[](http://depts.washington.edu/labweb/index.htm)

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| **University of Washington,**  **Harborview Medical Center**  **325 9th Ave. Seattle, WA, 98104**  **Transfusion Services Laboratory**  **Policies and Procedures Manual** | **Original Effective Date:**  **August 15, 2011** | **Number:**  **1900-3** |
| **Revision Effective Date:**  1/15/14 | **Pages:**  2 |
| **TITLE:** QSE: Process Improvement  Quality Policy: Process Improvement | | |

**Policy:**

The Harborview Medical Center Transfusion Service collects and analyzes data including near miss events, to determine where preventive and corrective actions are needed, and follow up on implementing the necessary preventive or corrective actions

**Purpose:**

To provide direction for the processes and procedures for identification and development of preventive actions for anticipated quality problems and corrective actions for identified opportunities for improvement.

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| **Role** | **Responsibility** | **Related Documents** |
| Medical Director | * Participate in policy decisions regarding quality indicators and data collection methods. * Follow regulatory requirements for data collection, such as transfusion practice review. * Review and approve processes and procedures. * Participate in decisions about corrective action. * Review and approve corrective action results. * Participate in improvement teams. | Transfusion Practice Committee Minutes |
| Laboratory Manager | * Participate in policy decisions regarding quality indicators and data collection methods. * Review and implement new processes and procedures. * Participate in decisions about corrective action. * Review and implement corrective action results. * Participate in data collection * Work with Quality Coordinator to design audit plan * Work with Quality Coordinator to prepare annual quality report. | * SQ Operations Reports |
| Quality  Coordinator | * Prepare quarterly reports for Transfusion Practice Committee. * Use data and information about operational processes and performance, as well as occurrence management to identify opportunities for quality improvement. * Lead quality improvement teams * Work with Lab manager to design audit plans. * Responsible for implementation and maintenance of audit plan. * Prepare audit reports. * Work with manager to prepare annual quality reports. |  |
| **Role** | **Responsibility** | **Related Documents** |
| Laboratory Staff | * Participate in improvement teams when asked. * Help with data collection when assigned. * Identify opportunities for quality improvement observed through operational processes. |  |
| **Quality Element** | **Action** | **Related Documents** |
| Continual Improvement | HMC Transfusion Service has a defined, systematic approach for continual improvement of operational processes and the quality management system that includes the review of the following:   * Assessment Results * Audit Results * Non-conforming products and tissue * Proficiency Testing Results * Quality Control Records and Review * SQ Quality Assurance Report * Quality Indicator Data * Quality Improvement Monitor Form | * QIM Form * Proficiency Testing Process * SQ Operations Report * Monthly Data Collection * Audit Plan * Training Evaluation Process * Blood Product Inspection Policy |
| Implementing Corrective Actions and Preventive Actions | * Corrective action is taken when actual nonconformances, deviations, complaints, and process failures occur. * Corrective action will address the root causes of such events to reduce or eliminate their recurrence. * Preventive action is taken when data analysis or trends indicate the potential for a nonconforming product or service. * Preventive action will eliminate the root causes of potential nonconformances in order to prevent their occurrence. * Corrective actions and preventive actions will be appropriate to the level of risk and potential for serious adverse outcomes associated with the issue being addressed. | * Occurrence Management Policy * Using the Quality Improvement Monitor Form |
| Monitoring | * Corrective actions and preventive actions are monitored to verify successful implementation. * The results are reviewed by the Medical Director. | * Occurrence Management Policy * Using the Quality Improvement Monitor Form * Quality Policy: Monitoring and Assessment |
| Follow-up | * Monitoring after Corrective Action will be reviewed. * The Manager in conjunction with HR and Medical Director will determine whether any additional action is needed. |  |

**References**

AABB Standards for Blood Banks and Transfusion Services, Current Edition.

Quality Manual Preparation for Blood Banking, Lucia Berte, AABB Press, 2nd Edition.