|  |  |  |  |
| --- | --- | --- | --- |
|  | **Quality Assurance and Improvement Plan**  **IPP#20** | **Dept:** | **Inpatient Phlebotomy 324305** |
| **Effective Date:** | **2/17/2011** |
| **Revised Date:** | **March 2019** |
| **Contact:** | **Laurie Watson** |
| **Name & Title: Greg Pomper, MD Medical Director** | | **Date:** |  |
| **Signature:** | | | |

1) **General Procedure Statement:** To give guidelines to staff concerning the proper Process for Quality Assurance and Quality Improvement Plan.

* 1. **Purpose:** This procedure is to serve as a guide for trained personnel in the Inpatient Phlebotomy Department to perform the services described herein. These guidelines should be used in conjunction with proper training and only by qualified Phlebotomists.
  2. **Responsible Department/Party/Parties:** 
     1. Procedure owner/ Implementer: Inpatient Phlebotomy
     2. Procedure prepared by: Laurie Watson MT(ASCP)
     3. Who Performs procedure: Inpatient Phlebotomy

**2)Procedure: Quality Assurance Plan**

INPATIENT PHLEBOTOMY Quality Assurance and Improvement Plan

Inpatient Phlebotomy is the section of WFBH Pathology Laboratories that is responsible for inpatient blood collection services. The quality of the blood collection service is determined by the adherence to proper Phlebotomy technique and by the timeliness, accuracy, and completeness of the total collection process.

The following performance monitors for Inpatient Phlebotomy were selected because they track common, important problems that significantly impact the quality of care received by the patients of the Medical Center. These parameters are bench marked against laboratory experiences and expectations.

**5)** **Review/Revision/Implementation:**

All procedures must be reviewed at least every 2 years.

* All new procedures and procedures that have major revisions must be signed by the CLIA Laboratory Medical Director.

* All reviewed procedures and procedures with minor revisions can be signed by the designated section manager.

Pathology QA/QI Program

Inpatient Phlebotomy (QA)

INPATIENT PHLEBOTOMY Quality Assurance and Improvement Plan

Inpatient Phlebotomy is the section of NCBH Pathology Laboratories that is responsible for inpatient blood collection services. The quality of the blood collection service is determined by the adherence to proper Phlebotomy technique and by the timeliness, accuracy, and completeness of the total collection process.

The following performance monitors for Inpatient Phlebotomy were selected because they track common, important problems that significantly impact the quality of care received by the patients of the Medical Center. These parameters are bench marked against laboratory experiences and expectations.

QA MONITORS AND REPORTING

1. Phlebotomists go to inpatient nursing units with collection lists that are generated through the LIS in the laboratory. Any samples not collected must be cancelled or rescheduled in the LIS with the reason and initials of the person notified. The number of test requests that are credited for technical difficulty will be tallied monthly. This number will be tabulated and reported to the Pathology QA Committee along with any comments relating to specific problems or corrective actions. The goal is to not exceed 0.8% unsuccessful attempts.
2. The number of accidental needle-stick/blood and body fluid exposures to the phlebotomists will be recorded as an indicator of adherence to proper phlebotomy technique. These will be tabulated, reviewed, and reported as above. The goal is to keep this at one or less per month. If this threshold is exceeded, it will be investigated and retraining will occur if necessary.
3. Hand Hygiene compliance is observed throughout the month by the Infection Prevention team, and is reported monthly. The goal is to achieve 90% compliance for Wash In and Wash Out.
4. Suggestions for expansion or improvement of Inpatient Phlebotomy activities will be reviewed and documentation maintained as to the disposition of the suggestions. Documentation will include implementation, modification, outcomes or corrective action as needed.
5. Physician satisfaction is monitored by recording the complaints or concerns filed by or on behalf of the physicians.
6. Employee concerns related to safety and quality laboratory testing will be reported as they are submitted.

|  |  |  |
| --- | --- | --- |
| Revised  March 5, 2019 | Gregory Pomper, MD  Medical Director | Laurie Watson, MT(ASCP)  Manager, Inpatient Phlebotomy |

**Wake Forest Baptist Hospital**

**Clinical Laboratories**

**QA/QI Annual Assessment**

|  |  |  |
| --- | --- | --- |
| **Section:** | **Completed by:** | **Date** |
| **Inpatient Phlebotomy** | **Laurie Watson** | **March 5, 2019** |
|  |  |  |

**Criteria Yes No Comment**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Does the QA/QI report follow the QA/QI Plan? | **X** |  |  |
|  |  |  |  |
| 2. Are monitored elements objective and measurable? | **X** |  |  |
|  |  |  |  |
| 3. Are monitored elements appropriate? | **X** |  |  |
|  |  |  |  |
| 4. Are appropriate data collection methods used? | **X** |  |  |
|  |  |  |  |
| 5. Do indicators related to both quality and appropriateness? | **X** |  |  |
|  |  |  |  |
| 6. Are patterns/trends identified on a timely basis? | **X** |  |  |
|  |  |  |  |
| 7. Are action plans developed? | **X** |  |  |
|  |  |  |  |
| 8. Are reports detailed enough to be useful? | **X** |  |  |
|  |  |  |  |
| 9. Has any process resulted in improved patient care? What/How? | **X** |  | **Involve Nursing Education and Wake One teams for shared Process Improvement. Items include but not limited to tube types, labeling/ordering/transporting lab samples, improving communication. Process Improvement Team in place for Shared Unit/Lab to Collect samples** |
|  |  |  |  |
| 10. Should all monitors be continued? If no, which ones. | **X** |  |  |
|  |  |  |  |
| 11. Are revisions needed for the QI plan? |  | **X** |  |
|  |  |  |  |
| 12. Are all staff aware (involved in) QA/QI activities? | **X** |  | **Data is shared and discussed at staff meetings and with the Process Improvement team/Nursing.** |
|  |  |  |  |
| **Manager Signature:** |  |  |  |
|  |  |  |  |
| **Medical Director Signature:** |  |  |  |
|  |  |  |  |