1. **Purpose:**

The Quality Assurance / Quality Indicator Program for the Clinical laboratory at Doctors Medical Center of Modesto are designed to monitor high risk or problem prone tasks, in addition to routine quality control and maintenance. When opportunities are identified for improvement, correction action will be taken; the process will continue to be monitored for performance improvement (PI). Where appropriate the target goal will reflect the desired outcome 90% of the time or greater for average of the last four months. Data will be evaluated monthly.

This Performance Improvement Plan describes the approach of Laboratory to quality that is used to plan, design, and measure, assess and improve Laboratory and POC performance. Under this plan, our services:

* Provide high-quality, clinical services and demonstrates the outcomes of services

(based on the Partnership for Change Initiative as applicable):

* Achieves performance improvement goals in a systematic manner through collaboration with our medical directors and staff.
* Provides a culture where care is delivered in a safe environment and quality is measured, monitored, and continuously improved;
* Utilizes performance improvement information and aggregate data (non-patient identifiable) in formulating and achieving objectives of the strategic plan.

Opportunities for process improvement will be identified from a variety of sources such as:

1. Industry standard goals
2. Regulatory requirements
3. Amended reports
4. Customer complaints
5. Observed process errors
6. Laboratory quality variance program.
7. Hospital patient safety program (eSRM)
8. **Mission, Vision, Values**
	1. Mission: Laboratory
* Doctors Medical Center Laboratory’s Mission Statement is:

“To collect high quality specimens in a compassionate, caring and timely manner and to provide high quality, cost effective and timely Laboratory results responsive to the needs of our customers”

* The Laboratory’s Performance Improvement Program Mission Statement is: “Doctors Medical Center Laboratory commits to continuously improving quality services by meeting or exceeding identified expectations of our external and internal customers consistent with our mission and strategic goals.”
	1. Vision Statement:

“The vision of this Performance Improvement Program is to ensure that patients are provided high quality care in an environment of minimal risk. This Doctors Medical Center (DMC) Program, under the direction of Administration and the Medical Staff Leadership, has the responsibility for monitoring the identified aspects of patient care, from admission through discharge in order to identify and take advantage of opportunities for improved patient care and safety.”

* 1. Values:

In order to continuously improve care and services, the following values have been developed:

1. The laboratory pathologist, administrative and supervisory staff monitor and evaluate the quality and appropriateness of care and services and clinical performance. The Laboratory will resolve identified problems and report information to the Pathology Committee.
2. Necessary information is communicated to laboratory staff and management when problems or opportunities to improve patient care and/or services involving more than one department/service occurs.
3. The status of identified problems is tracked to assure improvement or resolution.
4. Information from departments/services/clinics and the findings of performance improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/ service.
5. Important aspects of care and service to the health and safety of patients are identified: occur frequently or affect large numbers of patients; place patients or staff at risk of serious consequences or deprivation of substantial benefit if care and service is not provided correctly or not provided when indicated; or care and service provided was not indicated or tends to produce problems for patient or staff.
6. **Assignment of Responsibility**
	1. **Laboratory Medical Director**

The Laboratory Medical Director is responsible for establishing and maintaining the laboratory’s Performance Improvement Program. It is the Laboratory Director’s duty to assure that laboratory services are appropriately delivered within the guidelines established by the medical staff and hospital leadership while meeting all standards and regulations. The laboratory’s Medical Director has delegated oversight of performance improvement functions to the Laboratory Administrative Director and supervisors.

The Board of Governors requires the medical and organization’s staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the performance improvement activities will be evaluated and reported to the Board of Governors.

##### Laboratory Leadership

The Laboratory Administrative Director along with the Supervisors have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders perform the following functions:

1. Adopt an approach to performance improvement, set exceptions and priorities for organization-wide performance improvement, that are designed to improve safe patient care delivery, outcomes, and customer satisfaction.
2. Ensure that important processes and activities are measured, assessed, and improved systematically throughout the organization.
3. Participate in interdisciplinary and interdepartmental performance improvement activities in collaboration with the medical staff.
4. Allocate adequate resources including personnel, time, and data collection systems for assessment and improvement of each department’s clinical and support processes.
5. Assure that the department staffs understand the performance improvement processes.
6. Analyze and evaluate the effectiveness of the performance improvement activities.

##### Medical Staff, Employees, and Contracted Services

The medical staff, employees, and contracted services (pathology assistants) participate in identifying opportunities for improvement, data collection, multidisciplinary teams and implementing actions to sustain improvements as appropriate.

* 1. **The Pathology Committee**

The Pathology Committee has the responsibility to assure that the principles of performance improvement are utilized throughout the departments. The Pathology Committee has representation from the medical staff, laboratory and respiratory care management and staff and reports to the Medical Executive Committee. Pertinent quality and performance improvement issues will also be communicated to the Hospital Quality Council.

The Pathology Committee meets bi-monthly or as indicatedand performs the following functions:

1. Establishes goals and priorities for performance improvement activities and patient safety in accordance with the organization’s mission, vision, values, strategic plan, (and the Partnership for Change Initiative).
2. Assures that the participants have the appropriate education and other support for performance improvement activities.
3. Assures department- wide communication of performance improvement activities and accomplishments.
4. Establishes the prioritization of departmental performance activities.
5. Reviews and approves departmental activities and proposed actions.
6. Maintains an ongoing inventory and consolidated documentation of all performance improvement activities, including quality controls and improvements to patient safety.
7. Provides information and ongoing communication to the Quality Council.
8. Evaluates the effectiveness of the performance improvement process.
9. Reviews, analyzes and acts upon AABB, JCAHO, HCFA and other State and Federal required measures.
10. Identifies significant medical staff practice variations and forwards the variation to the appropriate medical staff committee for further evaluation and action.

