**Rush Copley Laboratory Quality Plan**

**Purpose:**

Rush Copley Laboratory’s Quality Plan attests to quality and standardization within our laboratory that support our ability to consistently produce accurate and timely laboratory results. The Quality Plan covers all areas of the laboratory and includes clinical staff and patients. Quality metrics are documented monthly and reviewed annually for overall effectiveness.

**Quality System Essentials**

**Structure**

* **Organization and Leadership**
	+ Structure
	+ Mission, Vision
	+ Leadership Review

Our structure is represented in the laboratory organizational chart

Our Mission: The mission of Rush Copley is to provide advanced medicine with quality outcomes and extraordinary care. Our laboratory subscribes to the same mission.

Our Vision: To become the region’s leading healthcare system. This is accomplished through relationships with medical staff, employees and the community. Our laboratory contributes to the vision by a strong partnership with nursing, and enhanced communication with all hospital departments for the benefit of our physicians, patients and their families.

Leadership Review: Operating within a Quality System allows us to meet and exceed the requirements of regulatory and accreditation agencies and facilitates service satisfaction for our medical staff and patients. We evaluate the effectiveness of our Quality Program through audits, monitoring and review by our manager/director and Medical Director (Technical Specialist).

**Facilities and Safety Management:**

**Environmental Conditions:**

* + The laboratory is maintained in a clean and organized state.
	+ Our temperature and humidity are controlled by a sophisticated hospital system.
	+ The hospital supplies our deionized water for laboratory faucets and monitors the composition, resistivity and pressure. The laboratory monitors the water monthly for bacterial growth
	+ Chemistry and Hematology instruments receive water from a reverse osmosis system installed by a third-party vendor approved by our chemistry and hematology vendors.
	+ Annually the staff is surveyed about ergonomics with the intention of identifying issues before health problems occur.
	+ Lighting is adequate and anti-fatigue mats are placed in strategic locations.
	+ Locker room, two bathrooms and a break room to service all lab employees.

**Communications:**

* + Within each department there is a communication log. Any information that is important for that specific department is written in the communication log for all staff to read.
	+ All lab employees are required to read the log at the start of their shift.
	+ A verbal “hand-off” process is required at shift change allowing the staff leaving to relay essential information to the staff coming on duty.
		- Each morning there is a department huddle where issues over the last 24 hours related to instrument, supplies, IT and staffing are discussed. Minutes are emailed and printed daily.
	+ The hospital email system is widely used for hospital and lab email communication.
	+ Periodically there are lab meeting or email update with topics such as finance, staffing, technical updates and computer updates made available to all staff.
	+ Staff is encouraged to give input and feedback to any issue they deem necessary.
	+ Nursing has several Congresses which lab participates. Important nursing information is disseminated and frequently lab will discuss changes that affect nursing.
	+ Monthly newsletters for the hospital, nursing and medical staff include laboratory essential information concerning new testing, new products and changes in policy or protocol.

**Safety:**

* + All staff is required to read and sign off on the laboratory safety manual.
	+ When newly hired, all employees are given basic fire, electrical, hazardous material safety training.
	+ Annually all hospital employees are required to take net learning classes that cover a wide range of safety topics to include Slips and Falls, Patient handling, Needle, Sharps and Splash pre-cautions and reporting of work-related injuries.
	+ Fluid resistant lab coats and safety shields/goggles/masks, gloves are provided to the staff.
	+ Employees wear powder free, latex free nitrile gloves in a size that protects them and allows them to work effectively.
	+ Quarterly Environment of Care and Hazard surveillance audits are conducted to audit compliance with hospital, CAP and Joint Commission standards.
	+ Hazardous materials, such as specimens, are placed in appropriate biohazard containers that are removed daily.
	+ Laboratory equipment is kept in good working order and electrical safety checks are provided by the biomedical engineering department.
	+ Laboratory conducts a full evacuation fire drill annually.
	+ Emergency Management: Laboratory abides by the hospital Emergency Management Plan and participates in annual disaster drills.

