PATHOLOGY & LABORATORY MEDICINE SERVICE

VA Maryland Health Care System

Baltimore, Maryland 21201

SELECTION, TRAINING, COMPETENCY ASSESSMENT AND EDUCATION OF PATHOLOGY AND LABORATORY MEDICINE (PLMS) PERSONEL version 0.1

General Procedure # GEN00029

DATE ADOPTED	*Author of Procedure/Policy*	Chief of Service
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6/1/17	0.1	

REVISION HISTORY

Date revised	Revision #	Changes made	Signature
5/25/17	1	Med Training Continuing Education Program	

I. EMPLOYEE SELECTION

A. The High Performance Development Model will be used when interviewing potential PLMS staff as per Network 5 Policy.

B. All potential new employees are subject to random pre-employment drug screening as per VA policy.

C. Selection for employment is based on education, experience, attitude, and flexibility within equal employment opportunity guidelines. The Clinical Laboratory Improvement Act of 1988 (CLIA 88) regulations for employment qualifications have been adopted by the Department of Veterans Affairs.

D. The credentials of all new Medical Technologists and Pathologists are entered into and cleared through VetPro.

E. New PLMS employees will also be entered into the College of American Pathologist (CAP) qualifications spreadsheet maintained by the lab manager.

F. This policy does not apply to non-lab staff performing point of care testing.

II. TRAINING

A. All staff members will be provided a general orientation to the department, receive a copy of their Position Description or Functional Statement and their Performance Appraisal Standards and be given the opportunity to ask questions prior to the completion of their training.

B. All new staff will receive introductory training for computer use, lab safety, quality management and other general lab policies.

C. Section/discipline specific training will be accomplished using the appropriate "Training Guidelines and Checklist" (See attachment A) based on the duties to be performed.

The checklist will:

1. Provide documentation of relevant duties and responsibilities, and that training occurred. Provide a permanent record of the processes and procedures that an individual is authorized to perform.
2. Highlight the major steps in a test system.
3. Be updated when a procedure, process, or SOP manual is revised.

D. Training will be based on the Test Systems the employee will be expected to perform.

1. A test system is the process that includes pre-analytic, analytic, and post-analytic steps used to produce a test result or set of results. The laboratory must identify the test systems that an employee will use to generate patient test results.
2. A test system may be manual, automated, multi-channel or single use and can include reagents, components, equipment or instruments required to produce results.

3. A test system may encompass multiple identical analyzers or devices.
4. Different test systems may be used for the same analyte.

III. RESPONSIBILITIES:

A. The supervisor (or designee):
   1. Obtains and reviews applicable SOPs/Flow charts pertaining to the process for which the guideline is needed.
   2. Obtains training guideline and checklist template (Attachment A is only a guideline. Other formats may be used as appropriate).
   3. Writes a draft training guideline using the major steps of the system as items to be read, discussed, observed and performed.
   4. Includes all pertinent information necessary to adequately train a new person in this process (ex. Data entry, QC, result reporting, reference ranges, troubleshooting, information specific to the procedure as well as general information and/or safety considerations, as applicable).
   5. After training is complete the supervisor defines the specific area(s) an employee is competent to work in.
   6. The supervisor will develop a (regular annual) schedule to evaluate the competency of their staff. Note: A lead technologist may be designated to perform parts of the competency assessment, but the section supervisor has the ultimate responsibility.

B. The trainee (staff, volunteer, student) is responsible for:
   1. Reading the applicable sections of the appropriate Procedure Manual(s)
   2. Directly observing their trainer at work in the designated area
   3. Discussing each checklist item with the trainer
   4. Satisfactorily performing each checklist process under the direct observation of the trainer
   5. Successful completion of current training and assessments. (The employee must meet minimum acceptable levels required for each duty to be performed).

C. The trainer (any PLMS employee rated no less than "acceptable" and a minimum of 1 year experience) will be responsible for:
   1. Discussing the applicable sections of the SOP Manual with the trainee to ensure comprehension
   2. Observing the trainee perform each task, and making suggestions for improvement as needed.
   3. Signing-off training checklist as applicable

D. The Laboratory Director is responsible for:
   1. Establishment of this policy, ensuring that it is followed and thereby assuring that staff is competent to process specimens, perform tests and report results.

