

# Laboratory Medicine – December 2022

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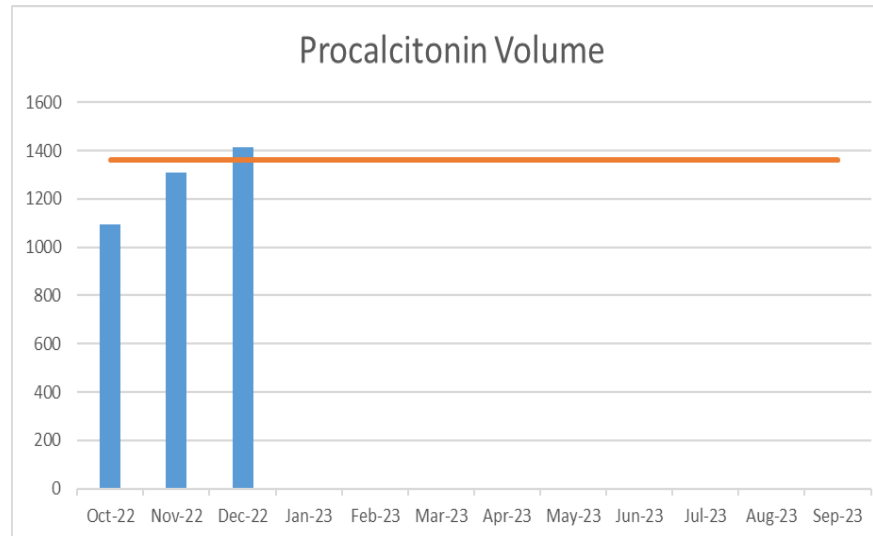
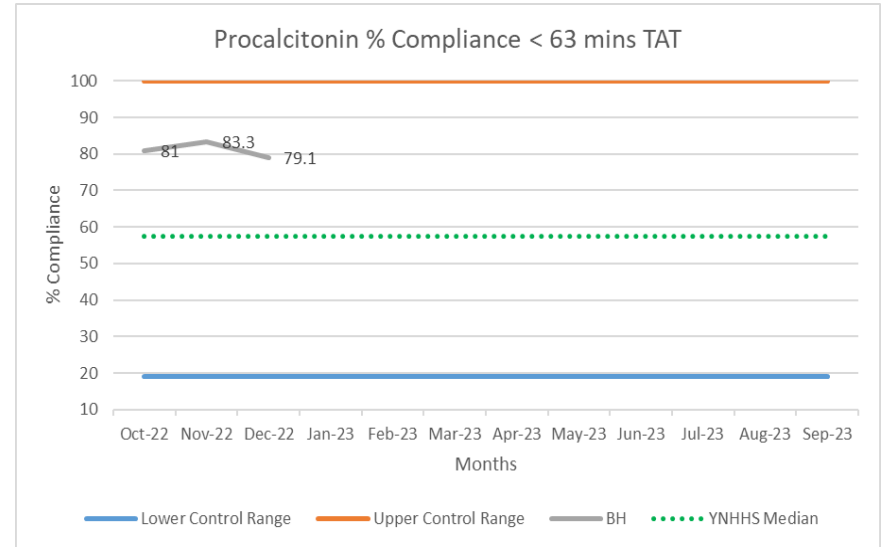
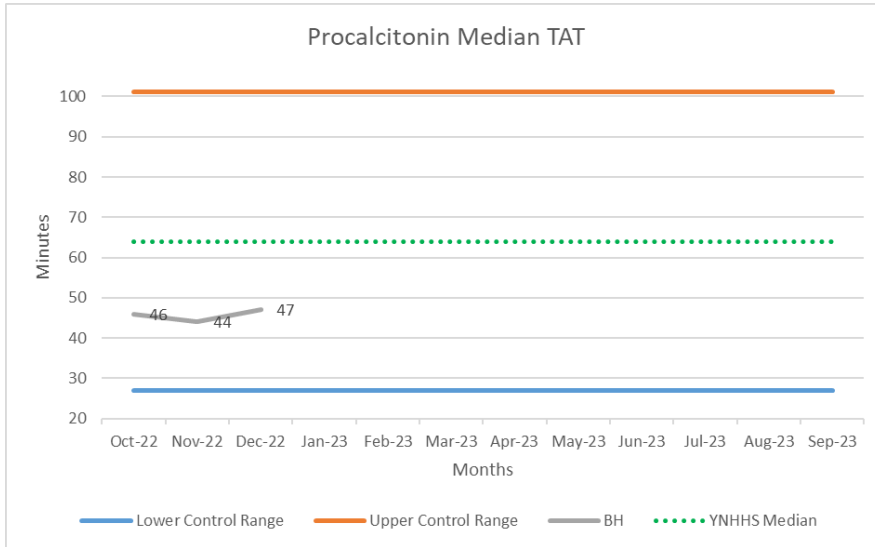
January 26, 2023

# Bridgeport and Milford Campuses Turnaround Time Goals

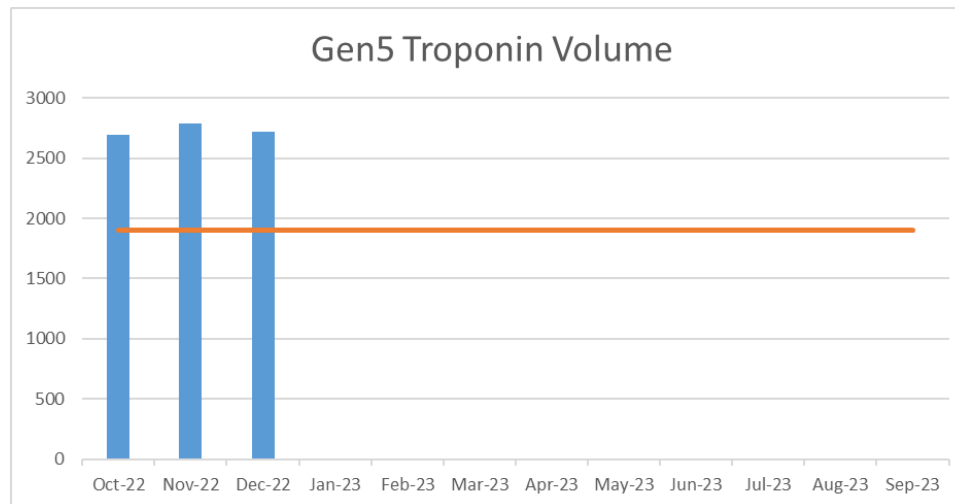
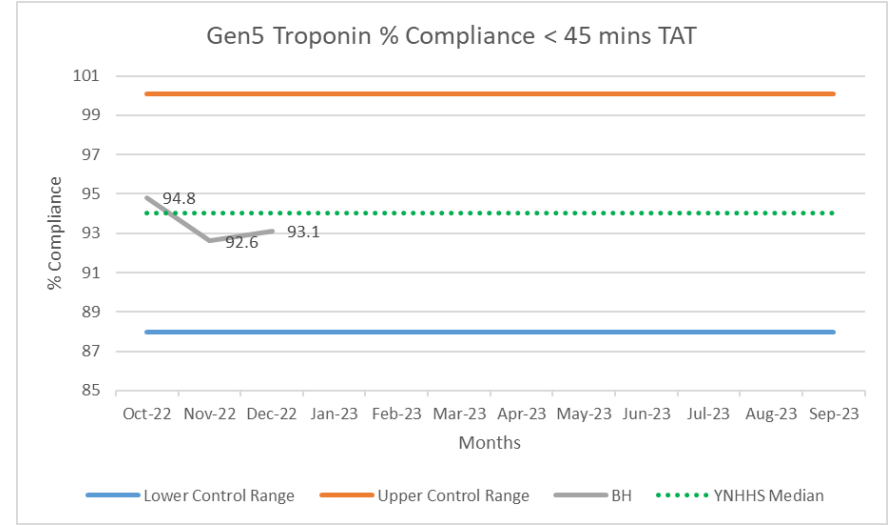
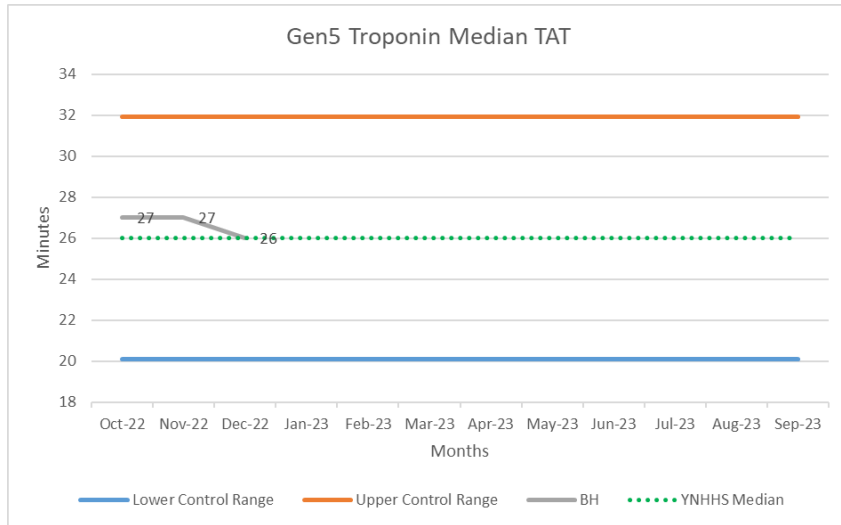
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- Mean determined from median TAT across the Yale New Haven Health System delivery networks
  - Bridgeport and Milford Campuses – Bridgeport Hospital, Greenwich Hospital, Lawrence Memorial Hospital, Westerly Hospital, St. Raphael and York Street Campus – Yale New Haven Hospital and Shoreline Medical Center
- Standard Deviation calculated
- 2 SD Range established and represents the upper and lower limits
  - If data set within control range, no corrective actions are necessary

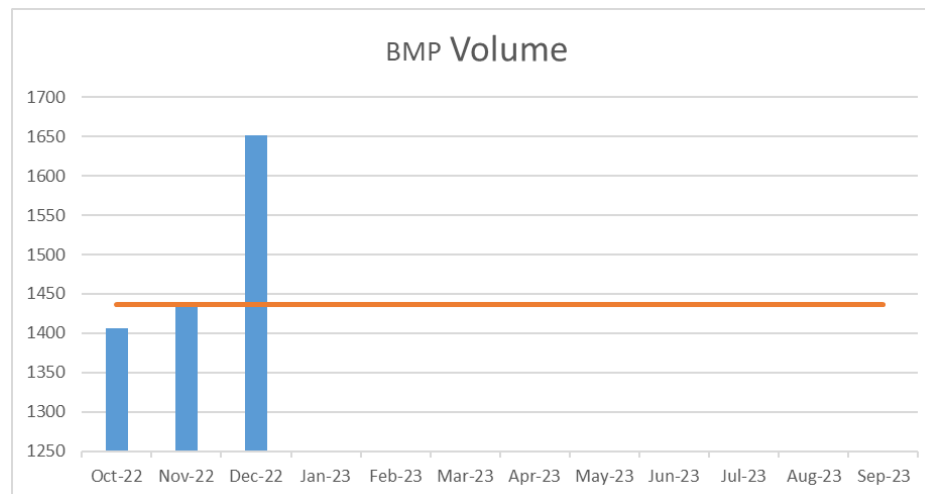
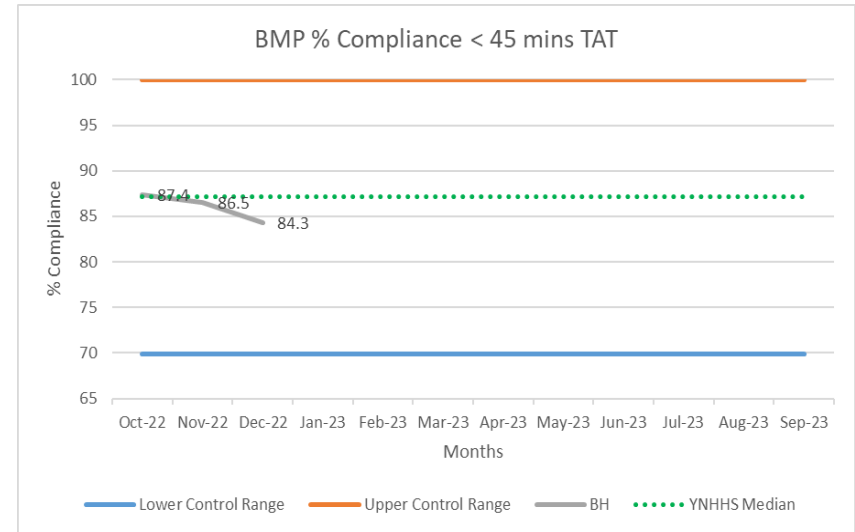
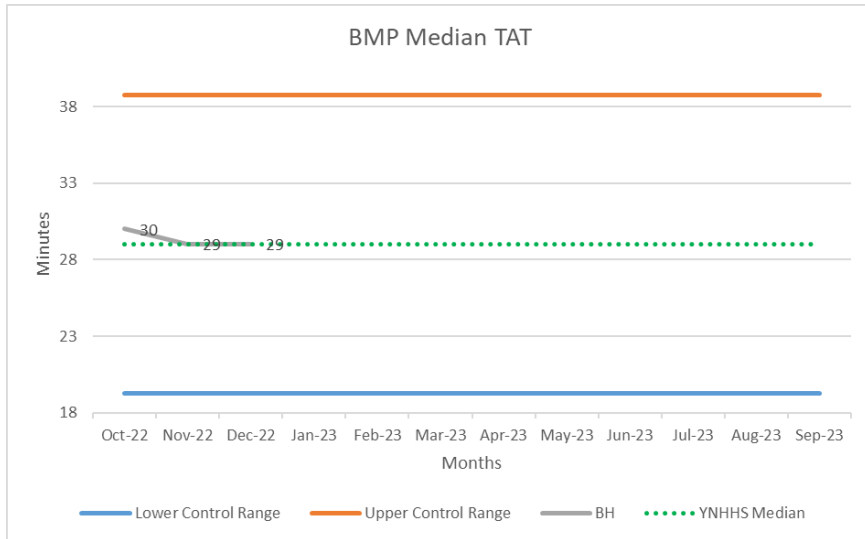
# Bridgeport Campus – Procalcitonin



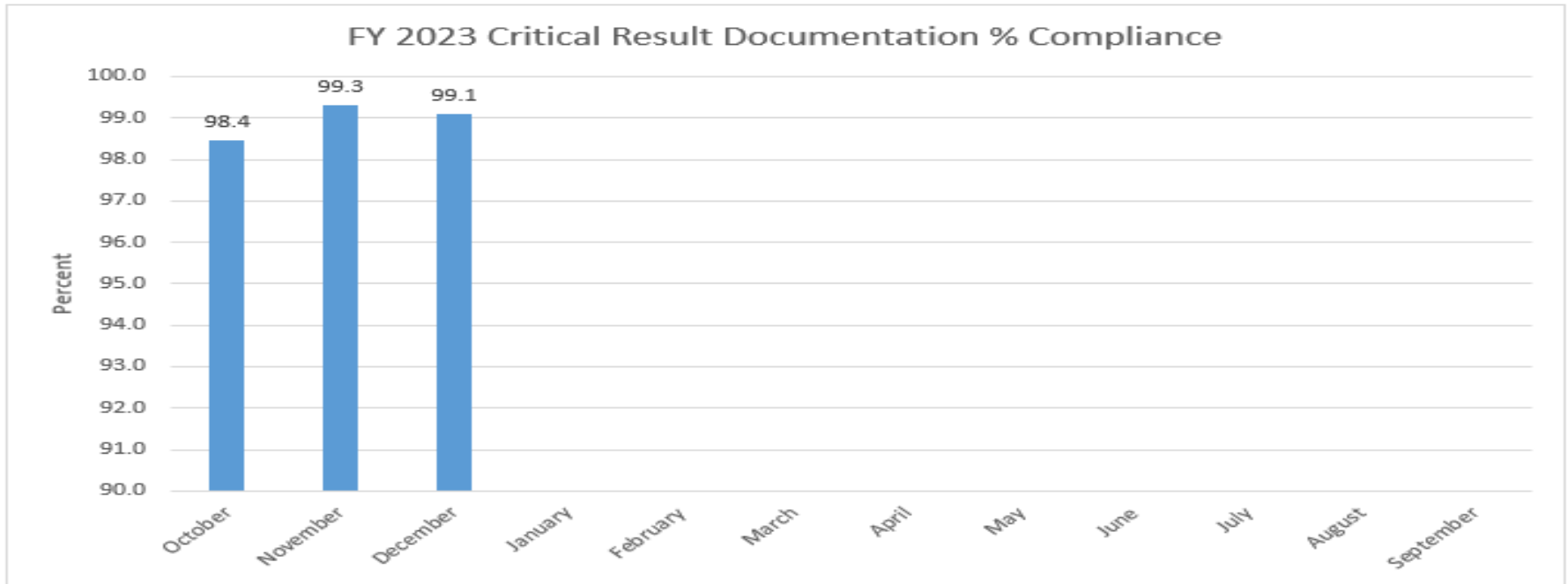
# Bridgeport Campus – Gen 5 Troponin TAT



# Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT



# Chemistry & Immunology



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
n	1415	1425	1418									
#compliant	1393	1415	1405									
#noncompliant	22	10	13									

no name	7	1	1									
no full name	8	4	1									
no title	4	4	1									
incorrect doc	1	1	10									
incorrect person	2											

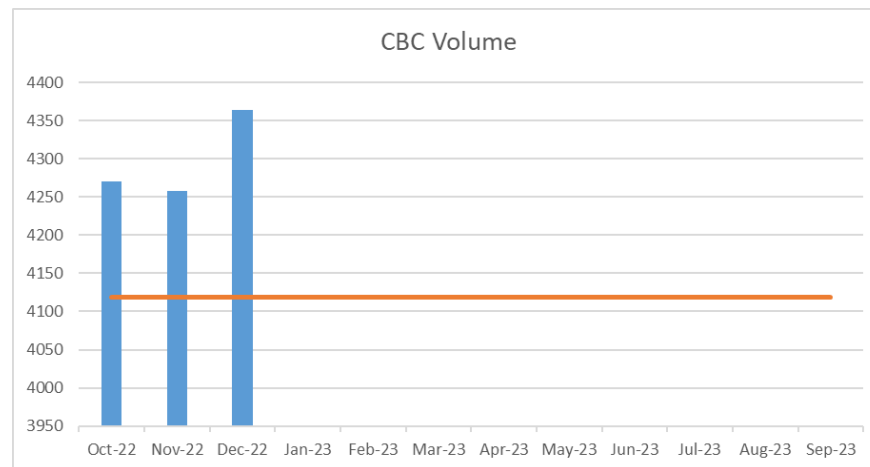
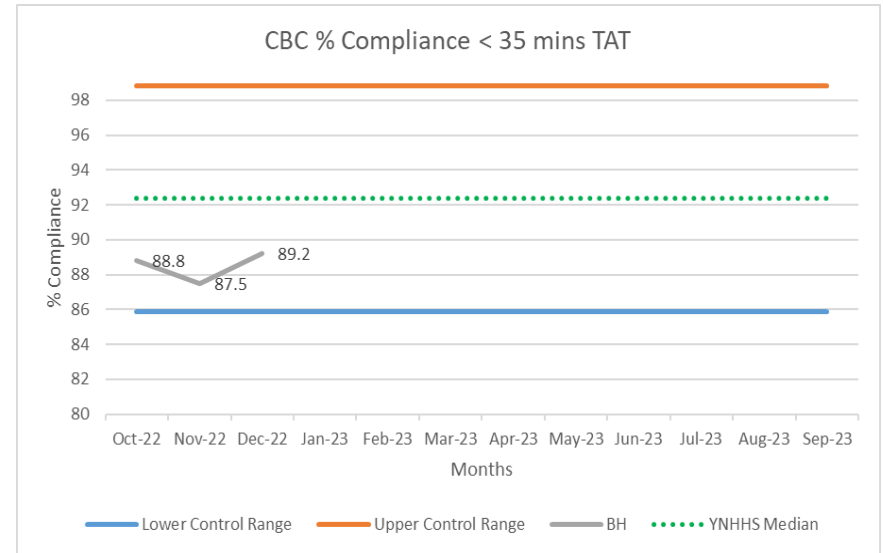
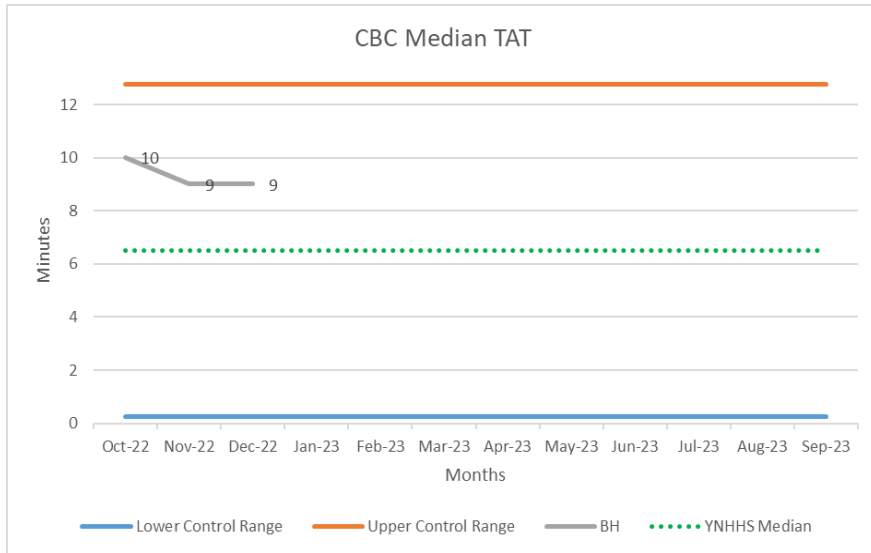
Two techs require counseling. Each outlier was addressed with individual tech.