**Personnel Management**

* Staff Qualifications
* Our laboratory follows the CLIA Laboratory Personnel Standards.
* Certifications, Registration etc. are verified by Human Resources prior to beginning employment.
* Proof of education and registration (where appropriate) is obtained and maintained as part of the personnel file.
* Job Descriptions
	+ Each job class within the laboratory has a job description.
	+ Job descriptions are reviewed annually for pertinence.
* Orientation and Training:
	+ All laboratory hires attend a 2-day hospital orientation program. Phlebotomists attend a third day of clinical orientation.
	+ Once in the laboratory new hires are required to read the general laboratory policy manual and the safety manual.
	+ They are acquainted with their personal protective equipment, and shown the fire exits and location of fire extinguishers.
	+ The training schedule is presented, and they receive their checklist for the first area in their rotation.
	+ Each week for the first month new staff meets with the lab manager to discuss any issues and the progress they are making.
	+ Once their checklist is complete competency assessments are performed.
	+ All staff must pass their competencies to work independently.
* Competency:
	+ Once training of new employees is complete, and annually thereafter, all staff undergoes competency assessment. See 4840-G-303
	+ Competency for each employee includes:
* Direct Observation of patient testing
* Monitoring the recording and reporting of test results
* Review of results, QC and preventative maintenance records
* Direct observation of system checks
* Assessment of performance using blind samples or proficiency testing samples.
* Critical thinking skills
* Continuing Education:
	+ All laboratory staff is encouraged to maintain current knowledge in their respective areas of expertise.
	+ This education can take multiple forms such as journal articles, formal seminars, and webinars.
	+ Instrument manufacturers will present lunch and learns, and our MedTraining software has an on-line library with many topics that can be viewed.
	+ Staff are responsible for their own continuing education credits and supplying that information to lab management.
* **Process Management**
* The laboratory uses process management to transform policy into action. Processes and procedures direct how the laboratory manage pre-analytical, analytical and post analytical activities. Process management also helps to effectively and efficiently utilize costly human and other resources.
* New and modified quality and technical processes are assessed for risk, analyzed, and designed to ensure consistency, meet customer expectations and support adherence to regulatory and accreditation requirements.
* All processes are documented with procedures (instructions), flow charts or other forms of communication to laboratory personnel on how to meet regulatory requirements, and customer expectations while performing their work.
* Biological reference intervals are included in the documentation (procedure) for each test method as appropriate
* New testing methods are validated and /or verified as meeting intent before implementation. This applies to all equipment, instruments, computer systems and related software, and reagent kits. The laboratory uses a verification process to challenge previously validated performance to confirm acceptable repeatable performance.
* Quality control (QC) is used to control and ensure efficiency and effectiveness of critical processes. QC is monitored with recording, review and evaluation of results obtained so that errors can be prevented and /or detected. A documented QC plan is maintained for each testing method, which specifies the control materials used, frequency of running the QC material and actions to take when the QC is out of range.
* The laboratory reviews and evaluates procedures and processes through QC, audits and staff suggestions. The information is used to make any necessary changes or improvements. When such changes are needed, they may develop into a quality improvement initiative.
* **Equipment Management**
	+ Laboratory equipment is provided and replaced as needed to ensure quality of lab services.
	+ The laboratory selects equipment by identifying the necessary functional specifications, the environment and engineering requirements
	+ Acquisition and purchasing are done in collaboration with the hospital’s management team, legal department and purchasing and contracting resources.
	+ Each piece of new equipment is uniquely identified with an asset tag and thoroughly checked out by the biomedical engineering team before placing into the laboratory.
	+ Installation is performed by the manufacturer or in accordance with the operator’s manual.
	+ Performance qualification (method verifications and validations) are performed by the laboratory personnel to ensure that, through documented procedures, instruments and equipment perform as intended.
	+ Laboratory personnel are authorized to use equipment through training and competency assessment. Staff follows the manufacturer’s instructions and approved procedures. All procedures are kept current and readily available.
	+ Calibration, using calibration materials traceable to certified standards and following the manufacturer’s recommendations are performed. Actions are taken before resuming use when verifications fail to meet the predetermined criteria.
