# PATHOLOGY QUALITY MANUAL

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QUALITY MANUAL

This document, together with all related procedure manuals, represents the Quality Management System of the Department of Pathology, Peterborough and Stamford Hospitals NHS Foundation Trust. It has been compiled to meet the requirements of the 2012 revision of ISO 15189 Medical Laboratories – Requirements for quality and competence and appropriate national and international standards. All procedures herein are mandatory within the Laboratory.

Pathology Quality Manager
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1. INTRODUCTION & SCOPE

This Quality Manual describes the Quality Management System (QMS) in use throughout this laboratory. The QMS is the process developed to support the generation of an efficient and effective, high quality and appropriate laboratory advice, testing and recommendation service.

It encompasses all elements of quality delivery, including management systems, quality assurance and quality control.

The scope of the service provided by the Pathology Service is as follows:

An in-house routine diagnostic service for haematology/blood transfusion, biochemistry and microbiology based on the Peterborough City Hospital (PCH) site – these services are supplemented by a 24 hour on-call arrangement for the testing of urgent samples. Microbiology comprises – Bacteriology, virology-serology, mycology and parasitology.
An in-house routine diagnostic service for immunology and andrology based at the PCH site.
An in house routine diagnostic service for histopathology, gynaecological and non-gynaecological cytology based at PCH.
A bereavement service, body store and post-mortem suite based at PCH. The post-mortem service is provided out of routine hours via an on-call system.

1.1 LABORATORY BACKGROUND

The Department of Pathology is part of the Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). As the legal entity PSHFT can be held legally accountable for all of its laboratory activities.

The merger of Peterborough Hospitals Trust and Stamford Hospital created the Department of Pathology in its present format in April 2002.

On April 1st 2004 Monitor (the Regulator) granted Foundation Status, so creating Peterborough and Stamford Hospitals NHS Foundation Trust

It is primarily concerned with the analysis of clinical samples from the hospitals and the community. The hospitals served are Peterborough City Hospital and Stamford & Rutland Hospital. Contracts are held for Pathology work from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and the local private hospital (Fitzwilliam Hospital). The community catchment includes parts of Cambridgeshire & Peterborough Clinical Commissioning Group (CCG), South Lincolnshire CCG, NHS Nene CCG and NHS East Leicestershire and Rutland CCG.
Other sources include HM Coroners, Ministry of Defence (MoD) establishments at RAF Wittering, St. George’s Barracks and Kendrew Barracks, Environmental Officers of Local Councils, HM Prison Peterborough, the Driver and Vehicle Licensing Authority and Aviation Accident Investigations. A variety of commercial contracts are held for food and environmental testing.

The contact details of the laboratory site are:
Peterborough City Hospital
Edith Cavell Campus
Department of Pathology
Department 413
Bretton Gate
Peterborough
PE 3 9GZ
Tel: 01733 678468

1.2 MISSION STATEMENT

The Department of Pathology seeks to provide a high quality analytical, interpretive, advisory and consultancy service that is cost-effective and responsive to the needs of our commissioners and patients.

It is committed to maintaining a safe working environment, a highly skilled workforce and utilising up to date technology to deliver the right result on the right specimen from the right patient that is accurate, properly interpreted and delivered within a clinically appropriate timescale.

The Pathology Management & Governance Committee (MGC) is dedicated to ensuring that this philosophy remains central to the practice of Clinical Pathology at Peterborough.

1.3 SERVICE SCOPE

1.3.1. Clinical Biochemistry

The Department is divided into an Automated Section and a Separation Sciences section. A Consultant Chemical Pathologist provides the Clinical cover.

The Automated Section provides a diagnostic and therapy monitoring service during 24 hours, weekdays, weekends and Public Holidays, using a variety of current techniques including ion specific electrodes, photometry and immunoassay (for endocrinology, tumour markers, vitamins, etc). This section has duplicate analysis platforms to provide resilience for the Service. This section is staffed throughout each 24-hour period. This section also oversees the point of care systems, in particular, blood gas analysis.
The Separation Science section also oversees a range of techniques for diagnostic and monitoring assays including High Performance Liquid Chromatography (for HbA1c and urine aromatic amines) and electrophoresis. This section provides a full service during core hours, weekdays, and a limited service during weekend mornings.

1.3.2. Immunology

The Immunology Laboratory at Peterborough City Hospital offers a range of diagnostic, prognostic and monitoring tests in autoimmune serology. A broad array of allergy testing is available as well as investigation of latent tuberculosis. Tests required for suspected immune deficient patients are performed across a number of pathology disciplines including Immunology.

Under the terms of a Service Level Agreement (SLA), a Consultant Immunologist from Path Links Pathology Service Network (based at Scunthorpe General Hospital) provides supervision of the laboratory. Routine running of the laboratory is overseen by a Principal Clinical Scientist. More unusual immunology tests are forwarded to referral centres, which include Addenbrooke’s Hospital in Cambridge and the Churchill Hospital, Oxford.

A Clinical Scientist is available onsite to give clinical interpretation of results and to advise on which assays would be appropriate to request for different clinical situations, in particular co-ordinating and interpreting tests for immune deficiency some of which are not performed in Immunology (e.g. immunoglobulins and lymphocyte subsets).

Andrology testing, both for sub-fertility investigations and for post-vasectomy checks is also carried out in the Immunology Laboratory.

1.3.3. Point of Care Testing

‘Near-patient testing’ (NPT) and ‘Point-of Care testing’ (POCT) are used synonymously to describe analytical procedures performed by healthcare professionals outside of the conventional laboratory. Operators performing the analysis must be appropriately trained and their competency recorded and monitored. The service must comply with those standards required for accreditation of the Pathology Department and adhere to the strict guidelines recommended by the Medicines and Healthcare Products Regulatory Agency (MHRA), Clinical Pathology Accreditation (CPA) UK Ltd ‘Additional Standards for Point-of-Care Testing (POCT) Facilities’ and the UK Accreditation Service (UKAS).

The Point of Care service currently oversees procedures performed using connected blood glucose meters; blood gas analysers; paediatric HbA1c analyser; Haematology results generated in the Haematology/Oncology OPD and International Normalised Ratio (INR) analysis performed on the ward. Further developments will include blood ketone estimation, Urinalysis using connected devices and any POCT
service approved by the POCT committee. Point of Care covers the Pathology disciplines of Clinical Biochemistry, Haematology and Microbiology, and operates Trust wide; wherever near patient testing is performed.

1.3.4. Haematology and Blood Transfusion

The Department of Haematology includes General & Specialised Haematology, Coagulation and Blood Transfusion sections. Five Consultant Haematologists provide the medical cover.

The Haematology section provides a diagnostic & monitoring analytical service of malignant and non-malignant blood disorders using state of the art technology & computer software. Included here is detection & identification of parasitic infections.

Specialised Haematology section included flow-cytometry based leukaemia / lymphoma diagnosis and leucocyte subset analysis in immunodeficiency syndromes.

The Coagulation section uses similar levels of technology but the aims are screening, diagnosis of coagulation defects including coagulopathies, providing qualitative as well as quantitative information as well as monitoring patients on short & long-term anticoagulant therapy. This section is intimately involved with the anticoagulant service.

The Blood Transfusion section also utilises state of the art technology & software and has been a leader in the field of modern practice. Services provided are compatible blood and blood products as and when required making the most efficient use of a valuable and dwindling resource. It also provides a serological antenatal service to the community including monitoring of prophylactic anti D and diagnostic service for the investigation of haemolytic disease.

1.3.5. Cellular Pathology

Histopathology provides a service for the clinical diagnosis of disease from human tissue samples.

Six (whole time equivalent) Consultant Histopathologists provide medical cover for the Service.

Gynaecological Cytology provides a screening service for the detection of precancerous abnormalities of the uterine cervix.

The Non-Gynaecological service provides clinical diagnosis of disease from aspirated or expelled fluid samples.

The Bereavement Centre offers support to the family of deceased patients. The Mortuary provides a service for the receipt and storage of deceased patients prior to
funeral and the assessment of cause of death to meet statutory requirements or for purposes of teaching and clinical audit.

1.3.6. Microbiology

Provides a Clinical microbiological diagnostic service to the Clinical Directorates (CDs) and co-ordinates comprising PSHFT and its associated general practitioner community. The Laboratory is a designated Public Health England (PHE) Collaborating Centre.

Clinical input is provided from two Consultant Clinical Microbiologists.

Comprehensive microbiological and epidemiological information and support is available to consultants in Communicable Disease Control and their colleagues in Public Health Medicine.

Local surveillance and special studies in infectious disease are undertaken.

Microbiological support for the Control of Infection function is provided.

Investigation and support in community and national outbreaks of communicable disease is available when required.

1.3.7. Phlebotomy

Venous blood sampling is an integral part of the diagnostic process that facilitates appropriate treatment and patient care. It is essential that samples of high quality are taken with minimum discomfort to the patient. It is also vital to minimise the risk of cross-infection between patients.

An inpatient service is provided at PCH Monday to Friday 0800–1200 by a team of skilled phlebotomists, who are re-assessed and competencies are checked at a maximum of two years. Staff are responsible to the Deputy Head BMS Clinical Chemistry and on a day to day basis to the Pathology Support Services Manager.

The Sarstedt blood collection system is used to take blood samples. All request forms should be made available for collection each day at 0800 in the relevant ward areas. The phlebotomists take routine bloods only. Emergency bloods should be taken by the ward medical staff.

1.3.8. Stamford

From September 2012 routine processing of Clinical Biochemistry, Haematology and Blood Transfusion samples ceased at Stamford. All samples are now processed at the PCH facility. A phlebotomy service only remains at Stamford – this is available from Monday to Friday from 0830 to 1700 hours. The staff are managed by the Pathology Support Services Manager.

All pathology specimens are now transferred to the PCH laboratory site for processing.
1.3.9. Referral of Specimens

The Pathology Service is supported by referring work to specialist centres.

Full details are given in Appendix 4 Referral Centres Used of this quality manual.

1.3.10. Service Guides

A guide to using the service is available to all users of the Service through the internet site at www.pch-pathlab.com and also via the Trust Intranet (internal users) and Extranet (external e.g. General Practitioners and staff).

1.3.11. Opening Hours

All laboratories:

Core hours of the Department of Pathology are 9am to 5 pm Monday to Friday, but each department has extensions to reflect service need.

An on call service provides cover for haematology, chemistry and microbiology services whenever the laboratories are not manned.

Bereavement Centre / Mortuary:

The Bereavement Centre and Mortuary at Peterborough City Hospital operates from 0800 to 1630 Monday to Friday. There is an on call facility that provides a mortuary service outside of these hours.

1.4 ON CALL ARRANGEMENTS

1.4.1. Clinical Chemistry

The Department of Clinical Biochemistry offers an out of hours service to service users.

Staff

Participation in this service is undertaken by HCPC Registered Biomedical Scientists (BMS), is voluntary and is available to any BMS competent within the discipline, provided the first criterion is met.

Hours of Service

The normal (in hours) day is taken as Monday to Friday inclusive, from 0800 – 1630 with an extended service until 2000 from February 2010.

Duties outside of these times are considered out of hours.

Reertoire
The assays available to service users out-of-hours tend to be all general routine biochemistry analytes that are available on routine analytical platforms. However, this list is not exhaustive and is subject to change. If staff are unsure, they would seek advice from senior Biochemistry staff (usually Consultant Chem Path or Head BMS).

The following analyses are available without recourse to Clinical/Senior staff: sodium, potassium, chloride, creatinine (U/E); CO₂; urea; albumin; total bilirubin; alkaline phosphatase; ALT; total protein (LFT); calcium; inorganic phosphate; amylase; uric acid; glucose; troponin T; CPK; CRP; direct bilirubin; magnesium; paracetamol; salicylate; lipids; CoOx; and paraquat.

