Patient Safety and the Laboratory
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Patient Safety =

Freedom from accident or injury caused by delivery of health care.
Learning Objectives

1. List the CAP Patient Safety Goals
2. Proactively address common risks
3. Monitor laboratory performance
4. Respond to incidents
5. Document your patient safety program
### CAP Patient Safety Goals

1. Improve **patient and sample identification** at specimen collection, analysis and resulting

2. Improve **communication** of life threatening or life-altering information

3. Improve identification, communication and correction of **errors**

4. Improve the **coordination of the laboratory’s patient safety role** within healthcare organizations
Where did the CAP Patient Safety Goals come from?
Woman Sues Pathologist Over Medical Error

Wisconsin Woman Sues Pathologist Over Mistaken Removal of Breasts

_The Associated Press._ ST. PAUL, Minn. April 9 — The woman whose breasts were removed after she was mistakenly told she had cancer is suing the pathologist who made the misdiagnosis and the pathologist's employer.

L--- M---- of Woodville, Wis., filed the lawsuit Tuesday in Ramsey County District Court.

She underwent a double mastectomy after doctors informed her last May that she had an aggressive form of cancer. The diagnosis was based on a lab mix-up that confused her tissue with another woman's.
Learning Objectives

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Incident: Communication Failure

- After 4 days blood culture shows GPC in clusters. By this time the patient has been discharged, and antibiotics discontinued. Dr. R called.
- Patient never treated for infection. Admitted to another hospital with *S. aureus* sepsis one week later and expired.
- Patient had been admitted by Dr. P, an internist. Dr. P received discharge report of positive culture.
- Hospital and follow-up care provided by Dr. G, a cardiologist. Dr G did not receive discharge report.
Studies of Microbiology Errors

164,000 microbiology results

480 corrected reports

179 “significant”

32 with clinical impact

Tasks
- Gram Stain interpretation (20)
- Biochemical/antibiotic testing (7)
- Colony morphology (6)
- Did not follow work protocol (6)
- Trichrome stain (O &P) (1)
- Susceptibility interpretation (1)
- Data entry error (1)

Consequences
- Delayed therapy (19)
- Unnecessary therapy (8)
- Inappropriate therapy (8)
- Unnecessary level of care (5)
**Q-TRACKS 2004: QT1 - Patient Identification Accuracy**
Quarterly Summary Report: October-December, 2004

**Performance Indicator Calculation:**

\[
\text{Wristband Error Rate} (\%) = \frac{\text{Number of wristband errors}}{\text{Total number of wristbands checked}} \times 100
\]

**Performance Indicator Percentiles:**

<table>
<thead>
<tr>
<th>Percentile</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Quarter</td>
<td>0.03</td>
<td>0.21</td>
<td>0.74</td>
<td>1.96</td>
<td>3.17</td>
</tr>
<tr>
<td>Cumulative Quarters</td>
<td>0.15</td>
<td>0.41</td>
<td>1.02</td>
<td>3.83</td>
<td>4.24</td>
</tr>
</tbody>
</table>

**Demographics Summary:**

<table>
<thead>
<tr>
<th>Institution Type</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nongovernmental</td>
<td>64.0</td>
</tr>
<tr>
<td>Voluntary, nonprofit hospital</td>
<td>11.4</td>
</tr>
<tr>
<td>Proprietary hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>Private, independent laboratory</td>
<td>0.0</td>
</tr>
<tr>
<td>Group practice</td>
<td>0.0</td>
</tr>
<tr>
<td>Independent blood bank</td>
<td>0.0</td>
</tr>
<tr>
<td>University hospital</td>
<td>3.6</td>
</tr>
<tr>
<td>Children's hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>System/Integrated Delivery Network</td>
<td>7.9</td>
</tr>
<tr>
<td>Other, nongovernmental</td>
<td>0.9</td>
</tr>
<tr>
<td>Governmental, Federal</td>
<td>0.0</td>
</tr>
<tr>
<td>State chronic hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>State acute hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>County hospital</td>
<td>7.0</td>
</tr>
<tr>
<td>City hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>University hospital</td>
<td>0.0</td>
</tr>
<tr>
<td>Other, governmental, nonprofit</td>
<td>0.0</td>
</tr>
<tr>
<td>Other, governmental, federal</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Q-PROBES 2003: QP032 - Inpatient Anticoagulation**
Individual Report of Results

