Yale NewHaven Health Bridgeport Hospital

# Laboratory Medicine – January 2022

February 24, 2023

# Bridgeport and Milford Campuses Turnaround Time Goals

- 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

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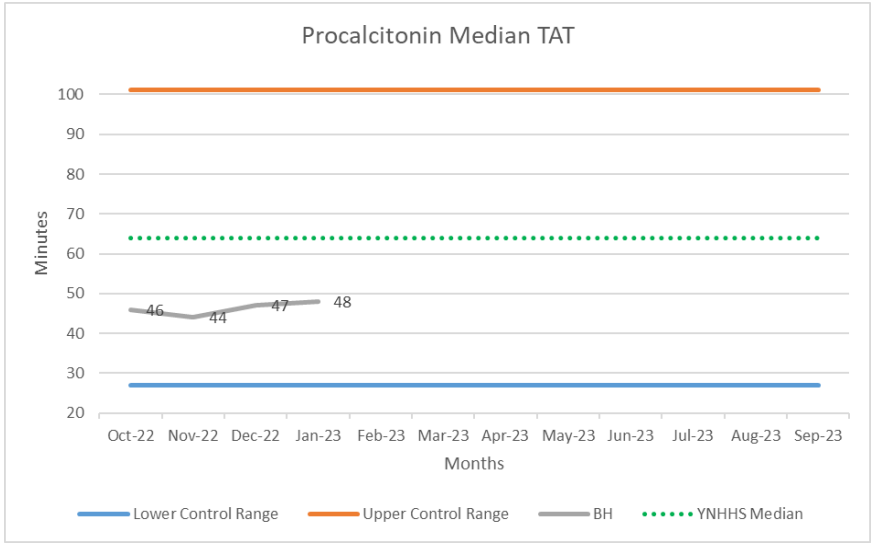
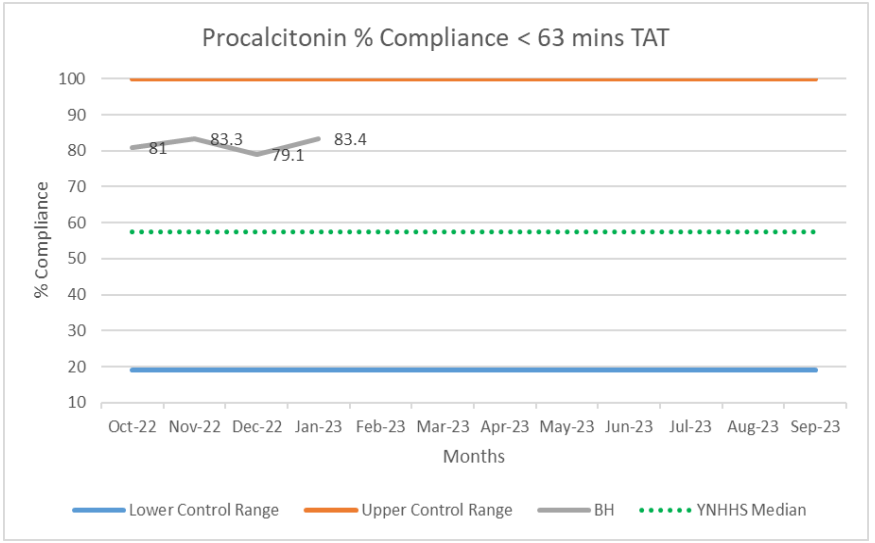
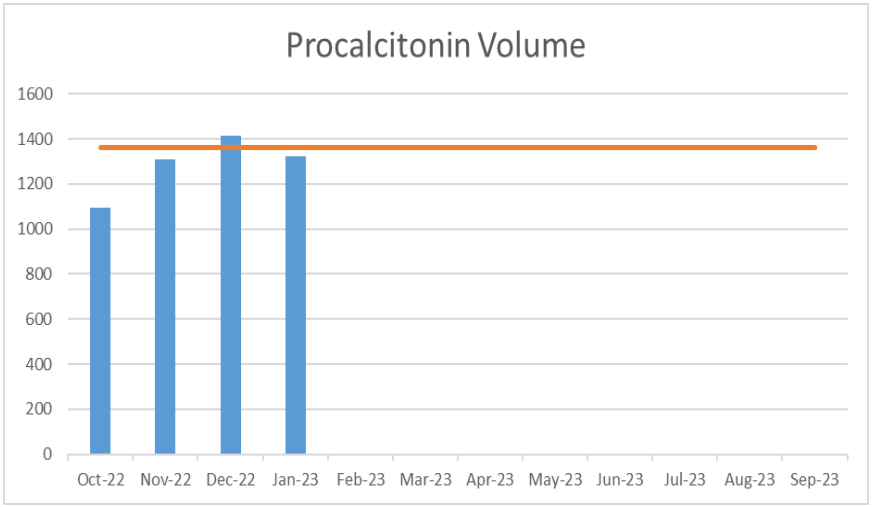
# Bridgeport Campus – Procalcitonin

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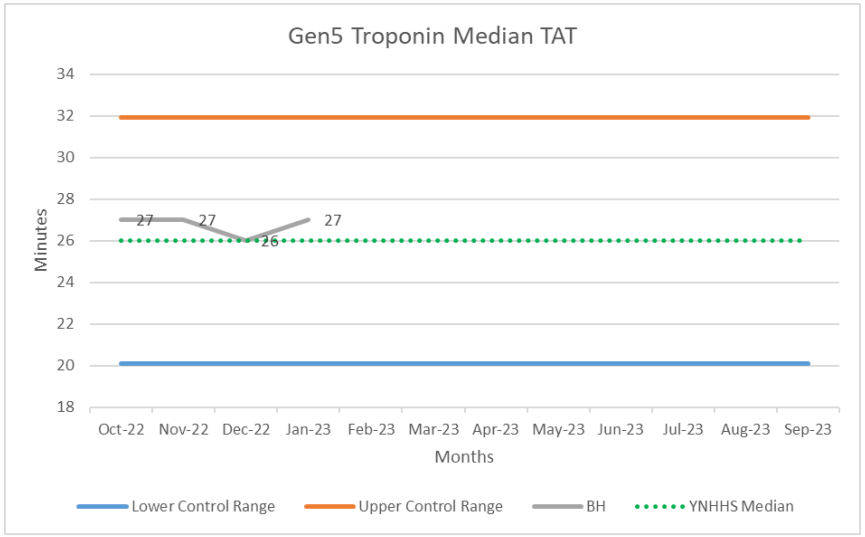
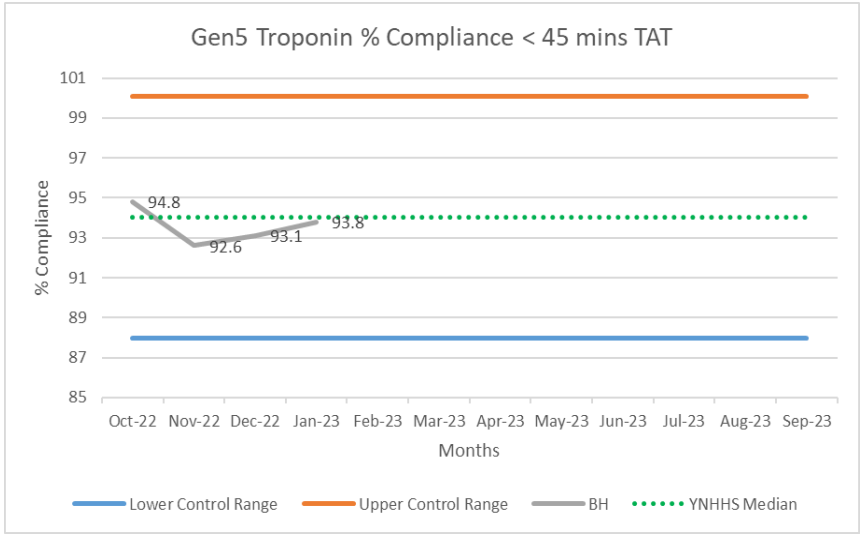
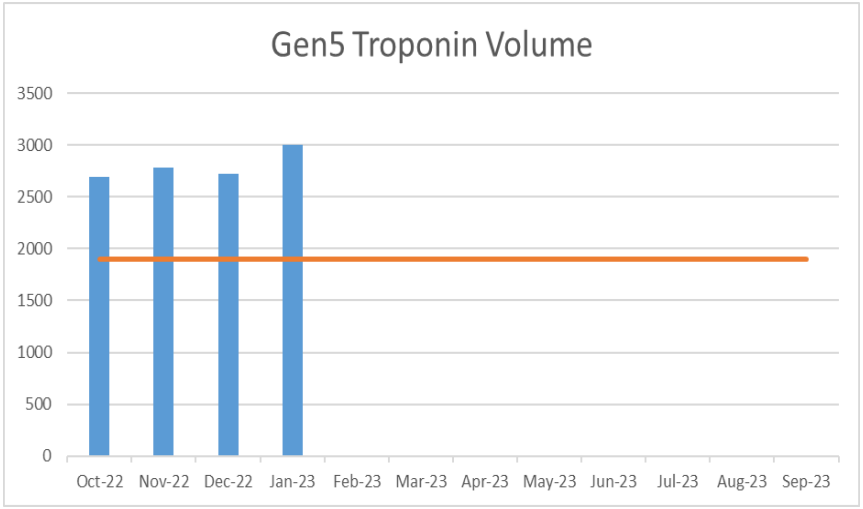
# Bridgeport Campus – Gen 5 Troponin TAT

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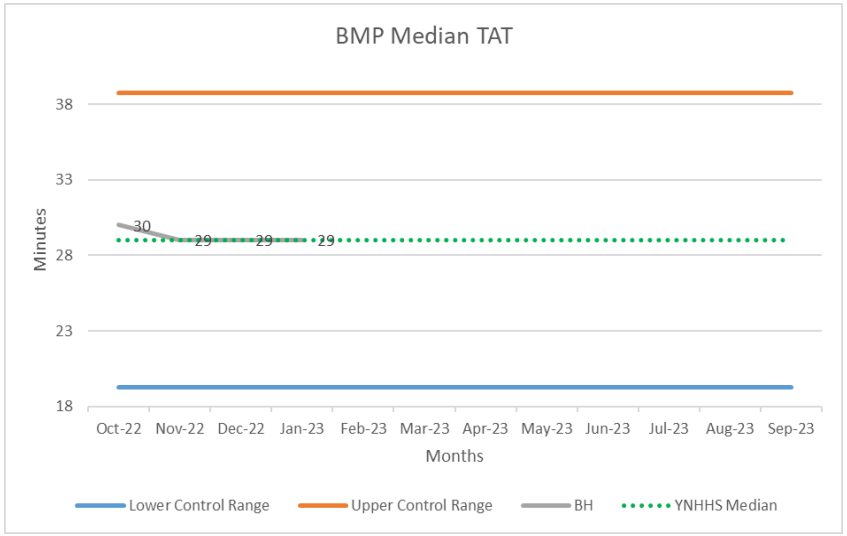
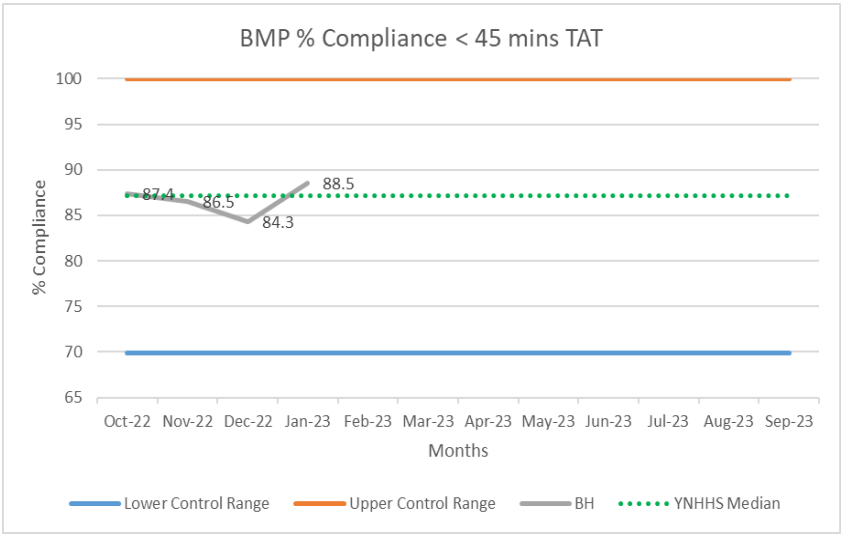
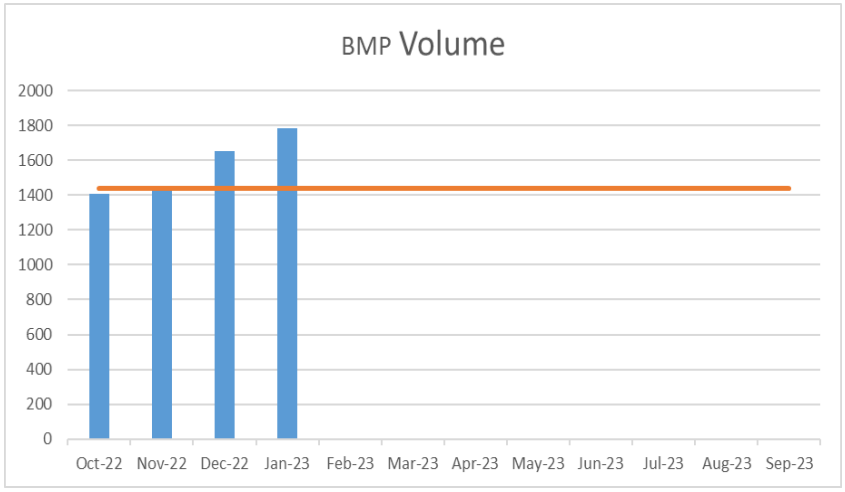
# Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT

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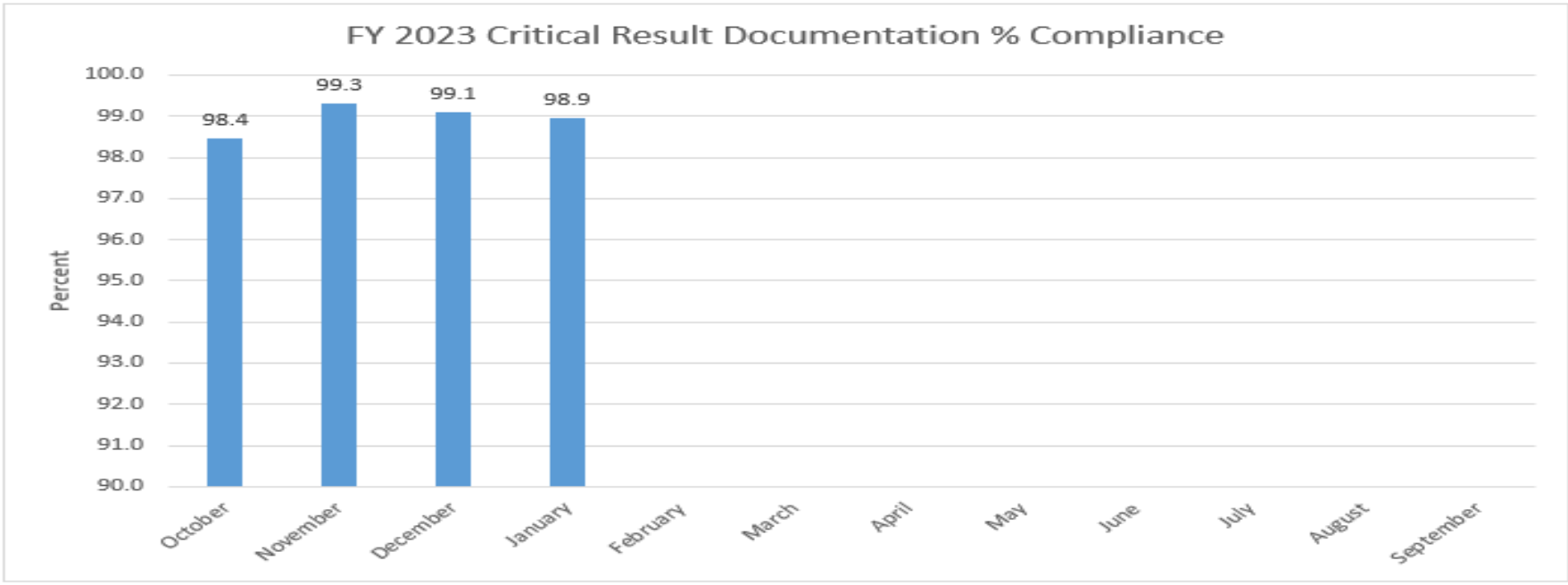
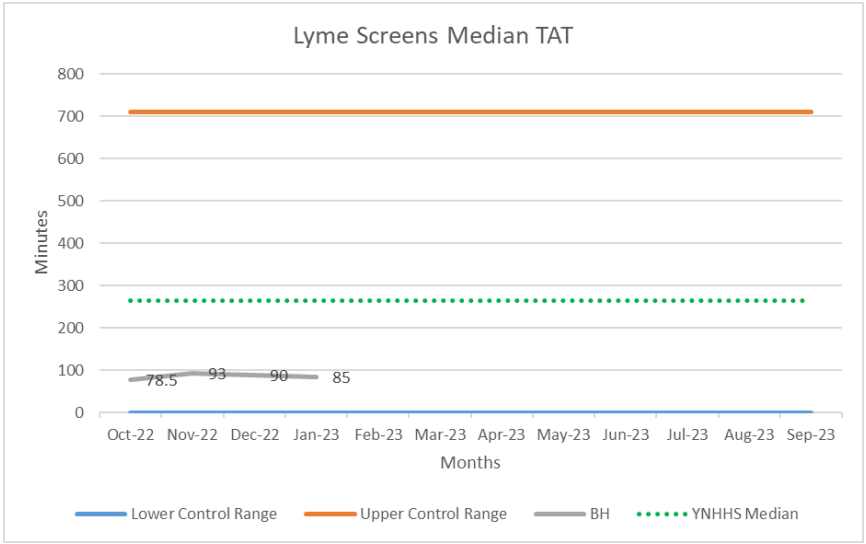
# Chemistry & Immunology

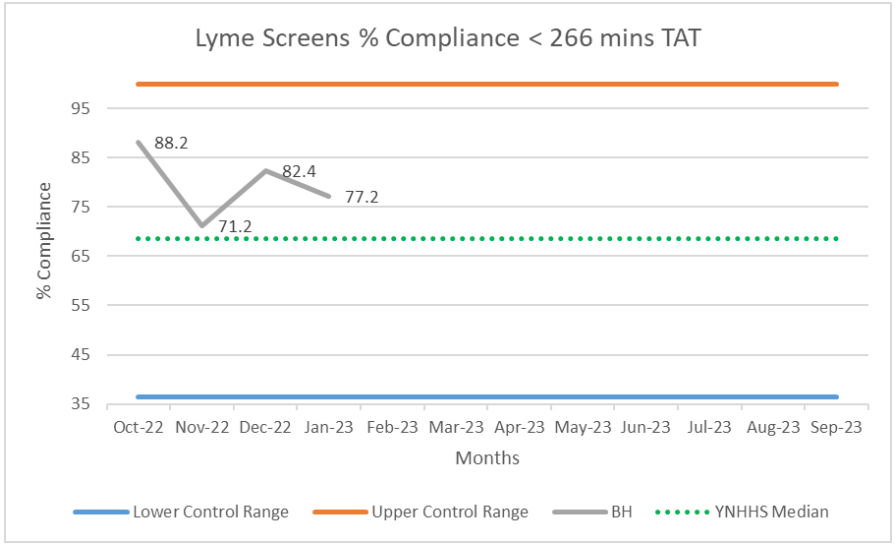


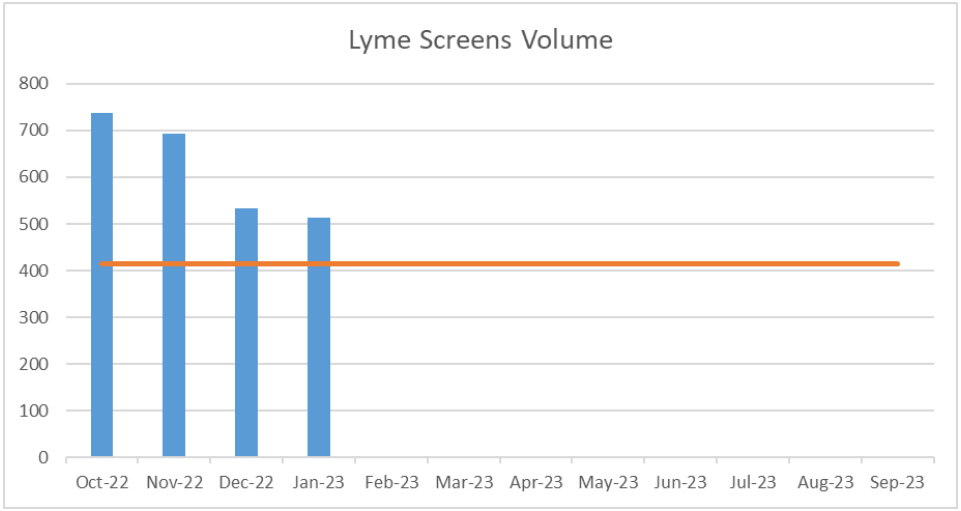

| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| n | 1415 | 1425 | 1418 | 1509 | | | | | | | | |
| #compliant | 1393 | 1415 | 1405 | 1493 | | | | | | | | |
| #noncompliant | 22 | 10 | 13 | 16 | | | | | | | | |
| | | | | | | | | | | | | |
| no name | 7 | 1 | 1 | 6 | | | | | | | | |
| no full name | 8 | 4 | 1 | 0 | | | | | | | | |
| no title | 4 | 4 | 1 | 7 | | | | | | | | |
| incorrect doc | 1 | 1 | 10 | 2 | | | | | | | | |
| incorrect person | 2 | | | 1 | | | | | | | | |

Two techs require counseling regarding no name entered and including the credentials.
Each outlier was addressed with individual tech.

# Bridgeport Campus – Lyme Screens TAT

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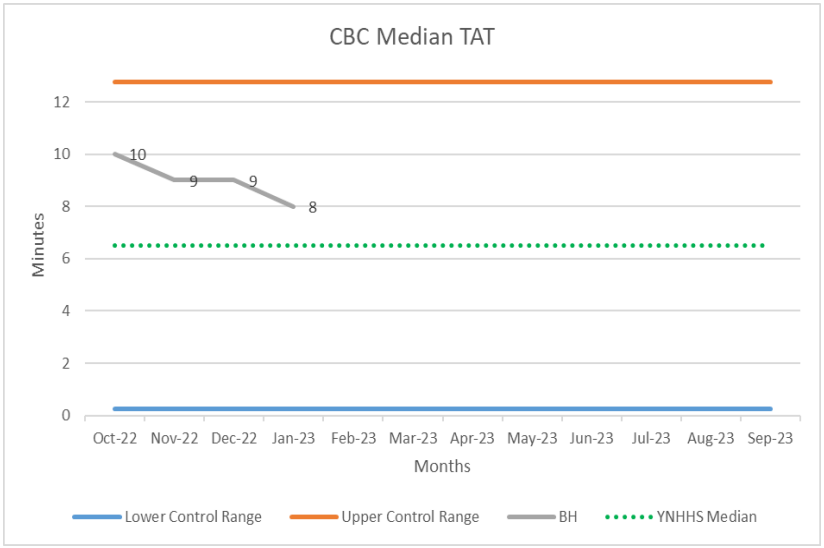
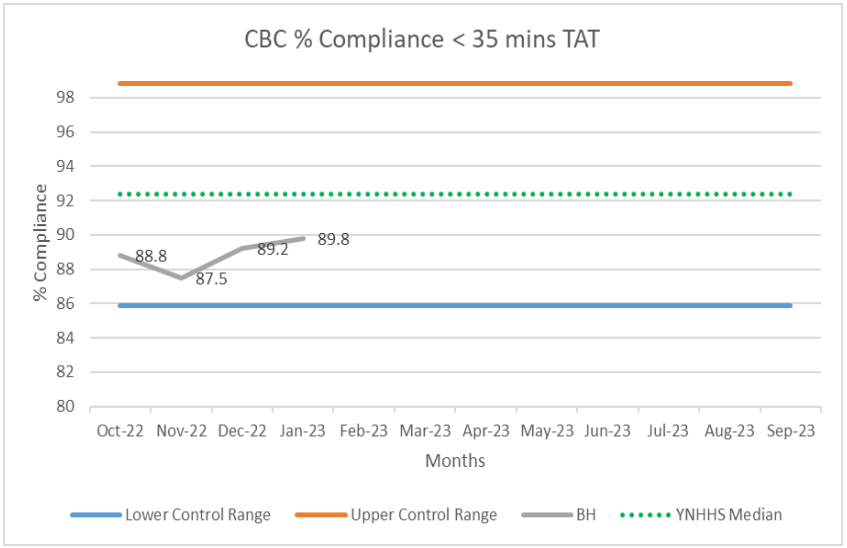
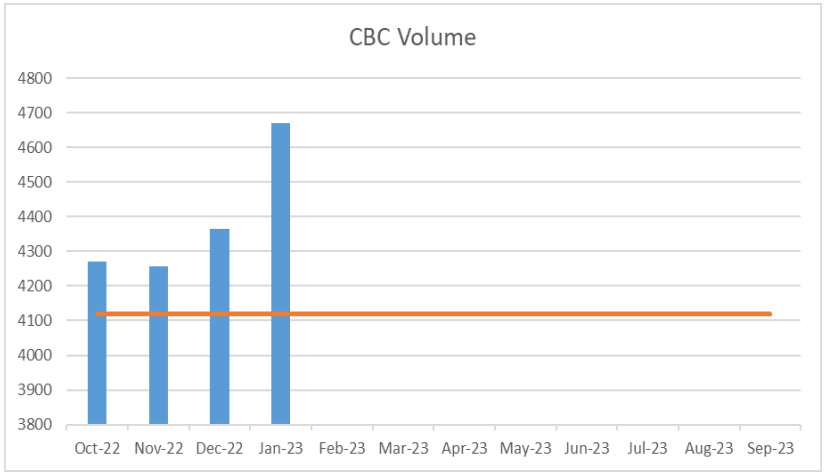
# Bridgeport Campus – Complete Blood Count (CBC) ED TAT

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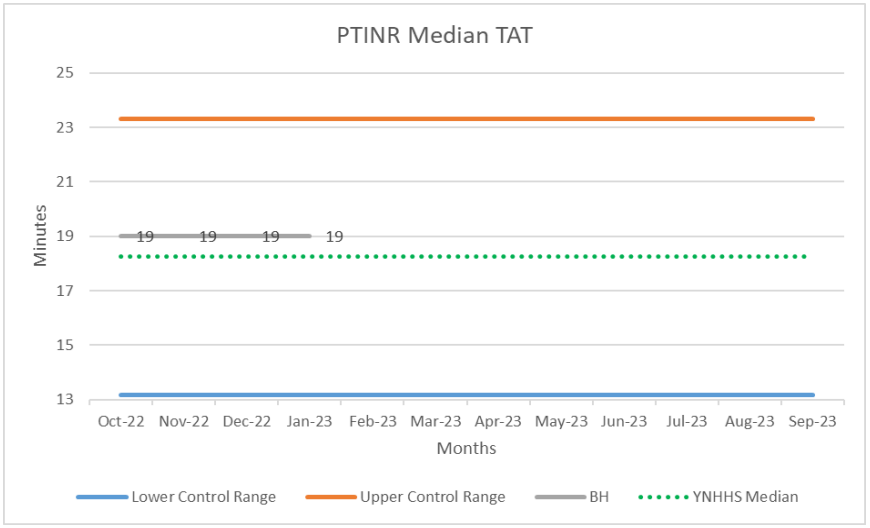
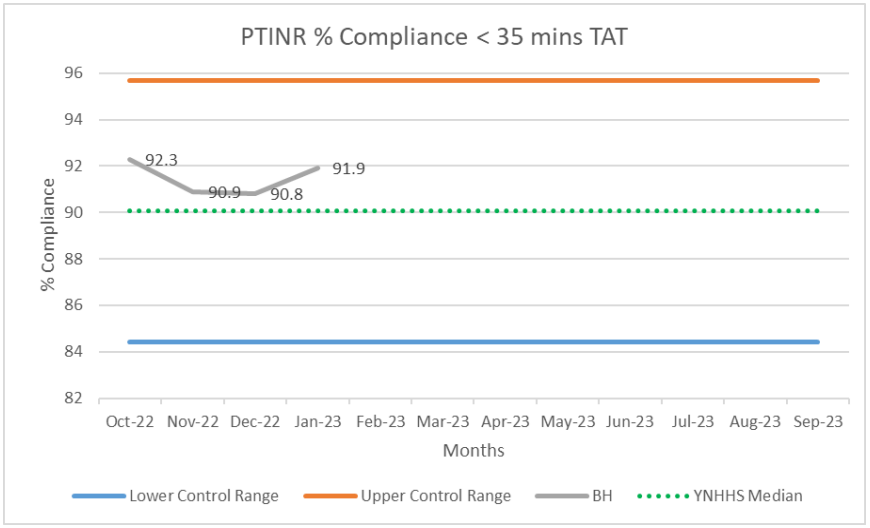
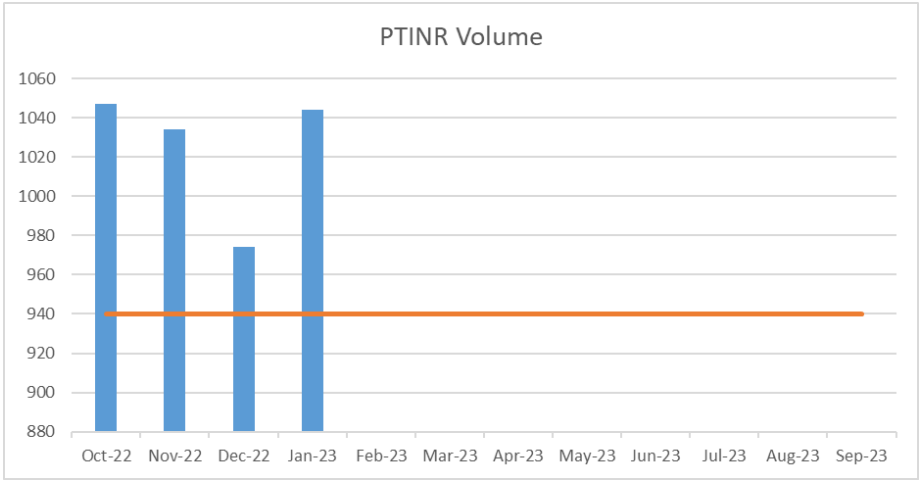
# Bridgeport Campus – PTINR ED TAT