The following analyses are available but the laboratory should be contacted and made aware of the request: lactate; blood gases; ammonia; iron (in cases of suspected toxicity); plasma osmolality; urine osmolality; phenytoin; lithium; digoxin; theophylline pregnancy test; urine porphyrin; urine porphobilinogen.

Also available at weekends are: E₂, LH, progesterone; hCG (to 13:00); gentamicin and vancomycin (both to 13:00; other requests via the Consultant Microbiologist).

Requests received out of hours for process during out of hours should be marked either URGENT or EMERGENCY.

The service is available to all wards at PCH and Stamford, the Fitzwilliam Hospital and on occasions to GP/Rapid Response teams (usually agreed with duty BMS directly).

The emphasis should be on providing a service to users, making access easy and offering a fast turnaround of results, maintaining high quality.

Duty staff will visit the tube transport station in the Department every even 2 hours, and process work up to 02.00 (last pod visit). Start again 06.00.

For work that cannot wait for these programmed run times, the requester will bleep the duty BMS and give advice on the request. All emergency requests should also bleep duty BMS – this includes all blood gas ammonia and lactate requests.

1.4.2. Immunology

The normal (in hours) day is taken as Monday to Friday inclusive, from 0800 – 1630.

Few tests performed by the department are required clinically on an urgent out-of-hours basis. The laboratory at Addenbrooke’s Hospital does carry out a limited out-of-hours service if the request is approved by the Addenbrooke’s Duty Immunologist who can be contacted via the Addenbrooke’s switchboard (short dial code 6100).
1.4.3. Haematology and Blood Transfusion

Staff

Participation in this service is undertaken by HCPC Registered Biomedical Scientists (BMS), is voluntary and is available to any BMS competent within the discipline, provided the first criterion is met.

Hours of Service

The normal (in hours) day is taken as Monday to Friday inclusive, from 0800 – 1630 with an extended service until 2000

Duties outside of these times are considered out of hours.

Staff requesting on call tests MUST bleep the oncall Haematologist Contact via bleep 1151 or switchboard for:

- **ALL** requests for blood & blood products.
- If the diagnosis is query Malaria.
- If the results have not appeared on the ward terminal for when you need them.

1.4.4. Microbiology

1) **Introduction**

Out of hours service for essential and urgent work by its very nature is almost always hospital based clinical bacteriology, but the service is available to others e.g. GPs and Environmental Health Departments if urgently needed.

a) **Essential Microbiology Service.**

Such work is carried out 7 days a week between 0845 – 1700 with an extension up until 2000 Monday to Friday by an HCPC Registered Biomedical Scientist (BMS) attending the department. Reading and reporting of culture plates is the prime function with no service offered, for example, for routine Serology or Virology.

Significant positive results on important specimen (e.g. blood culture, C.S.F. etc) will be telephoned before the BMS leaves the department.

b) **Urgent Microbiology Service.**

This service operates at all other times than those mentioned above, by calling the Biomedical Scientist (BMS) on-call to attend from their home base. Use of the service should be restricted to genuine emergencies only.
The emergency duty roster is held at PSHFT main switchboard (Tel: 01733-678000) through whom the duty BMS can be contacted. A mobile phone and a radio-pager are available for use at the convenience of the BMS On-Call.

c) Medical Advice.

Medical advice is available out of hours from a Consultant Medical Microbiologist who is also contactable via PSHFT main switchboard (Tel: 01733-678000). A mobile phone and radio-pager are carried.

1.4.5. Cellular Pathology

There are no formal arrangements for processing samples out of hours although this may be possible in cases of urgent clinical need where the case has been discussed with a Consultant Histopathologist and they have given permission for urgent processing to take place.

1.4.6. Mortuary

An on call service is available which covers outside of normal working hours.

2. REFERENCES

Conformity assessment – Vocabulary and general principles (ISO 17000:2004) – available via Q-Pulse
General requirements for the competence of testing and calibration laboratories (ISO 17025:2005 – available via Q-Pulse.
Rules and Guidance for Pharmaceutical Manufacturers and Distributors 2007 - the 'Orange Guide'
3. TERMS & DEFINITIONS

3.1 ACCREDITATION

Procedure by which an authoritative body gives formal recognition that an organization is competent to carry out specific tasks.

3.2 POST-EXAMINATION PROCESSES (POST-ANALYTICAL PHASE)

Processes that follow the examination, including: review of results, retention and storage of clinical material, sample (and waste) disposal, formatting, releasing, reporting and retention of examination results.

3.3 PRE-EXAMINATION PROCESSES (PRE-ANALYTICAL PHASE)

Processes that start, in chronological order, from the clinician’s request and include: the examination request, preparation and identification of the patient, collection of the primary sample(s), transportation to and within the laboratory, and end when the analytical examination begins.

3.4 PRIMARY SAMPLE (SPECIMEN)

Discrete portion of a body fluid, breath, hair or tissue taken for examination, study or analysis of one or more quantities or properties assumed to apply for the whole.

3.5 QUALITY MANUAL

Describes the quality management system in use by an organization.

3.6 QUALITY MANAGEMENT SYSTEM (QMS)

Comprehensive and co-ordinated efforts that are designed to direct and control an organization with regard to quality.

3.7 QUALITY MANAGER

An individual with delegated responsibility and authority to ensure compliance with the quality management system.

3.8 RECORD

Any information that produces evidence (e.g. requests, examination results and reports, instrument printouts, laboratory workbooks and worksheets, accession records, calibration records, quality control records, audit records, complaints and action taken, external quality assessment records, instrument maintenance records, incident / accident reports, staff training and competency records, personnel records).
3.9 SOP
Standard Operating Procedure

4. MANAGEMENT REQUIREMENTS

4.1 ORGANIZATION AND MANAGEMENT RESPONSIBILITY

4.1.1. Organization

Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT) was among the first wave of foundation trusts and received its provider licence (number 120083) from Monitor in April 2004. PSHFT is also registered with the Care Quality Commission (CQC). PSHFT is the entity that is held legally responsible for all of its activities and, under the terms of the Health and Social Care Act (2012) PSHFT is assessed for regulatory compliance against the Act by both Monitor and CQC. The Pathology Laboratory is a part of PSHFT’s Cancer and Diagnostics Clinical Directorate which in addition to pathology also includes diagnostic imaging, oncology and clinical haematology.

Ethical Conduct –
Via the Pathology MGC laboratory management ensures that there is no involvement in any activities that could diminish confidence in the laboratory’s competence, impartiality, judgement or operational integrity.
All of the activities undertaken are free from any undue commercial, financial, or other pressures and influences that could adversely affect the quality of work produced.
Should competing interests exist – MGC requires that staff openly declare these via completion of a register of interests form in compliance with the Trust’s Policy on Business Conduct and Bribery Avoidance (available on SharePoint).

All staff are aware of the need to formally raise concerns when they encounter or suspect wrong doing or malpractice and it would be in the public interest for these concerns to be raised. The Trust Policy ‘Raising Concerns in a Safe Environment’ outlines the process to be followed and quotes examples of when this may apply. These include:
- Wilful neglect which compromises health and safety
- Patient abuse or neglect or ill treatment
- Unlawful or unprofessional conduct and/or performance
- Disregard of Health and Safety rules
- Receipt of gifts or hospitality outside of Trust policy
- Conflict of interest
- Fraud or financial mismanagement

All staff are aware of the requirement to ensure that all samples are dealt with in accordance with UK legal requirements including compliance with environmental and waste regulations.
All staff are aware of the need to ensure that confidentiality of information is maintained at all times in accordance with the Trust’s Data Protection and Confidentiality, and Information Governance Policies (available on SharePoint).

**Laboratory Director**

The Laboratory Director is Dr Sateesh Nagumantry who is the Pathology Associate Clinical Director (ACD) for the Cancer & Diagnostics Directorate and is a Consultant Haematologist. Dr Nagumantry is accountable to Dr Rege the Clinical Director who together with Ms Clapton (the Directorate General Manager) have executive accountability for the service via the Trust’s Chief Operating Officer as shown on the organisation chart below.

For full details of the laboratory director’s role and responsibilities please see the associated Laboratory Director document (ref: GEN-QP-LabDirector) which is available via Q-Pulse.
4.1.2. Management Responsibility

4.1.2.1. Management Commitment

Laboratory Management is committed to the development, implementation and continual improvement of its quality management system (QMS). This requirement is achieved by:

Ensuring that all laboratory personnel are aware of and comply with regulatory and accreditation requirements.

Ensuring that all laboratory personnel are aware of and comply with the needs and requirements of service users.

Establishment of the departmental Quality Policy (see below).

Ensuring that quality objectives and plans to achieve these objectives are in place.

Defining the responsibilities, authorities and interrelationships of all personnel (see QM Appendix 1 – available via Q-Pulse)

Establishment of effective communication processes with staff and also with the service stakeholders.

Establishment of and appointment to the role of Pathology Quality Manager (PQM).

Ensuring that management quality reviews occur on at least an annual basis.

Ensuring that staff are competency assessed to provide assurance that they are competent to perform their assigned activities.

Ensuring that there are adequate resources to enable the proper conduct of pre-examination, examination and post-examination activities.

4.1.2.2. Needs of Users

Laboratory management regularly reviews the service provided to ensure that its meets the needs of service users and the patient population served.

Direct meetings are held with commissioners where feedback is provided, issues are discussed and any required actions agreed. In addition, hospital clinicians provide feedback via formal clinical ward rounds and during Multi-Disciplinary Team (MDT) meetings.

Complaints received from users are fully investigated and any necessary corrective actions undertaken.

Assessment of user satisfaction and complaints is conducted on an annual basis and consideration of the findings form part of the annual management review.
4.1.2.3. Quality Policy

Laboratory management has defined the following Quality Policy which meets the requirements of this International Standard and is appropriate to the purpose of this organization.

The Pathology Service is committed to providing a service of the highest quality and shall be aware and take into consideration the needs and requirements of its users.

In order to ensure that the needs and requirements of users are met, the Department will:

- operate a quality management system to integrate the organisation, procedures, processes and resources.
- set and review quality objectives and plans in order to implement this quality policy.
- ensure that all personnel are familiar with this quality policy to ensure user satisfaction.
- ensure that all personnel are familiar with the contents of the quality manual and all procedures relevant to their work.
- uphold professional values and be committed to good professional practice and conduct.
- commit to the health, safety and welfare of all its staff.
- ensure that visitors to the department will be treated with respect and due consideration will be given to their safety while on site.
- keep advised of and implement, where applicable, all current legislation relating to the Health and Safety of staff and visitors.
- comply with relevant environmental legislation.
- conform to confidentiality in accordance with The Data Protection Act, NHS Information Governance and Caldicott Guidelines.

The Department will continue to comply with standards set by ISO 15189, CPA / UKAS, The Blood Safety and Quality Regulations and The Human Tissue Authority and is committed to:

- staff recruitment, training, development and retention at all levels to provide a full and effective service to its users.
- the proper procurement and maintenance of such equipment and other resources as are needed for the provision of the service.
- the collection, transport and handling of all specimens in such a way as to ensure the correct performance of laboratory examinations.
- the use of examination procedures that will ensure the highest achievable quality of all tests performed.
- reporting results of examinations in ways which are timely, confidential, accurate and clinically useful.
- the assessment of user satisfaction, in addition to internal audit, external quality assessment, identification and control of nonconformities in order to produce continual quality improvement.
Signed on behalf of the Department of Pathology

…………... ................................... …Date……1st January 2015………………

Chair Pathology Management & Governance Committee (MGC)

This Quality Policy is reviewed at least annually as part of the Management Review process.

