Yale NewHaven Health Bridgeport Hospital

Laboratory Medicine – September 2023

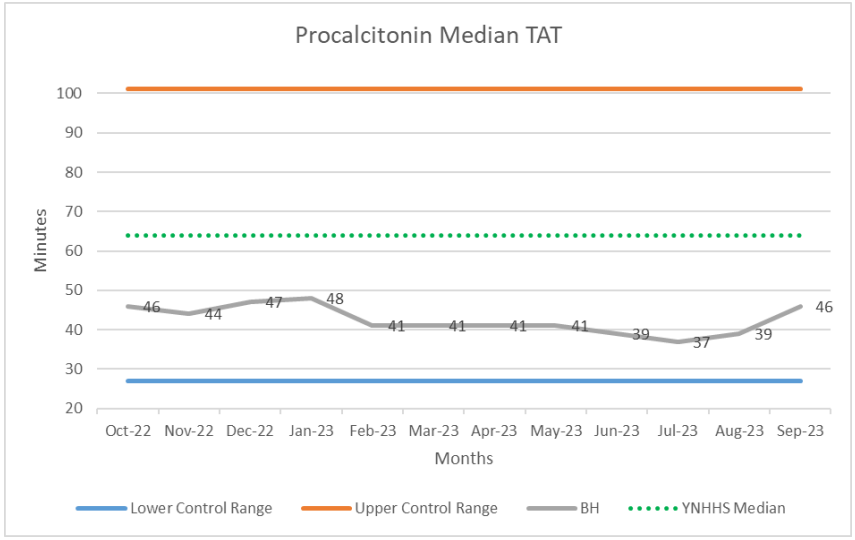
October 25, 2023

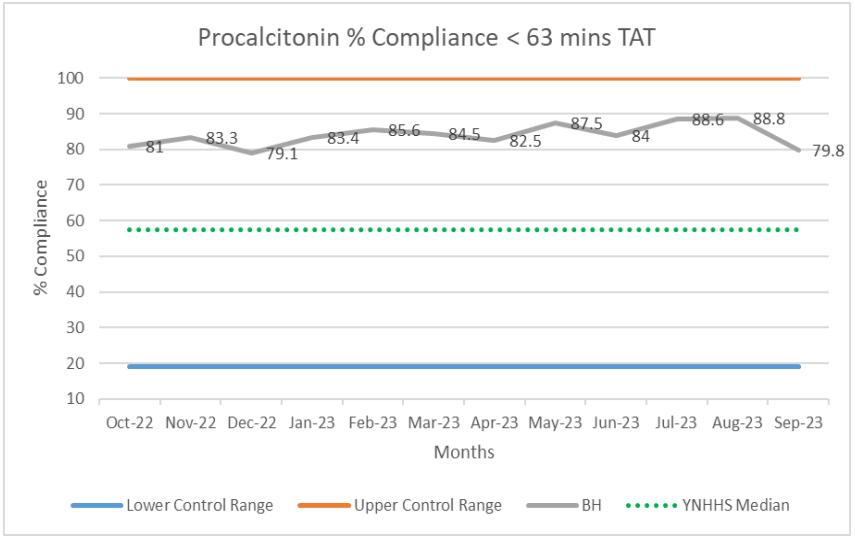
Bridgeport and Milford Campuses Turnaround Time Goals

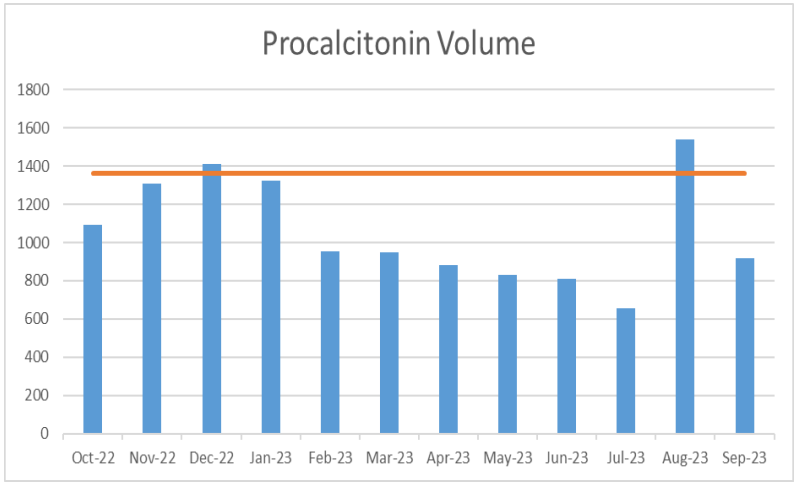
- Mean determined from median TAT across the Yale New Haven Health System delivery networks
  - Bridgeport and Milford Campuses – Bridgeport Hospital, Greenwich Hospital, Lawrence Memorial Hospital, Westerly Hospital, St. Raphael and York Street Campus – Yale New Haven Hospital and Shoreline Medical 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

Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – Procalcitonin

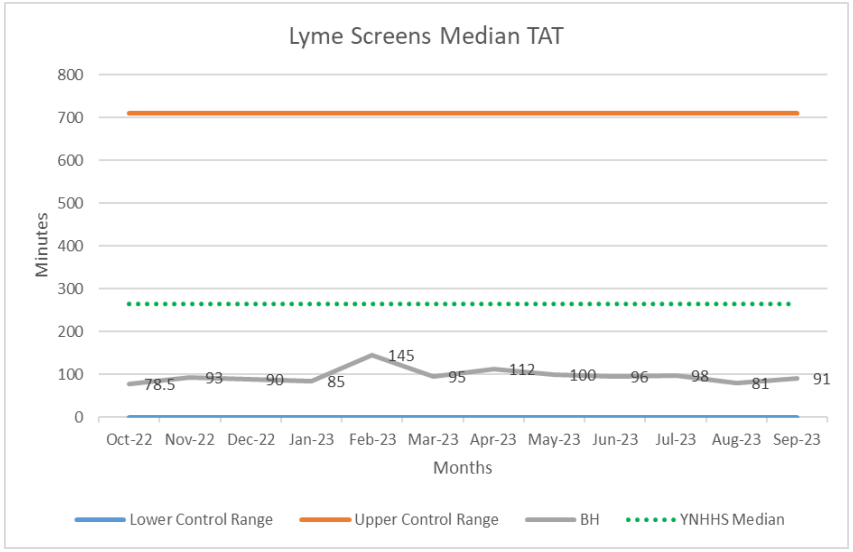


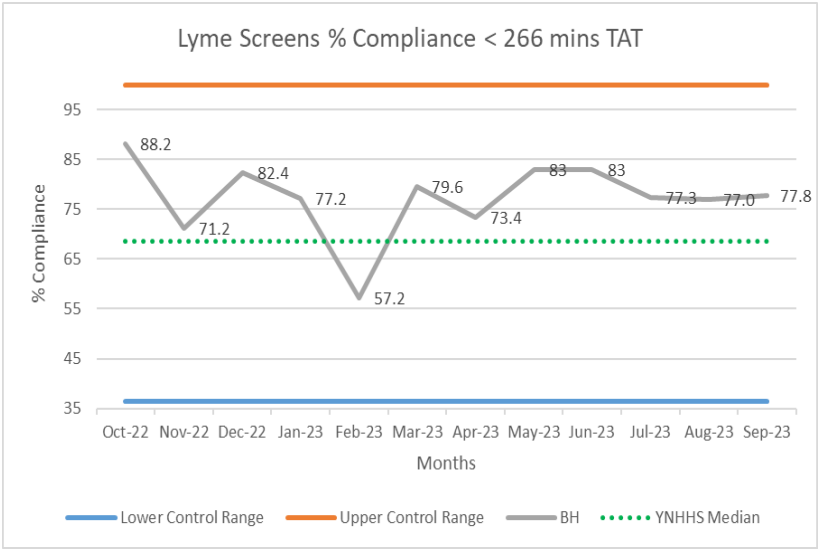


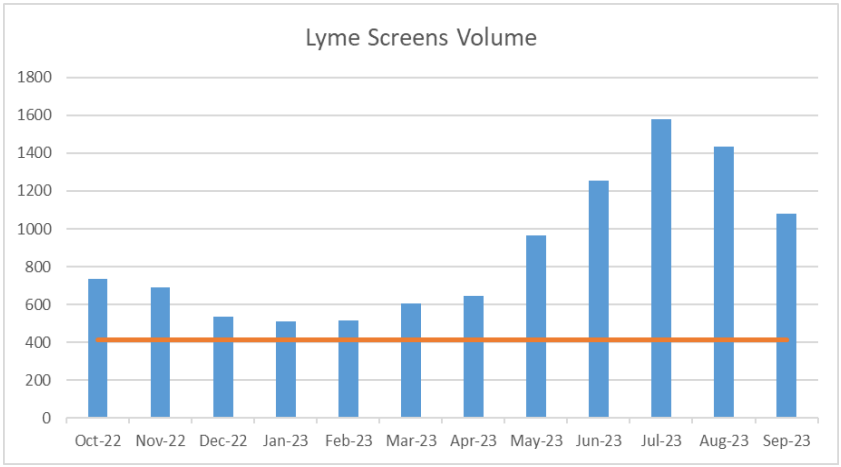


Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – Lyme Screens TAT

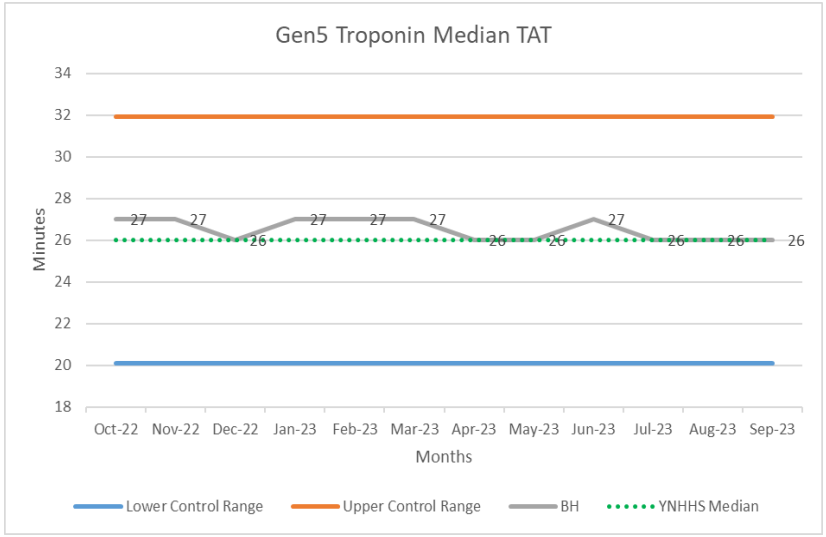


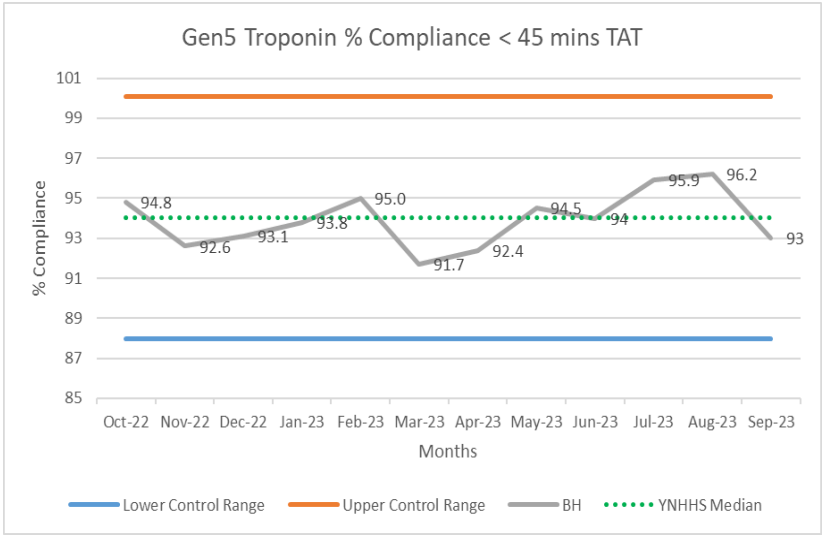


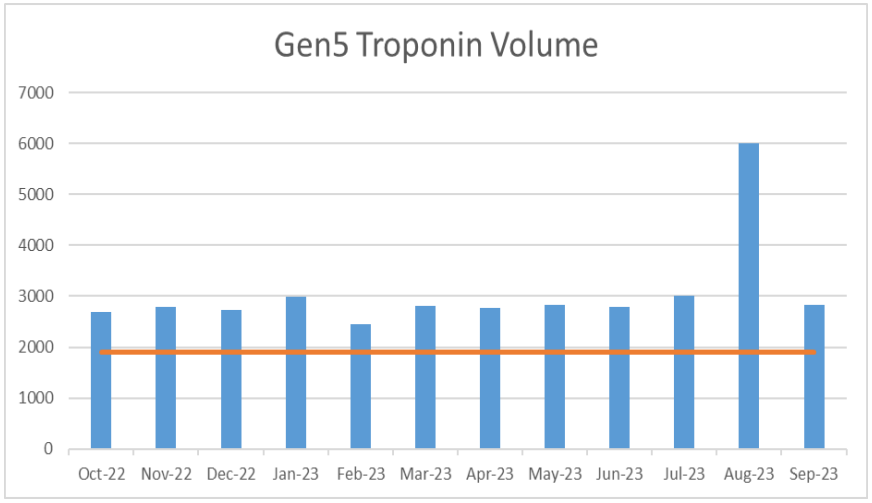


Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – Gen 5 Troponin TAT

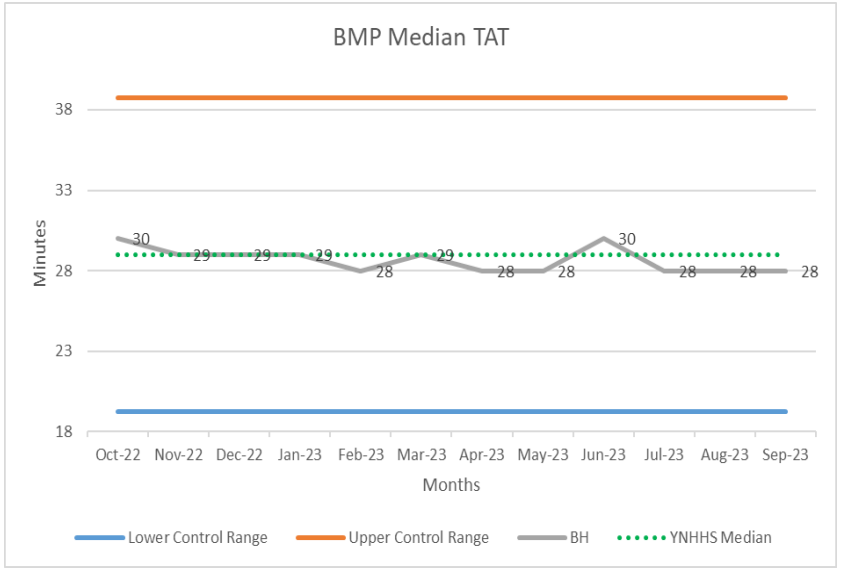


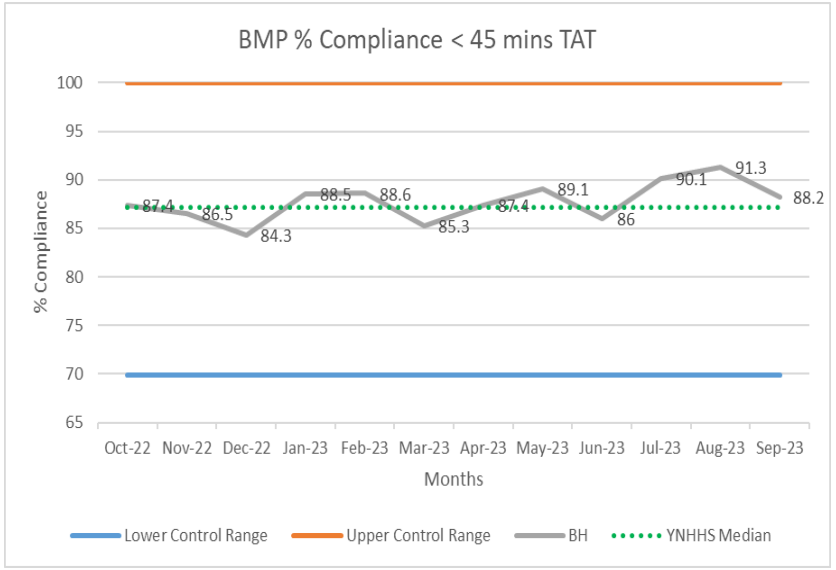


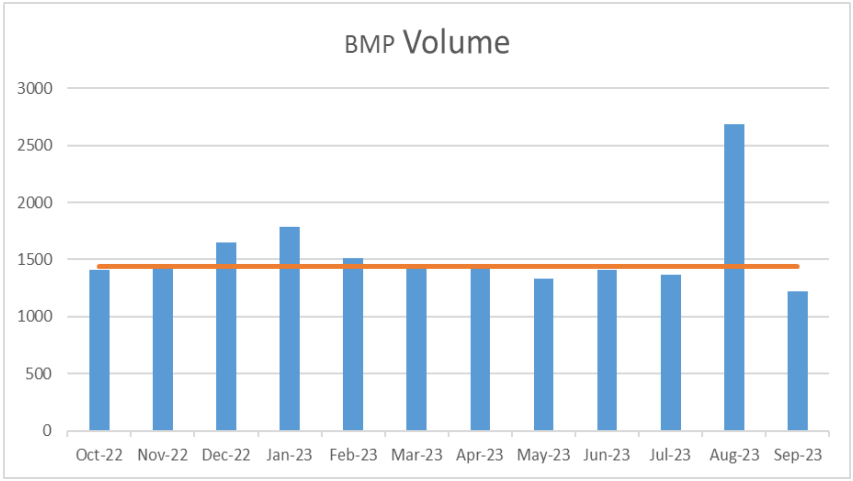


Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT

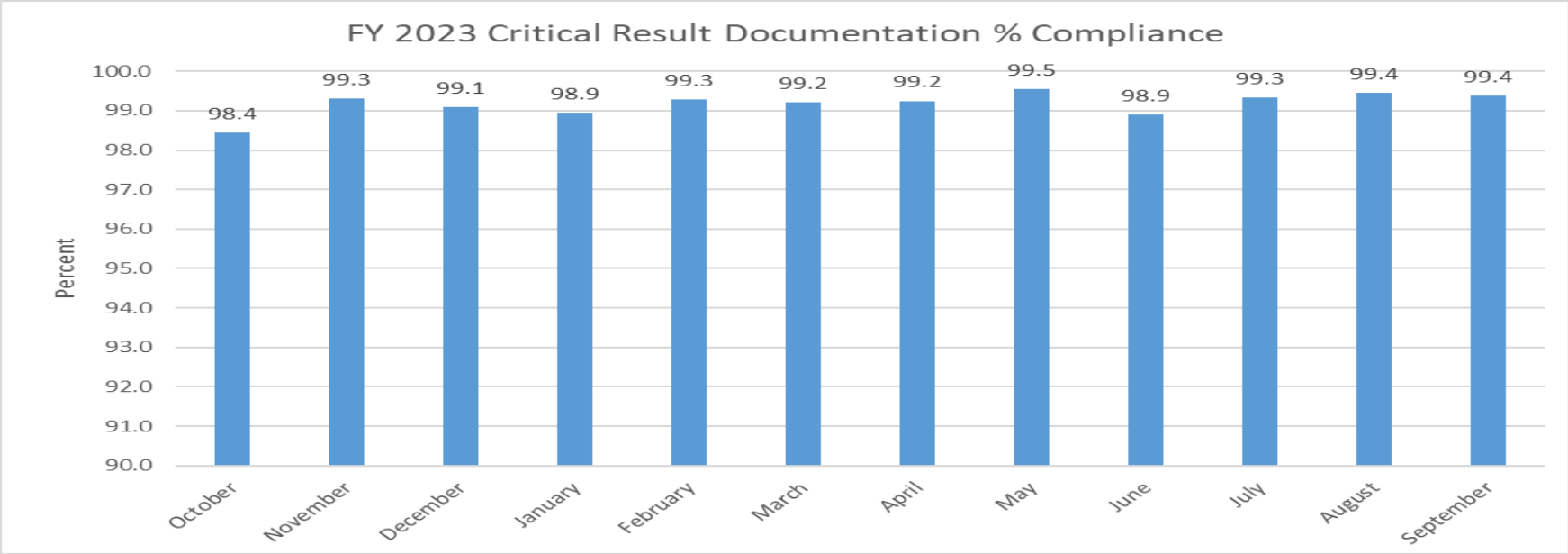






Yale NewHaven Health Bridgeport Hospital

Chemistry & Immunology

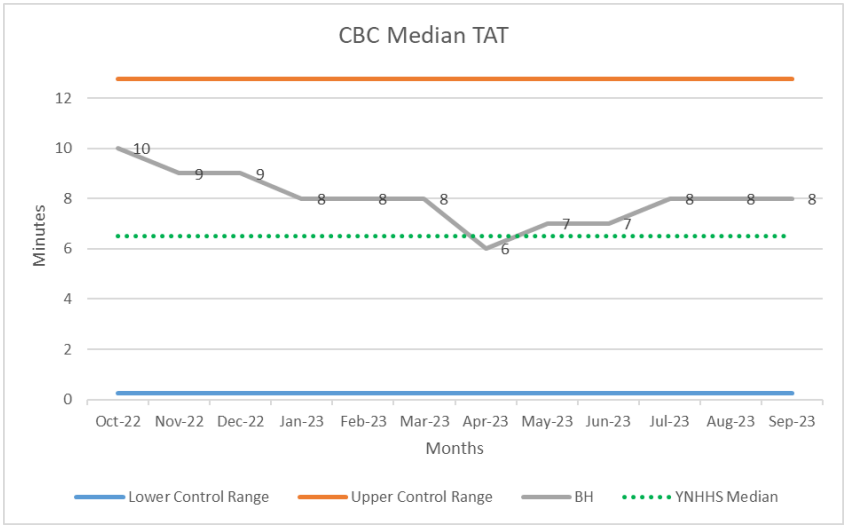


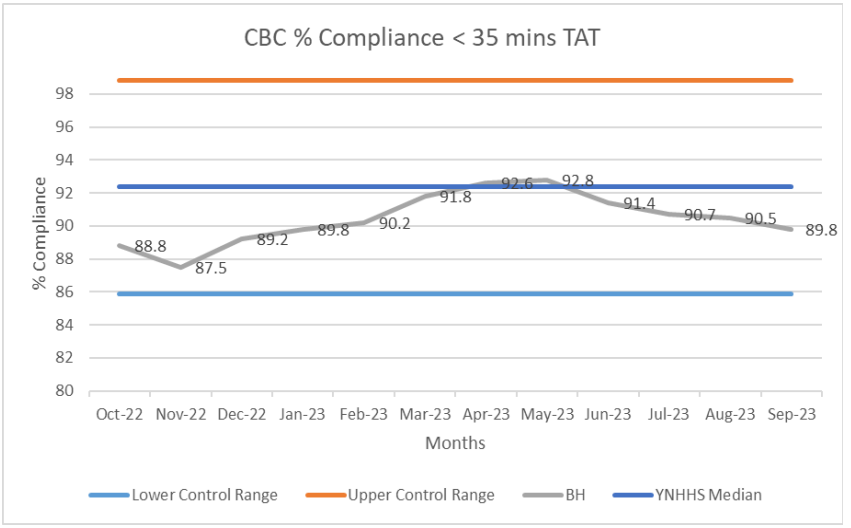
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
n	1415	1425	1418	1509	1241	1391	1328	1330	1351	1344	1257	1272
#compliant	1393	1415	1405	1493	1232	1380	1318	1324	1336	1335	1250	1264
#noncompliant	22	10	13	16	9	11	10	6	15	9	7	8

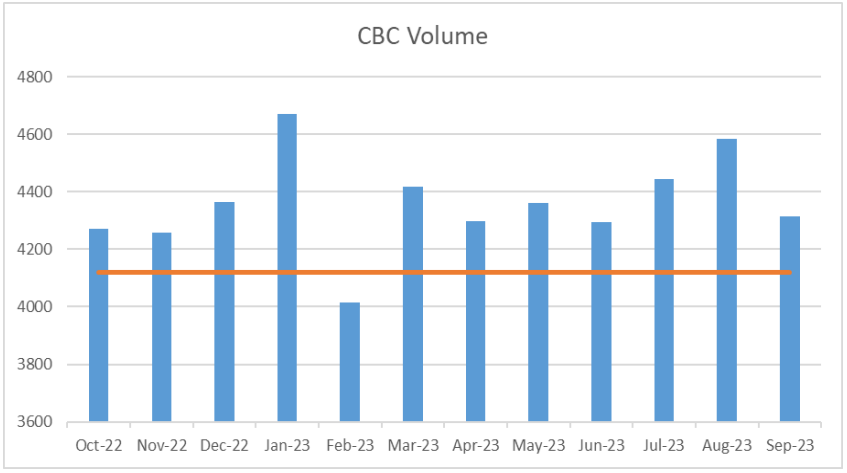
no name	7	1	1	6	4	5	5	2	4	2	4	4
no full name	8	4	1		1	2			3	3		2
no credentials	4	4	1	7	2	1	4	4	4	2		2
incorrect docum.	1	1	10	2	2	1	1		4		1	
incorrect person	2			1						1	2	
not called						2				1		

no name: tech must backspace the field and enter correct name
Each outlier was addressed with individual tech.