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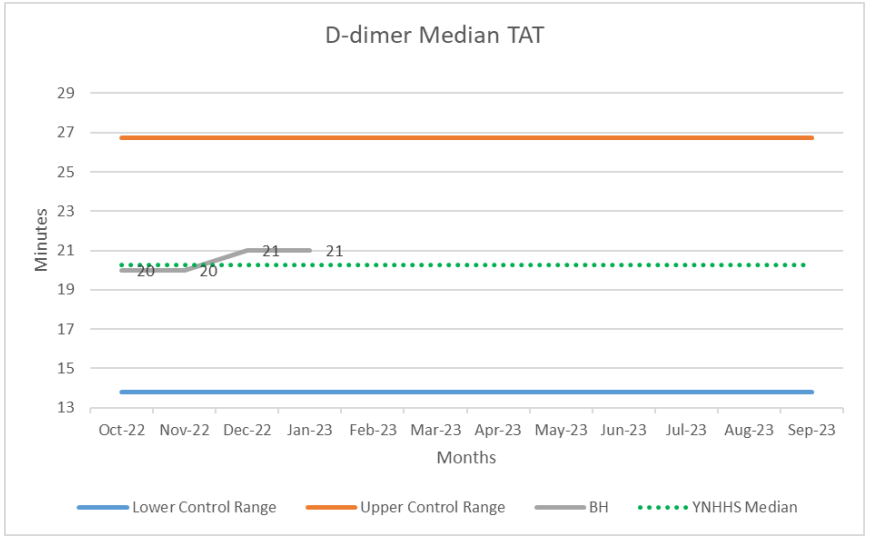
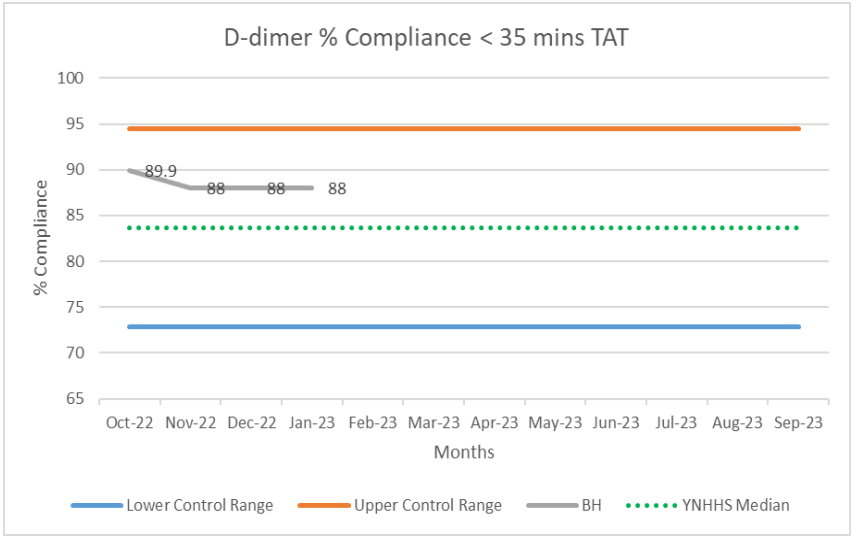
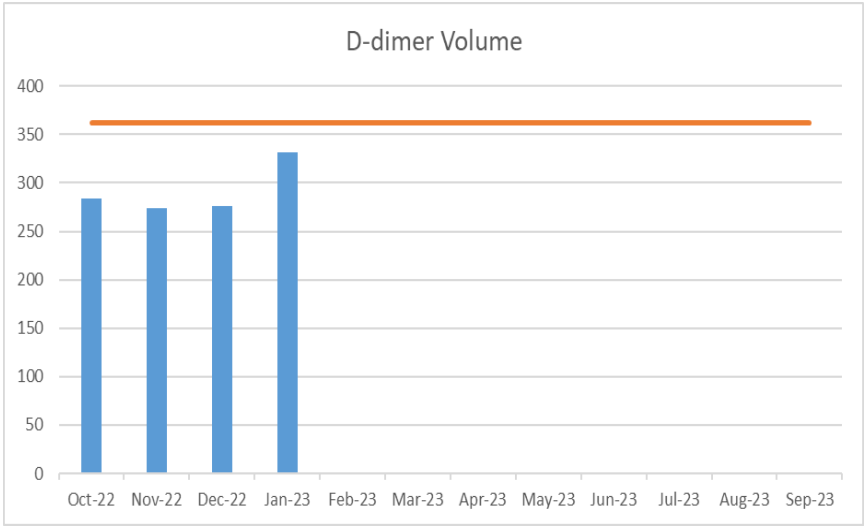
# Bridgeport Campus – D-dimer ED TAT

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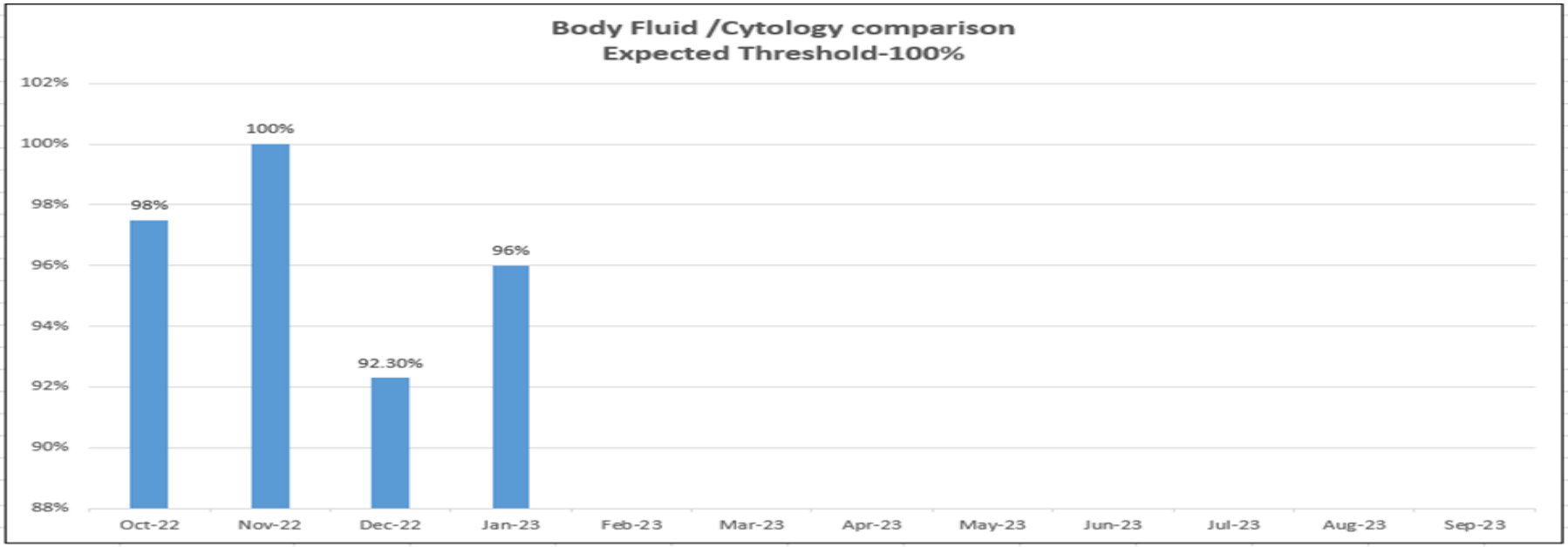
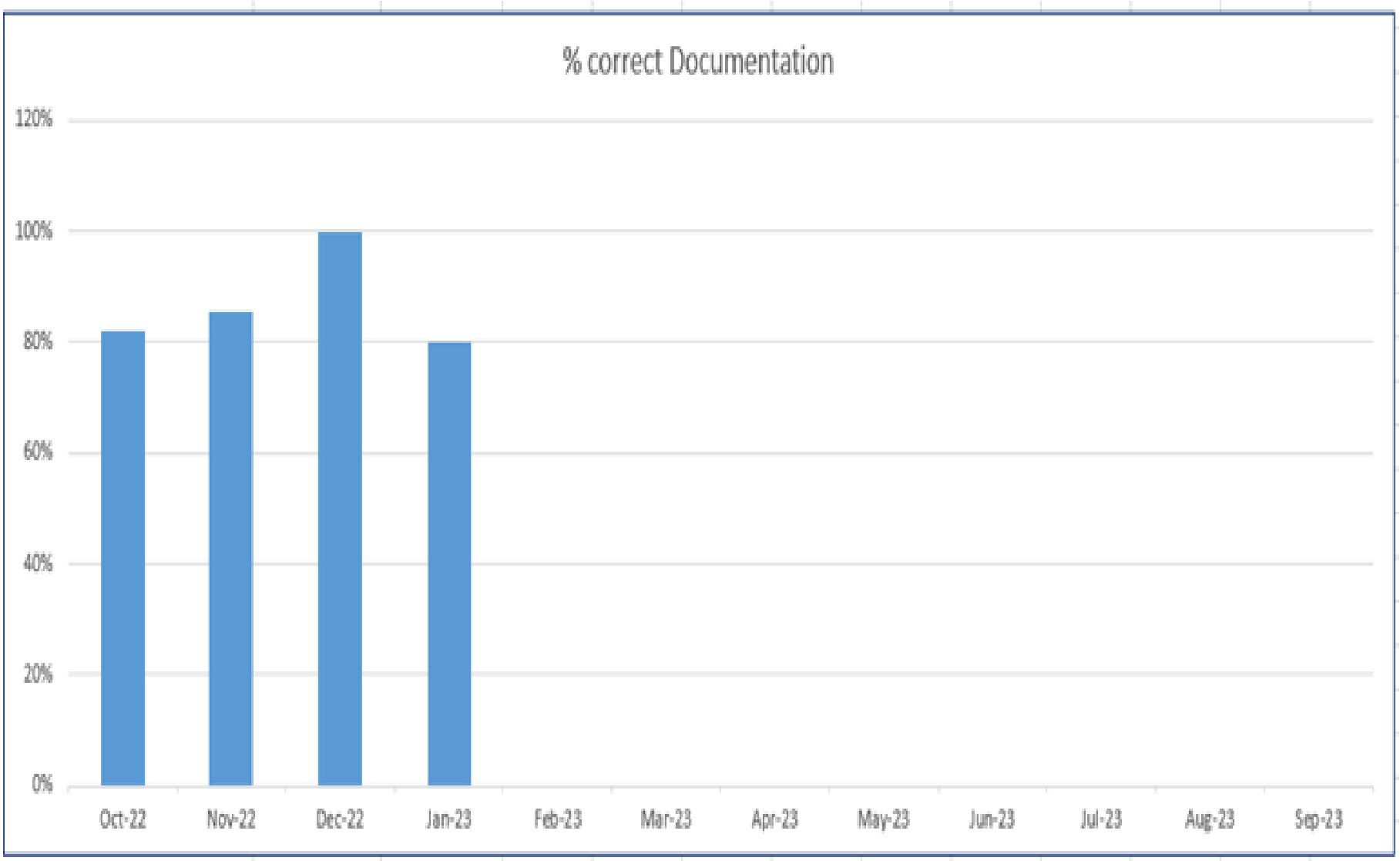
# Aspect of Care




| | 22-Oct | 22-Nov | 22-Dec | 23-Jan |
|---|---|---|---|---|
| Total # of Fluids | 142 | 155 | 128 | 157 |
| Cytology Ordered | 67 | 65 | 65 | 71 |
| # of fluid diffs that did not correlate | 2 | 0 | 6 | 3 |
| Threshold achieved | 98% | 100% | 92.30% | 96% |
| Expected | 100% | 100% | 100% | 100% |
| Action / Outcome | Dr. Chen not available to look at slides. 3 experienced Techs looked at smears and did not see anything suspicious. | | 6 slides - no correlartion. Reviewed by Dr. Chen. No malignant cells seen on 5 of the slides. 1 slide positive. Reviewed with tech. | 3 slides being reviewed by Dr. Minerowicz |

# Aspect of Care



# Aspect of Care

| | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|
| corrected appended results | 11 | 7 | 8 | 5 |
| incorrect documentation | 2 | 1 | 0 | 1 |
| correct documetation | 9 | 6 | 8 | 4 |
| % correct | 82% | 86% | 100% | 80% |
| Target | 100% | 100% | 100% | 100% |
| Action/outcome: | Both were called but improperly documented. New employee-retrained on policy | Talked to the technologist. Was not called because tech thought that by adding comment he did not need to call. | | Spoke to tech. First time occurrence. |

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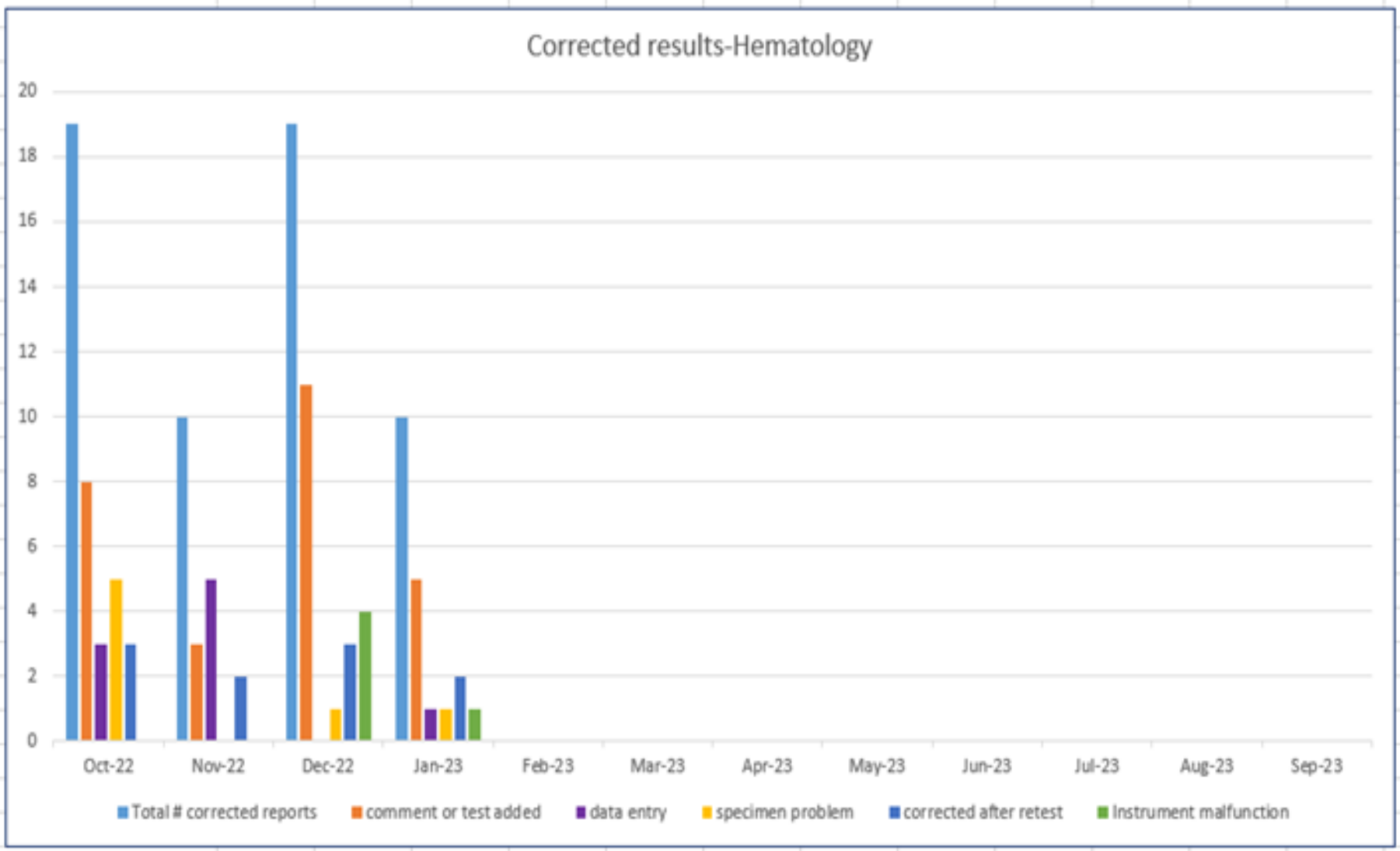
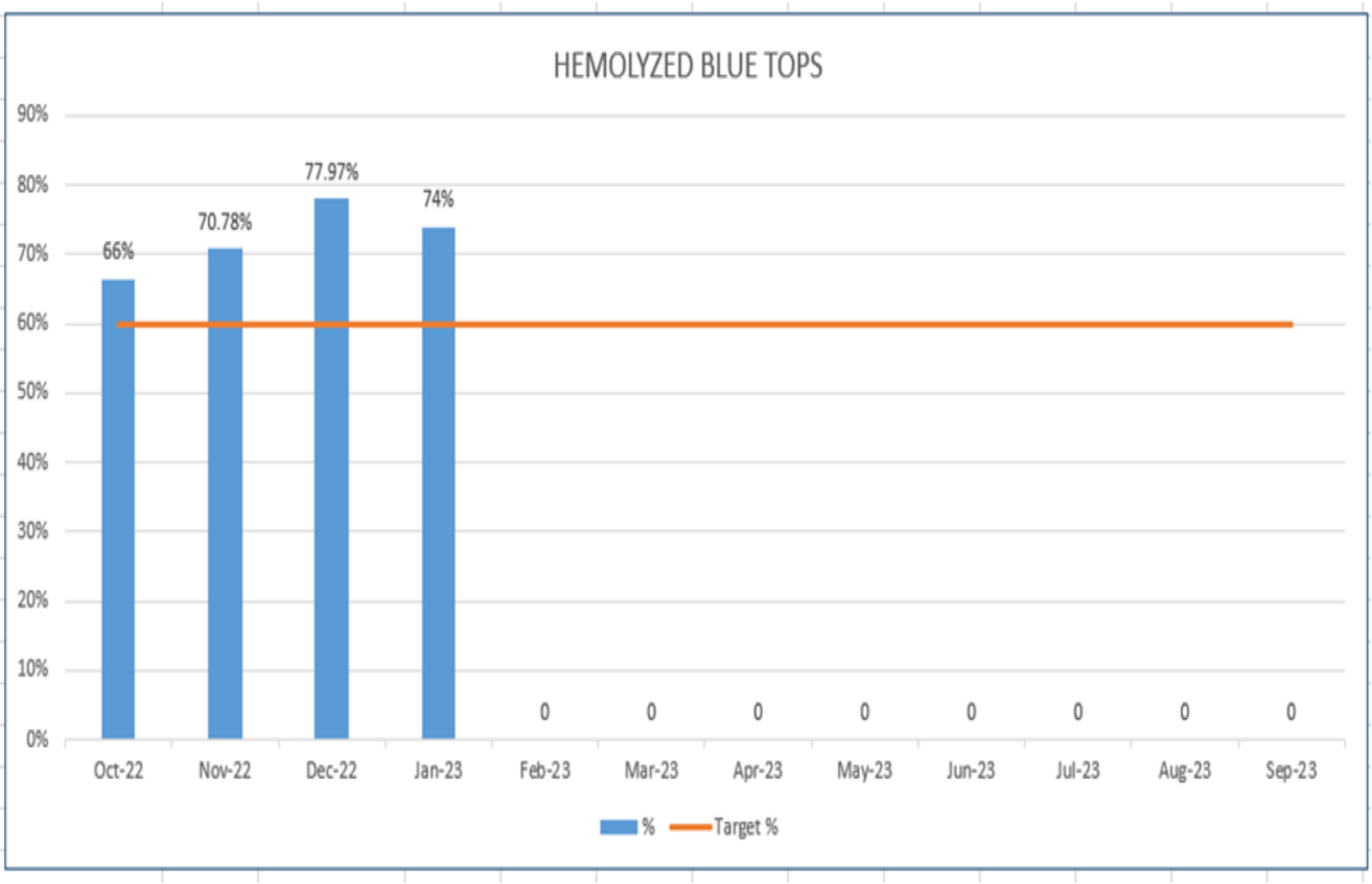
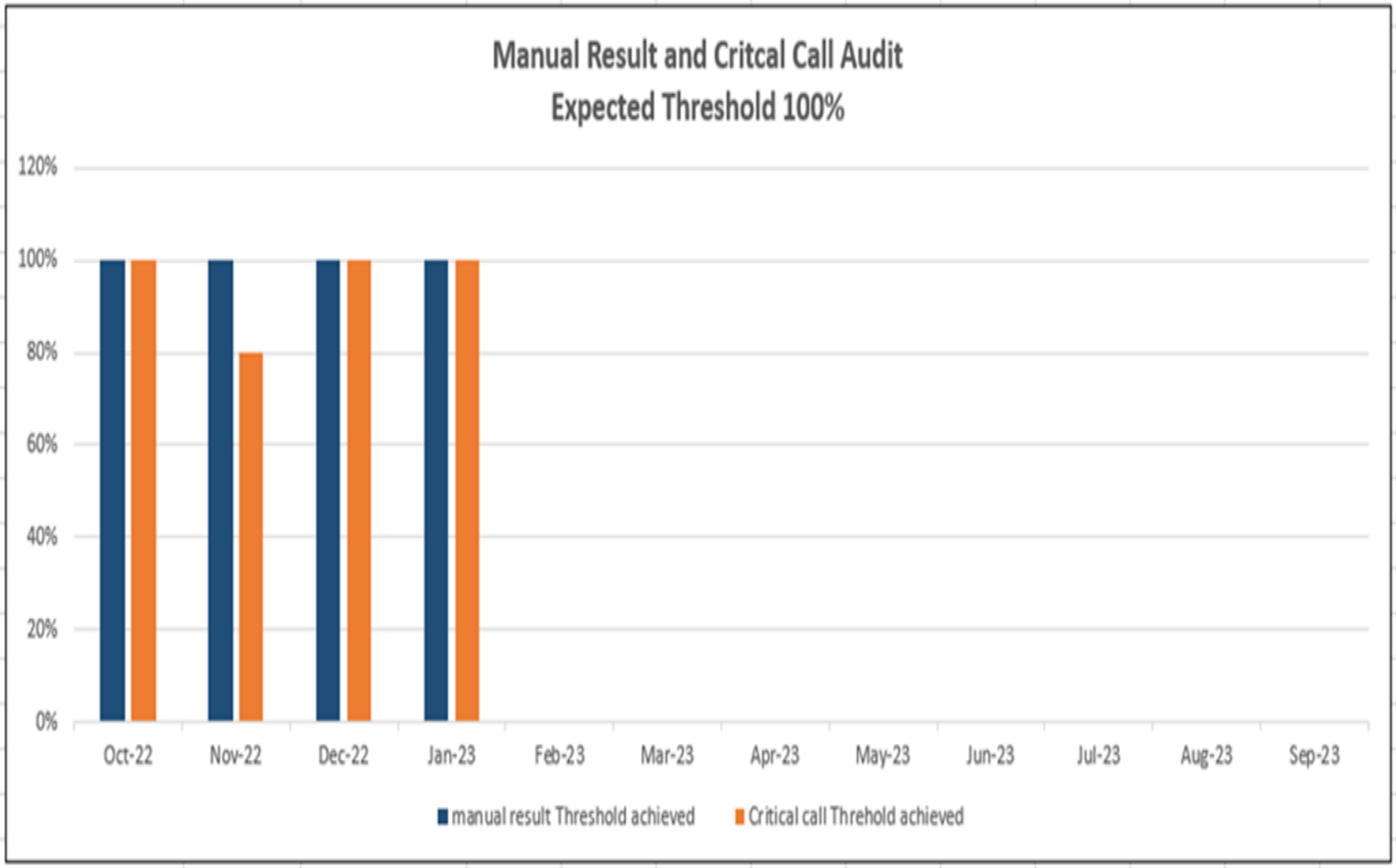
# Aspect of Care



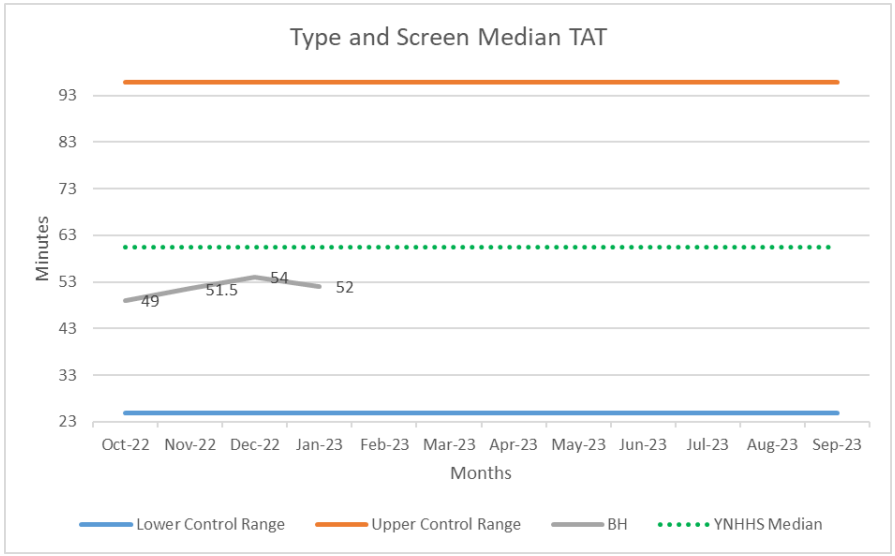
# Aspect of Care

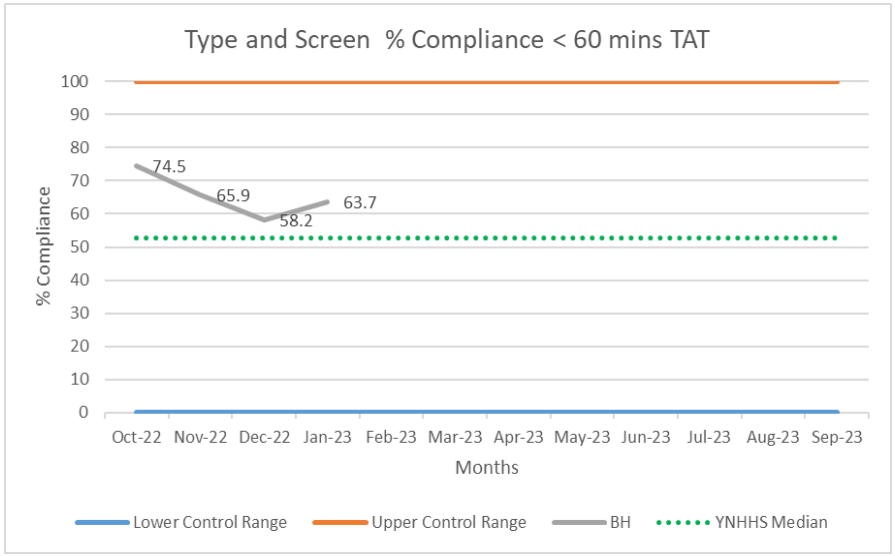


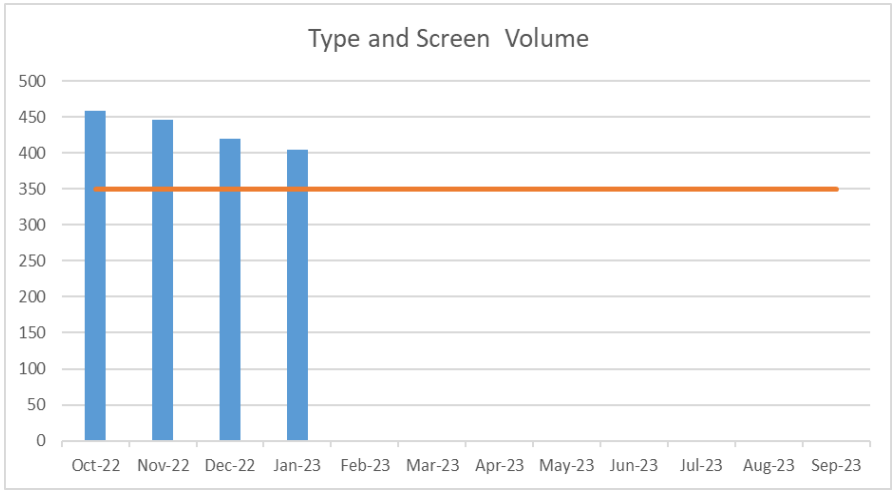
# Aspect of Care



# Bridgeport Campus – Type and Screen ED TAT




Yale NewHaven Health
Bridgeport Hospital

# Bridgeport and Milford Hospital Transfusion Reactions FY23

| Bridgeport and Milford Hospital Transfusion Reactions FY23 | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Feb | | | | | | | | | | | | | | | | | | |
| Mar | | | | | | | | | | | | | | | | | | |
| Apr | | | | | | | | | | | | | | | | | | |
| May | | | | | | | | | | | | | | | | | | |
| Jun | | | | | | | | | | | | | | | | | | |
| Jul | | | | | | | | | | | | | | | | | | |
| Aug | | | | | | | | | | | | | | | | | | |
| Sep | | | | | | | | | | | | | | | | | | |
| Total | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Yale New Haven Health Bridgeport Hospital

# Bridgeport Hospital Blood Bank
# RBC

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 449 | 440 | 410 | 394 | $344,884.50 |
| Wasted | 4 | 5 | 7 | 8 | $4,248.00 |
| Total | 453 | 445 | 417 | 402 | $349,132.50 |

Yale NewHaven Health Bridgeport Hospital

# Bridgeport Hospital
# Blood Bank
# Cryo

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| **Transfusion** | 8 | 11 | 16 | 21 | $18,564.00 |
| **Wasted** | 2 | 2 | 0 | 1 | $1,657.50 |
| **Total** | 8 | 13 | 16 | 22 | $19,558.50 |

Yale NewHaven Health Bridgeport Hospital

# Bridgeport Campus
# FFP

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 52 | 50 | 35 | 36 | $36,373.50 |
| Wasted* | 22 | 11 | 27 | 24 | $15,930.00 |
| Total | 74 | 61 | 62 | 60 | $52,303.50 |

*Due to ACS Trauma Requirements

Yale NewHaven Health Bridgeport Hospital

# Platelet Utilization

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 48 | 39 | 61 | 65 | $143,419.29 |
| Wasted | 27 | 36 | 19 | 32 | $76,759.62 |
| Total | 75 | 75 | 80 | 97 | $220,178.91 |
| % wasted | 36% | 48% | 24% | 33% | |
| Wasted/Day | 0.87 | 1.2 | 0.63 | 1.07 | $507.69 |

| | | | | | |
|---|---|---|---|---|---|
| Number of Extended Plts | 38 | 44 | 53 | 48 | $123,219.39 |
| Number Transfused | 16 | 20 | 27 | 18 | $54,539.73 |
| Number Discarded | 22 | 24 | 26 | 30 | $68,679.66 |

Yale NewHaven Health Bridgeport Hospital

# Bridgeport Campus – 2022 Point of Care Performance Report Summary

| MONTH | Threshold | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| Incorrectly documented Urine POC Pregnancy Internal QC | 0 errors | 13 | 9 | 15 | 19 | | | | | | | | | There were 10 staff that needed to have their competency reviewed. 3 were repeat offenders so their manager was notified of the issue. One was given misinformation by another staff member so this was clarified with both of them (she previously had no errors). |
| | | | | | | | | | | | | | | |
| # of i-STAT codes / # of cartridges run | | 28/333 | 17/323 | 18/221 | 18/325 | | | | | | | | | 5 codes obtained on 1 patient by 2 staff - MD indicated she knew it was a sample issue Competency completed with 1 MD that had multiple codes and cartridge handling was being performed correctly when observed. |
| i-STAT Quality Check Codes | <5.0% | 8.4% | 5.3% | 8.1% | 5.5% | | | | | | | | | |