2. Evaluating the pathologists using Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) tools.
3. Developing competency assessment tools to evaluate the performance of non-pathologists who assist in gross tissue examinations as well as the performance of the cytotechnologist/cytotechnitian on a regular, periodic basis.
4. In conjunction with the Lab Manager the Laboratory Director or designee will evaluate the supervisors and the Ancillary Testing Coordinator based on their regulatory responsibilities.

IV. COMPETENCY ASSESSMENT

A. All staff who is involved in testing process must undergo competency assessment. Competency must be assessed for all major platforms/test systems that a person is authorized to perform patient testing on. (i.e. is in their scope of practice). Staff who performs patient testing must be assessed under all 6 elements (see Attachment B). Personnel who perform only pre and post analytic activities (such as, histology processing or data entry) are not subject to the 6 elements listed below, however the laboratory must ensure that these employees are competent to perform *their tasks* and remain competent.
   1. Per CLIA/CAP requirements, General Supervisors and the Ancillary Testing Coordinator are also held to the competency requirement and it must be performed on an annual basis. However the extent of this competency can be determined by the Medical Director. Competency assessment for this staff must be able to exhibit the level of expertise needed to perform their responsibilities (i.e. signing off on competency for General Supervisors, or training and performing competency assessments for the Ancillary Testing Coordinator). If they perform patient testing, even once a year, then they must be assessed with all six elements of competency as applicable.

B. How often: During the first year that a lab staff member performs non-waived testing on patient samples, competency must be assessed at least semi-annually and then annually thereafter. For waived testing only annual competency assessment is required.

C. Any staff member required to perform a procedure infrequently due to low volume or staffing situations may be assessed more often on that particular procedure in order to remain competent. These frequencies will remain at the discretion of the supervisor of the procedure in question.

D. **Elements of competency assessment** include but are not limited to the following elements as applicable to the person's duties. For non-waived testing all six elements must be assessed annually for each test system that an employee uses to generate patient test results. (For waived testing, it is not necessary to assess all six elements

at each assessment event: the laboratory may select which elements to assess but TJC requires at least 2).

1. Direct observations of routine patient-test performance. Depending on the staff member's scope of practice this element may assess the pre-analytic or analytic phase. For example: patient identification and preparation; specimen collection and handling; and sample processing and testing.
2. Monitoring the recording and reporting of test results including manual entry and/or critical calls as applicable.
3. Review of intermediate test results or worksheets, QC records, proficiency testing results and maintenance logs, etc.
4. Direct observation of performance of instrument maintenance and function checks
5. Assessment of test performance through external proficiency testing (ex. CAP), previously analyzed specimens or internal blind testing samples.
6. Evaluation of problem-solving skills through:
   a) Quizzes-locally developed or from Talent Management System (TMS) which has several useful competency assessment quizzes.
   b) Review of documentation following resolution to actual issues such as demonstration that appropriate corrective actions were taken on failed QC, or occurrence reporting.
   c) Employee self- documentation

E. Each supervisor may develop their own section/system specific competency assessment checklist to assist with documentation. (See Attachment C for example). Ongoing quality surveillance activities that are conducted throughout the year by the supervisor encompass many of the elements of competency assessment.
   1. Routine daily activities that can be used to demonstrate competency may include as applicable-review of: critical value documentation, patient results, temperature logs, instrument maintenance logs, worksheets, QC, troubleshooting and calibration records.
   2. Documentation must include the test system being evaluated, date of the assessment, initials/signatures and how each element was assessed

F. Staff will be assigned to technical areas on a rotational basis in order to maintain competency. Each supervisor will determine the number of shifts per month that is needed to maintain competency in their respective areas.

G. Retraining must occur following a change in test methodology or instrumentation changes. Affected employees must all be re-assessed before reporting test results.
   1. Retraining/re-education will occur on an "as needed" basis if assessment shows deficiencies, or if problems or errors are discovered during routine QA monitoring. Prior to proceeding determine whether or not:
      a. All work processes are fully documented, clear and easy to understand

b. The employee had been sufficiently trained in the process and that the effectiveness of the training was determined

c. The employee was the only person with this performance problem

2. Applicable sections of the "Training Guidelines and Checklist" will be used for remedial training.

3. Personnel may not perform unsupervised until successful competency can be demonstrated and documented.

V. CONTINUING EDUCATION PROGRAM

A. Objective

1. The objective of the education program in Pathology and Laboratory Medicine is to meet the changing needs of the laboratory, to improve staff job performance and improve job satisfaction. The lab education program serves all staff members in PLMS. Additionally, some components of this program are extended to other services, particularly ancillary testing sites.

