March 2004

## Washington State Medical Test Site Rules PRE-INSPECTION SELF-ASSESSMENT CHECKLIST

## **GRAM STAINS**

TEST COMPLEXITY:	Moderate: Endocervical or urethral for GC only; OR As part of the presumptive identification of GC from selective media	
	High: All other gram stains	
PROFICIENCY TESTING:	Required	
PERSONNEL		
complexity testing [42	The director, supervisor and testing personnel meet personnel qualifications for moderate or high complexity testing [42 CFR Part 493 subpart M (CLIA) - Available from the LQA Office or online at: www.phppo.cdc.gov/clia/regs/toc.asp]	
Documentation of perso	onnel education, experience, training for the testing performed	
Assessment of personn	el competency initially, at 6 months and annually thereafter	
Training is provided to	personnel when problems are identified	
Laboratory safety polic	ies are written and staff members adhere to them	
QUALITY CONTROL		
	which include: specimen collection and handling; preparation of stains; iew and interpretation; reporting protocol; quality control; quality	
Have available reference	ce books, atlases to aid in the identification of organisms	
	g of gram stain reagents with positive and negative reference organisms stains and each week of patient testing	
Reagents are properly l	abeled, stored and used within expiration date	
Microscope maintenand	ce is performed and recorded	
QUALITY ASSURANCE		
Policies are written and proficiency testing and	there is evidence of review of quality control, quality assurance, patient test results	
Evidence of correlation	of gram stain results to culture results (whether done in-house or sent out)	

 Policies are written regarding specimen acceptance/rejection
 Policies are written defining critical limits (where applicable)
 Documentation of corrective actions when problems are identified
 Assure that adequate space and facilities are available
 Adhere to local, state and federal regulations for hazardous waste disposal
RECORDKEEPING
 Patient test orders include: patient name or identifier; name and address or identifier of person ordering the test; date and time of specimen collection; source of specimen; patient age (or date of birth) and sex
 Patient test records include: name or identifier; date received; date tested; person who performed the test
 Patient test reports include: name and address of where tests were performed; patient name and unique identifier; date reported; normal ranges; specimen source and limitations
 Records are kept for 2 years of lot numbers and expiration dates of stains, and dates when placed into use
 The following records are maintained for 2 years: Requisitions; test records; reports; quality control; quality assurance; proficiency testing data