
  - **Inadequate cross-checking**
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- **Clerical errors**
- **Analyte printout results listed in different order than logbook reporting columns**

- **Results not communicated in a timely fashion**
- **Results lost**
- **Critical values not reported**  
**Confidentiality breached**
- **Failure to track referral specimens or failure to follow-up on overdue specimens**

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- **Unable to retrieve information when needed**
  - **Lack of adherence to document retention schedule**
  - **Water or moisture damage**