<table>
<thead>
<tr>
<th>Inpatient Anticoagulation Monitoring</th>
<th>Your Result</th>
<th>Your Rank</th>
<th>All Institutions</th>
<th>10th</th>
<th>50th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients with aPTT or activated-Factor X obtained within 12 hrs. of heparin admin.</td>
<td>100.00</td>
<td>95</td>
<td>85.49</td>
<td>87.56</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with platelet count obtained within 72 hrs. of heparin admin.</td>
<td>96.43</td>
<td>6</td>
<td>66.67</td>
<td>93.33</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with at least one therapeutic aPTT or activated-Factor X within 24 hrs. of heparin admin.</td>
<td>96.43</td>
<td>70</td>
<td>53.00</td>
<td>80.00</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with fewer than two supra-therapeutic aPTT or activated-Factor X within 72 hrs. of heparin admin.</td>
<td>85.71</td>
<td>84</td>
<td>11.11</td>
<td>66.67</td>
<td>90.00</td>
<td></td>
</tr>
</tbody>
</table>

*Higher percentile ranks indicate better relative performance.*
RISK

CONTROLs

- Written Procedure
- Room Layout
- Warning Signal
- Staff Training
- Structured Form
Patient Identification Errors
United States Non-Exempt Clinical Laboratories, Annual

Identified Before Reporting = 2,880,000 Errors

Identified After Reporting = 432,000 Errors

Adverse Event = 160,000 Errors
## Reasons for ID Errors

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Errors</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary specimen label error</td>
<td>2,691</td>
<td>55.5</td>
</tr>
<tr>
<td>Initial registration/order entry error</td>
<td>1,088</td>
<td>22.4</td>
</tr>
<tr>
<td>Other clerical error</td>
<td>604</td>
<td>12.4</td>
</tr>
<tr>
<td>Other reason for error</td>
<td>205</td>
<td>4.2</td>
</tr>
<tr>
<td>Aliquot/block/slide label error</td>
<td>184</td>
<td>3.8</td>
</tr>
<tr>
<td>Result entry error</td>
<td>80</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Wristband Errors Observed in 131 Hospitals, 2005 CAP Q-Tracks Data

<table>
<thead>
<tr>
<th>All Institutions Percentiles</th>
<th>10th</th>
<th>25th</th>
<th>50th Median</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>(% of wristbands with any errors)</td>
<td>0.08</td>
<td>0.24</td>
<td>0.82</td>
<td>1.62</td>
<td>2.45</td>
</tr>
</tbody>
</table>
Please, DO NOT touch any buttons except the "Feed" button.
For alignment issues call TFS. Do not try to fix yourself.
Thank you!
Cumulative Risk

- 12 steps subject to ID error
- Each step 99.95% accurate
- Odds of ID error occurring in 12 steps = \(1 - (0.9995)^{12} = 0.6\%\) of cases
- 60,000 accessions/year x 0.6\% = 360 ID errors/year
- If 90\% caught and 90\% don’t matter then

\(~4\) patients are harmed per year
Reducing ID Errors

- **Limit preprinting of labels**
  
  *inadequate numbers of printers cause labels to queue up*

- **Look for ID errors prior to result release**
  
  *high pre-release ID error detection → lower post verification ID errors*

- **Investigate patient ID when patient not on file**
  
  *significantly associated with lower post-verification ID error rate*

- **Monitor ID errors on ongoing basis**
  
  *significantly associated with lower post-verification ID error rate*

- **Use rigid acceptance criteria for label non-conformities**
  
  *significantly associated with lower post-verification ID error rate*

- **Match ID on results to paper requisition**

- **Speed up label print time**
  
  *Long print times encourage batching of work*

- **Dual entry of key demographic information**
Improvement Takes Time

- 6-7 years: 6.2%
- 5 years: 5.6%
- 4 years: 4.1%
- 3 years: 3.8%
- 2 years: 2.7%
- 1 year: 0.8%

Mean reduction in wristband error rate (%)
Check Digits

Medical Record Number
46384739
46384740
46384751

Specimen Accession Number
S-07-124338
S-07-124349
S-07-124350
Read accession number on slide

Perform voice recognition. Call up case in computer. Scraper patient name off screen. Read into headset.

