	<b>SRI NATHELLA SAMPATHU CHETTY CLINICAL LABORATORY</b>	<b>Minutes of the MRM Review Meeting-1</b>
	<b>(UNIT OF MEDICAL RESEARCH FOUNDATION)</b>	

**Meeting No: 01**

**1. Date of Meeting: 07.12.2005**

**2. Participants:**

S.No.	NAME	DESIGNATION
1.	Dr. K. Ravishankar	CEO
2.	Dr. S.B. Vasanthi	Management Representative
3.	Dr. N. Angayarkanni	Quality Manager
4.	Dr. H.N. Madhavan, Dr. S. Ramakrishnan; Dr. G. Kumaramanickavel, Dr. Krishnakumar, Dr. Lilly Therese, Dr. J. Malathi.	Heads of the Laboratories and supervisors
5.	Ms. R. Punitham.	Coordinator
6.	Ms. R. Padmavathy, Mr. P. Krishnamoorthy, Ms. B. Mahalakshmi, Ms. K. Vanitha, Ms. R. Selvi, Mr. P. Sureshkumar, Ms. Shyamala Selvaraj, Ms. R. Punitham, Ms. S. Srilekha.	Internal Auditors
7.	Mr. T. Rathinam, Ms. Revathi Krishnan, Mr. U. Paulmani	Representatives from the support services

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S.No	Points Discussed in MRM	Particulars	Responsibility	Target Date
1	Follow up of previous management reviews	Not applicable as this is the first Management review meeting	---	---
2	Status of corrective actions taken and requires preventive actions	The corrective actions have been appropriately taken for the non-conformances raised during the internal audit and the same is also documented. The effectiveness of the action taken will be monitored.	---	---
3	Reports from managerial and supervisory personnel	<p><b>I. Calibrations:</b> It was decided that the calibration for the Agilent HPLC used for chromatography.</p> <p><b>II. Preventive maintenance:</b> It was decided that the HOD / Supervisors of the labs and the technicians will co-ordinate with the bio-Medical engineering dept and ensure preventive maintenance is done within the specified due dates.</p> <p><b>III. Recommendation based on Breakdown of Equipments:</b> The microscope and the centrifuge in JKC lab undergoes breakdown. Mean while there is an additional microscope &amp; centrifuge to cater to the need. Lab supervisor has decided to raise the Indent after recommendation for condemnation.</p> <p><b>IV. Authorization Signature:</b> The eligibility of the Jr. scientists who are MS (MLT) to authorize of lab reports will be verified by applying to the NABL authorities, along with the application being sent.</p> <p><b>V. Staff performance</b> All the staff in the department are being evaluated for their competence and the same has been recorded.</p>	<p>Bio-Engineering Department</p> <p>Head-Respective Depts. Bioengineering Dept.</p> <p>Director – Lab, Bio-Engineering</p> <p>QM</p> <p>Concerned dept.</p>	<p>Before Next Management Review</p> <p>Continuous process</p> <p>Before Next Management Review</p> <p>Will be sent along with the application for NABL on or before 30th Dec '05</p>

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		<b>VI. Internal Quality Controls:</b> The internal controls are run as required by the ISO 15189 standard in all the departments where applicable and are also recorded appropriately. The CV values are calculated using the control values and the LJ charts are also maintained.	Concerned departments	----
4	Outcome of Internal Quality Audit.	Audit cycle no: 01 Departments covered: All Number of NC's raised: 24 Number of NC's closed: 23 Open NC: 1 <b>Refer Annexure: 'a'</b> For corrective & preventive action	Concerned departments	----  30 <sup>th</sup> January '06
5	Assessment by external bodies	No external body assessment was held.	QM	---
6.	Outcome of external quality assessment and interlab comparison	<b>1. Haematology and Clinical Pathology:</b> <b>EQAS programme:</b> Once in 3 months AIIMS <b>Code No:</b> 304 <b>Distribution No:</b> 89 <b>Result of EQAS:</b> Satisfactory <b>Corrective / Preventive action taken:</b> Nil <b>EQAS programme:</b> Once in 4 months: CMC (for coagulation tests) <b>Result of EQAS:</b> Result Awaited <b>Corrective / Preventive action taken:</b> --- <b>2. Clinical Biochemistry:</b> <b>EQAS programme:</b> CMC: Once in a month <b>Result of EQAS</b> 56 <sup>th</sup> rank for the year 2004. (358 participants) <b>Corrective / Preventive action taken:</b> As in Records	Concerned departments	---