	+ The measurement accuracy and function of equipment is verified periodically or at defined intervals.
	+ Routine maintenance follows the manufacturer’s recommendations
	+ Troubleshooting of equipment problems is documented and functionality is verified after all repairs, adjustments or significant maintenance events, and before resuming use.
	+ Equipment is taken out of use with a record of the date, decontamination and removal of all confidential information and the final disposition.
* **Inventory Management**
	+ This process details procedures to obtain equipment, instruments, reagents, consumables and office supplies acquired from external sources which are needed for efficient, continual and cost-effective operations.
	+ The laboratory maintains good relationships with suppliers, contractors, and referral labs.
	+ Suppliers are selected based on group purchasing agreements and the ability of the vendor to meet the needs and expectations of the organization and laboratory.
	+ The laboratory, in conjunction with materials management create, review and amend agreements with vendors.
	+ The organization has a detailed process for the submission and approval for purchase of capital equipment.
	+ Periodic review of agreements with vendors is conducted to ensure expectations and requirements are met.
	+ Materials are inspected when they arrive and in some cases are evaluated to determine if they meet established acceptance and /or performance criteria.
	+ Materials are stored in designated areas and per manufacturer’s instructions.
* **Document and Record Management**
	+ This process gives to direction to managing and retaining documents for laboratory management and technical processes and procedures, and for managing and retaining records of patient results.
	+ Laboratory documents, policies, procedures and forms used by the laboratory are managed through creation, review and approval.
	+ New documents and those with significant changes are reviewed by the laboratory director and medical director and approved before use.
	+ All procedures are reviewed every two years to ensure that unchanged documents are still correct, complete and current. Review is conducted by the medical director or a CLIA appropriate designee.
	+ All procedures have document control sheet which outlines the historical record for each document until it is retired.
	+ Obsolete procedures are retired, marked as such and placed in a “retired procedure” file.
	+ Records management involves the creation, identification, change, review, retention and storage of paper and electronic records
	+ Records are stored, transported and maintained according to accreditation and organization guidelines.
	+ Record storage:
		- Preserves integrity
		- Provides accessibility
		- Protects confidentiality
		- Prevents damage
		- Facilitates retrieval
	+ Continuous access to records throughout the storage period is supported regardless of the medium used over the duration of the storage.
	+ Disposal and destruction of documents and records after the retention period is done by shredding or by certified vendor to ensure confidentiality of the contents.
* **Information Management**
	+ Information management provides processes/procedures for managing confidential information and its access when received from an external source or generated and entered into an electronic medical record and disseminated electronically or otherwise to users or other computer systems, auto-faxing, e-mail, interfaces and auto-verification.
	+ The processes for managing incoming and outgoing information are managed with commitment to the confidentiality, accuracy, timeliness of protected patient-related and other information.
	+ Laboratory has a process for managing requests for patient information. Patients may obtain results via the Medical Records Department.
	+ Security levels are assigned to restrict access to laboratory records. Passwords are not shared, and they are required to be changed on a regular basis.
	+ Security of the laboratory information system is under the oversight of the Copley Information Technology Department. Appropriate security, firewall and anti-virus software are in place.
	+ Security breaches, if identified are reported to the Information Technology department of the hospital.
	+ Access to patient files, staff’s own medical record and /or other employee’s records is monitored via “Fair Warning” software. Employees found to be in unauthorized medical records are disciplined.
	+ Date integrity is protected and verified on an ongoing basis by the laboratory. There is periodic review that data transfers correctly via instrument interfaces and into other computer systems accurately. Calculations are evaluated and reviewed annually and after the following situations:
		- At installation
		- Whenever a change is made to a software program or data file
		- After restoration of data files
		- After software updates
	+ System downtimes are managed to minimize interruption of patient care.
	+ Processes are in place for unscheduled downtime to ensure that the laboratory’s work and availability of results and reports are not compromised during the downtime.
* **Occurrence Event Management**
	+ Provides direction for the laboratory’s processes and procedures to capture events to identify systemic problems and commit to removing the cause and thus reduce risk.