4.1.2.4. Quality Objectives and Planning

The Trust decides upon its strategic objectives on an annual or biennial basis. Departmental objectives which link to these are then agreed by Pathology MGC. The laboratory Quality Forum (QF) has latitude to create its own specific departmental objectives as long as they clearly link to the departmental objectives.

The management review that is undertaken on an annual basis, determines whether the objectives have been successfully completed and provides an opportunity for revising such objectives and plans and the functioning of the QMS.

4.1.2.5. Responsibility, authority and interrelationships

Organisation Charts for Pathology can be found as an appendix of this quality manual (Appendix 1) which is available via the Documents Module of Q-Pulse. This details:

- Trust Management Structure
- Pathology Reporting Responsibilities
- Clinical Management Structure
- Technical Management Structure
- Quality Management Structure
- Clinical Biochemistry & Immunology Structure
- Haematology and Blood Transfusion Structure
- Cellular Pathology Structure
- Microbiology Structure

In addition, the names and roles of senior laboratory staff are contained within an appendix of this Quality Manual (Appendix 2) which can be accessed via the Documents Module of Q-Pulse.

Non-medical staff are accountable to the PSM through the Departmental Manager. Clinical scientist staff are accountable to the clinical head of department for clinical issues and managerially accountable to the PSM through the Departmental Manager

Pathology medical staff are accountable directly to the Directorate Associate Clinical Director (ACD).
Departmental QOs are responsible through their Departmental Manager to the PQM for issues relating to quality and the maintenance of the QMS.

Departmental H&S Officers are responsible through their Departmental Manager to the PSM who has ultimate responsibility for ensuring the Health, Safety and Welfare of staff and visitors within Pathology.

Departmental Training Officers are responsible through their Departmental Manager to the PSM who has ultimate responsibility for ensuring compliance with National and Trust training requirements.

It is a policy of the laboratory that all senior Biomedical Science staff must have proven technical and managerial competencies appropriate to the post held. They must be Registered with the HCPC and have relevant qualifications such as Licentiate, Member or Fellowship of the Institute of Biomedical Sciences (IBMS) or be HCPC registered Clinical Scientists

Registered Medical, Biomedical Scientists and Clinical Scientists are authorised signatories for clinical reports within their specialist areas of competence:

In the absence of key managerial staff, the appropriate appointed deputy fulfils the role of the absent member of staff.

All staff are issued with a job description detailing the general extent and limitations of their responsibilities. These are reviewed annually at My Performance Appraisal (MPA) meetings for laboratory and clerical staff and at appraisals for medical staff.

On a day-to-day basis, specific duties relating to these responsibilities are discharged through the member of staff with direct responsibility for the supervision of any given individual.

- It is the responsibility of all employees to become familiar with and participate in Quality Management and the requirements of the Pathology QMS.
- Staff must at all times follow documented and approved SOPs.
- Staff must become familiar with the contents of this Laboratory Quality Manual.
- Staff must complete a Trust Datix adverse event record and a Corrective Action / Preventative Action (CA/PA) record on Q-Pulse as soon as a nonconformity is identified in order that prompt and appropriate action can be taken to control the problem.
- Staff must participate in annual appraisal.
- BMS staff must record self-assessments and Continuing Professional Development (CPD) activities within their personal portfolios and ensure that their competency records are kept up to date.
This document forms part of the laboratory documentation. It is an overview of quality and should be read in conjunction with other documentation:

Trust Policies available on SharePoint via the intranet

Laboratory Quality Policies¹:

Quality Audit Manual
Evaluation & Quality Assurance
Quality Improvement
Education Support Policy

4.1.2.6. Communication

Staff meetings occur in laboratory areas and active participation by all staff is encouraged. These meetings also offer opportunities for staff to suggest changes and quality improvements. Minutes of the meetings are taken, recorded on Q-Pulse and distributed electronically to the staff via Q-Pulse.

A number of management meetings occur to ensure that there is suitable dialogue between pathology and Trust management as shown here:

¹ Available on Q-Pulse
In addition, there are regular opportunities for service user feedback on the effectiveness of the laboratory’s service via dedicated commissioner meetings, formal clinical rounds, MDT participation and via periodic service user feedback surveys.

The main management committees within the Pathology service together with their remits are listed within appendix 3 of this Quality Manual (available via Q-Pulse).

Terms of reference exist for these meetings. Minutes of these meetings are held with specific action points noted and assigned to specific staff together with an agreed timescale for implementation.

4.1.2.7. Quality Manager

A Pathology Quality Manager (PQM) has been appointed who is a member of the Pathology Management & Governance Committee and who ensures on behalf of MGC that the Quality Management System functions effectively. The PQM’s job description is available via Q-Pulse.

4.2 QUALITY MANAGEMENT SYSTEM (QMS)

4.2.1. General requirements

Through the creation of this quality manual laboratory management has provided documentary evidence of the existence of a QMS. Laboratory management will endeavour to improve the effectiveness of this QMS in accordance with the requirements of International Standard ISO 15189:2012.

4.2.2. Documentation requirements

Hierarchy of the documentation system is shown below:

Hierachy of the documentation system is shown below:

- Specifications / Standards / Regulations
- Quality Manual
- Documented quality and system procedures (SOPs)
- Work instructions, forms, reports, records etc.

The quality manual defines and describes the QMS in use at PSHFT. It contains a copy of the department’s Quality Policy together with a statement of our aspirations with regard to quality.

The master copy and approval record for this document is contained within Q-Pulse. If printed, this is a controlled document ONLY if printed on pink paper and shown within the distribution list.
This Quality Manual outlines the general form of the Quality System in operation in the Department of Pathology, identifying the general arrangements for ensuring that the quality policy is adhered to by staff at all times. It describes the Quality Management System for the benefit of laboratory management and staff and provides information for users and for inspection/accreditation bodies.

The sections of the Quality Manual are arranged so that they equate with the ISO 15189 Standard. Under each of the standards is a brief description of the way in which the Department of Pathology seeks to comply with the particular standard and references are given to appropriate procedures.

More detailed procedures pertaining to the implementation of the quality management system in different parts of the laboratory can be found in the following manuals:

- Quality Audit Manual\(^2\) (GEN-QP-AudMan)
- Pathology Education Support Policy\(^3\) (GEN-TRN-Policy)
- Quality Improvement\(^4\) (GEN-QP-QImprovement)
- Evaluation & Quality Assurance\(^5\) (GEN-QP-EvalQA)
- Laboratory Health and Safety Manual\(^6\) (HS-H&S-Manual)
- Trust Procedures and Policies\(^4\)
- Trust Risk Management & Risk Assessment Policy\(^5\)
- Trust Health & Safety Policy\(^6\)

**Departmental SOP Manuals**

**Clinical Biochemistry**
- Methods Manual
- Instrument Manuals
- Administration Manuals
- Laboratory IT Manual
- Specimen Handling

**Haematology and Blood Transfusion**
- General Haematology Manual
- Coagulation Manual

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\(^2\) Available via Q-Pulse
\(^3\) Available via Q-Pulse
\(^4\) Available via the Intranet on SharePoint
\(^5\) Available via the Intranet on SharePoint
\(^6\) Available via the Intranet on SharePoint

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The master copy and approval record for this document is contained within Q-Pulse. If printed, this is a controlled document ONLY if printed on pink paper and shown within the distribution list.
Blood Transfusion Manual

**Immunology**
- Equipment Manuals
- ELISA assays
- Immunofluorescence
- Allergy assays
- Semenology
- Laboratory Support Manual

**Cellular Pathology**
- Clinical procedures Manual
- Management procedures Manual
- Laboratory procedure Manuals for:
  - Histopathology
  - Gynaecological cytology
  - Non-gynaecological cytology
  - General laboratory areas.
- IT procedures Manual
- Quality procedures Manual
- Office administration Manual
- Bereavement Centre / Mortuary procedure Manuals

**Microbiology**
- Clinical Bacteriology Manual
- Blood Culture Manual
- Mycology Manual
- Enteric Section Methods Manual
- Urine Section Methods Manual
- Serology / Virology Section Methods Manual
- Containment Level 3 Room Manuals
- Molecular Manual
- Wash Up Manual
- Administration Manual

The quality manual is reviewed by the PQM and PQF annually or following an adverse event or internally or externally sourced audit which suggests that deficiencies exist or improvements could be made.

The quality manual (and any subsequent revisions) is circulated to all laboratory staff electronically via Q-Pulse – staff are required to read the contents and acknowledge that they have done so, also using Q-Pulse.

Service users also have access to the quality manual from the home page of the pathology website at: [http://www.pch-pathlab.com/cms/](http://www.pch-pathlab.com/cms/)
4.3 DOCUMENT CONTROL

This standard is fulfilled by the SOP *Preparation and control of documents*\(^7\) (GEN-QP-DocCtrl)

The master list of all controlled documents is held on Q-Pulse. Each discipline maintains and updates a record of all controlled documents. The PQM is responsible for all aspects of the document control system.

Document preparation and approval

New documents are prepared by relevant competent staff. These draft documents are reviewed and approved using the Q-Pulse approval process by a senior member of the laboratory staff or Clinical Head of Department before issue.

Change and version control

All documents and revisions are controlled via Q-Pulse conformance management software. Changes to existing documents are described on the ‘Document Review History’ panel which is located on the front page of the SOP template – this information is also recorded within the ‘Change details’ of the specific document record on Q-Pulse.

The master electronic copies are held on the Trust Q-Pulse server. A full back up is performed by the Trust IT department weekly with incremental back-ups performed daily. Documents accessed via Q-Pulse are presented to users in read only format to prevent unauthorised amendment.

Document review

It is the responsibility of senior technical staff to review all methods and procedures relevant to their area of testing on a regular basis and to ensure that documented methods accurately reflect what is done in practice at all times. Q-Pulse provides alerts to document owners when a document is due for review. Laboratory protocols are updated on a biennial basis whilst other documents, such as risk assessments, are reviewed annually in order to comply with Trust requirements.

When a new document revision is created the existing copy is stored indefinitely within the obsolete register of Q-Pulse.

4.4 SERVICE AGREEMENTS

The contractual arrangement between the laboratory and its users is defined by the laboratory request form that is completed either electronically via Sunquest Integrated Care Environment (ICE) system or via a manual request form.

\(^7\) Available on Q-Pulse
Each request form (together with its relevant primary samples) is checked for conformity with the laboratory’s labelling requirements which are made available to users via the laboratory’s internet website. If the form or samples do not meet these requirements then the request may be rejected, the user notified of this and a repeat sample requested. For samples that cannot readily be replaced that were procured within the Trust the form and samples will be quarantined and the user notified to attend the laboratory to address any labelling deficiencies. For samples that cannot readily be replaced that were procured outside of the Trust the form and samples will be returned to the user along with details of the deficiency and the user requested to address the deficiencies and return the form and samples back to us when this has been achieved.

The procedure for review of service agreements has been established as part of Trust requirements and via the SLA Procedure (GEN-MP-SLA).

Formal contract reviews occur at least annually to ensure that user satisfaction is being maintained.

The review also ensures that the requirements of both parties are adequately defined, documented and understood.

The contract review process includes the following:-
Analysis of User Surveys.
User surveys are performed at least annually. Results from the user surveys are used wherever possible to determine key objectives for the following year.

User complaints.
Records of service user reviews are held within the CAPA module of Q-Pulse together with a record of any actions stemming from these meetings.

4.5 EXAMINATION BY REFERRAL LABORATORIES

The general requirements for sample referral to reference laboratories are described in the Referral to other laboratories SOP (GEN-QP-Referral) which is available via Q-Pulse. This is then supplemented by more detailed departmental methods. All procedures adhere to current UN 3373 regulations re the transportation of samples.