Bridgeport Campus – Complete Blood Count (CBC) ED TAT

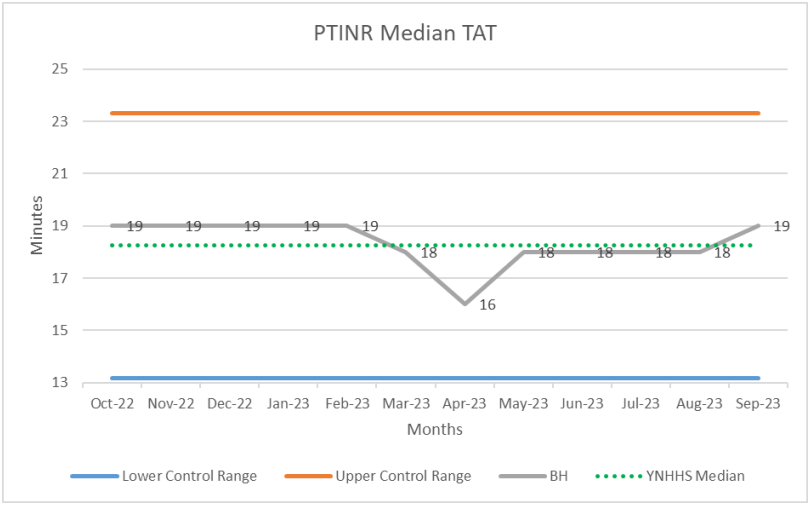


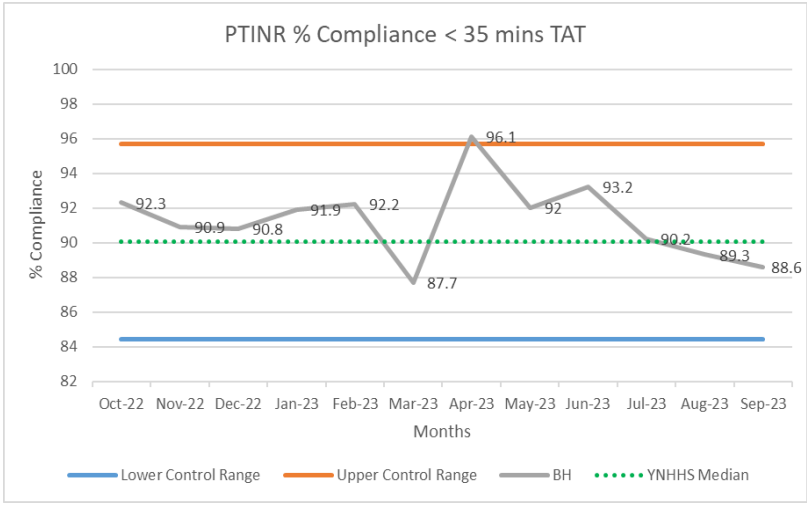


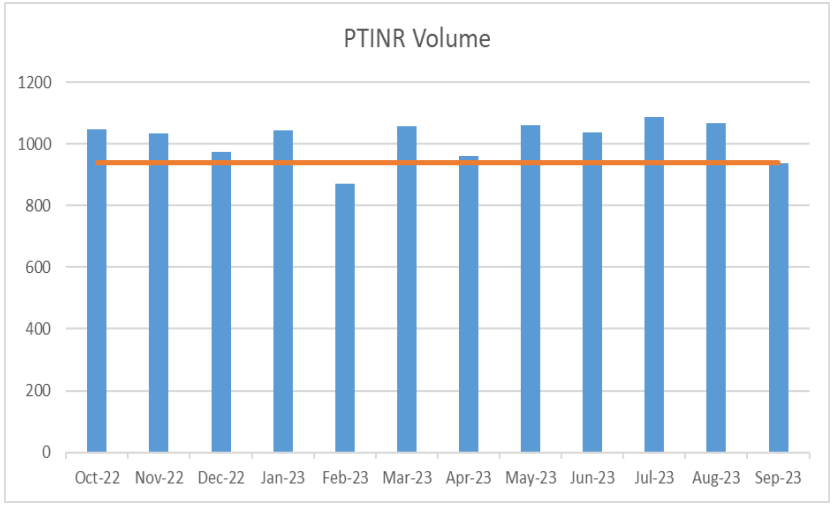


Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – PTINR ED TAT

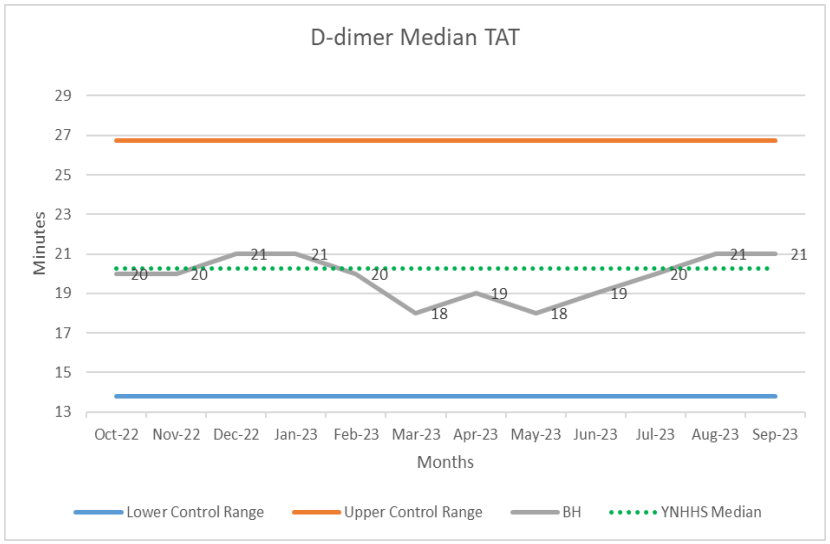


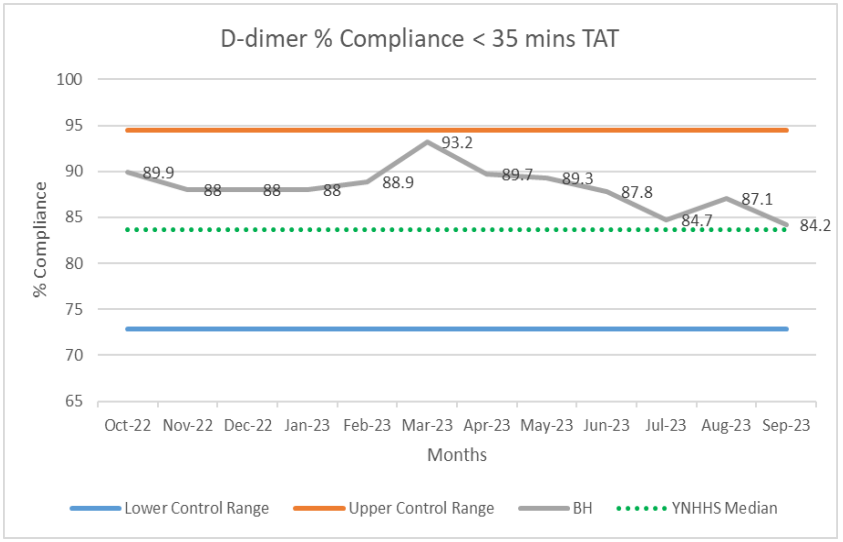


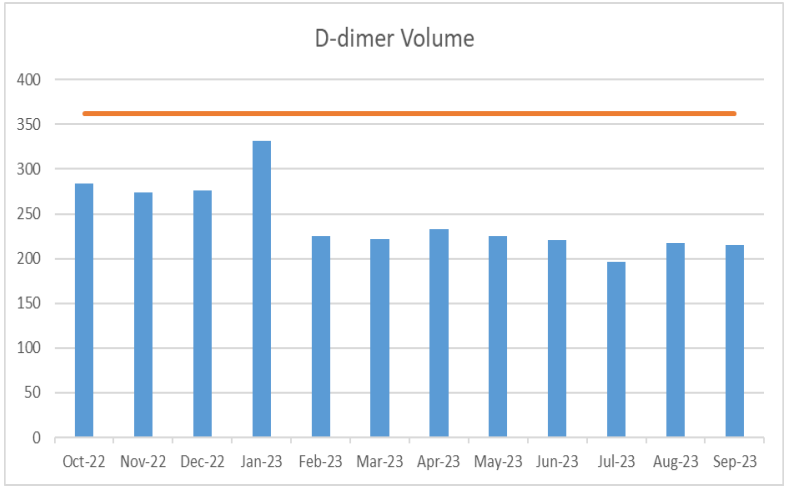


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – D-dimer ED TAT

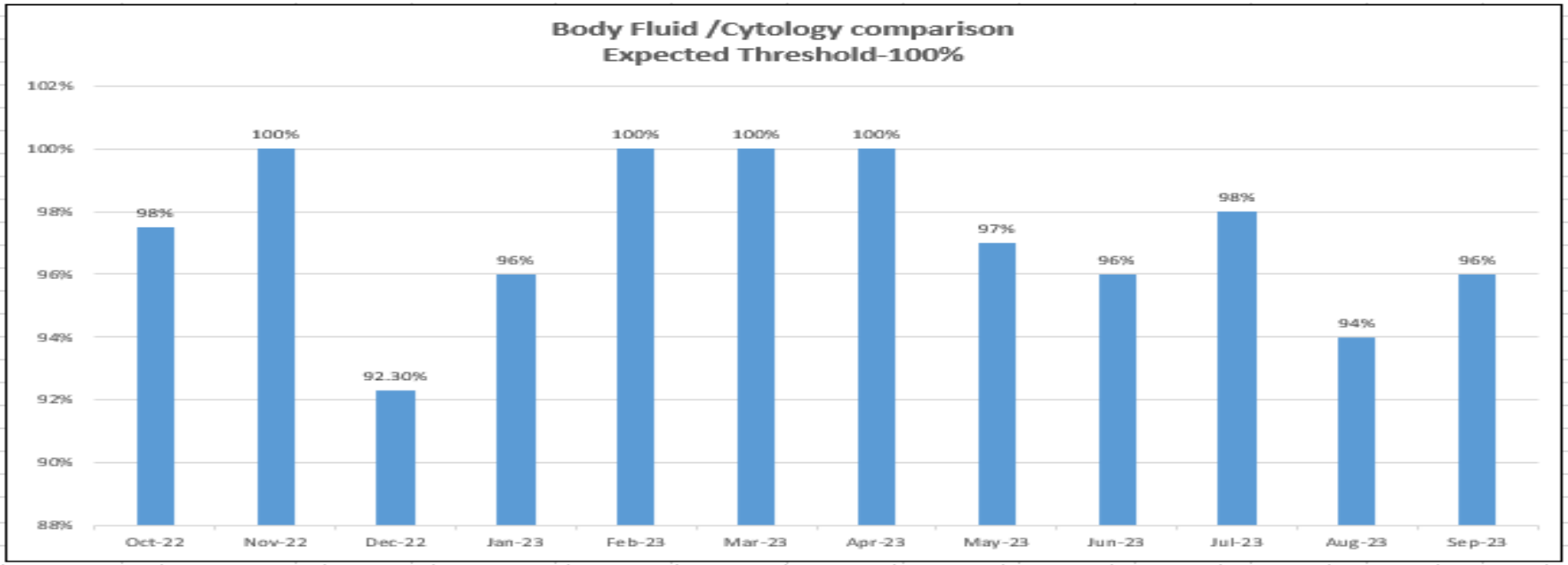






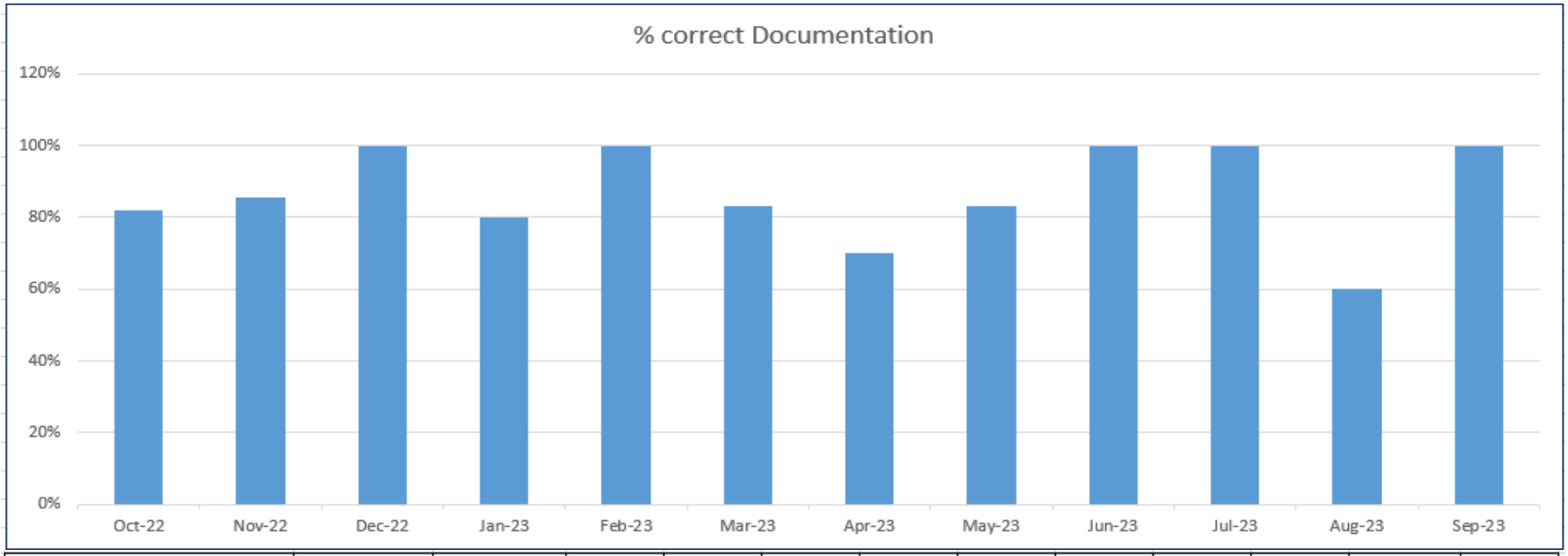
Yale NewHaven Health
Bridgeport Hospital

Aspect of Care



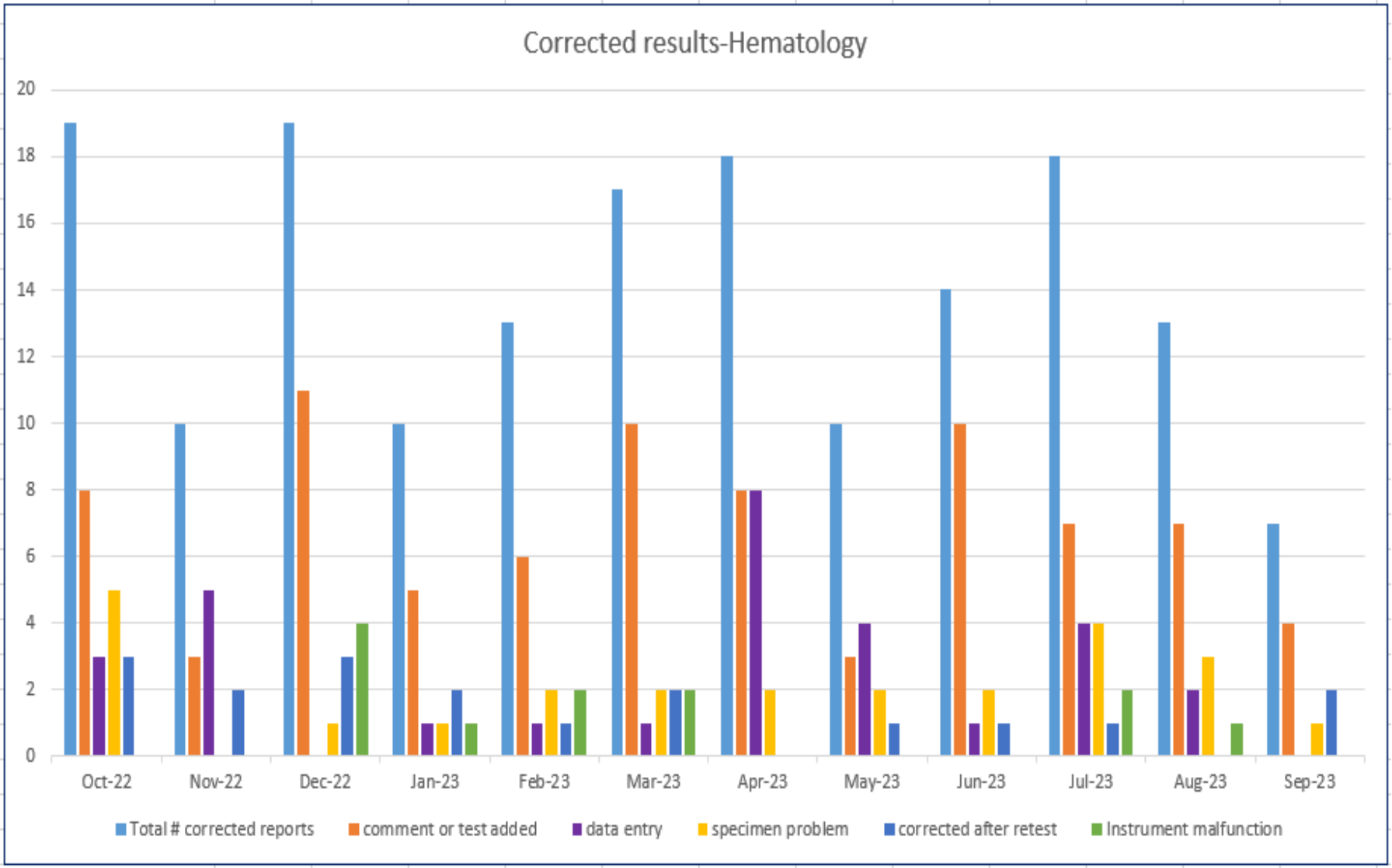
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Total # of Fluids	142	155	128	157	142	175	150	163	135	145	170	148
cytology ordered	67	65	65	71	62	85	59	82	68	73	90	71
# of fluid diffs that did not correlate	2	0	6	3	0	0	0	2	3	3	5	3
Threshold achieved	98%	100%	92.30%	96%	100%	100%	100%	97%	96%	98%	94%	96%
Expected	100%	100%	100%	100%	100%	100%	100%	100%	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 correlation. 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 1 of 3 had malignant cells. Reveiwed slide with tech.			Will report out April next meeting	reveiwed by Dr. Minerowicz. 1 of the 2 slides had abnormal cells present	reveiwed by Dr. Minerowicz. 2 of the 3 slides did not show malignant cells. 1 slide had malignant clumps. Reviewed with tech	Reveiwed by Dr. Minerowicz. No malignant cells seen on any of the slides.	1 of 5 showed malignant cells	Dr. Minerowicz to review

Aspect of Care

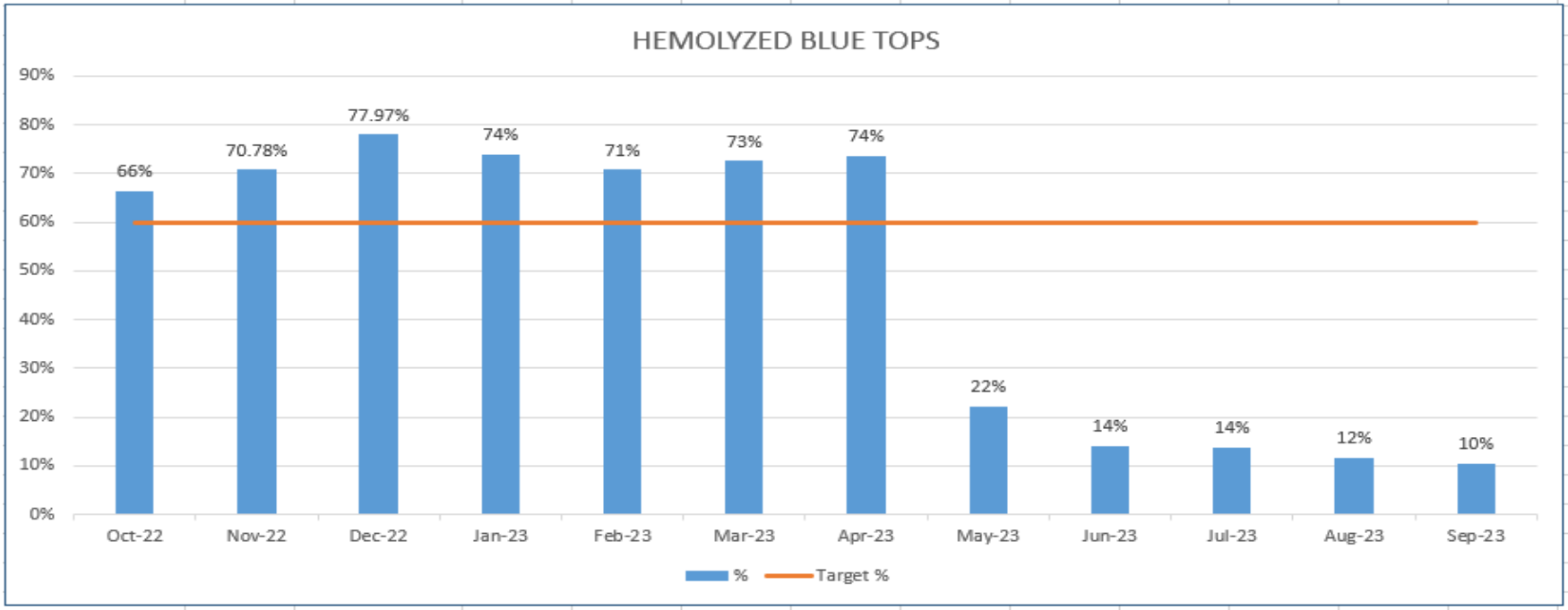


	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
corrected appended results	11	7	8	5	6	6	10	6	6	9	5	3
incorrect documentation	2	1	0	1	0	1	3	1	0	0	2	0
correct documetation	9	6	8	4	6	5	7	5	6	9	3	3
% correct	82%	86%	100%	80%	100%	83%	70%	83%	100%	100%	60%	100%
Target	100%	100%	100%	100%	100%	100%	100%	100%	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.		after hours. Forgot to leave info for day shift to call.	Spoke individually to the techs. Same technologist for 2 of the 3				tech individually. One was changed after calling nurse for clarification of fluid type but	

Aspect of Care

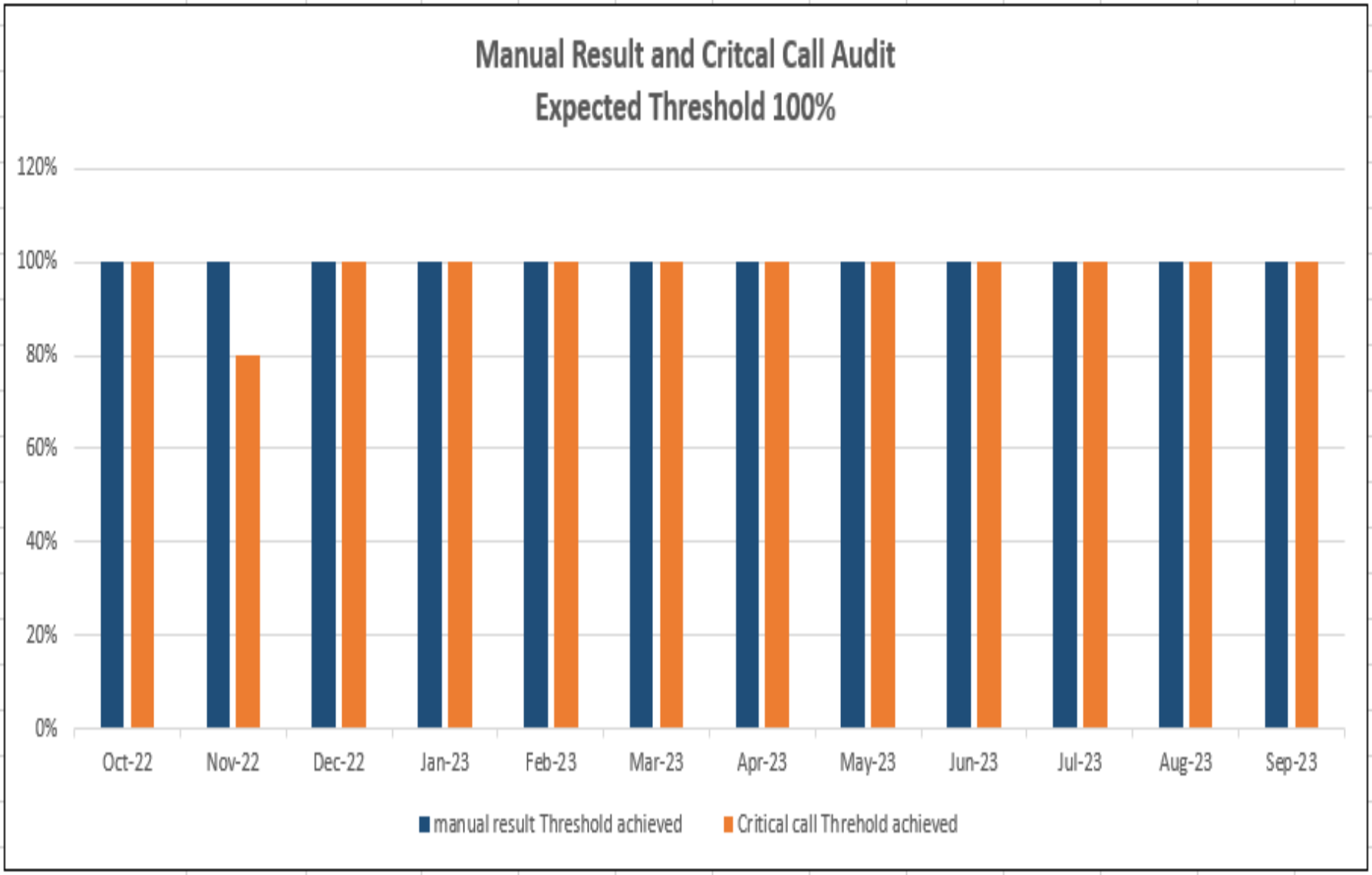


Aspect of Care

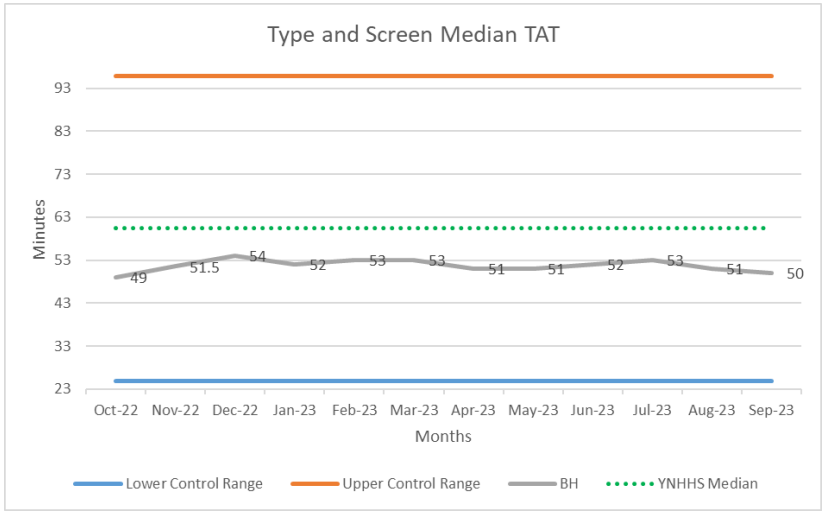


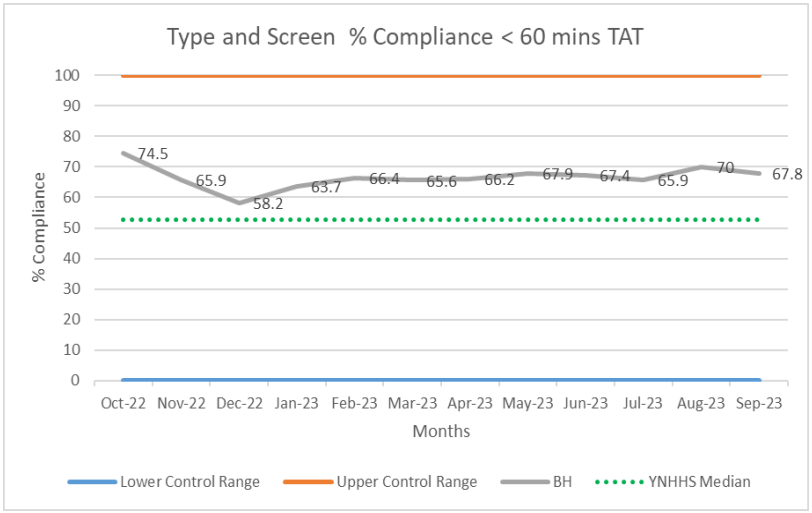
Month	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
%	66%	70.78%	77.97%	74%	71%	73%	74%	22%	14%	14%	12%	10%
Target %	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%
Total Hemolyzed	309	308	286	333	359	401	473	225	170	160	197	279
Blue tops	205	218	223	246	254	291	348	50	24	22	23	29
Action/Outcome		Study on the effect of hemolysis on results in-progress				in process of standarizing criteria across YNHHS	Hemolysis tolerance changed from 0 to ≤3 on May 8.					