# Bridgeport Campus – Lyme Screens TAT

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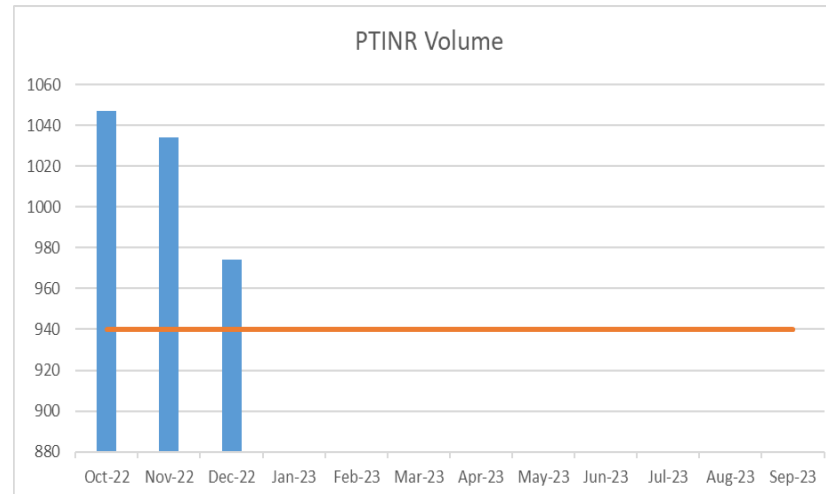
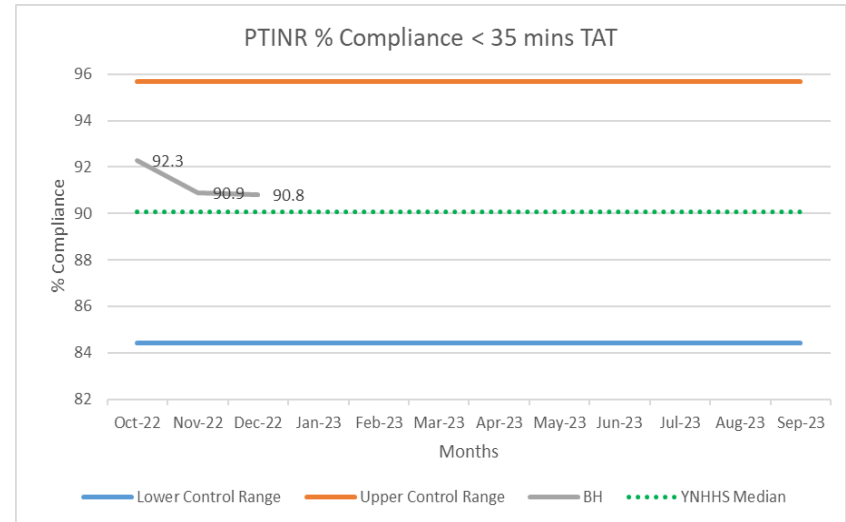
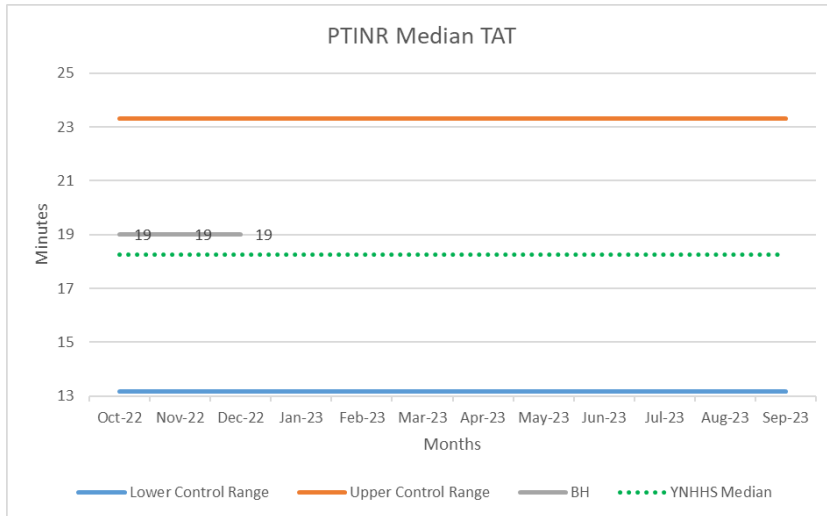
- TAT
  - Oct 2022 – 78.5 minutes
  - Nov 2022 – 93 minutes
  - Dec 2022 – 90 minutes
- Volume
  - Oct 2022 – 738
  - Nov 2022 – 692
  - Dec 2022 – 534

# Bridgeport Campus – Complete Blood Count (CBC) ED TAT

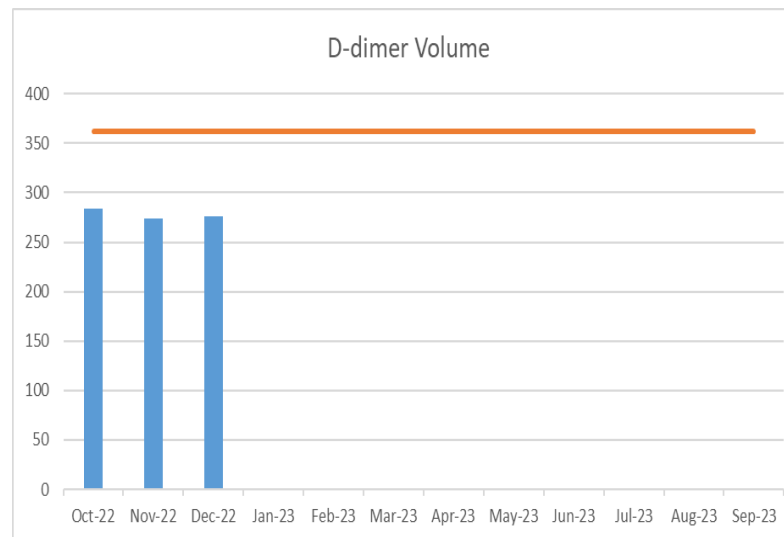
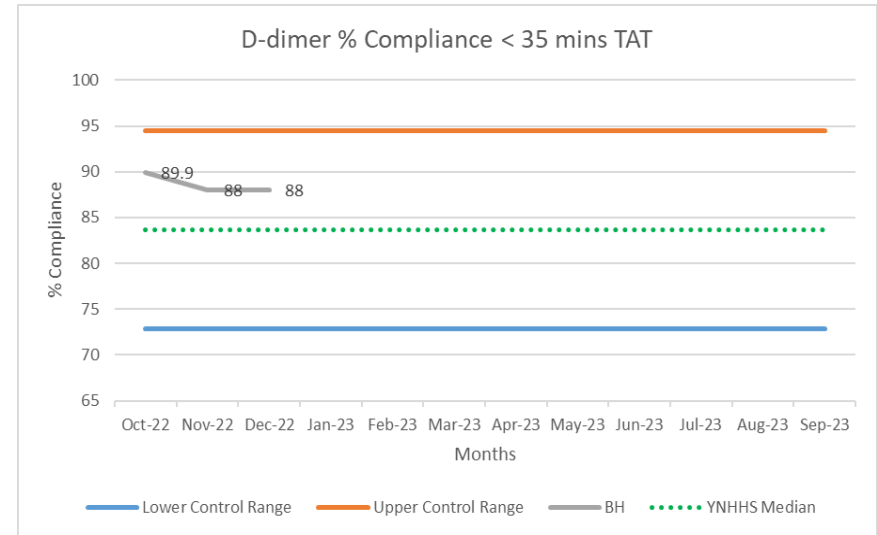
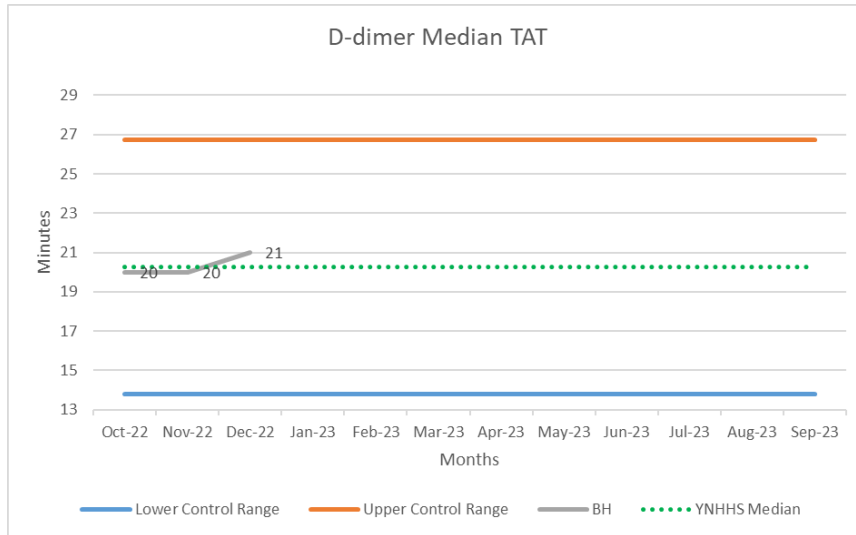




# Bridgeport Campus – PTINR ED TAT



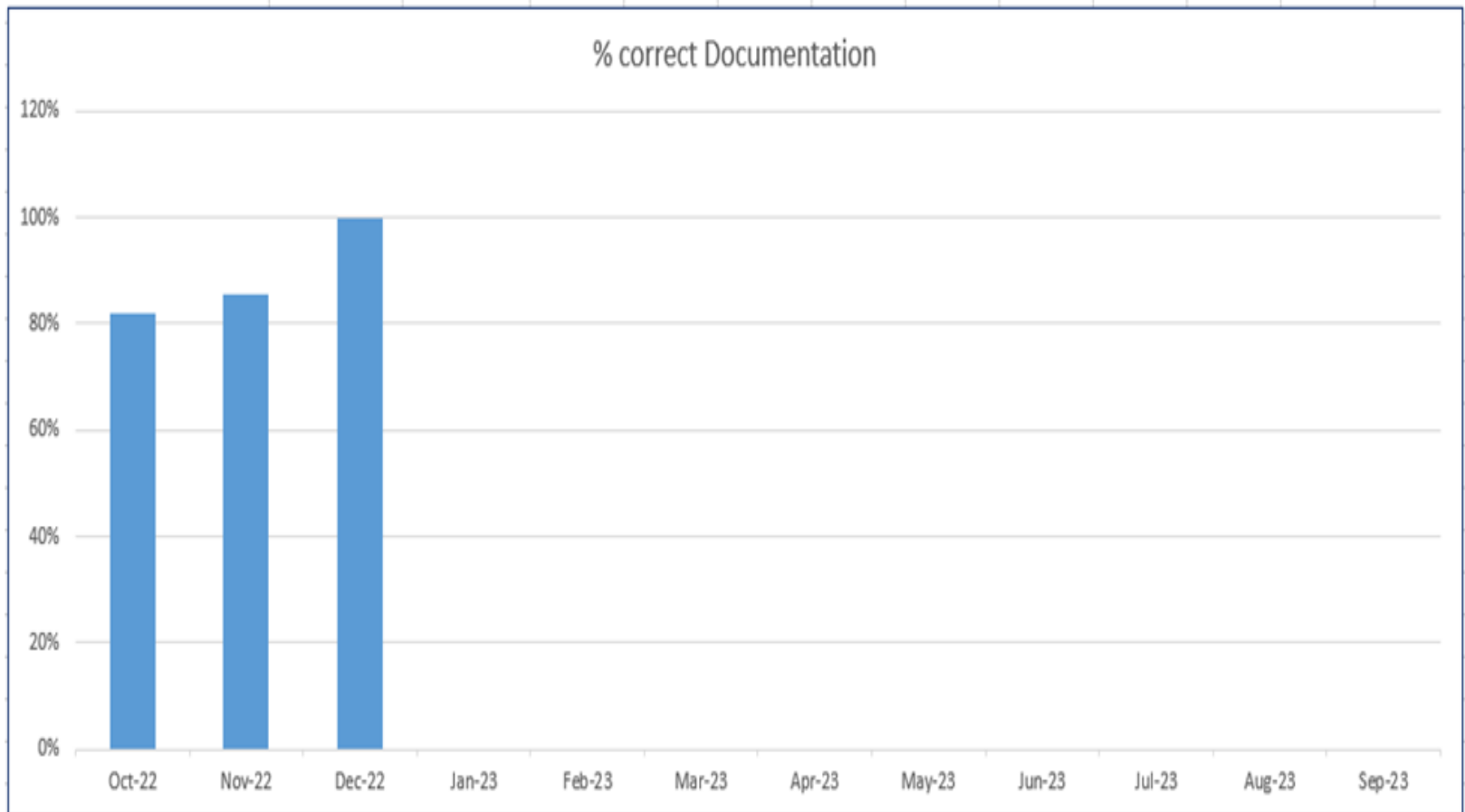
# Bridgeport Campus – D-dimer ED TAT



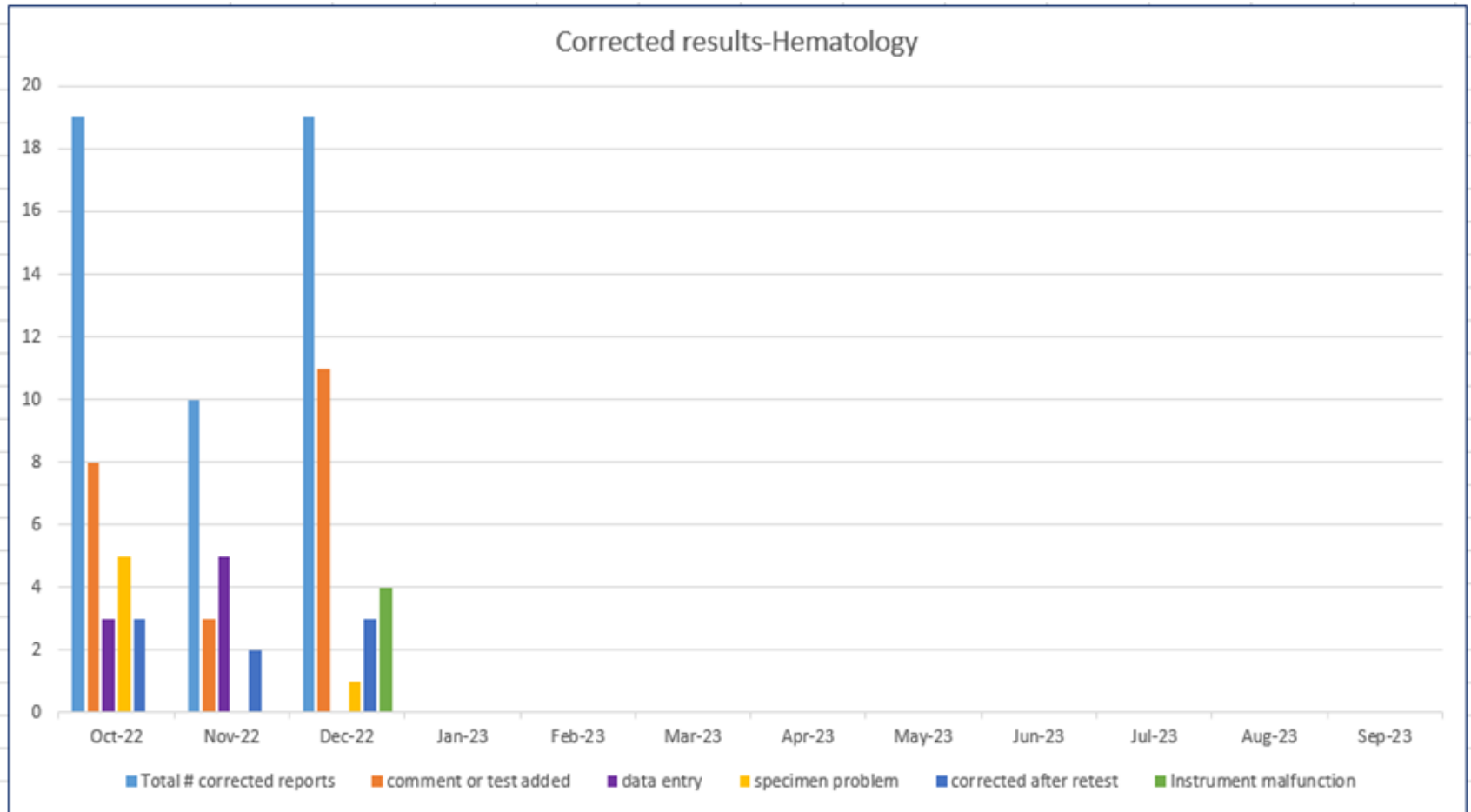


# Aspect of Care

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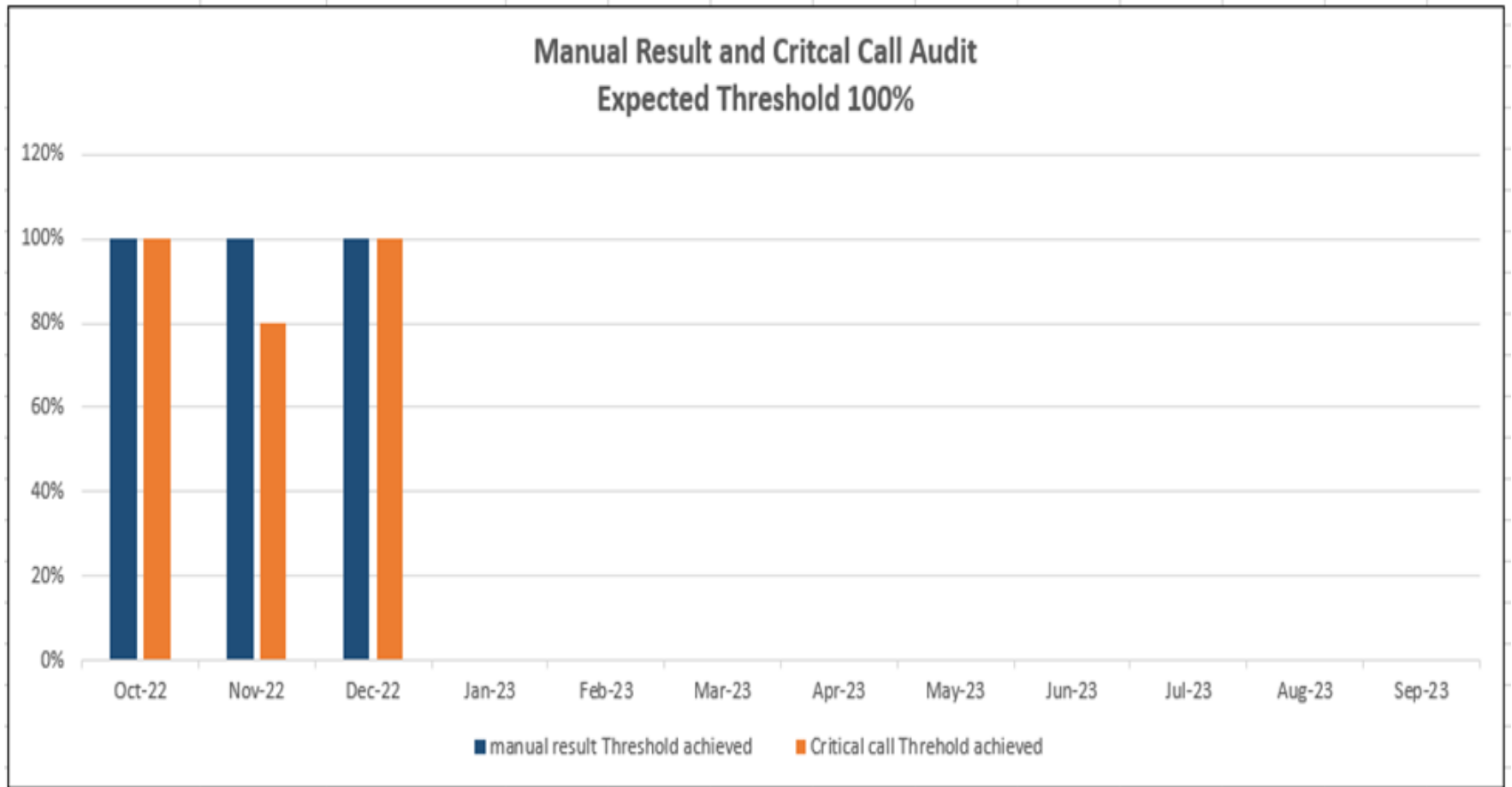


# Aspect of Care

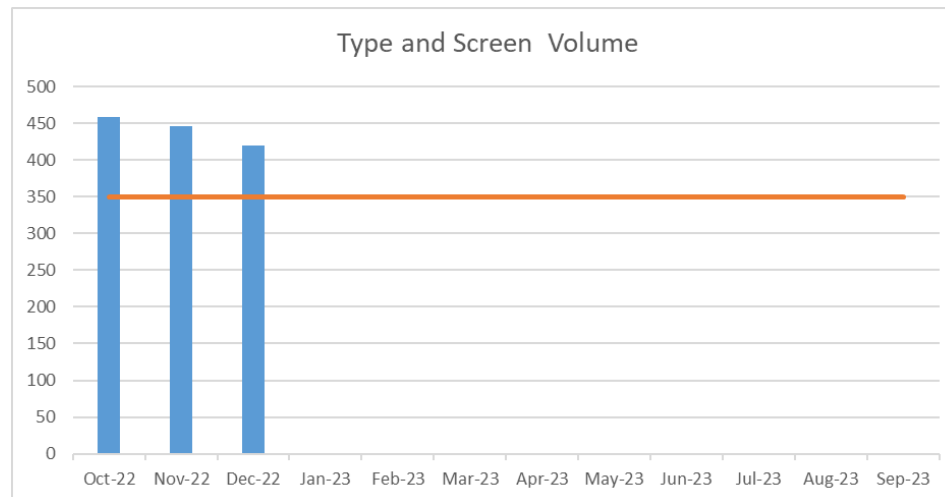
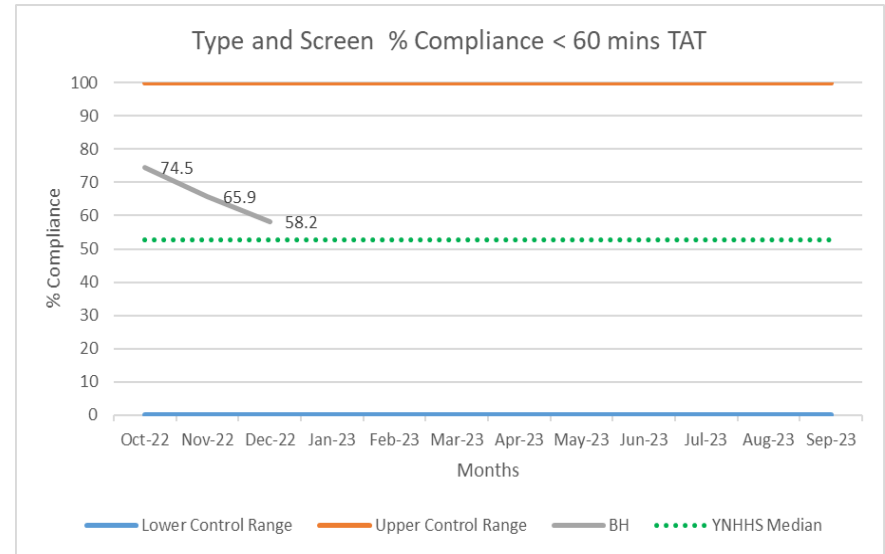
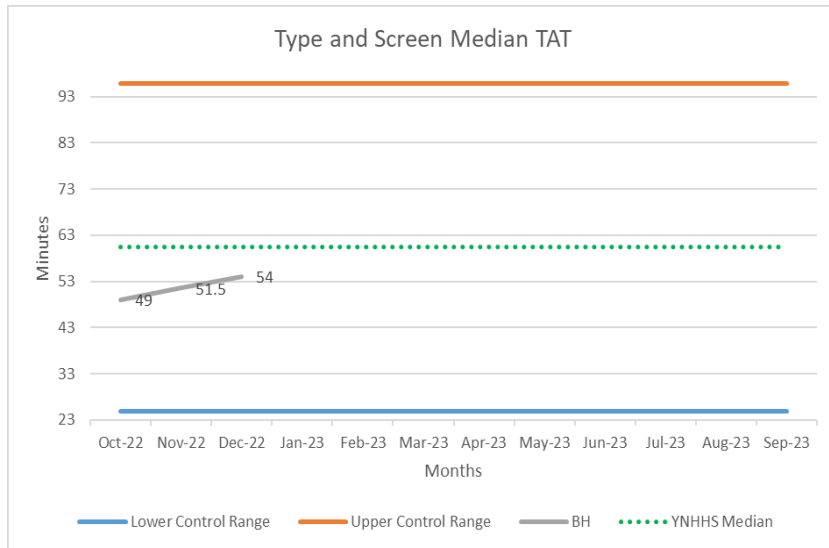




# Aspect of Care



# Bridgeport Campus – Type and Screen ED TAT





# Bridgeport and Milford Hospital Transfusion Reactions FY23

<b>Bridgeport and Milford Hospital Transfusion Reactions FY23</b>																		
Months	Total Per Site		Allergic		Febrile		Anaphy		TACO		TRALI		Hemolytic		Septic		Other	
	BH	MC	BH	MC	BH	MC	BH	MC	BH	MC	BH	MC	BH	MC	BH	MC	BH	MC
Oct	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nov	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jan																		
Feb																		
Mar																		
Apr																		
May																		
Jun																		
Jul																		
Aug																		
Sep																		
<b>Total</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

# Bridgeport Hospital Blood Bank RBC

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	Oct	Nov	Dec	Total Amount
Transfusion	449	440	410	\$344,884.50
Wasted	4	5	7	\$4,248.00
Total	453	445	417	\$349,132.50

# Bridgeport Hospital Blood Bank Cryo

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	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Total Amount</b>
<b>Transfusion</b>	8	11	16	\$11,602.50
<b>Wasted</b>	2	2	0	\$1,326.00
<b>Total</b>	8	13	16	\$12,265.50

# Bridgeport Campus FFP

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	Oct	Nov	Dec	Total Amount
<b>Transfusion</b>	52	50	35	\$36,373.50
<b>Wasted*</b>	22	11	27	\$15,930.00
<b>Total</b>	74	61	62	\$52,303.50

\*Due to ACS Trauma Requirements

# Platelet Utilization

	Oct	Nov	Dec	Total Amount
Transfusion	48	39	61	\$145,439.28
Discarded	27	36	19	\$105,039.48
Total	75	75	80	\$250,478.76
% Discarded	36%	48%	24%	
Discarded/Day	0.87	1.2	0.63	\$696.22