	+ The organization supports a “just culture” environment, promoting a non-punitive approach in which personnel at every level feel free and comfortable reporting issues or events.
	+ Laboratory staff uses a quality improvement and assessment form to record minor events within the laboratory.
		- Documentation is done on the laboratory occurrence form.
		- Root Cause Analysis may be performed based on the nature of the occurrence.
	+ The organization has an on-line occurrence reporting form to be used for events outside of the department that involve another department or non-laboratory staff. Items that should be entered into the hospital’s system are listed below but are not limited to just these. When in doubt enter the report into the hospital’s on-line occurrence report.
		- Lost specimen
		- Wrong patient/test/result
		- Mislabeled or unlabeled specimen
		- Contaminated specimen
		- Wrong patient/site/test
		- Incorrect result (corrected report)
		- Significant delay in testing
		- Affect patient care or safety
	+ All laboratory staff is encouraged to self-report if they participate in an event. Both reports identify the “what, who, how and why” of the problem as can best be determined.
	+ The Lab’s internal quality improvement and assessment forms are managed internally where they are reviewed by the manager, administrative director and medical director. Anything meeting the criteria for hospital reporting / impact patient care and safety is also entered into the hospital’s occurrence report.
	+ The hospital’s occurrence reports are referred to the risk management and quality departments for review along with Lab management.
	+ The laboratory documents each occurrence report and if an event repeats it can be made into a quality improvement initiative which will be reviewed by the laboratory quality improvement team, risk management and quality departments.
	+ When occurrence information is received it is reviewed and analyzed to facilitate identification of patterns or trends that highlight the need for a root cause analysis and corrective action.
	+ Occurrences are recorded on a spreadsheet and if further investigation is warranted that is documented.
	+ The needed follow-up is documented on the spreadsheet once completed.
	+ The laboratory responds to manufacturer’s recalls of materials, software and equipment as soon as it becomes aware of the problem. Products are discontinued and the event is documented.
* **Monitoring and Assessment Management**
	+ Provides direction for the procedures used for internal and external monitoring and assessment to verify that lab processes meet requirements and are functioning in overall effectiveness of the Quality Management System.
	+ The laboratory demonstrates commitment to quality practices through enrollment in external accreditation by the College of American Pathologists.
	+ The laboratory verifies accuracy and reliability of testing and specimens through enrollment and participation in external proficiency testing programs. If no formal program is available, the lab would maintain an alternative method of verification.
	+ The laboratory conducts internal audits and verifications of compliance using a quality dashboard which is updated monthly. The quality indicators measure performance across pre-analytical, analytical and post-analytical processes. Action is taken when the information from the indicators demonstrates unacceptable performance or a trend in that direction.
	+ Blood utilization is monitored with several quality indicators. The laboratory participates in the blood utilization committee.
* **Service and Satisfaction Management**
	+ Employees are surveyed annually to assess their engagement with the organization and the laboratory. Action plans are generated based the score achieved.
	+ Employees are surveyed annually for their opinion of our organization’s Culture of Patient Safety. Departments are asked to pick 1-2 items from the results and develop an action plan addressing the topic
	+ Patients receive a Press Ganey survey which, when returned is scored and makes up our HCAHPS score. Everyone employee has an annual goal to achieve a certain percentage as an organization. This is part of each employee’s annual appraisal.
* **Continual Improvement Management**
	+ A process for identifying opportunities for improvement and using a defined strategy to eliminate process problems and enhance patient satisfaction, reduce waste and lower costs. Using the Occurrence reports, internal lab quality assessment forms and the lab quality metrics dashboard, concerns are identified, and the quality committee will meet to begin the root cause analysis.
	+ The strategy used involves:
		- Identifying opportunities
		- Select which opportunity to focus on
		- Using Fish Bone diagrams to determine root cause
		- Generate ideas for solutions
		- Determine how to implement the agreed upon solutions
		- Determine how to evaluate success
		- Determine how to sustain the improvement
	+ Annually the Quality Management System is reviewed for effectiveness in pursuit of being a high-reliability laboratory/organization.
	+ The quality activities in the laboratory are reported within the hospital, and the laboratory is a member of the following committees where quality is discussed:
		- Hospital Quality Committee
		- Ancillary Committee
		- Compliance Committee
		- Nursing and Patient Quality Committee
		- Regulatory Readiness Committee
		- Safety Committee