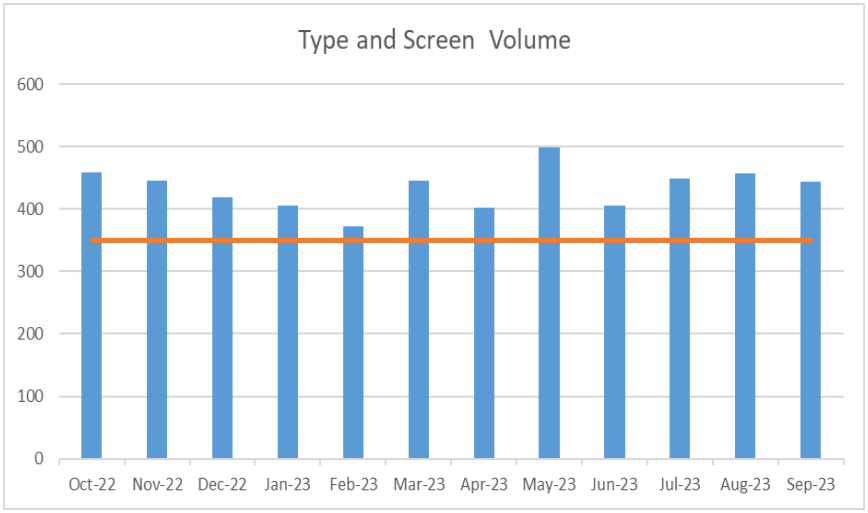
Aspect of Care



Bridgeport Campus – Type and Screen ED TAT





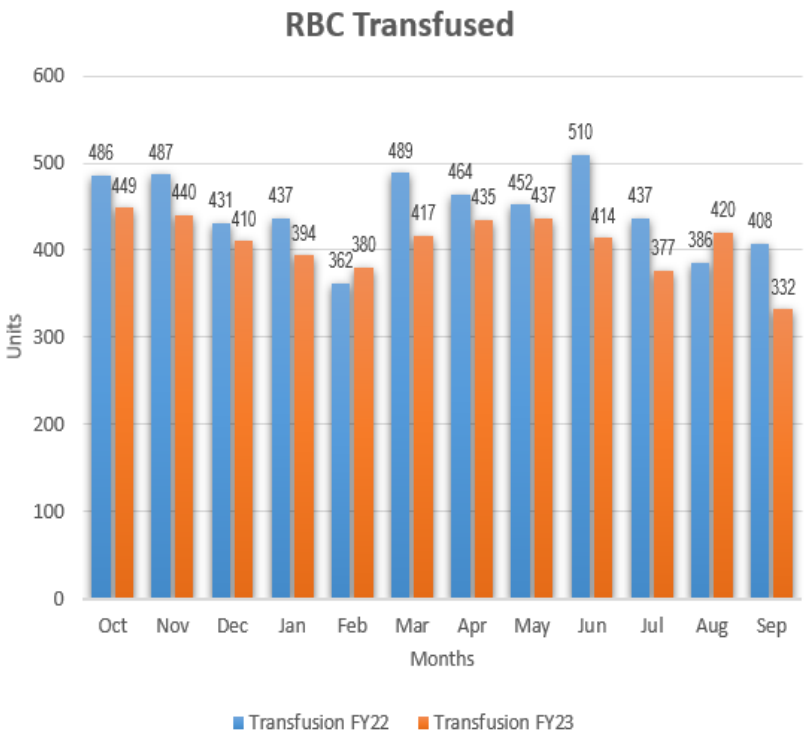


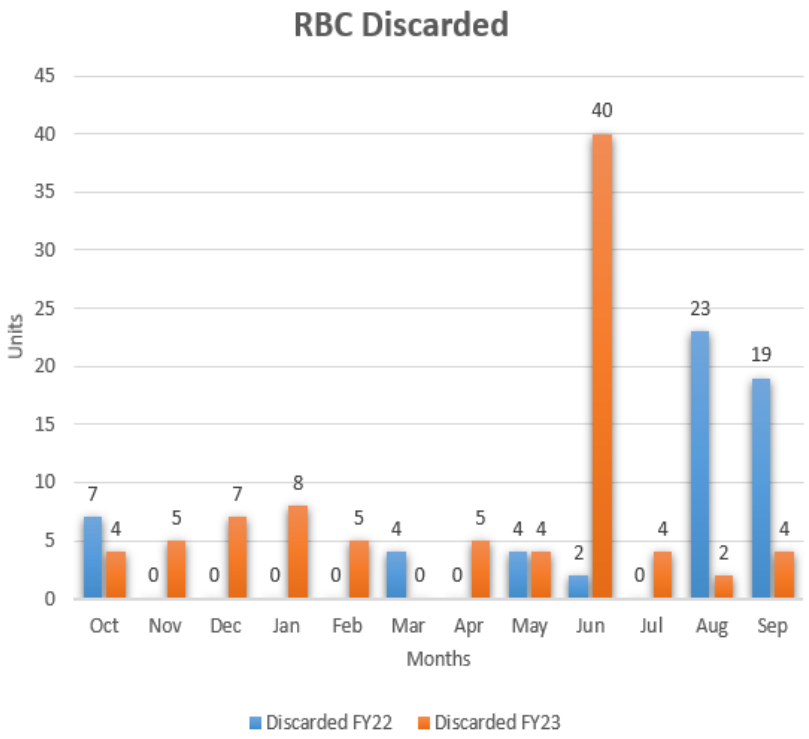
Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus

RBC Transfused

RBC Discarded



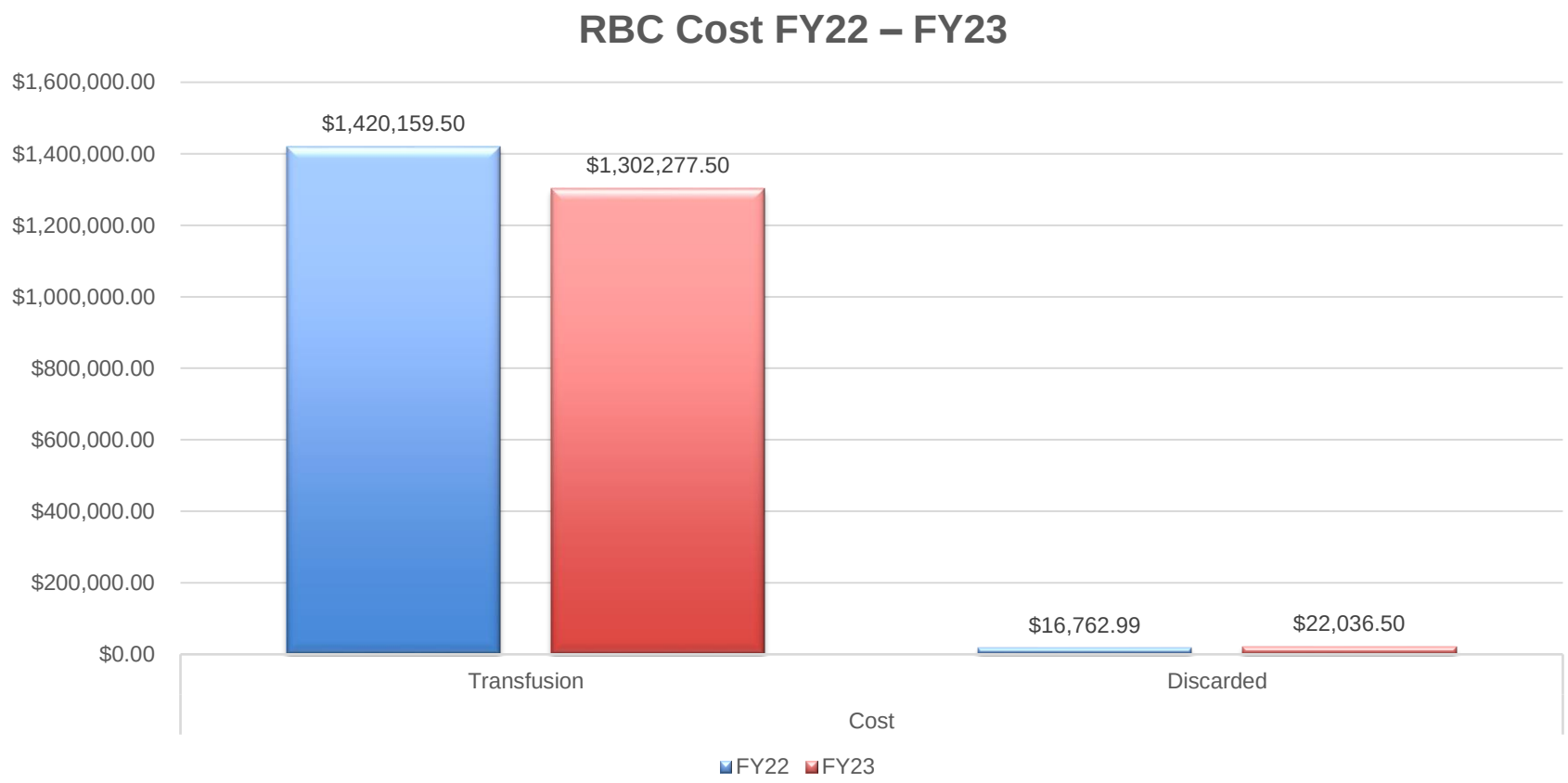


*Discarded included expired and wasted.

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Bridgeport Campus



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Yale NewHaven Health Bridgeport Hospital

Bridgeport Hospital Blood Bank
RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfused	449	440	410	394	380	417	435	437	414	377	420	332	409±33	$1,183,068.00
Discarded	4	5	7	8	5	0	5	4	40	4	2	4	7±11	$22,036.50
Expired*	4	1	7	8	4	0	5	4	40	4	0	0	6±11	$20,178.00
Wasted**	0	4	0	0	1	0	0	0	0	0	2	4	1±2	$1,858.50
Total	453	445	417	402	385	417	440	441	454	381	422	336	416±35	$1,205,370.00

*Expired – Unit reached expiration date on shelf during storage

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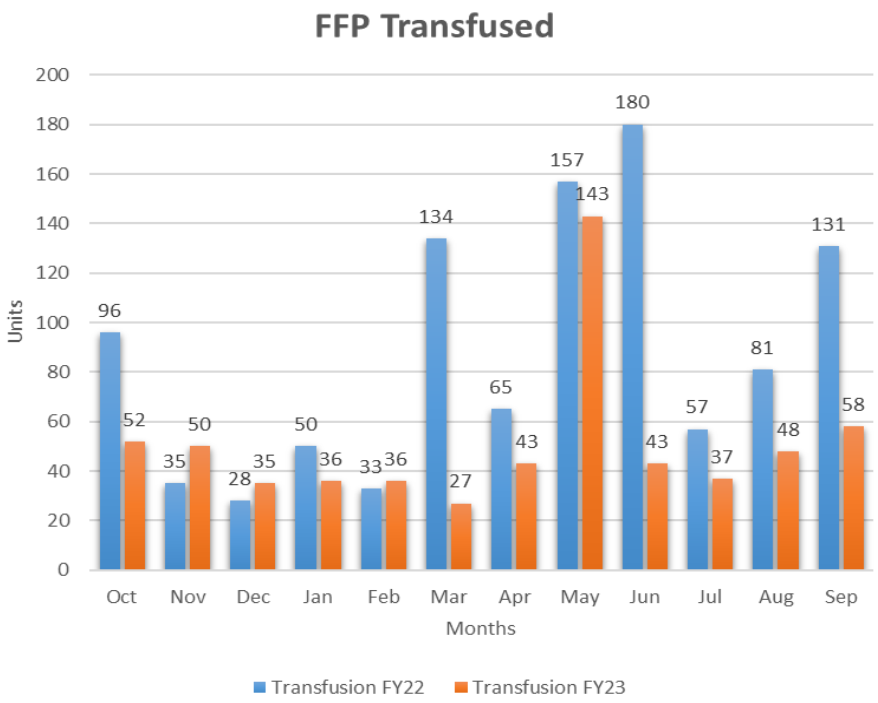
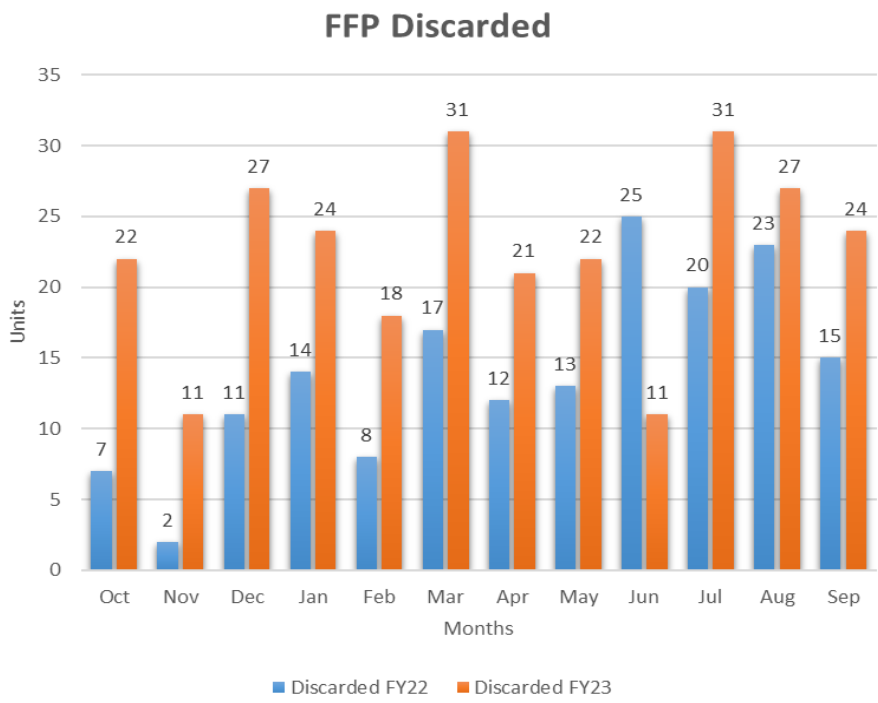
Bridgeport Campus

FFP Transfused

FFP Discarded





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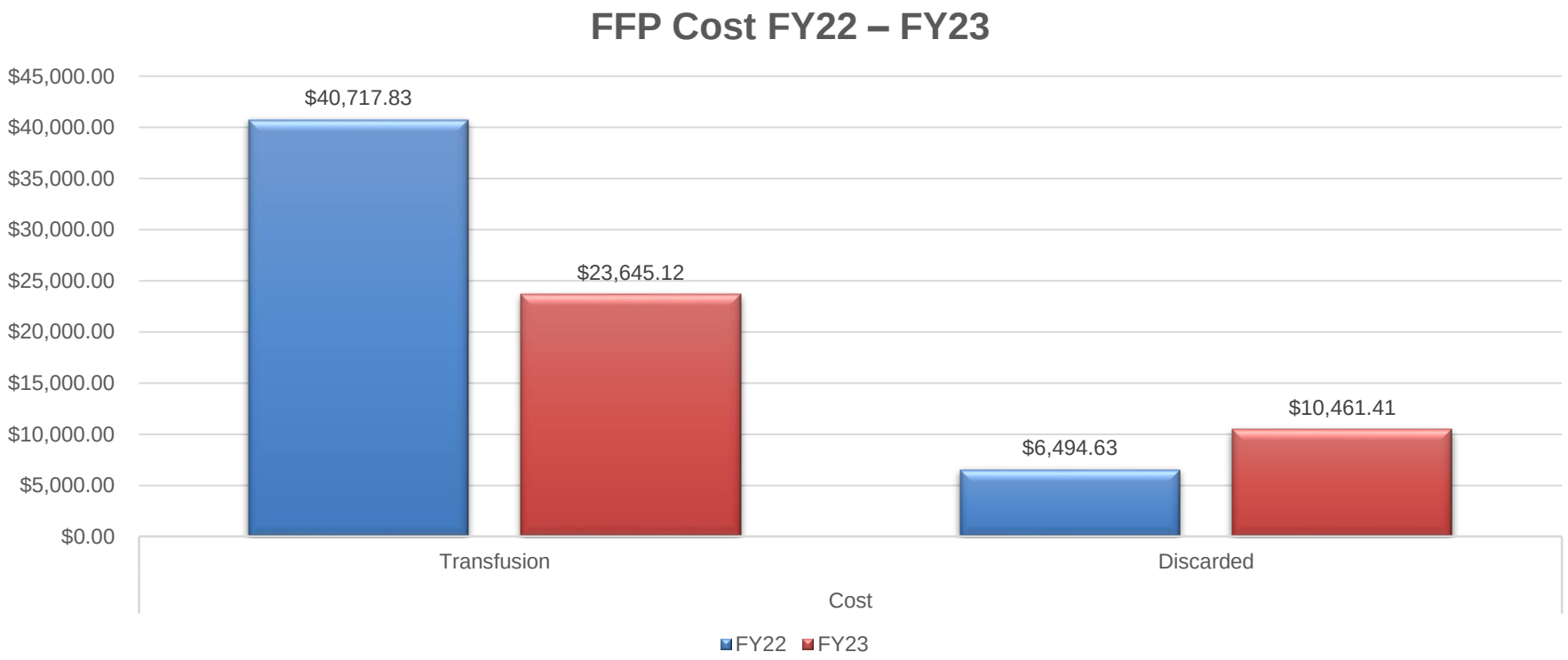
Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus
FFP Cost FY 22-23



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*Discarded included expired and wasted.

Yale NewHaven Health Bridgeport Hospital

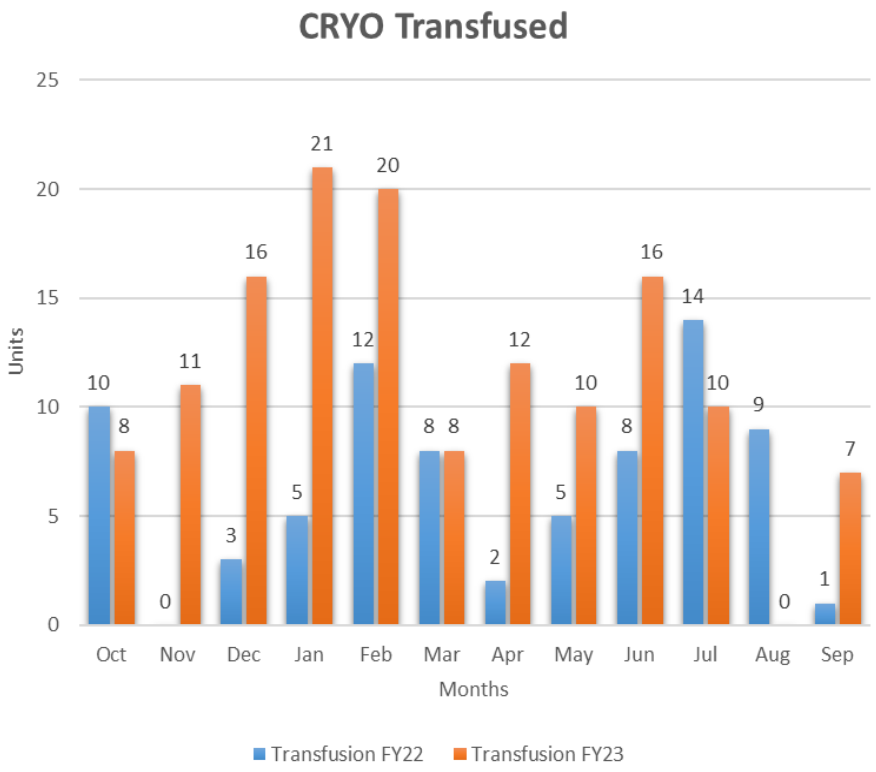
BH Campus
FFP

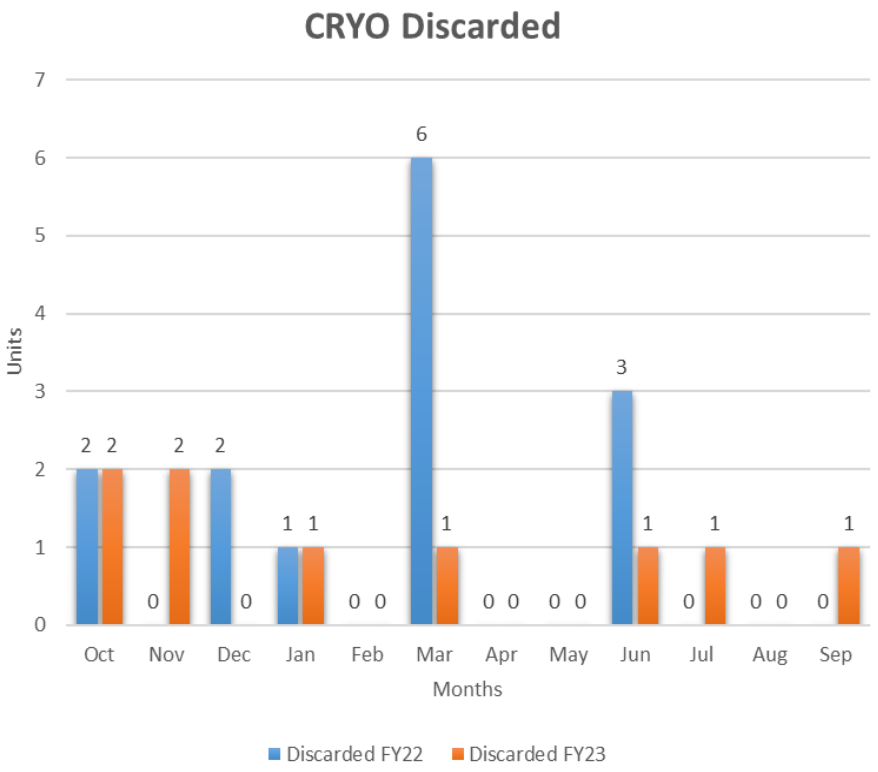
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfusion	52	50	35	36	36	27	43	143	43	37	48	58	51±30	$23,645.12
Discarded	22	11	27	24	18	31	21	22	11	31	27	24	22±7	$10,461.41
Expired*	0	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Wasted**	22	11	27	24	18	31	21	22	11	31	27	24	22±7	$10,461.41
Total	74	61	62	60	54	58	64	165	54	68	75	82	73±30	$34,106.53

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Bridgeport Hospital
Blood Bank
Cryo





*Discarded included expired and wasted.

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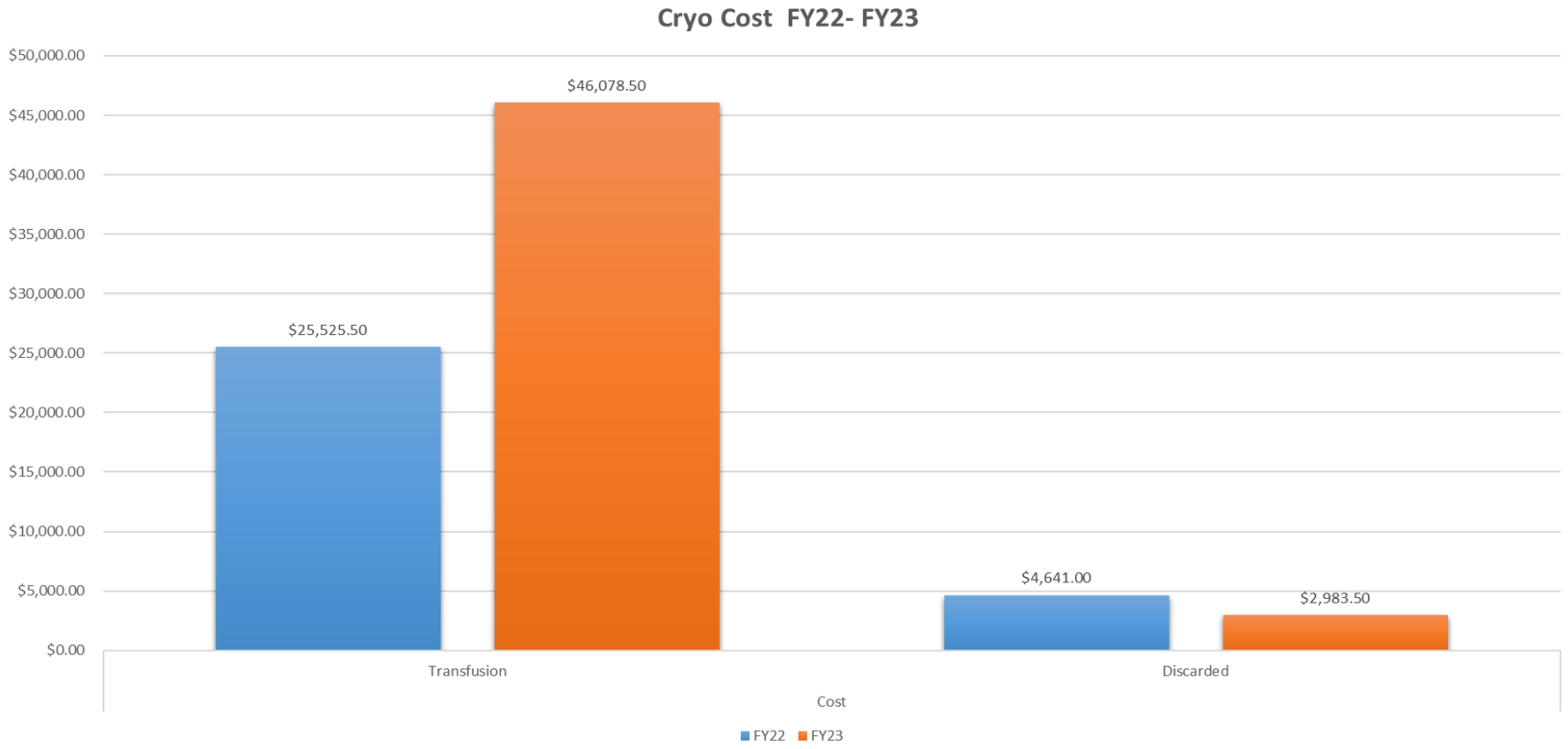
Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus
Cryo Cost



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Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus
Cryo

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfusion	8	11	16	21	20	8	12	10	16	10	0	7	12±6	$46,078.50
Discarded	2	2	0	1	0	1	0	0	1	1	0	1	1±1	$2,983.50
Expired	2	1	0	0	0	1	0	0	1	1	0	0	1±1	$1,989.00
Wasted	0	1	0	1	0	0	0	0	0	0	0	1	0±0	$994.50
Total	8	13	16	22	20	9	12	10	17	11	0	8	12±6	$48,399.00

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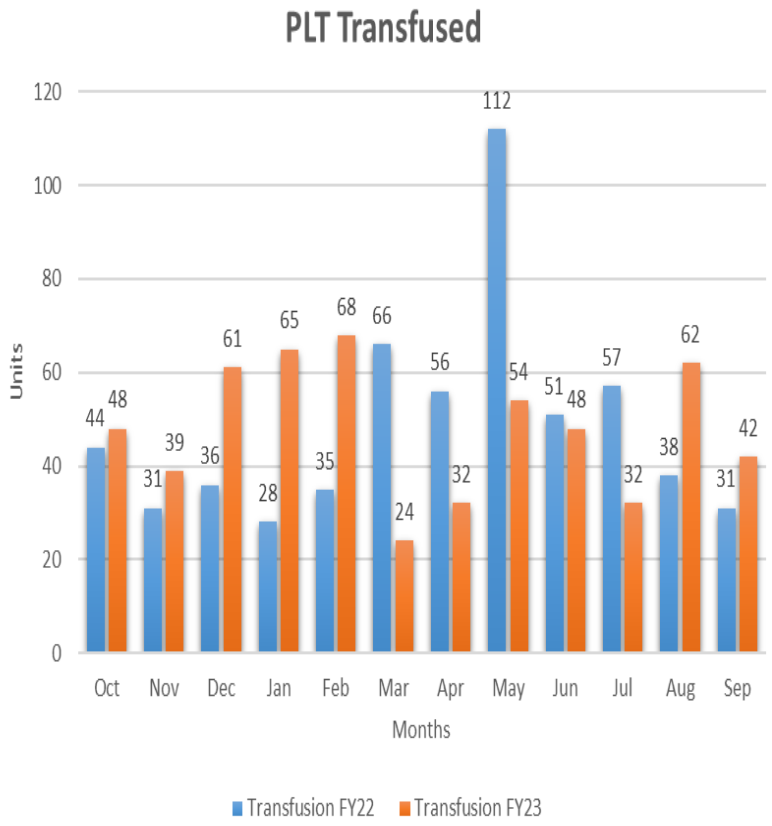
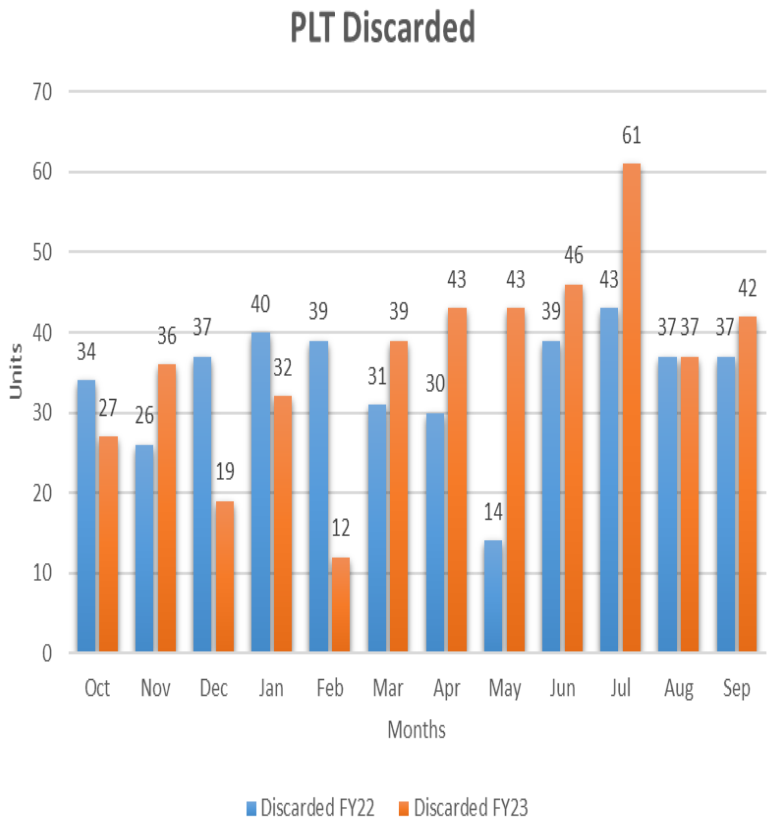
**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Bridgeport Campus

PLT Transfused



PLT Discarded



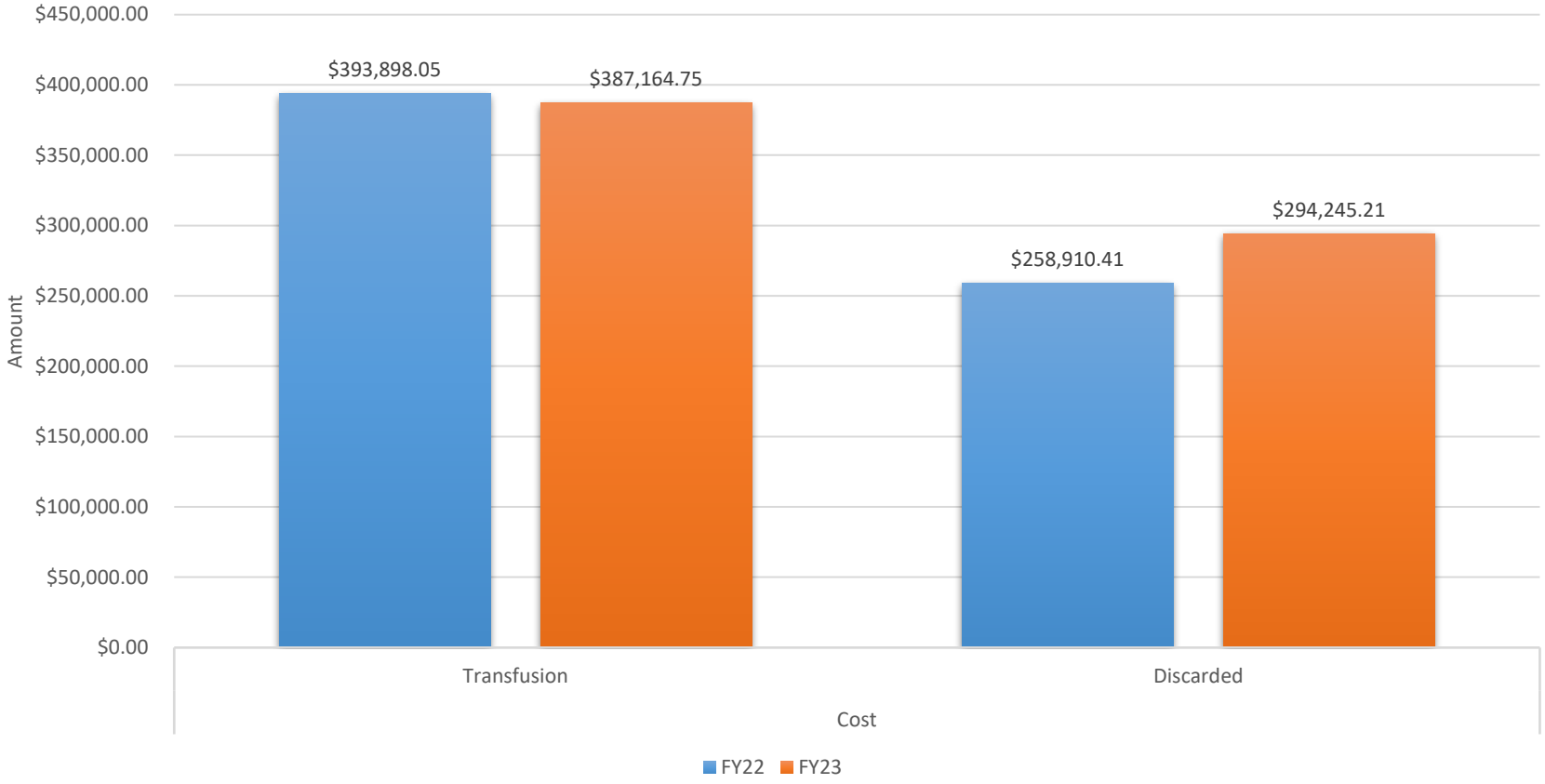
*Discarded included expired and wasted.