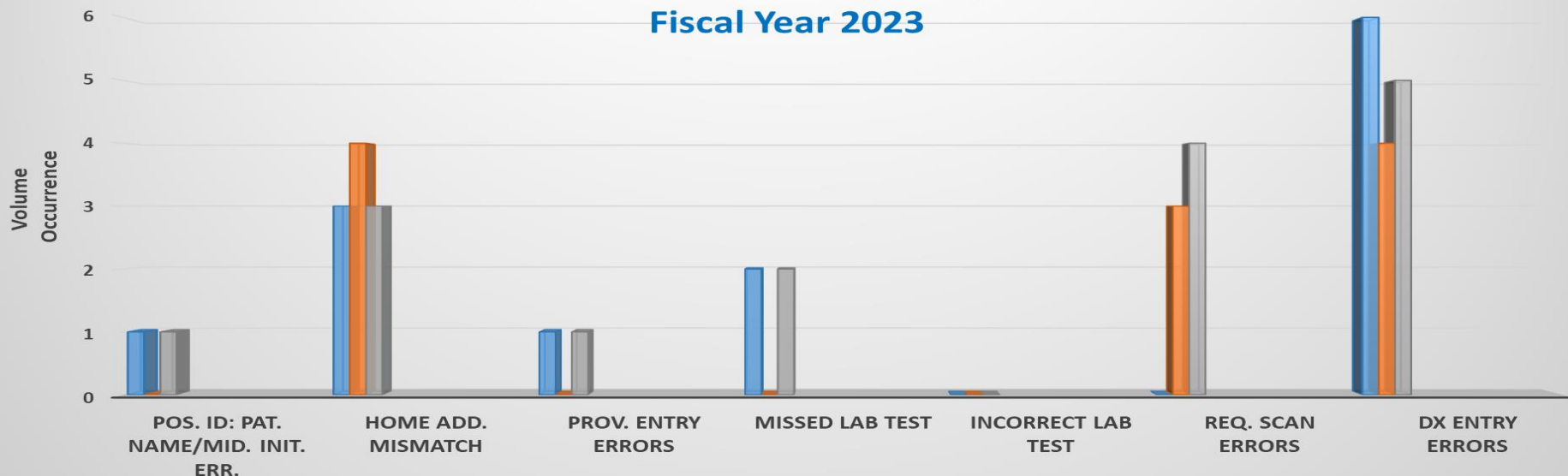
Number of Extended Plts	38	44	53	\$141,399.30
Number Transfused	16	20	27	\$60,599.70
Number Discarded	22	24	26	\$80,799.60



# Test Requisition QI Monitoring Check Vol. Occurrence

## Milford Draw Station (40 Commerce Park, MFD., CT.)

### Fiscal Year 2023



	Pos. ID: Pat. Name/Mid. Init. Err.	Home Add. Mismatch	Prov. Entry Errors	Missed Lab Test	Incorrect Lab Test	Req. Scan Errors	Dx Entry Errors
OCT 2022	1	3	1	2	0	0	6
NOV 2022	0	4	0	0	0	3	4
DEC 2022	1	3	1	2	0	4	5
JAN 2023							
FEB 2023							
MAR 2023							
APR 2023							
MAY 2023							
JUNE 2023							
JULY 2023							
AUG 2023							
SEPT 2023							

■ OCT 2022      ■ NOV 2022      ■ DEC 2022      ■ JAN 2023  
■ FEB 2023      ■ MAR 2023      ■ APR 2023      ■ MAY 2023

**Pos. Patient ID for Pat. :**

- a. Full Name including Mid. Init.
- b. Date of Birth (DOB)
- c. Medical Record Nbr (MRN)

**Prov. Error:** Missing / different Provider from requisition listing (i.e. "CC" etc.)

**Missed Lab Test:** Test on requisition; not ordered in EPIC

**Incorrect Lab Test:** EPIC ordered test different from Requisition

**Req. Scan Error:** Requisition NOT saved or scanned incorrectly.

**Dx Errors:** One or more requisition Dx Not listed or are different in EPIC, for visit.

# Milford Draw Station

## Outpatient Test Requisition QC Monitoring Check

### Error Metric Defined

**DECEMBER 2022**

**A. Missing Dx errors generally appear with (multiple Dx entries; greater than 5-6).**

**(address, phone number, not included on requisition).**

**Note: Use of a non-YNH/EPIC lab requisitions, with missing demographic information, consequently would be reflected in a higher demographic error rates than is otherwise indicated (7 vs 3).**

**C. Three instances of address mismatch (New Milford vs Orange; Regent Terr. Vs Tippy Rd.; Trumbull vs Shelton).**

**D. 1 instance of missing name-middle initial, of patient, from EPIC, yet listed on requisition.**

**E. 1 instance of provider mismatch (Mendite vs Wang).**

**F. Four instances of apparent document scan errors:**

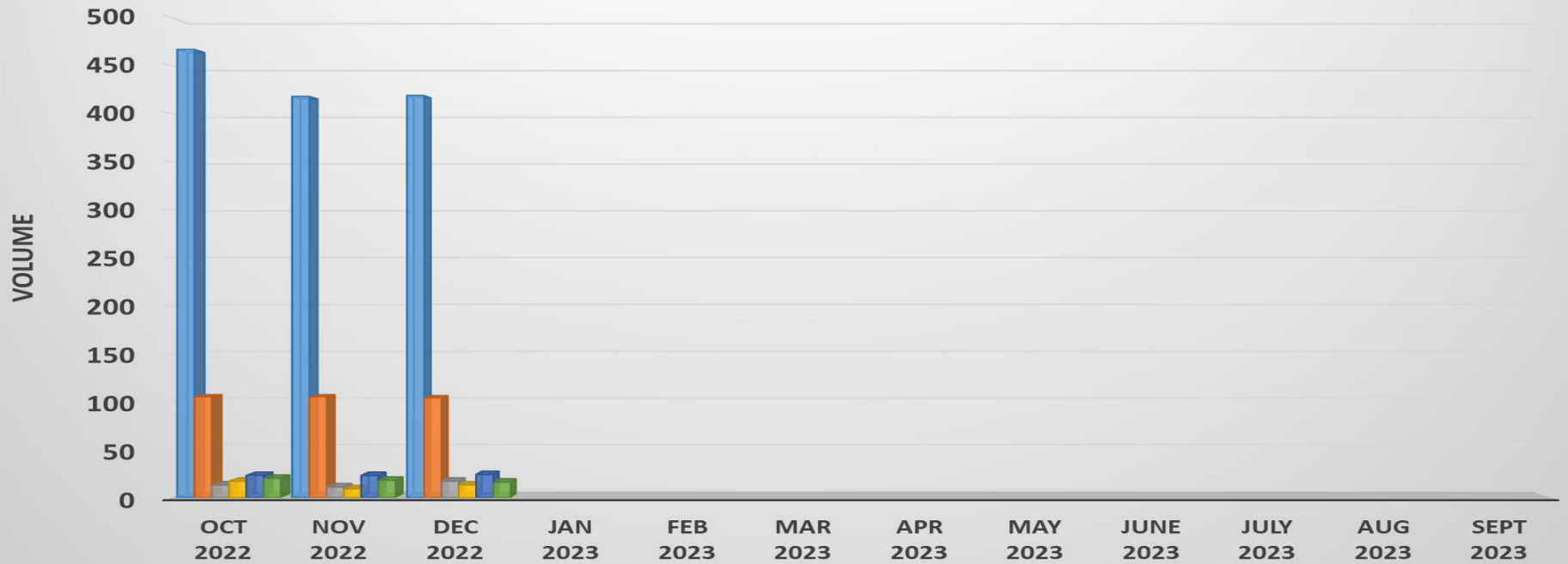
**a. 3 instances of missing lab requisition, yet orders placed for stated DOS.**

**b. 1 instance of scan error where requisition scanned into a different patient file (James vs. Julie).**

**G. EPIC use providers (not Milford practice providers) is reflected in other patients visiting the Milford site draw station, thereby demonstrating additional convenience for YNH patients and their providers.**



# Patient and Requisition Volume QC Monitor Check Milford Draw Station (40 Commerce Park MFD, CT) Fiscal Year 2023



	OCT 2022	NOV 2022	DEC 2022	JAN 2023	FEB 2023	MAR 2023	APR 2023	MAY 2023	JUNE 2023	JULY 2023	AUG 2023	SEPT 2023
Tot. Patient Volume	467	418	419									
# of Req. Reviewed	105	105	104									
Mnthly Errors	13	11	17									
EPIC Prov. Entry	17	9	13									
# of Business Days/month	23	23	24									
Est. Ave. Patients per day	20	18	16									

■ Tot. Patient Volume     
 ■ # of Req. Reviewed     
 ■ Mnthly Errors
 
  

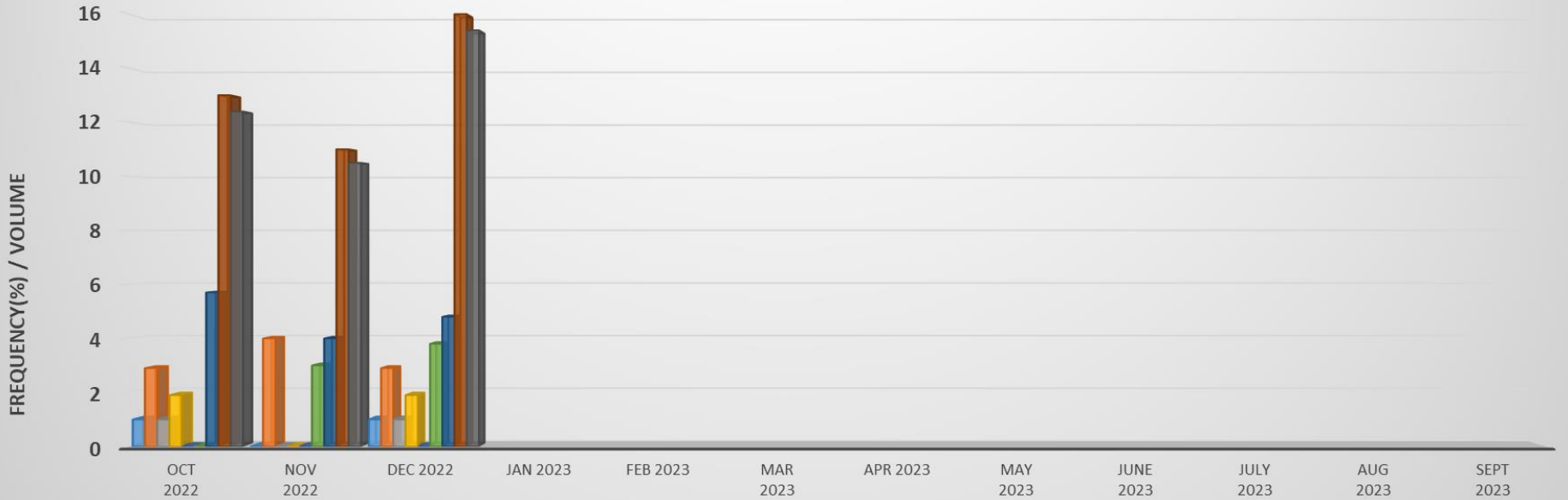
■ EPIC Prov. Entry     
 ■ # of Business Days/month     
 ■ Est. Ave. Patients per day

Note: EPIC Prov. Entry: Lab test orders transcribed, into EPIC, directly by NEMG/YNHH Provider or authorized Provider staff.

# Lab Requisition QC Data Entry Error Rate (%)

## Milford Draw Station (40 Commerce Park, MFD., CT)

### Fiscal Year 2023



	OCT 2022	NOV 2022	DEC 2022	JAN 2023	FEB 2023	MAR 2023	APR 2023	MAY 2023	JUNE 2023	JULY 2023	AUG 2023	SEPT 2023
Pos. ID: Pat. Name/Mid. Init. Errors (as %)	1	0	1									
Home Add. Mismatch (%)	2.9	4	2.9									
Prov. Entry Error (%)	1	0	1									
Missed Lab Test (%)	1.9	0	1.9									
Incorrect Lab Test (%)	0	0	0									
Req. Scan Error (%)	0	3	3.8									
Dx Entry Error (%)	5.7	4	4.8									
Total Errors	13	11	16									
Total Error Rate (%)	12.4	10.5	15.4									

■ Pos. ID: Pat. Name/Mid. Init. Errors (as %)	■ Home Add. Mismatch (%)	■ Prov. Entry Error (%)
■ Missed Lab Test (%)	■ Incorrect Lab Test (%)	■ Req. Scan Error (%)
■ Dx Entry Error (%)	■ Total Errors	■ Total Error Rate (%)

# Lab Requisition QC Data Entry Error Rate (%)

## Milford Draw Station (40 Commerce Park, MFD., CT)

### Fiscal Year 2023



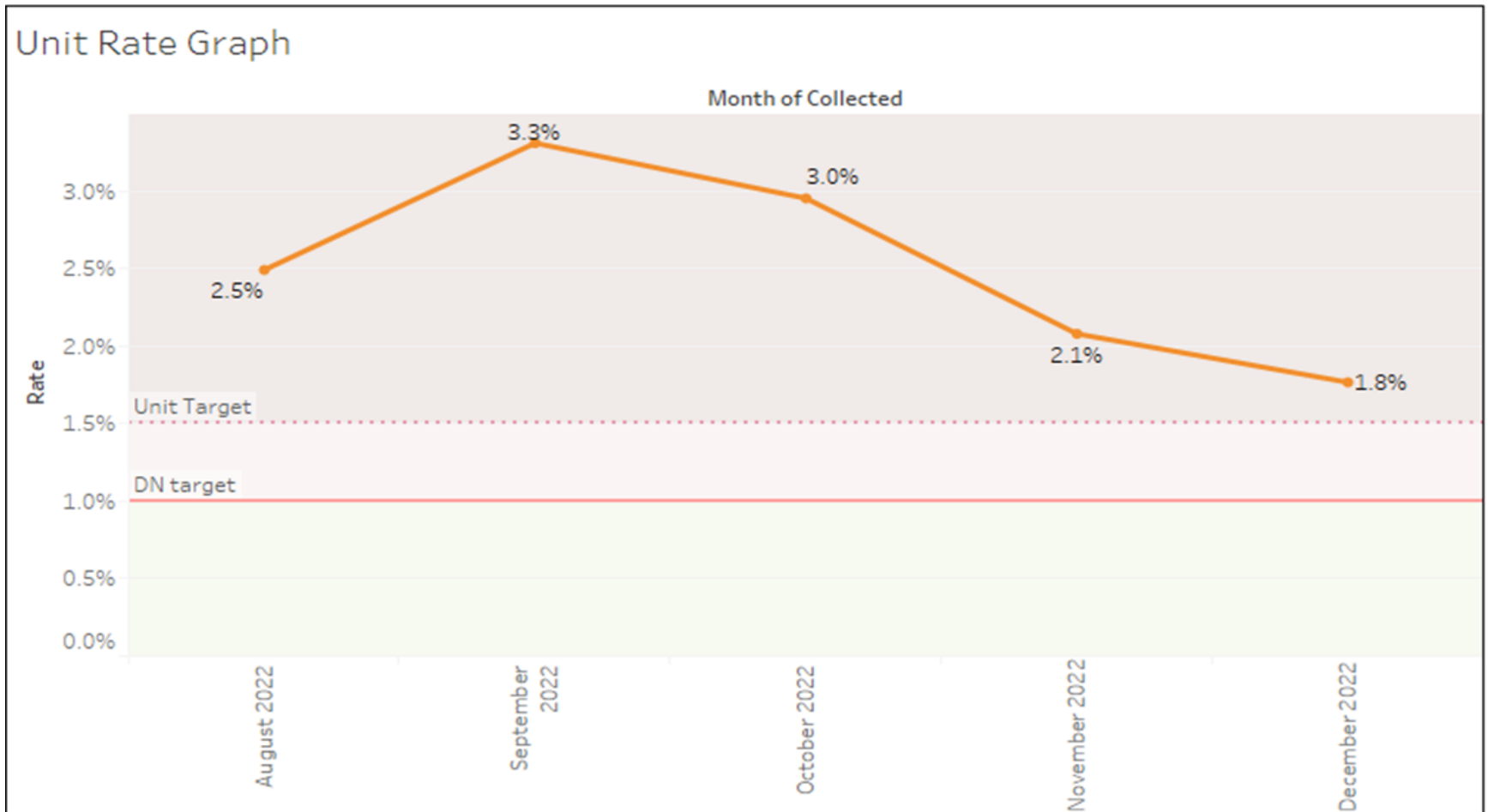
	OCT 2022	NOV 2022	DEC 2022	JAN 2023	FEB 2023	MAR 2023	APR 2023	MAY 2023	JUNE 2023	JULY 2023	AUG 2023	SEPT 2023
Pos. ID: Pat. Name/Mid. Init. Err. (as %)	1	0	1									
Home Add. Mismatch (%)	2.9	3.8	2.9									
Prov. Entry Error (%)	1	0	1									
Missed Lab Test (%)	1.9	0	1.9									
Incorrect Lab Test (%)	0	0	0									
Req. Scan Error (%)	0	2.9	3.8									
Dx Entry Error (%)	5.7	3.8	4.8									
Total Errors (as # of Occ.)	13	11	16									
Total Error Rate FY2023 (%)	12.4	10.5	15.4									
Ave Error Rate FY2022 (%)	15.5	15.5	15.5									

- Pos. ID: Pat. Name/Mid. Init. Err. (as %)
- Home Add. Mismatch (%)
- Prov. Entry Error (%)
- Missed Lab Test (%)
- Incorrect Lab Test (%)
- Req. Scan Error (%)
- Dx Entry Error (%)
- Total Errors (as # of Occ.)