Referral facilities are only used:

- When the requested test or examination procedure is outside of our stated repertoire and to undertake the test in-house would be inappropriate in terms of ensuring the quality of the result and / or it would be economically non-viable.
- To provide an expert opinion on a case initially tested and reported by the laboratory.

Laboratory Management are responsible for selecting and monitoring the quality and competency of referral laboratories and consultants on an ongoing basis. Wherever possible samples are referred only to those laboratories that are CPA or ISO 15189 accredited. Turnaround times produced by referral centres are checked periodically. Annually referral centres are checked against the UKAS website to ensure continuing compliance against their standards. Also, if the referral laboratory is not listed as ‘Accredited’ on the UKAS website, they are requested to produce documentary evidence to demonstrate continued suitable performance in interlaboratory comparison programmes for the assay(s) being undertaken.

The PSHFT laboratory retains responsibility for ensuring that the results of tests undertaken by referral laboratories are provided to the test requester.

Any referral tests undertaken are clearly identified as having been generated by the referral laboratory on the report issued to the test requester.

A list of referral centres and facilities currently in use is available as an appendix of this quality manual (Appendix 4) which is available via the Documents Module of Q-Pulse.

4.6 EXTERNAL SERVICES AND SUPPLIES

The selection and purchase of laboratory equipment is governed by the *Procurement of pathology equipment* SOP (ref: GEN-MP-EqProc) which is available via the Documents Module of Q-Pulse.

An inventory of capital equipment is held within each pathology department.

The selection and purchase of laboratory services and supplies is governed by the *Procurement of services and supplies* SOP (ref: GEN-MP-SuppliesProcure) which is available via the Documents Module of Q-Pulse.

Details of the procedures for purchase, receipt and issue of consumables and reagents and verification of identity and condition are in accordance with Trust non-stock Requisition Policy that also includes procedures for Receipt and returns. For further details consult the *Trust Standing Financial Instructions* (available via SharePoint).

A list of approved suppliers of equipment, reagents and consumables is kept within the Suppliers Module of Q-Pulse.

The performance of these suppliers is monitored as part of supplier reviews with the details of this monitoring recorded within the CAPA Module of Q-Pulse.
4.7 ADVISORY SERVICES

Information for users and patients (E1)

Information for service users, such as sample requirements, clinical limitations of specific tests and frequency of performing specific tests is made available for all users via the Peterborough pathology website at:

http://www.pch-pathlab.com/cms/

Patient information sheets follow the Trust Standard documentation. All patient information sheets are assessed and approved by the Trust Reading Group prior to release for use. This group includes patient representatives.

The laboratory LIMS is set to screen certain analytes, producing alert messages denoting items that require further action.

Interpretative reports and clinical advice are the responsibility of the Pathologists, Clinical Scientists and competent Biomedical Scientists. Such staff are always available to discuss results with clinical colleagues. Advice on individual clinical cases or in terms of obtaining professional judgement on specific results can be obtained by contacting the laboratory results enquiry line (01733 678468).

Clinical staff are also available to assist users to obtain the most effective utilisation of the laboratory service. Laboratory staff are also able to offer advice to assist with the correction of specific problems that may be experienced by users, such as instances of sample rejection due to a failure to meet laboratory acceptance criteria.

4.8 RESOLUTION OF COMPLAINTS

Complaints are handled centrally by the Trust Complaints Office. They are disseminated via General Managers for departmental investigation.

Where a person wishes to complain they may make the complaint to the complaints manager or any other member of staff. A complaint may be made orally or in writing (including electronically) and where it is made orally, the complaints manager must make a written record of the complaint which includes the name of the complaint, the subject matter of the complaint and the date which it was made. When the complaint is made in writing the complaints manager must make a written record of the date on which it was received.

Where the complaint is made in writing it will be treated as being made on the date on which it was received by the complaints manager.

The Trust has a generic form that staff should complete when taking the details of a verbal formal complaint. This is available as Appendix 1 of the Trust’s Complaint Policy available via SharePoint.
The full procedures for this standard are detailed in Trust Complaint Policy available via SharePoint.

The laboratory investigates all complaints received from clients or other parties and any anomalies identified relating to the laboratory’s accredited activities. A Q-Pulse CA/PA record is generated of any such complaints or anomalies and of any actions taken by the laboratory in response.

For anomalies that arise due to kit or equipment failure, the Trust Medical Devices Group is notified and if appropriate a Generic Technical Problem Report shall be completed and sent and discussed with the Medicines and Healthcare products Regulatory Agency (MHRA).

http://www.mhra.gov.uk/index.htm

Records of dealing with complaints and anomalies are dealt with locally but held centrally by the Trust.

All complaints are reviewed at the laboratory management review meeting.

4.9 IDENTIFICATION AND CONTROL OF NONCONFORMITIES

For further details on this standard see the Evaluation & Quality Assurance SOP (GEN-QP-EvalQA) and the Quality Improvement SOP (GEN-QP-QImprovement) via Q-Pulse

The procedure details the following:

a) responsibility and authority for the management of nonconformities
b) the remedial actions to be taken
c) suspension of examinations and withholding of reports
d) assessment of the medical significance of any nonconforming examination and where appropriate notification to the requesting clinician
e) consideration of whether the results of any nonconforming examinations already released are recalled or appropriately identified, as necessary
f) who has the responsibility for authorisation of the resumption of examinations
g) the documenting and periodic review of nonconformities by laboratory management to detect trends and initiate corrective action.

4.10 CORRECTIVE ACTION

For further details on this standard see the Evaluation & Quality Assurance SOP (GEN-QP-EvalQA) and the Quality Improvement SOP (GEN-QP-QImprovement) via Q-Pulse

Corrective actions are undertaken for all incidents recorded using the Trust Datix system. The systems and procedures used by the Pathology Department to identify
and control non-conformities, as described in section 4.9, ensure where appropriate an investigative process to determine the cause of the problem is in place. The nature of the corrective action depends on the classification of the non-conformity and on the magnitude of the risk to the patient.

Where corrective action proposes change, then such change is authorised as per the requirements of the change control procedure (see SOP GEN-QP-ChangeCtrl).

Procedures for corrective action include investigation and documentation of the causes of non-conformances. Laboratory Management ensure by review that corrective actions taken are effective by periodic review of the incidents and by trend analysis. Such reviews are incorporated into the monthly Quality Forum and the annual management review meeting.

Where the identification and investigation of non-conformances or the corrective actions performed therein implies non-compliance with the stated policies and procedures of the Quality Officer for that department may instigate a quality audit of the appropriate area or activity. The results of such audits are part of the quality management system review.

4.11 PREVENTATIVE (PREVENTIVE) ACTION

For further details on this sub-clause see the Quality Improvement SOP (GEN-QP-QImprovement) via Q-Pulse

Preventative actions are firmly embedded within the QMS. Examples include:

System:
- Training
- Risk Assessment
- H&S inspection
- Performance of quality audits and the actioning of recommended findings (previously observations) arising from these audits.
- Equipment maintenance & Calibration
- Internal QC & QA
- Interlaboratory comparison programme data (EQA)
- Communication meetings
- Checklists – e.g. for equipment procurement to ensure that all required records are satisfactorily updated when a new piece of equipment is purchased.

The purpose of the above processes is to promote experiential learning amongst staff.

The outcomes of internal audits, preventative and corrective actions, are communicated to staff in order to encourage staff to consider other initiatives and seek opportunities for further preventive actions.
4.12 CONTINUAL IMPROVEMENT

All standard operating procedures are reviewed regularly as per the requirements of the *Preparation and Control of Documents* SOP (see GEN-QP-DocCtrl) in order to ensure the accuracy of the content and also as an opportunity to identify potential sources of improvement in Quality Management or Technical Practices. All suggested changes are logged via the Change request facility within the Q-Pulse Document Module.

Actions taken to improve the quality of service are periodically reviewed for effectiveness. Such reviews include monitoring the levels of non-conformances traceable to the area or activity the quality improvement action is associated with.

The Laboratory has produced a number of performance indicators, which are used to monitor the Laboratory’s contribution to patient care and also to indicate future quality objectives and performance improvements.

User feedback is also obtained on a regular basis with any opportunities for improvement stemming from these surveys explored to ensure that the service is responsive to user needs and requirements.

The Laboratory is also committed to ensuring that staff feel suitably empowered to make suggestions for quality improvement – they can make these suggestions via departmental meetings, in one to one discussions with senior staff or by raising a ‘change control’ request via the Q-Pulse CAPA Module.

4.13 CONTROL OF RECORDS

The Laboratory aims to comply with the national guidance document *The retention and storage of pathological records and specimens* as co-authored by the Royal College of Pathologists (RCPath) and the Institute of Biomedical Science (IBMS).

The storage facilities for these records provide a suitable environment so that access is restricted and so that loss due to damage or deterioration is minimised.

Please refer to the Laboratory’s *Control of Process and Quality Records* SOP (ref: GEN-QP-QARecs) for further details of the documents that are retained and their specific retention periods.

The list of approved suppliers available to the laboratory is maintained via the Suppliers Module of Q-Pulse.
4.14 EVALUATION AND AUDITS


A programme of audits is created annually within each department that aims to audit the pre-examination, examination and post-examination processes.

The Laboratory uses internal audit to provide evidence that the QMS is conformed to, effective, implemented and maintained across all Departments. The Quality Forum has introduced a rolling series of horizontal audits which are used to assess departmental compliance with each of the ISO 15189:2012 sub-clauses. Assessment audit tool template documents have been devised and are available via Q-Pulse.

The effectiveness of preventative actions, corrective actions and subsequent improvements resulting from these audits is evaluated and monitored as part of management review.

4.14.2. Periodic review of requests and suitability of procedures and sample requirements

Audits of the laboratory’s test repertoire occur periodically to ensure that the tests offered remain clinically appropriate for users and the local population. These audits require suitable consideration of sample volumes, the collection devices used and any preservative requirements to ensure optimal sample collection and preservation of the sample measurand.
4.14.3. Assessment of user feedback

Regular forums exist for discussion with service users via Multi-disciplinary Team meetings (MDTs), formal contract review meetings, Hospital Transfusion Committee (HTC) and Human Tissue Authority (HTA) meetings. In addition, service user opinion is canvassed annually by means of user survey. Together these provide ample opportunity for users to offer feedback on the quality of service being provided and in addition provide opportunities to consider service improvement suggestions.

4.14.4. Staff suggestions

The Laboratory is committed to ensuring that staff feel suitably empowered to make suggestions for quality improvement – they can make these suggestions via departmental meetings, in one to one discussions with senior staff or directly to their departmental manager via the change control request template within the Q-Pulse CAPA Module.

4.14.5. Internal audit

The designated Quality Officers under the guidance of the Quality Manager decide upon the programme of audits to be carried out within their respective areas. Audit officers are required to familiarise themselves with the Laboratory's quality system and have received training in auditing techniques. Wherever possible auditors will be independent of the laboratory area being audited in order to provide objectivity and impartiality.

Nonconformities identified from these audits are recorded via the Q-Pulse CAPA Module. Root cause analysis of any identified nonconformities will be undertaken and agreed corrective or preventive actions will be recorded within these CAPA records.

For further details on the performance of audits please see the Laboratory Quality Audit Manual (ref: GEN-QP-AudMan) which is available via Q-Pulse.

4.14.6. Risk management

A comprehensive risk assessment process is in place which considers risk to service provision as well as to health and safety associated risks. Any significant or high risks are recorded via the Trust Risk Register with regular updates provided to Trust Management on any progress taken to mitigate these risks. Any audit findings which have a potential impact upon patient safety are prioritised for urgent action in order to mitigate this risk. Any corrective or preventative actions are recorded within the appropriate CAPA record on Q-Pulse.
4.14.7. Quality indicators
The laboratory has determined a number of quality indicators which are used to evaluate performance in pre-examination, examination and post-examination processes. The indicators include stated turnaround times for examinations which have been determined in discussion with service users.