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Yale NewHaven Health Bridgeport Hospital

PLT Cost
FY 22 – FY 23



*Expired – Unit reached expiration date on shelf during storage
**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

*Discarded included expired and wasted.

Platelet Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Mean ± SD	Total Amount
Total	76	75	80	97	80	63	75	97	94	93	99	84	84±12	$681,409.96
Transfused	48	39	61	65	68	24	32	54	48	32	62	42	46±16	$373,698.15
Discarded	28	36	28	32	12	39	43	41	46	61	37	42	37±12	$299,631.85
Expired*	27	36	28	32	12	39	43	41	46	61	37	42	37±12	$298,958.52
Wasted**	1	0	0	0	0	0	0	0	0	0	0	0	0±0	$673.33
% Discarded	36%	48%	35%	33%	15%	62%	57%	42%	49%	66%	37%	50%		
Discarded/Day	0.87	1.2	0.93	1.07	0.43	1.26	1.43	1.32	1.53	1.97	1.19	1.40	1±0	$775.22

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

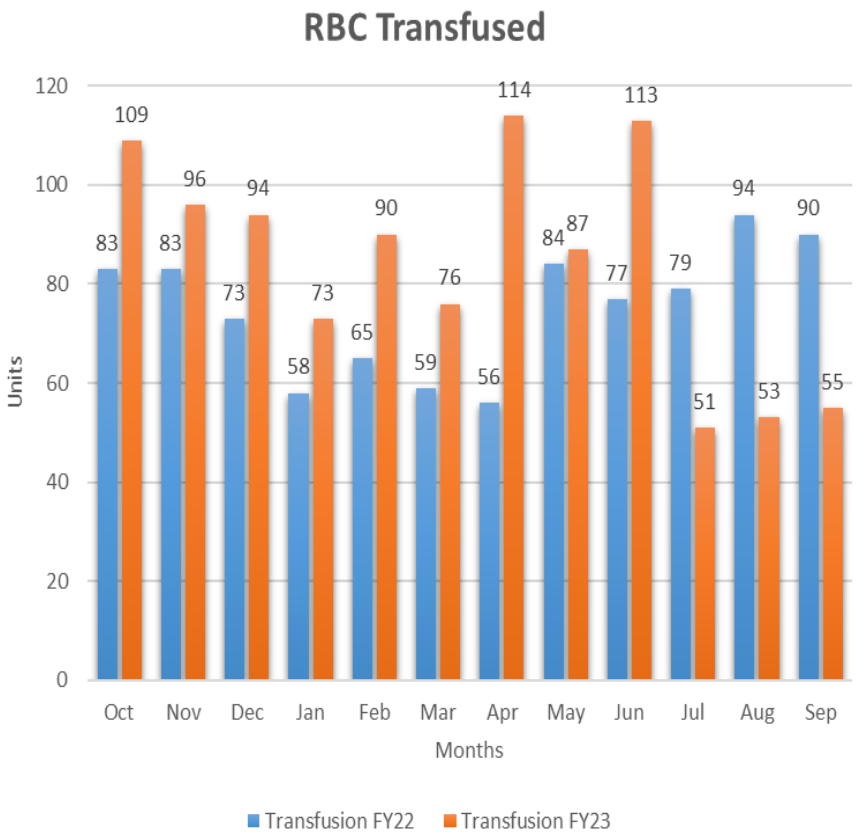
Extended PLT Summary
8/22 – 9/23

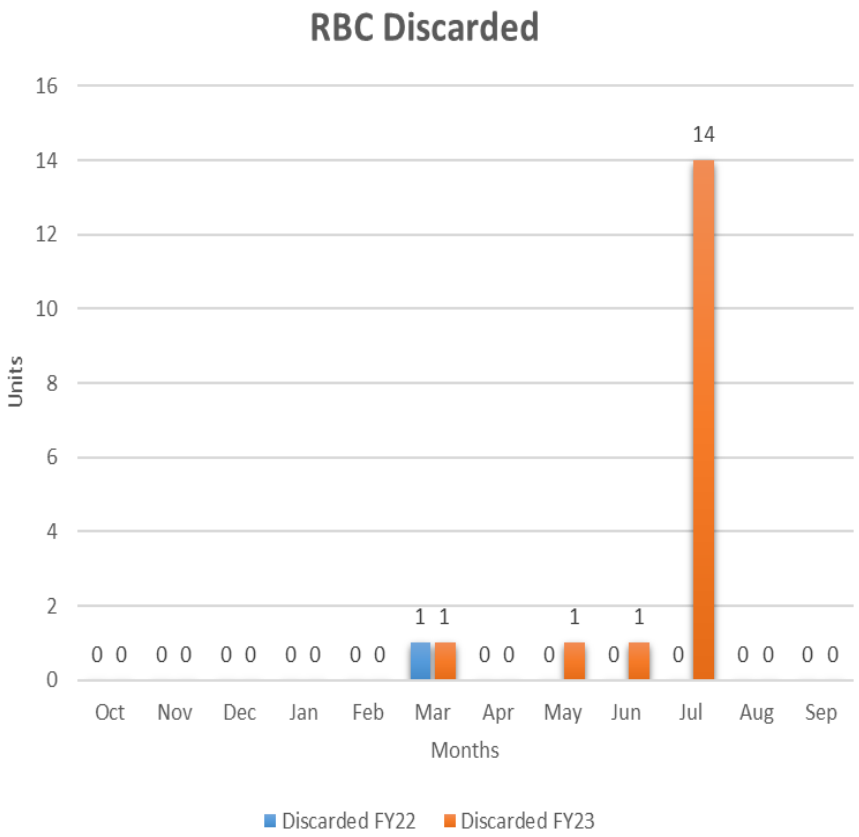
	22-Aug	22-Sep	22-Oct	22-Nov	22-Dec	23-Jan	23-Feb	23-Mar	23-Apr	23-May	23-Jun	23-Jul	23-Aug	23-Sep	Mean	SD
Total Number of Platelets Available	74	68	76	75	85	97	80	63	75	97	94	93	99	84	82.86	14
Total Number of Platelets Transfused *	37	31	48	39	61	65	68	24	32	54	48	32	62	42	45.93	12
# of Non-Extended Platelets Transfused	26	15	32	19	34	47	49	19	26	40	28	29	51	33	32	11
# Extended Platelets Transfused*	11	16	16	20	27	18	19	5	6	14	20	3	11	9	13.93	7
Total # Platelets Discarded	37	37	28	36	24	32	12	39	43	43	46	61	37	42	36.93	11
# Non-Extended Platelets Discarded	10	1	1	3	1	2	5	3	10	2	6	16	8	2	5	5
# Extended Platelets Discarded	27	36	27	33	23	30	7	36	33	41	40	45	29	40	31.93	9

*Savings =196 PLTS X $673 = $131,908

Yale NewHaven Health Bridgeport Hospital

Milford Campus





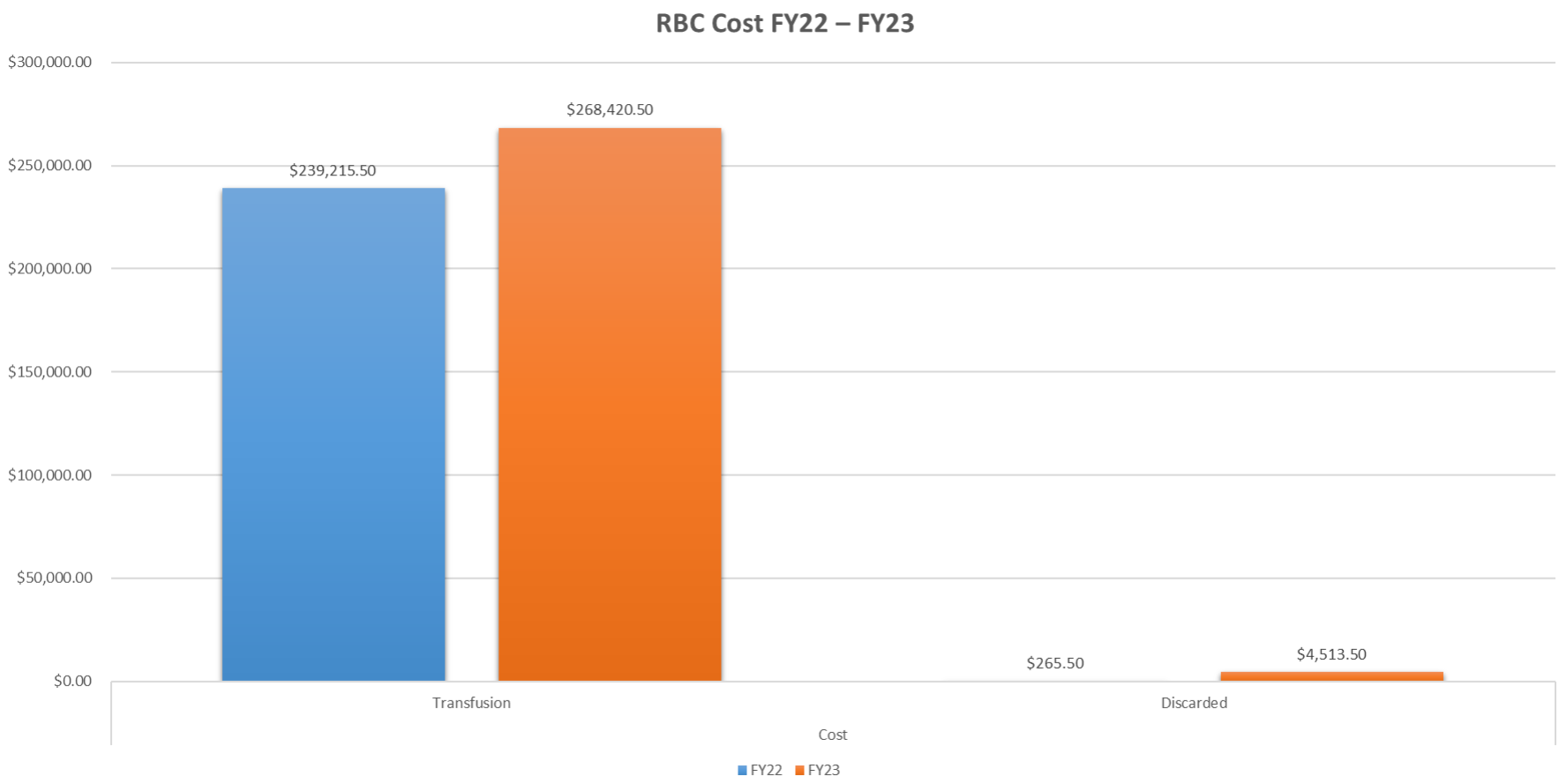
*Discarded included expired and wasted.

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Yale NewHaven Health Bridgeport Hospital

Milford Campus



*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

*Discarded included expired and wasted.

Yale NewHaven Health Bridgeport Hospital

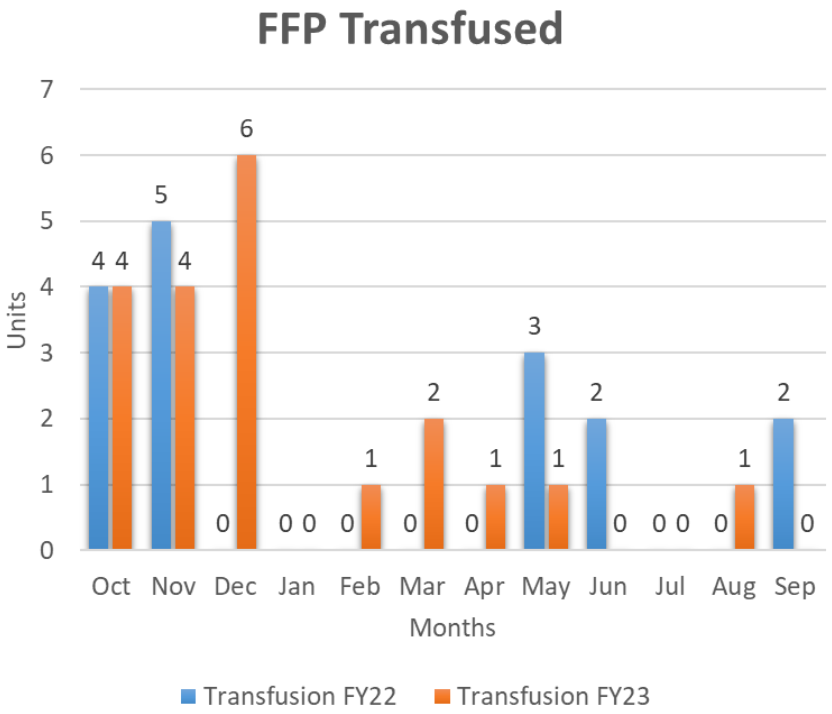
Milford Campus
RBC

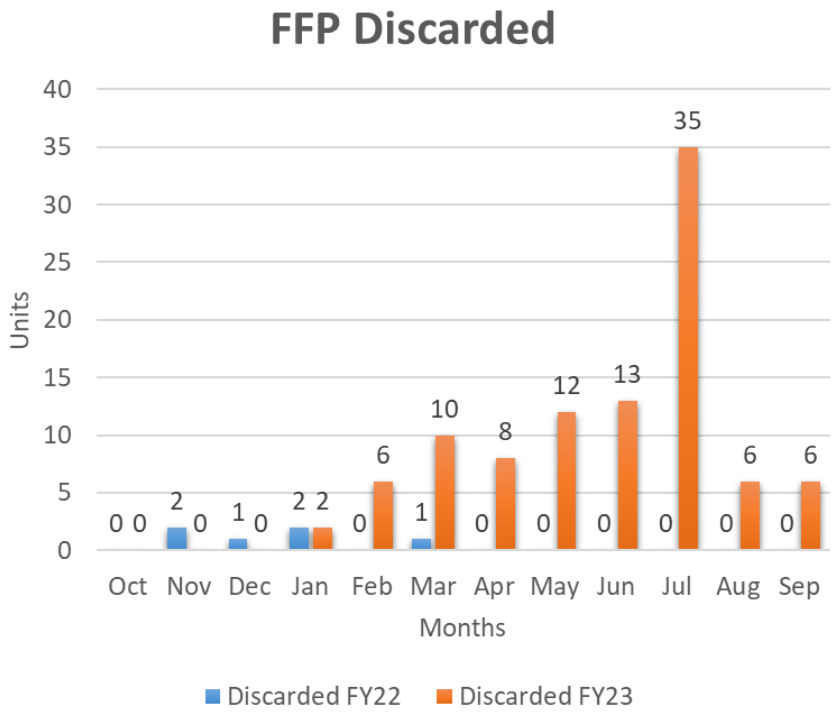
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfusion	109	96	94	73	90	76	114	87	113	51	53	55	84±23	$268,420.50
Discarded	0	0	0	0	0	1	0	1	1	14	0	0	1±4	$4,513.50
Expired*	0	0	0	0	0	1	0	1	0	13	0	0	1±4	$3,982.50
Wasted**	0	0	0	0	0	0	0	0	1	1	0	0	0±0	$531.00
Total	109	96	94	73	90	77	114	88	114	65	53	55	86±21	$272,934.00

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Milford Campus





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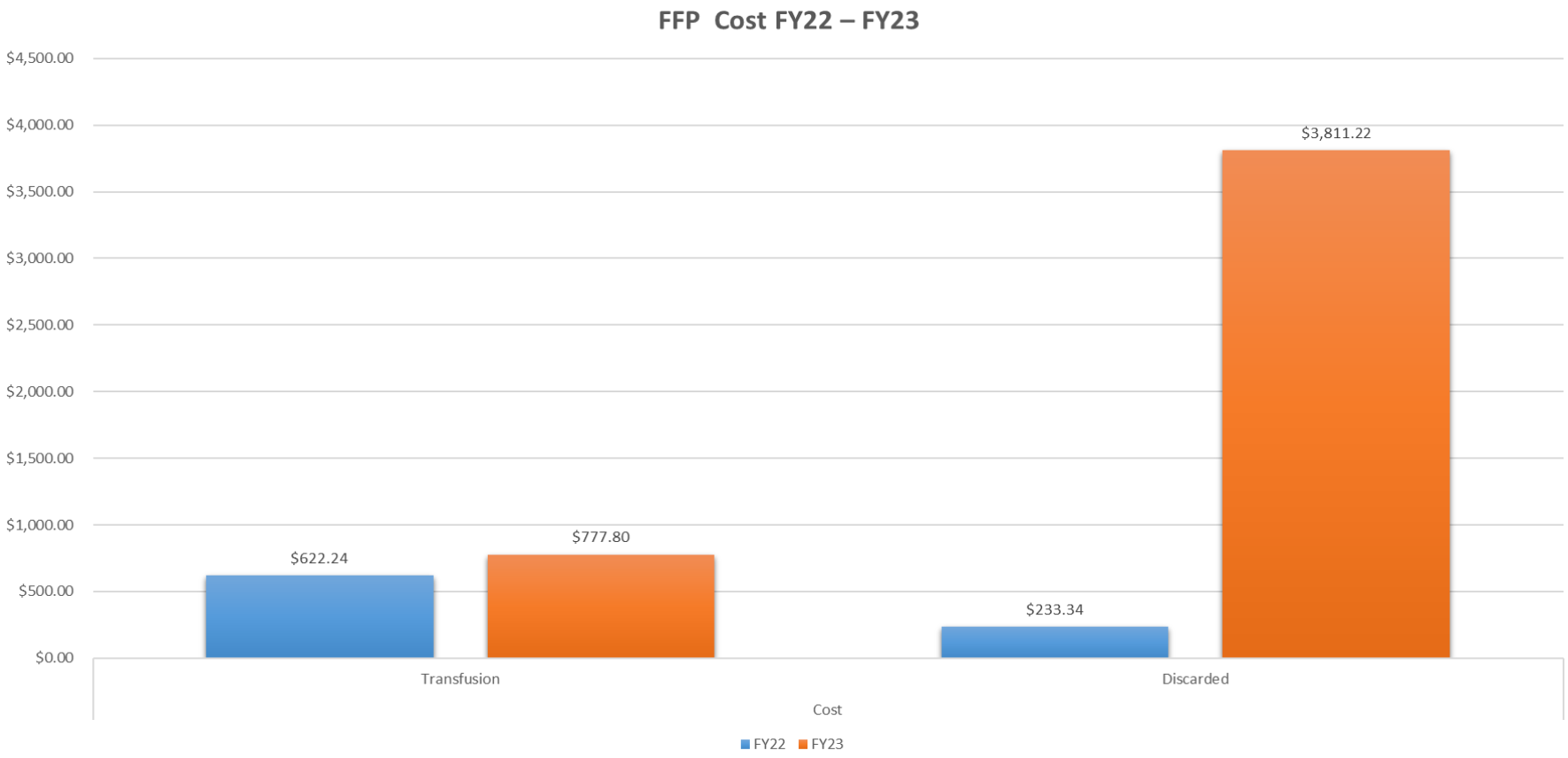
Yale NewHaven Health Bridgeport Hospital

Milford Campus



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*Discarded included expired and wasted.

Yale NewHaven Health Bridgeport Hospital

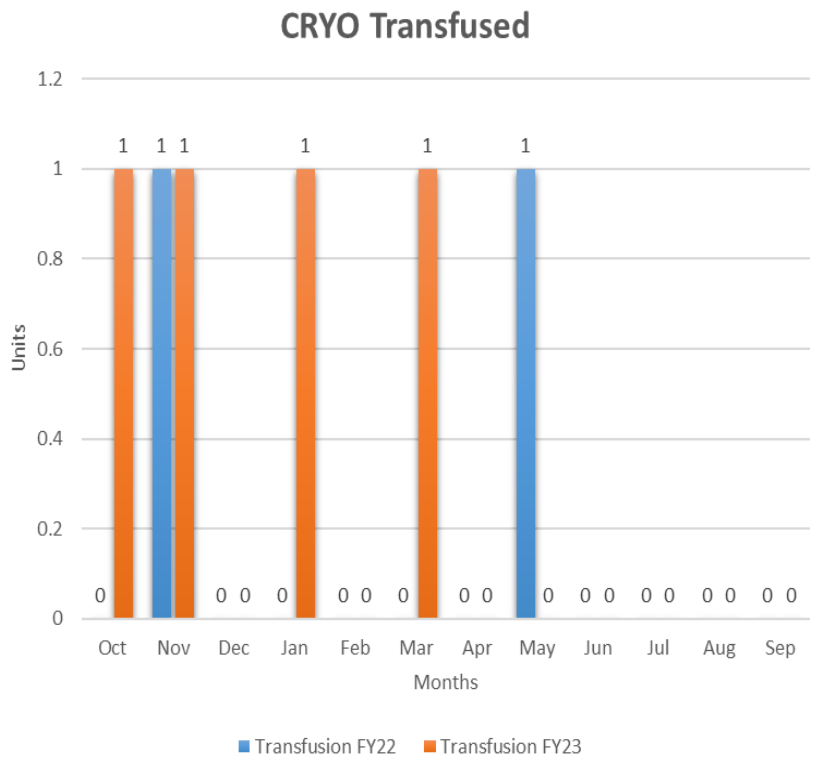
Milford Campus

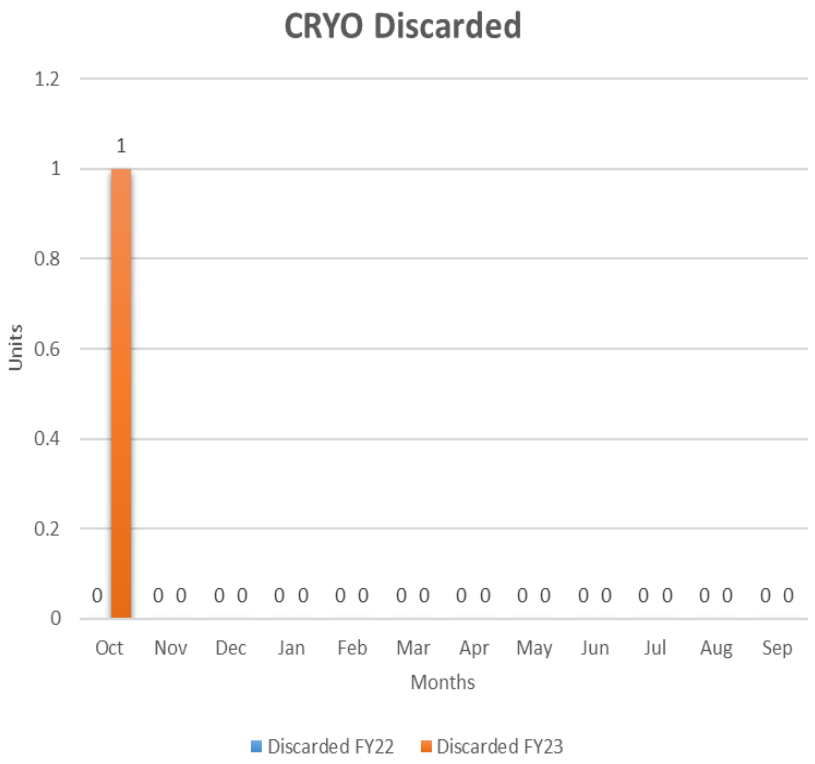
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfusion	4	4	6	0	1	2	1	1	0	0	1	0	2±2	$777.80
Discarded	0	0	0	2	6	10	8	12	13	35	6	6	8±10	$3,811.22
Expired*	0	0	0	0	0	0	0	0	0	0	0	0	0±0	$0.00
Wasted**	0	0	0	2	6	10	8	12	13	35	6	6	8±10	$3,811.22
Total	4	4	6	2	7	12	9	13	13	35	7	6	10±9	$4,589.02

*Expired – Unit reached expiration date on shelf during storage

**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Milford Campus





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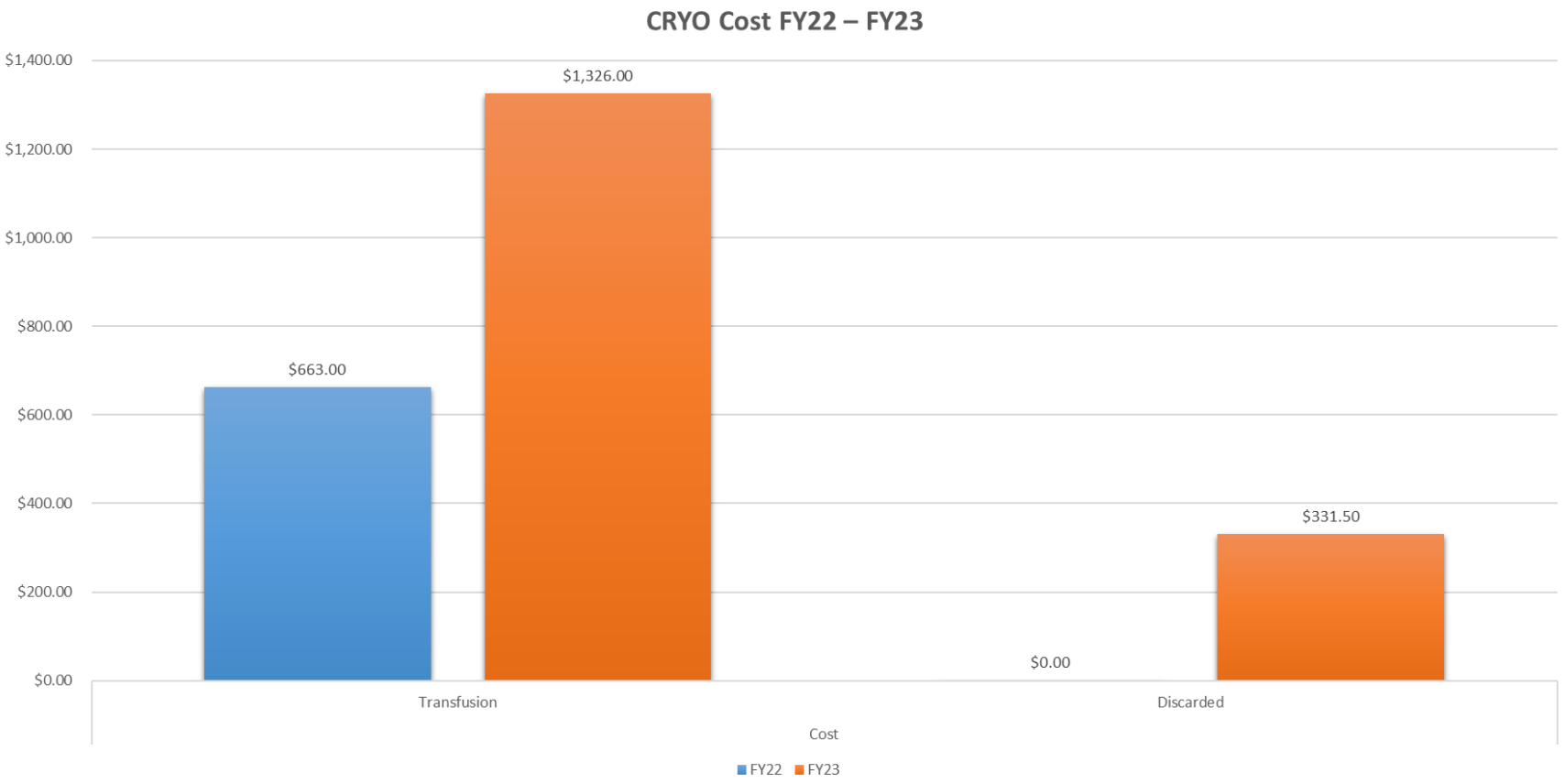
Yale NewHaven Health Bridgeport Hospital

Milford Campus



*Expired – Unit reached expiration date on shelf during storage

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*Discarded included expired and wasted.