Request new input

Patient name heard in headset = name printed on paperwork

No

Yes

Proceed with sign-out

No
Do we need labels at all?
Single Piece Specimen Flow
Single Piece Specimen Flow
New Distribution/Setup Area
Learning Objectives

1. List the CAP Patient Safety Goals
2. Proactively address common risks
3. **Monitor laboratory performance**
4. Respond to incidents
5. Document your patient safety program
Monitoring

• Quality Control
  Real time monitoring of unstable processes. Deviations require corrective action.

• Quality Planning
  Episodic, after-the-fact analysis of key outcomes. Investigation may suggest that better controls are needed.
This is Quality Control – real time monitoring of key processes. Deviations require corrective action.
This is Quality Planning – episodic, after-the-fact analysis of key outcomes. Investigation may suggest that better controls are needed.
This is **Quality Control** – real time monitoring of key processes. Deviations require corrective action.
This is Quality Planning – episodic, after-the-fact analysis of key outcomes. Investigation may suggest that better controls are needed.
Quality Control Has Control Limits

Examples:

• Refrigerator must be 4-8° C
• Gram positive cocci must stain gram positive
• Reagent grade water has < 100 cfu/ml
• Low control between 0.05 and 0.1 ng/ml
Quality Planning Has No Control Limits

Compare to national benchmarks to determine whether better controls are needed
   Example: frozen section accuracy

Compare to past performance to determine whether some change has made quality better or worse
   Example: nursing phlebotomy & acceptable specimens

Compare problem types to determine where to focus efforts
   Example: causes of identification errors
Safety Monitors – Quality Planning

- ID Errors During Order Entry
- Label Errors
- Critical Values Not Called
- Corrected Reports (%)
- Corrected Reports (time)
Learning Objectives

1. List the CAP Patient Safety Goals
2. Proactively address common risks
3. Monitor laboratory performance
4. **Respond to incidents**
5. Document your patient safety program
Incident Management System

1. Process to **discover** incidents
2. Process to **investigate** incidents
3. **Address** individual incidents
4. **Prevent** recurrence of similar incidents
## Errors Involving Laboratory A

### 2007 Incident Tracking (N=505 Incident Reports)

<table>
<thead>
<tr>
<th>Phase of Testing</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preanalytic</td>
<td>82%</td>
</tr>
<tr>
<td>Analytic</td>
<td>14%</td>
</tr>
<tr>
<td>Postanalytic</td>
<td>4%</td>
</tr>
</tbody>
</table>
Learning Objectives

1. List the CAP Patient Safety Goals
2. Proactively address common risks
3. Monitor laboratory performance
4. Respond to incidents
5. **Document your patient safety program**
Documenting a Patient Safety Program

• Statement of Purpose
• Authority
• Relation to Other Quality/Safety Programs
• Setting a Tone
• Identify Risks
• Control Measures to Mitigate Risks
• Monitoring
• Incident Management
• Limitations
• Periodic Review & Revision
CLINICAL LABORATORY QUALITY MANAGEMENT AND PATIENT SAFETY PLAN
CONSOLIDATED LABORATORIES OF OKLAHOMA

PURPOSE
The purpose of the quality management and patient safety plan is to provide reasonable assurance to management, physicians, and patients that laboratory operations meet defined standards for quality and patient safety, are in compliance with applicable laws and regulations, and that performance will improve in selected areas.

PROGRAM STRUCTURE
The quality management plan contains seven elements. The first element is a commitment to establish a “tone” that reinforces quality and patient safety. This tone is established as much by day-to-day action of management and staff as by policies and procedures.

Culture
The laboratory is committed to a culture of quality, patient safety, and organizational integrity. Management and staff should accept established performance standards, controls, discipline, and structure. All employees are encouraged to discuss quality, patient safety, and other concerns without fear of retribution.

