Hematology and Coagulation Checklist

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INTRODUCTION
This checklist is used in conjunction with the All Common and Laboratory General Checklists to inspect a hematology laboratory section or department.

Certain requirements are different for waived versus nonwaived tests. Refer to the checklist headings and explanatory text to determine applicability based on test complexity. The current list of tests waived under CLIA may be found at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm.

Laboratories not subject to US regulations: Checklist requirements apply to all laboratories unless a specific disclaimer of exclusion is stated in the checklist. When the phrase "FDA-cleared/approved test (or assay)" is used within the checklist, it also applies to tests approved by an internationally recognized regulatory authority (eg, CE-marking).

HEMATOLOGY

SPECIMEN COLLECTION AND HANDLING
Inspector Instructions:
- Sampling of hematology specimen collection and handling policies and procedures
- Sampling of patient CBC specimens (anticoagulant, labeling, storage)
All blood specimens collected in anticoagulant for hematology testing are mixed thoroughly immediately before analysis.

NOTE: Some rocking platforms may be adequate to maintain even cellular distribution of previously well-mixed specimens, but are incapable of fully mixing a settled specimen. For instruments with automated samplers, the laboratory must ensure that the automated mixing time is sufficient to homogeneously disperse the cells in a settled specimen.

Evidence of Compliance:
✓ Records of evaluation of each specimen mixing method (eg, rotary mixer, rocker, automated sampler, or manual inversions) for reproducibility of results, as applicable

REFERENCES

NOTE: Blood specimens for routine hematology tests (eg, CBC, leukocyte differential) must be collected in potassium EDTA to minimize changes in cell characteristics. Laboratories must follow manufacturer’s recommendations for use of alternative anticoagulants.

REFERENCES

NOTE: Microspecimen containers such as those used for other capillary blood CBC parameter determinations need not be collected in duplicate. Because of the risk of injury, the use of glass capillary tubes is discouraged; if glass capillary tubes are used, measures have been implemented to reduce risk or injury.
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REFERENCES

COMPLETE BLOOD COUNT (CBC) INSTRUMENTS

CALIBRATION

Commercially available calibrator materials represent a convenient way to ensure that CBC instruments yield accurate results. Because of differences in technology, such calibrators are typically instrument-specific, and are cleared by the Food and Drug Administration for such use. These calibrators have more rigorous assignment of target values than ordinary commercial QC materials. Commercial control materials are not suitable for routine instrument calibration.

Inspector Instructions:

- Sampling of CBC calibration policies and procedures
- Sampling of CBC calibration records
- What is your course of action if the CBC instrument fails to pass all calibration parameters?
- When was the last time you performed a calibration procedure and how did you verify the calibration?

HEM.25400 Precalibrated Instrument Verification Phase II

If precalibrated instruments are used, the manufacturer’s calibrations are verified with appropriate control materials for the system.

NOTE: This requirement does not apply to CBC instruments that can be calibrated by the laboratory.

Evidence of Compliance:
✓ Records of calibration verification following manufacturer’s instructions

REFERENCES

HEM.25700 Calibration Phase II

The laboratory follows defined criteria for periodic analyzer calibration using stabilized materials with target values certified by the manufacturer using primary reference procedures.

REFERENCES
CBC INSTRUMENT QUALITY CONTROL

Longitudinal process quality control (QC) procedures for individual instruments may include:

1. Use of preserved or stabilized whole blood controls
2. "Moving average" monitoring
3. Retained patient specimens, or
4. Some combination of the above

At least two different controls must be assayed and evaluated every 24 hours. For each QC procedure employed, the laboratory must have appropriate QC ranges. For example, expected recovery ranges for commercial control materials are NOT the same as between-run SD ranges, and are probably too wide for daily QC of a single instrument. The laboratory should calculate its own imprecision statistics for each instrument.

Inspector Instructions:

- Sampling of QC policies and procedures
- Sampling of QC records from the previous two-year period
- Sampling of CBC error detection policies and procedures

- How do you determine when QC is unacceptable and when corrective actions are needed?
- How does your laboratory establish or verify acceptable QC ranges?
- How do you ensure results from CBC specimens with cold agglutinins, nucleated RBCs and lipemia are reported accurately?