Yale NewHaven Health Bridgeport Hospital

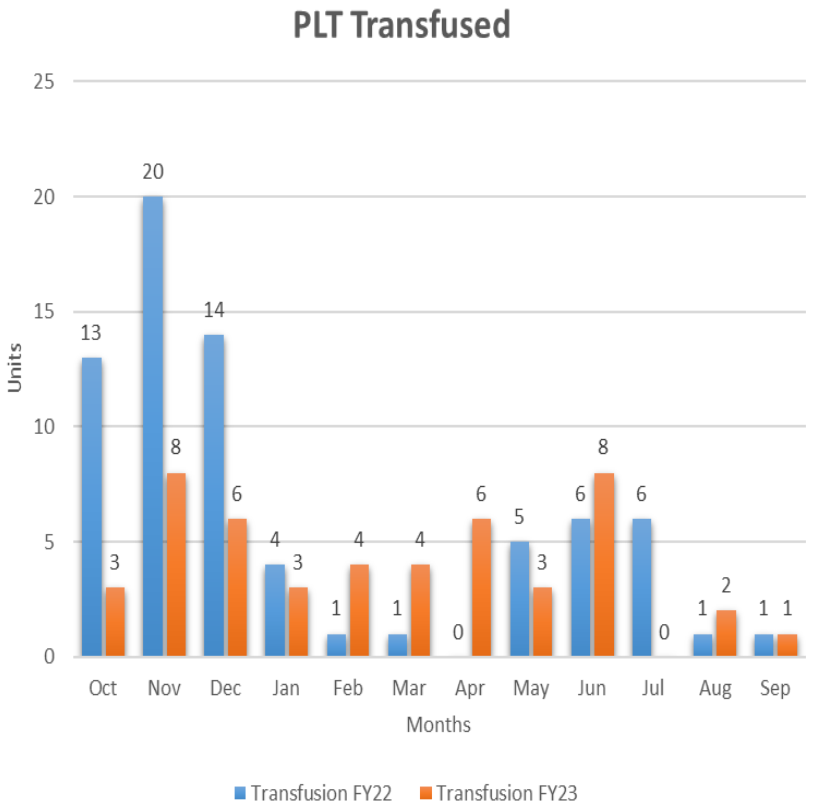
Milford Campus
Cryo Utilization

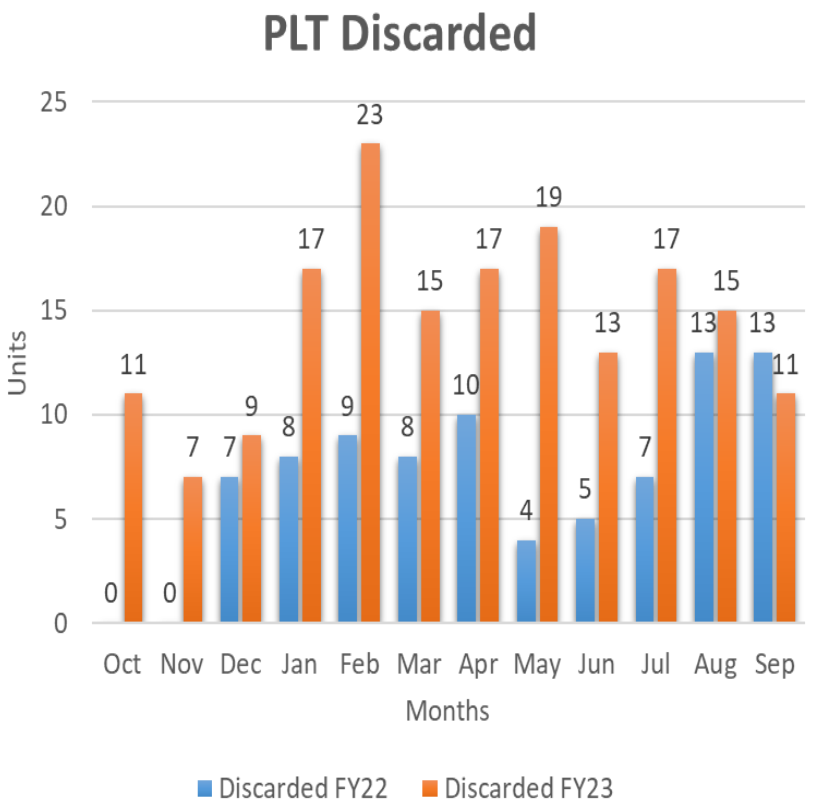
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Transfused	1	1	0	1	0	1	0	0	0	0	0	0	0±1	$1,326.00
Discarded	1	0	0	0	0	0	0	0	0	0	0	0	0±0	$331.50
Expired*	1	0	0	0	0	0	0	0	0	0	0	0	0±0	$331.50
Wasted**	0	0	0	0	0	0	0	0	0	0	0	0	0±0	$0.00
Total	2	1	0	1	0	1	0	0	0	0	0	0	0±1	$1,657.50

*Expired – Unit reached expiration date on shelf during storage
**Wasted – Returned unit discarded due to inadequate handling by the clinical team after product released by the blood bank

Yale NewHaven Health Bridgeport Hospital

Milford Campus





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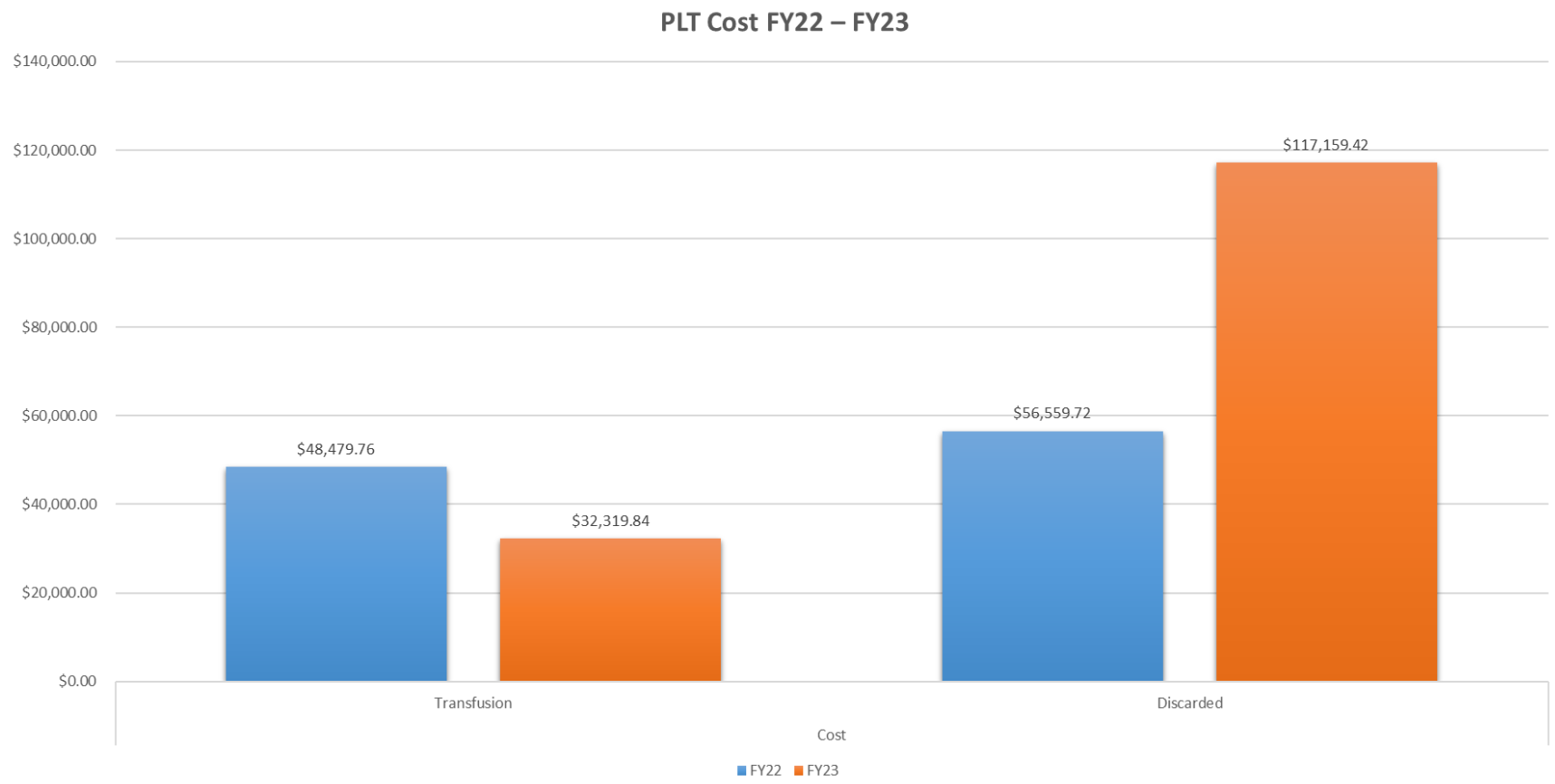
Yale NewHaven Health Bridgeport Hospital

Milford Campus



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Yale NewHaven Health Bridgeport Hospital

Milford Campus

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total Amount
Total	14	15	15	20	27	19	23	22	21	17	17	12	19±4	$149,479.26
Transfusion	3	8	6	3	4	4	6	3	8	0	2	1	4±3	$32,319.84
Discarded	11	7	9	17	23	15	17	19	13	17	15	11	15±5	$117,159.42
Expired*	11	7	9	17	23	15	17	19	13	17	15	11	15±5	$117,159.42
Wasted**	0	0	0	0	0	0	0	0	0	0	0	0	0±0	$0.00
% Discarded	78.57%	46.67%	60.00%	80%	85%	78.95%	73.91%	86.36%	61.90%	100.00%	88.24%	91.67%		
Discarded/Day	0.3548	0.2258	0.2903	0.5667	0.8214	0.5357	0.6071	0.6786	0.4643	0.6071	0.5357	0.3929		$4,094.18

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Bridgeport and Milford Hospital
Transfusion Reactions
FY 23

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	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
Mar	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Apr	4	0	1	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0
May	4	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0
Jun	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Jul	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aug	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Sep	2	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	17	0	4	0	7	0	0	0	1	0	0	0	1	0	0	0	5	0

Bridgeport Campus – 2023 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 Volume = 1260	9 Volume = 1117	15 Volume = 1136	19 Volume = 1284	24 Volume = 1189	13 Volume = 1428	16 Volume =1260	9 Volume = 1314	9 Volume = 1300	10 Volume = 1086	10 Volume = 1452	10 Volume =1207	1 with lot/exp not entered and 9 QC entries (1 staff had 2) needed review. Emails sent to staff reminding them to review entries before verifying. This was the first result issue for all.
# of i-STAT codes / # of cartridges run		28/333	17/323	18/221	18/325	12/418	10/315	13/267	9/301	14/325	16/335	10/398	19/301	5 of the errors were environment and cartridge based. All of I.R. staff were trained in September so there were a few codes generated during training and practice. No other specific user issues were identified.
i-STAT Quality Check Codes	<5.0%	8.4%	5.3%	8.1%	5.5%	2.9%	3.2%	4.9%	3.0%	4.3%	4.7%	2.5%	6.3%	

Yale NewHaven Health Bridgeport Hospital

Yale NewHaven Health

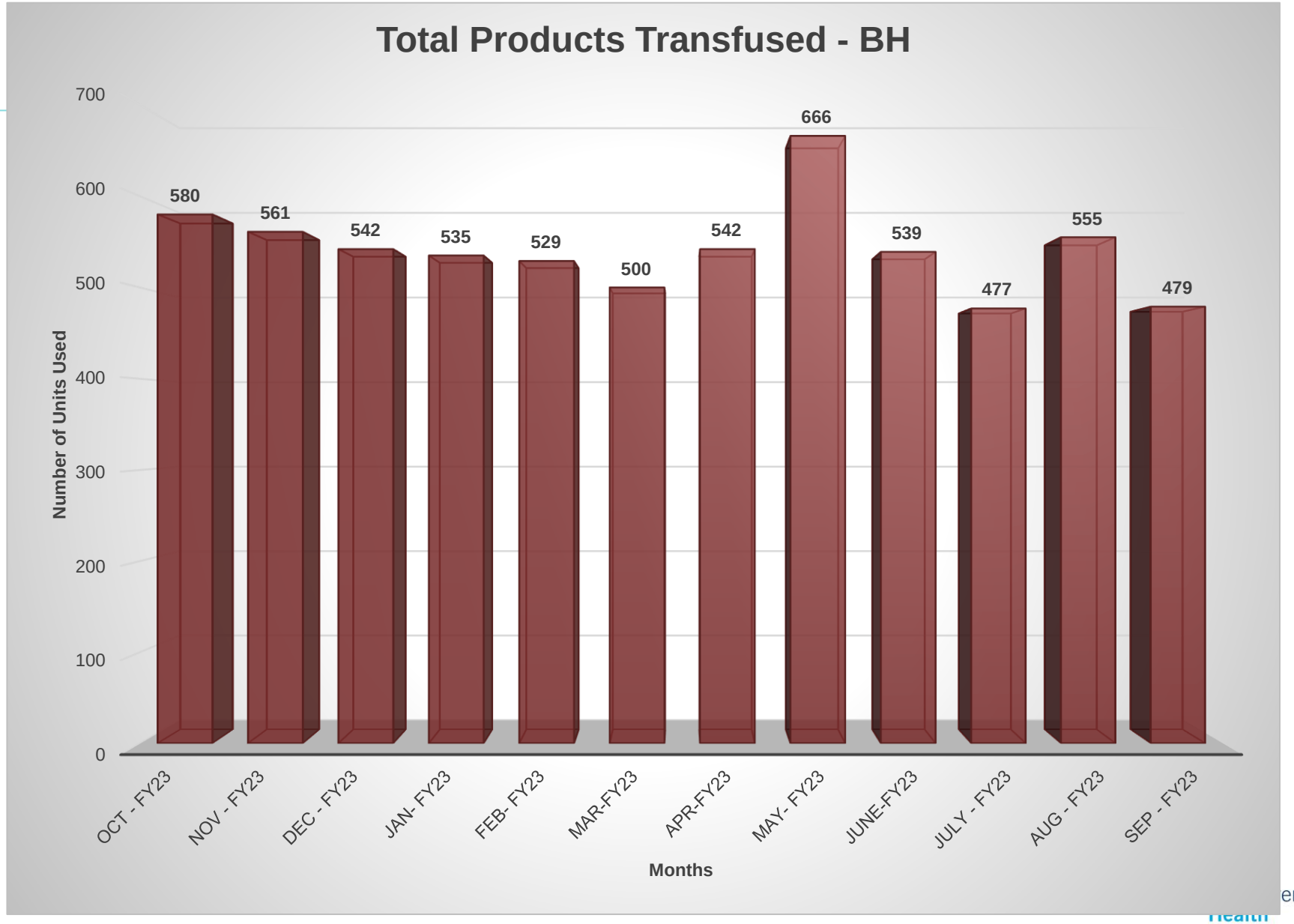
CRSQ Report Out

Committee of Regulatory, Safety, & Quality

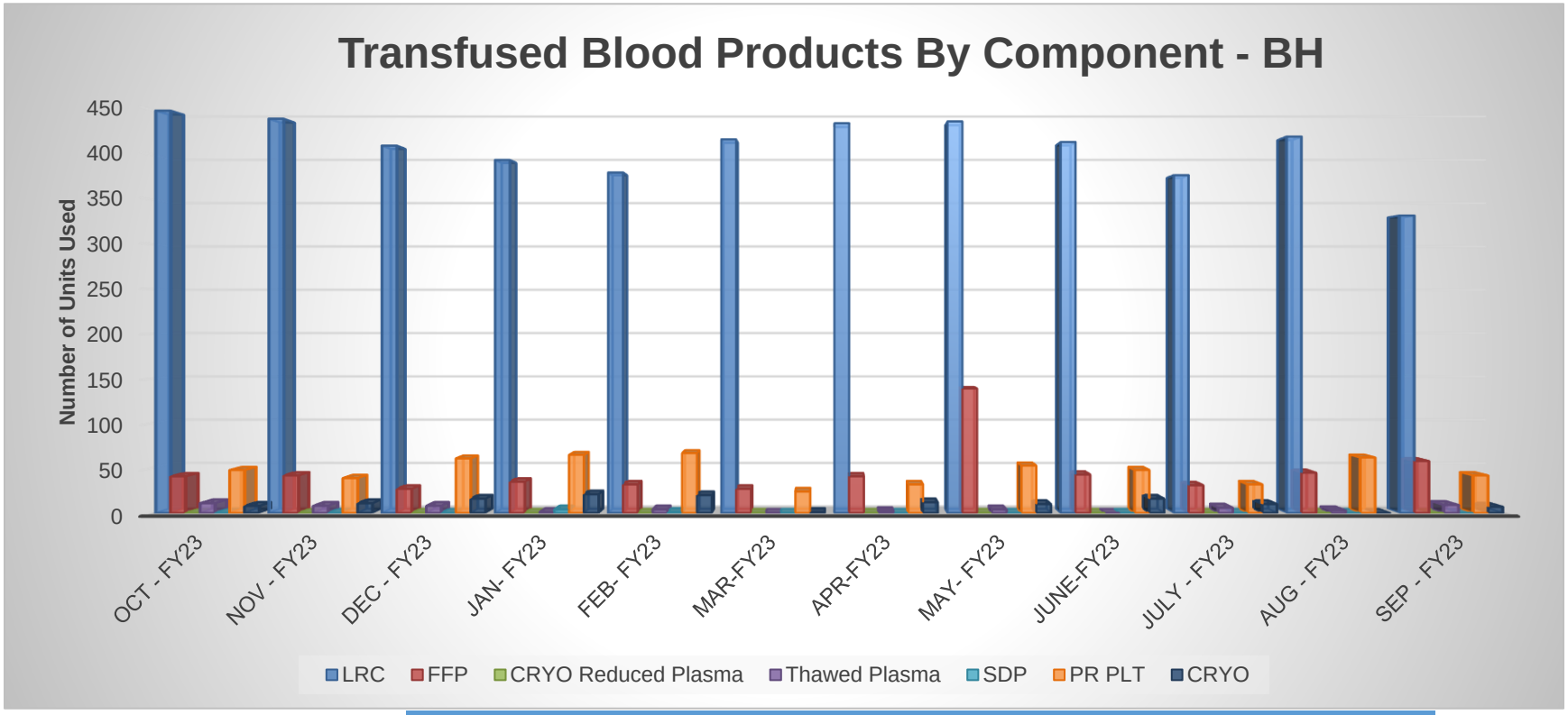
Bridgeport Hospital

Laboratory Blood Bank

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



PI.01.01.01 EP6

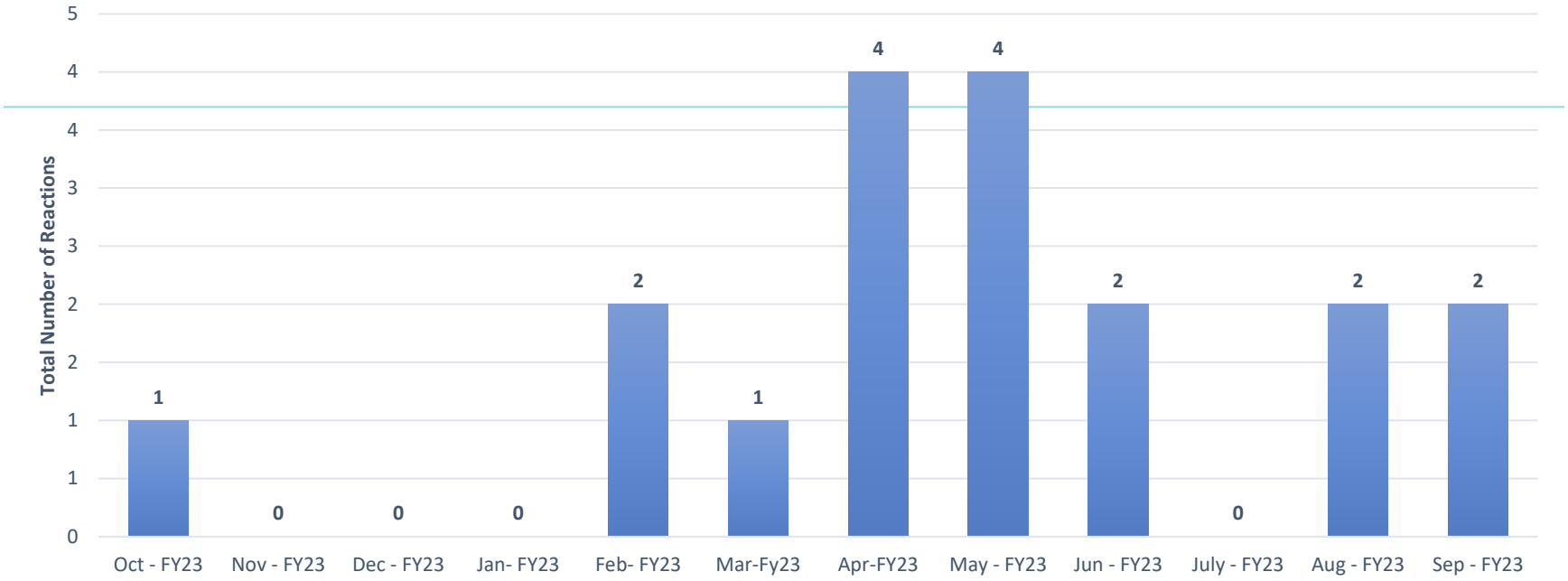


	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO
Oct - FY23	449	41	0	11	0	48	8
Nov - FY23	440	42	0	8	0	39	11
Dec - FY23	410	27	0	8	0	61	16
Jan- FY23	394	35	0	1	4	65	21
feb- FY23	380	32	0	4	1	67	20
Mar-FY23	417	27	0	0	0	24	1
Apr-FY23	435	41	0	2	0	32	12
May- FY23	437	139	0	4	0	53	10
June-FY23	414	43	0	0	0	48	16
July - FY23	377	31	0	6	0	32	10
Aug - FY23	420	45	0	3	0	62	0
Sep - FY23	332	58	0	9	0	42	7