For a description of the indicators currently in use please see the Quality Improvement SOP (ref: GEN-QP-QImprovement) via Q-Pulse.

These indicators are reviewed annually as part of the annual management review and updated accordingly and based upon user feedback. Feedback on performance of these indicators is also used to assist in the determination of laboratory quality objectives.

4.14.8. Reviews by external organizations
Any nonconformity identified following a review of the laboratory service undertaken by an external organization is recorded using the Q-Pulse CAPA Module and the resulting corrective actions recorded here as for other nonconformities that are identified within the QMS.
Currently the laboratory / host Trust is assessed by the following external organizations:

- Care Quality Commission (CQC)
- Health & Safety Executive (HSE)
- NHS Litigation Authority (NHSLA)
- Medicines and Healthcare products Regulatory Agency (MHRA)
- Human Tissue Authority
- United Kingdom Accreditation Service (UKAS)

Full details of the regulatory, accreditation and other approval bodies that the laboratory interacts with are contained within an appendix of this quality manual (Appendix 5) which is available via the Documents Module of Q-Pulse.

4.15 MANAGEMENT REVIEW
MGC reviews performance of the QMS on an annual basis as part of its formal Management Review (AMR).
During this the following elements are considered:

- the periodic review of requests, and suitability of procedures and sample requirements
- assessment of user feedback
- staff suggestions
- internal audits;
• risk management
• review of previously set quality objectives and setting of new objectives.
• use of quality indicators and the appropriateness of these in terms of assessing the laboratory's contribution to patient care.
• reviews by external organizations
• results of participation in inter-laboratory comparison programmes including EQA) performance.
• monitoring and resolution of complaints
• performance of suppliers
• identification and control of nonconformities including the causes of nonconformities and patterns or trends which highlight potential process problems.
• results of continual improvement including current status of corrective actions and preventative actions
• follow-up actions from previous management reviews;
• changes in the volume and scope of work, personnel, and premises that could affect the quality management system;
• recommendations for improvement to the quality management system, including the impact upon the quality policy, quality objectives and technical requirements.

• Review of on-going training and education programmes.

The findings of the AMR are formally documented and forwarded to Pathology MGC for formal ratification subsequent to publication within the Documents Module of Q-Pulse. The quality objectives generated as a result of the AMR and monitored via the Pathology Quality Forum.

5. TECHNICAL REQUIREMENTS

5.1 PERSONNEL
For further details on the laboratory's compliance with this standard please see the Personnel Management SOP (GEN-QP-PersonnelMgt) which is available via the documents module of Q-Pulse.
5.1.1. General

The Trust’s Human Resources (HR) Department has developed a comprehensive portfolio of procedures for personnel management. These policies are available to all staff on the Trust Intranet site. In addition the Cancer & Diagnostics Directorate to which pathology belongs also has its own designated Human Resources Business Partner (formerly HR Manager) and HR Advisor who provide support and advise on HR matters.

5.1.2. Personnel qualifications

The Laboratory has documented the personnel qualifications required for each employment grade – the details are contained within Personnel Management SOP which is available via the documents module of Q-Pulse.

In accordance with the Trust’s Professional Clinical Registration Policy (accessible via SharePoint) staff that are employed to grades where mandatory registration is required (e.g. registered nurse, doctors, clinical scientists and biomedical scientists) are required to provide documentary evidence of their registered status to the HR Department upon appointment. Evidence of continued registration status is then managed centrally by the Trust for medical and dental staff and for those bank or agency staff that are sourced using the Trust’s Flexible Staffing Service (FSS). For all other staff groups the process is managed at Directorate level.

Staff are aware that it is their responsibility to maintain their registered status and that a failure to do so will result in the Trust preventing them from undertaking any duties where registration is required and that the HR Department will be consulted regarding suitable action to be taken to address the lapse in registration.

5.1.3. Job descriptions

Each member of staff has a contract of employment and job description which detail their major responsibilities and requirements.

The employee signs both of these records and the Pathology or Departmental Manager holds copies in personnel files.

5.1.4. Personnel introduction to the organizational environment

In accordance with the Trust’s Induction Policy (available via SharePoint) it is a mandatory requirement that all staff that are new to the Trust attend for Trust induction.

The Trust induction programme is in 2 parts. Welcome to our Trust is a half-day session and is mandatory for all permanent staff to attend. It provides a high quality and comprehensive introduction to the NHS and the Trust. Sessions are run on a minimum of 1 per month to ensure it has taken place within an individual’s first month at the Trust. The second part is a work area local induction, a checklist for this must be
completed within the first 3 months of employment. The Departmental Manager or Training Officer must notify the Trust Learning & Development Department once the local induction has been completed.

All new members of staff undergo an induction programme appropriate to individual needs and designed to meet the following aims:

- To welcome staff into the laboratory and reduce the stress associated with commencing new employment
- To integrate employees into the laboratory quickly and efficiently
- To ensure staff understand the laboratory safety policies
- To ensure that staff are aware of and understand the Pathology QMS and their responsibilities associated with it.
- To give staff a clear understanding of their role and responsibilities
- To familiarise staff with personal and laboratory objectives
- To introduce existing staff to new personnel
- To identify immediate and future training needs

The Pathology Induction Manual (GEN-TRN-001) is available via Q-Pulse which details the information to be provided during the induction process.

Effective induction is the responsibility of the Departmental Head but the delivery of this is usually delegated to Departmental Training Officers. The Departmental Head signs the induction record sheets once they are satisfied that induction has been carried out satisfactorily. This is countersigned by recipients.

Departmental induction training normally occurs within the first few days at work. A programme is arranged with the Departmental training Officer in order to provide a smooth induction process. Trust induction is provided as soon as possible after the start date.

Supporting documentation is issued during the induction process and recorded on the induction record sheets. The Training Officer will meet with the new members of staff within the first month of induction to deal with any unresolved issues. Local and Trust Induction records are held in their staff competency record.

Specialist Registrars have a planned induction programme.
5.1.5. Training

This standard is fulfilled by the provision of the Pathology Training Policy Statement (GEN-TRN-PolStatement) and the Pathology Education Support Policy (GEN-TRN-Policy) (both are available via Q-Pulse).

Personnel that are undergoing training are supervised at all times

The PSM has overall responsibility for the delivery of all training undertaken in the laboratory. Departmental Training Officers are responsible for ensuring the existence of documented training programmes and liaison between professional bodies and local education providers. The effectiveness of the training programmes offered are reviewed as part of the departmental management reviews and following feedback from assessments undertaken by external agencies.

5.1.6. Competence assessment

All laboratory areas operate a system of competency assessment to provide evidence that staff have received suitable instruction and are suitably knowledgeable in the performance of procedures. These assessments are repeated at periodic intervals and during some in-house audits to ensure that the procedure is being performed to the appropriate standard and to check that the operator's knowledge remains current.

5.1.7. Reviews of staff performance

Laboratory management operates both an informal and formal responsive approach to individual staff needs. Staff can freely discuss their needs with senior laboratory staff on a day-to-day basis. This system is effective in dealing with immediate needs and this is supported by the Trust’s My Performance Appraisal (MPA) annual appraisal session.

An annual joint assessment is held between employees and line managers with the aim of identifying strengths and weaknesses, training needs, personal objectives for the year and facilitating actions to satisfy these needs. The Trust’s Appraisal & Development Policy is available via SharePoint. Annual appraisals take place between staff and line managers with at least yearly objectives being set. Copies of appraisal records are held in personnel files and a copy is provided to the member of staff. The Trust provides appraisal training for managers.

5.1.8. Continuing education and professional development

Details of staff training & education are available via the Pathology Training Policy Statement (GEN-TRN-PolStatement) and the Pathology education support policy (GEN-TRN-Policy). The Trust requires that all staff participate in continuing mandatory education for elements such as patient safety, fire safety, information governance, hand hygiene, child protection training, protection of vulnerable adults, equality and diversity awareness training and PREVENT training. Some of these
require update training on an annual or triennial basis. In addition, the laboratory provides programmes of on-going professional development that are all staff are given the opportunity to attend, a review of the effectiveness of these programmes is considered within the departmental management reviews.

5.1.9. Personnel records

Employee personal information in accordance with ISO 15189:2012 requirements is recorded in Personnel Files held by the Departmental Manager.

All staff have the right to examine personnel records of data kept by the Trust that refer to them. (See Trust policy on SharePoint Access to Personal Files.)

Some of the records listed within ISO section 5.1.9 and section B6.2 of the CPA standards may also be held by

- The Safety Officer
- The Occupational Health Department
- By staff in the workplace
- The Trust Fire Officer

5.2 ACCOMMODATION AND ENVIRONMENTAL CONDITIONS

5.2.1. General

The laboratory is organised to provide a safe working environment and to comply with appropriate Health and Safety legislation. All laboratory areas receive conditioned air as provided by the Hospital Building Management System in order to facilitate the correct operation of analysers.

The following specific functions are designated:

- Containment level 3 laboratory (see Containment Level 3 Manual, Microbiology)

PCH Access

All departmental staff and the designated cleaning and portering staff are allowed access to the laboratory.

All others (visiting maintenance personnel and other visitors to the department) are only allowed access following approval and must not be left unaccompanied.

Visiting Maintenance Personnel must report to Brookfield Multiplex Services and obtain permission to work prior to undertaking any work within the laboratory.
Visitors are expected to sign the visitor’s book on arrival and to wear a ‘Visitor’ badge whilst in the department. Anyone not following this procedure shall be challenged by a member of staff to determine the reason for their presence.

A security service is available for on call staff with the issue of Vocera wireless communication devices and, if necessary, personal Geonovo emergency devices.

Access to non-public areas at PCH is controlled by swipecard access doors. Pathology is situated on the fourth floor and access to all of the laboratory areas is also swipecard access controlled.

**Bereavement Centre**

Entrances to the PCH bereavement centre is via swipecard access only.

**Stamford Phlebotomy**

The entrance to the phlebotomy suite is kept locked at all times when staff are not in attendance.

**5.2.2. Laboratory and office facilities**

The facilities have been created with the express purpose of providing a suitable environment for the receipt, testing and reporting of patient samples.

The PCH access control system is designed to ensure that only staff with suitable authorisation are permitted unescorted access to laboratory areas. The physical laboratory has been designed to provide the correct environment for sample testing to take place and is compliant with local and national guidance and legislation for these type of facilities.

The facilities themselves have been designed to ensure provision of the following:

- adequate lighting
- adequate power supply (including contingency)
- adequate ventilation
- adequate water supply
- adequate waste disposal
- adequate staff communication systems (via VOIP telephone and Trust email systems)
- suitable safety systems (such as fire detection and alarm systems, fire-fighting equipment, emergency release door-mechanisms for cold-rooms, emergency drench showers and eyewash facilities)

**5.2.3. Storage facilities**

The storage of records complies with the *Guidelines for the Retention and Storage of Pathological Records, Archives and Specimens* published by the Royal College of Pathologists (RCPath), this is available via a link to the RCPath website via the Q-Pulse Documents Module (document reference GEN-EXT-001).
Haematology, Clinical Biochemistry and immunology request forms are stored for a minimum of 2 weeks within the laboratory area. This area is secure when the department is closed).

Blood Transfusion Records are stored for 30 years minimum, initially in the ‘Blood Transfusion Records’ room within the laboratory (room reference 4.PAT.095) and at a later date the oldest of these will be transferred to the Trust’s Health Records and Archived Document Storage (HRADS) facility which is located on the Westwood Farm Holdings industrial estate approximately 250 metres from the PCH site.

Andrology slides up to one year old are retained within the laboratory. Older slides are stored at a local remote storage facility and are retained for up to 30 years. Immunology clinical information, worksheets etc are kept for up to 2 years on-site and are then transferred to the local remote storage facility where they are retained for up to 30 years.