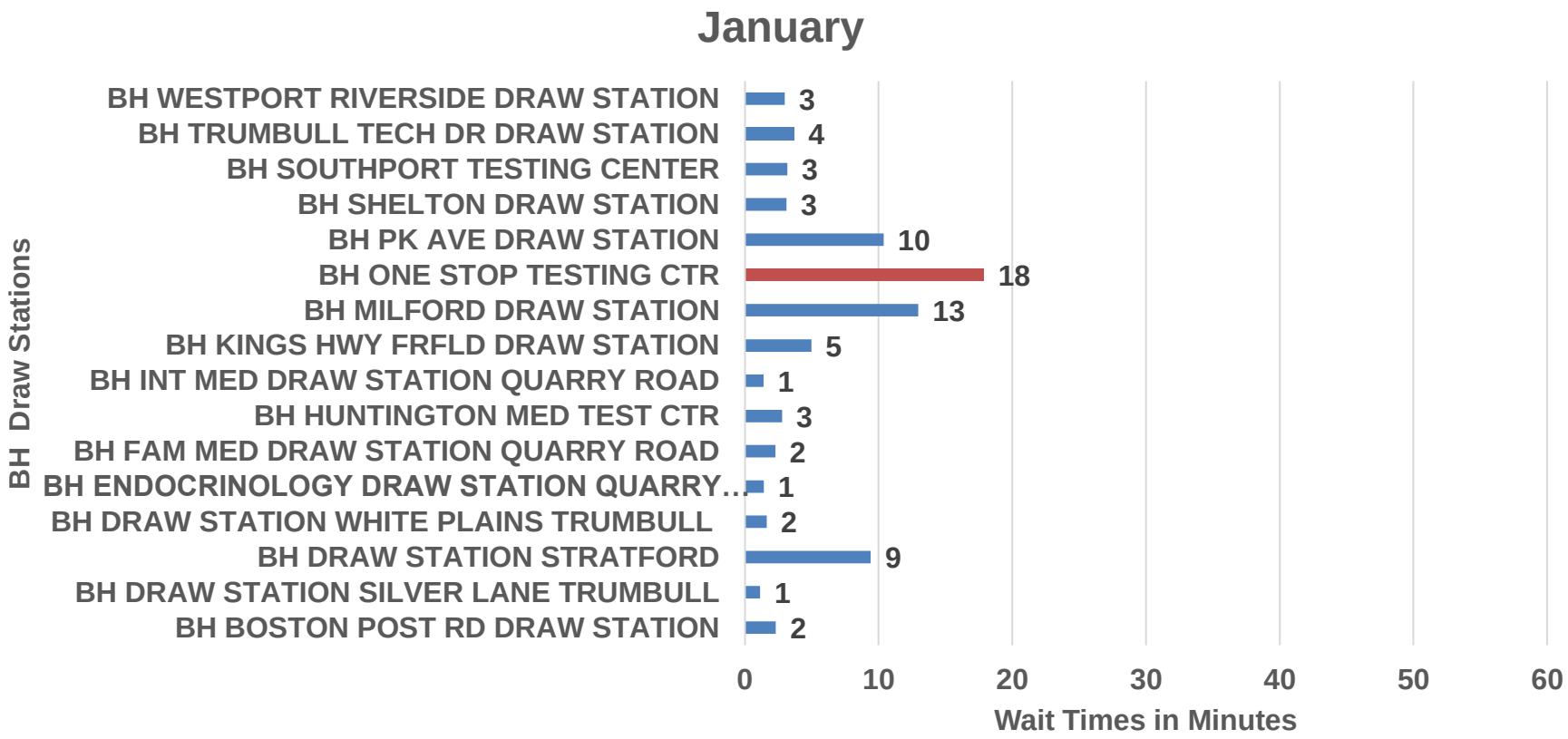
# Performance Improvement Plan

**Lab Outreach Pre-Analytical Quality Indicator Monthly Review**

**Year 2023**

# Average Wait Times

| | |
|---|---|
| Section | Lab Outreach/Phlebotomy |
| Phase | Pre-Analytical |
| Objective | Calculate the average times from patient check-in/registration to the point of specimen collection for each DN. This metric ensures patient satisfaction and monitors phlebotomists' productivity in each draw station location. |
| Method | Report from Helix- YNHHS Lab Blood Draw Wait Times report |
| Definitions | We will be measuring the rate of butterfly needle usage vs total encounters. |
| Expected Actions | To assess each draw station patient, wait-times vs the total number. A summary report will be prepared for the Director. Feedback will be provided to the draw stations. |
| Benchmarks | Overall rate for patient wait time goal for 15 minutes. |




**Summary:**

January: Overall goal reached for the month. January metrics are BH draw station average 5 minutes overall. One Stop location wait-time was the only location outside of the 15-minute wait time goal.

# Butterfly Needle Usage Rate

| | |
|---|---|
| Section | Lab Outreach/Phlebotomy |
| Phase | Pre-Analytical |
| Title | Butterfly Needle Usage Rate |
| Objective | Monitors the butterfly needle usage in the outpatient draw stations. Studies have shown that decreased butterfly needle usage results in less sample hemolysis, decreased costs, and less needlestick exposures. |
| Method | McKesson Supply Report or Infor Supply Report and Helix Reports - Collection Metrics monthly. |
| Definitions | We will be measuring the rate of butterfly needle usage vs total encounters. |
| Expected Actions | To assess each draw station butterfly usage rate. A summary report will be prepared for the Director. Feedback will be provided to the draw stations regarding butterfly usage rates. |
| Benchmarks | Overall rate for 20% butterfly needle usage rate. |

**Summary**

January: Overall goal reached for the month. Across all the BH locations 20 boxes of butterfly needles were ordered over the course of the month.

| | **January** |
|---|---|
| Number of Butterfly Needles | **1019** |
| Total Number of Patient Draws | **9302** |
| **All DRAW STATIONS** | **11%** |

# Cancel/Redraw Rates

| | |
|---|---|
| **Section** | Lab Outreach/Phlebotomy |
| **Phase** | Pre-Analytical |
| **Title** | Cancel/Redraw Rates |
| **Objective** | Monitors the cancel/redraw rates in the draw stations by measuring the number of cancel/redraws to overall samples collected as a percentage rate. |
| **Method** | Report on Helix – Redraw Rejection Cancellation and Lab Outreach Collection Metrics reports monthly. |
| **Definitions** | This metric will identify any collection procedure noncompliance and identify any areas that phlebotomists need retraining in. The redraw rates will be pulled monthly and compared to the 2022 metrics. |
| **Expected Actions** | To assess draw station locations, cancel/redraw rates. A summary report will be prepared for the Director to be discussed monthly. Feedback will be provided to the draw stations for improvements. |
| **Benchmarks** | Overall redraw rate goal of 5%. |

**Summary:**

January: Overall goal reached for the month. Majority of locations had a cancellation rate of 4% or less.

| | Jan |
|---|---|
| BH BOSTON POST RD DRAW STATION | 1.3% |
| BH DRAW STATION SILVER LANE TRUMBULL | 3.1% |
| BH DRAW STATION STRATFORD | 1.9% |
| BH DRAW STATION WHITE PLAINS TRUMBULL | 1.0% |
| BH ENDOCRINOLOGY DRAW STATION QUARRY ROAD | 2.6% |
| BH FAM MED DRAW STATION QUARRY ROAD | 2.5% |
| BH HUNTINGTON MED TEST CTR | 2.9% |
| BH INT MED DRAW STATION QUARRY ROAD | 4.4% |
| BH KINGS HWY FRFLD DRAW STATION | 2.1% |
| BH MILFORD DRAW STATION | 3.4% |
| BH ONE STOP TESTING CTR | 7.2% |
| BH PK AVE DRAW STATION | 4.6% |
| BH SHELTON DRAW STATION | 1.8% |
| BH SOUTHPORT TESTING CENTER | 3.0% |
| BH TRUMBULL TECH DR DRAW STATION | 2.3% |
| BH WESTPORT RIVERSIDE DRAW STATION | 4.6% |
| **ALL DRAW STATION AVERAGE** | **3.0%** |

***Notes:***

*Rejection reasons by location*

*Silver Lane - 5 collection issue: exceeded clinical time requirements, 5 collection issue: other, 1 collection issue: QNS*

*Kings Hwy - 10 collection issue: other, 1 collection issue: incorrect specimen type, 1 collection issue: QNS and 6 other (please specify)*

*One Stop - 38 collection issue: other, 35 other (please specify), 2 collection issue: clotted, 2 collection issue: incorrect specimen type, 2 collection issue: QNS, 1 collection issue: no initials (BB specimens)*

*PK Ave - 15 collection issue: other, 40 other (please specify), 1 Blood Bank: Two Samples Collected at same time (non PPID), 2 collection issue: clotted, 1 collection issue: exceeded clinical time requirements, 3 collection issue: hemolyzed, 1 collection issue: incorrect tube type/container, 4 collection issue: QNS*

*Westport Riverside - 14 collection issue: other, 1 collection issue: incorrect temperature, 2 collection issue: QNS and 1 other (please specify)*

# Centrifuge Compliance

| | |
|---|---|
| Section | Lab Outreach/Phlebotomy |
| Phase | Pre-Analytical |
| Title | Centrifuge Compliance |
| Objective | Ensures centrifuges in the draw station are functioning as intended which will result in better quality samples and decrease processing errors and specimen rejections. |
| Method | Auditing centrifuges and record service reports. BioMed (TriMedx) service reports will save in DN specific folders. |
| Definitions | Every month each DN will be audited on the number of compliant centrifuges and be given a compliance percentage. For example, if all 32 centrifuges in the YNH area are serviced before the due date then they will be at 100% compliance every month. |
| Expected Actions | The team will also be keeping centrifuge records up-to-date for compliance across all Delivery Networks. A summary report will be prepared for the Director. |
| Benchmarks | Overall centrifuge compliance goal of 100%. |

**Summary**

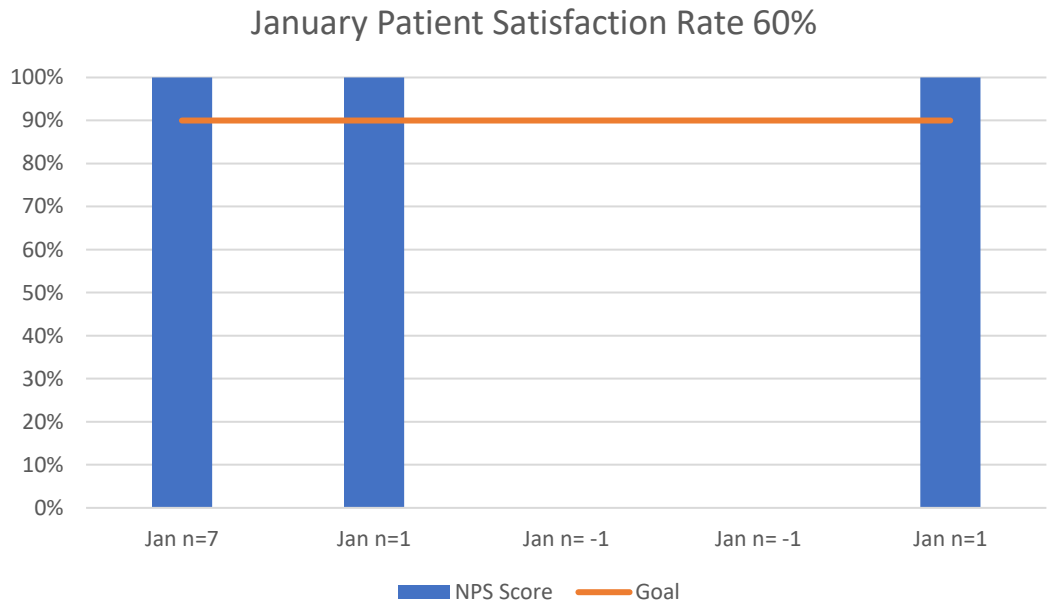
January: Overall goal for the month was met. All centrifuges are update with inspections.

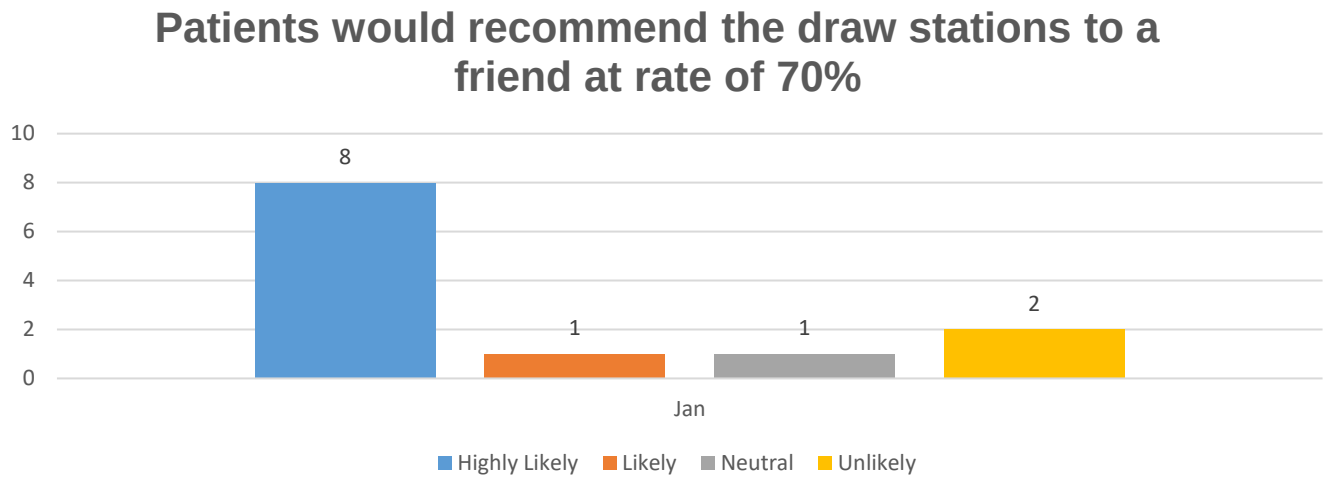
| | January |
|---|---|
| **Number of Compliant Centrifuges** | 19 |
| **Total Number of Centrifuges** | 19 |
| **ALL DRAW STATIONS** | **100%** |

# Patient Satisfactory Survey

| | |
|---|---|
| Section | Lab Outreach/Phlebotomy |
| Phase | Pre-Analytical |
| Title | Patient Satisfactory Survey |
| Objective | Achieving high levels of satisfaction is directly dependent on the high- quality patient care provided by phlebotomists in draw stations. In order to find out the pain-points of patients, whether there's any room for improvement, and what measures can be implemented to enhance services. |
| Method | Key Survey Reports and Press Ganey surveys scores |
| Definitions | The Key Survey report will be pulled monthly. |
| Expected Actions | To assess each draw station the patient experience surveys or scores. A summary report will be prepared for the Director. Feedback will be provided to the draw stations to make improvements to help increase patient satisfaction. |
| Benchmarks | Overall patient satisfaction rate 90%. |

**Summary** January: Overall goal not for the month.
Across a portion of the draw station locations 70% of patients were likely to recommend our facilities to a friend, 100% of patients felt our facilities were neat and clean, and 100% of patients felt they were treated with respect during their visit.






*Notes:*

*There are 3 dissatisfied patients that caused the satisfaction rate to be below the goal. These are the responses to "Were you treated respectfully during your visit and what is the most important thing we could do to increase your satisfaction."*

*MR4407630 at Park Avenue Draw Station*

*Patient's comments (I feel I was not heard, To listen to a patient when they tell you your experiences have been and ask if they could use the butterfly needle so I wouldn't have to be stuck 3 times before they stuck me with the needles that where larger than my veins. And was told because of shortage they have to do it this way. To me no excuse!)*

*MR3373791 at Park Avenue Draw Station*

*Patient's comments (No smile, no interaction, seemed bored, Because I needed to be at the hospital for a short procedure, rather than a surgical center, I had blood drawn and an ekg while there in the interest of time. Registration was lovely. The rest of it? I would not use that facility when there are so many other options.)*

*MR2601743 at Park Avenue Draw Station*

*Patient's comment (She introduced herself but really was not friendly at all, She should have been more friendly. Didn't say hello or make me feel welcome. I tried to interact because I am afraid of needles and make a little small talk, she was not interested at all)*

# Transcription Accuracy Rate

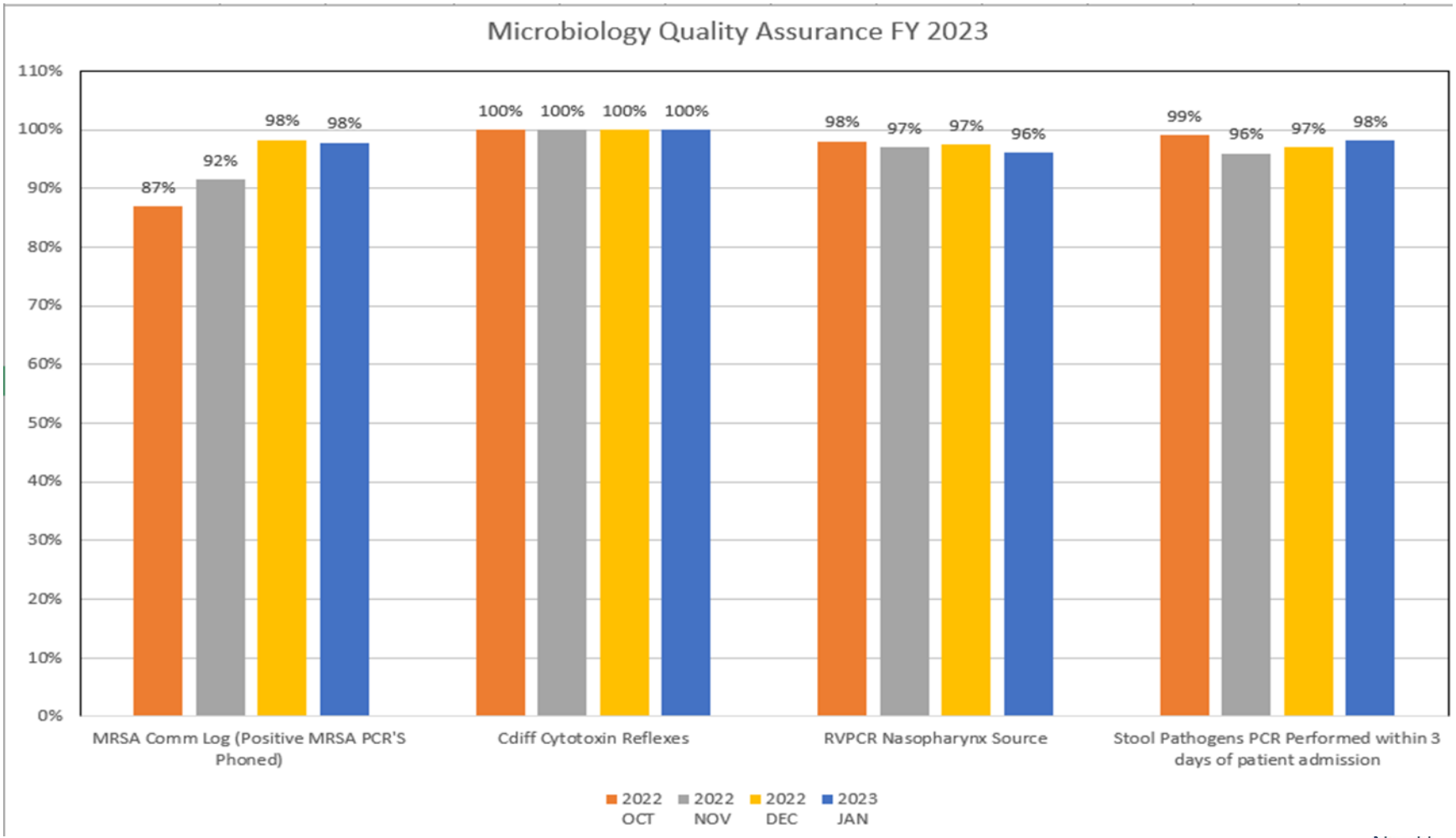
| | |
|---|---|
| Section | Lab Outreach/Phlebotomy |
| Phase | Pre-Analytical |
| Title | Transcription accuracy rate |
| Objective | Monitors the accuracy of the phlebotomist's transcriptions into EPIC from paper requisitions. |
| Method | Report run by Lab Billing department daily. |
| Definitions | Report is run by Lab Billing, and they randomly select up to 5 transcribed requisitions from each DN daily. The areas evaluated for accuracy will be the provider's name, tests ordered, scanning of req into EPIC and charges. Lab Billing will track the requisitions selected and errors in a separate spreadsheet on the YNH :/L shared drive. |
| Expected Actions | To assess each draw station transcription accuracy. A summary report will be prepared for the Director. Feedback will be provided to the draw stations. |
| Benchmarks | Overall rate for 90% transcription accuracy. |

**Summary**

January: Overall goal reached for the month. For the month of January, the # of providers transcribed correctly 102/103, sum of tests transcribed correctly 392/396 and # of requisitions scanned in EPIC 51/65.

| | Jan |
|---|---|
| ALL DRAW STATION AVERAGE | **97%** |

# Microbiology Quality Measures for FY 2023

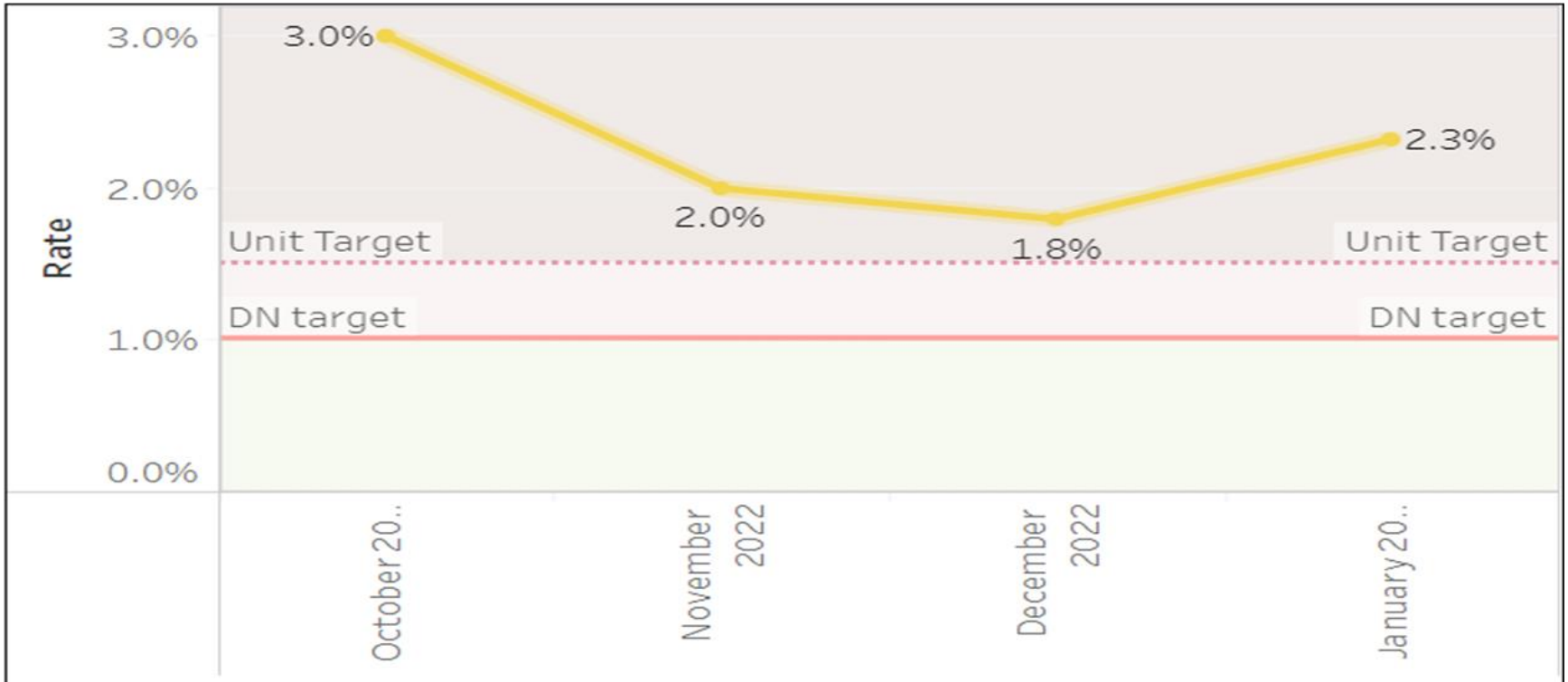



NewHaven Health
Bridgeport Hospital

# Microbiology Test Volumes

| 2023 Total V | October | November | December | January |
|---|---|---|---|---|
| MRSA | 459 | 447 | 492 | 441 |
| MRSA + | 39 | 47 | 58 | 46 |
| Cdiff | 155 | 130 | 148 | 168 |
| Cdiff + | 28 | 22 | 29 | 24 |
| RVP | 312 | 297 | 272 | 231 |
| Stool | 144 | 128 | 136 | 146 |
| Stool Admitted | 49 | 49 | 67 | 56 |
| Errors | 4 | 0 | 1 | 0 |

# BH Blood Culture Contamination Rate



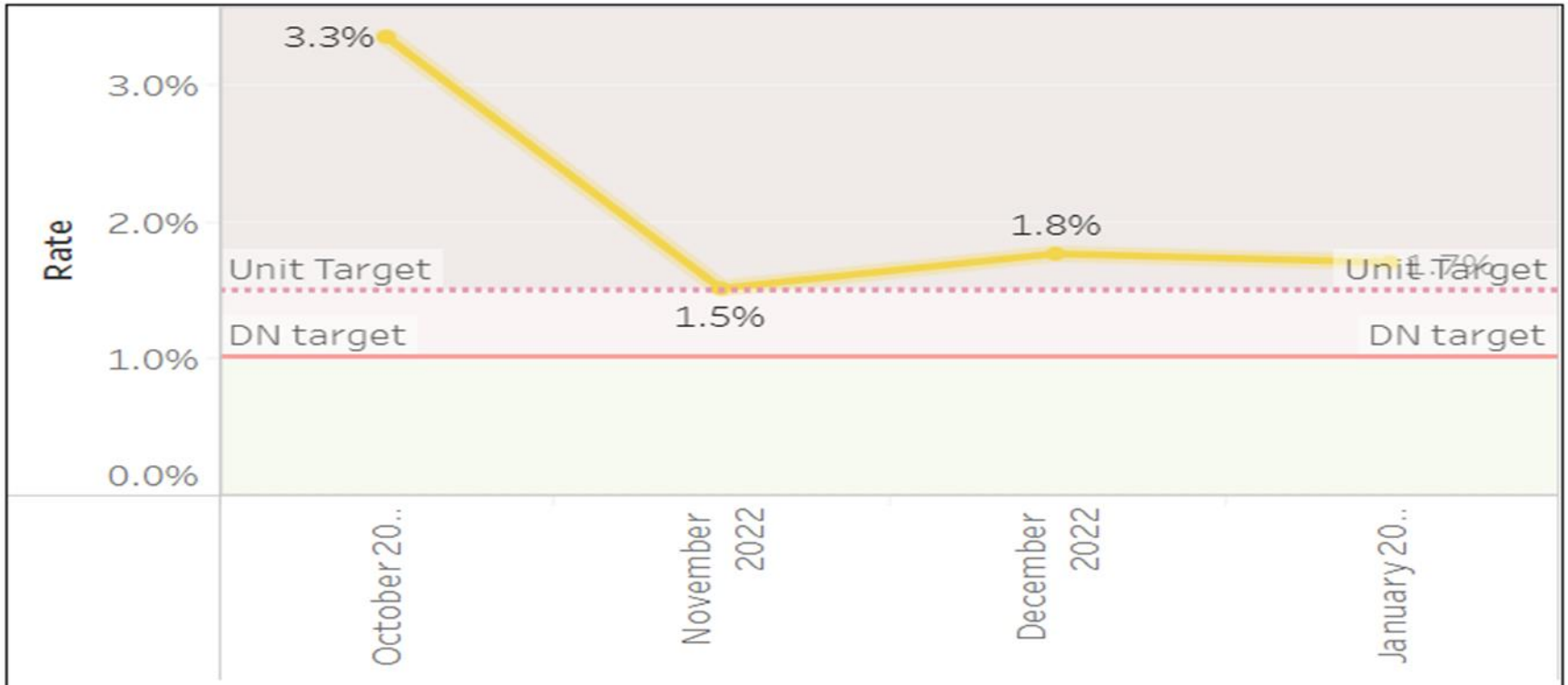

Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best practices are followed, a target contamination rate of 1% is achievable."

DN
BH/MC

Campus
BH

Yale NewHaven Health
Bridgeport Hospital

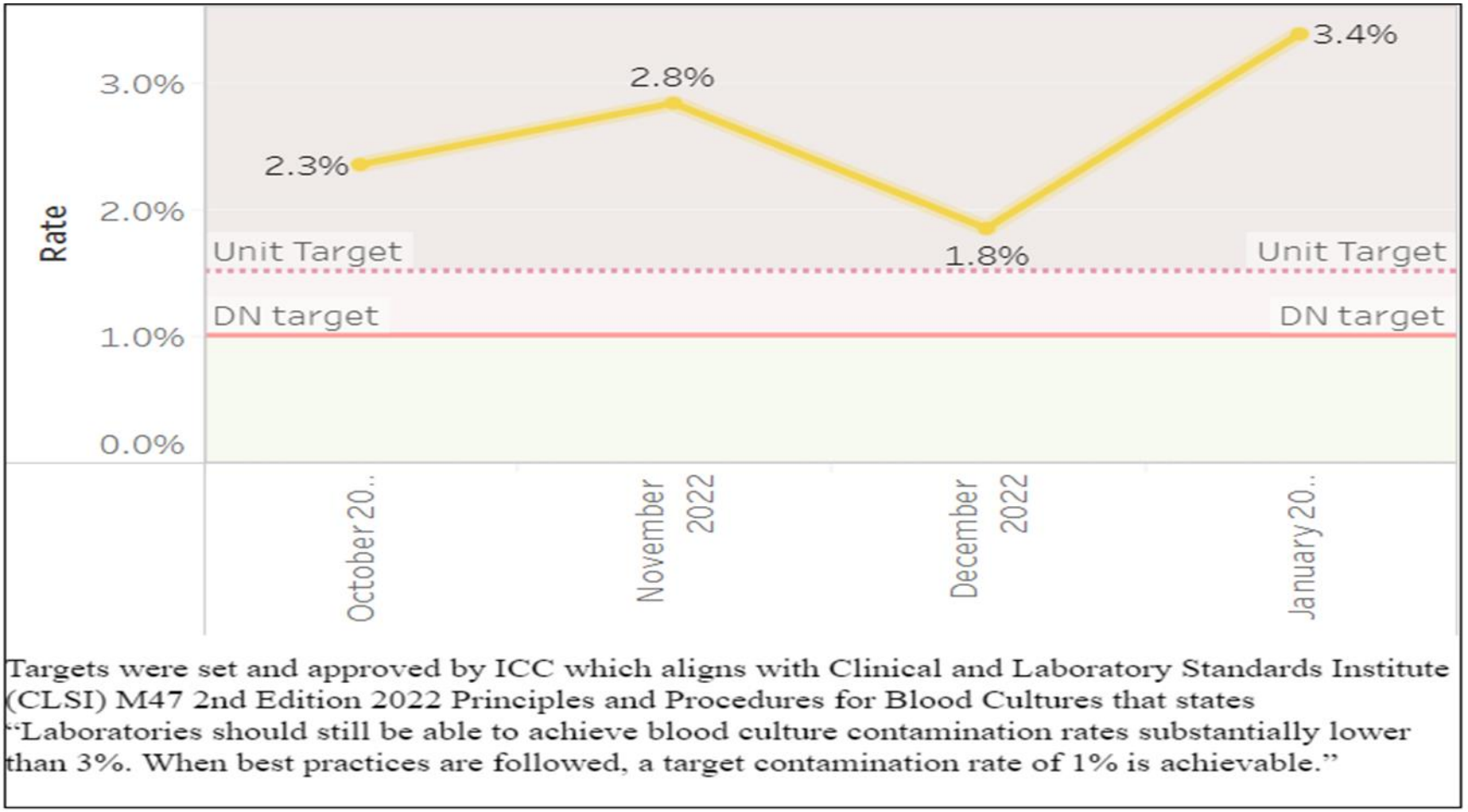
# BH Blood Culture Contamination Rate(ED only)




Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best practices are followed, a target contamination rate of 1% is achievable."