B. Documentation

1. Documentation of mandated educational activities takes place via facility education tracking software (VA Talent Management System-TMS). TMS may also be used to document non-mandated continuing education.

2. Supervisors can generate reports that detail the amount of time spent and the educational activities for each employee. These can be used to review the employee's educational record during performance reviews.

3. Med Training is the laboratory web based continuing education program available for competencies, training, updates to new /updated policies and procedures. Supervisor and users are able to add custom training and assign them to specific staff. Also, supervisors are able to generate reports for all assigned competencies.

C. Educational Activities

1. Mandated Programs

a. New Employee Orientation

(1) All personnel new to the Department of Veterans Affairs Maryland Health Care System (VAMHCS) will attend a 3 day orientation program formulated by the Staff Training and Educational Section of Human Resources Management. The program includes but is not limited to education regarding benefits, ethics, conduct, military diversity and smoking policies.

(2) PLMS supervisors will orient new staff members to their service specific functions and expectations.

Safety Training A PLMS Safety Committee member provides all staff members a safety in-service on an annual basis.

b. All staff members must complete the programs mandated for designated hospital personnel at the frequencies indicated. These hospital mandatories include but are not limited to privacy, infection control, safety, and Safe Medical Device Reporting and may be accessed through TMS.

2. Lab sponsored educational activities:
   a. Lab administration continually assesses the educational needs of staff based on staff feedback, new technologies, hot topics, and changes in practice, etc.
   b. Various methods are used to educate staff including but not limited to:
      (1) Teleconferences/Audioconferences
      (2) Reading material placed into section education centers
      (3) Conferences both on an off-site
      (4) In-services
      (5) Computer based learning
3. Staff meetings are held on a regular basis. All staff is responsible for meeting contents regardless of attendance. Staff meetings will be used to disseminate information such as:
   a. A review of problems/errors/trends.
   b. An introduction of new procedures, forms, or techniques.
   c. In-service presentations by other hospital staff or customer service representatives (e.g. Infection Control, Nursing Service, or equipment manufacturers, etc.)
   d. Training for new or revised techniques/procedures.
   e. Dissemination of facility/network information may also be distributed through email (e.g. Pulse Points, network goals, facility updates).
   f. Review of workflow/workload.
   g. Any additional topics necessary

VI. PERFORMANCE APPRAISALS

A. The critical elements of all staff members' performances are unique to the Position Description or Functional Statement of his or her job and will be used for his or her evaluation.
   1. This method seeks to measure the employee's work effectiveness using objective criteria.
   2. Additionally, a performance appraisal takes many corporate requirements into account

B. The section supervisor will evaluate each staff member annually.

C. Performance is monitored throughout the year by the supervisor and a mid-year review of each staff member's performance is conducted.

D. Failure to maintain successful performance at any time will result in the staff member being placed on a Performance Improvement Plan (PIP). The PIP is a tool that will enable the supervisor to systematically assist the staff member in improving performance to a successful level.
E. Failure of the staff member to maintain a successful level of performance following completion of the PIP could result in transfer, demotion or termination.

VII. REFERENCES

A. AABB Technical Manual 15th Edition, 2005
B. Assessment Of Employee Competence (512-05/HR-005)
C. College Of American Pathologists Standards for Laboratory Accreditation
D. Disciplinary and Major Adverse Actions Title 38 U.S.C. Employees (512-05/HR-003)
E. Performance Appraisal Program Title 5 (Incl. FWS and NAF) and Title 38 Hybrid Positions (512-05/HR-015)
F. The Joint Commission (TJC)
G. Performance Management for Title 38 Employees (512-05/HR-017)
H. VAMHCS Orientation Program (512-05/HR-022)

VIII. ATTACHMENTS

A. Training guideline and checklist –template
B. Performance Appraisal Program Tittle 5 and Title 38 Hybrid (512-05/HR-015)
C. Competency Assessment Evaluation- example