Histology retain recent block and slide cases within the department and at the HRAD building.

Microbiology records are stored on a six-month rolling basis within the department with selected records where there is a clinical indication e.g. HIV records stored for a duration guided by clinical indication. All storage rooms within the department are secure. Records requiring longer term storage are transferred to the HRAD facility.

These storage facilities comply with Caldicott Principles, Information Governance and the Data Protection Act

The storage of clinical samples is always kept separate from those materials used in testing in order to reduce the possibility of cross-contamination.

The bulk storage of flammable liquids and gases is via facilities situated outside of the main PCH building. Quantities of flammable liquids required for daily use within laboratories are kept inside purpose designed metal flammable store cabinets and are returned to these units for temporary storage. Waste flammable liquids are also stored temporarily in these cabinets until they can be transported by Soft FM staff to the external store. Waste flammable liquids are only removed from the Trust site using approved and licensed waste consignors.

The following storage facilities are also provided:

- Refrigerators (4°C) for clinical samples
- Cold rooms (4°C) for storage of kits and reagents
- -20°C and -80°C storage for samples, cultures and reagents
- Room temperature storage in locked stores
• Hazardous substances are segregated according to their classification either in the lockable flammables store and, laboratory flammables cabinets or poisons cabinet.

• Separate storage for blood and blood products is provided which comply with specific regulation for this material.

• Reagents, calibrators and quality control material are stored in appropriate conditions according to instructions

All freezers and refrigerators are temperature monitored and records retained

5.2.4. Staff facilities

The laboratory sites provide adequate staff toilet facilities and basic catering facilities within a separate rest room area. Full canteen facilities are also available on the site. The laboratory is provided with:

• Areas for hanging laboratory coats
• Storage area for clean laboratory coats
• Lockers for staff to store personal belongings
• Wash hand basin facilities
• Shower facilities
• A meeting room for meetings / seminars.
• A quiet room for interviews and study.

5.2.5. Patient sample collection facilities

There is full patient access to Phlebotomy at Stamford including disabled access. The waiting area is separate from the phlebotomy room where samples are procured. Within the phlebotomy room each phlebotomy station is segregated off so that patients are afforded suitable privacy. Access to toilet facilities and also to emergency first-aid if required is provided via the Out-Patients Department which is situated very close to the phlebotomy facility.

The sample collection facility used for blood samples (Sarstedt-Monovette) has been selected due to its superior sample collection performance, high level of patient comfort during the procedure and its lack of adverse effect on the quality of result produced following testing.
5.2.6. Facility maintenance and environmental conditions

Staff are required to maintain good housekeeping throughout the laboratory at all times. The environment is required to be kept clean and tidy, in a manner that is compatible with the level of safety required for the operation of a laboratory handling samples for biological examination.

The laboratory requires the monitoring, recording and control of environmental conditions wherever they may impact upon the quality of the result obtained. Where the data from such recording are out of specification and there is an impact on the quality of the product or service provided then a nonconformity is raised via the Q-Pulse CAPA Module and any necessary corrective actions taken.

Quiet environments are provided in certain laboratory areas e.g. histology dissection room and cytology screening room so that the quality of work generated within these areas is not unduly affected by background noise or frequent interruptions.

5.3 LABORATORY EQUIPMENT, REAGENTS AND CONSUMABLES

5.3.1. Equipment

The selection and purchase of laboratory equipment is governed by the Procurement of Pathology Equipment SOP (GEN-MP-EqpProc) which is available via the Documents Module of Q-Pulse.

Laboratory Management aims to ensure that the necessary resources are available through capital and material budgetary submissions. Only equipment fit for its intended purpose is used by the Pathology Department including equipment used for point of care testing.

The laboratory submits periodic requests for equipment replacement to the Trust Investment Appraisal Group in order to ensure that systems are kept up to date and prior to service quality being impaired due to poor performance. Increasingly the laboratory is obtaining major equipment as part of a Managed Equipment Service (MES) – as part of this there is a commitment from the supplier to provide on-going software and hardware safety enhancements and at year 5 to discuss technology upgrades / refreshment.

Before new electrical equipment is put into routine use it is suitably electrically safety tested by Asteral or Brookfield Multiplex as per Trust requirements. The equipment will then undergo checking to verify that it is achieving the required performance in accordance with the Validation Overview SOP (GEN-QP-Validation) which is available via Q-Pulse. Individual laboratory departments have more detailed procedures covering this requirement. The records of equipment verification are kept within individual departmental records or on the Asset Module of Q-Pulse.

Individual equipment is uniquely labelled with the supplier’s serial number so that each can be definitively identified. Manufacturer equipment operation manuals are held within laboratory departments.
After installation, full operator training is carried out either on site, at the instrument manufacturer’s premises or at another laboratory. All new instruments come with a minimum of one year’s parts and labour warranty. After this initial period, a service contract for preventative maintenance is set up.

Any item of equipment that suffers damage or that shows signs of malfunction, or that is shown by calibration or otherwise to be defective and unfit for use shall immediately be withdrawn from service and labelled accordingly. Alternative arrangements shall be made until the item has been repaired and re-calibrated as appropriate. All such actions are recorded in the equipment manual.

Laboratory staff are only permitted to use a particular item of equipment unsupervised when the appropriate senior member of staff has established that they are competent to do so. This is then documented accordingly in the individual’s training record.

A copy of competencies for staff in relation to equipment is kept as part of the individual’s Training Record. This is in three stages:

- Primary Training
- Competent to Use
- Basic Maintenance

An inventory of capital equipment is held within each pathology department or on the Q-Pulse Asset Module.

Individual laboratory departments have procedures for the calibration of equipment that may directly or indirectly affect patient examination results. These procedures have been designed to ensure that the following criteria have been considered:

- Conditions of use and the manufacturer’s instructions.
- A record of the metrological traceability of the calibration standard and the traceable calibration of the equipment
- Verification of the required measurement accuracy and the functioning of the measuring at defined intervals.
- Ensuring that, where correction factors are applied as a result of calibration, any previous calibration factors are suitably updated.
- Ensuring that staff are aware that subsequent tampering or adjustment may invalidate any examination results achieved.
- If required, metrological traceability shall be to a reference material or reference procedure of the higher metrological order available. Where this is
not possible or relevant, then other means for providing confidence in the results will be applied, for example:

- The use of certified reference materials
- Examination or calibration by another procedure
- Mutual consent standards or methods which are clearly established, specified, characterised and mutually agreed upon by all parties concerned.

Records of the calibration status of equipment and the date of recalibration are kept within individual departments or are available via the Asset Module of Q-Pulse.

All pipettes that may directly or indirectly affect patient results are traceably serviced & calibrated by an external agency on an annual basis. Only contractors that are accredited to ISO 17025 and whose listed scope (witnessed via their own certificated evidence or via the UKAS website) will be selected to carry out the work.

All centrifuges are serviced by an external agency on a 6 monthly basis. Where specific spin speeds are required for specific examination procedures then the centrifuge spin speed will be traceably calibrated by an external agency whose listed scope (witnessed via their own certificated evidence or via the UKAS website) demonstrates that they are accredited to undertake this work in accordance with ISO 17025 accreditation requirements. All thermometers are calibrated against a metrologically certified reference thermometer upon acquisition and, as a minimum, on an annual basis thereafter.

All Blood Bank alarms at PCH are monitored by Brookfield Multiplex and by the Estates Department at Stamford. In addition, all of the Trust blood-banks are monitored using the Tutela system – further details are available at: http://www.tutelamedical.com/applications/blood-plasma-tissue

Records of maintenance and equipment failure are kept in the equipment inventory file kept locally within the department or on Q-Pulse. Files contain a full history of the piece of equipment and include copies of operator instructions, their unique identification, location, maintenance and monitoring record sheets. Details of technical characteristics may be found in either the manufacturers manuals or supporting in-house documented procedures.

Any defective equipment is immediately withdrawn from service and clearly labelled to show that it must not be used. Checks are made to assess if the defective equipment has had any impact upon examinations undertaken prior to the defect being discovered. If so, suitable remedial and corrective actions are undertaken. Upon suitable repair of the equipment verification checks will be made to ensure that it is working within the specified acceptance criteria prior to return to routine use.

A Declaration of Contamination Status form must be completed prior to an engineer commencing work on any equipment. This is contained as Appendix 3 within the
**Policy for decontamination (cleaning, disinfection and sterilisation) of re-usable medical devices and equipment** which can be accessed at: [http://sharepoint01/General/Document%20Library/Decontamination%20of%20Reusable%20Medical%20Devices.pdf](http://sharepoint01/General/Document%20Library/Decontamination%20of%20Reusable%20Medical%20Devices.pdf)

Adverse incidents associated with the use of equipment are recorded as nonconformities using the CAPA Module of Q-Pulse and these are assessed periodically for trends. In addition, any equipment failures which have resulted in the generation of incorrect results will also be logged via the Trust Datix adverse event reporting system. A serious equipment failure or trends that indicate equipment issues will be alerted to the equipment supplier and also to MHRA or HSE if necessary.

Records for equipment that contributes to the performance of examinations are kept within individual departments or on the Asset Module of Q-Pulse. As a minimum these records detail the following:

- Identity of the equipment.
- The manufacturer’s name, model and serial number or other unique identifier.
- Contact information for the equipment supplier
- Date of receipt into the laboratory and the date the equipment entered into use.
- Details of where the equipment is located within the laboratory.
- Equipment condition when received, i.e. new, used or reconditioned.
- Manufacturer’s instructions
- Records that confirm the equipment’s initial acceptability for use.
- Maintenance record including any preventative maintenance performed.
- Performance records that confirm the equipment’s ongoing acceptability for use. This must include:
  - Copies of calibration reports / certificates.
  - Verification data including dates, times and results.
  - Adjustments made.
  - Acceptance criteria
  - Date of next calibration and / or verification.
- Record of any damage, malfunction, modification or repair.
These records are held indefinitely within Q-Pulse or, as a minimum, with the times stated within the Control of Records SOP (see GEN-QP-QARecs via Q-Pulse).

5.3.2. Reagents and consumables

The selection and purchase of laboratory services and supplies is governed by the Procurement of services and supplies SOP (ref: GEN-MP-SuppliesProcure) which is available via the Documents Module of Q-Pulse. Further details of the receipt, storage, acceptance testing (where relevant), inventory management and issue of consumables and reagents and verification of identity and condition are detailed within individual departmental SOPs and are in accordance with the Trust non-stock Requisition Policy that also includes procedures for Receipt and returns. For further details consult the Trust Standing Financial Instructions (available via SharePoint).

The laboratory will use outside services and supplies of adequate quality to sustain confidence in the laboratory's test results. When purchasing services such as calibration then preference will be given to suppliers who are listed as being in compliance with the accreditation requirements of ISO 17025 for the scope of calibration required. All commercially sourced goods, kits and reagents will be CE marked wherever possible.

The laboratory will determine the status of any new outside services and supplies that it employs. Where no independent assurance of the quality of support services or supplies is available, necessary validatory checks, calibrations or other actions shall be carried out as appropriate, to ensure that purchased goods comply with specified requirements.

Reagents and consumables are stored according to manufactures’ descriptions and the details of batch numbers (where present) are recorded. On major instrumentation on-board systems record the data for quality control reagents automatically.

Handling and storage precautions are assessed using the COSHH procedure. The Trust uses the SYPOL system which requires completion of a Chemical Exposure Scenario (CARQ) Form (available here via SharePoint). This works in conjunction with a workplace risk assessment.

New lots or shipments of examination kits, or new formulations of kits which have a change in reagent or procedure are verified for performance before they are used for patient samples. A similar approach is adopted for changes in consumables that may affect the quality of examinations.