Yale NewHaven Health Bridgeport Hospital

# BH Blood Culture Contamination Rate (excluding ED)




Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best practices are followed, a target contamination rate of 1% is achievable."

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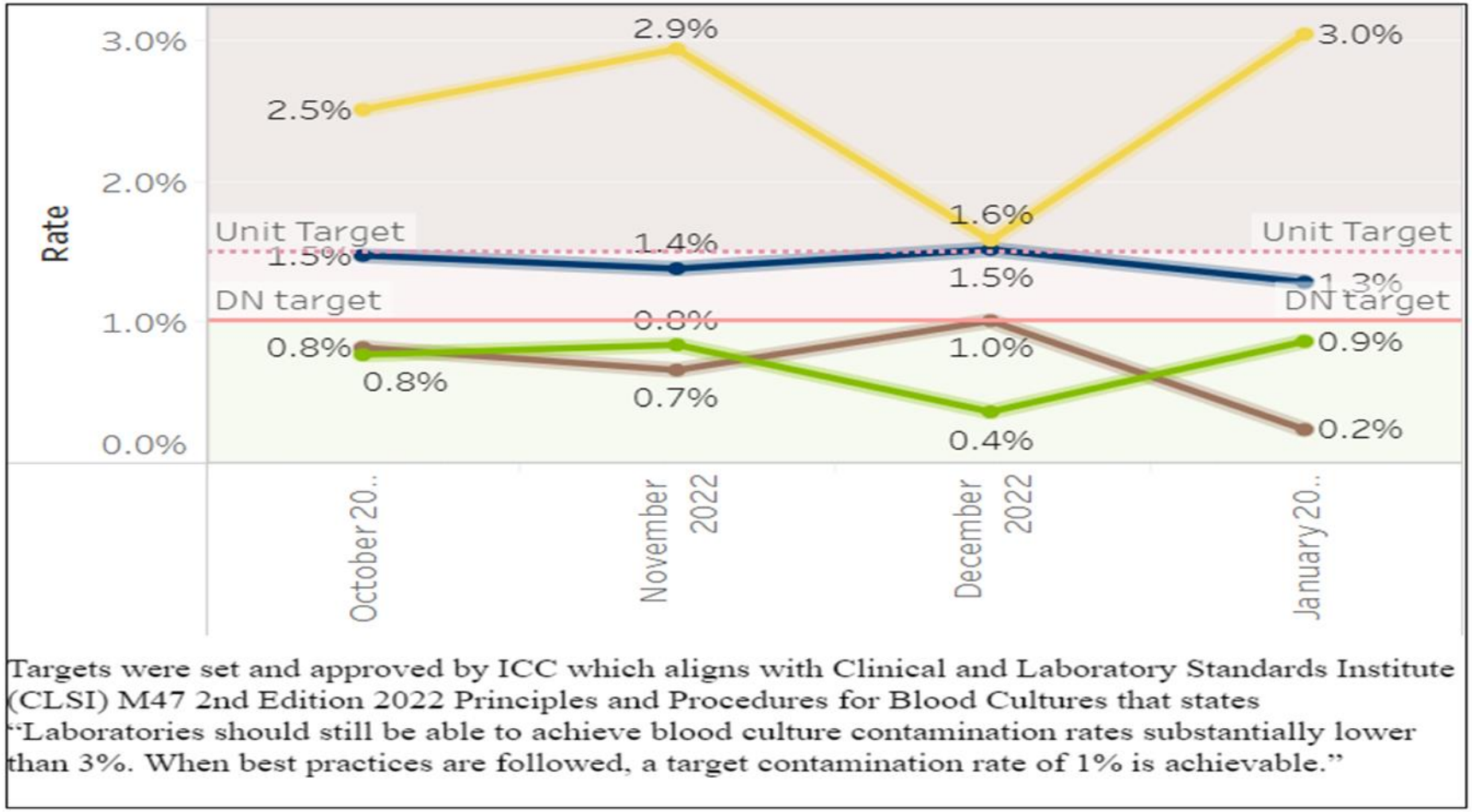
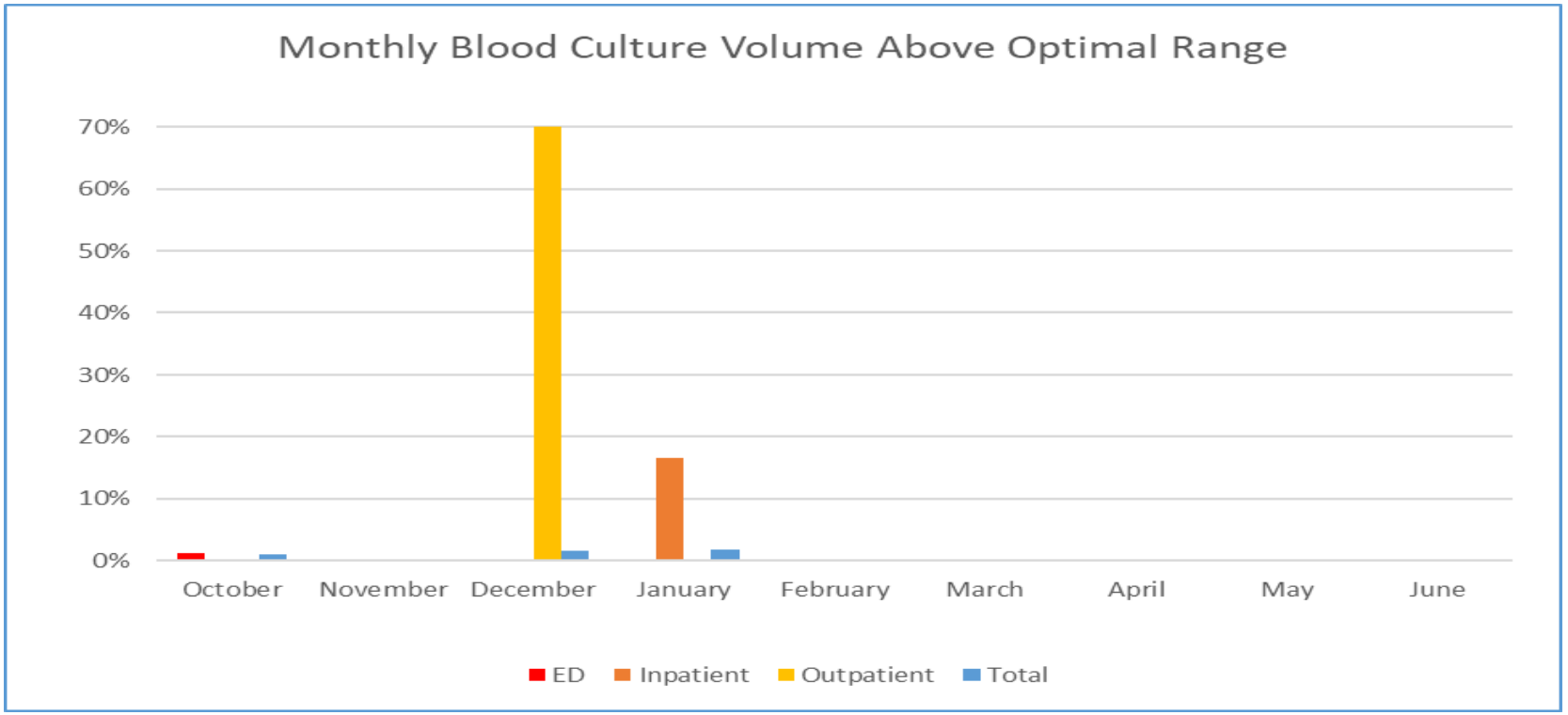
# Blood Culture Contamination Rate DNs Comparison




Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best practices are followed, a target contamination rate of 1% is achievable."

Yale NewHaven Health Bridgeport Hospital

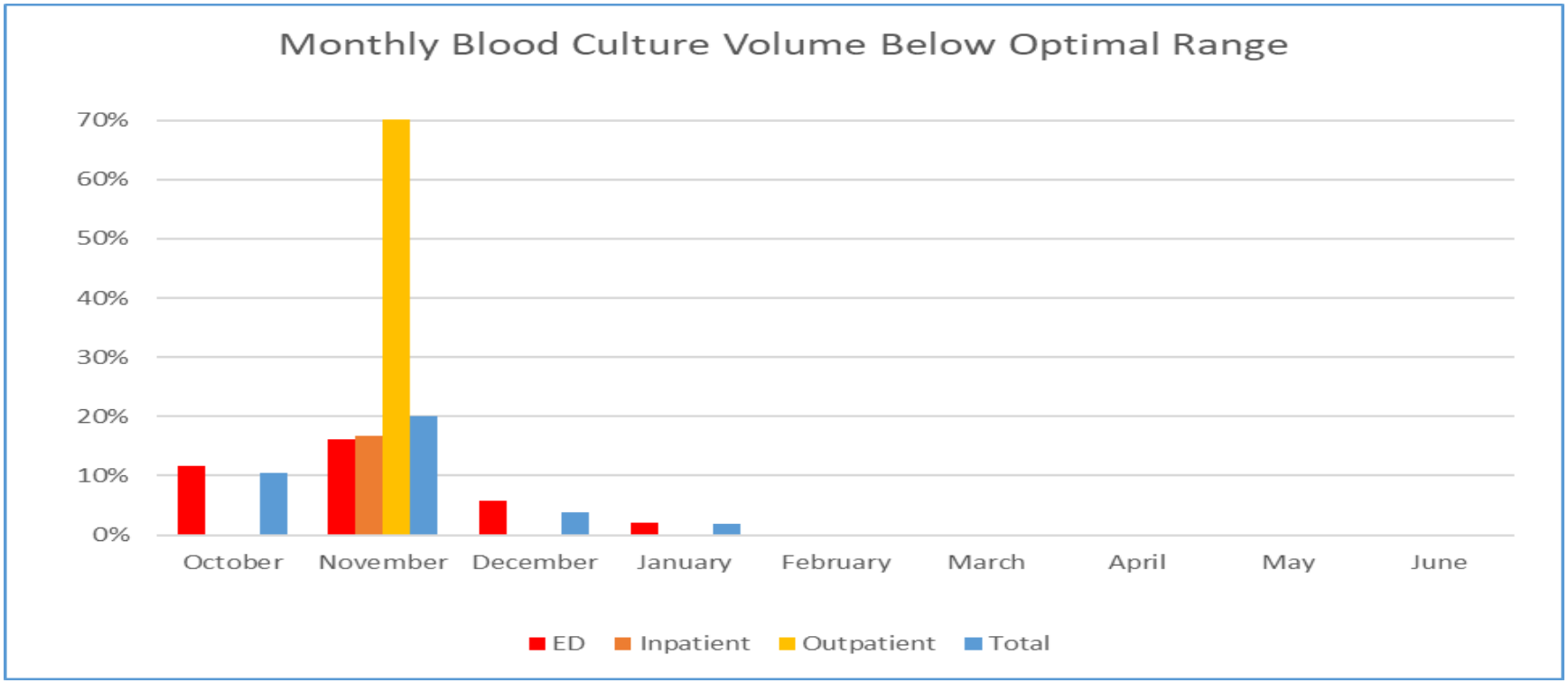
# Blood Culture Bottle Volumes – Above Optimal




| Total Number of Bottles Drawn | | | |
|---|---|---|---|
| Total | ED | Inpatient | Outpatient |
| 106 | 94 | 12 | 0 |
| Number of Bottles Above Acceptable Volume | | | |
| Total | ED | Inpatient | Outpatient |
| 2 | 0 | 2 | 0 |

Yale NewHaven Health Bridgeport Hospital

# Blood Culture Bottle Volumes – Below Optimal




| Total Number of Bottles Drawn | | | |
|---|---|---|---|
| **Total** | **ED** | **Inpatient** | **Outpatient** |
| **106** | **94** | **12** | **0** |
| **Number of Bottles Below Acceptable Volume** | | | |
| **Total** | **ED** | **Inpatient** | **Outpatient** |
| **2** | **2** | **0** | **0** |

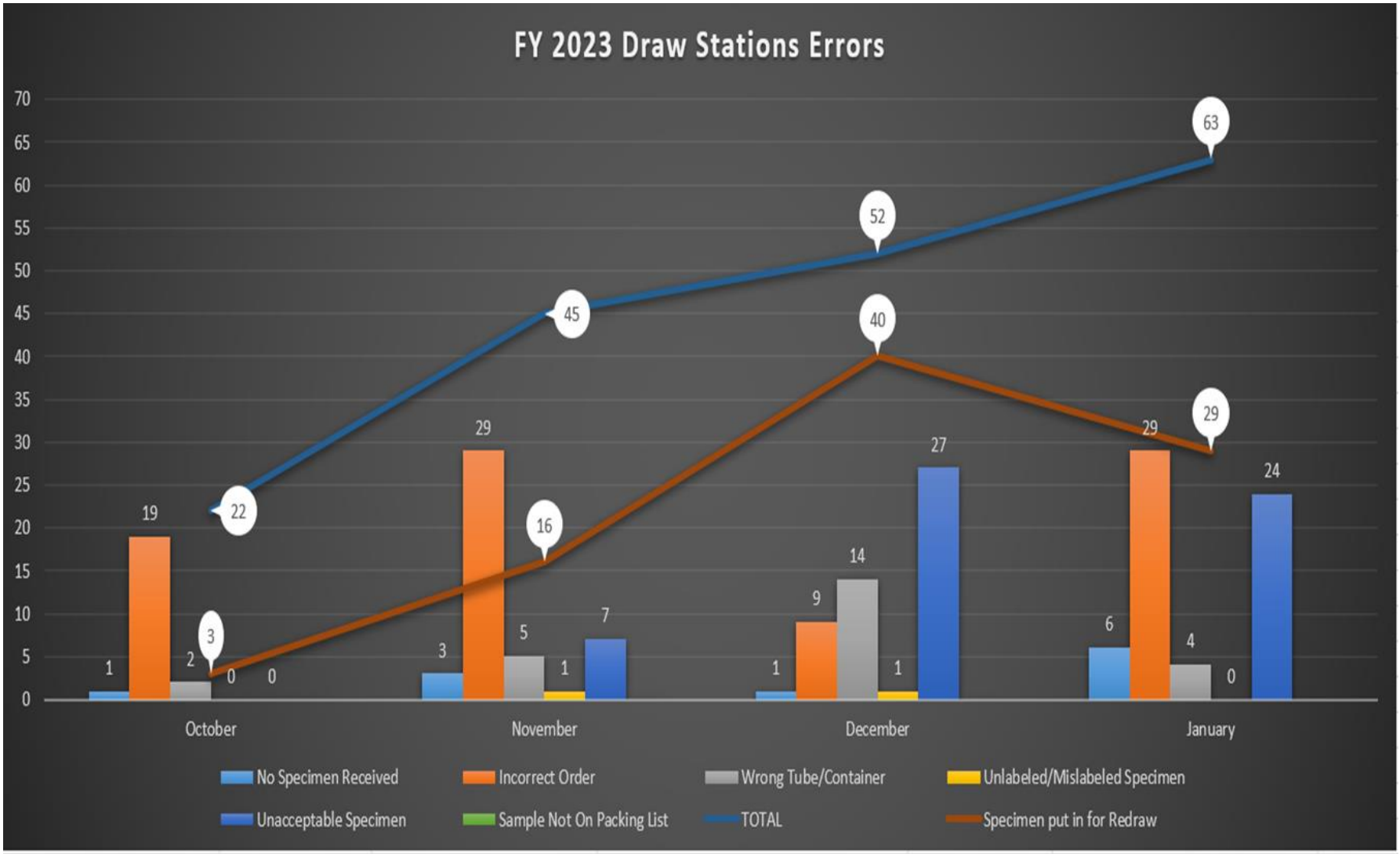
Yale NewHaven Health Bridgeport Hospital

# Molecular Statistics

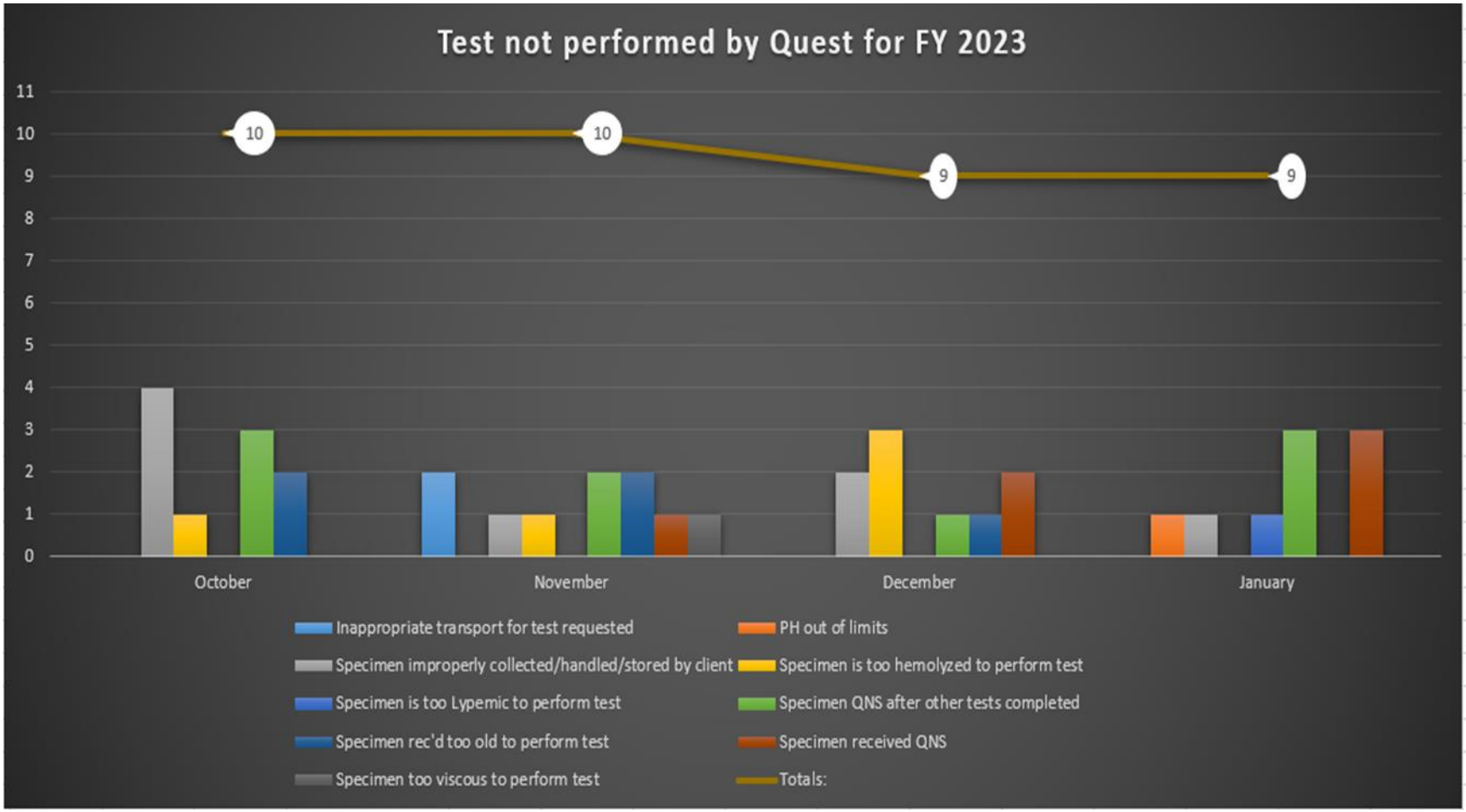
| Date | Tests | Sample size | Positive Count | % Positivity | Lower Limit | Upper Limit | Environment Monitoring | Epidemiological Trends | Evaluation Notes |
|---|---|---|---|---|---|---|---|---|---|
| Jan-23 | Chlamydia trachomatis, NAAT | 737 | 32 | 4.30% | 2% | 7% | Negative | None | None |
| Jan-23 | GBS PCR Pen Allergic | 17 | 7 | 41.20% | 0% | 49% | Negative | None | None |
| Jan-23 | GBS PCR Pen NonAllergic | 99 | 29 | 29.30% | 16% | 33% | Negative | None | None |
| Jan-23 | Group A Strep PCR | 365 | 83 | 22.70% | 2% | 22% | Negative | None | None |
| Jan-23 | HSV 1 AND 2 DIRECT PCR, | 21 | 6 | 28.60% | 0% | 55% | Negative | None | None |
| Jan-23 | Influenza A/B RNA, NAAT | 1,214 | 63 | 5.20% | 0% | 22% | Negative | None | None |
| Jan-23 | Influenza/RSV by RT-PCR | 3,409 | 110 | 3.20% | 0% | 18% | Negative | None | None |
| Jan-23 | MRSA Colonization Status | 382 | 45 | 11.80% | 5% | 18% | Negative | None | None |
| Jan-23 | MRSA/SAUR Blood PCR | 35 | 10 | 28.60% | 13% | 53% | Negative | None | None |
| Jan-23 | MTB w/rflx Rifampin PCR | 2 | 0 | 0.00% | 0% | 90% | Negative | None | None |
| Jan-23 | N. gonorrhoeae, NAAT | 736 | 18 | 2.40% | 1% | 3% | Negative | None | None |
| Jan-23 | Resp Virus PCR Panel | 186 | 41 | 22.00% | 3% | 53% | Negative | None | None |
| Jan-23 | SARS CoV-2 (COVID-19) RNA | 10,296 | 1,269 | 12.30% | 0% | 21% | Negative | None | None |
| Jan-23 | Stool Pathogens PCR | 131 | 21 | 16.00% | 0% | 19% | Negative | None | None |

Yale NewHaven Health Bridgeport Hospital

# FY2023 Draw Station Errors

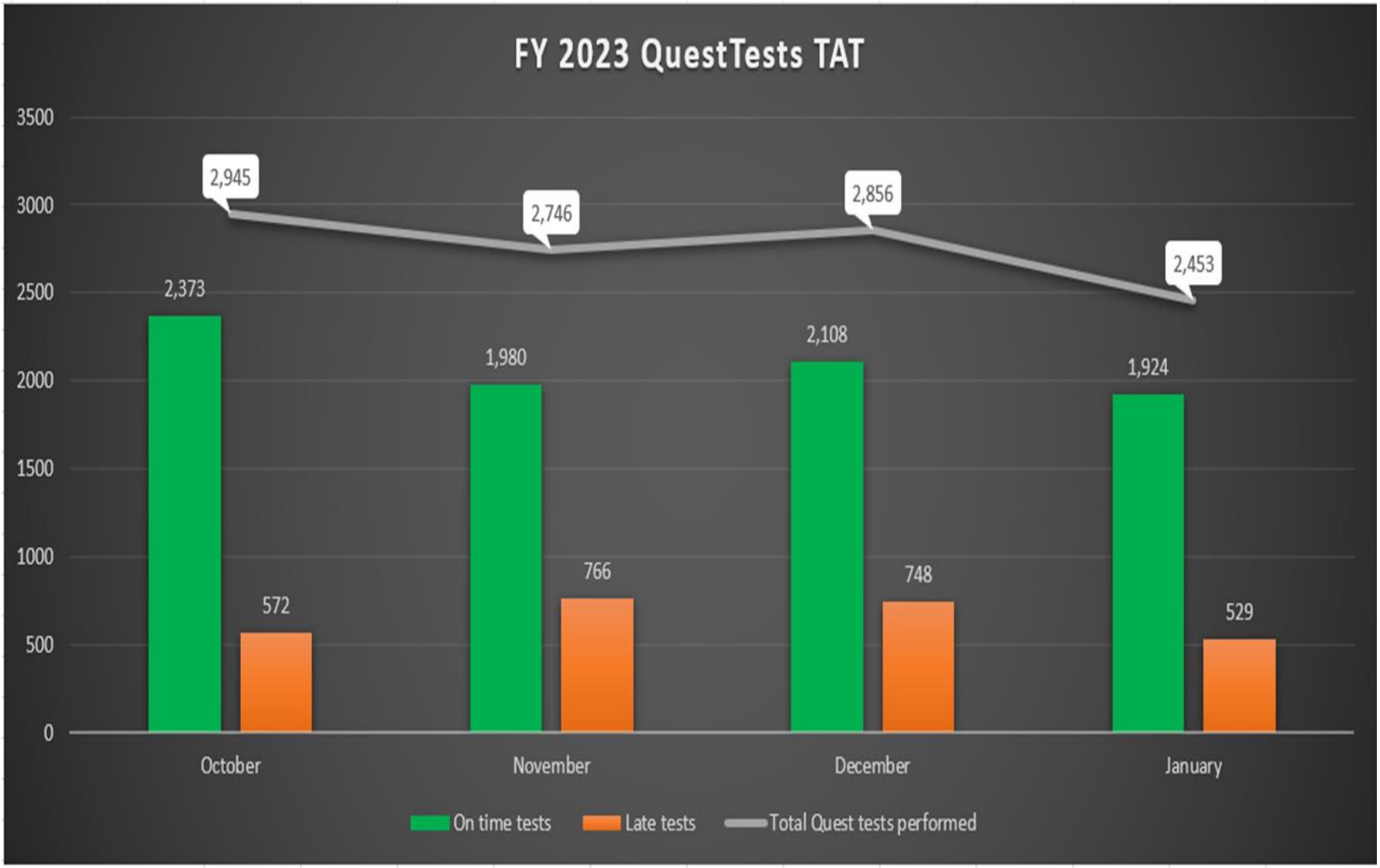


# Quest Rejected Tests

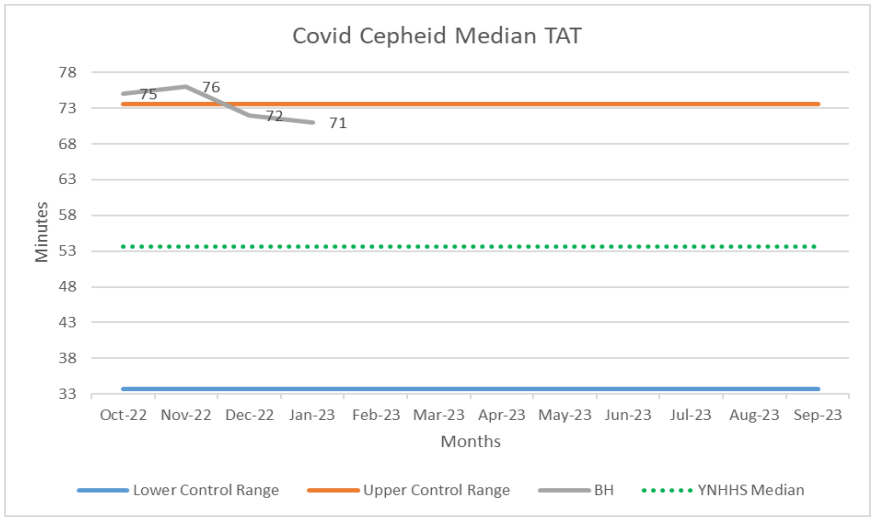


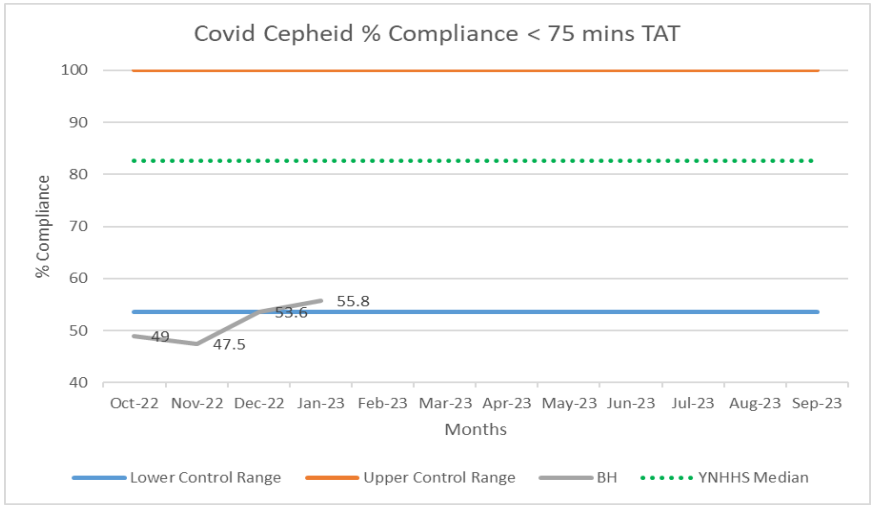

Yale NewHaven Health Bridgeport Hospital

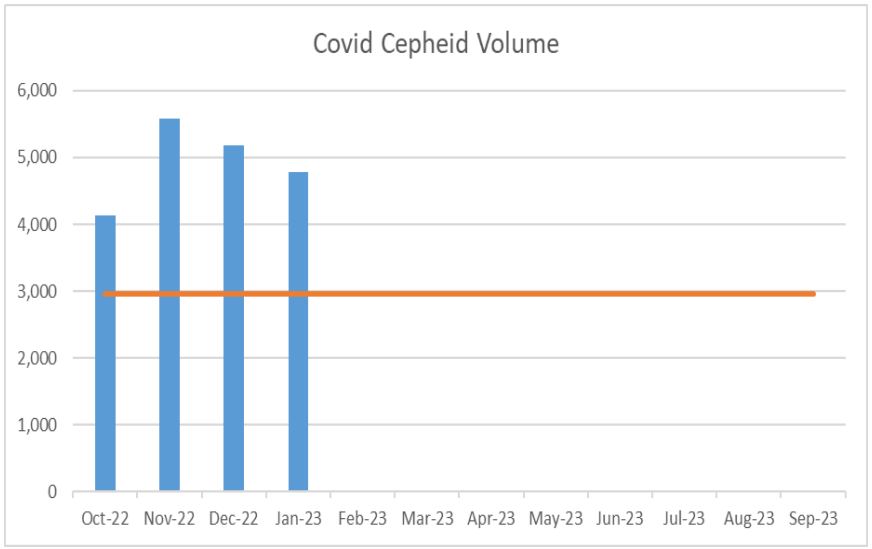
# Quest TAT


FY 2023 QuestTests TAT
3500
3000
2500
2000
1500
1000
500
0
2,945
2,746
2,856
2,453
2,373
1,980
2,108
1,924
572
766
748
529
October
November
December
January
On time tests
Late tests
Total Quest tests performed