PI.01.01.01 EP6

Yale NewHaven Health Bridgeport Hospital

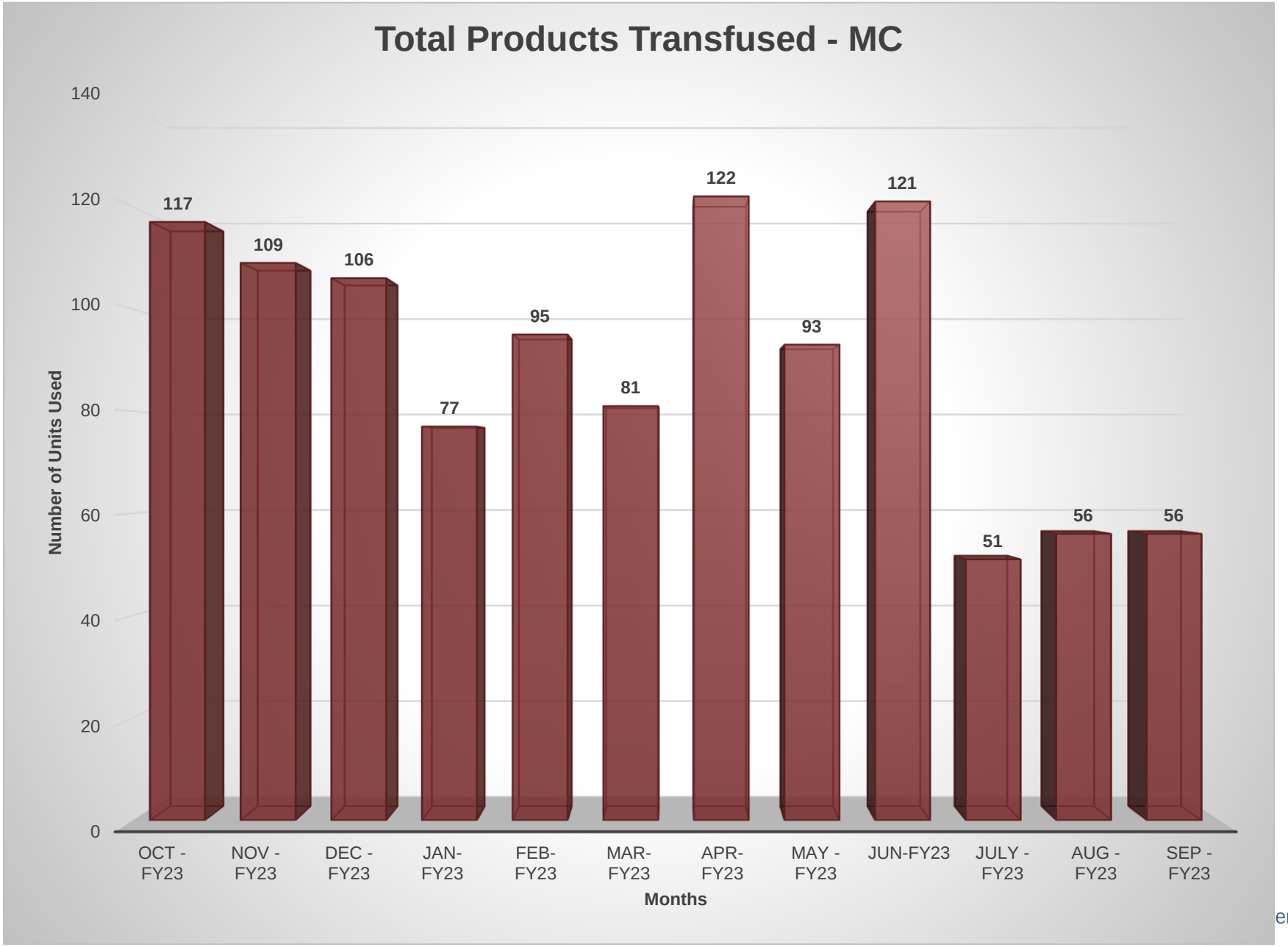
Total Transfusion Reaction - BH



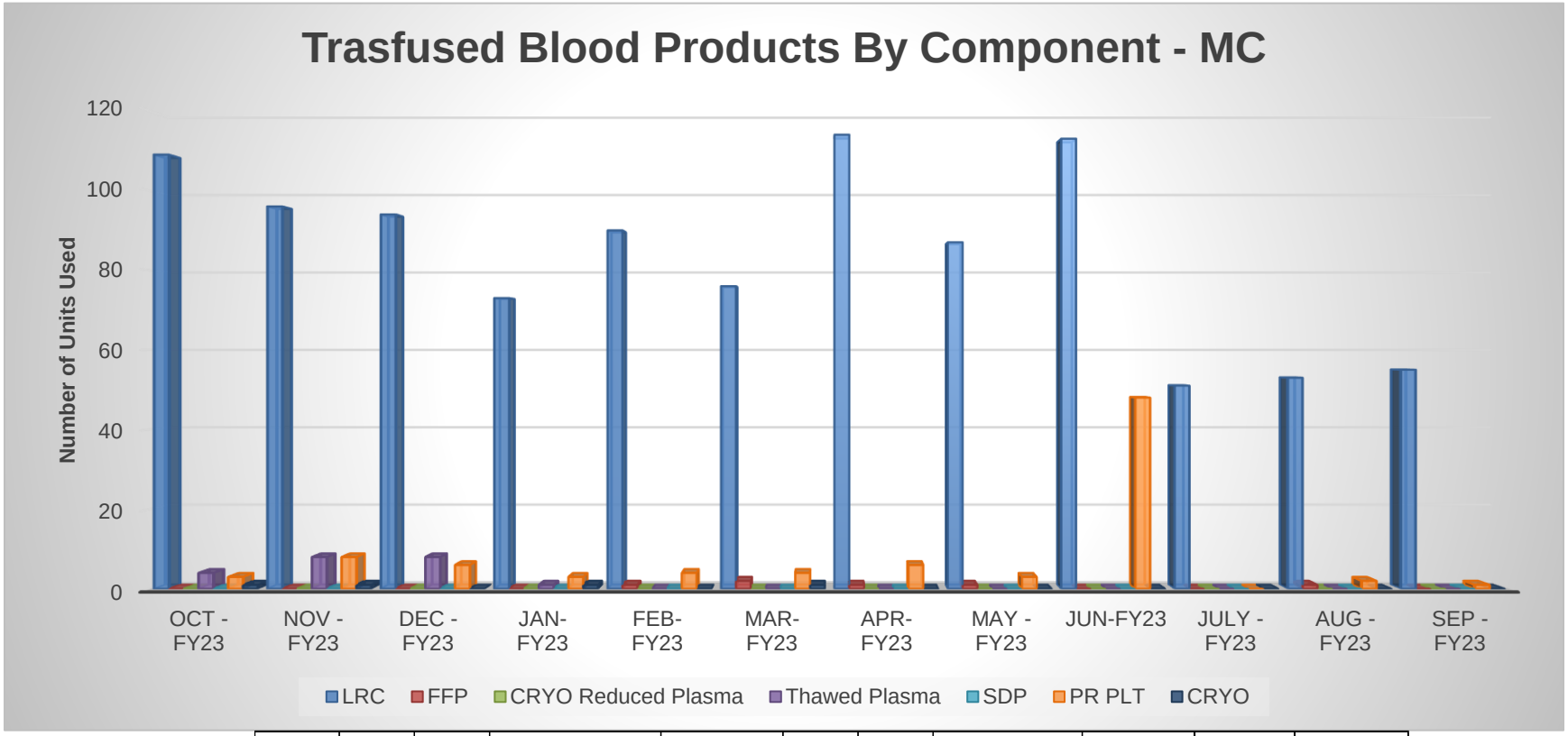
	Allergic	Febrile	Anaphylactic	Taco	Trali	Hemolytic	Other	Total
Oct - FY23	1	0	0	0	0	0	0	1
Nov - FY23	0	0	0	0	0	0	0	0
Dec - FY23	0	0	0	0	0	0	0	0
Jan- FY23	0	0	0	0	0	0	0	0
Feb- FY23	0	0	0	0	0	1	1	2
Mar-Fy23	0	1	0	0	0	0	0	1
Apr-FY23	1	2	0	1	0	0	0	4
May - FY23	1	1	0	0	0	0	2	4
Jun - FY23	0	0	0	0	0	0	2	2
July - FY23	0	0	0	0	0	0	0	0
Aug - FY23	0	2	0	0	0	0	0	2
Sep - FY23	1	1	0	0	0	0	0	2

PI.01.01.01 EP7

Yale NewHaven Health Bridgeport Hospital



PI.01.01.01 EP6

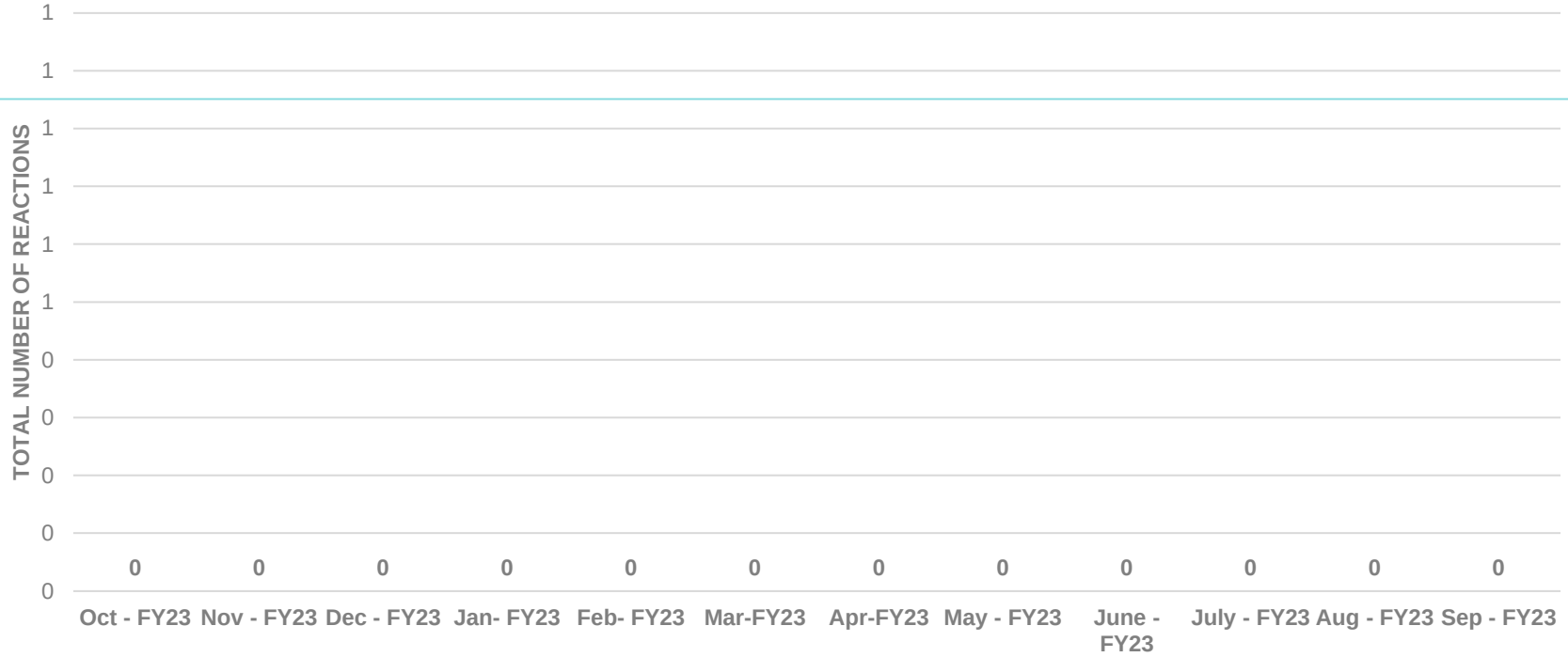


	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO	Total Products	Total Plasma	Total Platelets
Oct - FY23	109	0	0	4	0	3	1	117	4	3
Nov - FY23	96	0	0	8	0	8	1	109	4	8
Dec - FY23	94	0	0	8	0	6	0	106	6	6
Jan- FY23	73	0	0	1	0	3	1	77	0	3
Feb- FY23	90	1	0	0	0	4	0	95	1	4
Mar-FY23	76	2	0	0	0	4	1	81	0	4
Apr-FY23	114	1	0	0	0	6	0			
May - FY23	87	1	0	0	0	3	0	93	1	3
Jun-FY23	113	0	0	0	0	48	0	121	0	8
July - FY23	51	0	0	0	0	0	0	51	0	0
Aug - FY23	53	1	0	0	0	2	0	56	1	2
Sep - FY23	55	0	0	0	0	1	0	56	0	1

PI.01.01.01 EP6

Yale NewHaven Health Bridgeport Hospital

Total Transfusion Reaction - MC



	Allergic	Febrile	Anaphylactic	Taco	Trali	Hemolytic	Other	Total
Oct - FY23	0	0	0	0	0	0	0	0
Nov - FY23	0	0	0	0	0	0	0	0
Dec - FY23	0	0	0	0	0	0	0	0
Jan- FY23	0	0	0	0	0	0	0	0
Feb- FY23	0	0	0	0	0	0	0	0
Mar-FY23	0	0	0	0	0	0	0	0
Apr-FY23	0	0	0	0	0	0	0	0
May - FY23	0	0	0	0	0	0	0	0
June - FY23	0	0	0	0	0	0	0	0
July - FY23	0	0	0	0	0	0	0	0
Aug - FY23	0	0	0	0	0	0	0	0
Sep - FY23	0	0	0	0	0	0	0	0

PI.01.01.01 EP7

Yale NewHaven Health Bridgeport Hospital

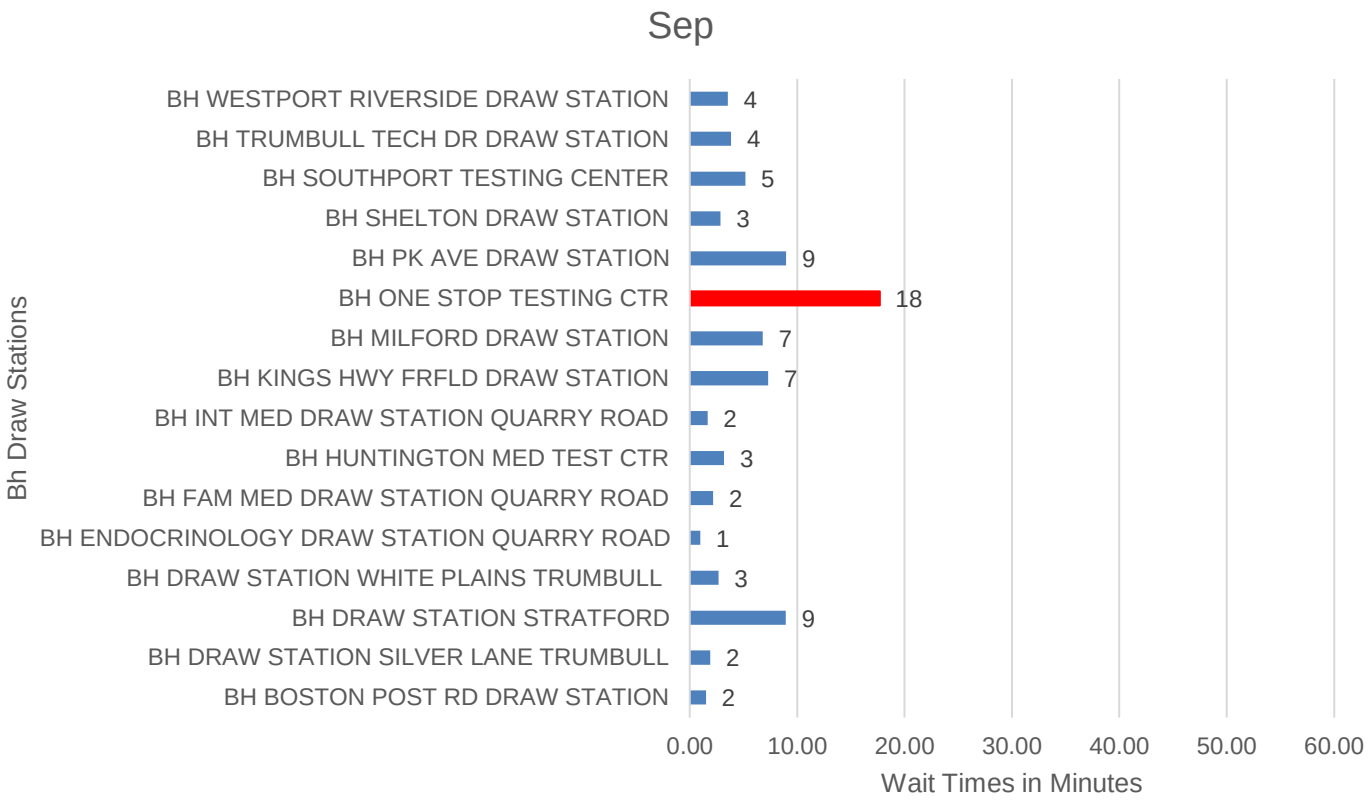
Performance Improvement Plan

Lab Outreach Pre-Analytical Quality Indicator Monthly Review

September 2023

Average Wait Times

Section	**Lab Outreach/Phlebotomy**
Phase	**Pre-Analytical**
Title	**Average Wait Times**
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	**The YNHHS Lab Blood Draw Wait Times report will be pulled monthly across all draw stations.**
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.**


Sep
BH WESTPORT RIVERSIDE DRAW STATION
BH TRUMBULL TECH DR DRAW STATION
BH SOUTHPORT TESTING CENTER
BH SHELTON DRAW STATION
BH PK AVE DRAW STATION
BH ONE STOP TESTING CTR
BH MILFORD DRAW STATION
BH KINGS HWY FRFLD DRAW STATION
BH INT MED DRAW STATION QUARRY ROAD
BH HUNTINGTON MED TEST CTR
BH FAM MED DRAW STATION QUARRY ROAD
BH ENDOCRINOLOGY DRAW STATION QUARRY ROAD
BH DRAW STATION WHITE PLAINS TRUMBULL
BH DRAW STATION STRATFORD
BH DRAW STATION SILVER LANE TRUMBULL
BH BOSTON POST RD DRAW STATION
4
4
5
3
9
18
7
7
2
3
2
1
3
9
2
2
Bh Draw Stations
0.00
10.00
20.00
30.00
40.00
50.00
60.00
Wait Times in 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.

February: Overall goal met for the month. February metrics are BH draw stations average 4 minutes overall. One Stop Testing Center was able to meet the patient wait-time of 15 minutes this month.

March: Overall goal met for the month. March metrics are BH stations average 5 minutes overall. Despite One Stop Testing high volume it was able to meet the patient wait-time of 15 minutes this month.

April: Overall goal met for the month. April metrics are BH draw stations average 5 minutes overall.

May: Overall goal met for the month. In May BH draw stations average 8 minutes wait-time with BH Shelton and BH One Stop having a noticeable increase in patient activity

June: Overall goal for the month was met. In June, BH draw stations averaged 5 minutes wait-time overall.

July: Overall goal for the month was met. In July, BH draw stations averaged 6 minutes wait-time overall.

August: Overall goal for the month was met. In August, BH draw stations averaged 5 minutes wait-time overall. BH One Stop is one of the busiest draw stations in the Bridgeport Area, due to its location and number of patients there is wait time greater than 15 minutes.

September: Overall goal for the month was met. In September, BH draw stations averaged 5 minutes wait-time overall. BH One Stop being the busiest location can maintain an average of less than 20 minutes for their wait time, this has not affected the rest of the BH draw stations

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.
February: Overall goal met for the month. Across all the BH locations 16 boxes of butterfly needles were ordered.
March: Overall goal met for the month. Across all the BH locations 16 boxes of butterfly needles were ordered.
April: Overall goal met for the month. Across all the BH locations 20 boxes of butterfly needles were ordered.
May: Overall goal met for the month. Across all the BH locations 16 boxes of butterfly needles were ordered resulting in a 3% decrease in butterfly usage from the previous month.
June: Overall goal met for the month. Across all the BH locations 12 boxes of butterfly needles were ordered resulting in a 5% butterfly usage decrease from April to June.
July: Overall goal met for the month. Across all the BH locations 28 boxes of butterfly needles were ordered resulting in a 10% butterfly usage increase from the previous month.
August: Overall goal met for the month. Across the BH locations 16 boxes of butterfly needles were ordered resulting in an 8% decrease in butterfly usage.
September: Overall goal met for the month. Across the BH locations 22 boxes of butterfly needles were ordered resulting in a 3% increase in butterfly usage from the previous month.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of Butterfly Needles	1019	800	800	1000	800	600	1400	800	**1100**
Total Number of Patient Draws	9302	9223	10958	8888	9996	9910	9024	10056	**9897**

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.

February: Overall goal met for the month. There has been an increase in redraw and cancellations across all the locations.

March: Overall goal met for the month. There has been an increase in redraw/cancellations at the same locations from February.

April: Overall goal not met for the month. There has been an increase in redraw/cancellations at 7 or the 16 locations for April.

May: Overall goal not met for the month. There has been an increase in redraw/cancellations at 8/16 locations for May, this month's cancel/redraw rate is 5.4%.

June: Overall goal for the month was met. There has been a decrease in cancel/redraw rate across 7/16 locations resulting in a 0.4% decrease. This month's cancel redraw rate is 5%.

July: Overall goal met for the month. There has been a decrease in cancel/redraw rate majority of locations resulting in a 1.6% decrease. This month's cancel draw rate is 3.4%.

August: Overall goal for the month was met. There has been a decrease in cancel/redraw rate of 0.7% for the month. Only two locations had a redraw/cancel rate above 5%.

September: Overall goal for the month was met. BH Fam Med Quarry Road, BH Huntington Med and BH One Stop were the locations this month with a major increase in cancel/redraw rates. This increase did not negatively affect the overall rate for all BH locations.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
BH BOSTON POST RD DRAW STATION	1.3%	2.5%	8.3%	4.9%	4.0%	3.5%	1.8%	1.4%	0.8%
BH DRAW STATION SILVER LANE TRUMBULL	3.1%	2.6%	2.6%	6.6%	3.0%	3.4%	0.5%	4.1%	2.4%
BH DRAW STATION STRATFORD	1.9%	1.7%	1.2%	3.2%	4.0%	2.1%	3.0%	0.0%	0.5%
BH DRAW STATION WHITE PLAINS TRUMBULL	1.0%	4.7%	2.0%	5.8%	4.8%	2.9%	1.5%	1.7%	2.3%
BH ENDOCRINOLOGY DRAW STATION QUARRY ROAD	2.6%	4.1%	3.9%	1.2%	7.7%	4.2%	0.6%	0.9%	1.5%
BH FAM MED DRAW STATION QUARRY ROAD	2.5%	4.3%	2.7%	1.2%	4.3%	4.5%	5.0%	3.8%	5.9%
BH HUNTINGTON MED TEST CTR	2.9%	4.9%	3.8%	3.4%	6.7%	12.5%	2.8%	7.4%	7.4%
BH INT MED DRAW STATION QUARRY ROAD	4.4%	6.8%	6.7%	9.0%	7.9%	10.0%	6.8%	4.9%	4.8%
BH KINGS HWY FRFLD DRAW STATION	2.1%	4.9%	7.3%	8.1%	2.5%	2.5%	2.7%	2.9%	0.7%
BH MILFORD DRAW STATION	3.4%	3.8%	4.3%	3.9%	4.3%	1.6%	0.8%	0.2%	1.3%
BH ONE STOP TESTING CTR	7.2%	7.1%	6.8%	11.3%	11.7%	13.0%	4.4%	5.2%	6.3%
BH PK AVE DRAW STATION	4.6%	7.2%	9.4%	9.4%	10.4%	9.8%	2.9%	2.1%	1.7%
BH SHELTON DRAW STATION	1.8%	2.4%	2.2%	4.2%	2.3%	3.4%	3.2%	2.9%	0.6%
BH SOUTHPORT TESTING CENTER	3.0%	4.4%	3.6%	2.5%	8.9%	0.8%	1.5%	1.0%	3.7%
BH TRUMBULL TECH DR DRAW STATION	2.3%	3.3%	3.1%	7.2%	4.7%	5.2%	10.1%	3.8%	1.8%
BH WESTPORT RIVERSIDE DRAW STATION	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%	1.0%	2.8%
ALL DRAW STATION AVERAGE	3.0%	4.1%	4.2%	5.1%	5.4%	5.0%	3.4%	2.7%	2.8%

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.

February: Overall goal for the month was met. All centrifuges are up-to-date.

March: Overall goal for the month was met. All centrifuges are up-to-date.

April: Overall goal for the month was met. All centrifuges are up-to-date.

May: Overall goal for the month was met. All centrifuges are up-to-date.

June: Overall goal for the month was met. All centrifuges are up-to-date.

July: Overall goal met for the month. All centrifuges are up-to-date.

August: Overall goal met for the month. All centrifuges are up-to-date.

September: Overall goal met for the month. All centrifuges are up-to-date.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of Compliant Centrifuges	19	19	19	19	19	19	20	20	20
Total Number of Centrifuges	19	19	19	19	19	19	20	20	20
ALL DRAW STATIONS	100%	100%	100%	100%	100%	100%	100%	100%	**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. January patient satisfaction rate was 60%. 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.

February: Overall goal for the month was met. Across the BH draw station locations 96% of patients were likely to recommend our facilities to a friend, 99% of patients felt our facilities were neat and clean, and 97% of patients felt they were treated with respect during their visit.

March: Overall goal for the month was met. Across the BH draw station locations 100% 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.

April: Overall goal for the month was met. Across the BH draw station locations 95% of patients were likely to recommend our facilities to a friend, 100% of patients felt our facilities were neat and clean, and 91% of patients felt they were treated with respect during their visit.

May: Overall goal for the month was not met. Across the BH draw station locations 89% of patients were likely to recommend our facilities to a friend, 94% of patients felt our facilities were neat and clean, and 89% of patients felt they were treated with respect during their visit.

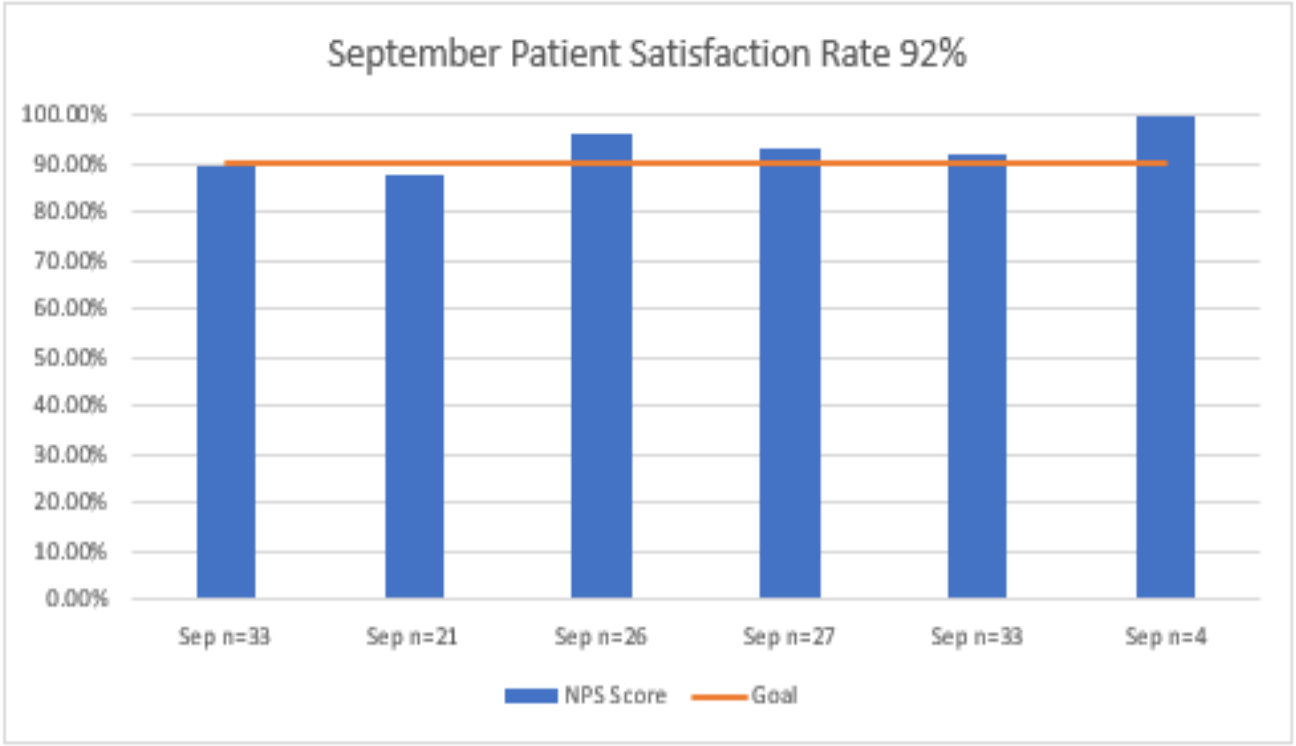
June: Overall goal for the month was not met. This month there was not a substantial amount of data from the surveys received. Across the BH draw station locations 87% of patients were likely to recommend our facilities to a friend, 100% of patients felt our facilities were neat and clean, and 100% of patients felt they were treated with respect during their visit.

July: Overall goal for the month was met. Across the BH draw station locations 96% of patients were likely to recommend our facilities to a friend, 98% of patients felt our facilities were neat and clean, and 97% of patients felt they were treated with respect during their visit.

August: Overall goal for the month was met. Across BH draw station locations 90% of patients were likely to recommend our facilities to a friend, 99% of patients felt our facilities were neat and clean, and 99% of patients felt they were treated with respect during their visit.

September: Overall goal for the month was met. Across BH draw station locations 92% of patients were likely to recommend our facilities to a friend, 98% of patients felt our facilities were neat and clean, and 98% of patients felt they were treated with respect during their visit.

Reviewed by:


September Patient Satisfaction Rate 92%
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Sep n=33
Sep n=21
Sep n=26
Sep n=27
Sep n=33
Sep n=4
NPS Score
Goal

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.

February: Overall goal for the month has been met. For the month of February, the # of providers transcribed correctly 60/60, sum of tests transcribed correctly 204/206 and # of requisitions scanned in EPIC 14/24.

March: Overall goal for the month has been met. For the month of March, the # of providers transcribed correctly 116/116, sum of tests transcribed correctly 329/329 and # of requisitions scanned in EPIC 35/45.

April: Overall goal for the month was met. For the month of April, the # of providers transcribed correctly 101/101, sum of tests transcribed correctly 313/318 and # of requisitions scanned in EPIC 34/48.

May: Overall goal for the month was met. For the month of May, the # of providers transcribed correctly 105/106, sum of tests transcribed correctly 389/391 and # of requisitions scanned in EPIC 103/103.

June: Overall goal for the month was met. For the month of June, the # of providers transcribed correctly 110/110, sum of tests transcribes correctly 527/528 and # of requisitions scanned in EPIC 108/108.