Each laboratory department utilises its own system of inventory control for reagents and consumables. Any uninspected or unacceptable items are kept separately from those that have been deemed acceptable for use. Instructions for the use of reagents and consumables are available via Q-Pulse or via hard-copy laboratory method SOPs.
Adverse incidents associated with the use of specific reagents or consumables are recorded as nonconformities using the CAPA Module of Q-Pulse and these are assessed periodically for trends. In addition, any failures which have resulted in the generation of incorrect results will also be logged via the Trust Datix adverse event reporting system. A serious failure or trends that indicate persistent quality issues will be alerted to the equipment supplier and also to MHRA or HSE if necessary.

Records of reagents and consumables that contribute to the performance of examinations are kept within the individual laboratory departments. These record include the following: (5.3.2.7):

- Name of the reagent or consumable.
- Manufacturer’s name and batch code or lot number.
- Contact details for the item supplier
- Date of receipt
- Date of expiry (if applicable)
- Date entered into service.
- Date material was taken out of service (if applicable)
- Condition when received (e.g. acceptable or damaged)
- Manufacturer’s instructions (if applicable)
- Records of confirmation of acceptance for use.
- Records that confirm the reagent’s or consumable’s on-going acceptance for use.
- For in-house preparations – details of the person undertaking the preparation and the date of preparation.

5.4 PRE-EXAMINATION PROCESSES

Information for patients and users

The laboratory has produced comprehensive information for its patients and service users. This information is accessible via the following Uniform Resource Locator (URL):

http://www.pch-pathlab.com/cms/

As a minimum, this information includes:

- Location of the laboratory.
• Types of clinical service provided, including the examinations referred to other laboratories.

• The laboratory service hours.

• Range of examinations offered by the laboratory. This includes:
  o Sample requirements
  o Primary sample volumes
  o Result turnaround times
  o Biological reference intervals
  o Clinical decision values.
  o Any special precautions.

• Instructions for suitable completion of request forms

• Instructions for preparation of the patient

• Instructions for samples collected by patients – these patient information leaflets are provided by the Trust’s document library facility.

• Sample transport instructions – including any special handling needs (e.g. for andrology samples).

• Requirements for patient consent (if required)

• Criteria for the acceptance and rejection of samples.

• Factors known to significantly affect the performance of the examination or the interpretation of the results.

• Availability of clinical advice on ordering examinations and on the interpretation of results.

• Laboratory’s policy on the protection of personal information (Trust Information Governance Policy)

• Laboratory’s complaint procedure (Trust complaints procedure)

**Request form information**

Request forms are designed to provide all relevant information required to provide a safe and meaningful report including clinical advice and to satisfy internal audit requirements.

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The master copy and approval record for this document is contained within Q-Pulse.
If printed, this is a controlled document ONLY if printed on pink paper and shown within the distribution list.
The laboratory's request form requires the following information to be provided:

- Patient identification. This includes:
  - Patient name
  - Gender
  - Date of birth
  - Unique identifier (e.g. Hospital DIS number, or NHS Number)
- Patient location details.
- Name of the requesting clinician.
- Result destination and contact details.
- Type of primary sample
- Anatomic site of origin, where relevant (e.g. within histopathology)
- Instructions for suitable completion of request forms
- Examinations requested.
- Clinically relevant patient information (e.g. patient's family history, travel and exposure history, communicable diseases).
- Date and (where relevant), the time of primary sample collection.
- Date and time of sample receipt.

Requests for laboratory investigation are produced using the Sunquest Integrated Clinical Environment (ICE) Order Communications Module. This facility allows users to be able to view all of a patient's results irrespective of whether they have been requested within the Trust or by GP. For service continuity purposes, should access to the ICE system be unavailable then separate departmental manual request forms are in use for haematology and blood transfusion, biochemistry and immunology, microbiology, cervical cytology and histopathology and non-gynaecological cytology investigations.

In addition, urgent tests can be requested verbally but these must then be confirmed by an electronic ICE request.

If information on a form provided by a user is unclear or incomplete, a call will be made to the user (if possible to identify) to clarify the situation before completing the examination.
Primary sample collection and handling

This is covered within the *Specimen Information* section of the Pathology User information web pages at: [http://www.pch-pathlab.com/cms/](http://www.pch-pathlab.com/cms/)

The information includes instructions on the processes to be followed prior to and during sample collection including the requirements for suitable storage of sample containers prior to use.

The sample collection procedures require that suitable checks are made to establish and confirm the identity of the patient, the labelling requirements to ensure acceptance by the laboratory, storage of procured samples prior to sample transport and the safe disposal of materials used during the sample collection process.

Sample transportation

This is covered in the Transportation Section of the Pathology User Information web pages. Copies of this document have been provided to Medirest who manage the hospital portering team, and to Sodexo and CitySprint Couriers who are contracted to transport pathology samples between the GP practices and PCH.

All pathology samples being transported by road are sealed within a triple layer system with an external rigid container in compliance with UN 3373 requirements.

All GP practices receive at least two sample collections per day – usually aimed towards the end of the morning and afternoon to maximise the samples collected but also to ensure that the integrity of the samples is not impaired due to prolonged storage following procurement. SRH and North Cambridgeshire Hospital (Wisbech) receive three collections due to the volume of samples being procured from these sites.

Sample reception

Procedures for this are detailed within specimen reception SOPs for each laboratory department. In addition, departmental SOPs also detail the criteria required for samples to be accepted for testing by the laboratory and what actions are to be taken for those samples that are rejected for testing. Periodic audits are undertaken to ensure that the laboratory’s criteria for sample acceptance and rejection are being adhered to. For samples that do not match the acceptance criteria but are clinically critical or are irreplaceable testing may be undertaken but all results will be issued with an alert indicating the nature of the problem and advising that necessary caution must be applied.

Bar codes or individual laboratory numbers are used for labelling request forms and specimens. All specimens, accompanying request forms and supporting documentation are uniquely identified throughout all stages of investigation by means of the unique laboratory number.
The patient, physician and examination related information on the request form and details of specimens received are entered onto the Laboratory Information Management System (LIMS) – CSC i.laboratory-TP (Telepath). For anonymised patients (e.g. from Department Of Sexual Health), the system accepts a number instead of a name.

Within cellular pathology, all sample requests are date and time stamped upon receipt within the laboratory. For all other disciplines this information is not routinely collected but periodic audits are conducted within these areas and these data indicate that the time delay encountered does not materially affect the quality of result generated following testing. The entry onto the LIMS system is automatically dated and timed as is the details of the operator undertaking the sample and request registration.

The following utilities are available to reduce errors:

- Hospital patient details are registered against the hospital DIS number to enable patient demographics to be called up.
- The DIS number is used to access stored patient demographics. (Haematology, Clinical Chemistry, Immunology & Microbiology)
- Cellular Pathology uses a Date of Birth search ('K' search on i.Lab-TP) to search for patients.

The procedures for specimen identification, Specimen rejection, Urgent Specimens and Medico legal specimens are all described in Departmental specific SOPs held on Q-Pulse

For additional information please consult the following laboratory departmental protocols:

Specimen reception

Sample acceptance/rejection (including unlabelled specimens)

Dealing with urgent requests for examinations.

Danger of Infection specimens

Sample breakage/spillage

Dealing with leaking or broken specimens is also described in the Pathology H&S Manual (ref: HS-H&S-Manual).

Pre-examination handling, preparation and storage

All samples received are stored within the laboratory in compliance with departmental procedures. These procedures are designed to ensure that samples
are stored securely and that sample damage, loss or deterioration during pre-examination activities, preparation and storage are minimised.

Time limits for requesting additional or further examinations on already received samples are contained within individual SOPs and also provided to users via the Specimen Information section of the Pathology User information web pages at: http://www.pch-pathlab.com/cms/

5.5 EXAMINATION PROCESSES

5.5.1. Selection, verification and validation of examination procedures

The laboratory only uses examination procedures which have been verified or validated for their intended use.

Prior to validation a set of performance requirements are established based upon the intended use for that examination.

Preference is given to examination procedures based upon:

- Instructions provided for use in in vitro medical devices
- Methods published in established / authoritative text-books, peer-reviewed texts or journals, or nationally or regionally agreed methods.
- In-house evaluation data
- Advice from reference laboratory evaluations
- Selection of well-established techniques in use in other laboratories

SOPs with common usage are agreed between departments.

Changes to procedures that may affect testing protocols or result interpretation are notified to all users of the service in advance of any change.

Where examination procedures are being used without deviation from the manufacturer’s requirements then the laboratory will independently verify the manufacturer’s validation performance characteristics prior to introducing the procedure into routine use.

For the following examination procedures:
- Non-standard methods
- Laboratory designed or developed methods
- Standard methods used outside of their intended scope
- Validated methods that are subsequently modified

The laboratory will extensively validate the procedure to ensure that the intended use of this examination has been fulfilled.
For both verification and validation the laboratory will keep extensive records of the testing procedures employed, contemporaneous evidence of the results achieved and evidence of suitable review and acceptance of the data generated.

Testing will be undertaken in accordance with the principles stated within the laboratory’s Validation Overview SOP (GEN-QP-Validation) which is available via Q-Pulse and the more detailed validation procedures held by individual laboratory departments.

For measured quantity values the laboratory will determine the measurement uncertainty for each examination procedure, will regularly review the estimates for this and aim to minimise the impact of this wherever possible.

The laboratory’s estimates of measurement uncertainty can be made available to service users upon direct request to the Pathology Quality Manager.

Further details of measurement uncertainty are contained within individual departmental SOPs for this which are available via the Documents Module of Q-Pulse.

Validation or verification files are generated for examination procedures. Historically these files have been retained within individual departments but new validations / verifications are now stored on the documents module of Q-Pulse for manual methods and the appropriate asset record of Q-Pulse for automated methods.

As a minimum these files contain the following:-

- Method Change Control Record Log
- Plan for validation / verification of the test method
- Test method verification data and approvals
- LIMS forms and documentation (as applicable):
  - Copy of test / profile change form
  - Copy of new code request form
  - LIMS enquiry reports, including calculations (if appropriate) and any coded text expansions.
  - Sample report printouts.
  - Confirmation that test result correctly shown (including reference ranges) on i.Lab-TP, Sunquest and remote systems
- Support documentation for stated reference ranges and clinical alert values if appropriate.
- Method summary report sheet including consideration of uncertainty of measurement.
- Manufacturer’s product inset / method sheet
- Details of any correspondence to service users
5.5.2. Biological reference intervals or clinical decision values

Wherever applicable, biological reference intervals have been calculated for examination procedures and made available to service users via the Specimen Information section of the Pathology User information web pages at: http://www.pch-pathlab.com/cms/

Biological reference intervals are periodically reviewed (by laboratory staff in liaison with the clinical head of that laboratory department) with respect to:

- Appropriateness to the population served.
- Changes in pre-examination procedures
- Changes in examination procedures

5.5.3. Documentation of examination procedures

A master copy of all SOPs as ‘read only’ is held centrally on Q-Pulse. Controlled hard-copies are issued to named individuals on pink paper. Records of all copies and their electronic distribution within the laboratory are held on Q-Pulse. Staff listed on the electronic distribution are required to electronically acknowledge that they are aware and have read the contents of the document.

A master list of documents for all pathology areas is held on Q-Pulse.

An SOP template is available via Q-Pulse to guide authors. Main headings are shown below and are selected for inclusion as appropriate to the examination procedure.