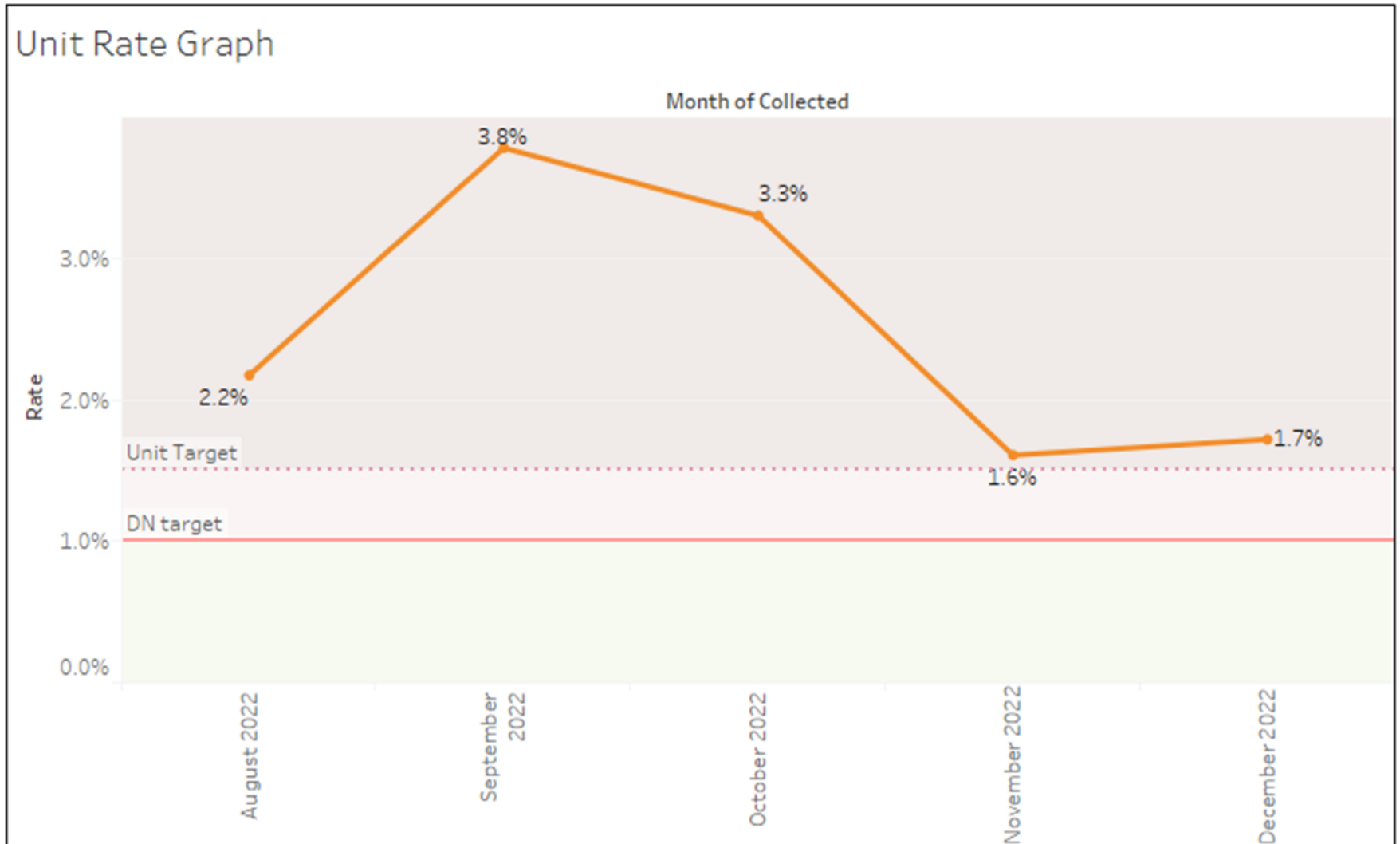


# BH Blood Culture Contamination Rate

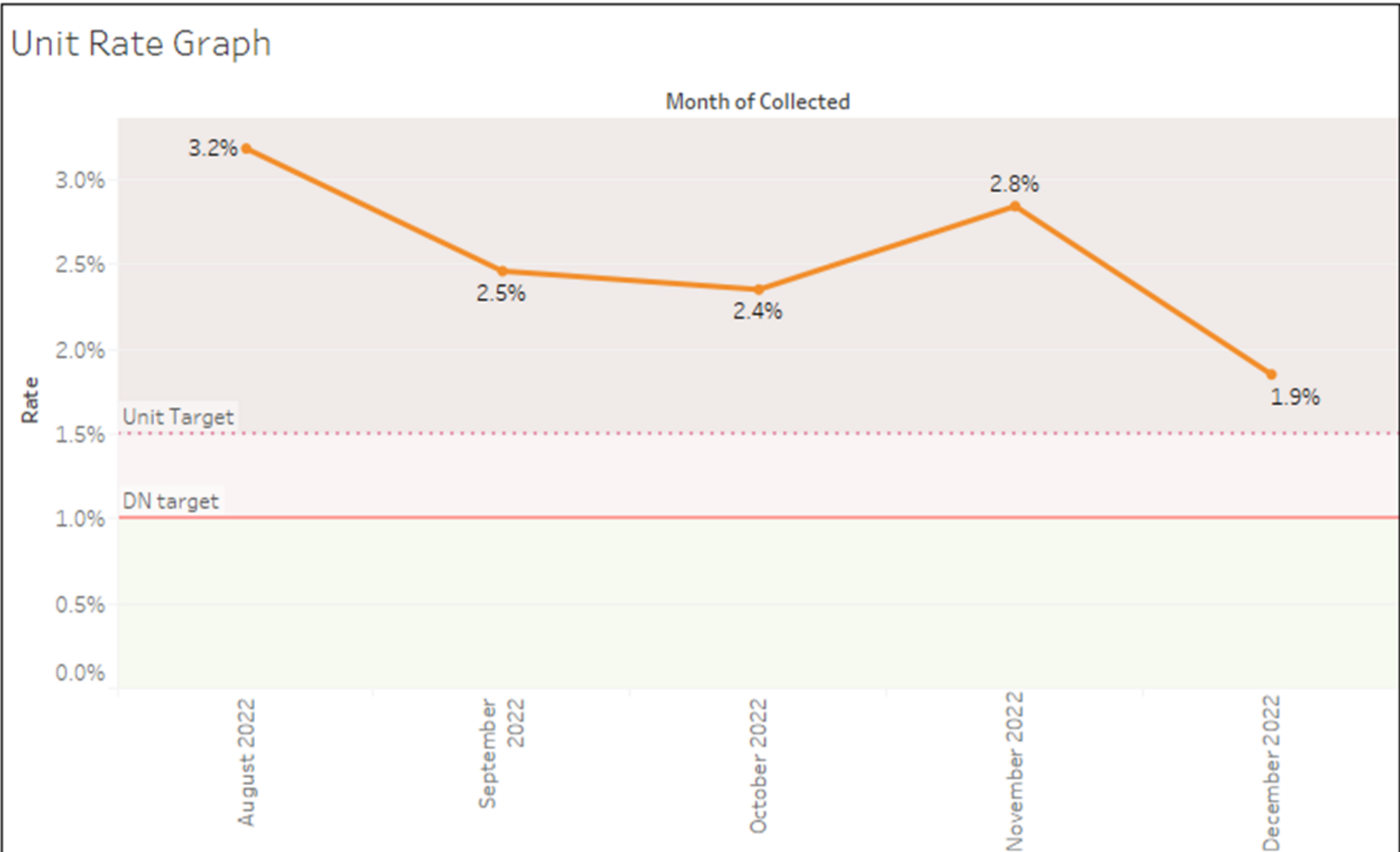


DN  
Campus  
BH/MC  
BH

# BH Blood Culture Contamination Rate(ED only)

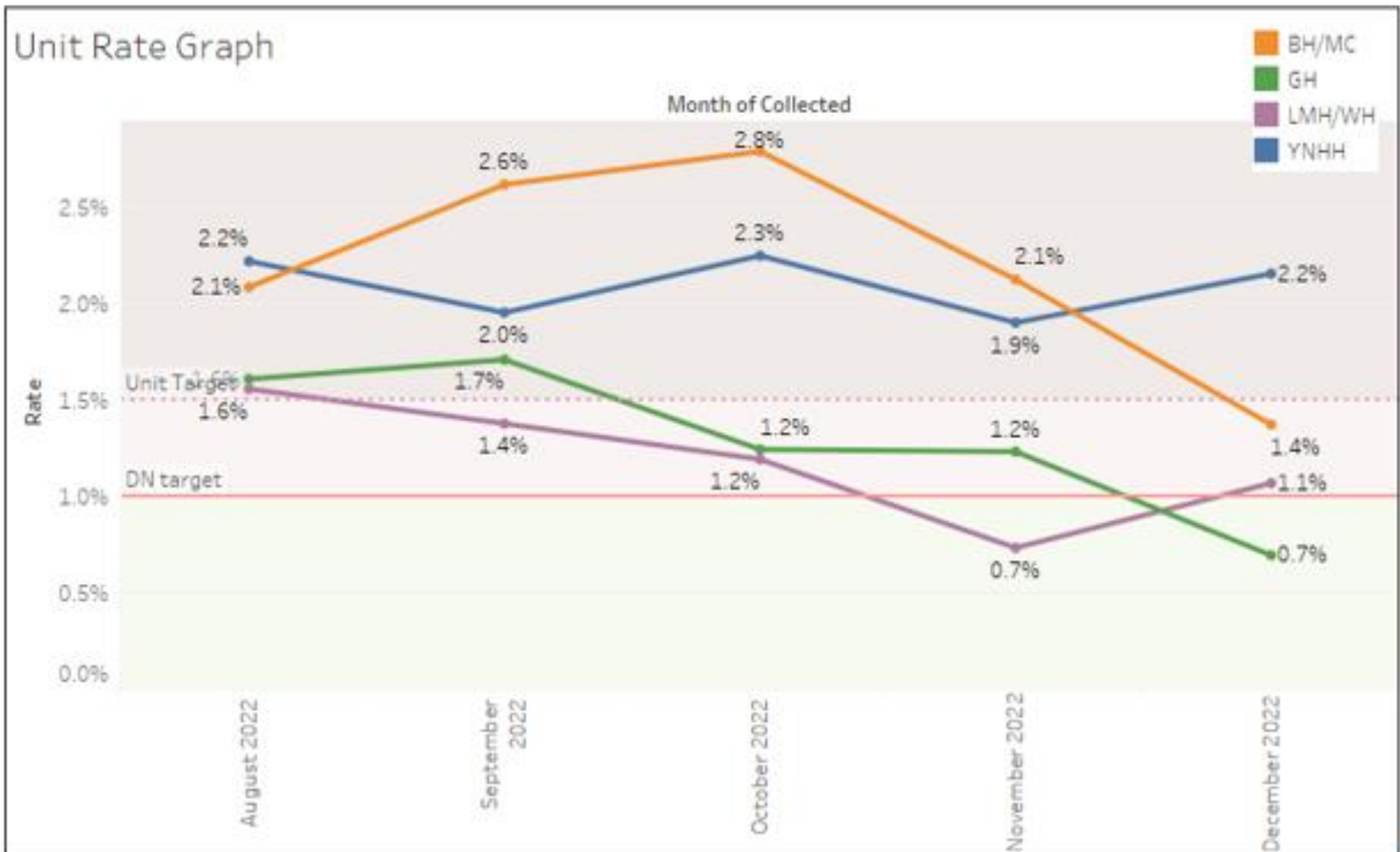


# BH Blood Culture Contamination Rate (excluding ED)

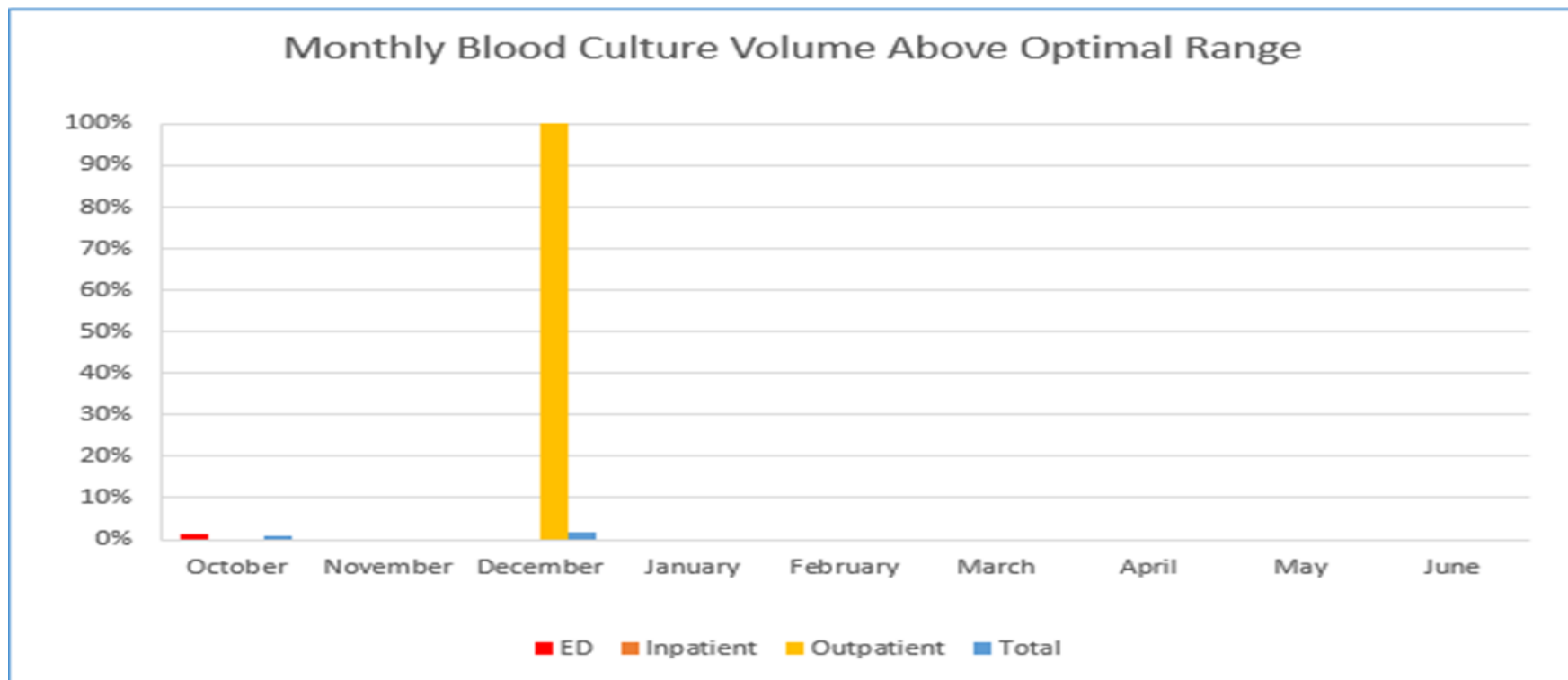




# Blood Culture Contamination Rate DNs Comparison



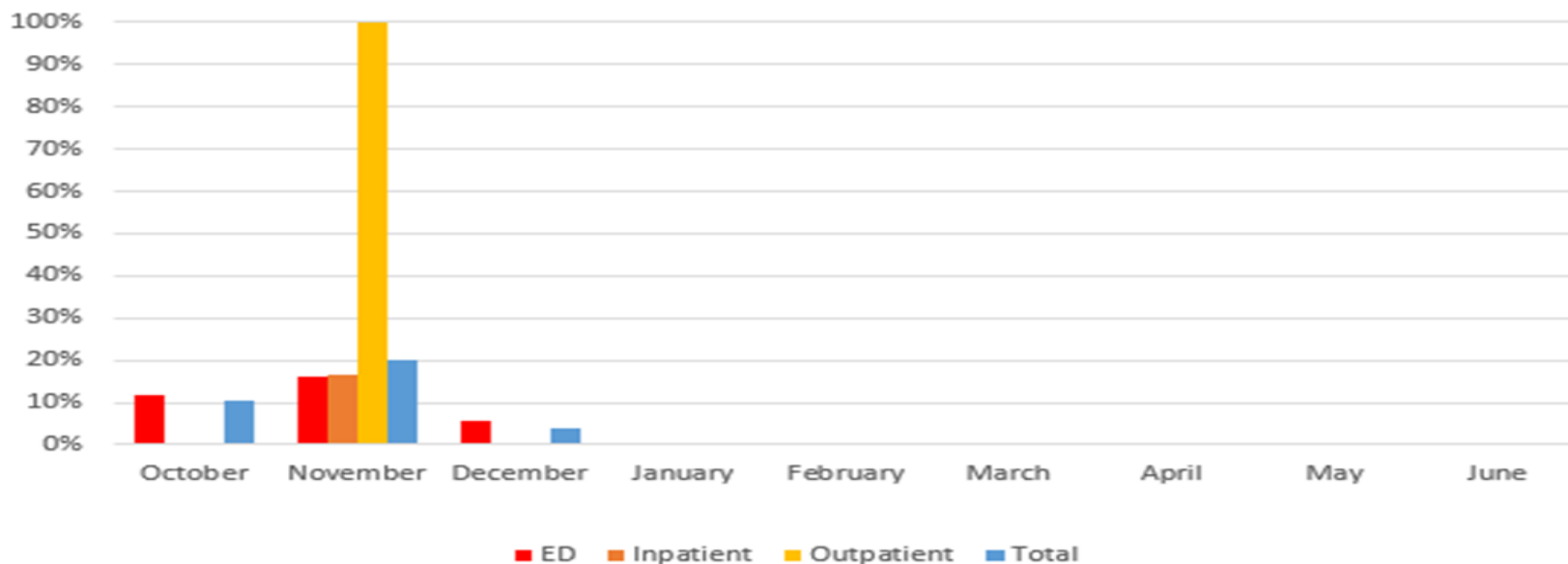
# Blood Culture Bottle Volumes – Above Optimal



Total Number of Bottles Drawn			
Total	ED	Inpatient	Outpatient
128	88	38	2
Number of Bottles Above Acceptable Volume			
Total	ED	Inpatient	Outpatient
2	0	0	2

# Blood Culture Bottle Volumes – Below Optimal

Monthly Blood Culture Volume Below Optimal Range



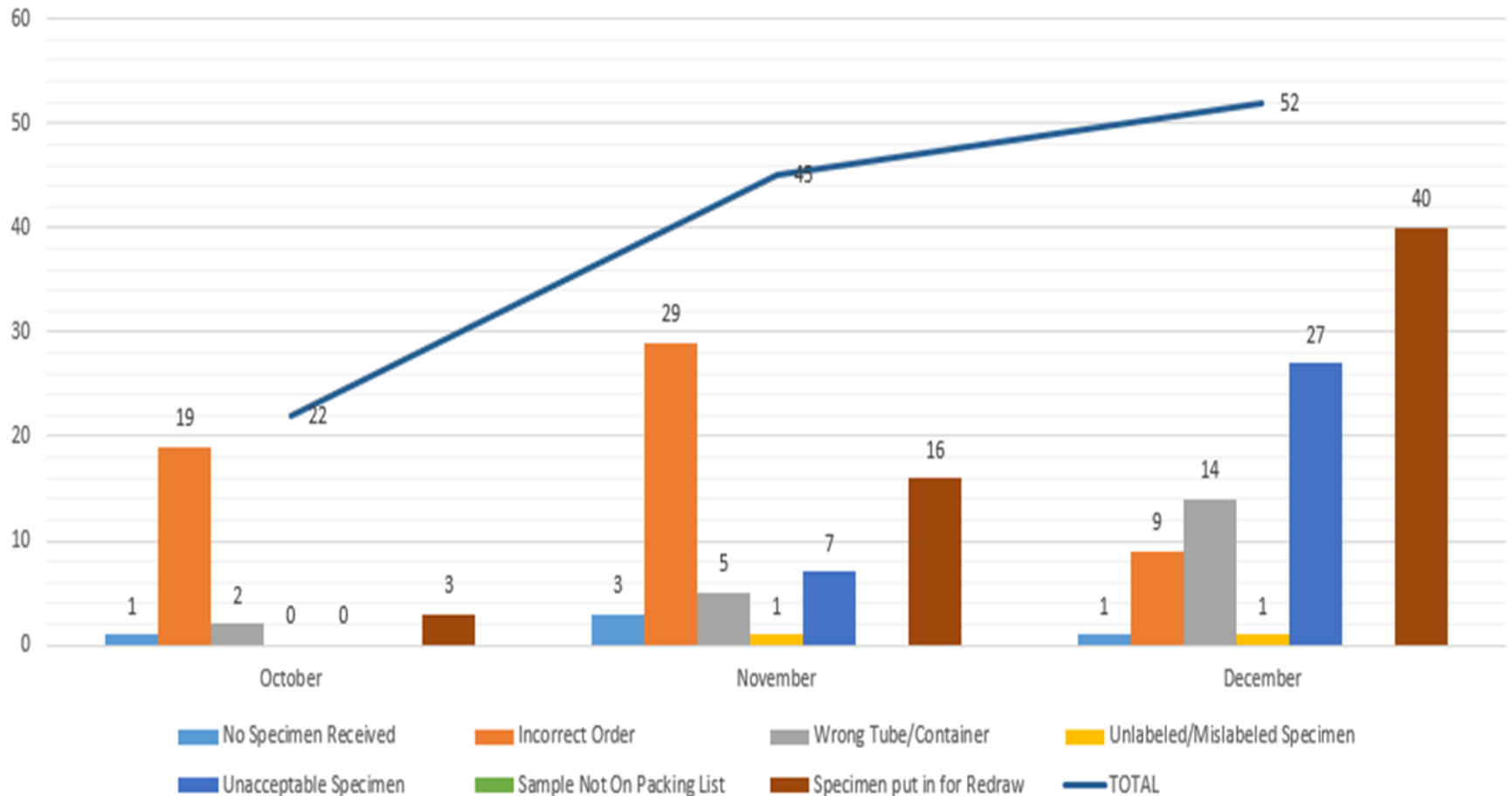
Total Number of Bottles Drawn			
Total	ED	Inpatient	Outpatient
128	88	38	2
Number of Bottles Below Acceptable Volume			
Total	ED	Inpatient	Outpatient
5	5	0	0

# Molecular Statistics

Date	Tests	Sample size	Positive Count	% Positivity	Lower Limit	Upper Limit	Environment Monitoring	Epidemiological Trends	Evaluation Notes
Dec-22	Chlamydia trachomatis, NAAT	683	27	4.00%	2%	7%	Negative	None	None
Dec-22	GBS PCR Pen Allergic	18	4	22.20%	0%	48%	Negative	None	None
Dec-22	GBS PCR Pen NonAllergic	92	25	27.20%	16%	33%	Negative	None	None
Dec-22	Group A Strep PCR	477	57	11.90%	2%	21%	Negative	None	None
Dec-22	HSV 1 AND 2 DIRECT PCR,	37	11	29.70%	0%	56%	Negative	None	None
Dec-22	Influenza A/B RNA, NAAT	2306	686	29.70%	0%	22%	Negative	Seasonal spike	None
Dec-22	Influenza/RSV by RT-PCR	4170	867	20.80%	0%	19%	Negative	Seasonal Spike	None
Dec-22	MRSA Colonization Status	435	59	13.60%	5%	19%	Negative	None	None
Dec-22	MRSA/SAUR Blood PCR	23	12	52.20%	13%	53%	Negative	None	None
Dec-22	MTB w/rflx Rifampin PCR	1	0	0.00%	0%	92%	Negative	None	None
Dec-22	N. gonorrhoeae, NAAT	683	13	1.90%	1%	3%	Negative	None	None
Dec-22	Resp Virus PCR Panel	260	57	21.90%	3%	54%	Negative	None	None
Dec-22	SARS CoV-2 (COVID-19) RNA	11710	1493	12.70%	0%	21%	Negative	None	None
Dec-22	Stool Pathogens PCR	130	14	10.80%	0%	18%	Negative	None	None