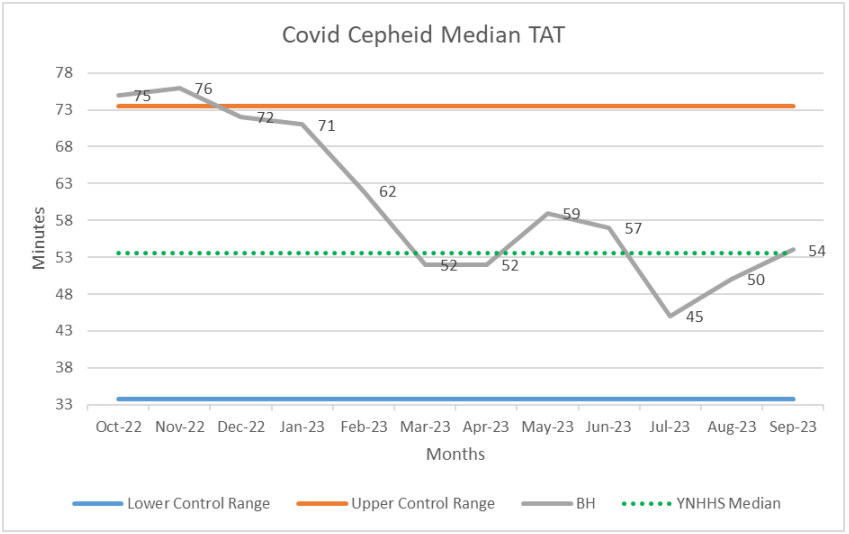
July: Overall goal for the month was met. For the month of July, the # of providers transcribed correctly 102/102, sum of tests transcribed correctly 355/357 and # of requisitions scanned in EPIC 101/101.

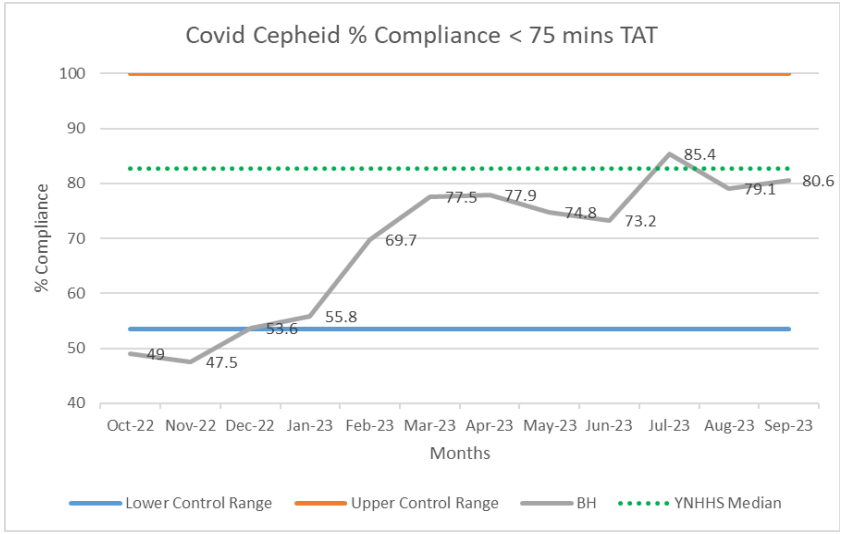
August: Overall goal for the month was met. For the month of August, the # of providers transcribed correctly 115/115, sum of tests transcribed correctly 341/343 and # of requisitions scanned in EPIC 114/114.

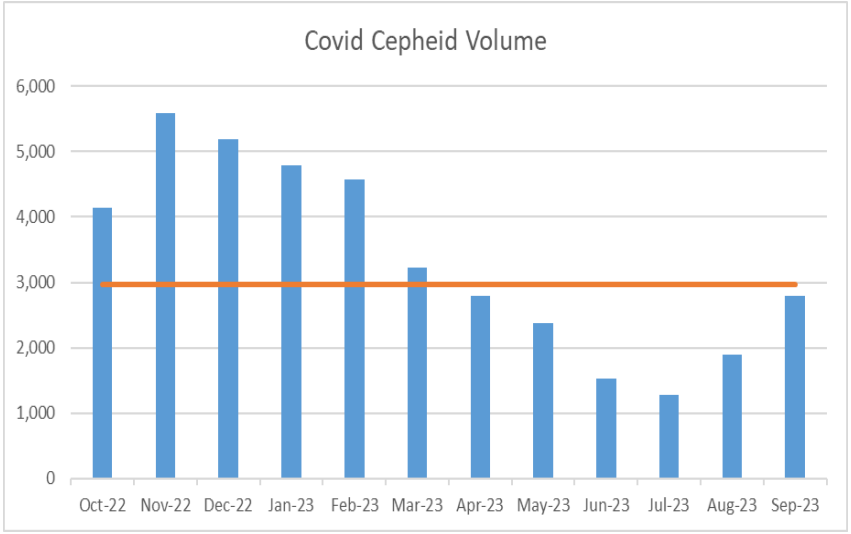
September: Overall goal for the month was met. For the month of September, the # of providers transcribed 101/101, sum of tests transcribed correctly 334/334 and # of requisitions scanned in EPIC 100/100.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ALL DRAW STATION AVERAGE	97%	96%	98%	96%	100%	100%	100%	100%	**100%**

Bridgeport Campus – COVID-19 Cepheid







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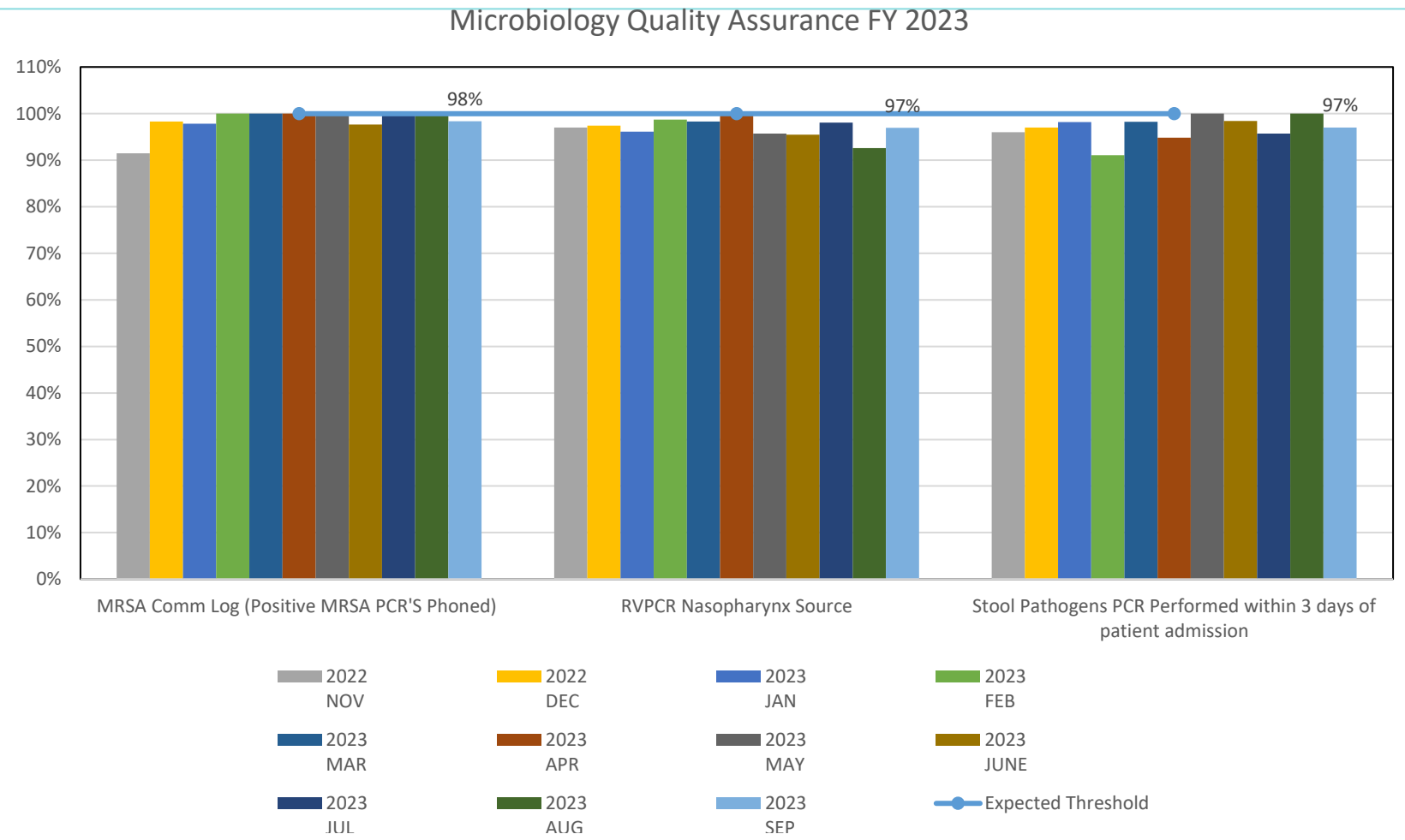
FY 2023 QA

Microbiology and Central Processing

September 2023

Microbiology Quality Measures September 2023



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Microbiology test volumes

2023 Total Volume	October	November	December	January	February	March	April	May	June	July	August	Sept
MRSA	459	447	492	441	396	460	472	465	418	465	449	470
MRSA +	39	47	58	46	46	65	30	41	43	46	42	61
Cdiff	155	130	148	168	161	156	170	181	185	150	136	143
Cdiff +	28	22	29	24	25	18	19	29	22	30	35	29
RVP	312	297	272	231	229	118	254	239	155	157	147	165
Stool	144	128	136	146	161	181	180	170	169	188	170	204
Stool Admitted	49	49	67	56	56	57	77	66	63	70	84	101
Errors	4	0	1	0	2	0	2	2	7	2	2	0

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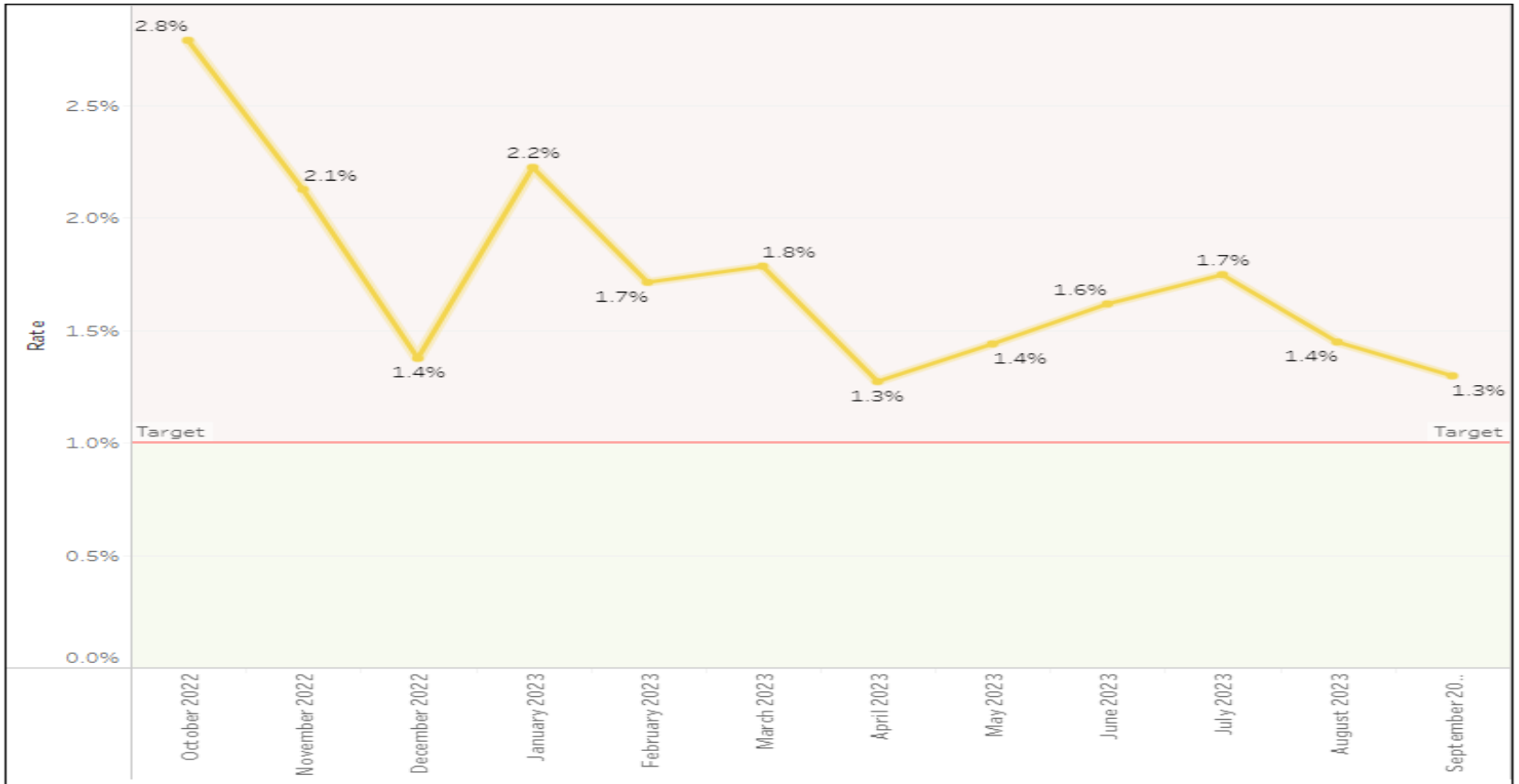
BH & MC Blood Culture Contamination Rate



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."

Yale NewHaven Health Bridgeport Hospital

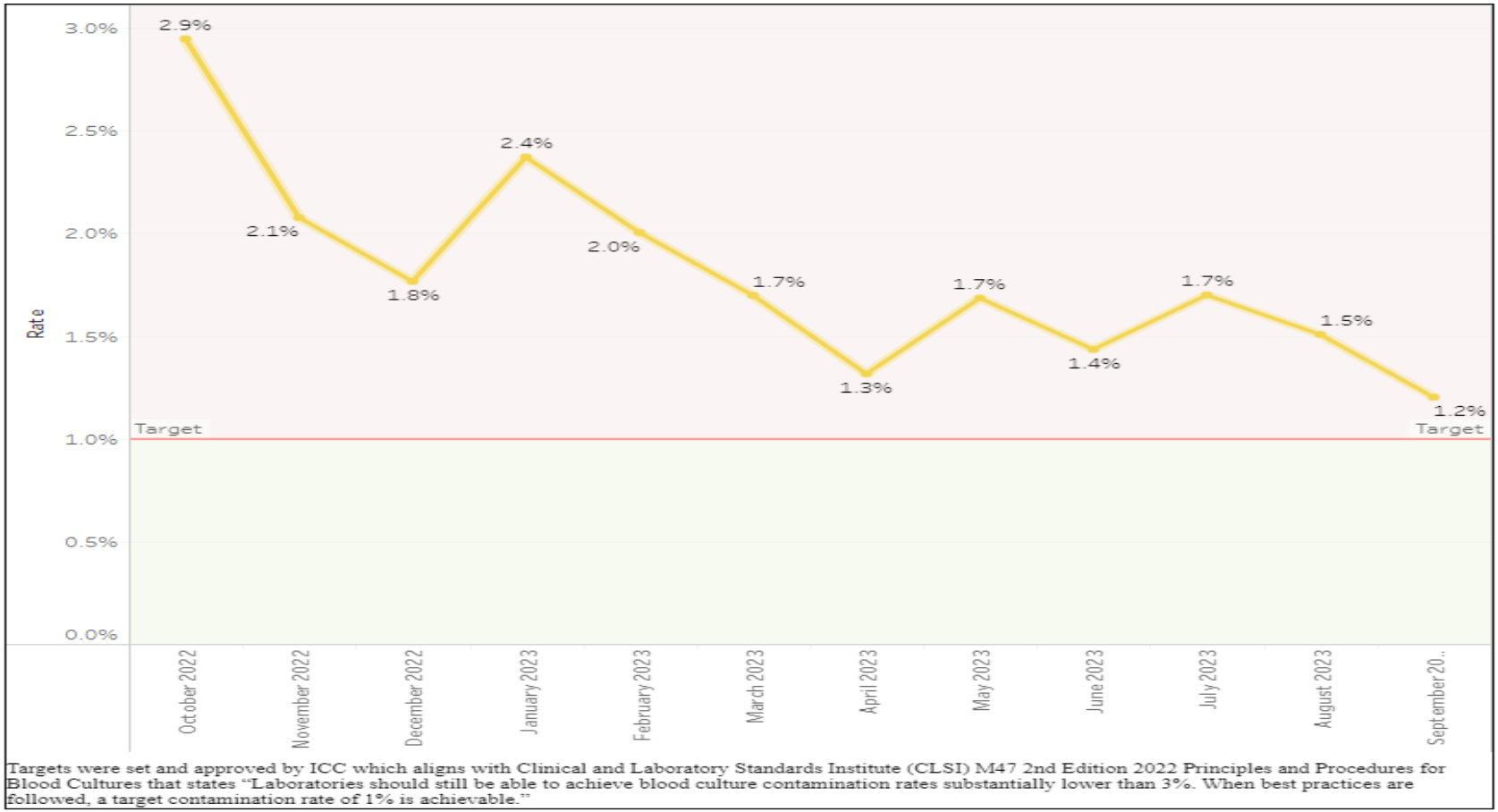
BH &MC Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	September ..	745	11	1.5%
		Inpatient	BH NORTHEAST 7	September ..	13	1	7.7%
			BH NORTHWEST 9	September ..	40	2	5.0%
	MC	Emergency ..	MC EMERGENCY DEPART..	September ..	247	5	2.0%
Grand Total					1,045	19	1.8%

Yale NewHaven Health Bridgeport Hospital

BH Blood Culture Contamination Rate



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Yale NewHaven Health Bridgeport Hospital

BH Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	September ..	745	11	1.5%
		Inpatient	BH NORTHEAST 7	September ..	13	1	7.7%
			BH NORTHWEST 9	September ..	40	2	5.0%
Grand Total					798	14	1.8%

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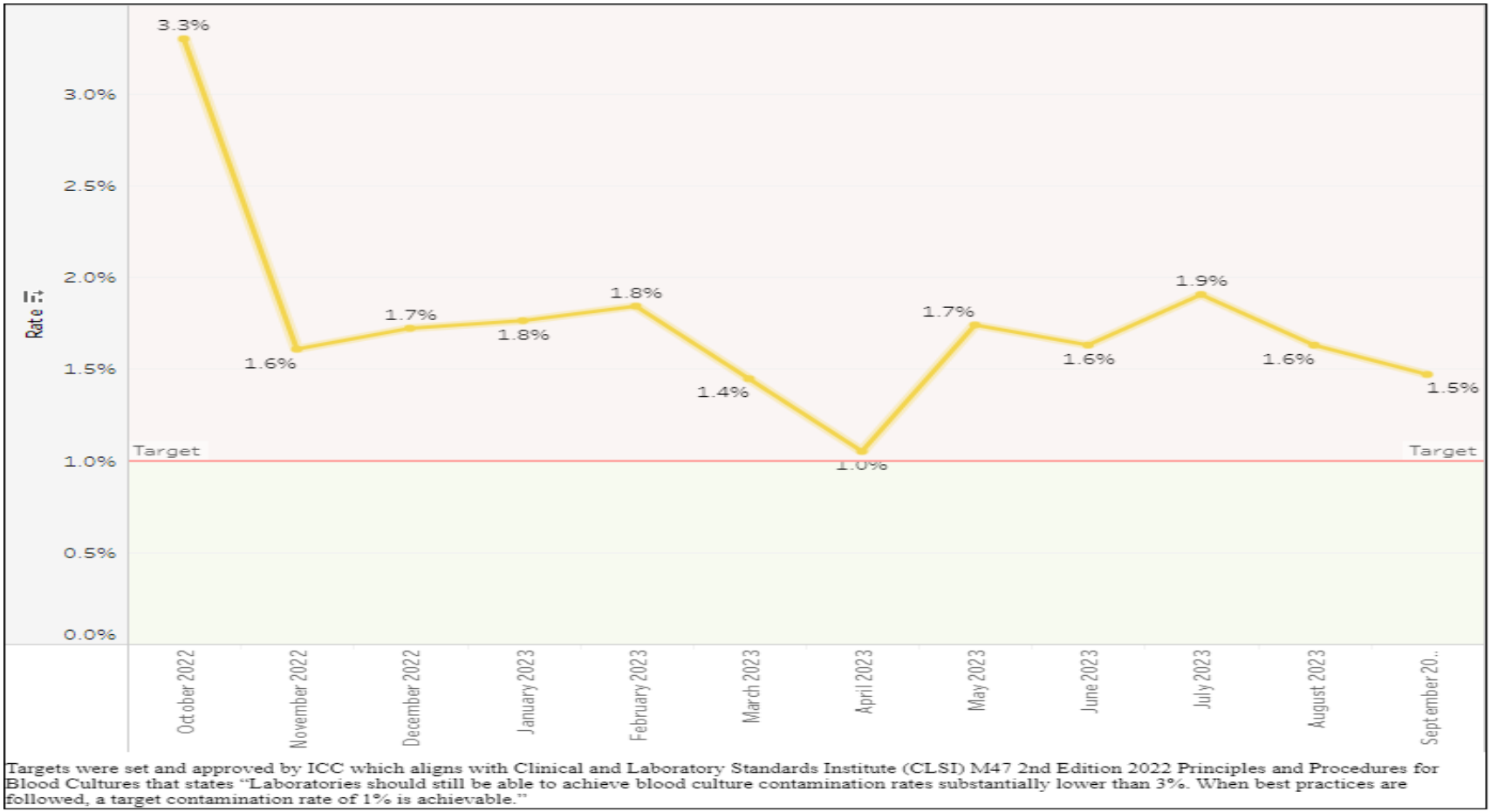
BH Blood Culture Contamination Rate(ED only)



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Bridgeport Hospital

BH ED Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	September ..	745	11	1.5%

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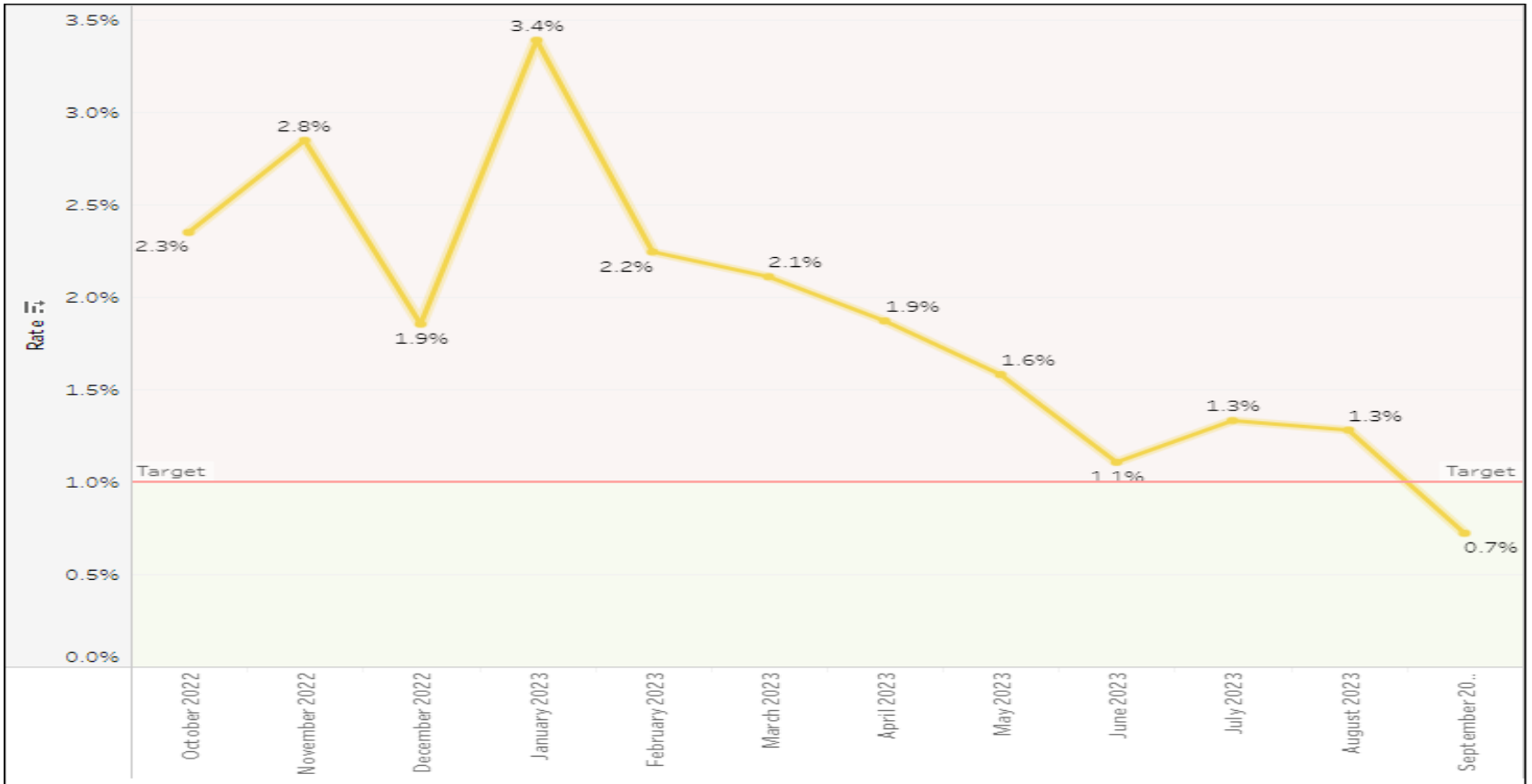
BH Blood Culture Contamination Rate (excluding ED)



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BH-All other units (excluding ED) Rate Breakdown

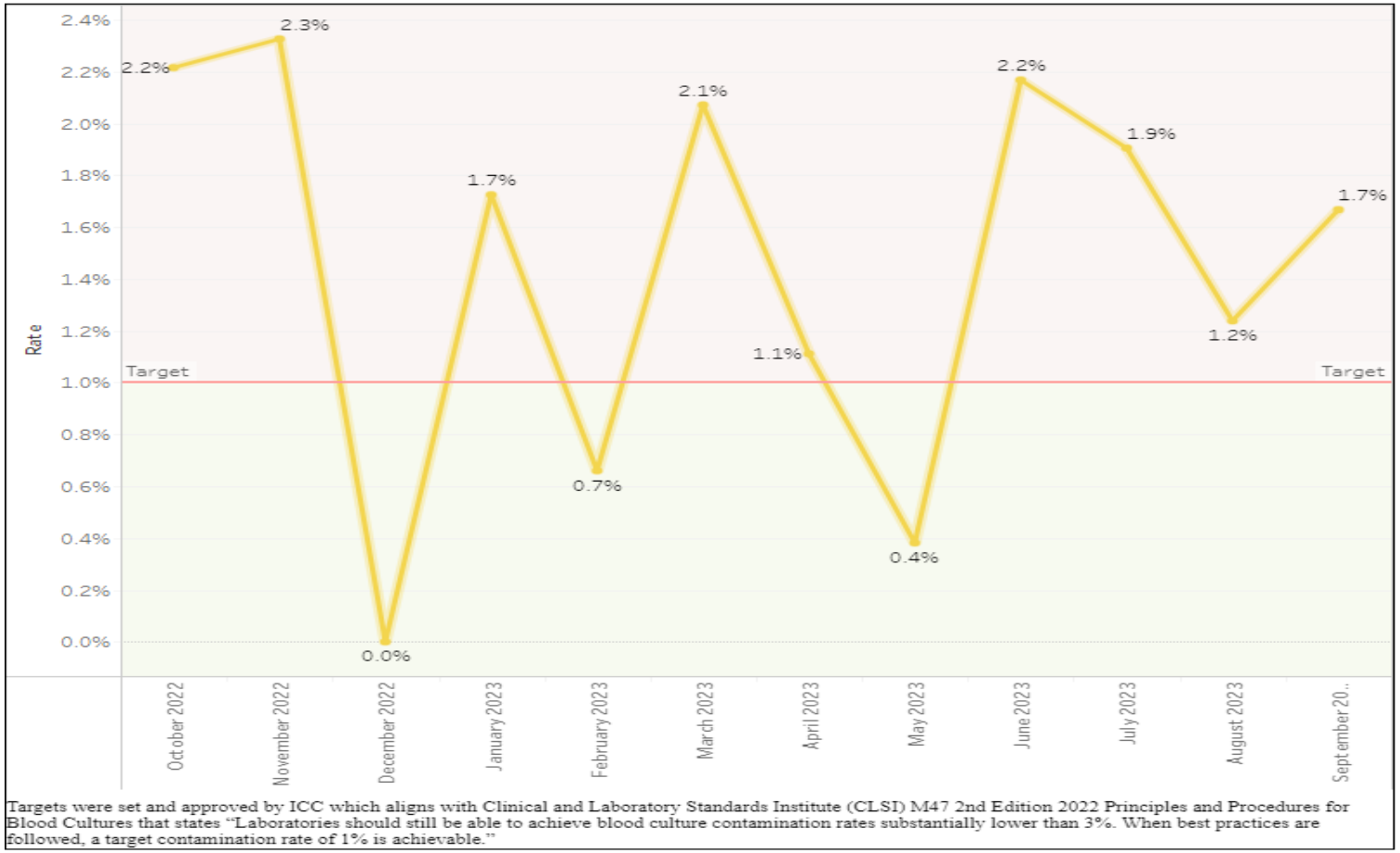
Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	September ..	745	11	1.5%
		Inpatient	BH NORTHEAST 7	September ..	13	1	7.7%
			BH NORTHWEST 9	September ..	40	2	5.0%
Grand Total					798	14	1.8%

- Total = 53
- Cont. count = 3
- Rate = 0.7%

Yale NewHaven Health Bridgeport Hospital

MC 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."

