QUEENSLAB
ESTD Group 2025

THE FLOOR REALITY

RETENTION AS SUPPLY RISK SERIES

FLOOR-LEVEL BRIEFING

PART II.

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QUEENSLAB GROUP
Commercial Intelligence Series — Operations Companion

FLOOR-LEVEL BRIEFING — PART II OF II
RETENTION AS SUPPLY RISK: A TWO-PART SERIES

Part II — The Floor Reality

What actually breaks a collection — and the bottleneck nobody names

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Prepared for: Head of Plasma Operations, Center Managers

Companion to: "Retention as Supply Risk" — this piece stays at floor level: what happens on a shift, not what it costs on a P&L

Basis: Practitioner observation across faculty hospital and private plasma-center settings, plus a synthetic dataset used to test the framework — not any single center's internal figures

Series: Part I — "The Commercial Model" — covers the segment economics and revenue case behind this briefing, for owner/commercial audiences

Why this exists

Commercial models talk about "retention" and "churn." On the floor, retention is decided in specific, nameable moments: a re-stick, a donor sent home for a bad lab, a wait with the needle already in or even wait to start the process at all. This briefing stays at that level — the failure modes and the throughput problem as they actually happen, with what a center can do about each one.

The four failure modes

Category	What it looks like on shift	What a center can actually do
Donor readiness	Inadequate prep, travel restriction, temporary medical deferral	Clearer pre-visit reminders (hydration, meal, meds); a real screening conversation, not a checkbox
Procedural	Failed venipuncture / re-stick, separator malfunction	Second-stick protocol and technique refreshers; separator maintenance on a fixed cadence, not reactive-only
Lab / QC	Failed screening, hemolytic or lipemic (chylous) sample rejection	Pre-draw fasting/hydration guidance tied to specific rejection types, not generic advice
Adverse event	Vasovagal reaction or collapse during or after the draw	Staff positioned for early symptom recognition; recovery space that doesn't feel like a hallway

The bottleneck nobody names

None of the four failure modes above happen if a donor never gets seen — or if a successful draw doesn't get closed out. When staffing can't keep pace with donor arrivals, two waits happen, and they are not the same problem:

- The wait to start — donor is ready, chair isn't. Frustrating, but low stakes.
- The wait to finish — the draw is done, the needle is still in the arm, and the donor sits until a nurse is free to close it out. This is the one donor remember, and the one that costs nothing clinically but everything experientially.

This is a capacity/throughput problem — arrival rate versus service rate — not a clinical one, and it doesn't show up in any failure-rate statistic, because the draw itself succeeded. It shows up later, as a donor who doesn't rebook.

Why it's getting worse, not better

The instinct is to blame headcount. The real mismatch sits one layer up, in the booking system itself. A center with, say, 15 seats run its appointment grid on a fixed slot cadence — booked every 15 minutes — sized around an older, longer collection time. Modern separators finish faster and with more session-to-session variability: a cycle that used to run 35–45 minutes now finishes in roughly 25–35. The slot grid was never resynced to that new speed, so donors get booked in at a rate the physical seat turnover doesn't actually match — arrivals scheduled faster than seats can clear, or seats sitting free between bookings that don't align with when a draw actually finishes. What reads on the floor as "staff can't keep up" is really a scheduling-configuration problem: the appointment system, not the roster, is running on the wrong clock. The fix is a grid re-sync, not more hands — rebuilding slot length (or adding a dynamic buffer) around the actual, now-shorter and more variable, cycle time, rather than the assumption baked in when the equipment was slower.

Where the staffing case still holds

None of this erases the staffing question — it narrows where the case is actually strong. Headcount is a real cost, and every operator has good reason to hold it tight. But on the center's highest-volume days — typically Friday through Sunday, the same days that carry the highest profitability — even a well-tuned booking grid hits a lower ceiling: the seat-turnover math that holds up on a Tuesday breaks under Friday-Saturday-Sunday volume. Added phlebotomist coverage specifically for those days, not as a permanent headcount increase, is the version of this ask that's easiest to justify financially — it adds capacity exactly where the volume (and the revenue) is highest, rather than spreading cost evenly across days that don't need it.

Why does this matter more for some donors than others

Donors who describe a center as "we" — relationship-driven, not bonus-chasing — are the ones most likely to be lost to exactly this kind of friction, not to a competitor's better offer. They don't leave because another center pays more. They leave because the tenth uneventful visit was the first one that felt careless.

What this briefing is not

This is not a staffing-ratio recommendation or a cost model — that number depends on a center's real shift data, which this briefing doesn't use. It's a naming exercise: put a label on what's actually happening on the floor, so it can be measured and fixed on purpose rather than absorbed as "just how it goes."

Part I — "The Commercial Model" covers the segment economics and revenue case behind this briefing: the two-segment churn model, the financial translation, and the registry what-if, for owner/commercial audiences.

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