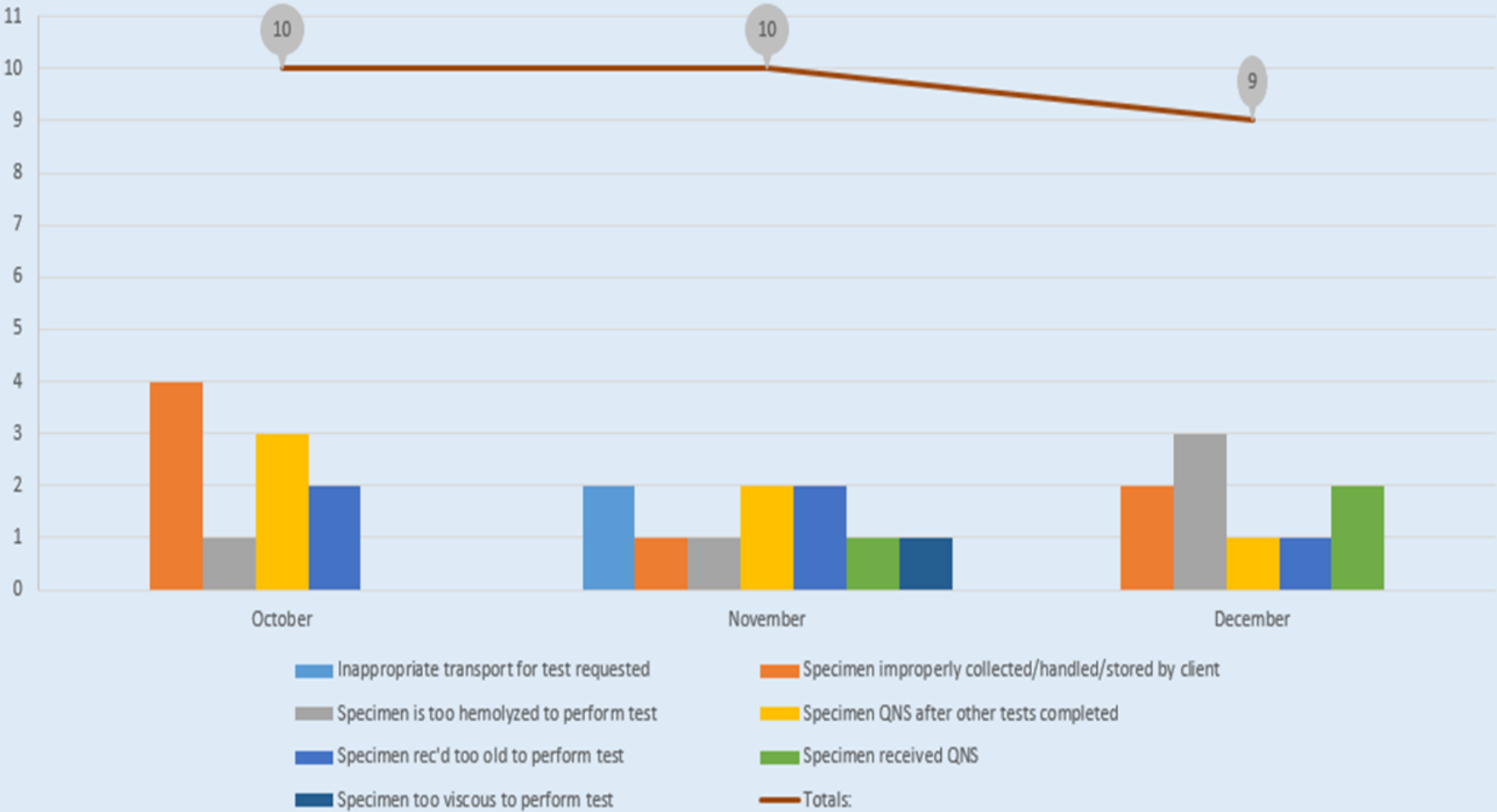
# FY2023 Draw Station Errors

FY 2023 Draw Station Errors

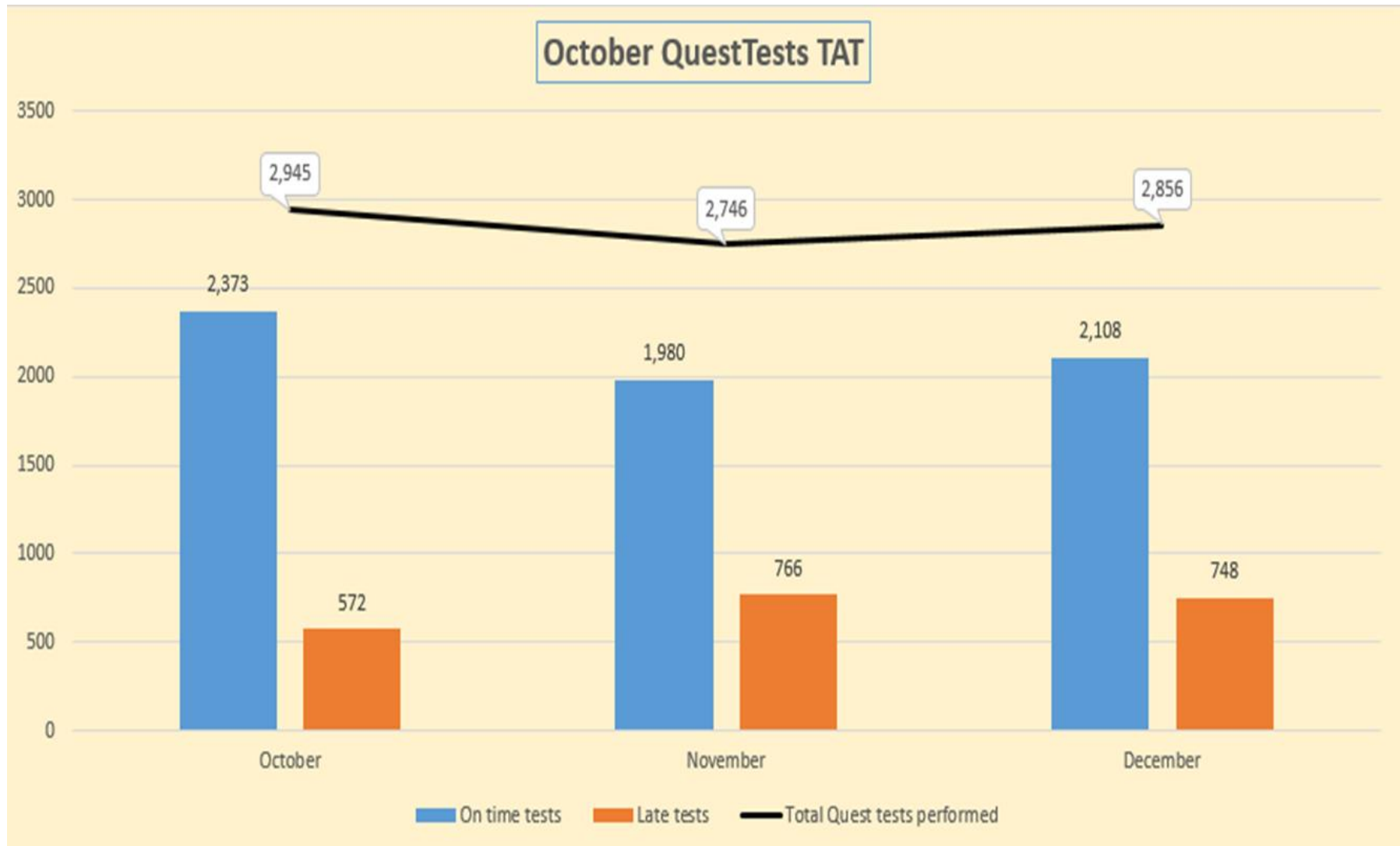


# Quest Rejected Tests

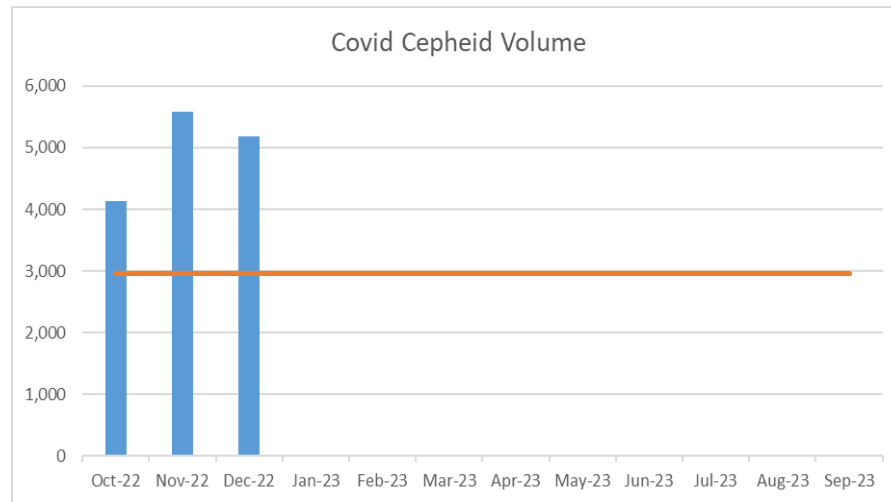
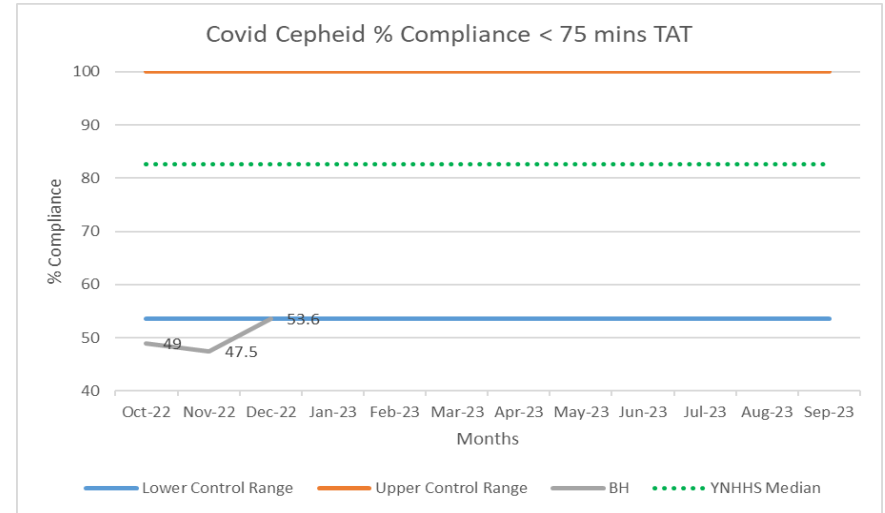
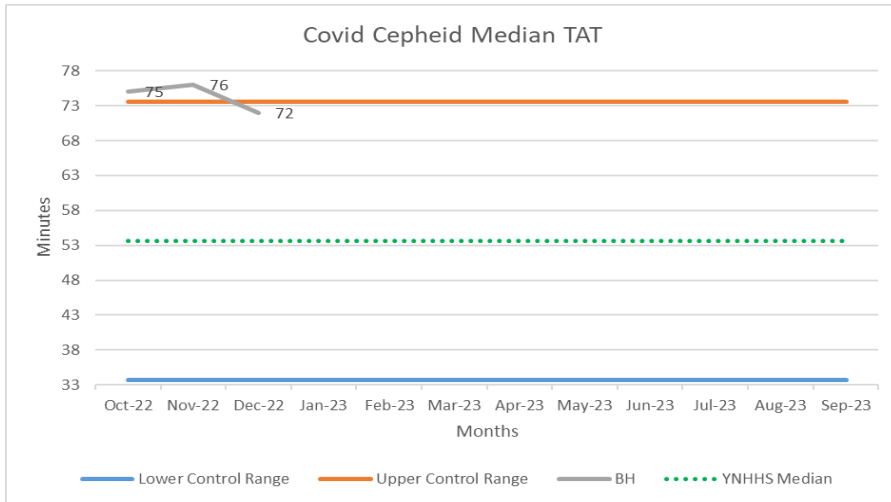
## Test not performed by Quest



# Quest TAT

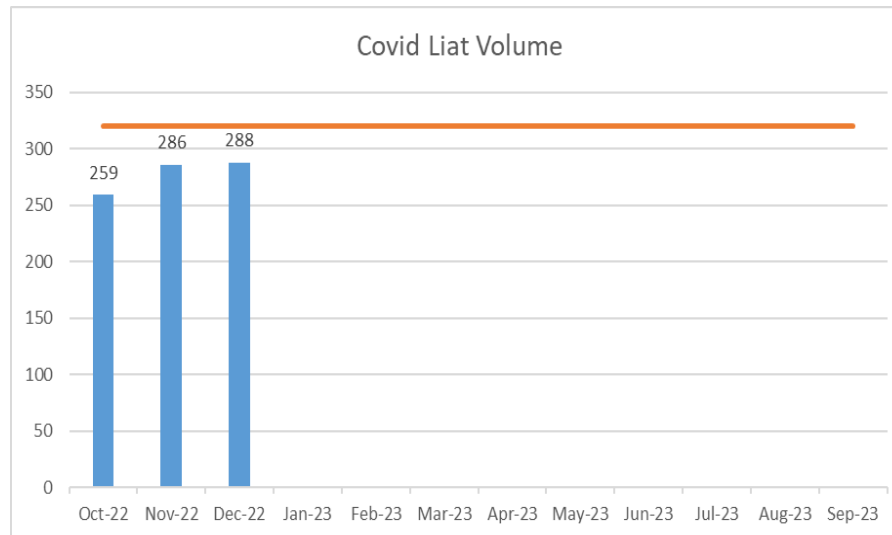
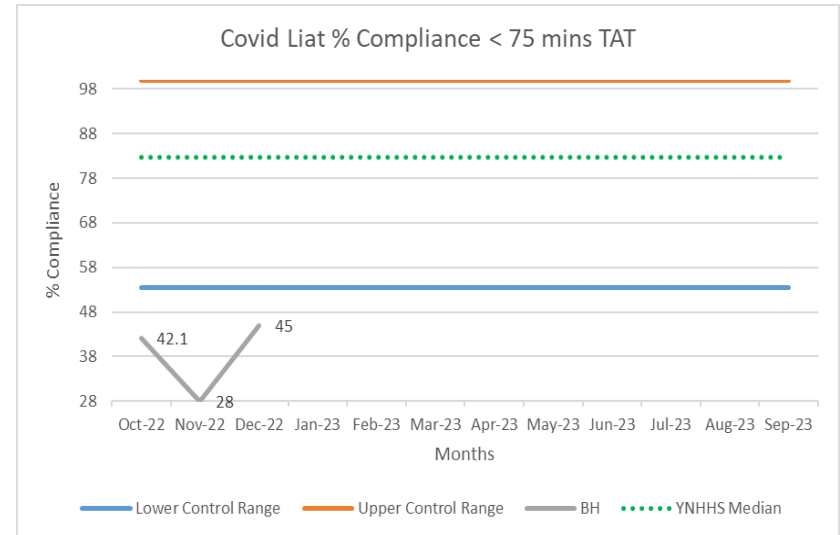
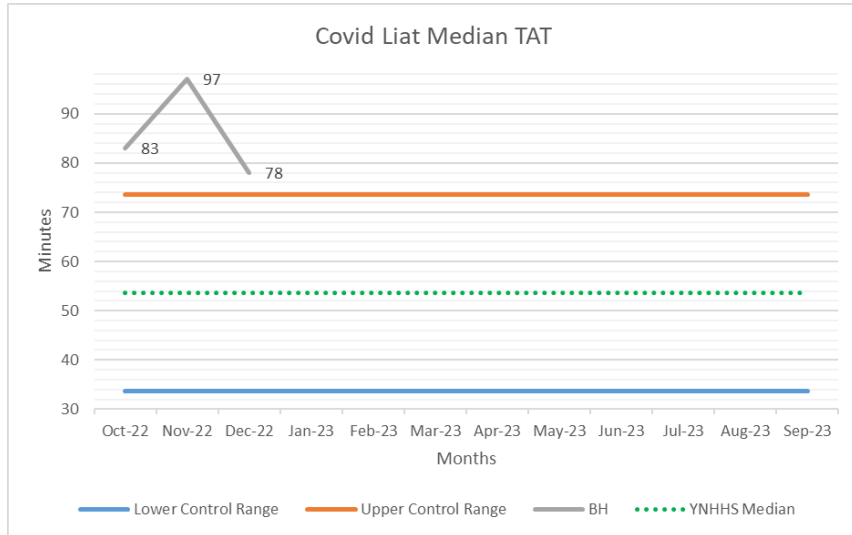


# Bridgeport Campus – COVID-19 Cepheid

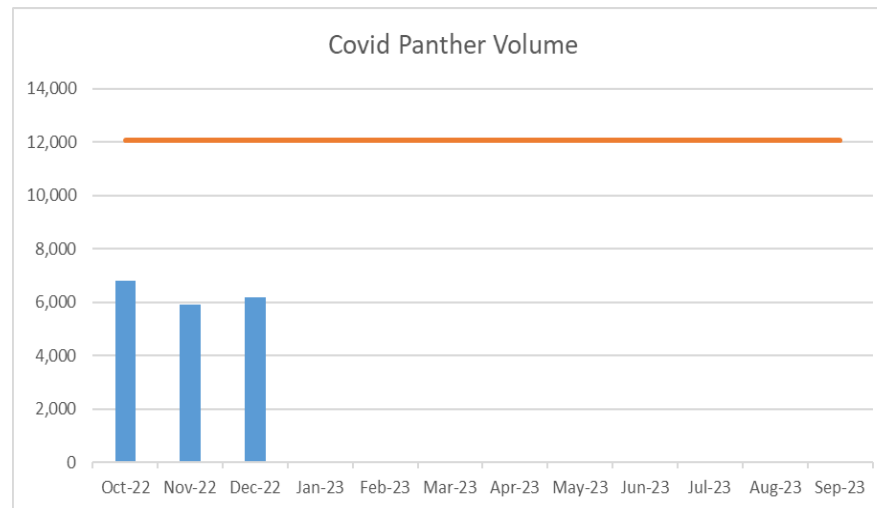
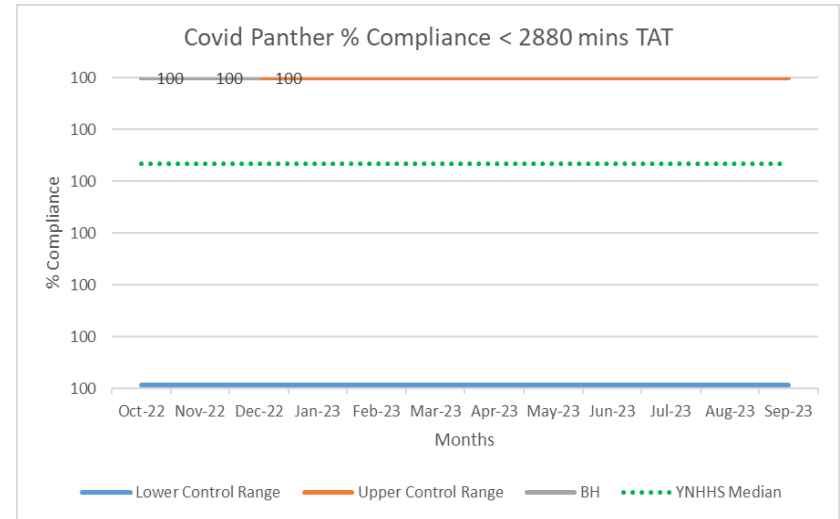
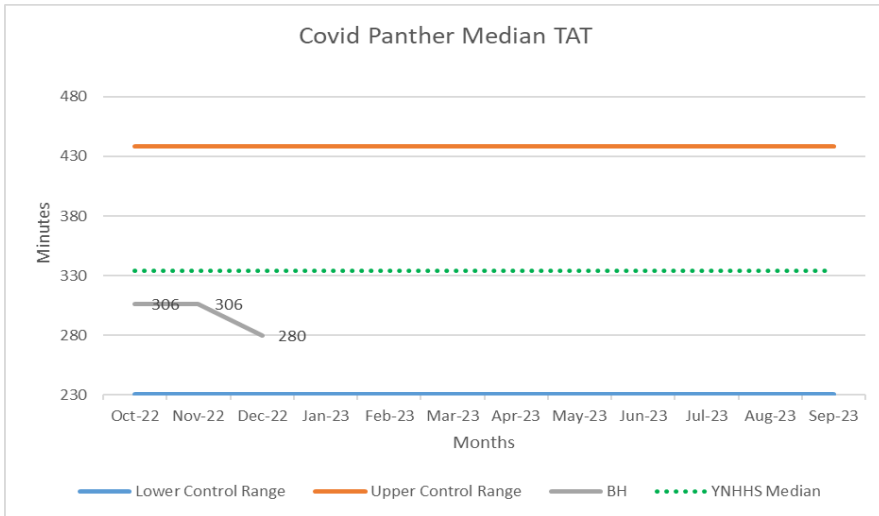




# Bridgeport Campus – COVID Liat

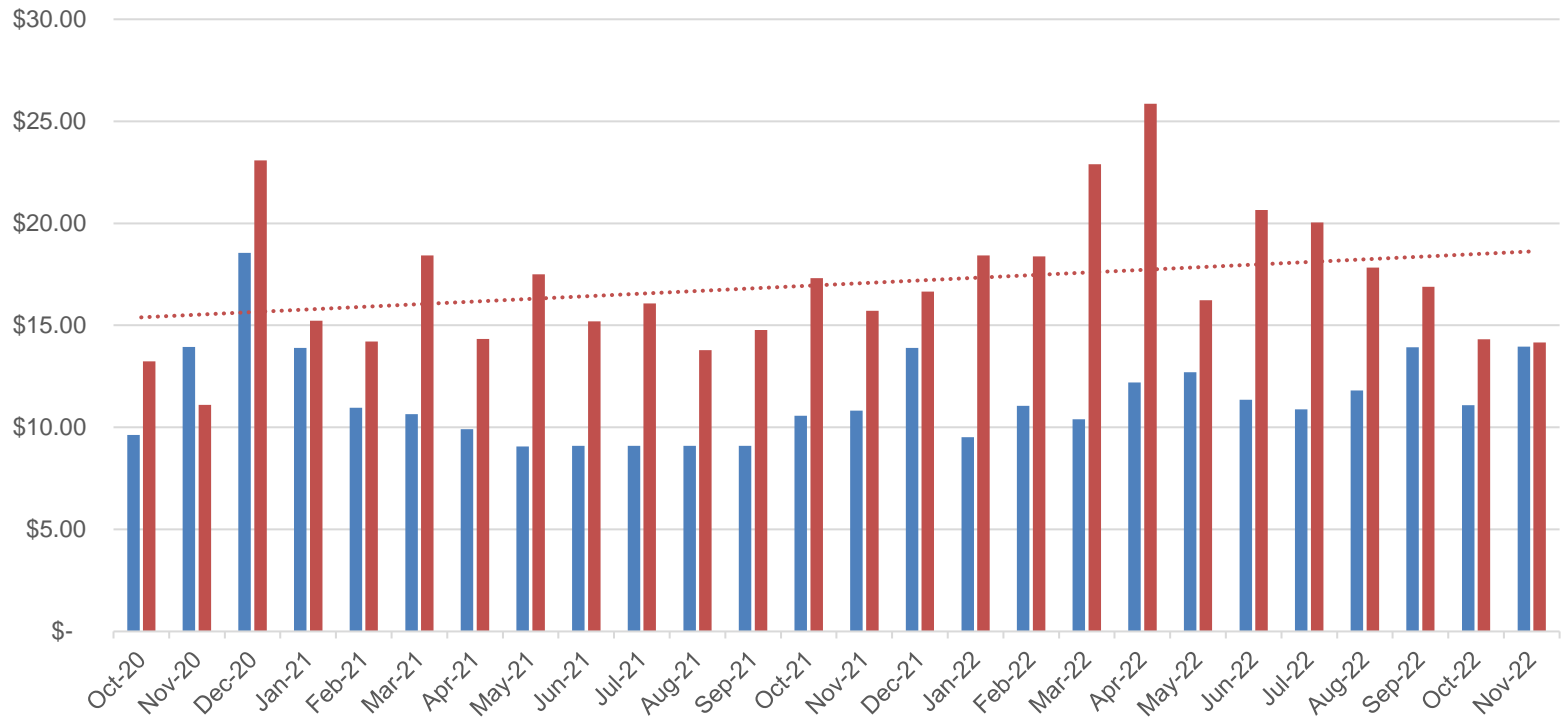


# Bridgeport Campus – COVID-19 Panther



# Cost Per Billable

FY2021 - FY2023 Cost Per Reportable (Total # of Expenses/# of Tests)  
Bridgeport vs. Milford

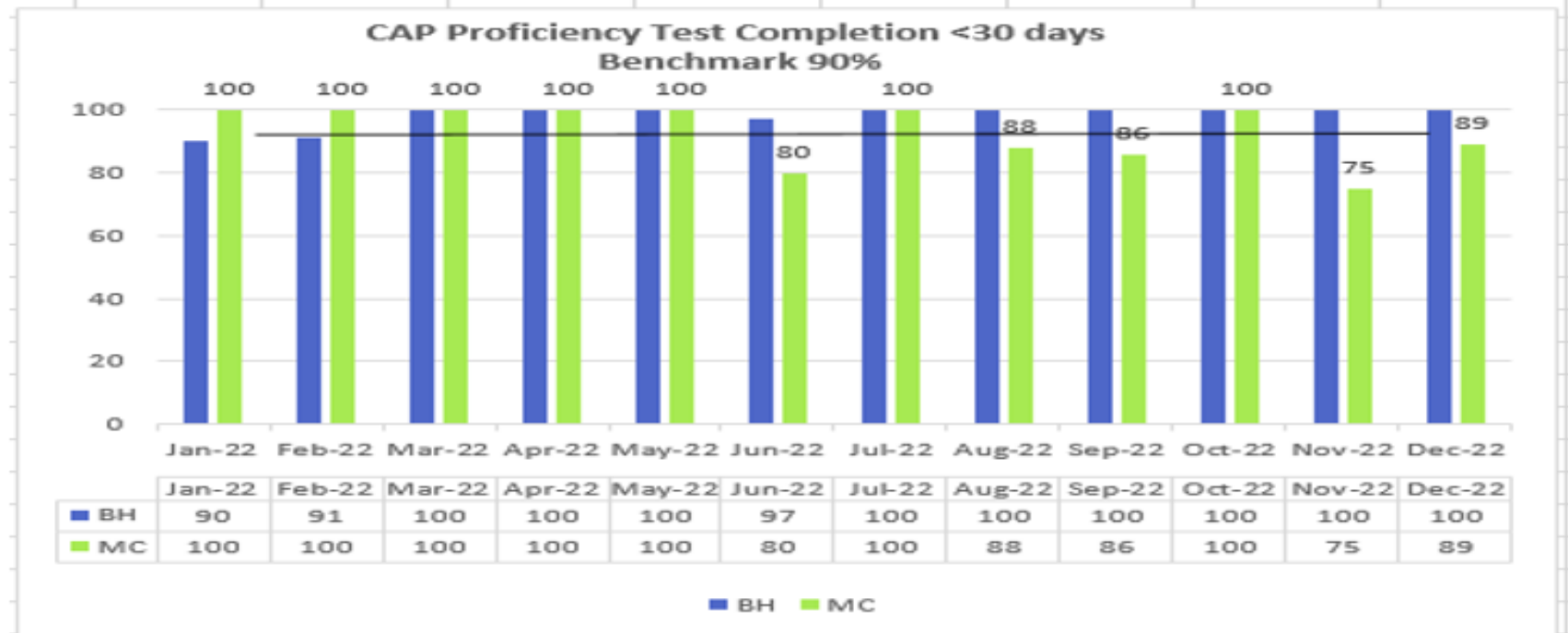


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
BH Cost per billable	\$9.	\$13	\$18	\$13	\$10	\$10	\$9.	\$9.	\$9.	\$9.	\$9.	\$9.	\$10.	\$10	\$13	\$9.	\$11	\$10	\$12	\$12	\$11	\$10	\$11	\$13	\$11	\$13
MC Cost per billable	\$13	\$11	\$23	\$15	\$14	\$18	\$14	\$17	\$15	\$16	\$13	\$14	\$17	\$15	\$16	\$18	\$18	\$22	\$25	\$16	\$20	\$20	\$17	\$16	\$14	\$14

■ BH Cost per billable    
 ■ MC Cost per billable    
 ⋯ Linear (MC Cost per billable)

# Lab General - Bridgeport

Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible
CAP PT Turnaround within 30 days	90%	BC	100% (27/27 surveys)	100%	None	None at BH, MC had surveys needing investigation due to >2 sdi	Lab management and administration
		MC	89% (8/9 Surveys)	75%			



# Lab General - Bridgeport

<b>Proficiency Testing Performance BC</b>	98%	128/132 Analytes	98%	98%	None	None required for benchmark-each section investigates failed/unsatisfactory performances. 3 surveys require investigation but were satisfactory	Laura
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## Proficiency Testing Performance Overview

Select View: Graph



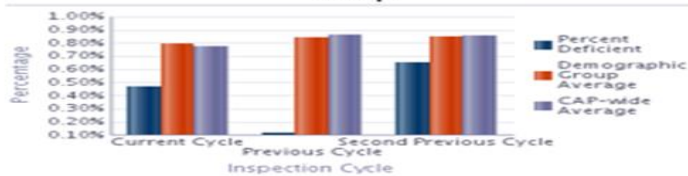
<b>12</b> Mailings with New Evaluations	<b>0</b> Mailings with Revised Evaluations	<b>0</b> Analytes with Unsatisfactory PT	<b>0</b> Analytes with Unsuccessful PT	<b>0</b> Analytes with Repeat Unsuccessful PT
--	---	---	---	--

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2022	99.33%	99.00%	98.64%
2021	99.81%	99.07%	98.67%
2020	98.76%	98.99%	98.58%