**Quality Monitoring Elements**

**• Patient and Specimen Identification**

* Upon drawing blood or obtaining any lab specimen two patient identifiers are used to ensure we are servicing the correct patient. The use of positive patient ID via our laboratory information system allows us to scan the patient's ID band and confirm we are with the correct patient. If we needed to resort to non-electronic ID methods, we would use the first and last name, and date of birth of the patient.
* Specimen must be labeled with the patient's full name, date of birth, date and time of the draw, and the initials of the staff collecting the specimen. Using the positive patient ID method of collection, we can print all labels at the bedside. The labels contain the patient’s name, DOB, medical record number and financial number, name of the tests to be collected, date and time of collection and initials of the person collecting the specimen**.**
* Specimens not labeled or labeled improperly and/or a red rule violation, (wrong patient drawn, or tube labeled with another patient’s label) are entered into the hospital quality system and addressed with the collector.
* As part of our pre-analytical quality measures, we do initiate a QA (quality assurance) form when it becomes known that someone in lab ordered the wrong test in our outpatient and reference send out areas.

**• Specimen Acceptability**

* Specimens are checked for hemolysis, lipemia and icterus before being analyzed for chemistry tests. Specimens that are QNS or clotted are submitted for recollection.
* **Turn Around Times**
* We monitor turnaround times for STAT testing of CBC, CMP and urinalysis from the Emergency Department.
* Lab monitors turnaround time for all Troponin orders on Code Stroke patients.
* Within 24-48 hours a department senior tech or designee reviews the "critical result report" and looks for the appropriate documentation of the results called and read back. Should either be missing a quality assurance form is be generated.

**• Satisfaction:**

* As part of the hospital's satisfaction survey, satisfaction with our phlebotomy service is a part of each patient survey.
* Every 2 years the physician staff is surveyed about their satisfaction with laboratory and pathology services.
* Annually all hospital employees are invited to take an engagement survey. The laboratory receives department specific results.

• **Corrected Reports**

* All corrected reports trigger a quality assurance report to be filled out.
* The manager or Clinical Lab Technical Specialist meet with the associate to determine the cause and do re-education if indicated or determine if workflow or process needs to be changed.
* Pathology monitors their corrected report statistics.

• **Blood Components**

* Cross-matched to Transfused Ratio
* Transfusion errors due to patient ID errors
* Transfusion reaction rate
* Hemolytic transfusion reaction rate

• **Blood Cultures**

* Contamination rate
* Bottle fill volume
* **Reference Lab**
* Turn- around time - % they met their published TAT
* Number of tests ordered but not performed. This could be a specimen problem or lab accident at the reference lab.
* Monitor their quarterly performance on proficiency surveys.

• **Proficiency Testing**

* Monitor our % of successful challenges

**• Safety**

* Number of needle sticks
* Employee injuries
* **Identifying and Evaluating Errors and Incidents**

The Quality Management Program encompasses both internal and external occurrence reporting. Internal process makes use of a QA (Quality assurance) form that allows an error or incident to be categorized as pre-analytical, analytical, post analytical or other.

Completion of Quality Assessment and Improvement Forms

1. Classify the report by checking off the appropriate category.

2. Fill out the date of report, hour and location of the occurrence.

3. Indicated the Lab departments and shift involved.

4. Factually record the incident or error. If there was immediate action taken document that action.

5. Submit the form to the senior technologist over the department involved, or manager and discuss the occurrence with them.

6. The senior tech will add any pertinent comments or recommendations, sign the report and submit to the manager for review.

7. The Administrative Director and Manager will review the report and sign it. If clarification is needed, the report will be returned to the Senior Tech, Coordinator or Manager.

8. QA assessments will be shared with the appropriate Laboratory Staff and/or Clinical Laboratory Technical Specialist.

9. The Occurrence will be tracked and trended on the "Quality Tracking" spreadsheet.

10. Trends or items of concern will be discussed at Department Meetings and/or Senior Tech Meetings.

External process makes use of the hospital on-line occurrence reporting system. An occurrence is defined as any event that occurs in the hospital that is outside of standard operating procedure and /or represents a deviation from the standard of care. It may also be defined as any unusual incident or unexpected event involving a patient or visitor that may or may not involve injury.

* **Quality Control**

Our quality control (QC) system is designed to ensure the accuracy and reliability testing process and results.

**Waived Testing**

• **Bedside Glucose Testing**

External QC, two levels, are run a minimum of every 24 hours

• ID NOW **Strep A Testing**

 Internal QC runs with each test

 External QC, positive and negative, run prior to putting the kit into use

• **Urine Pregnancy Testing**

 Internal QC is run with each test

 External QC, positive and negative, run prior to putting the kit into use

• **Urinalysis (Dipstick**)

 External QC, normal and abnormal, run each day of patient testing

 External QC is run when a new bottle of strips is opened.

• **ID NOW A & B 2 Assay**

 Internal QC runs with each test

 External QC, positive and negative, new lot and new shipment.

**Non-Waived Testing**

QC monitors the complete analytical process, including environmental conditions, the test system and the operator. QC monitors the accuracy and precision for immediate error detection and facilitates the detection of errors over time.

The manufacturer's directions for QC must be followed as a minimum. Failure to follow a manufacturer's directions moves a waived and moderately complex test into the high complexity category.

As a minimum, two controls per test per day must be analyzed in the same fashion as a patient sample. Each instrument in a department will have a designated QC plan including number of controls to be run, frequency of testing and appropriate review and documentation. Please refer to department specific procedures for details.