* 1. **Performance Improvement Teams**

The hospital Quality Council charters Performance Improvement Teams. Teams are multidisciplinary and include members of the medical staff and departments/services most closely related to the topic or who represent the focus of the team. The Pathology Committee identifies representatives for these teams.

**IV. Performance Improvement Methodology**

There is a planned, systematic, organization wide approach to improving the performance of care and services using the PDSA Cycle approach:

1. **Plan** - Analyze the problem

2. **Do** - Prevent the problem through solution planning

1. **Study -** Sustain the improvement through data analysis
2. **Act** - Multiply the gains through data analysis and standardize the change

**V. Prioritization**

Performance improvement initiatives will be based upon the following criteria:

1. Patient safety
2. Community needs
3. Needs and expectations of patients/residents and families
4. Low/high volume of occurrences
5. High risk
6. Problem prone occurrences
7. Financial impact
8. Regulatory (Federal and State) implications
9. Competency of staff and training needs
10. Support of the Strategic Plan and Partnership for Change initiative

**VI.** **Measuring and Monitoring Performance**

Processes, functions, or services are designed/redesigned well and are consistent with sound business practices. They are:

* Consistent with the mission of Laboratory and its vision, values, goals, objectives, and plans;
* Meeting the needs of individuals served, staff and others;
* Clinically sound and current;
* Incorporating information from within the organization and from other organizations about potential/actual risks to patients;
* Analyzed and pilot tested to determine that the proposed design/redesign is an improvement; and
* Incorporated into the results of performance improvement activities.

Data collection is systematic and is used to:

* Establish a performance baseline;
* Describe process performance or stability;
* Describe the dimensions of performance relevant to functions, processes, and outcomes;
* Identify areas for more focused data collection to sustain improvement.

The organization requires an intense analysis of undesirable patterns or trends in performance when the following is identified which includes but is not limited to:

* Levels of performance, patterns, or trends vary significantly and undesirable from those expected;
* Performance varies significantly and undesirable from that of other organizations;
* Performance varies significantly and undesirably from recognized standards;
* When a sentinel event occurs; (A Root Cause Analysis is completed according to the Sentinel Event policy.)
* Confirmed transfusion reactions;
* Close calls and hazardous conditions;
* Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses

**VII. Documentation of Performance Improvement Activities**

All minutes recorded within the Pathology Committee will be documented utilizing the format of conclusions, recommendations, actions, and follow-up (CRAF).

**VIII. Confidentiality**

All Performance Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulation of the Medical Staff.

* Confidential information may include but is not limited to: the medical staff committee minutes, performance improvement minutes, electronic data gathering and reporting, sentinel event and untoward event reporting and clinical profiling.
* Some information may be disseminated on a “need to know basis” as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proved a “need to know basis”, as approved by the Medical Executive Committee, Hospital Administration and/or the Board of Governors.
1. **Annual Evaluation**

Administrative management of Laboratory and its Medical Director will review the effectiveness of the Performance Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient safety. An annual evaluation will be completed to identify parts of the Performance Improvement Plan that require development, revision or deletion. Administrative management evaluate annually their contributions to the Performance Improvement Program and improving patient safely.

1. **Indicators Monitored**
2. **Pre-analytical**
	1. Proper bedside identification of the patient, using two identifiers, name and medical record number; Goal = 100% compliance
		1. Obtained from Lab Variance Log
		2. Obtained from eSRM quality reports
	2. Specimen handling including collection, labeling, preservation, transportation, and rejection; Goal <3.0% rejection
		1. Obtained from Lab Variance Logs
		2. Obtained from eSRM quality reports
	3. Nursing related variance including collection, labeling and standard operating procedure compliance; Goal XXX
		1. Obtained from Lab Variance Logs
		2. Obtained from eSRM quality reports
3. **Analytical – Microbiology**
	1. Blood culture contamination rate; Goal <3.0%
		1. Monthly report produced by Microbiology Supervisor
4. **Analytical – Blood Bank**
	1. Wasted units; Goal <10%
		1. Bi-monthly report produced by Blood Bank Supervisor
		2. Presented at the bi-monthly Pathology Quality meeting
	2. Single Unit transfusion; Goal >50% of all transfusions will be single unit
		1. Daily, monthly, quarterly and yearly reports available from the LIS
	3. Hemoglobin <7 gm / dl; Goal >40% of all transfusion have Hgb levels <7 gm/dl.
		1. Daily, monthly quarterly and yearly reports available from the LIS
	4. Labor and Delivery Patients:
		1. Positive for Anti-D due to RhIg shot – antibody identification is valid up to ten (10) days during the patient stay. Repeat antibody identification after ten (10) days. In the result column, click comment and type “Previously identified Anti-D antibody due to RhIg shot”
5. **Analytical – Point of Care**
	1. Performance of QC and Maintenance; Goal >90% compliance rate
		1. Obtained from monthly audit from Point of care
6. **Post Analytical**
	1. All critical results are reviewed to confirm notification of value and documentation of notification; Goal 100%
		1. Monthly report available from the LIS
	2. STAT TAT report; Goal >80% within 60 minutes from order to result
		1. Monthly report available from the EMR
	3. Troponin TAT report; Goal – 75 minutes
		1. Available from EMR
		2. Reported to ER and stroke committee monthly

Reviewed and accepted by:

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 Director of Laboratory Date

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 Medical Director of Laboratory Date

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 Laboratory Supervisor Date