## Accreditation Performance Overview

Select View: Graph

Deficient Accreditation Performance by Cycle and Group



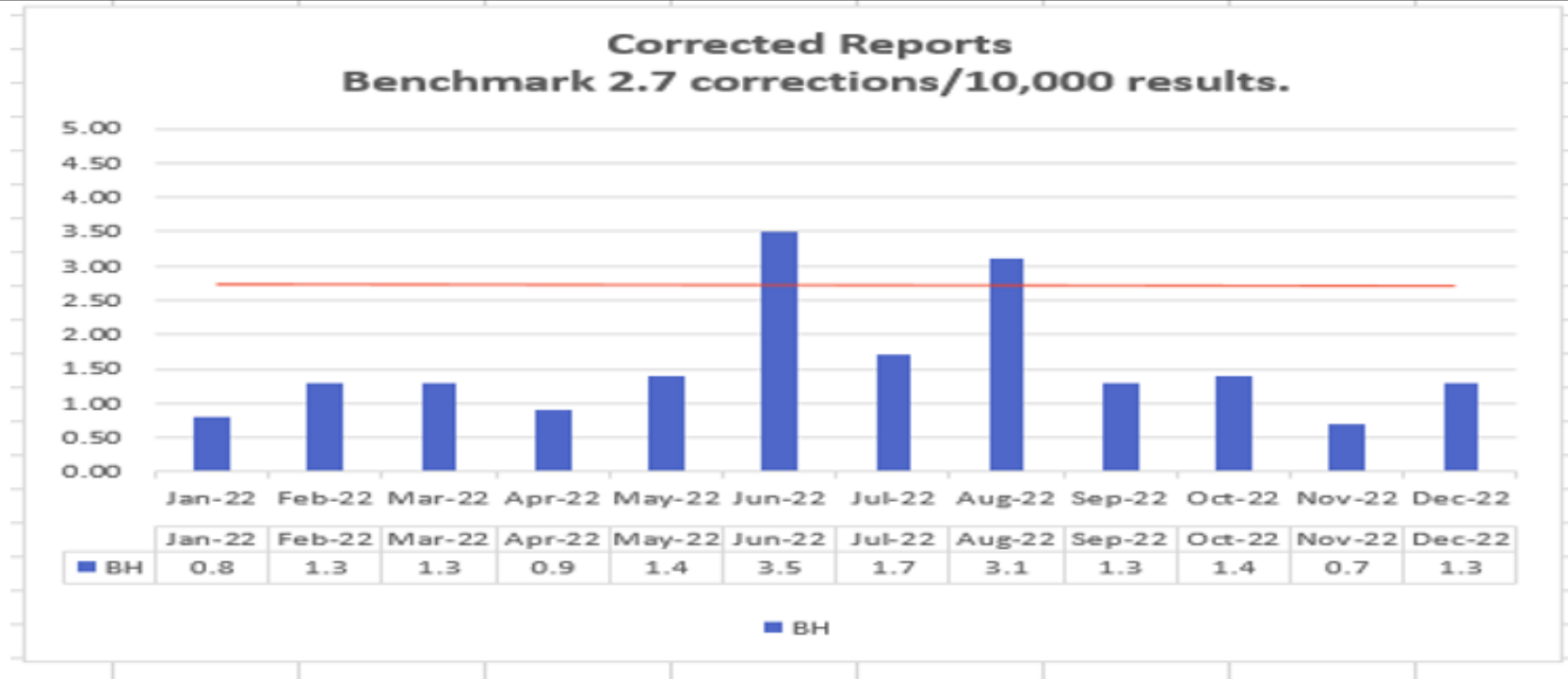
Last Accreditation Decision	Date
Accredited	5/9/2022

Current Cycle Inspection(s)			
Date	Inspection Type	% Deficient	Recurring Deficiencies
3/29/2022	Routine	0.47	1

Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.47%	0.79%	0.77%
Previous Cycle	0.11%	0.84%	0.86%
Second Previous Cycle	0.65%	0.84%	0.86%

# Lab General - Bridgeport

Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible
BC Lab Corrected/amended reports	<2.7/10,000 tests	197,012 tests	1.3 Per 10,000 results (0.13%)	0.7 (0.07%)	Corrected reports can lead to adverse patient outcomes	None needed benchmark met	Laboratory administration

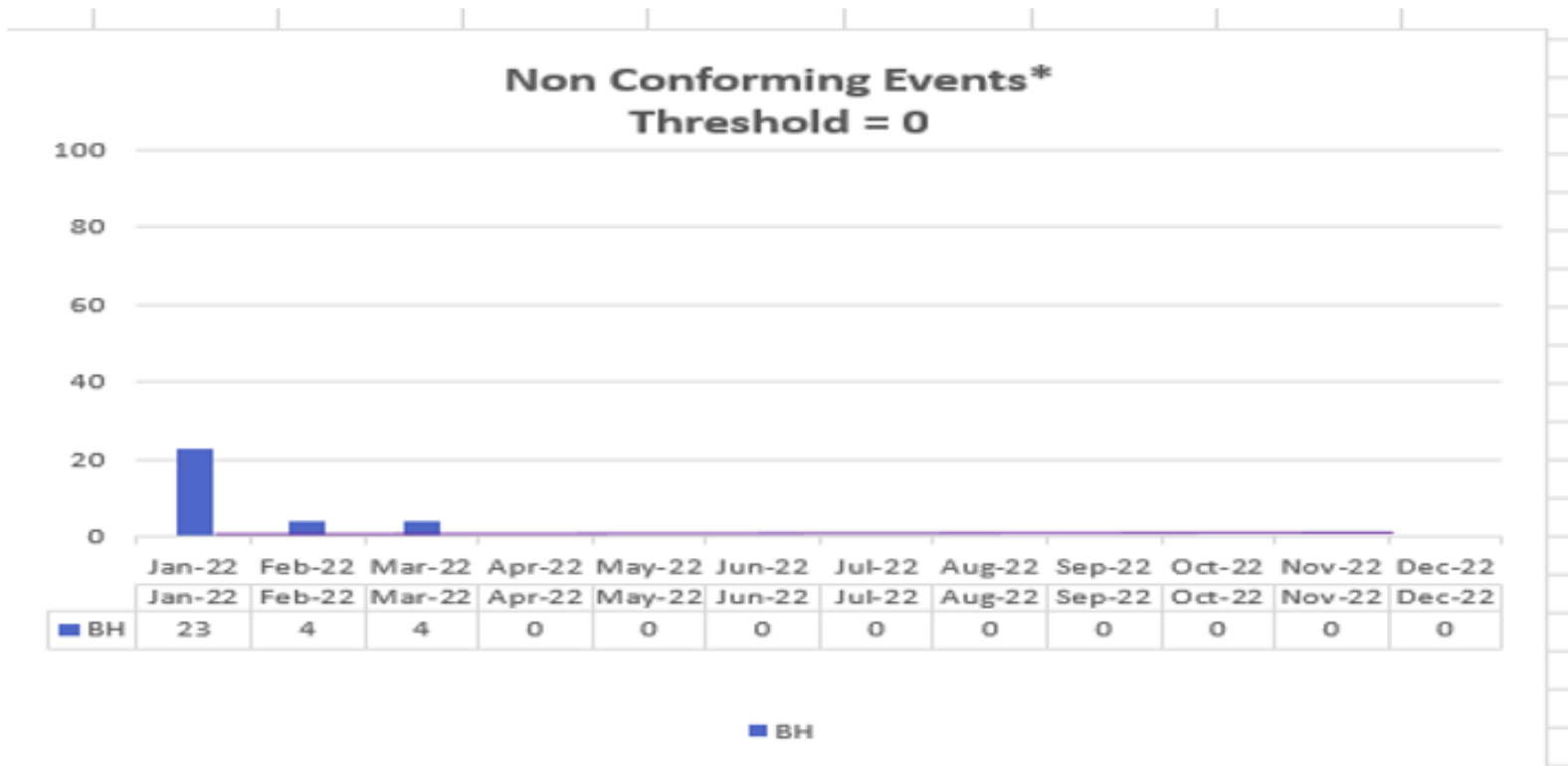


June 2022 above threshold due to courier transport issue identified late which resulted in specimens needing recollection after verification of results.

August 2022 above threshold due to electrode ISE malfunction requiring patients to be re-run with 38 corrected results.

# Lab General - Bridgeport

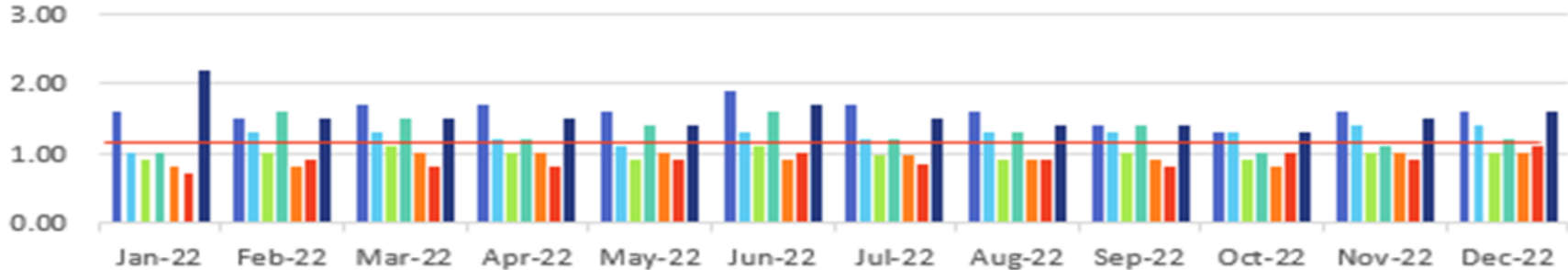
Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and 593follow-up	Responsible Staff
Nonconforming events BC	0	197,012 tests	0	0	None	None needed	Lab administration and management



\* Definition of Non Conforming events for this Quality Measure includes irreplaceable samples only.

# Lab General - Bridgeport

% Rejected Specimens  
 <3.5%\* Literature Benchmark  
 1.1% YNHHS Benchmark.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
■ BH	1.6	1.5	1.7	1.7	1.6	1.9	1.7	1.6	1.4	1.3	1.6	1.6
■ GH	1	1.3	1.3	1.2	1.1	1.3	1.2	1.3	1.3	1.3	1.4	1.4
■ LMH	0.9	1	1.1	1	0.9	1.1	0.99	0.9	1	0.9	1	1
■ MC	1	1.6	1.5	1.2	1.4	1.6	1.2	1.3	1.4	1	1.1	1.2
■ SRC	0.8	0.8	1	1	1	0.9	0.98	0.9	0.9	0.8	1	1
■ WH	0.7	0.9	0.8	0.8	0.9	1	0.85	0.9	0.8	1	0.9	1.1
■ YH	2.2	1.5	1.5	1.5	1.4	1.7	1.5	1.4	1.4	1.3	1.5	1.6

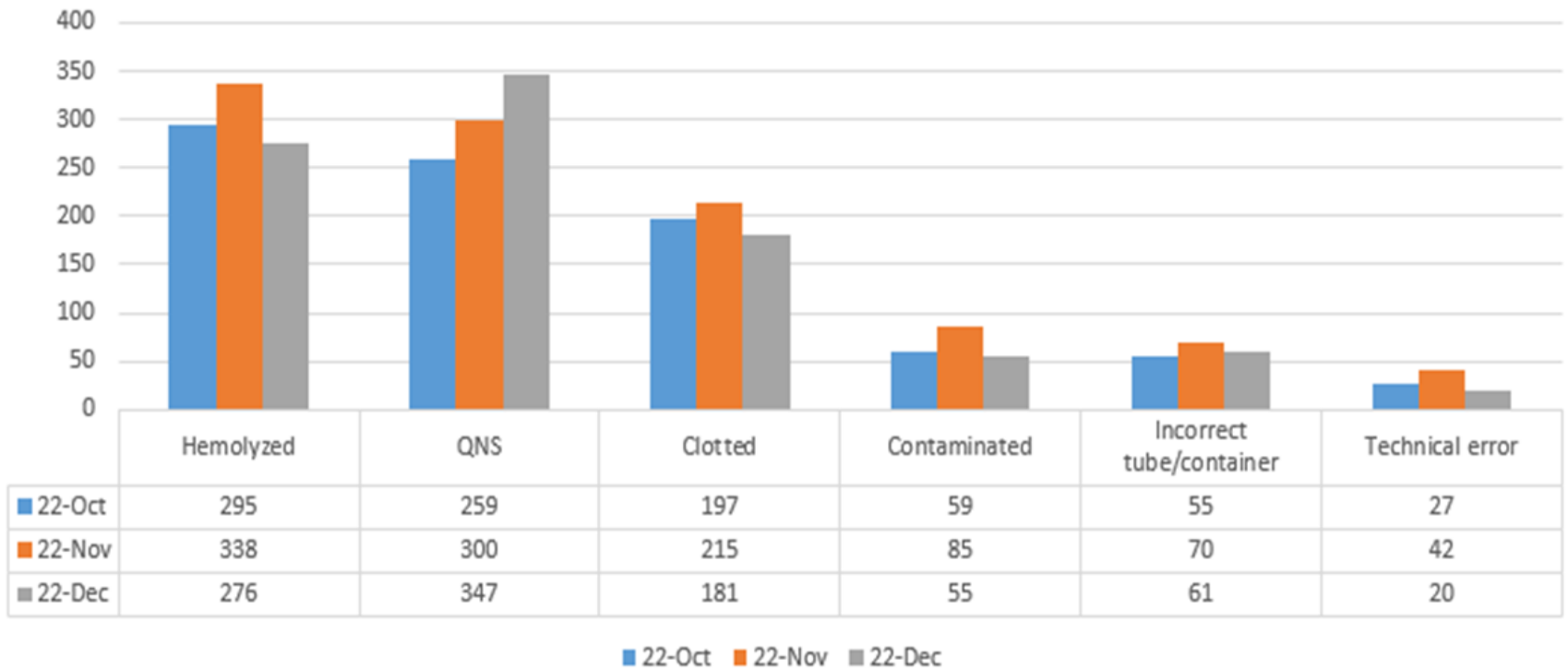
■ BH ■ GH ■ LMH ■ MC ■ SRC ■ WH ■ YH

\*Rooper L. Carter, J., Hargrove, J., Hoffman, S & Riedel, S. (2017). Targeting rejections: analysis of specimen acceptability and rejection. *Journal of Clinical Laboratory Analysis* . volume 31, issue 3



# Lab General - Bridgeport

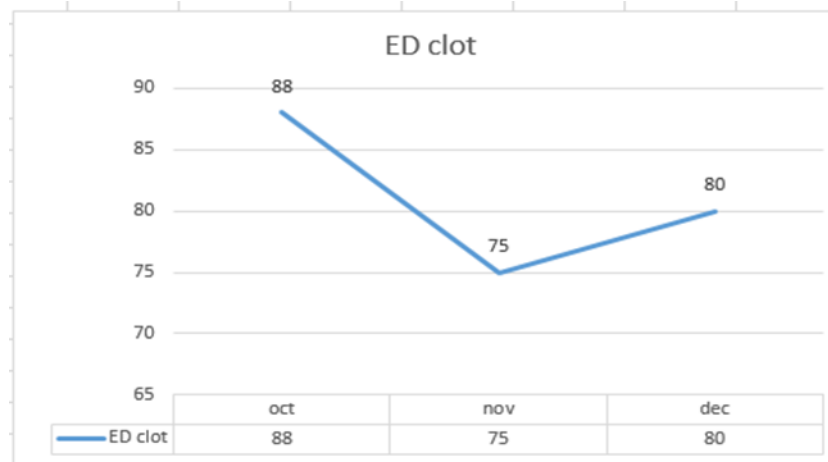
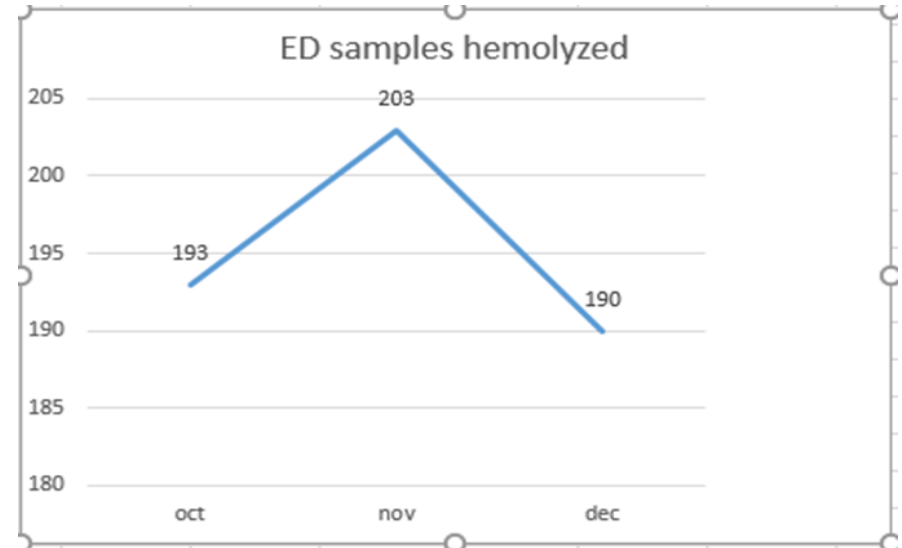
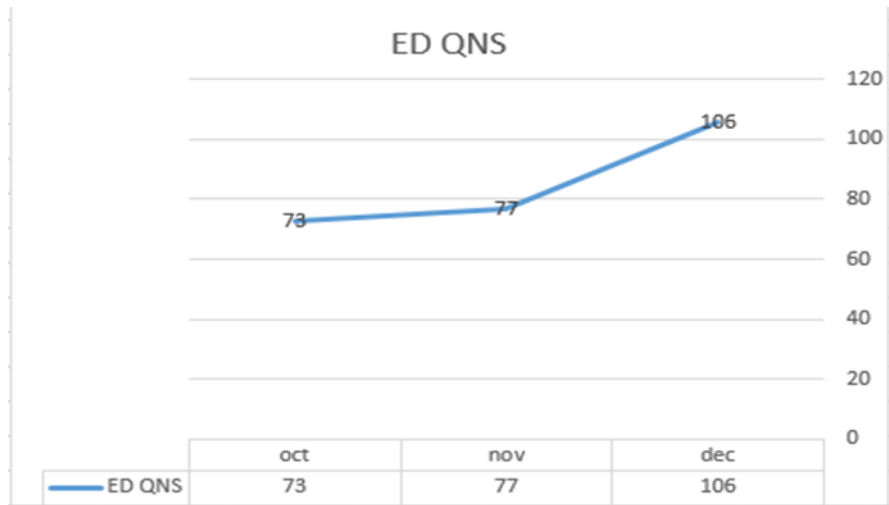
Rejected Specimens by Classification (all BH collection locations)



- Note-of the 20 technical error reason used for rejection, 18 were from Draw Stations-(pre-analytical)

# Lab General - Bridgeport

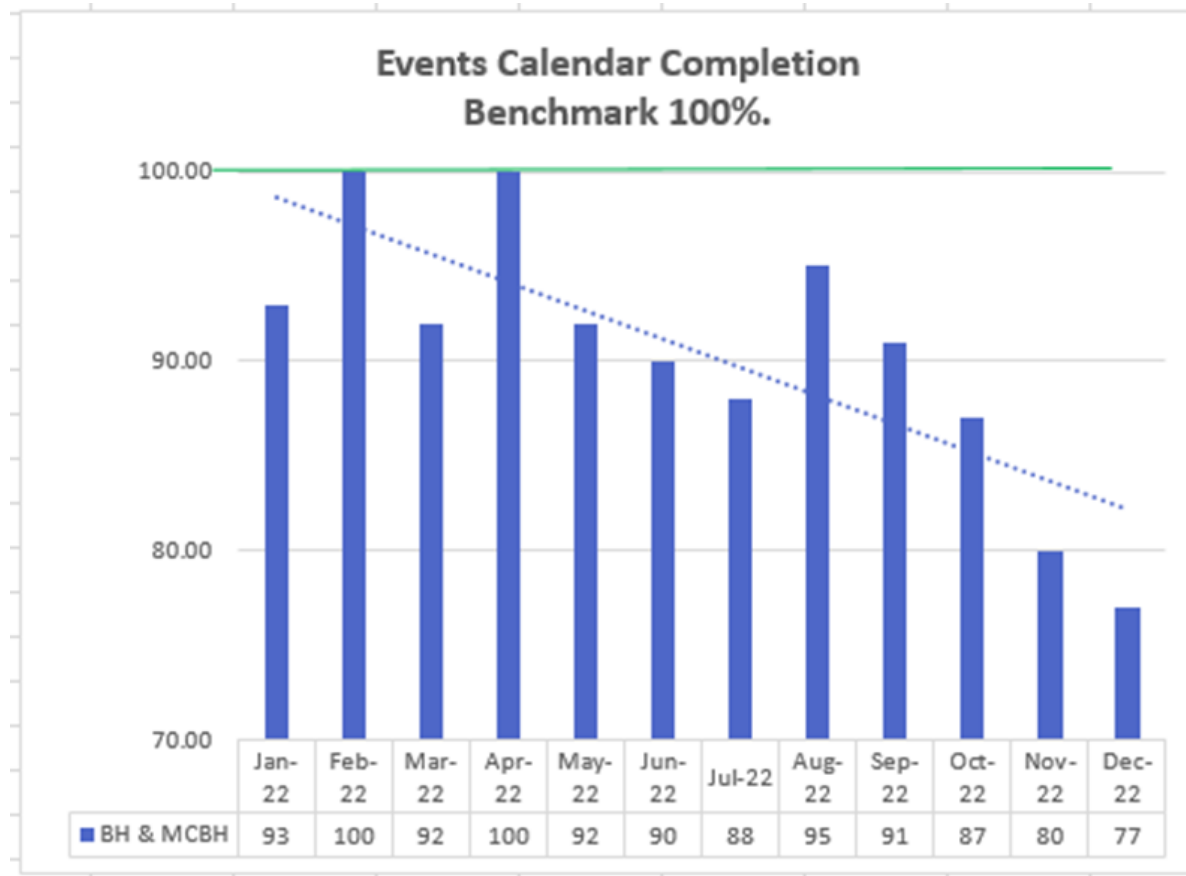
## ED ONLY Top 3 Rejects (BH only)



# Lab General - Bridgeport

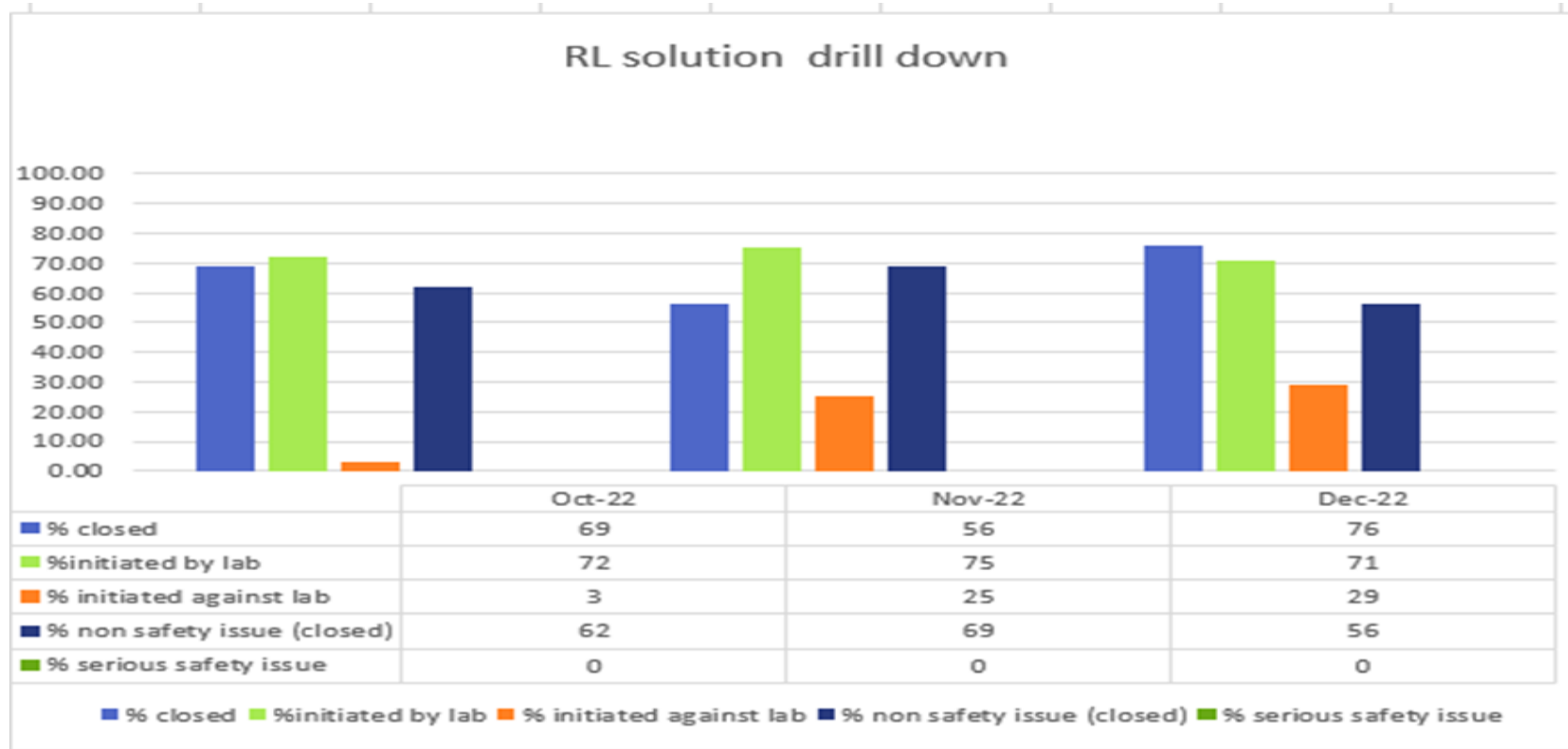
BH & MCBH Events Calendar Completion 77%