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		<p><b>EQAS programme:</b> Biorad Daily: -(QC level I and II)</p> <p><b>Result of EQAS:</b> Biorad: Has been within Mean <math>\pm 2</math> SDI throughout the year '04 – '05 and 05- till date).</p> <p><b>Corrective / Preventive action taken:</b> As in Records</p> <p><b>3. Microbiology and serology:</b>  <b>EQAS programme:</b> Once in 3 months, CMC for Bacteriology, serology and Mycology  <b>Result of EQAS:</b> Last Update from CMC (yearly) for 2004-05 is Very Good. 2005 –06: In processes  <b>Corrective / Preventive action taken:</b> nil</p> <p><b>4. Histopathology: Inter-Lab comparison:</b> Slide or a paraffin block sent once in 3 months to Speciality Ranbaxy, which is accredited, by NABL and CAP for histopathology. Initiated from Oct. 2005.  <b>Result of Inter Lab Comparison:</b> The report for the month of Oct. is 'Accepted'</p> <p><b>5. Cytogenetics:</b>  <b>Proficiency Testing:</b> Monthly Plate spread done by the technicians are internally compared and assessed by the Head/supervisor of the Dept. Initiated from Nov 05:  <b>Result of Proficiency Testing:</b> As in Records</p>	<p>Concerned departments</p>	<p align="center">---</p>
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S.No	Points Discussed in MRM	Particulars	Responsibility	Target Date
		<b>Corrective &amp; Preventive Action Taken</b> At present based on the No. Of collections, it is not practical to demarcate it. Toilets cleaned every 30min and documented.		
8	Nonconformities	The following NCs were discussed for which the corrective and preventive action were taken:  (The corrective and preventive action for the following is enclosed as <b>Annexure a</b> )	Concerned Departments	
9	Quality indication for monitoring the laboratory's contribution to patients care	The following are being done for patient cares that are documented 1. Inter Department communication on critical alert reports (measured) 2. Urgent reports (delivered in 2 hours time-measured) 3. Timely reporting 4. Rework entry – followed in the collection Dept.	Concerned departments	
10	Monitoring of turn around time	Within 2 hours: Routine blood investigations For other test parameters, the report time varies with the type of the test.	Concerned department	

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11	Results of continuous improvement process	<b>New Test parameters:</b> 1. Hematology and Clinical pathology: a. Kaolin Clotting Time test: Protocol modified-Method Update b. Platelet count: Protocol was modified - Method Update 2. Clinical Biochemistry: a. Vitamin A and E - HPLC (Modified method from Spectrophotometry to HPLC) 3. Ocular pathology: New stains introduced a. Toluidine Blue stain - Staining Mast cells (identification) b. Giemsa stain - Rickettsia, bacteria (improved method) c. Fontanamasson stain: Melanin and argentaffin granules 4. Microbiology: Nil 5. Cytogenetics: Nil	Concerned department	
12	Evaluation of suppliers	<ul style="list-style-type: none"> <li>• Material specification sheets given by the labs to the stores.</li> <li>• Goods evaluated by the laboratories and reported in the Delivery Chelan to the stores</li> <li>• Vendor selection and evaluation done by the stores.</li> </ul>	Concerned departments and Stores	---
13	Is the quality and appropriateness of the laboratory's contribution to patient care monitored and evaluated objectively?	Quality policy and Quality Objective will be reviewed in the next MRM.	---	---

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