Risk Assessment
Management has identified risks that could cause the laboratory to fail to meet its goal of providing quality service and patient safety. These risks range from the particular (e.g., the failure of a reagent lot to perform adequately) to the more general (e.g., failure to adequately train staff to perform a certain task). They may be internal to the section (e.g., a refrigerator failing to maintain its temperature) or external (e.g., operating room staff failing to properly collect tissue for culture). All phases of testing and all laboratory shifts are included in the risk assessment.

Internal Control
Control procedures have been developed to mitigate each significant risk. For example, in the case of reagents, control activities involve the use of quality control samples. In the case of employee training, control activities involve a training checklist for new employees and periodic assessment of employee competence.

External Control
The laboratory participates in external proficiency testing and is inspected by the College of American Pathologists as part of the CAP Laboratory Accreditation Program. In addition, the FDA, CMS, AABB, OSHA, and JCAHO may inspect the laboratory. Agencies outside the laboratory (CAP, institution privacy officer, safety officer, compliance officer) will receive in confidence employee concerns about quality or compliance issues that are not being addressed by laboratory management.

Information & Communication
Management reviews patient safety and quality records on a regular basis, and summaries are made available to the laboratory-wide quality committee and laboratory leadership. Results are shared within and outside the laboratory, as described in this plan.

Performance Improvement
Certain aspects of operations have been targeted for improvement during the current year. The improvement efforts are documented in this plan.

Monitoring
Ongoing monitoring takes a number of forms: (1) Staff and managers assess laboratory performance over time. Performance is compared to standards, benchmarks, and past performance, as applicable. (2) Complaints, deficiencies, unusual problems, and any patient adverse events are investigated. (3) The laboratory is subject to monitoring by external agencies (see section below).

QUALITY PLANNING
This quality plan itself is reviewed annually. As required, processes and procedures are changed or the quality plan is changed to reflect changing priorities or patterns that emerge from ongoing quality monitoring, complaints, deficiencies, or adverse events.

LIMITATIONS
Because resources are finite, not every process and element of service can be controlled completely. The laboratory cannot afford to have each test repeated by two technologists or backup equipment on-site for every instrument that could malfunction. Management has designed and implemented internal controls based on an analysis of cost, risk, and benefit. Even under ideal circumstances, internal controls cannot provide absolute assurance that all organizational objectives will be met. Factors outside the control or influence of management and staff can affect the laboratory’s ability to achieve its goals. Therefore, the laboratory’s quality management plan provides reasonable, but not absolute, assurance that the laboratory will meet its quality and patient safety objectives.

AUTHORITY
The pathologist in charge of the microbiology laboratory, acting as the designee of the laboratory director, has approved this plan, as evidenced by a signature. The technical manager of the section also approves this plan.