* **Proficiency Testing**
* CLIA and CAP require participation in a CMS-approved proficiency program (PT) every test performed in the laboratory.
* Proficiency testing or an external quality assessment are the mechanisms used to evaluate performance. Performance criteria is specified in three ways (target value =/-, percentage, group standard deviation (SD). Acceptable performance for one event (5 samples) is none or one wrong (80% correct or better); failure for an analyte is two or more incorrect results. For results that are not graded because of non-consensus or not enough responses, we still grade ourselves against the stated result by the PT provider.
* All proficiency testing events are reviewed by the department senior tech, lab manager/director and signed by the medical director.
* All failures are researched for cause, documented and signed by the medical director.
* **Staff Competency**

Every staff member who performs waived and non-waived testing in the laboratory has their competency assessed twice the first year of employment and annually thereafter. For nursing staff performing waived testing, they are assessed annually for competency. For specifics see the competency policy.

* **Quality Assessment and Peer Review in Surgical Pathology, Cytopathology and Autopsies.**
	+ Monitoring of discrepant Frozen Section and Final Diagnoses and reporting to Medical Staff On-going Professional Practice Evaluations (OPPE).
	+ Monitoring for discrepancies and correlating intra- and extra-departmental consultations.
		- * Review of previous and concurrent outside diagnoses and/or histological and cytological materials and correlation with present diagnoses and/or materials.

• Monitoring amended (corrected) Surgical Pathology, Cytopathology, and Autopsy Pathology and reporting to Medical Staff Ongoing Professional Practice Evaluations (OPPE).

• Monitoring requisition deficiencies and specimen adequacy in Surgical and Cyto-Pathology.

• Monitoring autopsy process for percent of total deaths for RCMC JC Regulatory Indicators.

• Monitoring Surgical Pathology, Cytopathology, Autopsy Pathology turnaround times and reporting for Medical Staff Ongoing Professional Practice Evaluation (OPPE).

• Monitoring and reporting percent discrepant Surgical Pathology and Cytopathology diagnoses and pre/post-operative diagnoses for referral to Surgical and OB/GYN Steering Committees for intensive assessment.

* + - * **Quality Improvement Activities**
* Quality Improvement activities initiate from the laboratory dashboard, internal and external occurrence reports.
* Employee injuries are recorded on the occurrence report and forwarded to Employee Health for follow-up.
* Educational activities will be made available to staff as appropriate.
* The Laboratory will perform interim self-inspection, opposite the credentialing year. Records of the self- inspection and efforts and actions taken to correct deficiencies during the process shall be recorded.
* The Lab Director or designee reviews the QA Program annually for its effectiveness.
* Errors, complaints and incidents are reviewed on a monthly basis to identify trends and initiate corrective/preventative actions.

**Hospital Wide Improvement Activities**

The laboratory is represented on the following hospital committees:

* Compliance
* Quality
* Safety
* Ancillary Committee
* Nursing and Patient Quality Congress
* Joint Commission Inspection Readiness Committee
* Hospital Policy and Procedure Committee
* Ancillary Committee
* Workplace Safety
* Environment of Care
* Hazardous Materials Sub-Committee
* Emergency Management
* Trauma Committee (ad hoc member)
* Lab/Nursing Collaborative

The laboratory tracks and submits data to the hospital quality team. This data is made part of the hospital quality dashboard.

**Laboratory Patient Safety goals**

* + Improve patient and sample identification at specimen collection, analysis and resulting.
	+ Improve verification and communication of life-threatening or life-altering information regarding malignancies, HIV (and other serious infectious diseases), cytogenetic abnormalities, and critical results.
	+ Improve identification, communication and correction of errors in a timely manner.
	+ Improve the coordination of the laboratory's patient safety role within healthcare organizations.
	+ All these goals are integrated into the lab QA program. Either internal lab QA forms or online occurrence forms are filled out for any of these variances and reviewed with the staff involved and signed off by or discussed with the Medical Director.

 **Employee Concerns**

Employees are encouraged to communicate concerns to the lab management staff with respect to quality of patient testing and safety. This can be done on a one-on-one basis, at Department Meetings, or by choosing "other" on the lab quality improvement forms. The laboratory has a representative on the hospital "Employee Advisory Committee." Any staff member can raise a concern to this person and have it addressed at the monthly meeting. Meeting minutes are available online to the entire hospital staff.

There is a CAP sign posted in-the laboratory with the phone number staff may use to communicate with CAP directly if they have a concern not addressed by laboratory management. CAP holds such communications in confidence and the laboratory management prohibits punitive action against an employee in response to a complaint or concern made to CAP or other regulatory organizations regarding lab quality or safety.