# Bridgeport Campus – COVID-19 Cepheid

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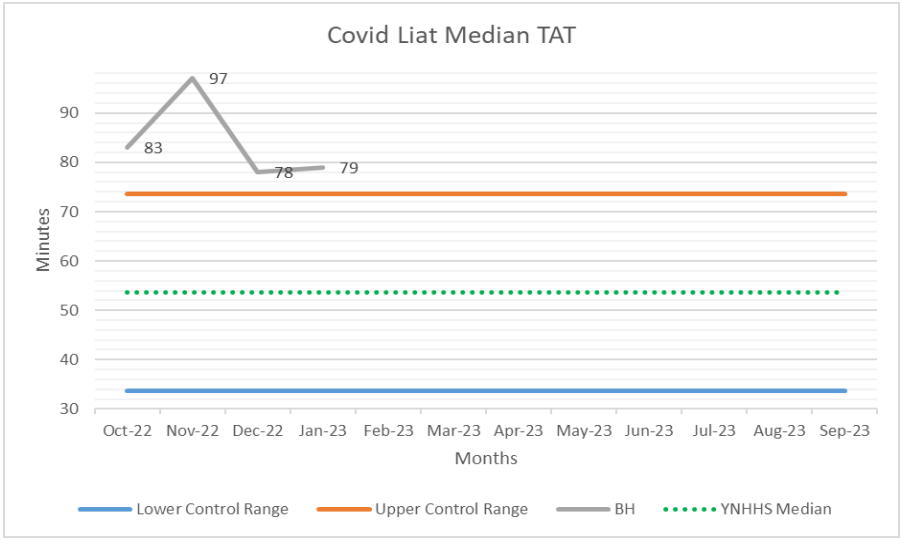
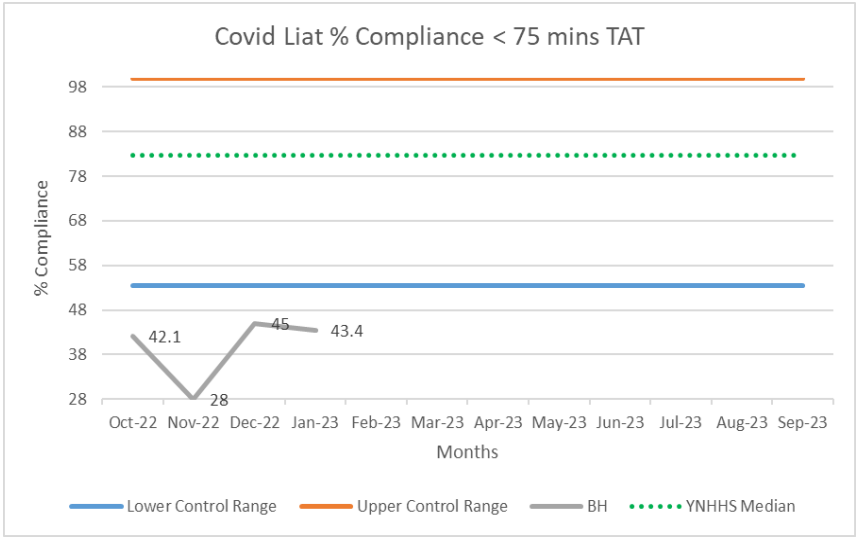
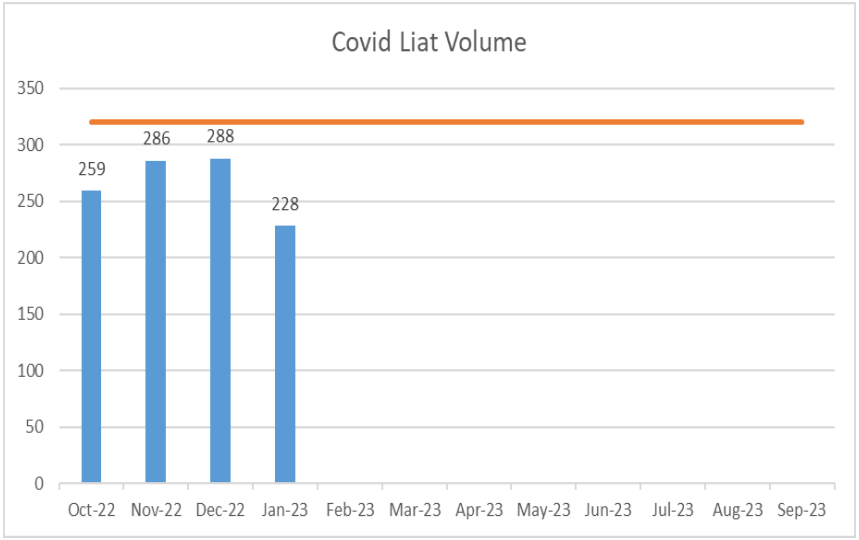
Bridgeport Hospital

# Bridgeport Campus – COVID Liat

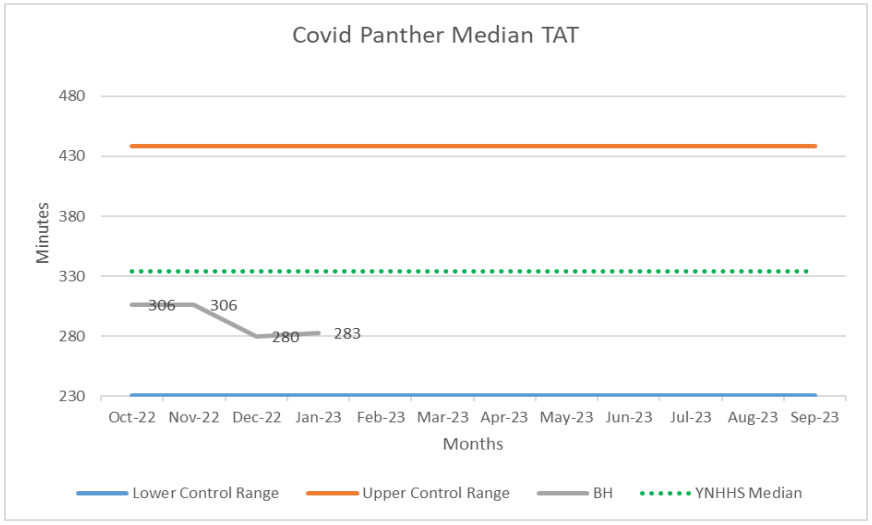


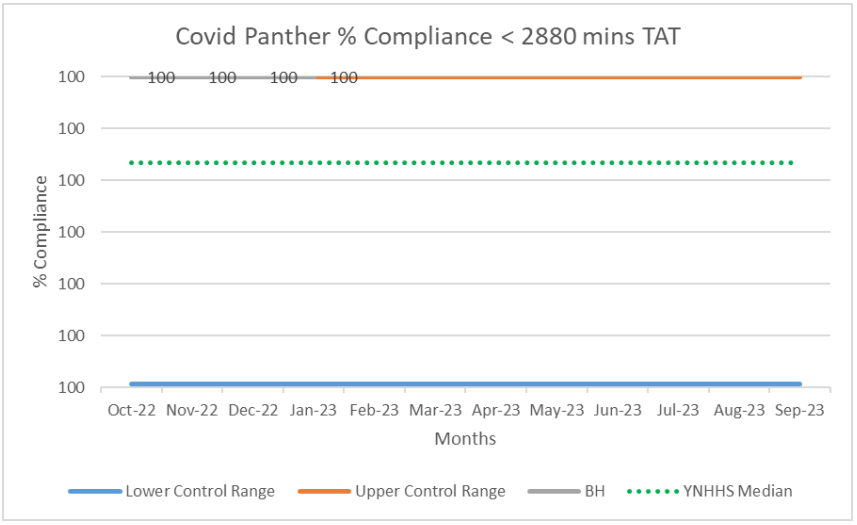



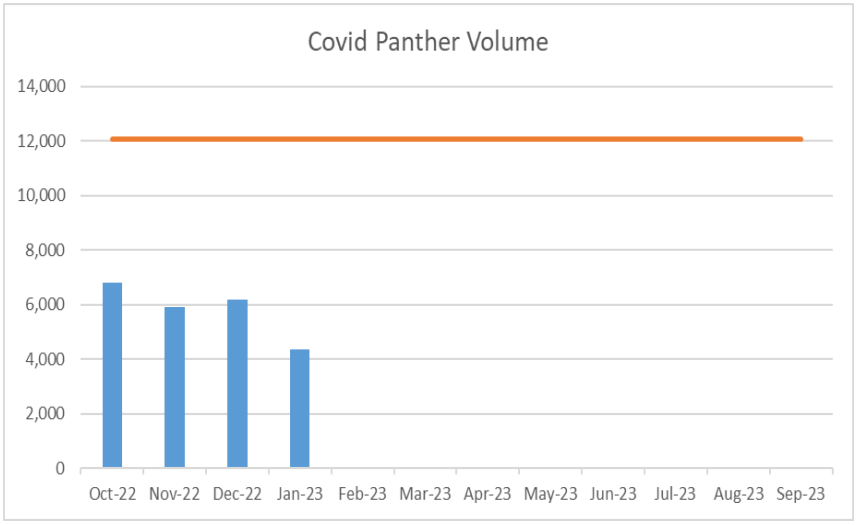




Yale NewHaven Health
Bridgeport Hospital

# Bridgeport Campus – COVID-19 Panther

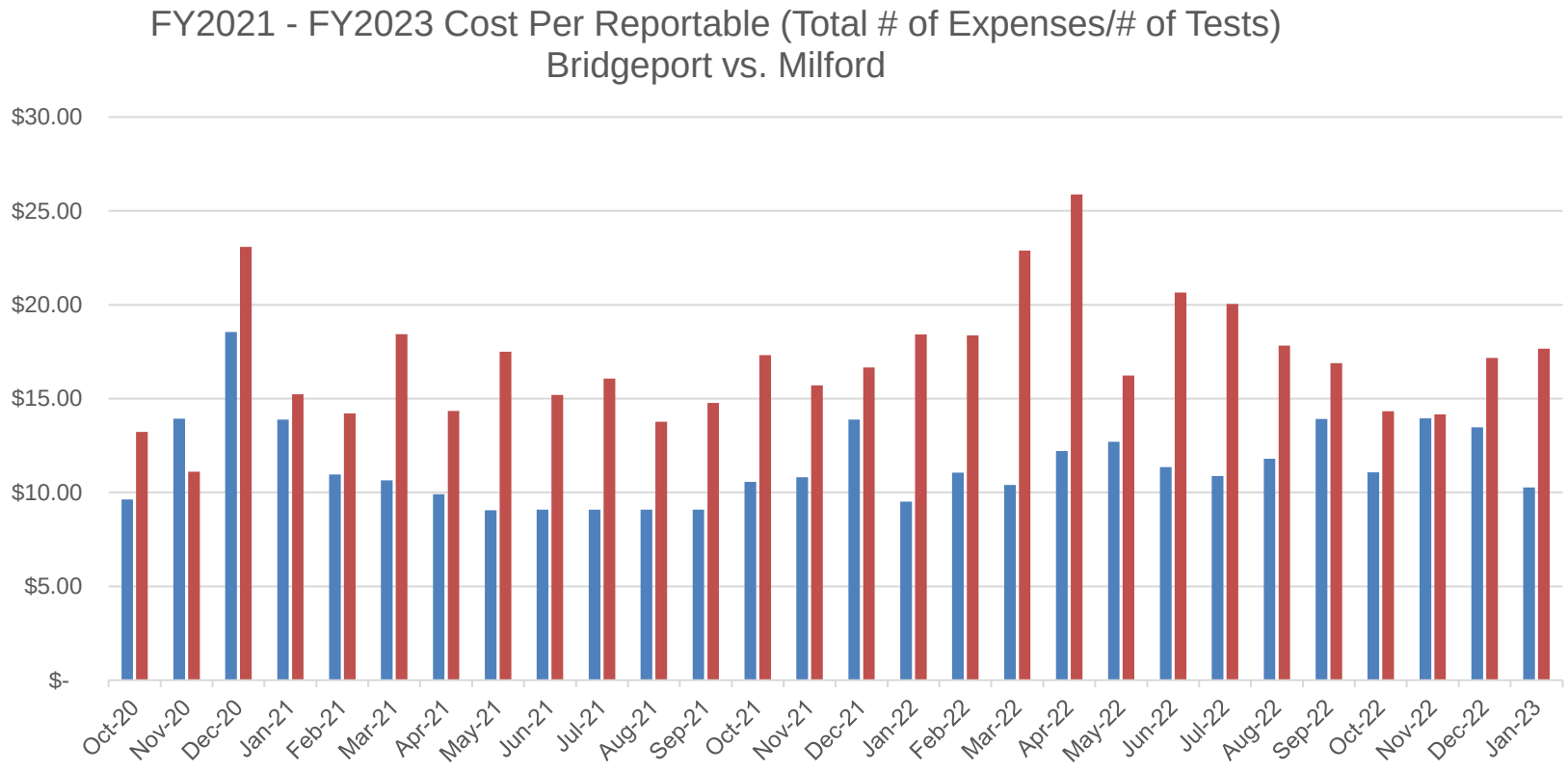



Yale NewHaven Health
Bridgeport Hospital

# Cost Per Billable




| | 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 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | $13 | 10.3 |
| 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 | 17.2 | 17.7 |

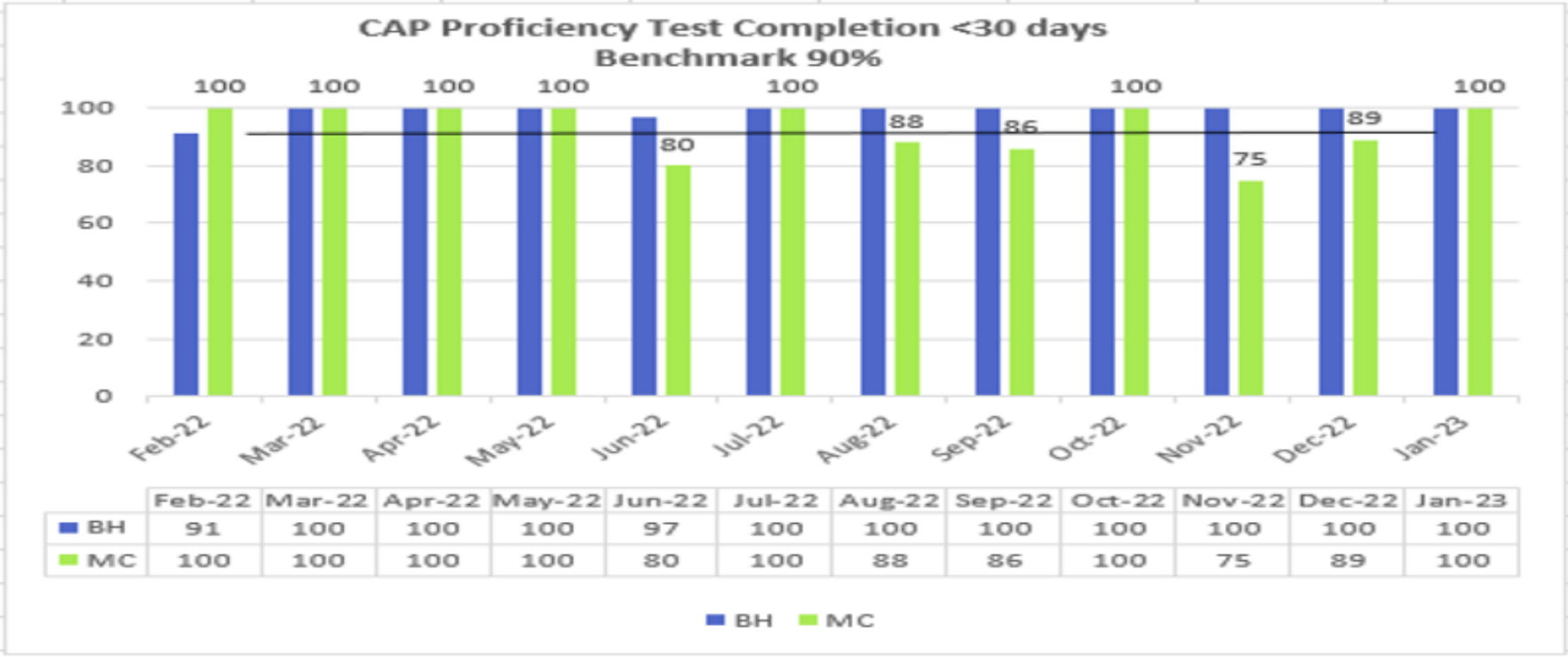
BH Cost per billable  MC Cost per billable

Yale NewHaven Health Bridgeport Hospital

# Lab General

**BH CL07D0099572/CAP1191901**
**MCBH CL07D0097265/CAP 1189901**

| 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<br><br>MC | 100% (16/16 surveys)<br><br>100% (4/4 Surveys) | 100%<br><br>89% | None | None needed. | Lab management and administration |




| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BH | 91 | 100 | 100 | 100 | 97 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| MC | 100 | 100 | 100 | 100 | 80 | 100 | 88 | 86 | 100 | 75 | 89 | 100 |

# Lab General - Bridgeport

## Proficiency Testing Performance Target 98%

| Campus | Analytes | Performance | Previous Month | Patient impact | Corrective actions |
|---|---|---|---|---|---|
| BH | 218/220 | 99% | 98% | None | None required for benchmark-each section investigates failed/unsatisfactory performances. 1 survey was unacceptable and has been investigated and corrective actions were initiated. |
| MCBH | 21/21 | 100% | 100% | None | None needed |

## Bridgeport Campus


| Reporting Year | Acceptable % | Demographic Group Average | CAP-wide Average |
|---|---|---|---|
| 2023 | 100.00% | 97.71% | 97.86% |
| 2022 | 99.32% | 98.99% | 98.63% |
| 2021 | 99.81% | 99.06% | 98.67% |

## Milford Campus


| Reporting Year | Acceptable % | Demographic Group Average | CAP-wide Average |
|---|---|---|---|
| 2022 | 99.94% | 98.99% | 98.63% |
| 2021 | 99.30% | 99.06% | 98.67% |

# Lab General

# Accreditation Performance Overview

## Bridgeport Campus

| Period Name | Percent Deficient | Demographic Group Average | CAP-wide Average |
|---|---|---|---|
| Current Cycle | 0.47% | **0.80%** | 0.78% |
| Previous Cycle | 0.11% | **0.84%** | 0.85% |
| Second Previous Cycle | 0.65% | **0.85%** | 0.86% |

**Accreditation Performance Overview**

Select View: Graph


| 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 |

## Milford Campus

| Period Name | Percent Deficient | Demographic Group Average | CAP-wide Average |
|---|---|---|---|
| Current Cycle | 0.62% | **0.80%** | 0.78% |
| Previous Cycle | 0.74% | **0.84%** | 0.85% |
| Second Previous Cycle | 0.73% | **0.85%** | 0.86% |


| Last Accreditation Decision | Date |
|---|---|
| Accredited | 5/9/2022 |

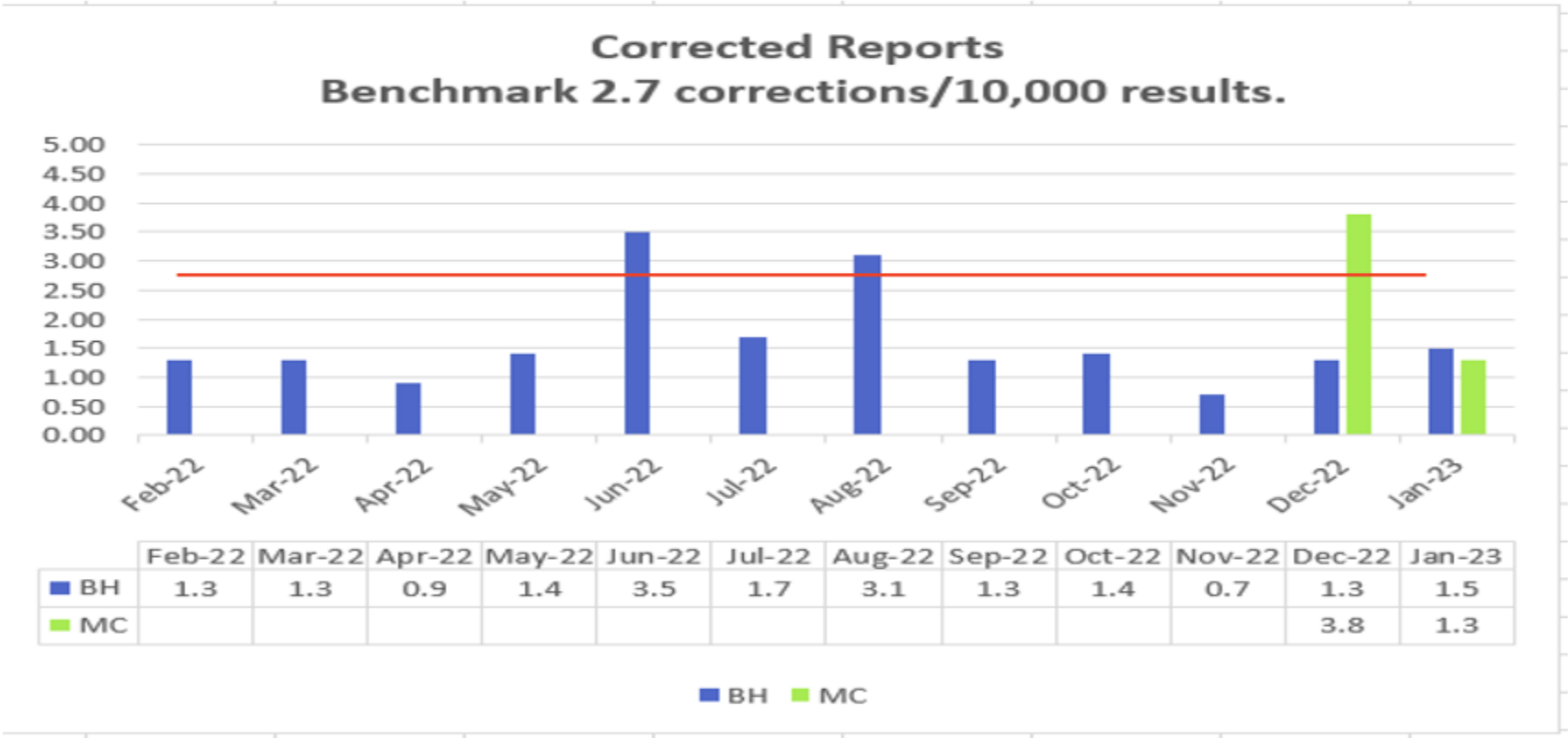
| Current Cycle Inspection(s) | | | |
|---|---|---|---|
| Date | Inspection Type | % Deficient | Recurring Deficiencies |
| 3/28/2022 | Routine | 0.62 | 0 |

# Lab General

| Quality Metric Corrected Reports Target<2.7/10,000 tests/month | Sample size (tests) | Current performance | Previous month | Patient Impact | Corrective action and follow-up | Responsible |
|---|---|---|---|---|---|---|
| BC Lab Corrected reports | 205,412 | 1.5 (0.015%) | 1.3 (0. 0.13%) | Corrected reports can lead to adverse patient outcomes | None needed benchmark met | Laboratory administration |
| MCBH Corrected reports | 23,943 | 1.3 (0.013%) | 3.8 | | None needed benchmark met Ongoing daily review of corrections w/director | |

Yale NewHaven Health Bridgeport Hospital

# Lab General

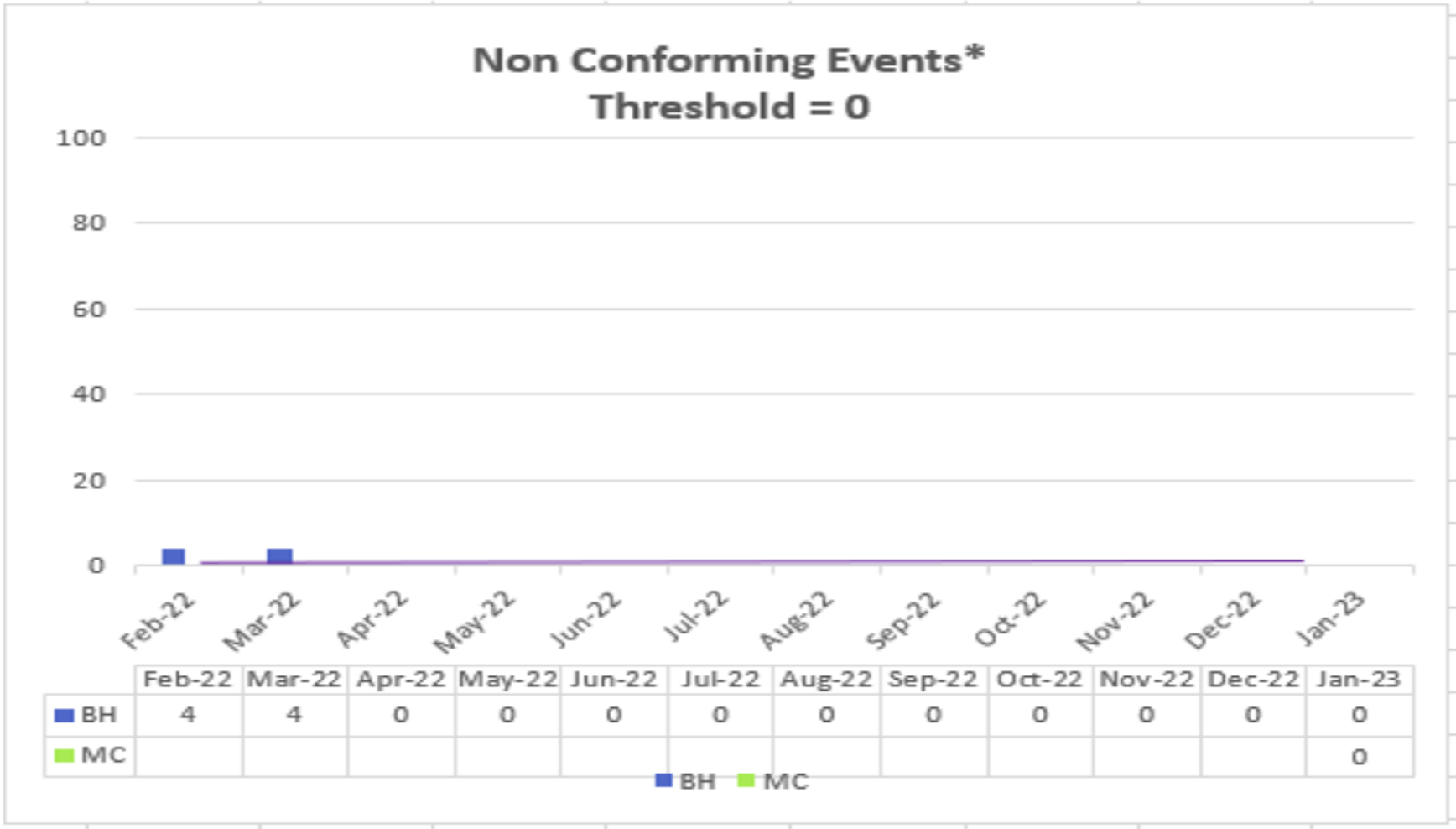



| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BH | 1.3 | 1.3 | 0.9 | 1.4 | 3.5 | 1.7 | 3.1 | 1.3 | 1.4 | 0.7 | 1.3 | 1.5 |
| MC | | | | | | | | | | | 3.8 | 1.3 |

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.

| Quality Metric | Target | Sample size | Current performance | Previous month | Patient Impact | Corrective action and 593follow-up | Responsible Staff |
|---|---|---|---|---|---|---|---|
| **Nonconforming events BC** | **0** | 205,412 Tests | 0 | 0 | None | None needed | Lab administration and management |
| **MC** | **0** | 23,943 | 0 | 0 | | | |

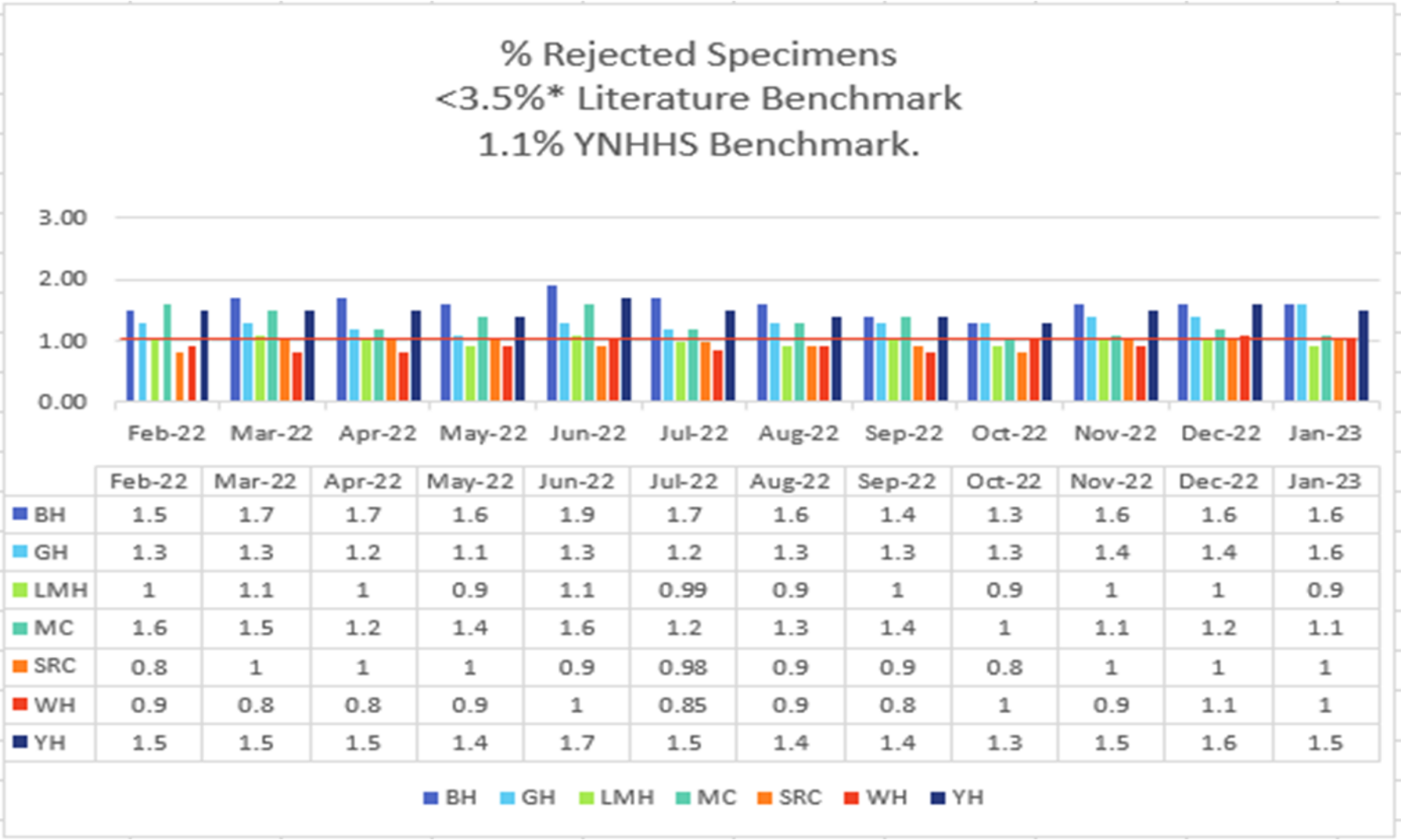
# Lab General




| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BH | 4 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MC | | | | | | | | | | | | 0 |