Pathologist signature: Date:
Technical supervisor signature: Date:
<table>
<thead>
<tr>
<th>FUNCTION AT RISK</th>
<th>CONTROL ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preanalytic Phase of Testing</strong></td>
<td></td>
</tr>
<tr>
<td>Test Ordering</td>
<td>See “Test Ordering Consultation” procedure</td>
</tr>
<tr>
<td>Specimen Collection</td>
<td>See “Blood Culture Contamination” procedure</td>
</tr>
<tr>
<td>Order Entry</td>
<td>See laboratory-wide procedure on Order Entry</td>
</tr>
<tr>
<td>Lost Specimens</td>
<td>See “Lost Specimens” procedure</td>
</tr>
<tr>
<td><strong>Analytic Phase of Testing</strong></td>
<td></td>
</tr>
<tr>
<td>Orderable Tests</td>
<td>See applicable individual procedures</td>
</tr>
<tr>
<td>Reagents/Stains/Additives/Media</td>
<td>See applicable individual procedures</td>
</tr>
<tr>
<td>Automated/Packaged tests</td>
<td>See applicable individual procedures</td>
</tr>
<tr>
<td>Equipment</td>
<td>See applicable individual procedures</td>
</tr>
<tr>
<td>Interpretive/Subjective Tests</td>
<td>See applicable individual procedures</td>
</tr>
<tr>
<td>Maintaining Control Strains</td>
<td>See “Maintaining Control Strains” procedure</td>
</tr>
<tr>
<td>New Procedures</td>
<td>See “New Procedure Checklist” procedure</td>
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<tr>
<td>Extramural Proficiency Testing</td>
<td>See “Handling PT Specimens” procedure</td>
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<tr>
<td><strong>Postanalytic Phase of Testing</strong></td>
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<tr>
<td>Report Quality</td>
<td>See “Report Review” procedure</td>
</tr>
<tr>
<td>Interpretation of Test Results</td>
<td>See “Test Interpretation Consultation” procedure</td>
</tr>
<tr>
<td>Reporting Critical Results</td>
<td>See “Critical Result Reporting” procedure</td>
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<tr>
<td><strong>General Laboratory Systems</strong></td>
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<tr>
<td>Personnel Initial Training</td>
<td>See “New Employee Training Checklist” procedure</td>
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<tr>
<td>Maintenance of Competence</td>
<td>See “Employee Competence Checklist” procedure</td>
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<td>Personnel Errors</td>
<td>See “Tabulation of Major Errors” procedure</td>
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<td>Staffing Plan</td>
<td>See “Laboratory Staffing Plan” procedure</td>
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<tr>
<td>Policy and Procedures</td>
<td>See “Document Control” procedure</td>
</tr>
<tr>
<td>Turnaround Time</td>
<td>See “Turnaround Time” procedure</td>
</tr>
<tr>
<td>Information Management</td>
<td>See laboratory-wide procedures on Data &amp; Confidentiality</td>
</tr>
<tr>
<td>Customer Satisfaction</td>
<td>See laboratory-wide procedure on Customer Satisfaction</td>
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<tr>
<td>External Inspection and Accreditation</td>
<td>See “CAP Accreditation” procedure</td>
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<tr>
<td>Legal and Regulatory Noncompliance</td>
<td>See “Reporting Noncompliance” procedure</td>
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<tr>
<td>Complaints and Unusual Problems</td>
<td>See “Incident Log” procedure</td>
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<tr>
<td>Sentinel Events</td>
<td>See laboratory-wide procedure on Sentinel Events</td>
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<tr>
<td>Correcting Errors</td>
<td>See “Correcting Errors” procedure</td>
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<tr>
<td>Documentation</td>
<td>See “Record Keeping” procedure</td>
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<tr>
<td>Risk</td>
<td>Control Measures</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Patient and Specimen Identification</strong></td>
<td>Wristbands placed by registration staff at time of patient registration (procedure)</td>
</tr>
<tr>
<td></td>
<td>Written order required for wristband removal (policy)</td>
</tr>
<tr>
<td></td>
<td>Specimens that have label which does not match paper requisition require escalation to manager (procedure)</td>
</tr>
<tr>
<td></td>
<td>Dual entry of patient birth date (software program)</td>
</tr>
<tr>
<td></td>
<td>Training of all registration staff and competency test</td>
</tr>
<tr>
<td></td>
<td>Patient ID numbers all have check digits, which are checked by LIS (environmental control)</td>
</tr>
<tr>
<td></td>
<td>Printers arranged to discourage queuing of specimens that can create ID errors (environmental control)</td>
</tr>
<tr>
<td></td>
<td>Staffing appropriate for workload (policy)</td>
</tr>
<tr>
<td></td>
<td>Importance of ID errors emphasized at monthly staff meetings (policy)</td>
</tr>
<tr>
<td></td>
<td>All of above</td>
</tr>
</tbody>
</table>
RISK ASSESSMENT

PURPOSE
Laboratory leadership conducts an annual risk assessment to identify significant laboratory-wide vulnerabilities. This assessment is informed by incidents that occur within the laboratory (and occasionally some sentinel events), regulatory and accreditation requirements, knowledge of generally recognized risks within the clinical laboratory industry, and the particular strategic direction management has set for the laboratory. As required, this risk assessment is updated.

Laboratory leadership has written some policies to address these risks. However, the most effective controls for addressing risks are usually located within individual laboratory sections. These controls might consist of section-specific procedures, a particular physical layout of the work area or a form that makes it more difficult for staff to make an error, or an alert or “hard stop” programmed into a computer. Laboratory leadership directs the managers and section heads of each laboratory section to address all of the risks listed below that are applicable to their section.

In addition to the risks identified below, sections are free to identify risks that are unique to their area or especially important within their section, and to develop control measures to mitigate these risks.