**TABLE OF CONTENT**

1. PURPOSE AND SCOPE
2. RESPONSIBILITIES
3. REFERENCES
4. DEFINITIONS
5. RELATED DOCUMENTS

The master copy and approval record for this document is contained within Q-Pulse. If printed, this is a controlled document ONLY if printed on pink paper and shown within the distribution list.
5.1 HEALTH AND SAFETY INFORMATION/INSTRUCTION

5.2 RISK SUMMARY

5.3 QUALITY CONTROL

5.4 EQUIPMENT AND SUPPLIERS

5.5 REAGENTS AND CONSUMABLES

5.6 USEFUL INFORMATION

6. ACTIONS AND METHODS

To include (as applicable):

- Calibration procedures
- Procedural steps
- Interferences / cross-reactions
- Principle of procedure for calculating results, including, where relevant, the measurement uncertainty of measured quantity values.
- Biological reference intervals
- Reportable interval of examination results.
- Alert / critical values.

(reference should also be sought from the RCPath advice document Out-of-hours reporting of laboratory results requiring urgent clinical action to primary care)

- Laboratory clinical interpretation
- Potential sources of variation

If there is a planned change to an examination procedure and the change will produce results or interpretation that are significantly different to the procedure they are due to replace then information on this change will be provided to service users prior to the changeover once the procedure has been suitably validated.
5.6 ENSURING QUALITY OF EXAMINATION RESULTS

5.6.1. General
The laboratory aims to ensure the quality of its examinations be performing them under suitably controlled conditions. This aim is supported by:

- A comprehensive quality control approach to pre-testing, testing and post testing processes.
- The approach to quality control is based on principles of in-process QC checks.
- As well as controlling the tests the key inputs to each process will be reviewed and signed off on a daily basis.

The details of each laboratory’s Quality Assurance programme may be found in the departmental SOPs on Quality Assurance and individual Method SOPs.

5.6.2. Quality control
The laboratory aims to select, wherever possible, quality control materials that will react in a manner as close as possible to patient samples. QC materials are periodically reviewed to ensure that they continue to offer a reliable indicator to examination procedure performance and thereby minimise the risk of production of erroneous patient results. Wherever possible, independently sourced third-party QC materials are used in order to reduce the possibility of bias associated with the use of reagents supplied by the system manufacturer.

Individual laboratory procedures exist to indicate the actions to take to prevent the release of patient results following a failure of QC. The process also details the actions to take regarding the re-examination of patient samples following QC rule violations, including the need to assess samples that have been examined since the last successful QC test.

QC data are also reviewed periodically in order to identify trends that may indicate deterioration in examination procedure performance so that suitable corrective action can be initiated. Trends noted in this way and the subsequent actions are recorded via the CAPA Module of Q-Pulse.

5.6.3. Interlaboratory comparisons
The laboratory aims to participate in third-party external quality assessment (EQA) schemes relevant to the testing repertoire undertaken. Wherever possible, preference is given to EQA schemes that have been assessed against ISO 17043 or to CPA Standards incorporating International Laboratory Accreditation Cooperation (ILAC) Guidance 13 and have been subsequently accredited by CPA / UKAS.

Where formal inter-laboratory comparison schemes are not available then the laboratory aims to provide objective evidence for the acceptability of examination results via a number of means, including the use of certified reference material, re-
assessment of samples previously examined and exchange of samples with other laboratories.

Results are either displayed on the laboratory notice board in numerical and graphical format or recorded on Q-Pulse and distributed to all staff to acknowledge.

Results are distributed to all departmental senior members of staff and are discussed at the Departmental Staff Meetings. The Pathology Quality Forum is informed via departmental reports of any unresolved issues.

All inter-laboratory poor performance is recorded as nonconformities within the CA/PA Module of Q-Pulse together with a description of the corrective actions taken to reduce the possibility of recurrence.

Full details of the quality assurance schemes that the laboratory currently participates in are available as an appendix of the quality manual (Appendix 6) which can be accessed via the Documents Module of Q-Pulse.

5.7 POST-EXAMINATION PROCESSES

5.7.1. Review of results

All reports undergo a data system check (manual or/and computerised) before issue governed by user defined rules. In biochemistry, most results on NPCL lists (e.g. endocrine and DFTs) are usually authorised by BMS staff using pre-defined criteria initiated by the Consultant Chemical Pathologist and issued to users. Other abnormal results (e.g. U/E) on NPCL are phoned and released exclusively by BMS staff on a 24/7 basis. All other significant positive results are authorised by medical or clinical scientist staff. Certain negative results, selected by the computer using approved, predefined rules, are printed without medical authorisation.

5.7.2. Storage, retention and disposal of clinical samples

The control of clinical material is described in the SOP Control of Clinical material (GEN-QP-ClnMrtrl) which is available via the Documents Module of Q-Pulse. This procedure fully describes how samples are indexed, stored and disposed of in accordance with regulations and national guidance. Retention periods are in accord with Guidelines for the Retention and Storage of Pathological Records, Archives and Specimens (Q-Pulse ref: GEN-EXT-001) which is co-authored by the Royal College of Pathologists and the Institute of Biomedical Science.

5.8 REPORTING OF RESULTS

Examination procedures provide details of specific reporting requirements. The laboratory issues reports electronically via the Sunquest ICE system. Some users still require us to provide them with additional hard-copy versions of these reports.

In addition, additional supplementary reports are issued following the receipt of reference laboratory results. Where a report delay is thought likely to potentially
compromise patient care an interim result may be offered so that service users are fully aware of the progress being made.

Periodic audits are undertaken to check the accuracy of results that are manually transcribed and also to check the accuracy of electronic results received by service users.

Laboratory reports are formulated to include at least the following data items:

- Name of the PSHFT laboratory issuing the report
- Identification of any tests undertaken by a referral laboratory
- Patient identification on each page of the report.
- Identification of the requester and the requester's location
- Date of the primary sample and (where appropriate and relevant) the sample collection time.
- The type of primary sample received
- The measurement procedure utilised (if appropriate)
- Examination results reported in SI units, units traceable to SI units, or other applicable units.
- Biological reference intervals (if appropriate)
- Result interpretation (if appropriate)
- Cautionary or explanatory notes
- Identification of the person reviewing the results and authorising the report release
- Date of report and time of release.
- Page number to total number of pages (e.g. Page 1 of 5, etc.)

5.9 RELEASE OF RESULTS

Individual laboratory departments hold departmental procedures which detail who may release results and the process to be followed. These procedures require suitable consideration of the following:

- Indication in the report if the quality of the primary sample received was unsuitable for examination or could have compromised the quality of the result generated.
- Checks to ensure that results are legible and without mistakes in transcription.
- If an examination result falls within established alert or critical values:
  - Has a physician (or other authorised health professional) been immediately notified?
  - Has a record of this action been made which details – the name of the person notified, details of the examination results conveyed, any difficulties encountered in making the notification and the name of the laboratory member who undertook the action?
- That checks are made to ensure that results are legible, without errors in transcription and that they have been made available only to those authorised to receive them.
• If results are distributed via telephone or some other electronic means then they are only provided to suitably authorised personnel. A record must be kept of all results issued via the telephone (details as shown above) and these must be followed up by the production of a formal written report.

5.9.1. Automated selection and reporting of results

The clinical biochemistry and haematology laboratory departments only currently use a system whereby some reports are selected for reporting automatically. In both areas there are specific protocols which cover how this process occurs.

The procedures consider:
• The criteria to be used for automated selection and reporting have been defined and approved by the clinical head of department.
• The criteria have been fully validated for proper functioning prior to use and are re-validated following system changes or at periodic intervals to ensure suitable functionality is maintained.
• All pertinent staff have been made aware of the procedure to be followed and the criteria to be used.
• The impact that sample interferences (e.g. haemolysis) may have upon the examination results.
• The process for incorporating analytical warning messages from instruments into the automated selection and reporting criteria.
• How results selected for automated reporting can be identified at the point of review, in advance of result release.
• How the process can be suspended rapidly if required.

5.9.2. Revised reports

In circumstances where it is found to be necessary to issue a supplementary report, a new test report is generated in accordance with the agreed departmental SOP. This revised report will make reference to the date and patient identity within the original report. If it is necessary to amend a result, a comment is attached to the result indicating that the result has been amended. If a significant anomaly is identified, the user is contacted and notified of the discrepancy. The revised record on the LIMS indicates the date of the change and the name of the person taking responsibility for this change. The LIMS retains the original version of the report which can be subsequently accessed by those with suitable access rights if required.

Records of amended results are recorded on The CA/PA Module of Q-Pulse together with an indication of the action taken to reduce the possibility of a recurrence.

5.10 LABORATORY INFORMATION MANAGEMENT

Staff are aware that information that they have access to in the course of their duties, regarding patients, contracts and other work matters, must be considered confidential and should not be disclosed to others, except where the third party has need of this information to carry out their duties as an employee of the Trust. As a part of the Trust’s
Information Governance (IG) requirements all staff are required to undertake mandatory update training sessions on IG.

The laboratory operates in accordance with the Trust’s procedures for data security, storage, archive and retrieval of records, electronic passage to remote users and disposal of records.

Data held is subject to legislation under the Data Protection Act that makes it a criminal offence to misuse personal information held on a computer.

Under The Data Protection Act it is a criminal offence to "knowingly or recklessly obtain, disclose or transfer personal data" held on computer-based and paper-based (or manual) data records, and constrains the international movement of such data primarily to the countries of the EC. If these principles are breached, you may be personally liable for committing a criminal offence.

The Trust has stated that staff who have access to computerised personal information related to patients in the course of their employment must regard such information as strictly confidential. Failure to adhere to this policy will be regarded as serious misconduct and lead to disciplinary action, which may lead to dismissal.

The Trust has generated policies for information government and allied these to information leaflets which are all available via the Document Module of Q-Pulse. In addition the laboratory has produced polices for Patient Confidentiality and for the Management of Data and Information to reinforce these requirements for laboratory staff.

Staff are aware that it is a Trust requirement to keep passwords for access to a computer system secret, that they must not write them down anywhere or divulge them to anyone else. The systems prompt changes in Passwords at regular intervals to maintain security.

The laboratory utilises the CSC Healthcare Group (formerly iSoft) i.Laboratory-TP (formerly Telepath) system for data management. The Trust IT Department provides management of the systems with support of the Pathology Services Manager (Mr Keith Palmer)

Telepath User Manuals are available within pathology. These detail the authorities and responsibilities of all personnel who use the system and focus in particular on:

- How to suitably access patient data and information
- How to enter patient data and examination results to the required consistent standard
- Who has the authority to change patient data or examination results and how these processes are to be undertaken
• Who has the authority to release examination results and patient reports.

**Information system management**

LIMS system management requirements are undertaken partly by laboratory staff and partly by the Trust IT department in accordance with an *IT SLA* (ref: GEN-SLA-IT) which is available via the Document Module of Q-Pulse.

The LIMS (i.lab-TP) has been validated for use within the laboratory. Any upgrades to the system software are thoroughly verified and approved for use prior to introduction by the use of formal change control recording and testing within the training environment that is available within the system. Each laboratory department has a procedure to be followed for testing these upgrades prior to release. All validation data associated with the testing (including any contemporaneous screen shot evidence etc.) are retained within the individual departmental records but over time future records will now be consolidated within the Telepath file record of the Asset Module of Q-Pulse.

Security access to the system is strictly controlled via the Trust IT department security procedures and subsequently via security access control for individual users.

Operational elements of system maintenance are undertaken by the Trust IT Department in accordance with the SLA mentioned above. Electronic data is also backed up by the Trust’s IT department in accordance with this SLA.

Periodic audits are carried out to provide an assurance that patient results issued electronically to users are accurately reproduced by the systems external to i.Lab-TP.

In the event of a protracted LIMS or electrical failure then section 3.2 of the *Pathology Business Continuity Plan* (ref: GEN-MP-BsCnPln) will be invoked until such time as there is a restoration of the LIMS. Further details of the continuity plan can be accessed via the Documents Module of Q-Pulse.