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

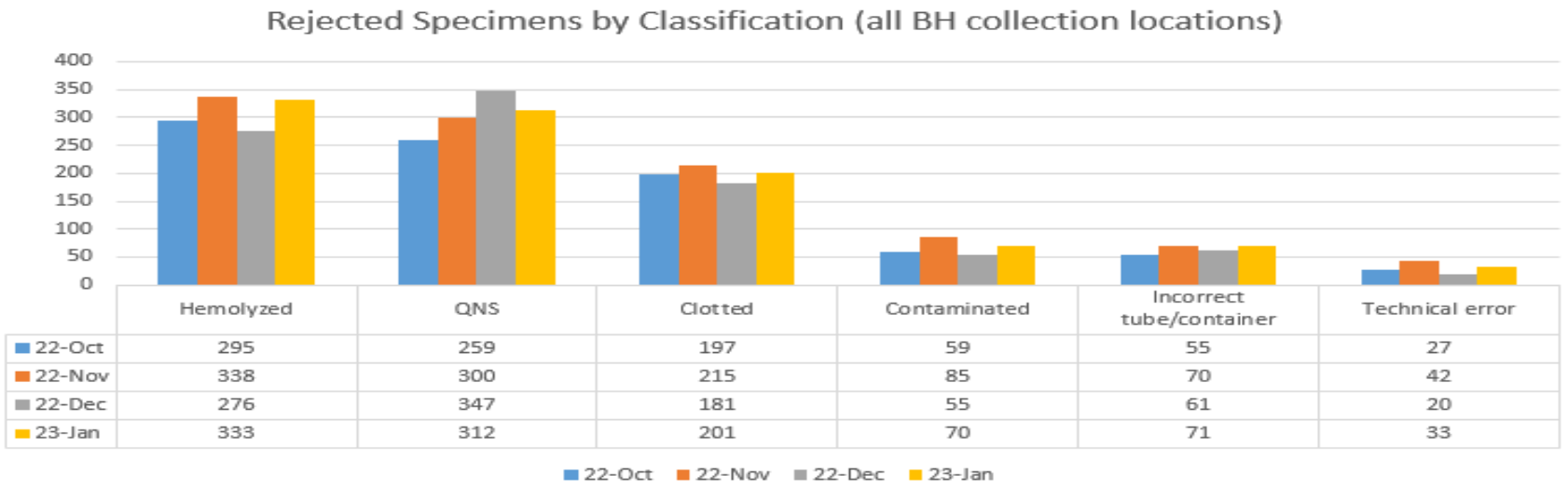
# Lab General




| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BH | 1.5 | 1.7 | 1.7 | 1.6 | 1.9 | 1.7 | 1.6 | 1.4 | 1.3 | 1.6 | 1.6 | 1.6 |
| GH | 1.3 | 1.3 | 1.2 | 1.1 | 1.3 | 1.2 | 1.3 | 1.3 | 1.3 | 1.4 | 1.4 | 1.6 |
| LMH | 1 | 1.1 | 1 | 0.9 | 1.1 | 0.99 | 0.9 | 1 | 0.9 | 1 | 1 | 0.9 |
| MC | 1.6 | 1.5 | 1.2 | 1.4 | 1.6 | 1.2 | 1.3 | 1.4 | 1 | 1.1 | 1.2 | 1.1 |
| SRC | 0.8 | 1 | 1 | 1 | 0.9 | 0.98 | 0.9 | 0.9 | 0.8 | 1 | 1 | 1 |
| WH | 0.9 | 0.8 | 0.8 | 0.9 | 1 | 0.85 | 0.9 | 0.8 | 1 | 0.9 | 1.1 | 1 |
| YH | 1.5 | 1.5 | 1.5 | 1.4 | 1.7 | 1.5 | 1.4 | 1.4 | 1.3 | 1.5 | 1.6 | 1.5 |

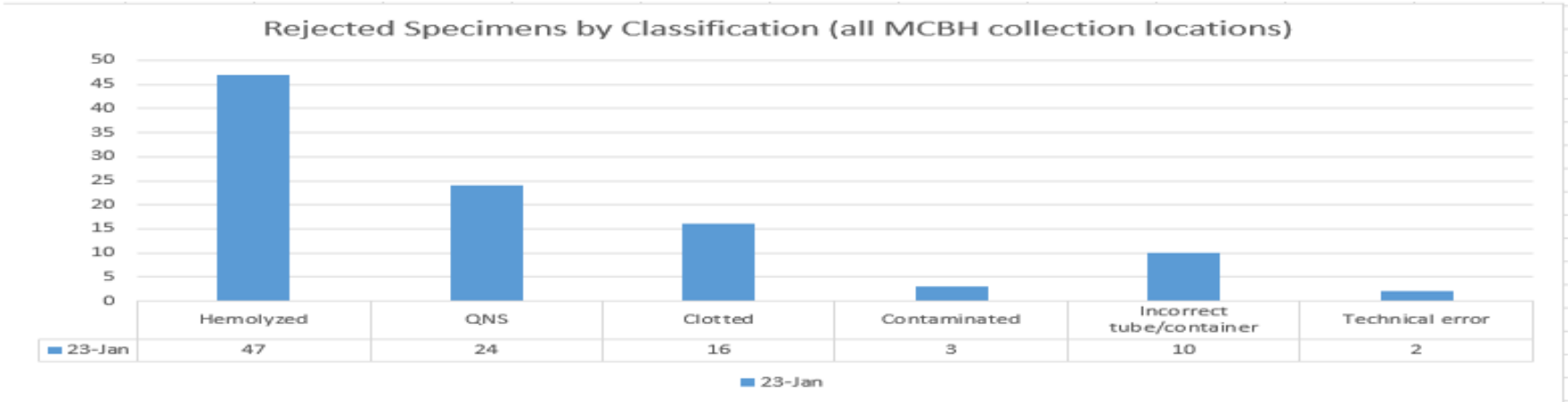
*Rooper L. Carter, J., Hargrove, J., Hoffman, S & Riedel,S.(2017). Targeting rejections: analysis of specimen acceptability and rejection. *Journal of Clinical Laboratory Analysis* .volume 31, issue 3

# Lab General



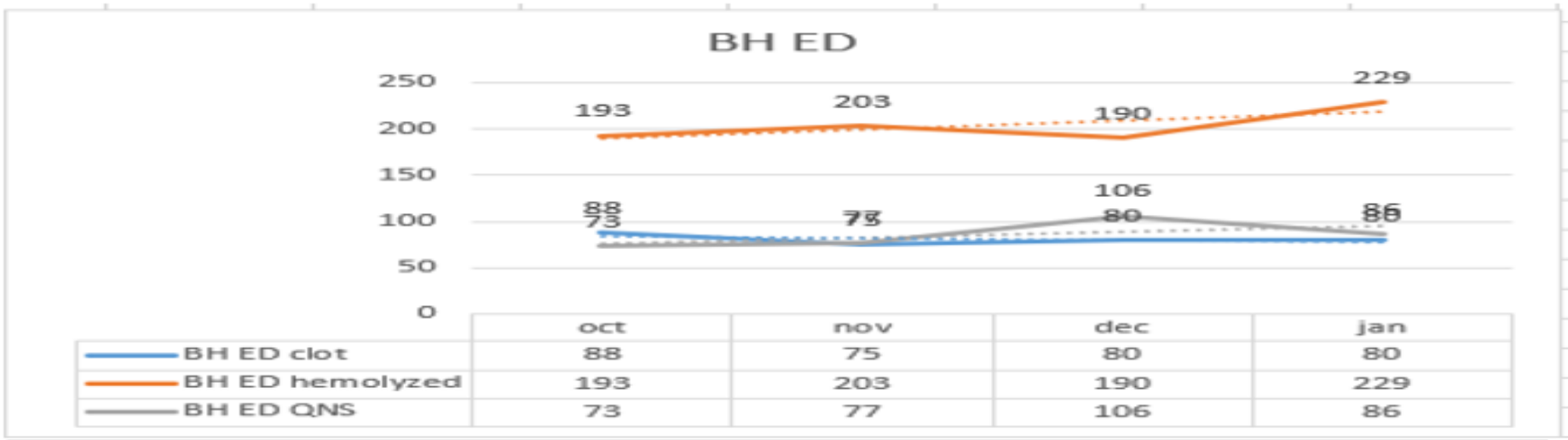

| | Hemolyzed | QNS | Clotted | Contaminated | Incorrect tube/container | Technical error |
|---|---|---|---|---|---|---|
| 22-Oct | 295 | 259 | 197 | 59 | 55 | 27 |
| 22-Nov | 338 | 300 | 215 | 85 | 70 | 42 |
| 22-Dec | 276 | 347 | 181 | 55 | 61 | 20 |
| 23-Jan | 333 | 312 | 201 | 70 | 71 | 33 |

*Most of the technical error cancellations were by our Outreach & Central Processing staff




| | Hemolyzed | QNS | Clotted | Contaminated | Incorrect tube/container | Technical error |
|---|---|---|---|---|---|---|
| 23-Jan | 47 | 24 | 16 | 3 | 10 | 2 |

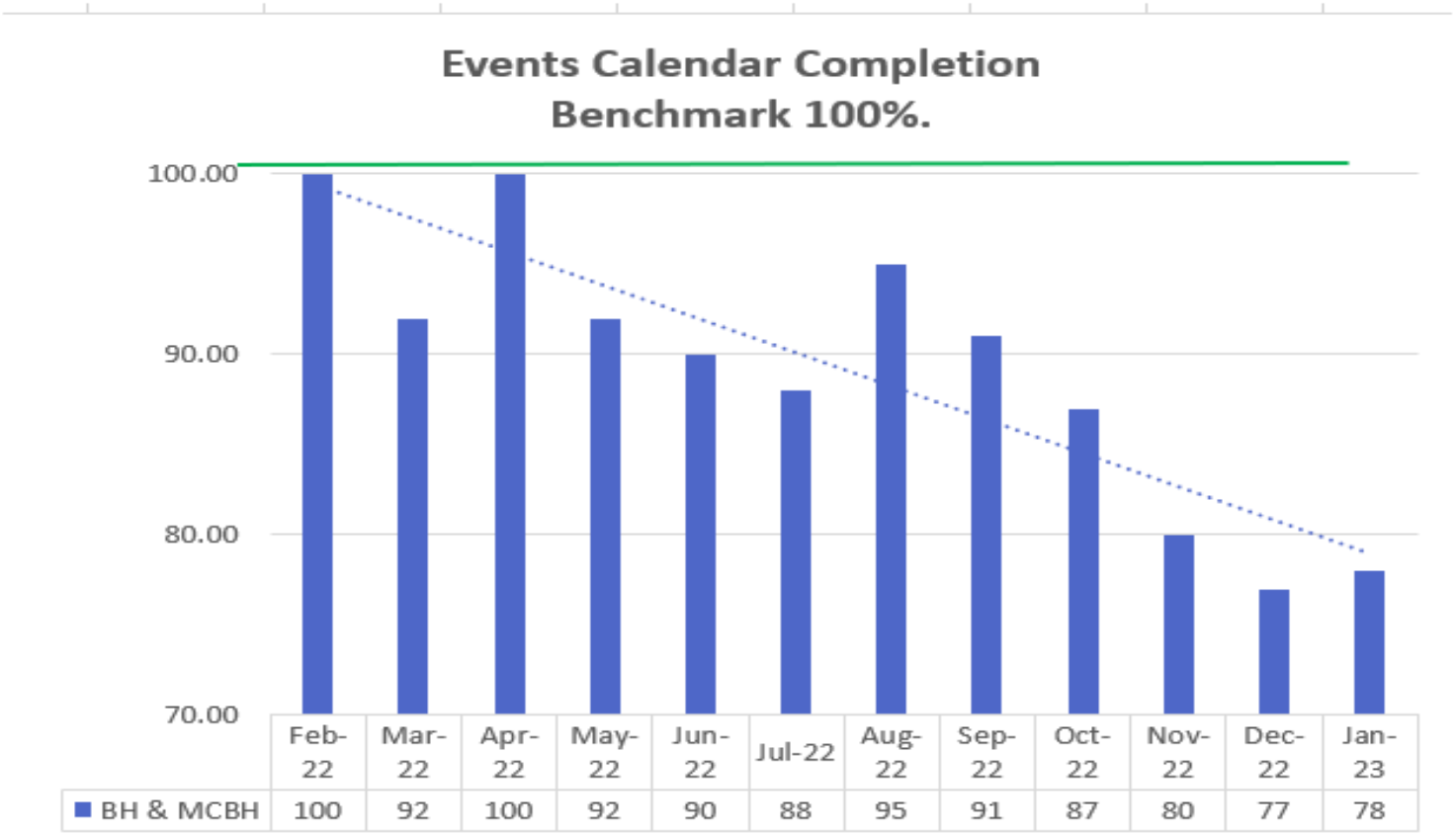
# Lab General


BH ED
250
200
150
100
50
0
193
203
190
229
88
73
75
77
80
106
80
86
oct
nov
dec
jan
BH ED clot
BH ED hemolyzed
BH ED QNS
88
75
80
80
193
203
190
229
73
77
106
86


MCBH ED
45
40
35
30
25
20
15
10
5
0
42
8
6
jan
MCBH ED clot
MCBH ED hemolyzed
MCBH ED QNS
6
42
8

# Lab General

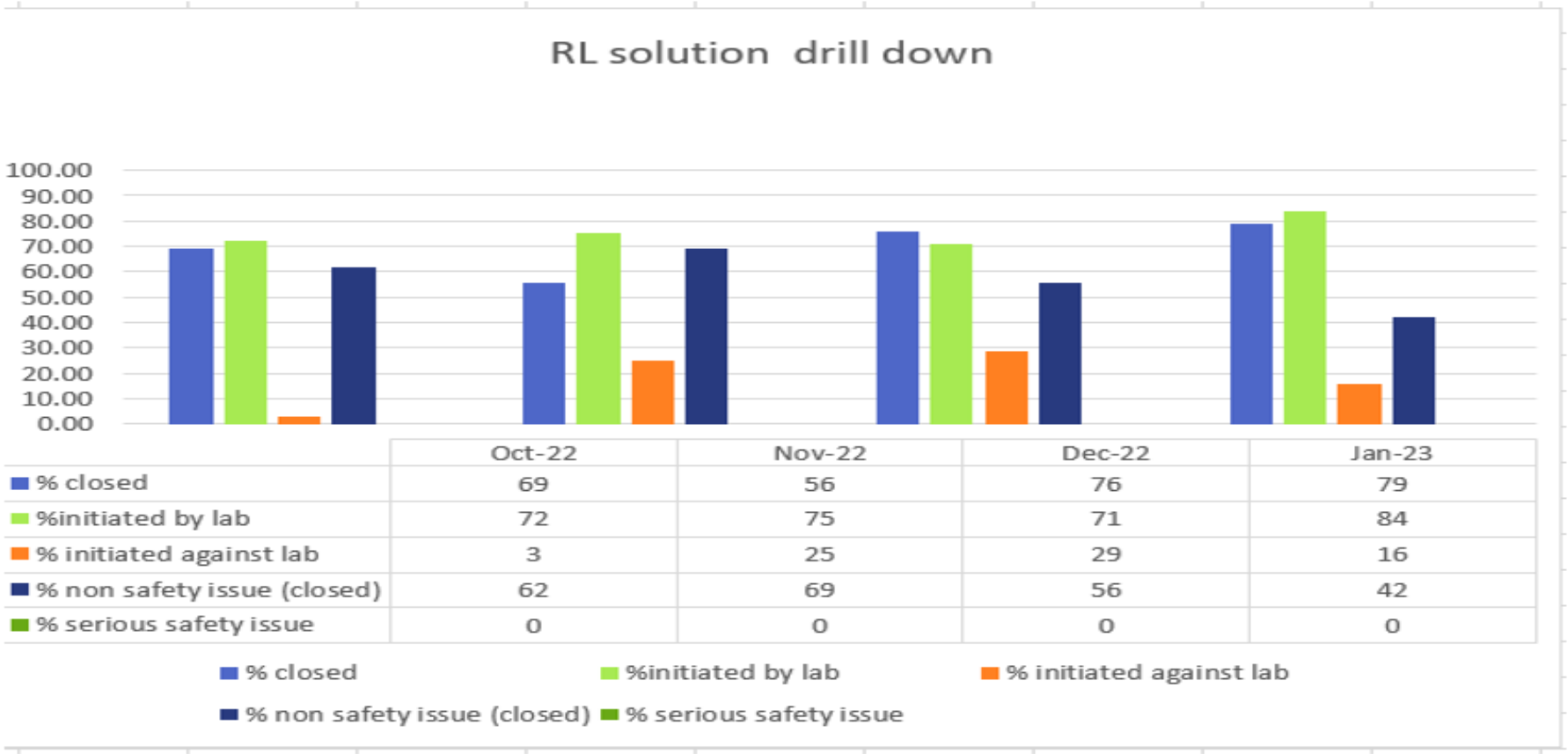
**BH & MCBH Events Calendar Completion 78%** **January 2023**
**Benchmark 100%**
**22/28 Events completed**




| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BH & MCBH | 100 | 92 | 100 | 92 | 90 | 88 | 95 | 91 | 87 | 80 | 77 | 78 |

# Lab General

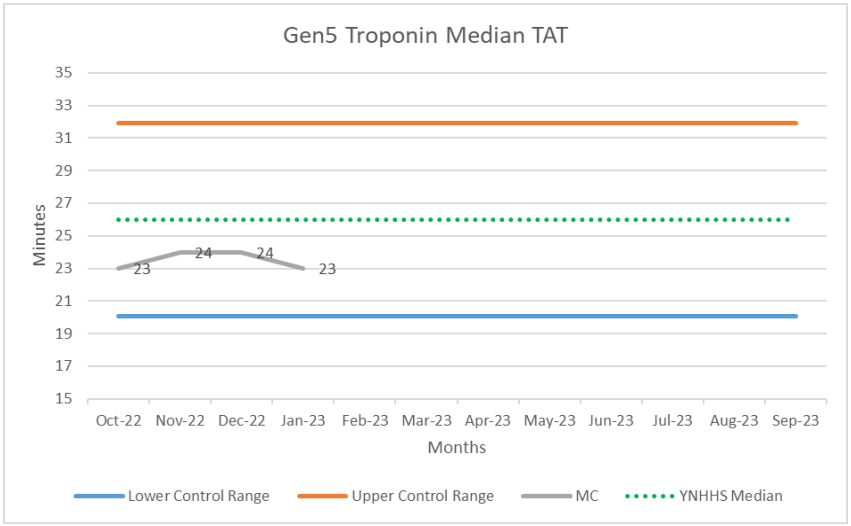
## BH RL SOLUTIONS MONITOR

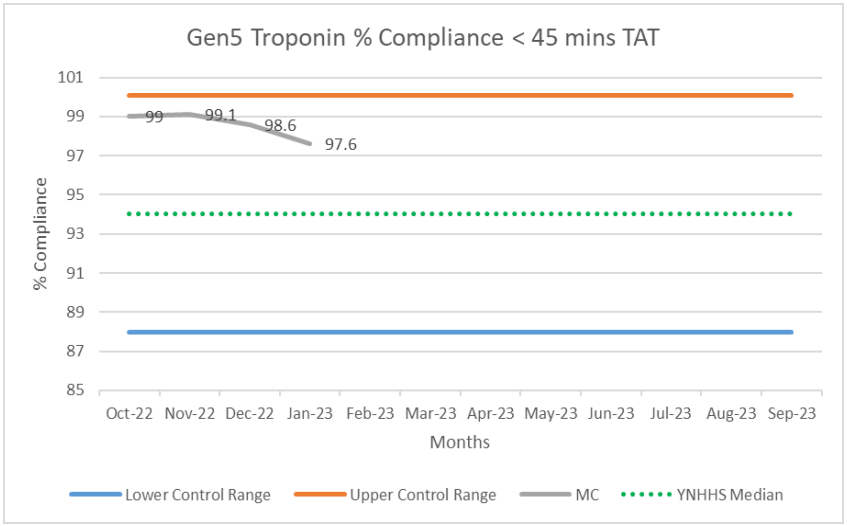


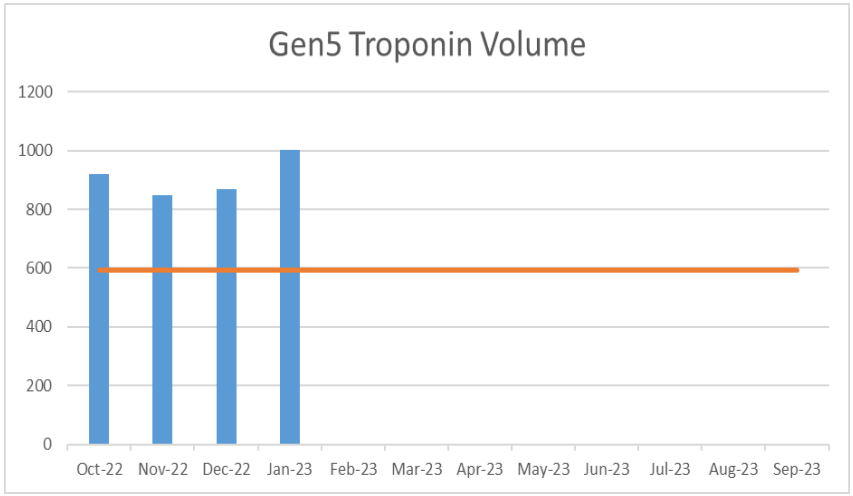

| | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
|---|---|---|---|---|
| % closed | 69 | 56 | 76 | 79 |
| %initiated by lab | 72 | 75 | 71 | 84 |
| % initiated against lab | 3 | 25 | 29 | 16 |
| % non safety issue (closed) | 62 | 69 | 56 | 42 |
| % serious safety issue | 0 | 0 | 0 | 0 |

**14/19 events 14 closed, 2 new, 3 in progress**
**16 lab initiated**
**0 Serious Safety Events, rest barrier catches not reaching patients**

# Milford Campus – Gen 5 Troponin TAT

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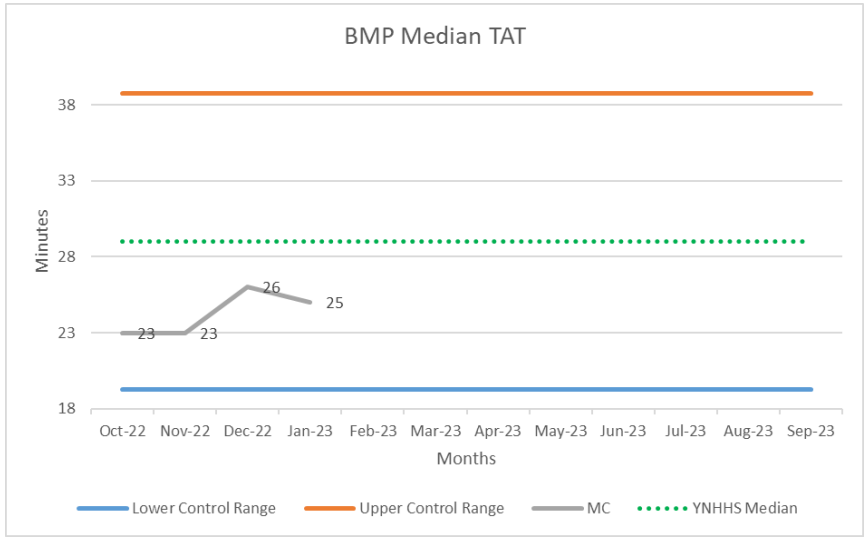
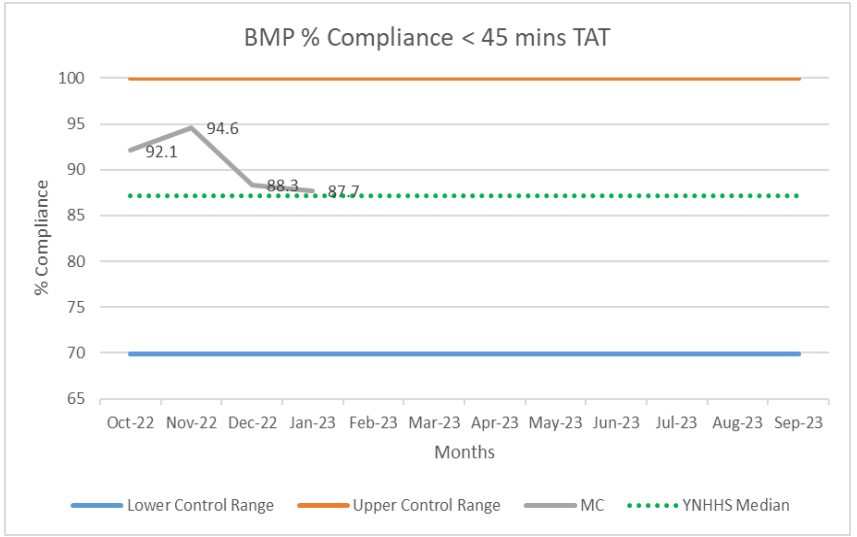
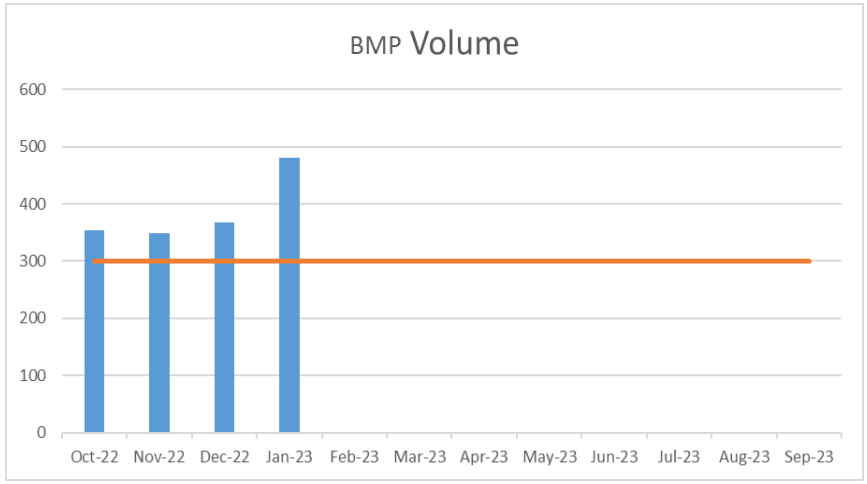
# Milford Campus – Basic Metabolic Panel (BMP) ED TAT

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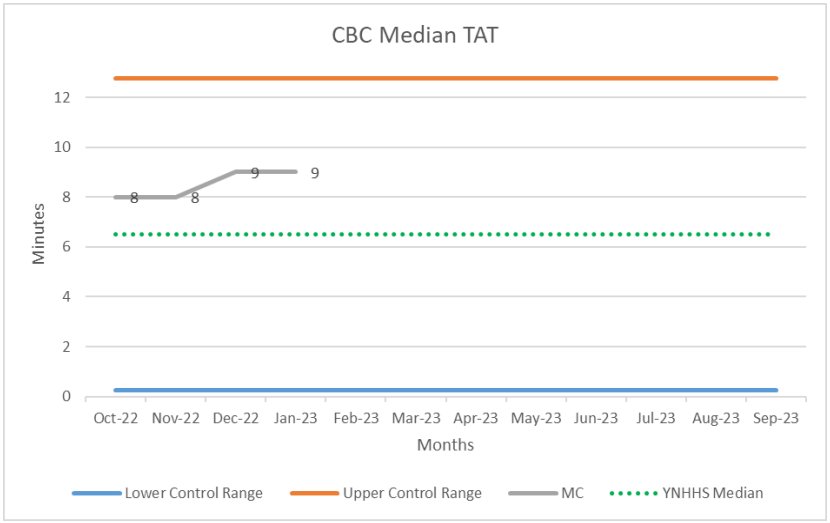
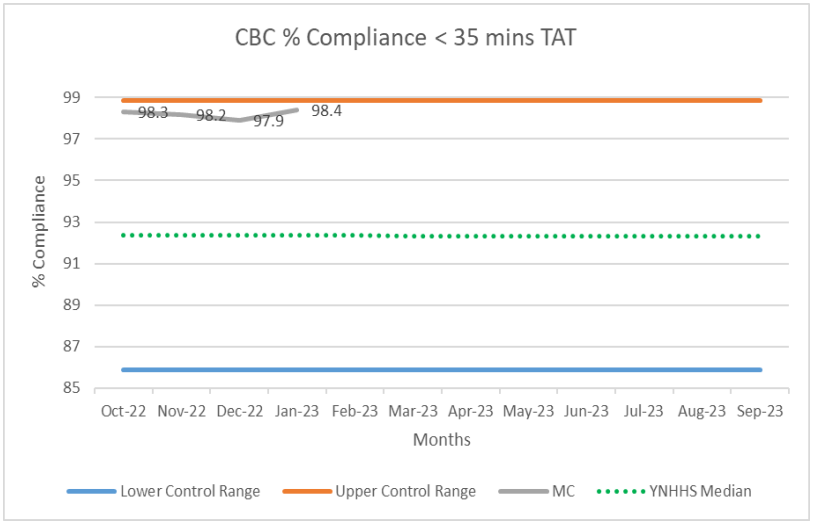
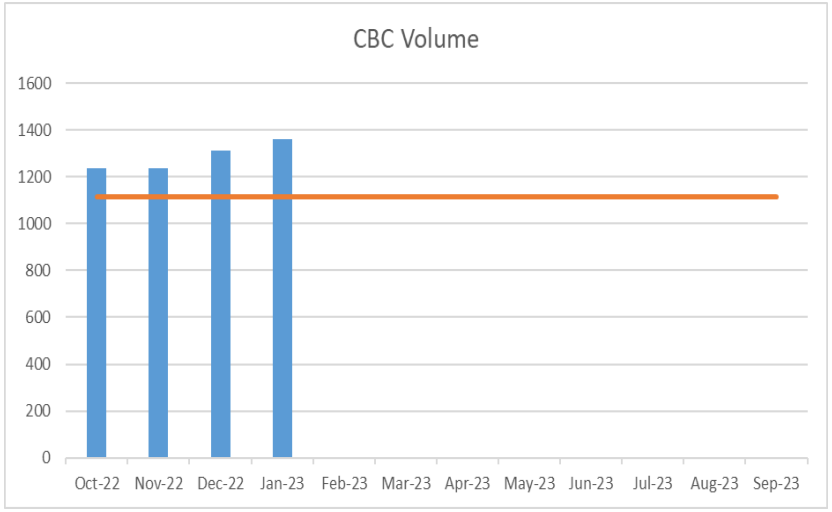
# Milford Campus – Complete Blood Count (CBC) ED TAT