- Review a sampling of QC data over the previous two-year period. Select several occurrences in which QC is out of range and follow records to determine if the steps taken follow the laboratory procedure for corrective action
- Select a spurious result example and follow the process used to ensure the correct results are reported

Stabilized Controls

HEM.25850 Stabilized Controls Phase II

The laboratory analyzes two different stabilized control specimens during each 24-hours of analyzer use.

NOTE: Stabilized control materials must be at two different analytic levels (ie, "normal" and "high"). Three levels of control is a conceptual carryover from clinical chemistry, and does not apply to hematology particle counting. Dilute, "low-level" (eg, leukopenic and thrombocytopenic) "oncology" controls are less informative indicators of calibration status and are neither required
nor recommended. For example, a 10% calibration bias will be numerically most apparent in a high-level control, less apparent in a normal-level control, and perhaps inapparent in a low-level control; it would be quite extraordinary for a low-level control to indicate a calibration problem that is not revealed by the other controls. There should be some relationship between the frequency of control runs and the numbers of patient specimens processed. If the frequency of commercial control use is less than two control specimens per 24 hours, one or more of the additional approaches to QC must be employed to produce a total of at least two different data points per 24 hours.

**Evidence of Compliance:**
✓ Records of QC results

**REFERENCES**

**Moving Averages**

The technique of weighted moving averages (derived from multiple batch analysis of patient samples) is acceptably sensitive to drifts or shifts in analyzer calibration if a supplemental QC routine (stabilized control material or retained patient specimens) is employed. The latter is needed to detect random error and to avoid bias due to masking of drift by characteristics of the subpopulations within each individual batch.

Laboratories analyzing fewer than 100 CBC specimens daily (long term average) should not use moving averages as the primary method for process control, as this would not generate sufficient data within a day to be of value.

Depending on the particular instrument, there may be "on-board" moving average analyses for RBC indices only. In such cases, additional QC techniques are required for WBC, PLT and WBC differential parameters. However, some laboratories have found the mathematical logic of moving averages, modified average of normals, etc., applicable to other CBC parameters, and some instruments have these capabilities built into their software. Or, such calculations may be performed with an associated computer.
Retained Patient Specimens

Use of retained patient specimens alone is inadequate for routine QC of the primary CBC instrument, and must be considered as a supplemental procedure, in combination with another QC system. Retained patient specimens, while conveniently available, present some difficulties in mathematically defining “agreement” between CBC results separated in time, as these are not stabilized samples. This is in contrast to commercial control materials that have been treated to reduce time-dependent degradation.

HEM.26660 QC - Retained Patient Specimens Phase I

When the laboratory uses retained patient specimens, statistically defined limits are used to determine agreement of sequential assays of a given specimen.

NOTE: Allowance should be made for time-dependent alterations in data from such labile specimens.

Evidence of Compliance:
✓ QC records for retained patient specimens

Error Detection and Verification

HEM.30070 Sampling Mode Comparison Phase I

The laboratory compares all results obtained for patient specimens analyzed in the multiple sampling modes of the CBC analyzer (eg, "primary" and "secondary" modes) at least annually to ensure that they are in agreement.

NOTE: Different modes may involve a different sample path before analysis. When samples are analyzed in more than one mode, it is important to ensure that all modes function properly. Re-analysis of a previously analyzed sample must be performed in the alternate mode(s), and results must agree with the initial mode within the tolerance limits established for agreement by the hematology laboratory’s quality control program, and any recommendations by the instrument manufacturer. Mode-to-mode correlation is not necessary for those analyzers that use the same pathway for all modes.

Evidence of Compliance:
✓ Records of sampling mode comparison studies

HEM.30100 Detection/Correction Procedure - WBC Phase II

The laboratory has a process to detect and correct automated WBC counts for the presence of nucleated red cells or megakaryocytes.
NOTE: The effect of nucleated erythrocytes and blood megakaryocytes on the apparent WBC count varies with the system used for analysis. Each laboratory must evaluate its system(s) and develop appropriate detection and correction procedures. This is important to prevent reporting a falsely high WBC concentration. With some automated CBC instruments, nucleated erythrocytes or megakaryocytes may present themselves histographically or cytotographically, and this can serve as an indicator for careful inspection of a stained blood film. The laboratory must establish if its particular instrument(s) includes some or all nucleated non-leukocytes in its apparent WBC "count".