Benchmark 100%  
17/22 Events completed



# Lab General - Bridgeport

## BH RL SOLUTIONS MONITOR



**16/21 events closed-5 open (4 tasked to lab mgt., 1 urology)**

**15 lab initiated**

**0 Serious Safety Events, rest barrier catches not reaching patients**

# Lab General - Bridgeport

## Incorrectly entered

**When and Where Event Occurred**

When and where the event occurred

Event Date (mm/dd/yyyy)	* 11-25-2022
Incident time	* 13:32
Site	* Bridgeport
Service Area	* Laboratory Service
Unit Event	* Histology

## Correctly entered

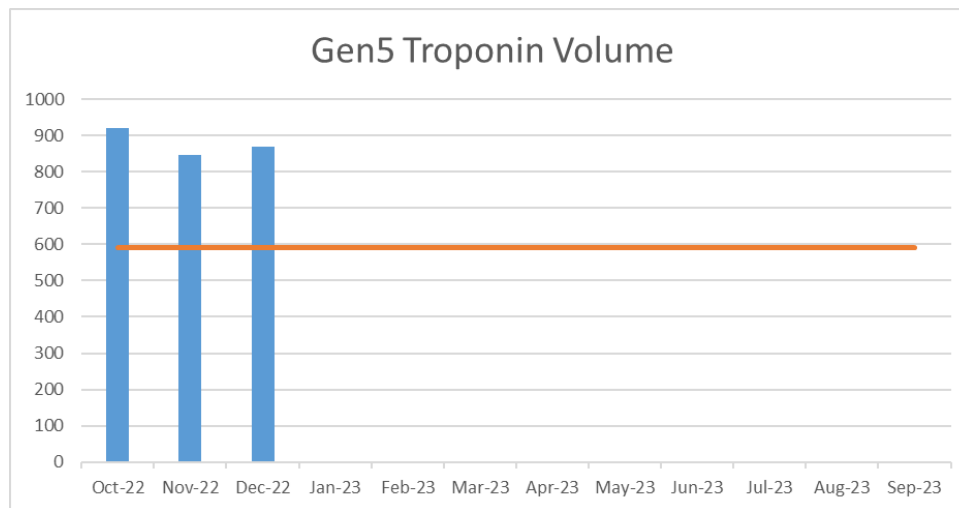
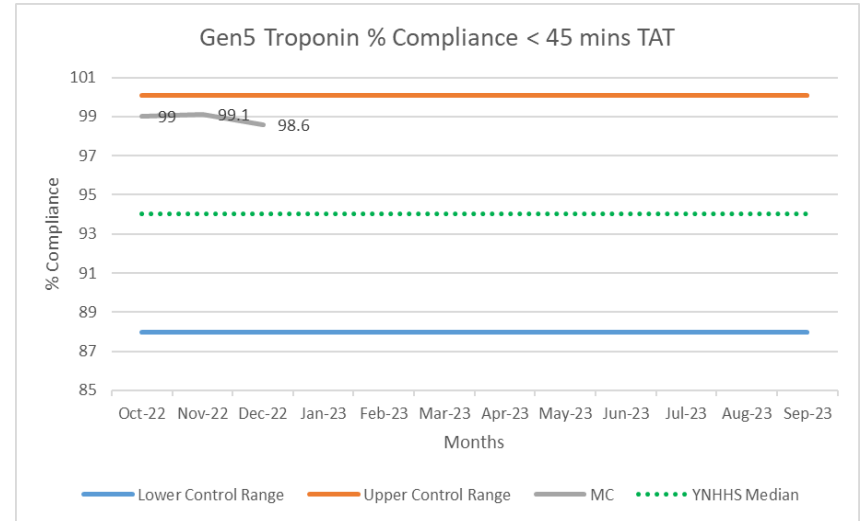
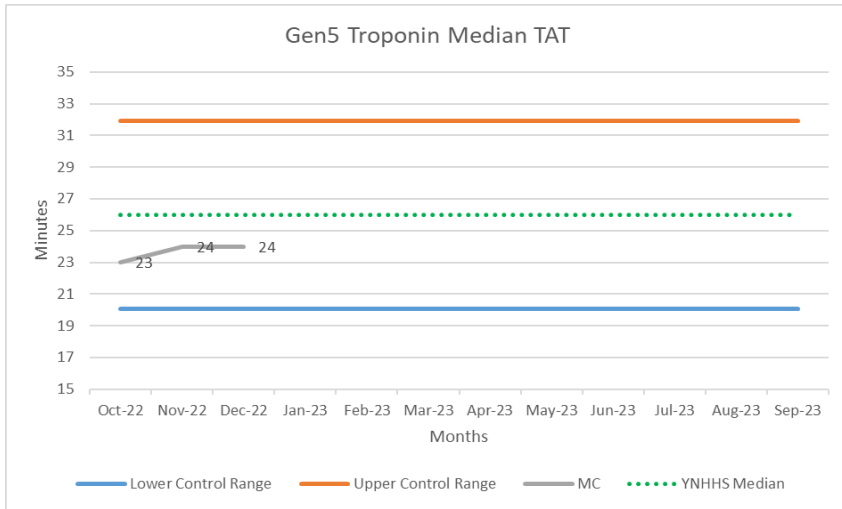
**When and Where Event Occurred**

When and where the event occurred

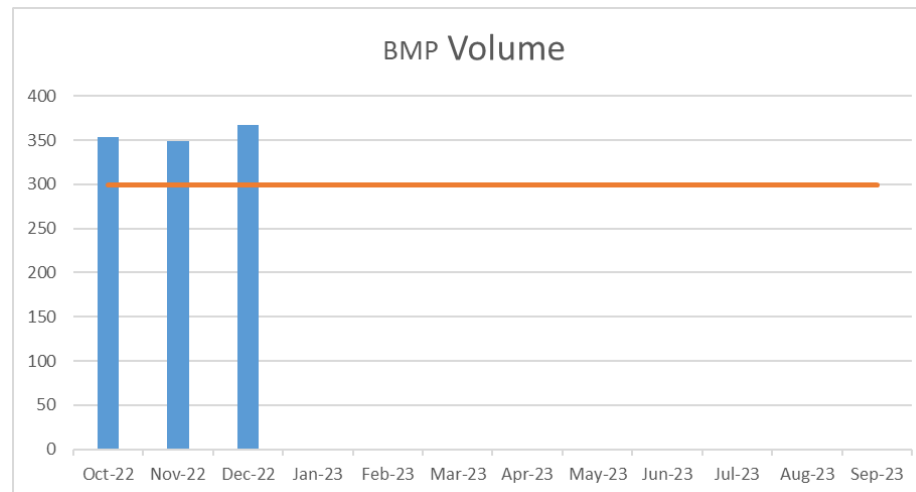
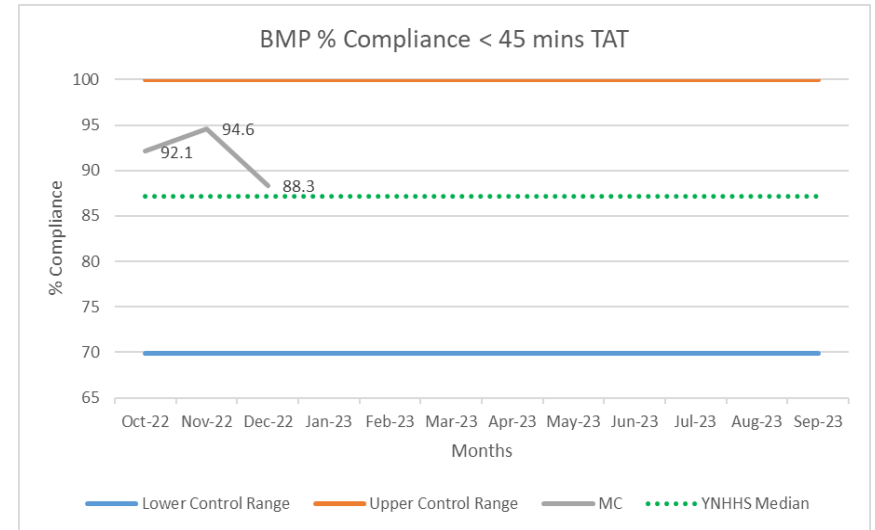
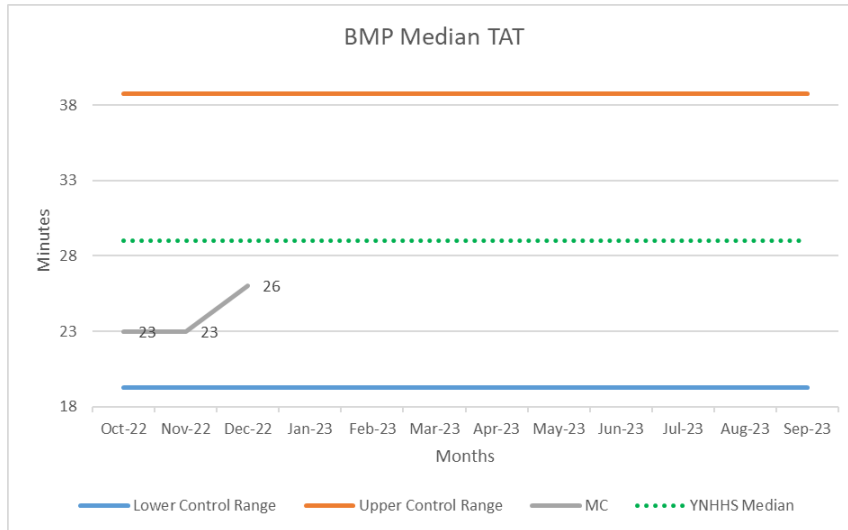
Event Date (mm/dd/yyyy)	* 11-15-2022
Incident time	* 17:18
Site	* Bridgeport
Service Area	* Surgical Service
Unit Event	* Wound Center

Later when filling out, there is another field that is optional to enter into that says "Was a 2<sup>nd</sup> dept. involved"-here you can click Yes and enter lab or leave blank.]

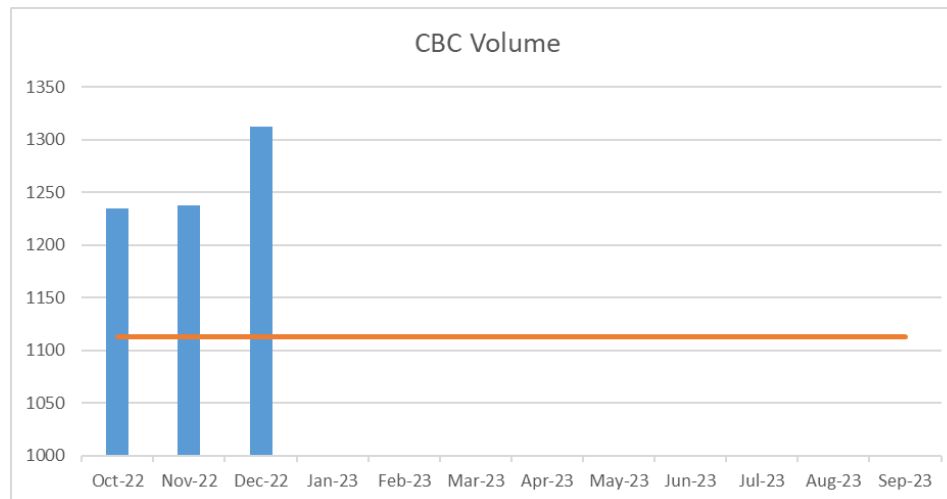
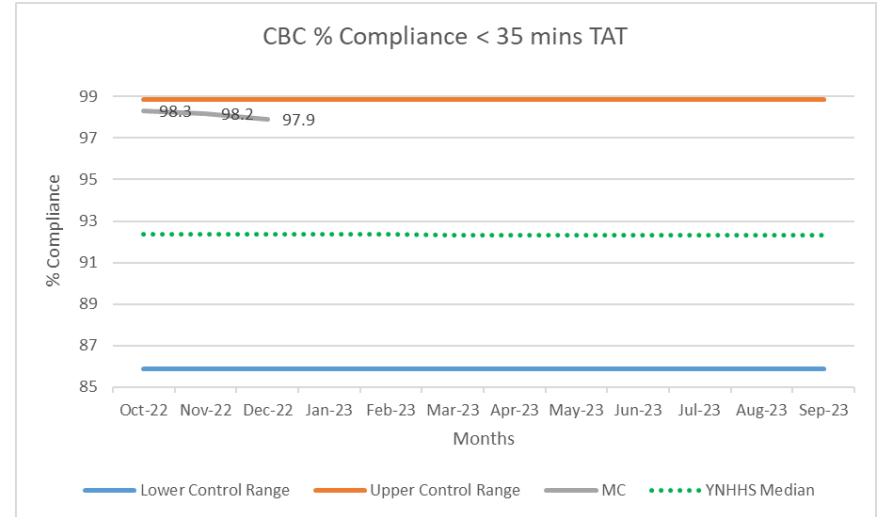
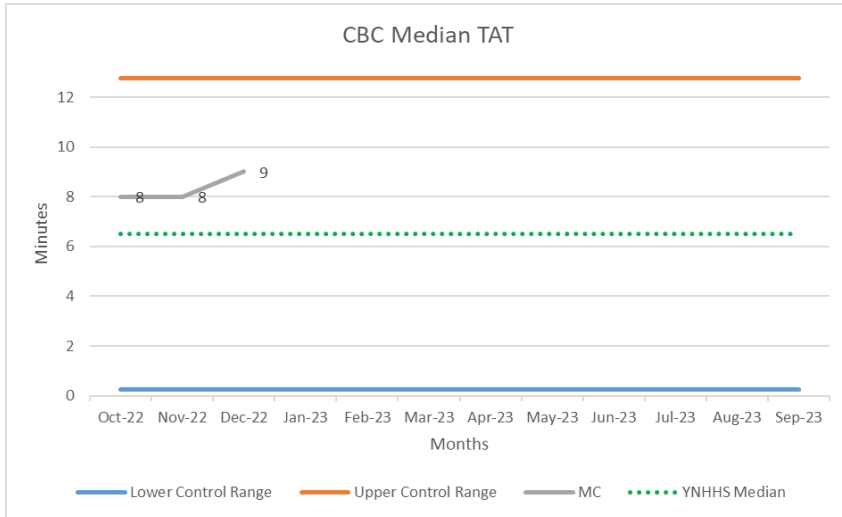
# Milford Campus – Gen 5 Troponin TAT



# Milford Campus – Basic Metabolic Panel (BMP) ED TAT

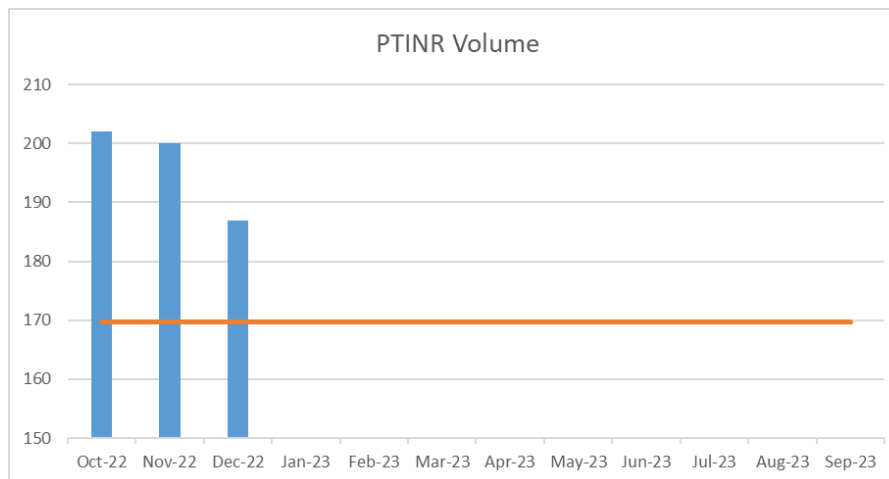
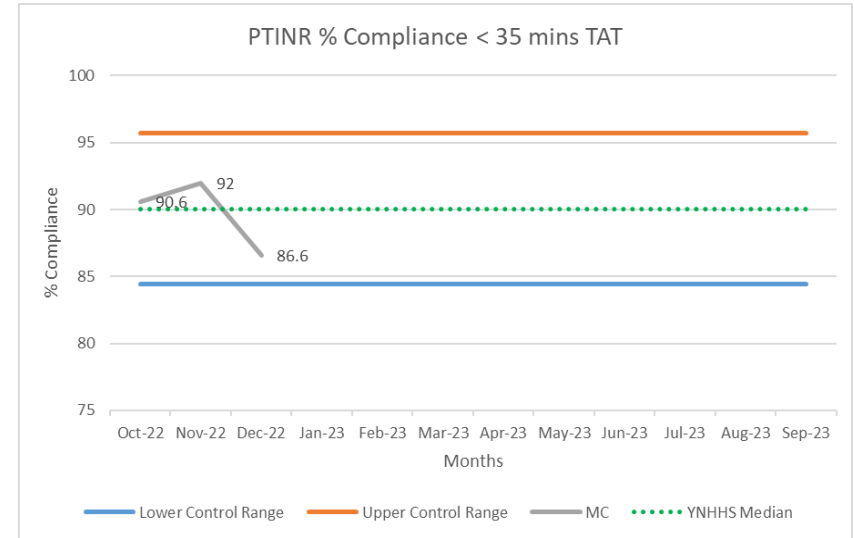
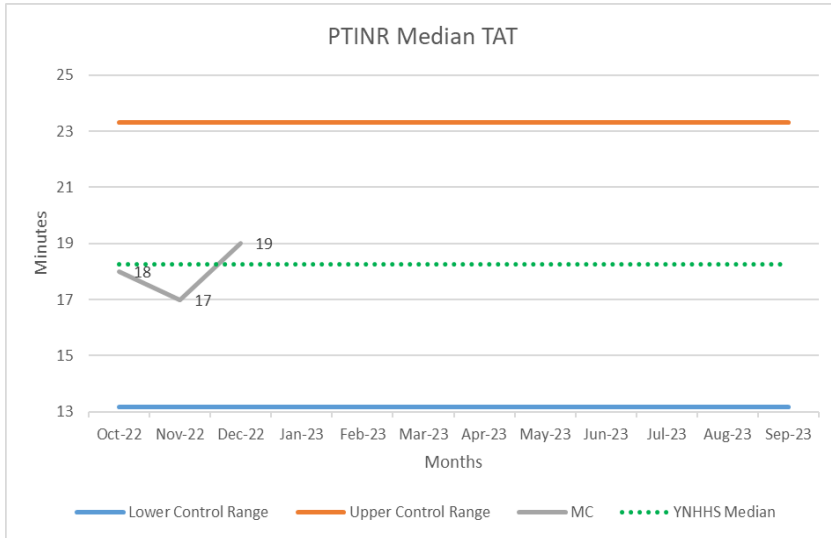


# Milford Campus – Complete Blood Count (CBC) ED TAT

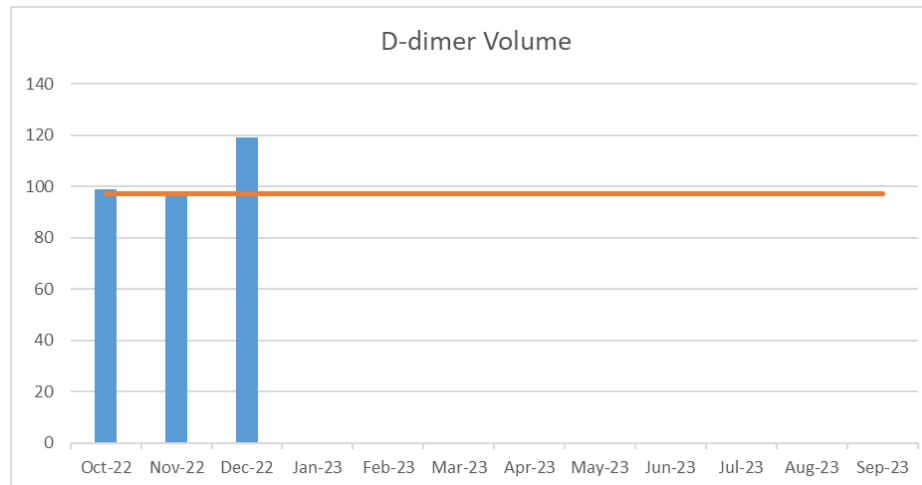
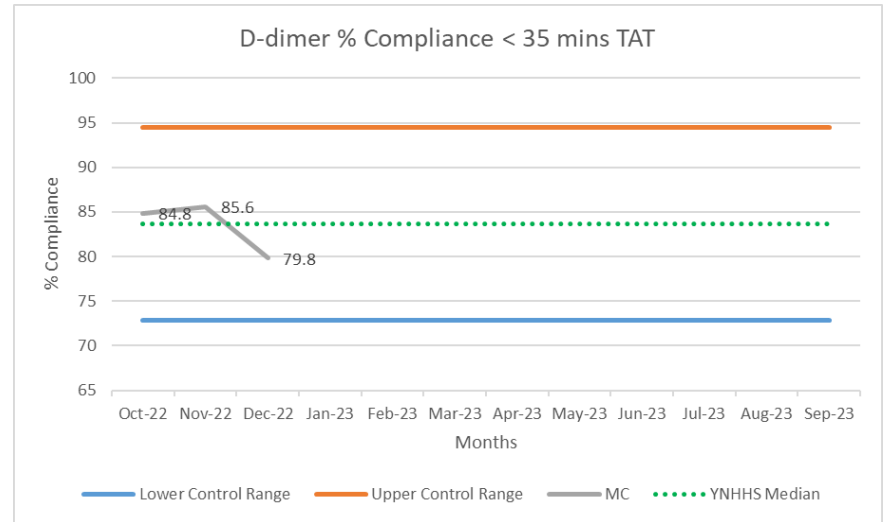
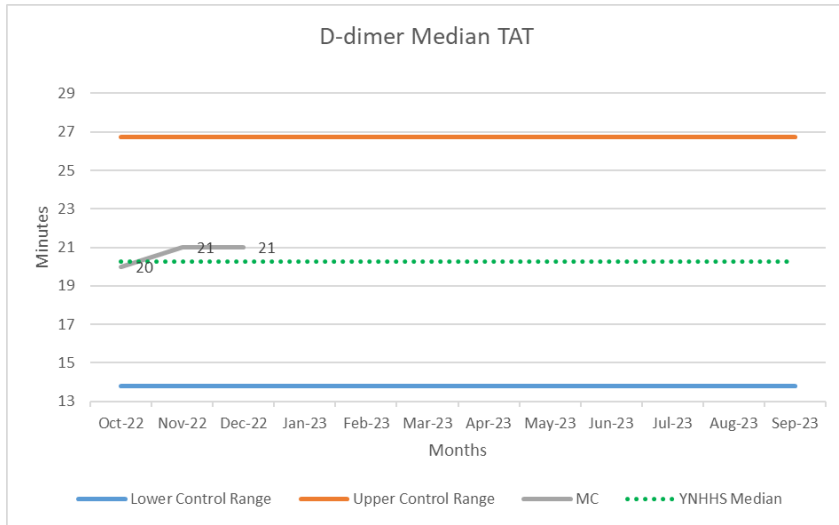