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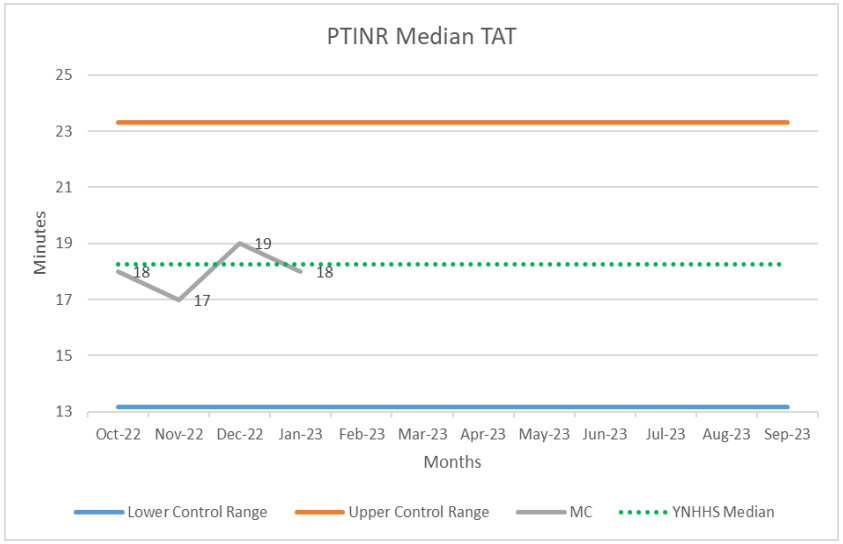
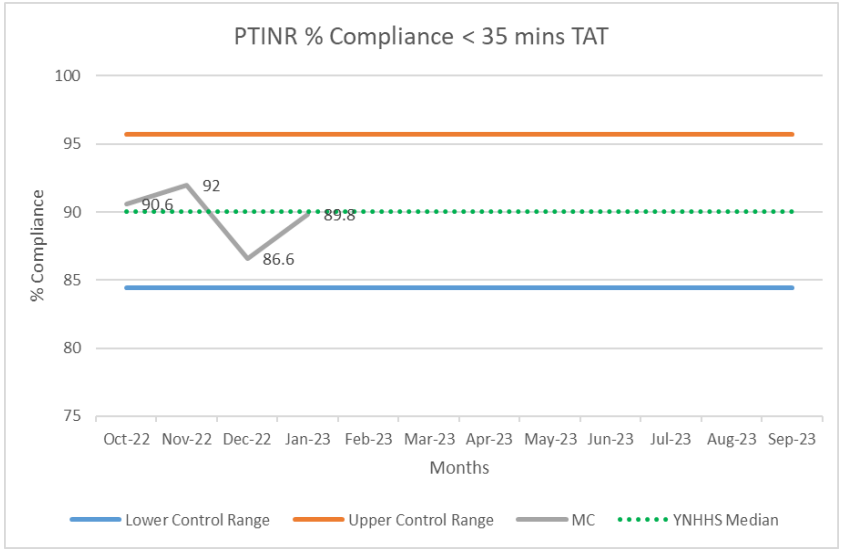
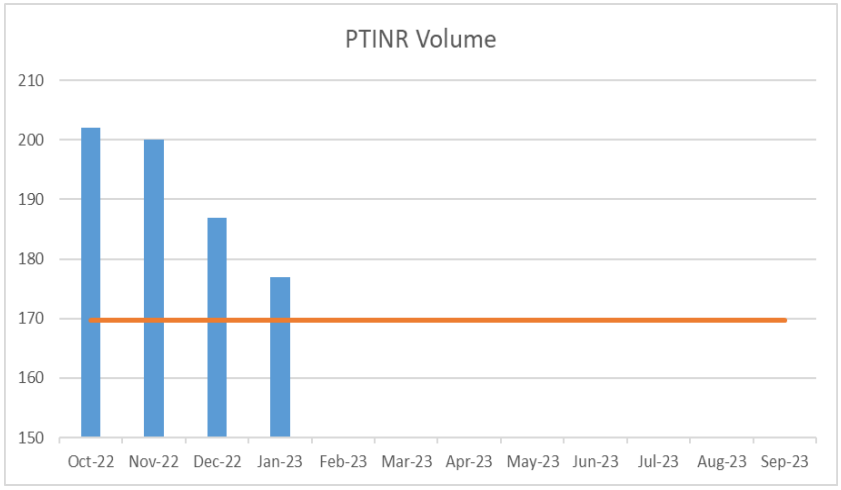
# Milford Campus – PTINR ED TAT

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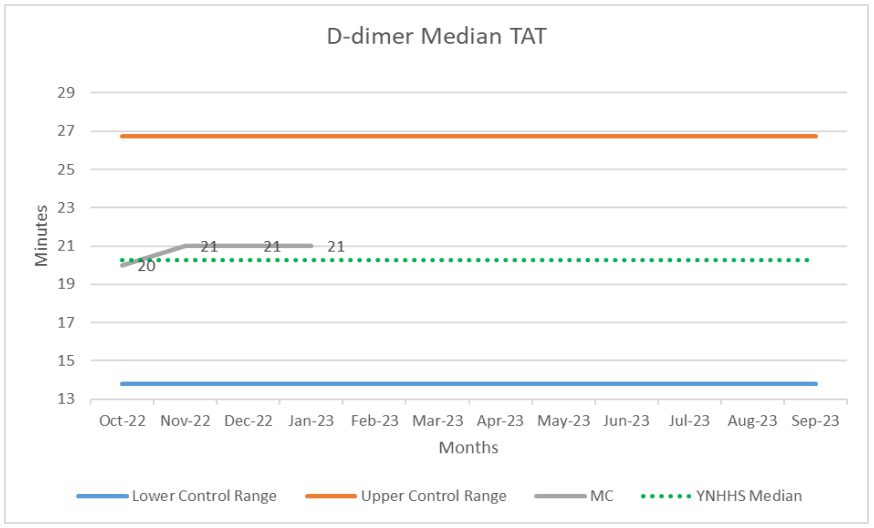
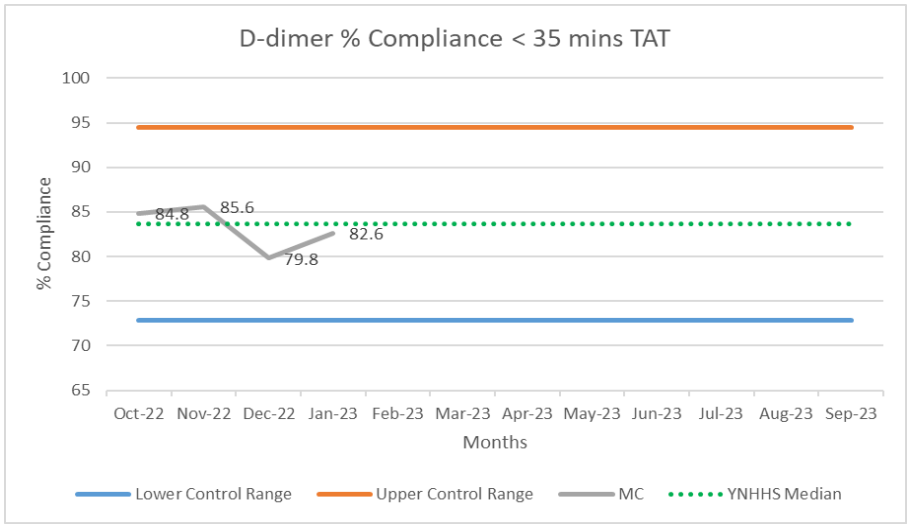
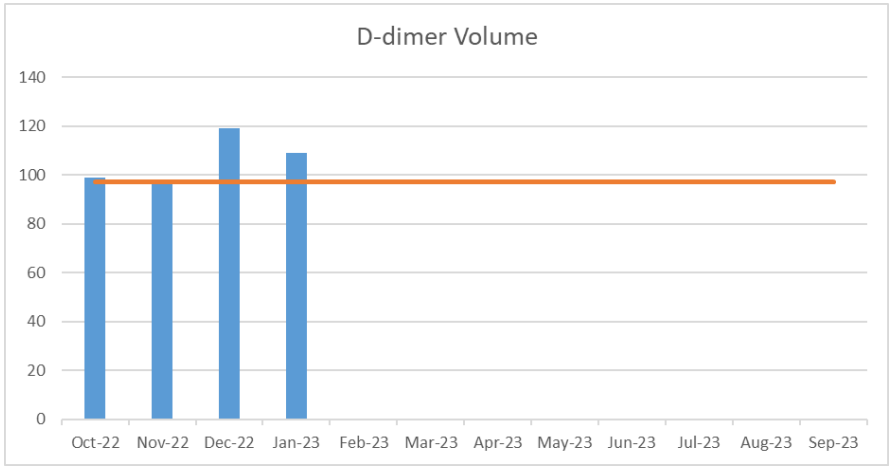
# Milford Campus – D-dimer ED TAT

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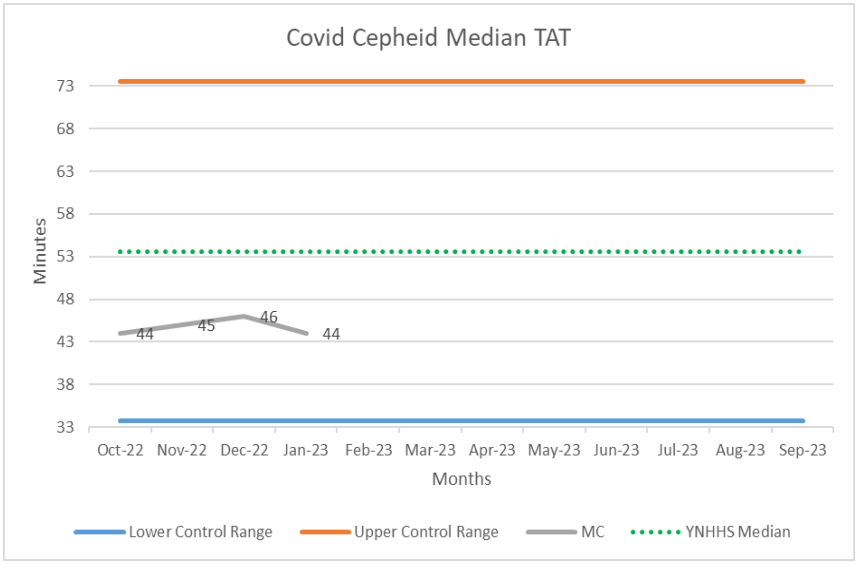
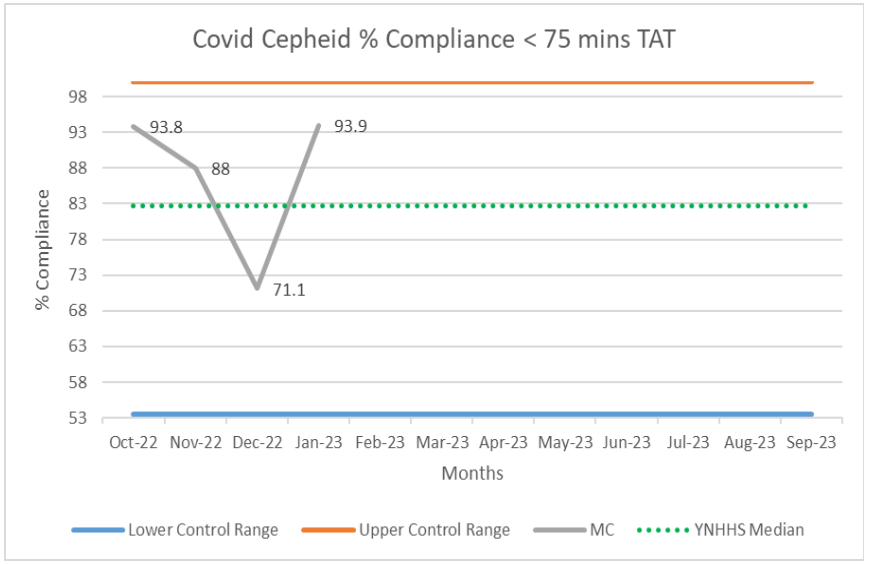
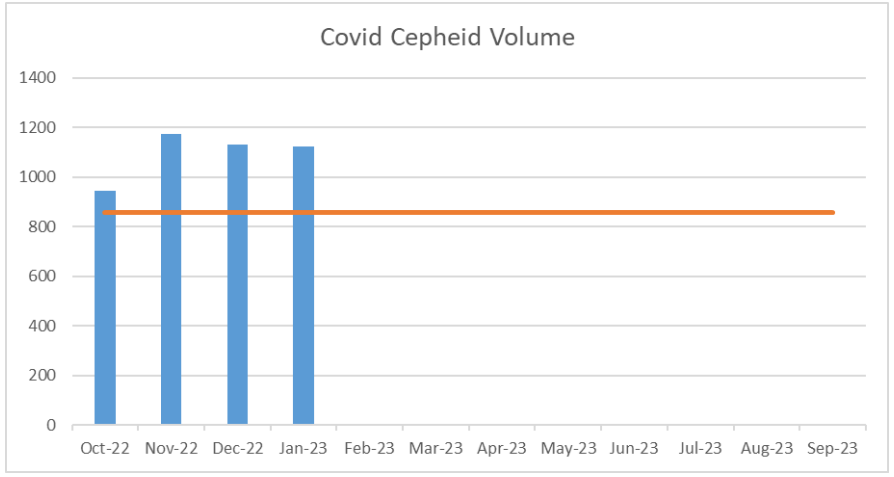
Bridgeport Hospital

# Milford Campus – COVID Cepheid PCR ED TAT

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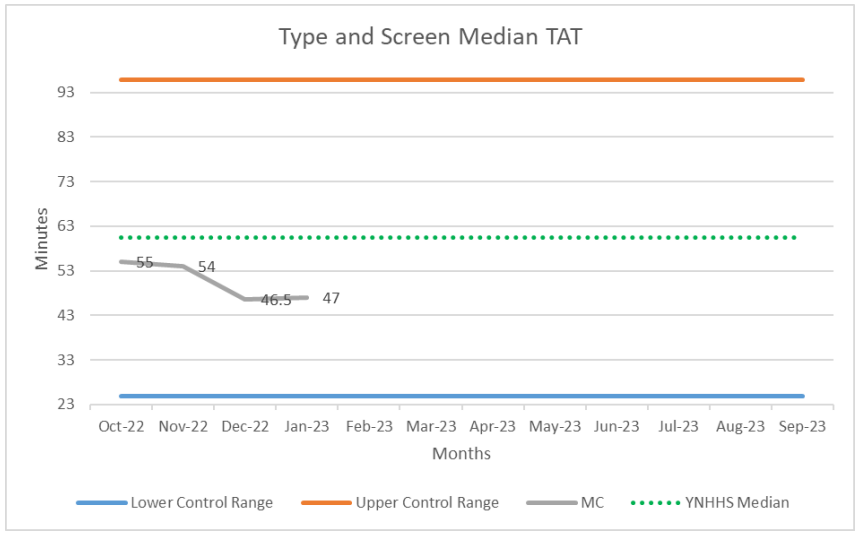
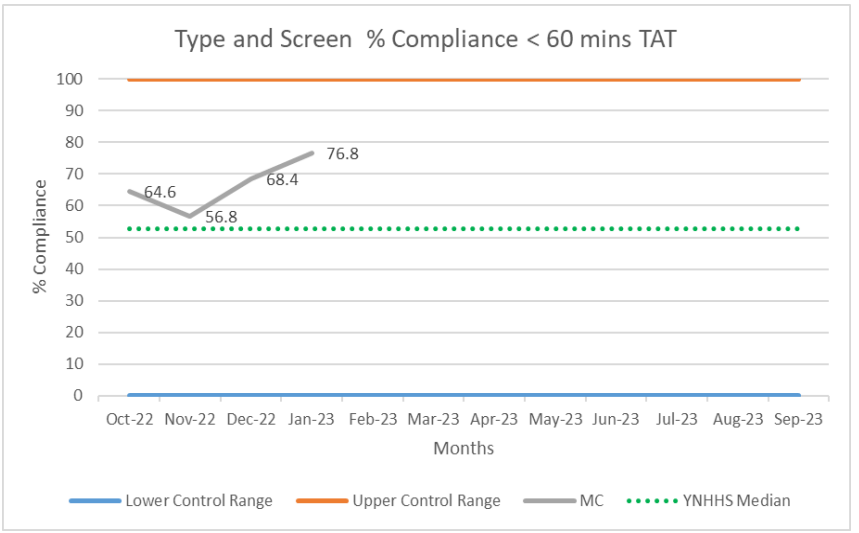
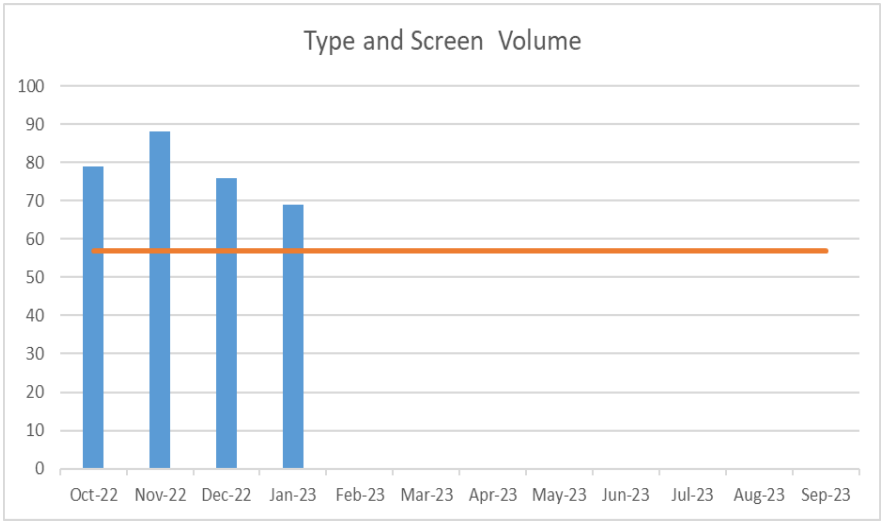
# Milford Campus – Type and Screen ED TAT




Yale NewHaven Health Bridgeport Hospital

# Milford Campus
# RBC

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 109 | 96 | 94 | 73 | $67,663.70 |
| Wasted | 0 | 0 | 0 | 0 | $0.00 |
| Total | 109 | 96 | 94 | 73 | $67,663.70 |

Yale NewHaven Health Bridgeport Hospital

# Milford Campus
# Cryo

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 1 | 1 | 0 | 1 | $663.00 |
| Wasted | 1 | 0 | 0 | 0 | $331.50 |
| Total | 2 | 1 | 0 | 1 | $994.50 |

Yale NewHaven Health Bridgeport Hospital

# Milford Campus
# FFP

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| **Transfusion** | 4 | 4 | 6 | 0 | $151.20 |
| **Wasted** | 0 | 0 | 0 | 2 | $0.00 |
| **Total** | 4 | 4 | 6 | 2 | $151.20 |

Yale NewHaven Health Bridgeport Hospital

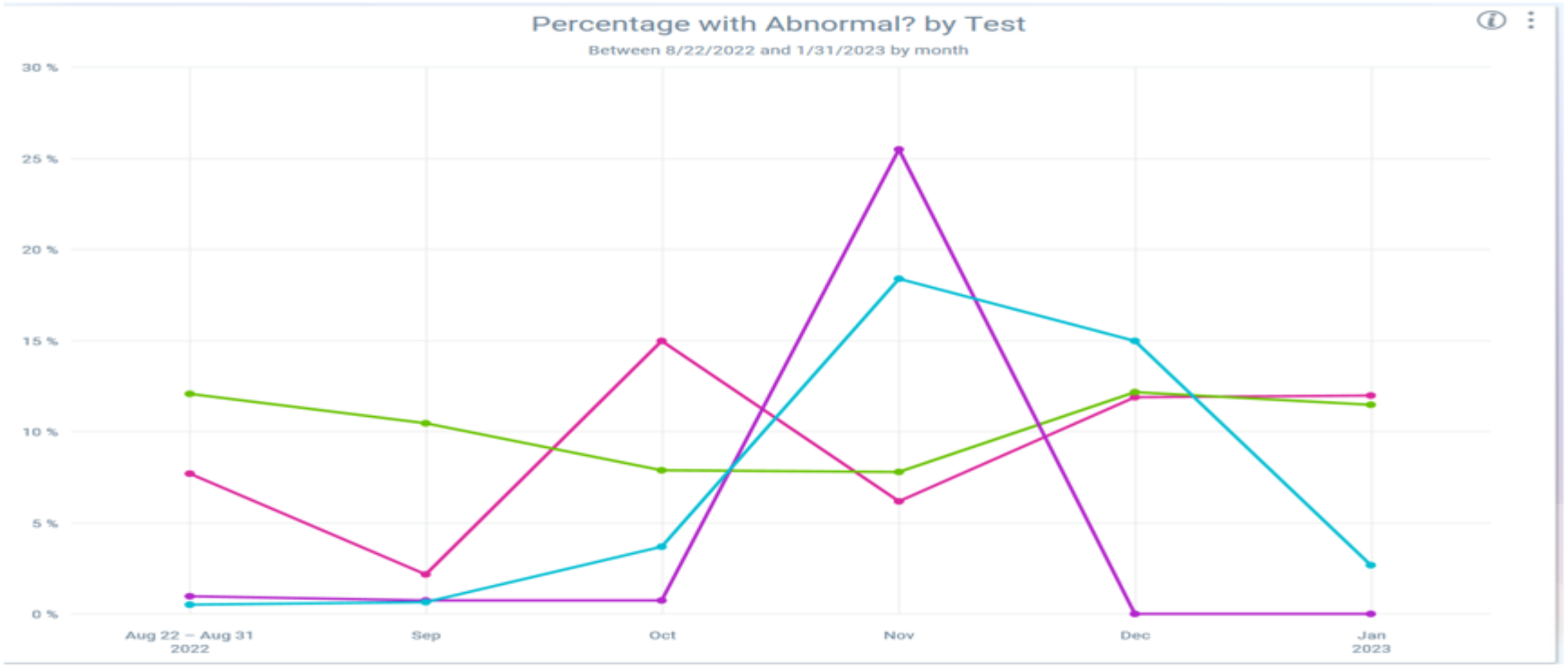
# Milford Campus
# Platelet Discarded

| | Oct | Nov | Dec | Jan | Total Amount |
|---|---|---|---|---|---|
| Transfusion | 3 | 8 | 6 | 3 | $11,441.00 |
| Discarded | 11 | 7 | 9 | 17 | $18,171.00 |
| Total | 14 | 15 | 15 | 20 | $29,612.00 |
| % Discarded | 78.57% | 46.67% | 60.00% | 80% | |
| Discarded/Day | 0.3548 | 0.2258 | 0.2903 | 0.566666667 | $586.16 |

Yale NewHaven Health Bridgeport Hospital

# Milford Campus Molecular Dashboard

## Milford Molecular Dashboard — January 2023




| Date | Tests | % Positivity | Derived Baseline | Environment Monitoring | Physician Feedback | Epidemiological Trends | Evaluation Notes | Corrective Action (if needed) |
|---|---|---|---|---|---|---|---|---|
| 23-Jan | SARS-CoV-2 | 11.5 | 0-22% | Negative | None | None | None | None |
| 23-Jan | Group A Strep | 12 | 0-19% | Negative | None | None | None | None |
| 23-Jan | Flu A/B | 0 | 0-7% | Negative | None | None | None | None |
| 23-Jan | Flu/RSV | 2.7 | 0-14% | Negative | None | None | None | None |

Yale NewHaven Health Bridgeport Hospital

# CRSQ Report Out

Committee of Regulatory, Safety, & Quality

January 2023

## Bridgeport Hospital

## Department of Laboratory Medicine

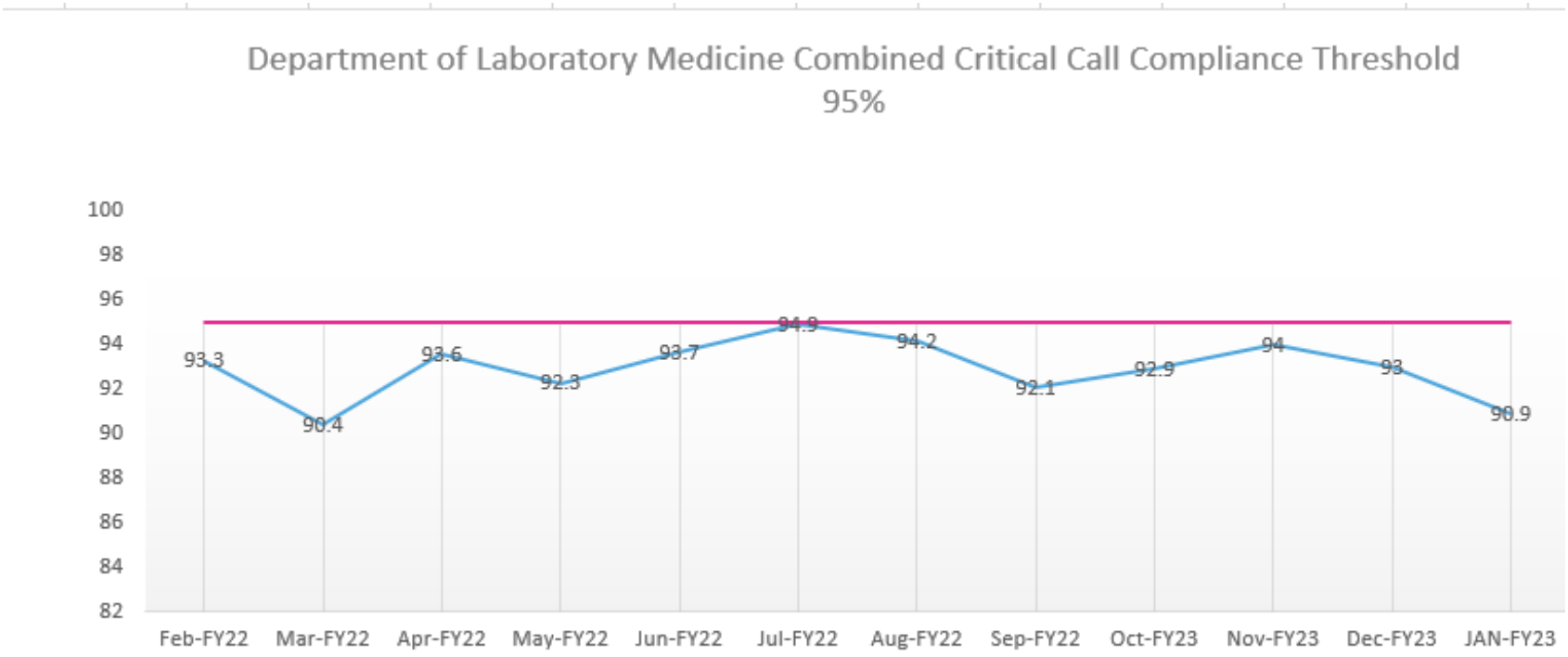
Teodorico Lee MPH, Christine Minerowicz M.D., Edward Snyder M.D.,
Laura Buhlmann M.S., Melissa Morales B.A.

| | |
|---|---|
| **SMART Aim**<br>*Specific-Measureable-Actionable-Relevant-Timely* | Increase the critical result notification compliance with our 30-minute goal to 95% at Bridgeport Hospital 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.<br>• We are currently at **90.9%** compliance as a department. |
| **Key drivers**<br>*measureable processes impacting the outcome* | Decrease the time from result verification to communication log completion.<br>• Increase performance of correct workflow (verify result first and then notify provider).<br>• Timely communication of outpatient critical values |
| **Interventions**<br>*actions/changes necessary to impact key drivers* | Standardize critical call list workflow<br>• Provided re-education and tips and tricks for the correct workflow.<br>• Identified a process to streamline outpatient critical calls (work with specific practices with known notification issues). |
| **Results***<br>*accomplishments, modifications, barriers* | Accomplishments<br>• July 2022 had a 94.9% compliance (highest in the12 month period of Feb 2022-Jan 2023).<br>• Department of Laboratory Medicine averages approximately 1900 critical calls per month. |

Note: There is an additional system project to standardize critical result notification workflow.
- Will allow reports and metrics to be standardized as well

Yale NewHaven Health Bridgeport Hospital

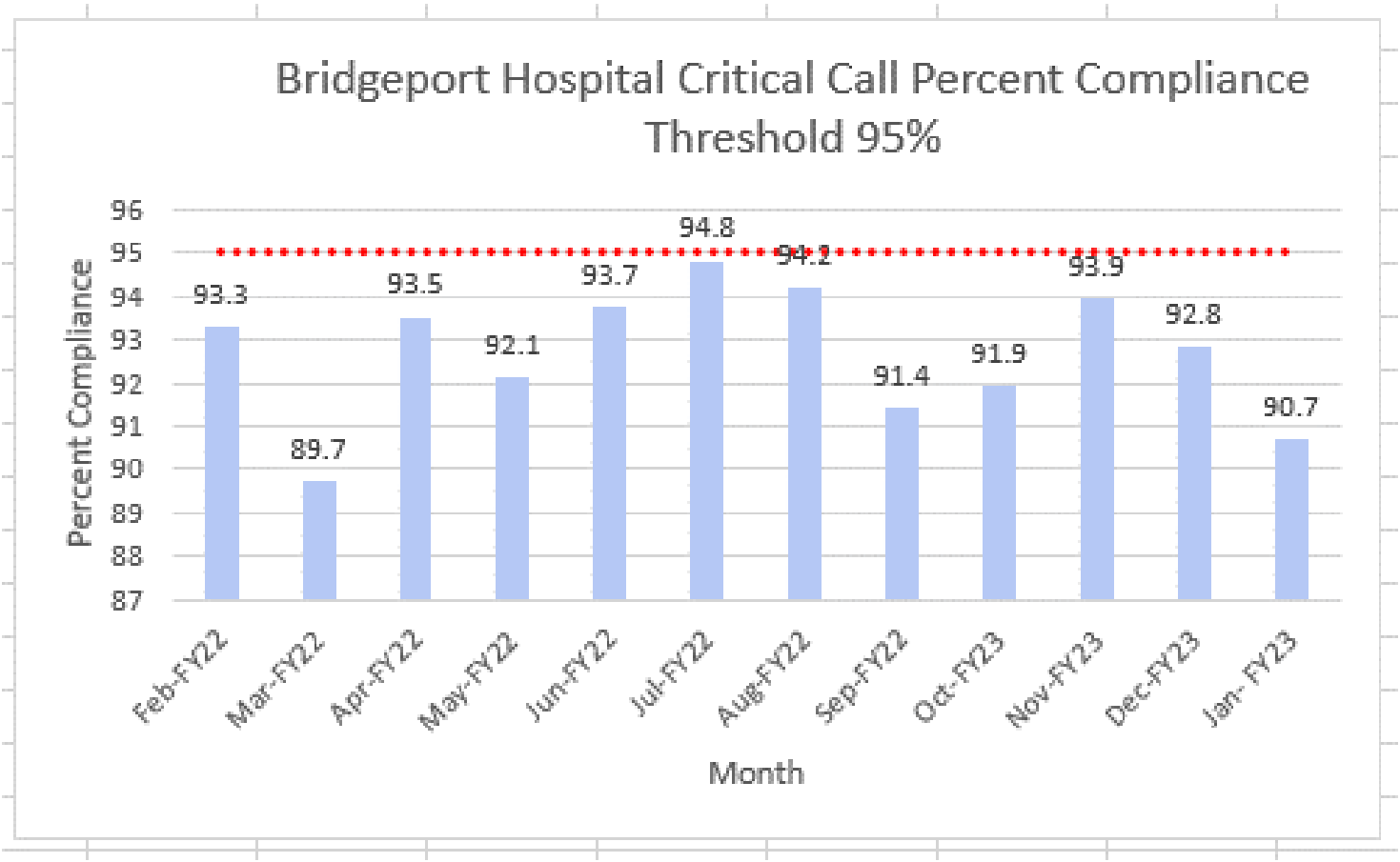
# Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 91.4% (cumulatively) 2/1/2022-1/31/2023