<table>
<thead>
<tr>
<th>SIGNIFICANT LABORATORY-WIDE RISKS</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>

Laboratory Organization

Management believes quality and patient safety suffer when the laboratory organizational structure and delegation of duties is not well specified. We have attempted to address this vulnerability with our laboratory organization and delegation of duties policies, which spells out how the people and work groups relate to one another and who is responsible for specific duties. Generally, organizational ambiguity is not a significant vulnerability within individual sections because they are small enough to allow more frequent direct communication. However, section heads and section managers should make clear who is responsible for completing each task within a section.

Patient and Specimen Identification

Misidentification of patients and specimens represents a widely recognized vulnerability in the clinical laboratory industry. While this vulnerability is most apparent in transfusion medicine, it impacts many sections of the laboratory. Laboratory section heads and managers should implement systems to ensure that specimens and patients are properly identified, and to detect misidentification wherever possible.

Introducing New Tests

The introduction of new tests (assays) into the laboratory is fraught with risk, because so many tasks must be completed before a new test can be placed into production. This includes the validation of instruments and new test systems, establishment of reference ranges, training of staff, validation of computer interfaces, set-up of reporting and billing procedures, and many other steps. Management has prepared a policy that spells out requirements that must be met before new tests are introduced into the laboratory (see Introducing New Tests). Laboratory section heads and managers should implement systems to ensure that this policy is followed.

Quality Management of Established Tests

Maintaining the accuracy of existing tests (assay) required ongoing quality management. This may involve the testing of control specimens, periodic instrument recalibration, quality control testing of reagents, supplies and equipment used in the testing process, and other safeguards. Management has prepared a policy that spells out requirements that satisfied for the ongoing quality management of established tests (see Quality Management of Established Tests). Laboratory section heads and
Re: Microbiology Section Annual Quality Report
To: Department of Pathology Quality Committee
Date: April 2, 2007
From: Paul Valenstein, M.D. (Microbiology Section Head)

Risk Assessment/Quality Planning
The section revised its annual assessment of quality risks. No new control practices or quality improvement initiatives were initiated. At a new monitor - critical result notification - will be introduced in the second half of CY 2007. Although the laboratory continues to monitor blood culture contamination, quality improvement activities related to blood culture contamination (feedback, etc.) have been suspended since contamination rates have been stable and acceptable for more than 2 yrs. The section’s risk assessment is described in its procedure manual.

Preanalytic: Specimen Collection and Processing
Blood culture contamination (mixture of specimen collection) is better (lower) than the national median (see graph). Lost specimens in microbiology remains below internal benchmark (see graphic); no external benchmarks available.

Analytic:
Mycoplasma testing that had been transferred to St. Joe Oakland was reinitiated, because section staffing was restored to budget and benchmark level (Micro tests/FTE = 7.5% percent of productivity). C. difficile toxin testing was reinitiated from Wade/MCL for economic reasons; the infectious diseases section has asked that the clinical sensitivity of this assay be examined more closely (the methodology used at SIMHS is the same used at Wade). This investigation will start in next few months. Immunosorbent for cryptococcs was introduced.

Postanalytic: Turnaround Time
Percent of preliminary urine cultures finalized within 1 day dropped below internal benchmark in 2 of 12 months (see graph). There are no external benchmarks for urine culture turnaround time. If trend continues, a new quality improvement initiative will be undertaken.

Other
The microbiology section tracks dozens of quality indicators on an ongoing basis. There were no significant changes to report in the section’s performance or regulatory requirements related to the following areas: Patient and Specimen Identification • Order Communication • Specimen Collection and Handling (other than above) • Appropriate Use of Laboratory Services • Introducing New Tests • Ongoing Quality Management of Tests • Reference Ranges • Reference Laboratories • Reporting Results • Interpretation of Results • Correcting Reporting Errors • Personnel • Information Management • Turnaround Time (other than above) • Laboratory Organization • External Inspection • External Proficiency Testing • External Accreditation • Incident Monitoring • Customer Satisfaction
Summary

1. List the CAP Patient Safety Goals
2. Proactively address common risks
3. Monitor laboratory performance
4. Respond to incidents
5. Document your patient safety program
Technical Assistance

http://www.cap.org

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Questions