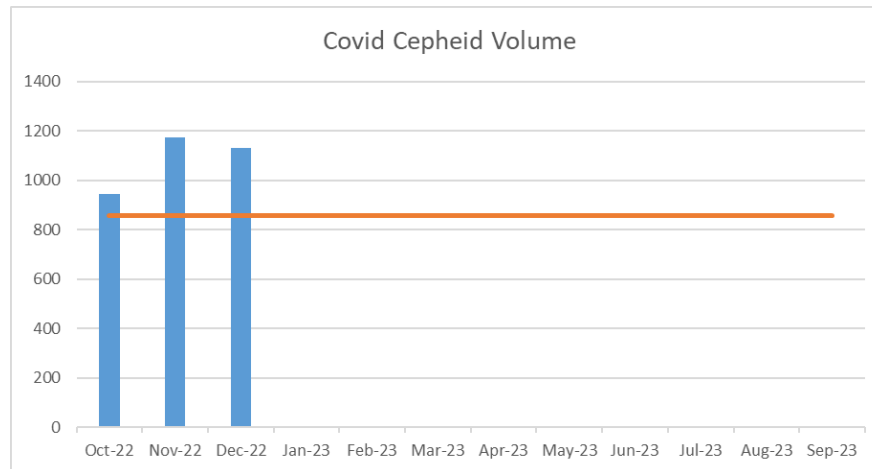
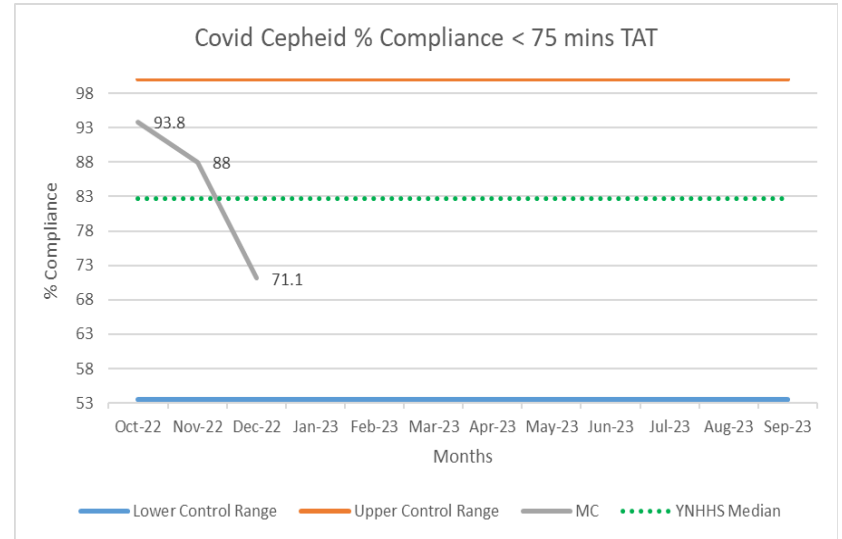
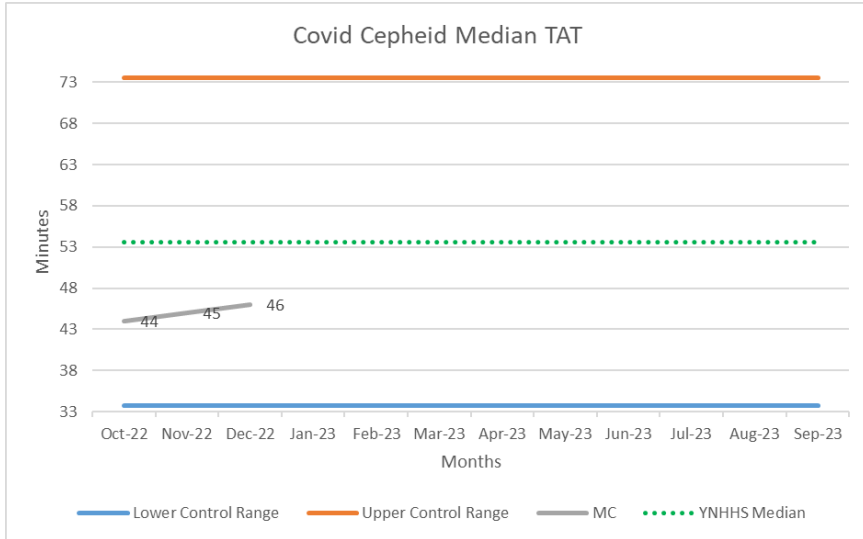
# Milford Campus – PTINR ED TAT



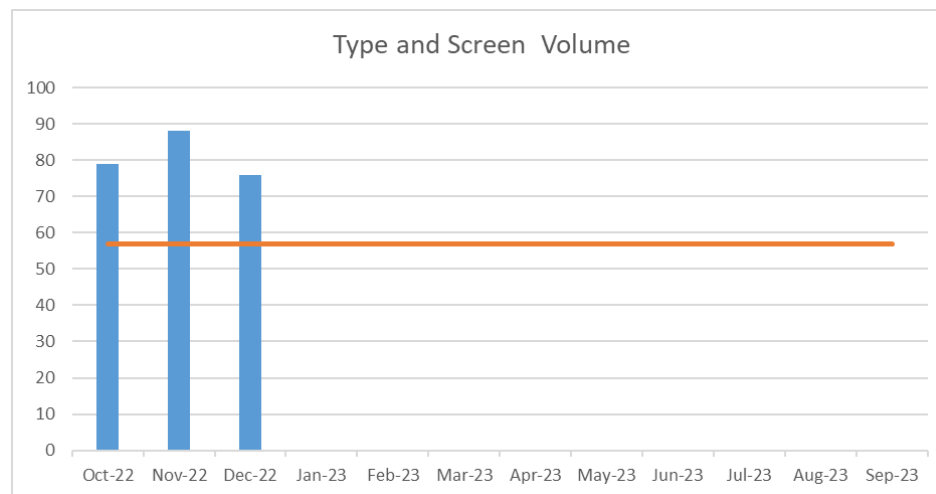
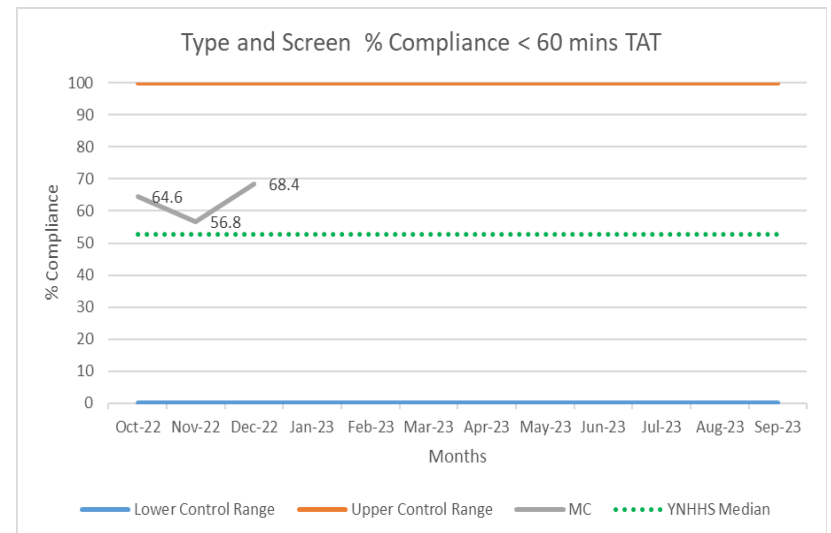
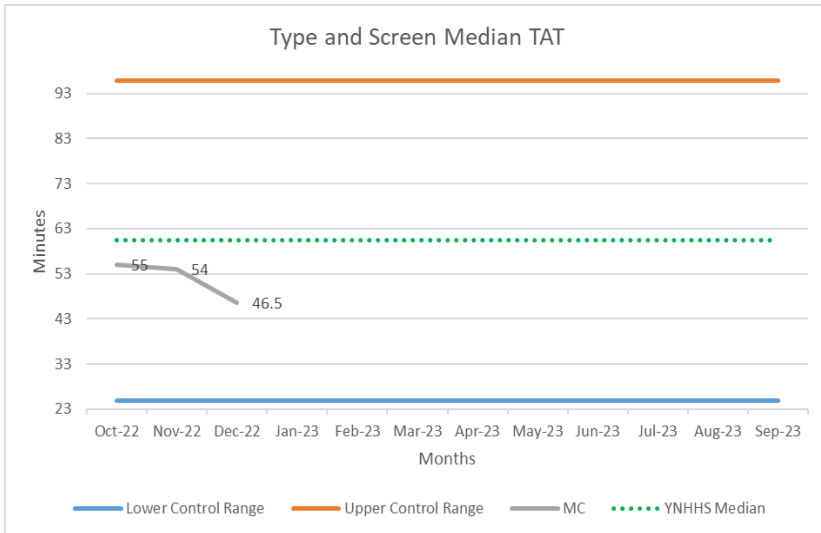
# Milford Campus – D-dimer ED TAT



# Milford Campus – COVID Cepheid PCR ED TAT



# Milford Campus – Type and Screen ED TAT



# Milford Campus RBC

<b>Milford Hospital Blood Bank</b>				
<b>RBC</b>				
	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Total Amount</b>
<b>Transfusion</b>	109	96	94	\$67,663.70
<b>Wasted</b>	0	0	0	\$0.00
<b>Total</b>	109	96	94	\$67,663.70

# Milford Campus Cryo

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	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Total Amount</b>
<b>Transfusion</b>	1	1	0	\$663.00
<b>Wasted</b>	1	0	0	\$331.50
<b>Total</b>	2	1	0	\$994.50

# Milford Campus FFP

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	Oct	Nov	Dec	Total Amount
<b>Transfusion</b>	4	4	6	\$151.20
<b>Wasted</b>	0	0	0	\$0.00
<b>Total</b>	4	4	6	\$151.20

# Milford Campus Platelet Discarded

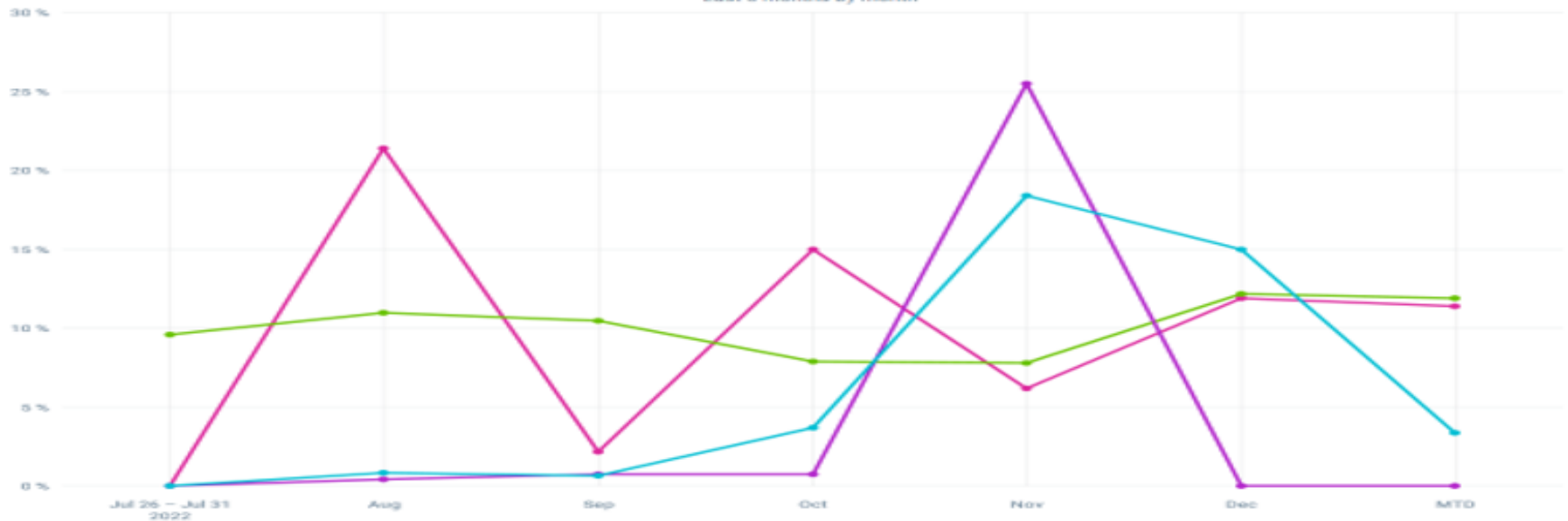
	Oct	Nov	Dec	Total Amount
<b>Transfusion</b>	3	8	6	\$11,441.00
<b>Discarded</b>	11	7	9	\$18,171.00
<b>Total</b>	14	15	15	\$29,612.00
<b>% Discarded</b>	78.57%	46.67%	60.00%	
<b>Discarded/Day</b>	0.35483871	0.225806452	0.290322581	\$586.16



# Milford Campus Molecular Dashboard

## Milford Molecular Dashboard

Percentage with Abnormal? by Test  
Last 6 months by month



- Group A Strep PCR
- SARS CoV-2 (COVID-19) RNA
- Influenza A/B RNA, NAAT
- Influenza/RSV by RT-PCR

Date	Tests	% Positivity	Derived Baseline	Environment Monitoring	Physician Feedback	Epidemiological Trends	Evaluation Notes	Corrective Action (if needed)
22-Dec	SARS-CoV-2		3-12%	Negative	None	Per CDC, Covid, Flu & RSV trending downward (lowest)	None	None
22-Dec	Group A Strep		0-24%	Negative	None		None	None
22-Dec	Flu A/B		0-0%	Negative	None		None	None
22-Dec	Flu/RSV		0-24%	Negative	None		None	None

in 3 months)

# Lab General – Milford (1 of 2)

Aspect of Care	Threshold Expected/Target	Sample Size	Data Source	Achieved Current month	Previous month	Corrective Action	Patient Impact	Follow up and evaluation	Staff responsible
Non-Conforming Events	0	# Tests 23,574	Manual Collection	0	0		none	Corrections without a completed comm log are seen as non-conforming. All corrected reports in December were accompanied by completed comm logs.	Supervisors
Proficiency Testing	98% CAP Q Probe data	# Analytes	CAP	100%	99%	None required	None	None needed	Supervisors
Laboratory corrected reports	2.7/10,000	# tests 23,574	Manual collection	3.8	1.35	The increase in corrected reports is due primarily to an increase in manual data entry errors. Staff members committing those errors have been interviewed and counseled by the lab manager regarding our 2-person verification policy.	none	The risk for data entry errors was increased in December due to an unexpected system-wide loss of instrument interfaces, forcing manual data entry of all testing during the evening shift. Pursuit of autoverification in Chemistry and installation of a slide label printer in Hematology promises to reduce the risk of report correction in coming months.	Supervisors
Laboratory Injuries	0	Employees n=33	IMC	0	0		none	none	Supervisors

# Lab General – Milford (2 of 2)

Redraws		# Tests 23,574				The excessive hemolysis of specimens is presumed to be the result of a model change of IV initiation sets. Supply chain issues prevent return to previous model.	Minor impact due to necessary recollection of samples. Percent redraws = 0.4%	"Other" category expanded using Tableau to capture Incorrect specimen type, Duplicate order, and Incorrect order by provider. "QNS" category divided into QNS and unable to obtain specimen.	Nursing, Providers & Phlebotomy
Clotted	0		Beaker+	18	15				
Contamination (IV & other)	0		Tableau	2	5				
Hemolyzed (RN)	0			40	21				
(Phleb)	0			4	5				
Not on ice	0			3	4				
QNS	0			23	16				
Wrong container	0			7	6				
Duplicate order	0			1	2				
Incorrect order by provider	0			0	0				
Unable to obtain specimen.	0			0	0				
Incorrect specimen type.	0			15	7				
Exceeded clinical time requirements				0	0				
Lab accident				3	0				
				0	0				
Critical Call TAT	30 min		Beaker	6.2	4.1	Formatted report to show true TAT. Comm log completed on 100% of critical calls	<30 minute compliance = 96%	System decision to call criticals after verifying occurred in April.  4 >30 min outliers skewed the mean, although we are still well under the benchmark of 30 min. MHB use by lead staff is being promoted to reduce the incidence of delayed critical reporting.	Supervisors

## CRSQ Report Out

Committee of Regulatory, Safety, & Quality

December 2022

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Bridgeport Hospital

Department of Laboratory Medicine

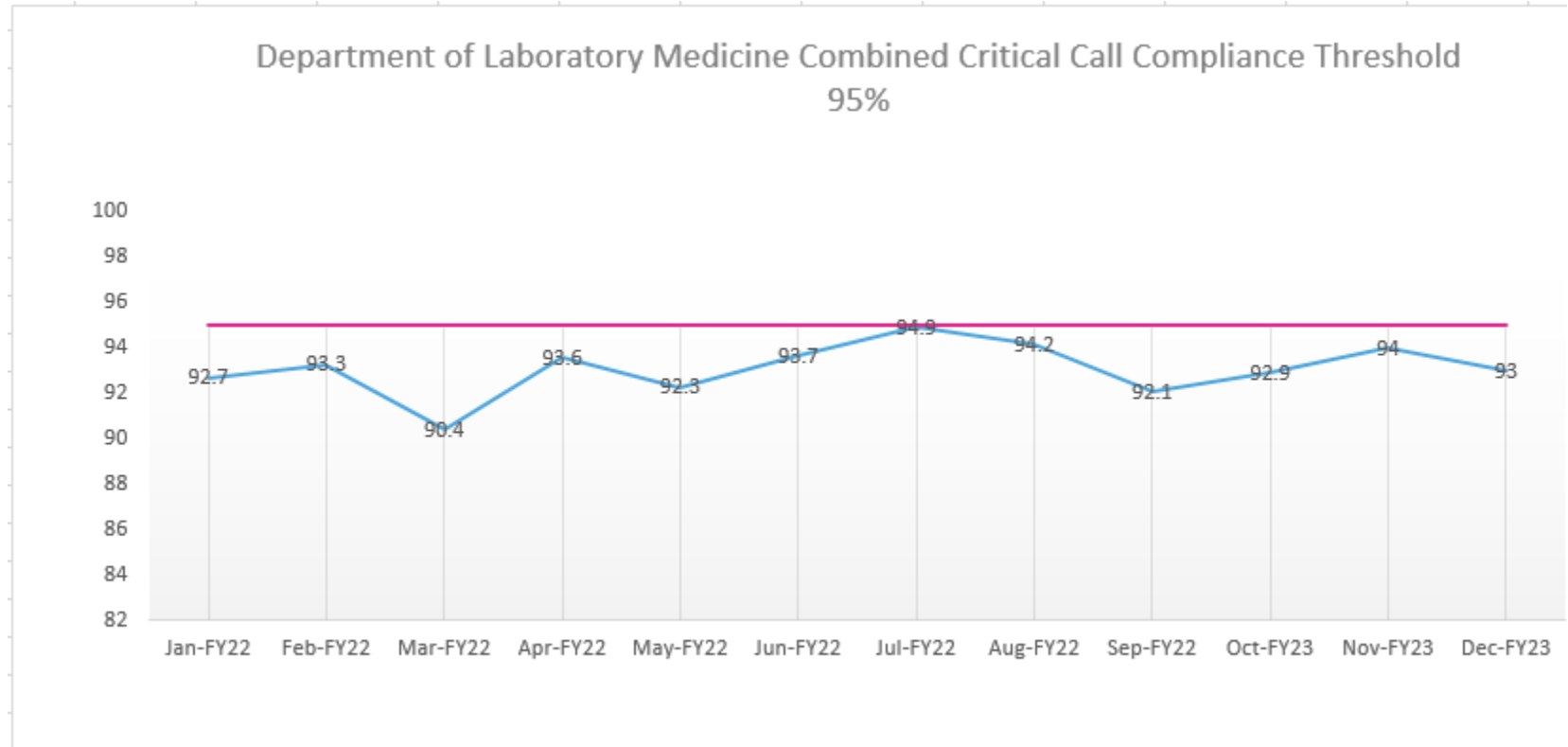
Teodorico Lee MPH, Mingkui Chen M.D., Christine Minerowicz M.D., Edward Snyder M.D., Laura Buhlmann M.S.

<p><b>SMART Aim</b> <i>Specific-Measurable-Actionable-Relevant-Timely</i></p>	<p>Increase the critical result notification compliance with our 30-minute goal to 95% at Bridgeport Hospital by September 30<sup>th</sup>, 2022.</p> <ul style="list-style-type: none"> <li>• The 30-minute time period is from the moment the critical value is final verified to the moment the communication log in Epic is completed.</li> <li>• We are currently at <b>93%</b> compliance as a department.</li> </ul>
<p><b>Key drivers</b> <i>measurable processes impacting the outcome</i></p>	<p>Decrease the time from result verification to communication log completion.</p> <ul style="list-style-type: none"> <li>• Increase performance of correct workflow (verify result first and then notify provider).</li> <li>• Timely communication of outpatient critical values</li> </ul>
<p><b>Interventions</b> <i>actions/changes necessary to impact key drivers</i></p>	<p>Standardize critical call list workflow</p> <ul style="list-style-type: none"> <li>• Provided re-education and tips and tricks for the correct workflow.</li> <li>• Identified a process to streamline outpatient critical calls (work with specific practices with known notification issues).</li> </ul>
<p><b>Results*</b> <i>accomplishments, modifications, barriers</i></p>	<p>Accomplishments</p> <ul style="list-style-type: none"> <li>• The Month of July 2022 had a 94.9% compliance (highest in the 12 month period of Dec 2021-Nov 2022).</li> <li>• Department of Laboratory Medicine averages approximately 1900 critical calls per month.</li> </ul>

Note: There is an additional system project to standardize critical result notification workflow.

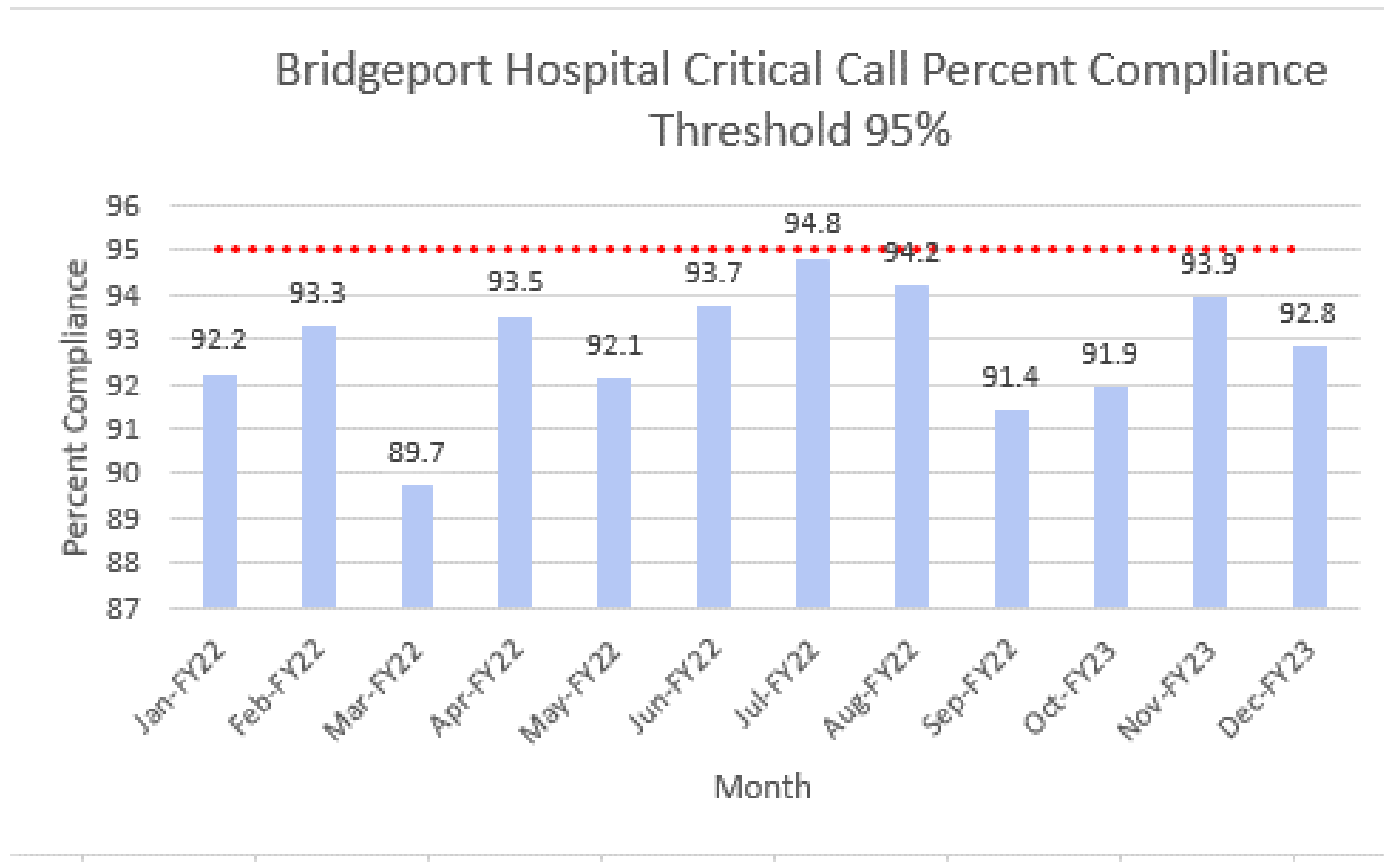
- Will allow reports and metrics to be standardized as well

# Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 93.1% (cumulatively) 1/1/2022-12/31/2022



# Bridgeport Campus Critical Call Percent Compliance 92.8%

1/1/2022-12/31/2022



# Milford Campus Critical Call Percent Compliance 95.0%

## 1/1/2022-12/31/2022