Yale NewHaven Health Bridgeport Hospital

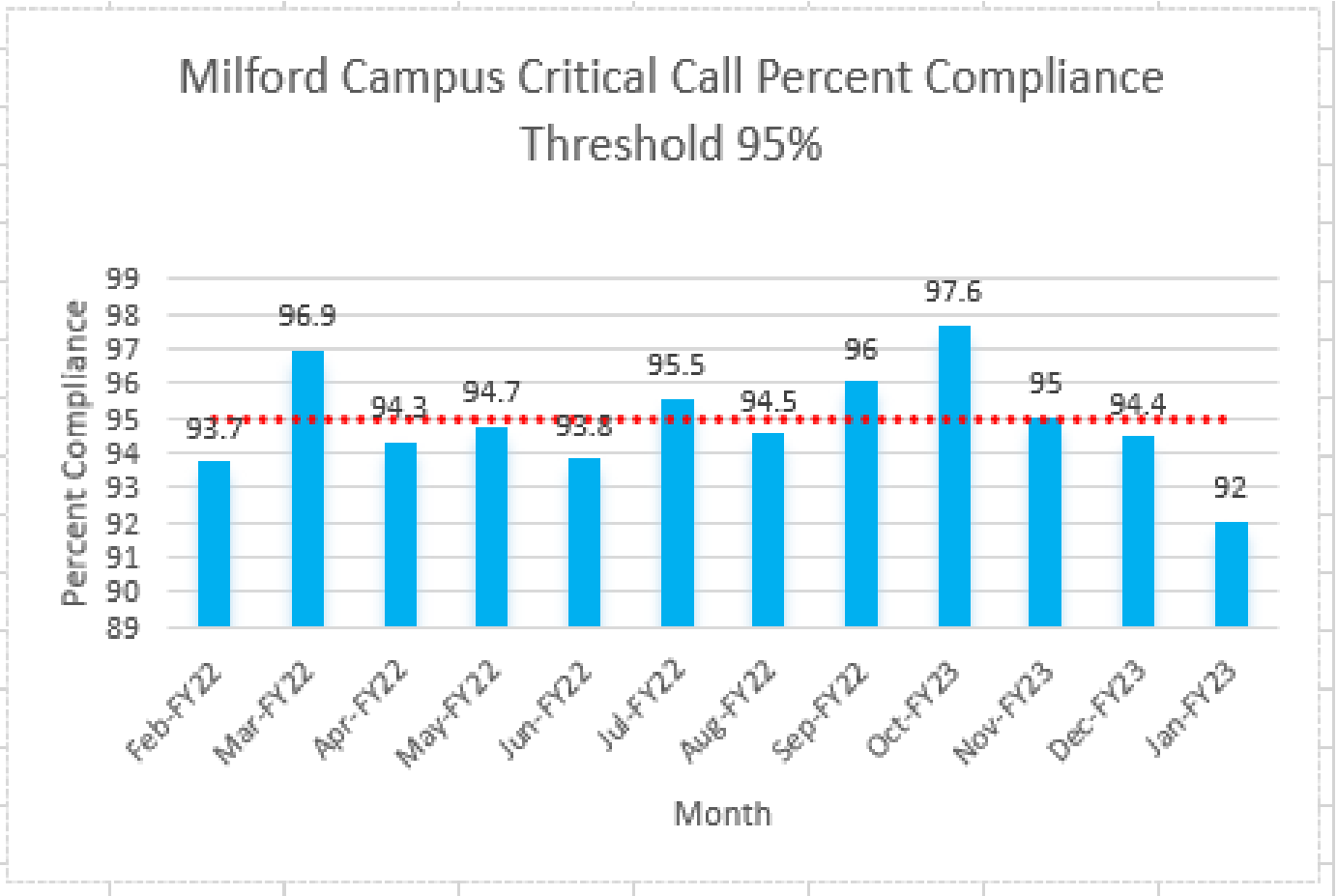
# Bridgeport Campus Critical Call Percent Compliance 91.3%

## 2/1/2022-1/31/2023




Yale NewHaven Health Bridgeport Hospital

# Milford Campus Critical Call Percent Compliance 92.4%
# 2/1/2022-1/31/2023




Yale NewHaven Health Bridgeport Hospital

Yale NewHaven Health

# CRSQ Report Out

Committee of Regulatory, Safety, & Quality

2/22/2023

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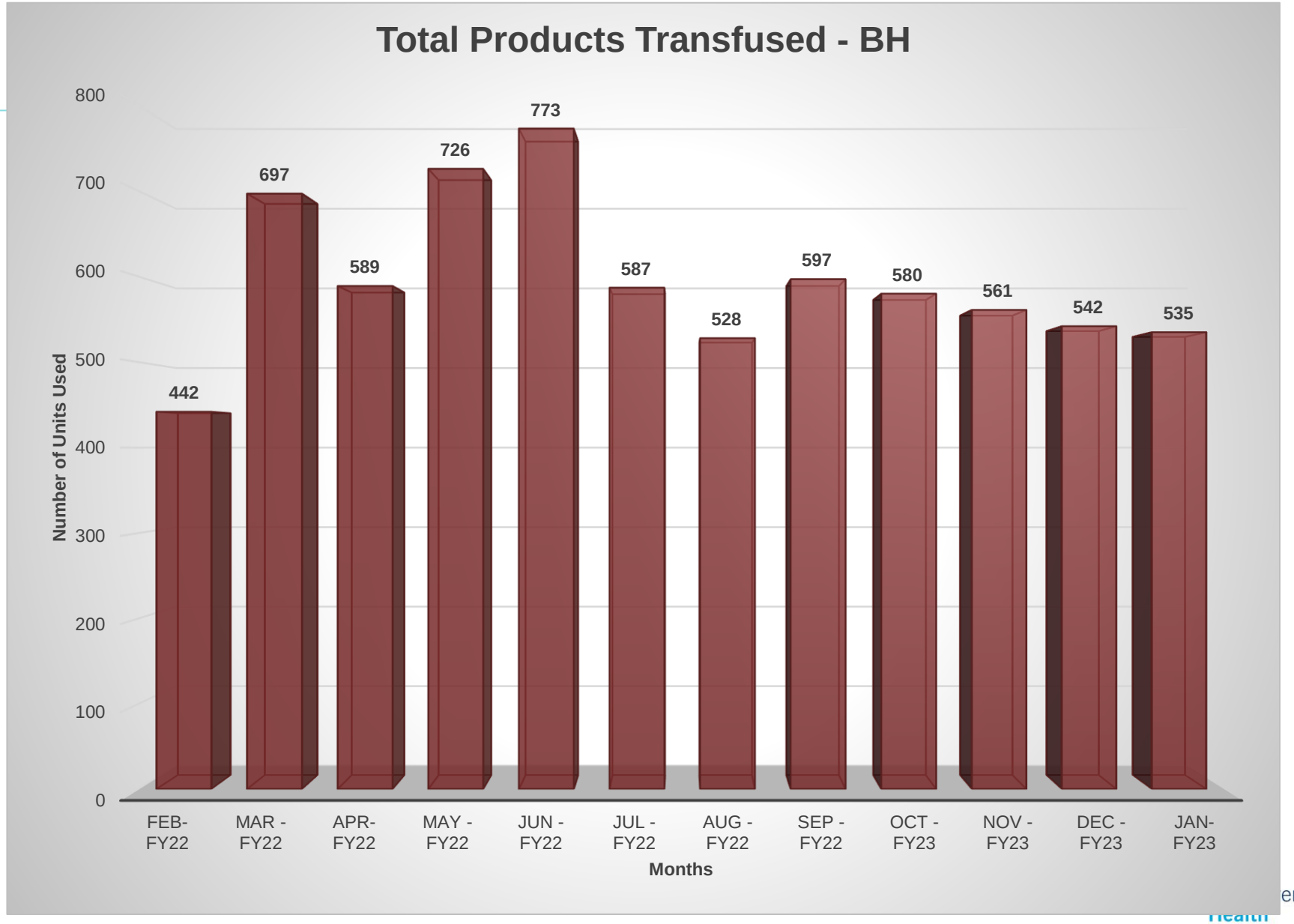
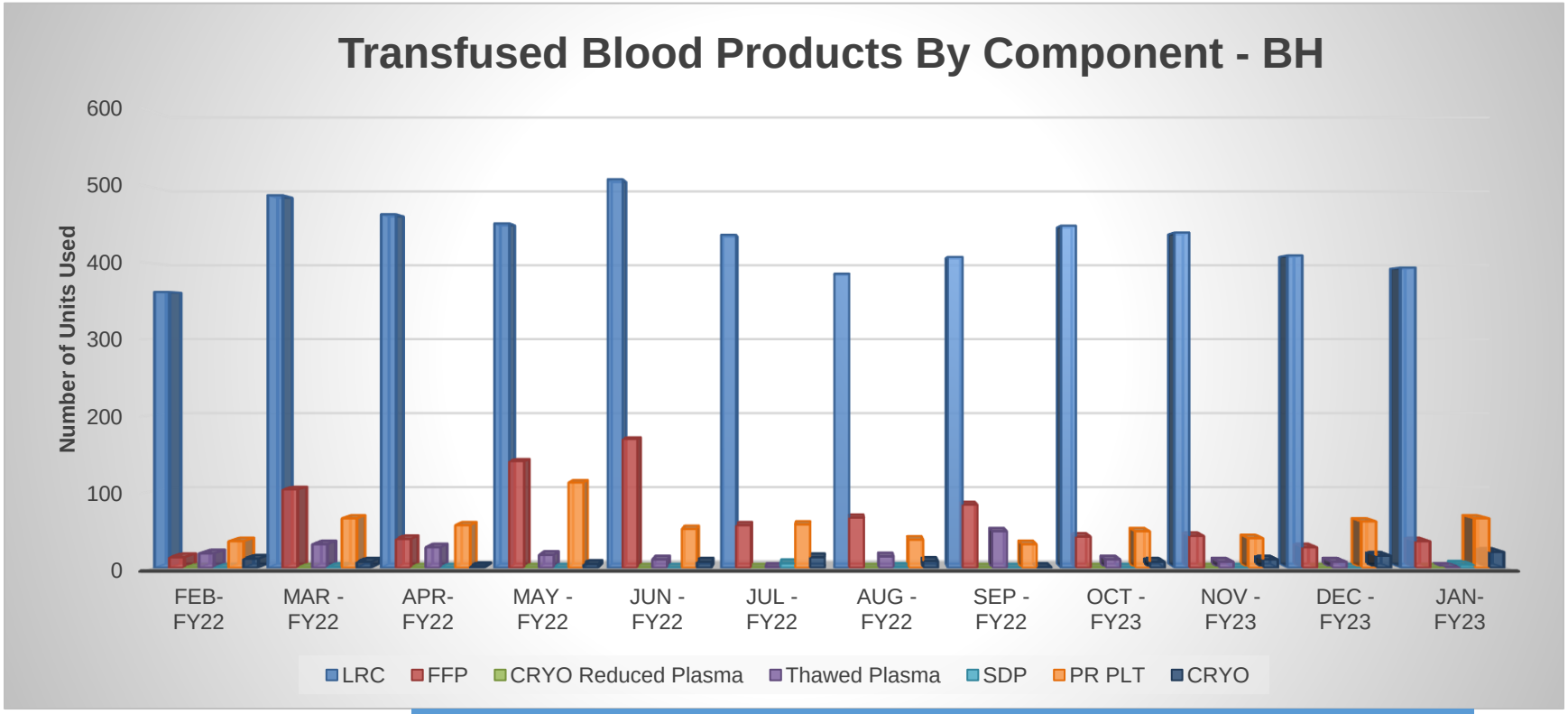
## Bridgeport Hospital

## Laboratory Blood Bank

Edward Snyder MD, Christine Minerowicz MD, Lisa Krause, Melissa Morales, Teodorico Lee, Laura Buhlmann



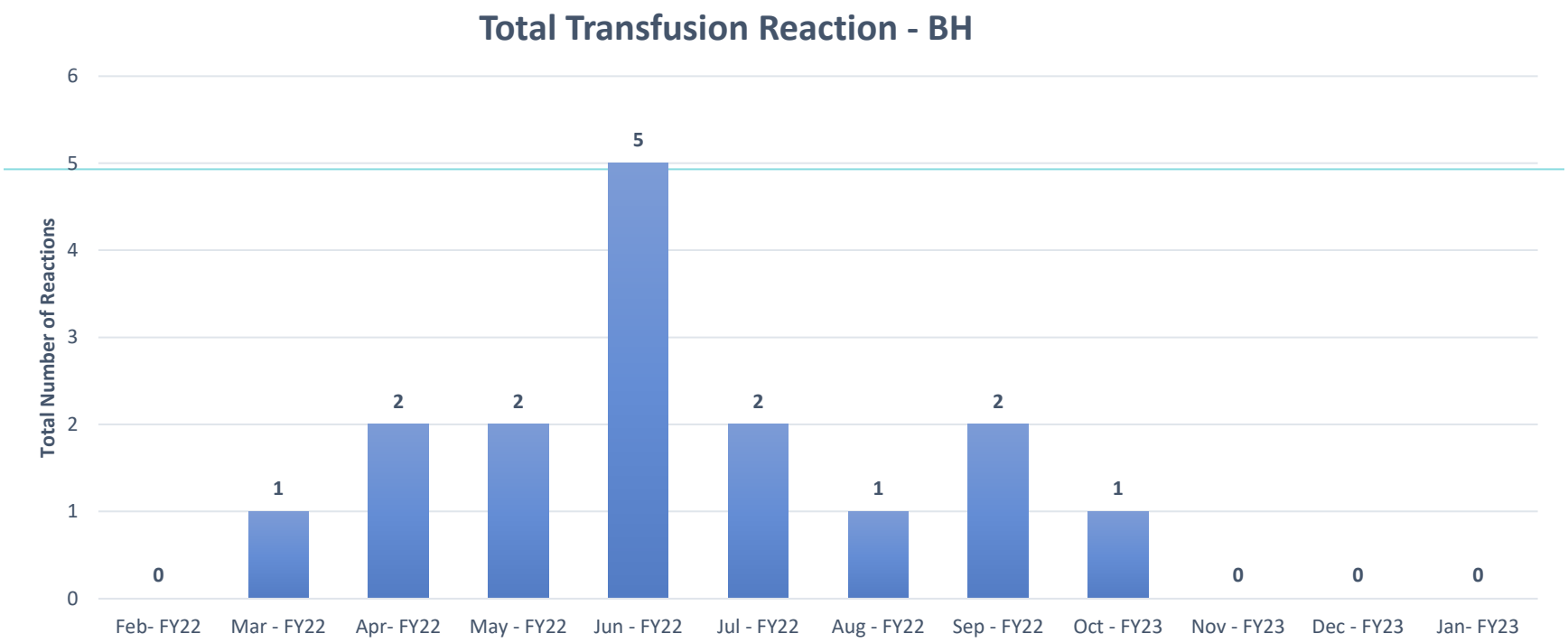

PI.01.01.01 EP6




| | LRC | FFP | CRYO Reduced Plasma | Thawed Plasma | SDP | PR PLT | CRYO |
|---|---|---|---|---|---|---|---|
| Feb- FY22 | 362 | 14 | 0 | 19 | 0 | 35 | 12 |
| Mar - FY22 | 489 | 103 | 0 | 31 | 1 | 65 | 8 |
| Apr- FY22 | 464 | 38 | 0 | 27 | 0 | 56 | 2 |
| May - FY22 | 452 | 140 | 0 | 17 | 0 | 112 | 5 |
| Jun - FY22 | 510 | 169 | 0 | 11 | 0 | 51 | 8 |
| Jul - FY22 | 437 | 56 | 0 | 1 | 6 | 57 | 14 |
| Aug - FY22 | 386 | 66 | 0 | 15 | 1 | 37 | 9 |
| Sep - FY22 | 408 | 83 | 0 | 48 | 0 | 31 | 1 |
| Oct - FY23 | 449 | 41 | 0 | 11 | 0 | 48 | 8 |
| Nov - FY23 | 440 | 42 | 0 | 8 | 0 | 39 | 11 |
| Dec - FY23 | 410 | 27 | 0 | 8 | 0 | 61 | 16 |
| Jan- FY23 | 394 | 35 | 0 | 1 | 4 | 65 | 21 |

PI.01.01.01 EP6

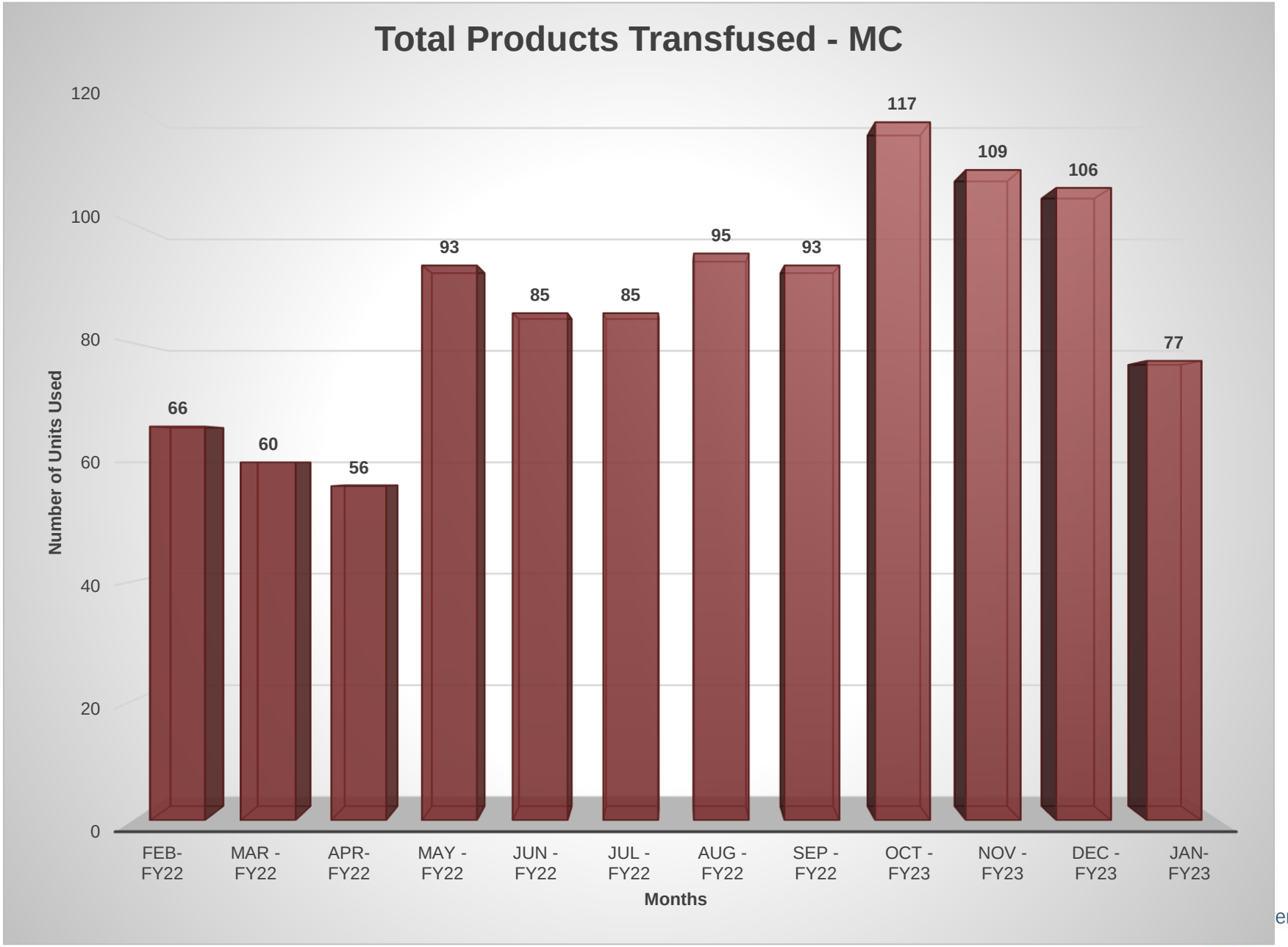
Yale NewHaven Health Bridgeport Hospital




| | Allergic | Febrile | Anaphylactic | Taco | Trali | Hemolytic | Other | Total |
|---|---|---|---|---|---|---|---|---|
| Feb- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0 |
| Mar - FY22 | 0.00 | (1) 0.14 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1 |
| Apr- FY22 | 0.00 | (2) 0.33 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2 |
| May - FY22 | (1) 0.13 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | (1) 0.13 | 2 |
| Jun - FY22 | (2) 0.22 | (3) 0.33 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5 |
| Jul - FY22 | (1) 0.2 | (1) 0.2 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2 |
| Aug - FY22 | (1) .19 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1 |
| Sep - FY22 | 0.00 | (1) .17 | 0.00 | 0.00 | 0.00 | 0.00 | (1) .17 | 2 |
| Oct - FY23 | (1) .17 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1 |
| Nov - FY23 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0 |
| Dec - FY23 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0 |
| Jan- FY23 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0 |

PI.01.01.01 EP7

Yale NewHaven Health Bridgeport Hospital

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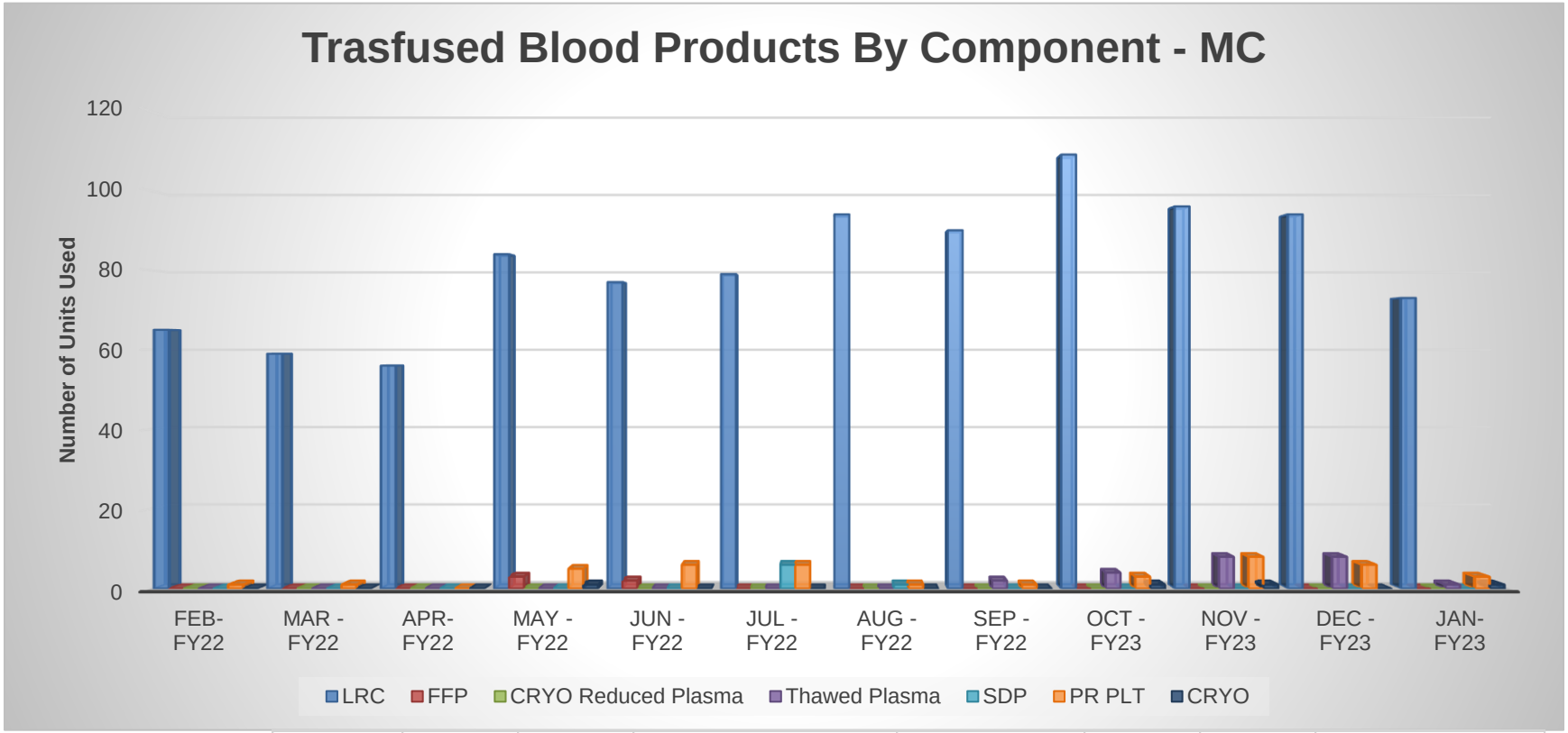


| | LRC | FFP | CRYO Reduced Plasma | Thawed Plasma | SDP | PR PLT | CRYO |
|---|---|---|---|---|---|---|---|
| Feb- FY22 | 65 | 0 | 0 | 0 | 0 | 1 | 0 |
| Mar - FY22 | 59 | 0 | 0 | 0 | 0 | 1 | 0 |
| Apr- FY22 | 56 | 0 | 0 | 0 | 0 | 0 | 0 |
| May - FY22 | 84 | 3 | 0 | 0 | 0 | 5 | 1 |
| Jun - FY22 | 77 | 2 | 0 | 0 | 0 | 6 | 0 |
| Jul - FY22 | 79 | 0 | 0 | 0 | 6 | 6 | 0 |
| Aug - FY22 | 94 | 0 | 0 | 0 | 1 | 1 | 0 |
| Sep - FY22 | 90 | 0 | 0 | 2 | 0 | 1 | 0 |
| Oct - FY23 | 109 | 0 | 0 | 4 | 0 | 3 | 1 |
| Nov - FY23 | 96 | 0 | 0 | 8 | 0 | 8 | 1 |
| Dec - FY23 | 94 | 0 | 0 | 8 | 0 | 6 | 0 |
| Jan- FY23 | 73 | 0 | 0 | 1 | 0 | 3 | 1 |

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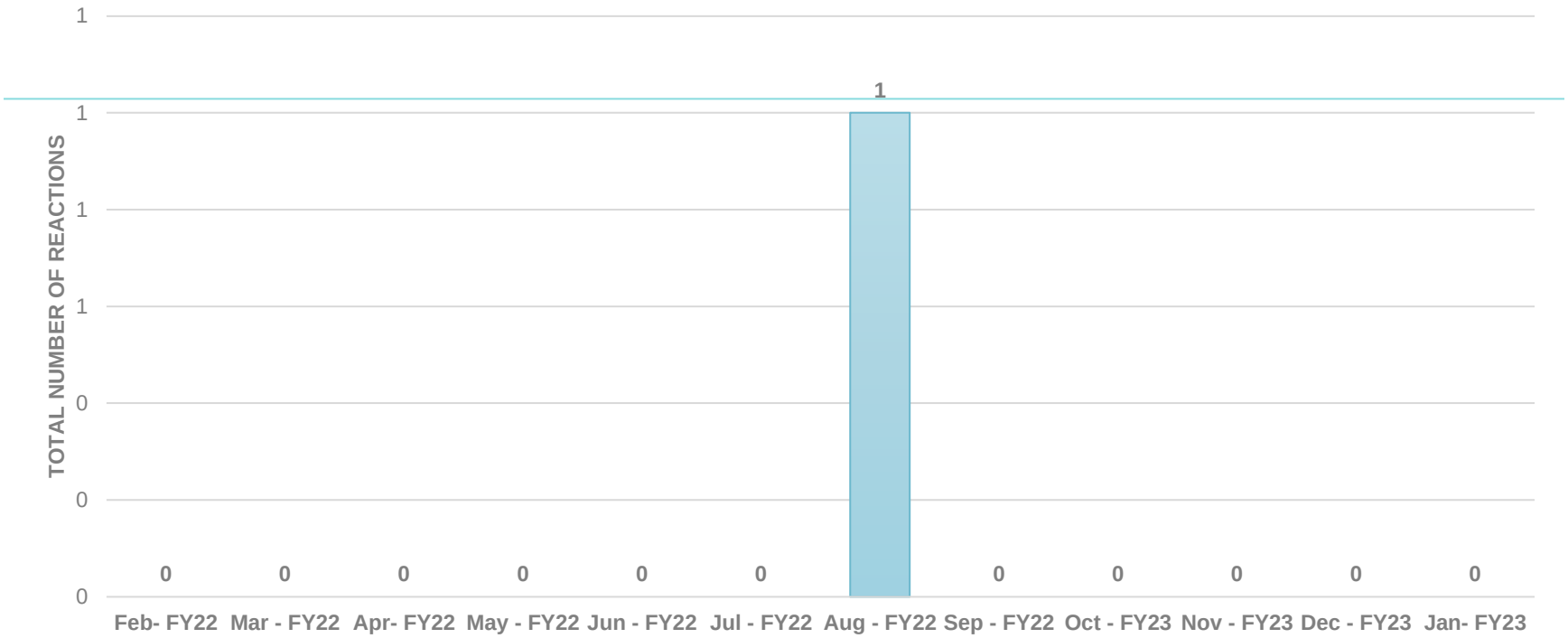
## Total Transfusion Reaction - MC




| | Allergic | Febrile | Anaphylactic | Taco | Trali | Hemolytic | Other |
|---|---|---|---|---|---|---|---|
| Nov- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Dec- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Jan- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Feb- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Mar - FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Apr- FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| May - FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Jun - FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Jul - FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Aug - FY22 | 0.00 | (1) 1.05 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Sep - FY22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Oct - FY23 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

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