Evidence of Compliance:
✓ Records showing actions taken to verify WBC concentration prior to reporting

REFERENCES

COAGULATION
SPECIMEN COLLECTION AND HANDLING - COAGULATION

Inspector Instructions:

- Sampling of coagulation specimen collection and handling policies and procedures
- Sampling of specimen rejection records/log
- Sampling of patient coagulation specimens (anticoagulant, labeling)
- How do you know if the specimen is clotted?
- What further actions are necessary if the specimen has a hematocrit of 60%?
- What is your course of action when you receive unacceptable coagulation specimens?
- How do you ensure that platelet-poor plasma is used for testing?
**specimens collected from a normal saline lock (capped off venous port) twice the dead space volume of the catheter and extension set should be discarded.**

**REFERENCES**


**HEM.36860 Anticoagulant - Coagulation**

**Routine coagulation specimens are collected into 3.2% buffered sodium citrate.**

**NOTE:** Sodium citrate is effective as an anticoagulant due to its mild calcium-chelating properties. Of the 2 commercially available forms of citrate, 3.2% buffered sodium citrate (105-109 mmol/L of the dihydrate form of trisodium citrate Na₃C₆H₅O₇·2H₂O) is the recommended anticoagulant for coagulation testing. Reference intervals for clot-based assays must be determined using the same concentration of sodium citrate that the laboratory uses for patient testing. The higher citrate concentration in 3.8% sodium citrate, may result in falsely lengthened clotting times (more than 3.2% sodium citrate) for calcium-dependent coagulation tests (ie, PT and aPTT) performed on slightly underfilled samples and samples with high hematocrits. The prolonged results are also more pronounced when the clotting time is abnormal, such as in samples from patients on warfarin therapy. Both the World Health Organization and CLSI recommend utilizing 3.2% sodium citrate (105-109 nm/L), as the thromboplastin International Sensitivity Index (ISI) values applied in the INR calculations are based on specimens collected in 3.2% sodium citrate. Coagulation testing cannot be performed in samples collected in EDTA due to the more potent calcium chelation. While certain assay systems, such as platelet mapping via thromboelastography require heparin, heparinized tubes are not appropriate for clot-based plasma assays due to the inhibitory effect of heparin on multiple coagulation proteins. Other testing for platelet function, such as light transmission platelet aggregation assay can be performed on 3.2% or 3.8% sodium citrate.

**REFERENCES**


**QUALITY CONTROL - COAGULATION**

**Inspector Instructions:**

- Sampling of quality control policies and procedures
- Sampling of QC records
How do you determine when QC is unacceptable and when corrective actions are needed?

- Review a sampling of QC data over the previous two-year period. Select several occurrences in which QC is out of range and follow records to determine if the steps taken follow the laboratory procedure for corrective action.

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HEM.37300

Coagulation Quality Control

Phase II

The laboratory performs controls using two different levels of control material each eight hours of patient testing and each time there is a change in reagents, or more frequently if specified in manufacturer's instructions, laboratory procedure, or the CAP Checklist.

NOTE: This includes photo-optical, electromechanical and manual methods.

For manual methods (ie, tilt tube method), controls must be performed by each individual who performs the tilt tube test in the same eight hour period.

If an internal quality control process (eg, electronic/procedural/built-in) is used instead of an external control material to meet daily quality control requirements, the laboratory must have an individualized quality control plan (IQCP) approved by the laboratory director defining the control process, including the frequency and use of external and internal controls. At a minimum, external control materials must be analyzed with new lots and shipments of reagents or more frequently if indicated in the manufacturer's instructions. Please refer to the IQCP section of the All Common Checklist for the eligibility of tests for IQCP and requirements for implementation and ongoing monitoring of an IQCP.

Evidence of Compliance:

✓ Records of QC results including external and internal control processes AND
✓ Manufacturer product insert or manual

REFERENCES

1) Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare, Medicaid and CLIA programs; CLIA fee collection; correction and final rule. Fed Register. 2003(Jan 24);5232 [42CFR493.1269(b)].
7) Department of Health and Human Services, Centers for Medicare and Medicaid Services. Clinical laboratory improvement amendments of 1988; final rule. Fed Register. 2003(Jan 24); [42CFR493.1269(b) & 42CFR.493.1269(c)(2)].