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Bridgeport Hospital

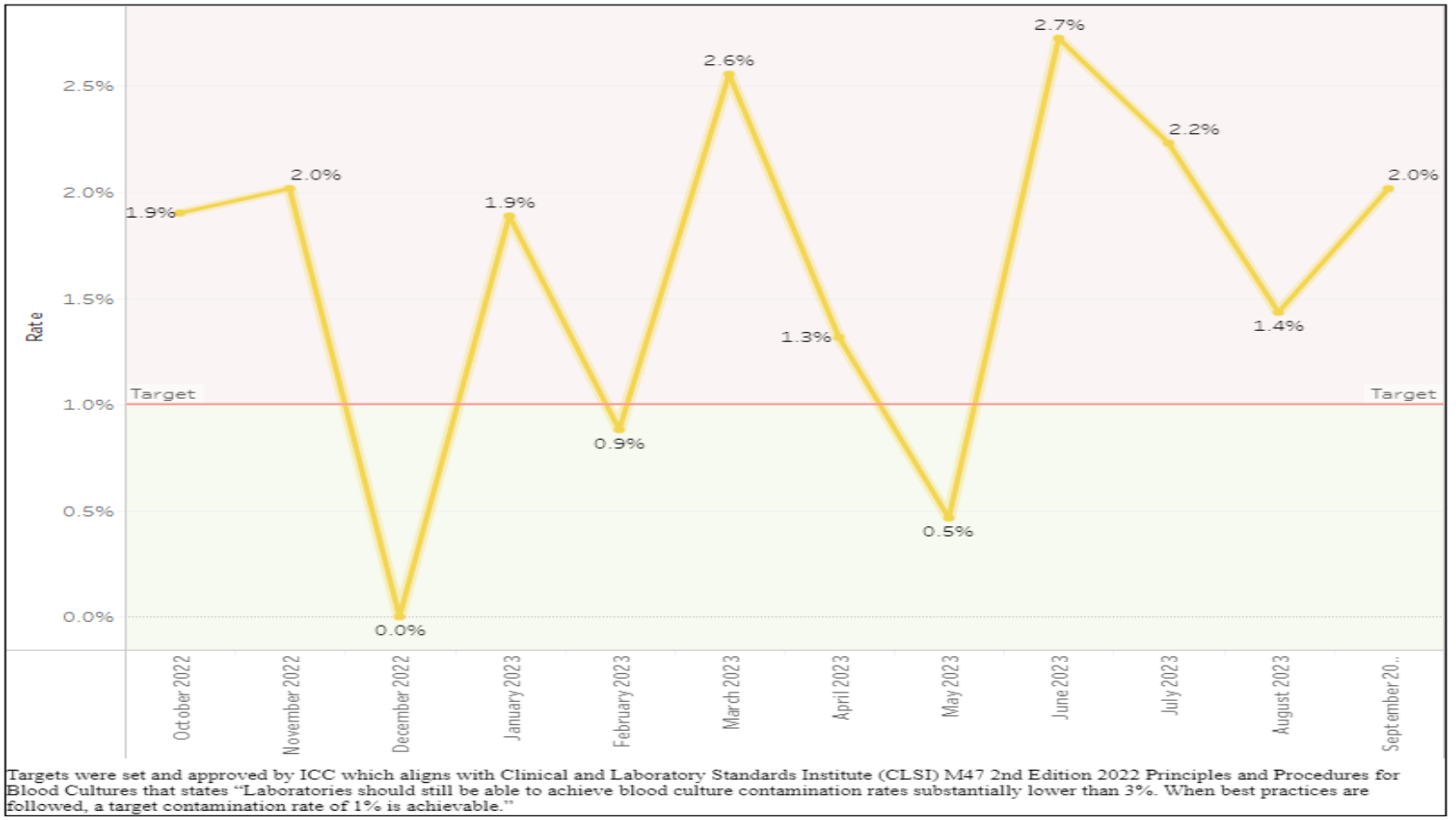
MC Unit Rate Breakdown

Overall

Specimen Count	300
Cont Count	5
Rate	1.7%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate(ED only)



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Yale NewHaven Health Bridgeport Hospital

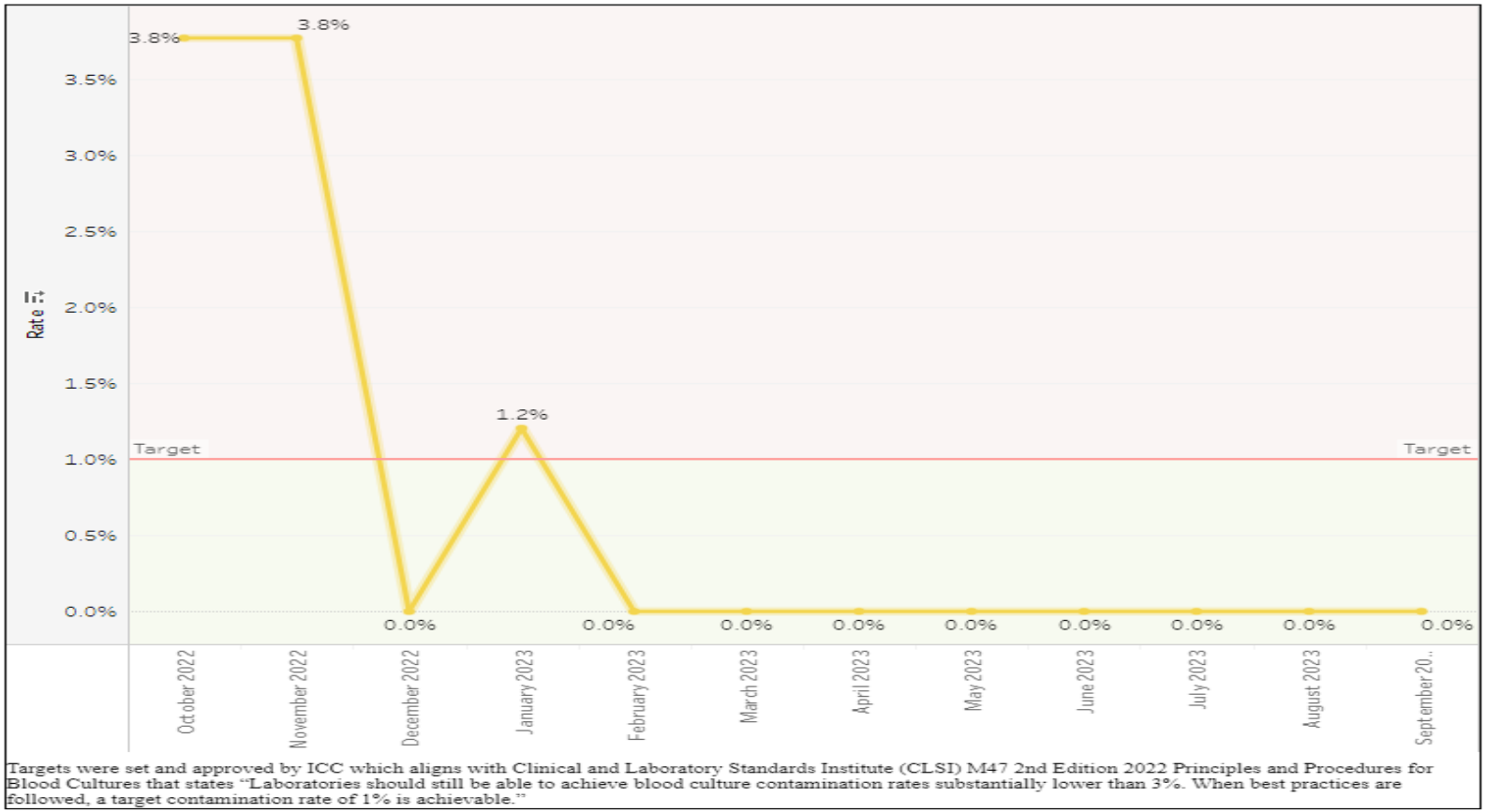
BH ED Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	September ..	247	5	2.0%
Grand Total					247	5	2.0%

Yale NewHaven Health Bridgeport Hospital

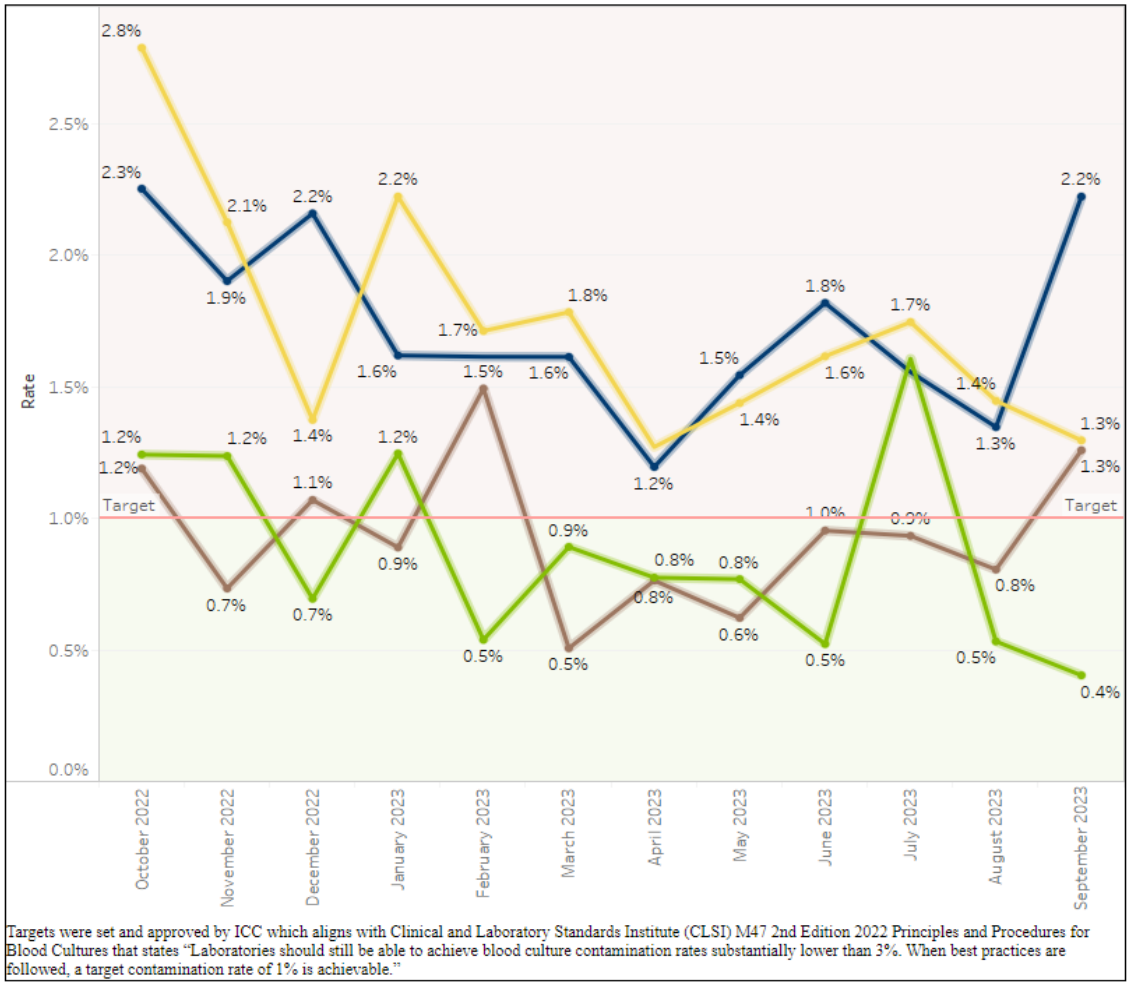
MC Blood Culture Contamination Rate (excluding ED)



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."

Yale NewHaven Health Bridgeport Hospital

Blood culture Contamination Rate DNs Comparison



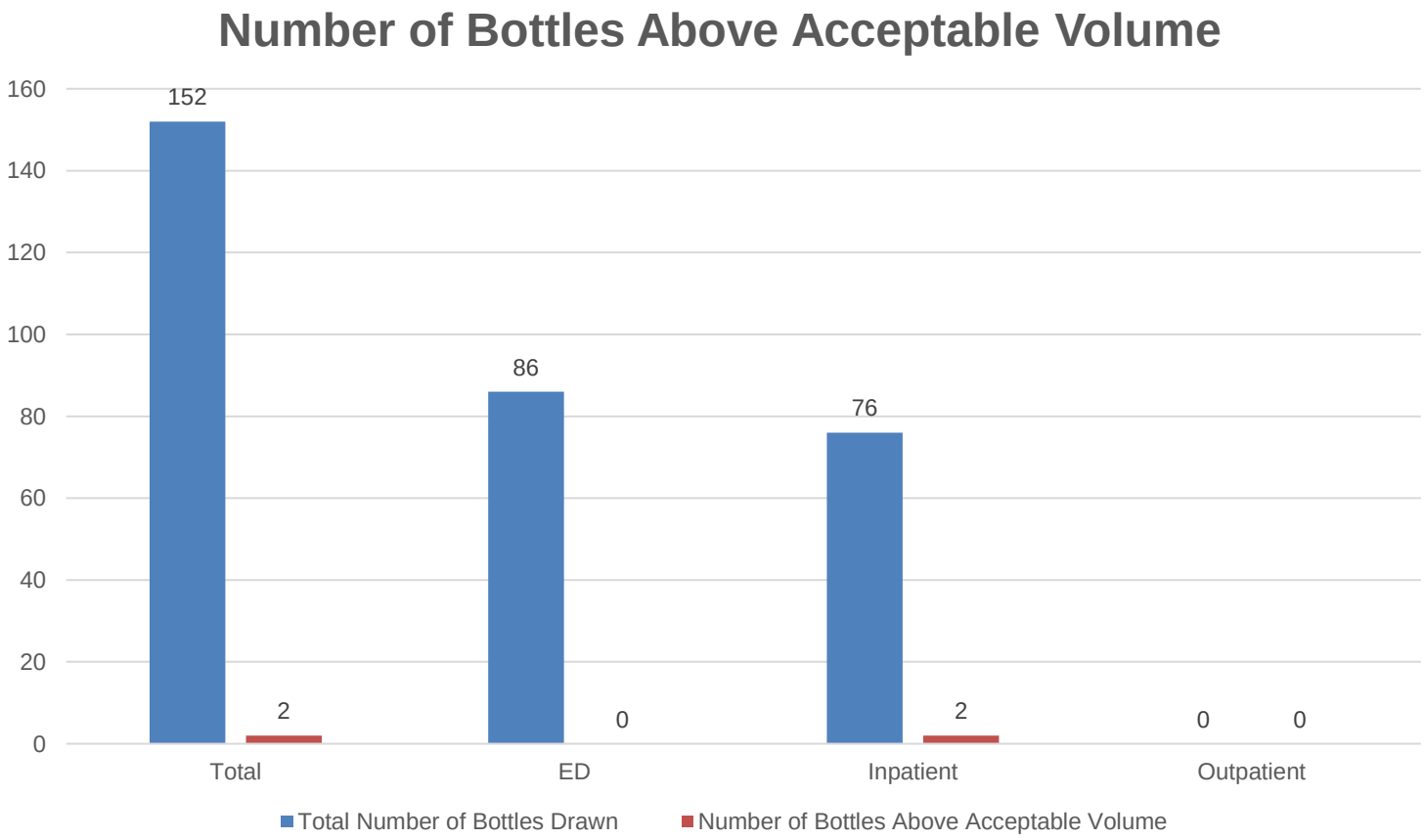
Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best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

- BH/MC =1.3 %
- YNHH = 2.2%
- LMH/WH = 1.3%
- GH = 0.4 %

DN
BH/MC
GH
LMH/WH
YNHH

Yale NewHaven Health
Bridgeport Hospital

Blood Culture Bottle Volumes – Above Optimal for August 2023



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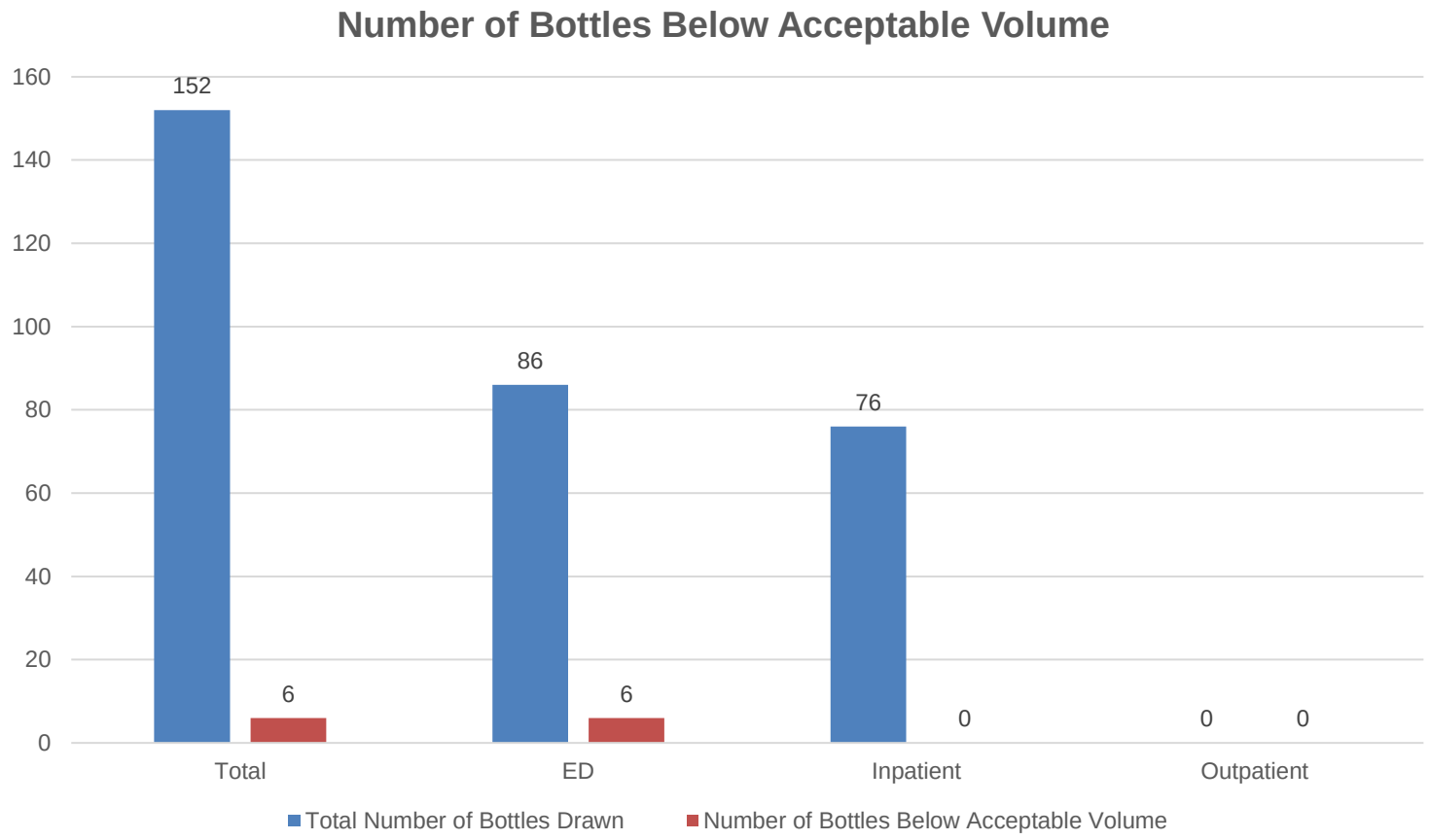
Blood Culture Bottle Volumes – Below Optimal for August 2023



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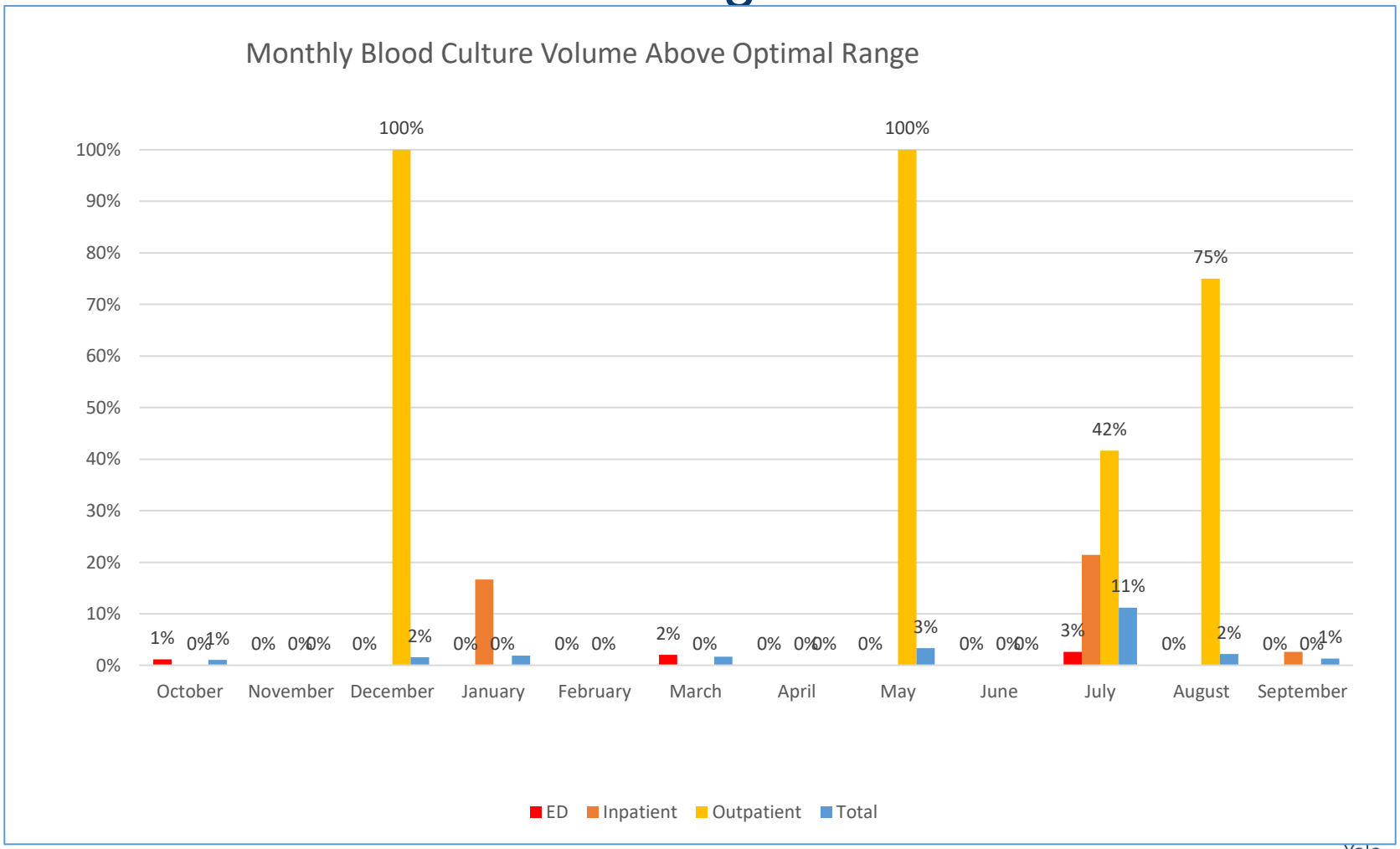
FY 2023 Blood Culture Volume Above Optimal Range



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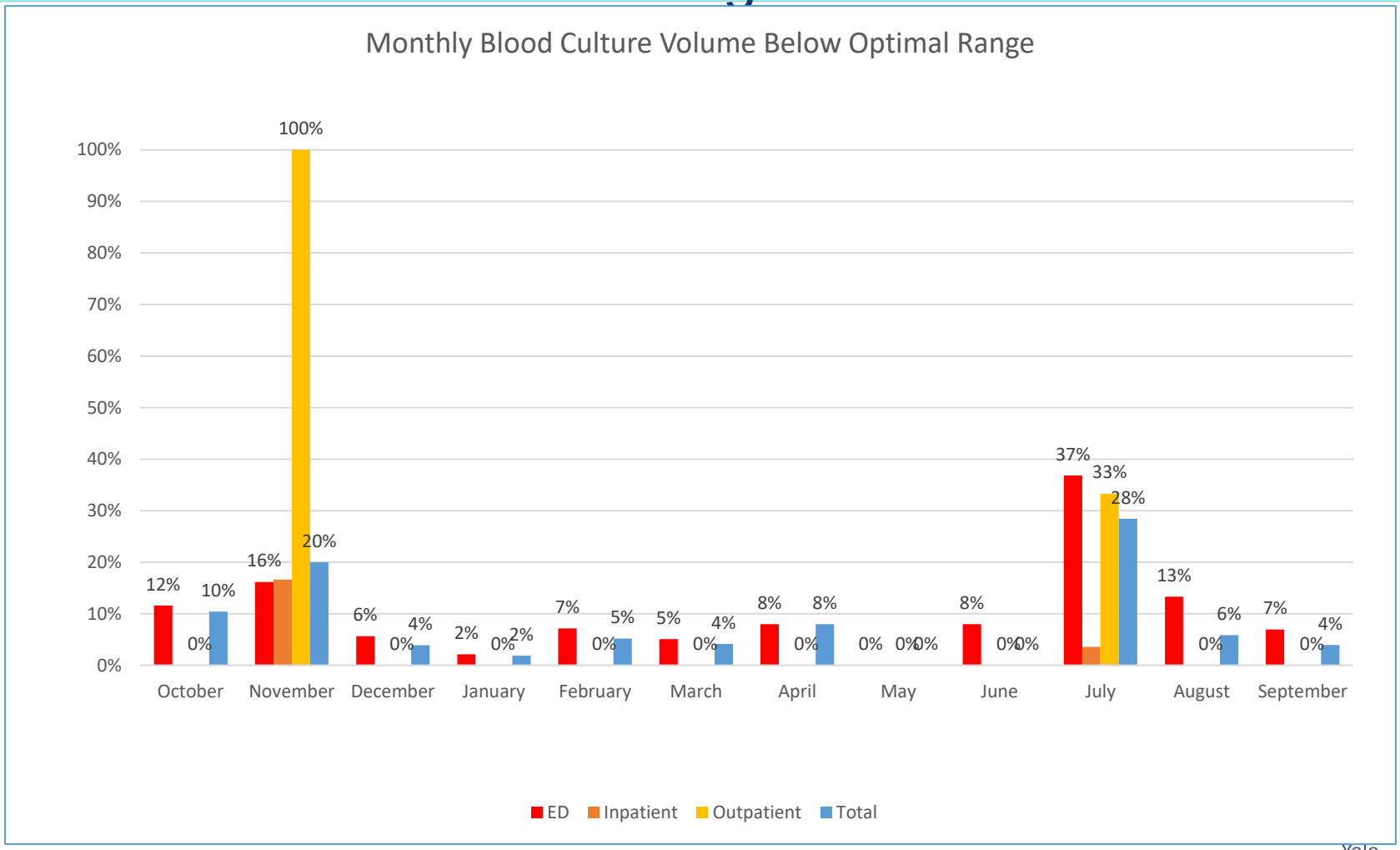
FY 2023 Blood Culture Volume Below Optimal Range



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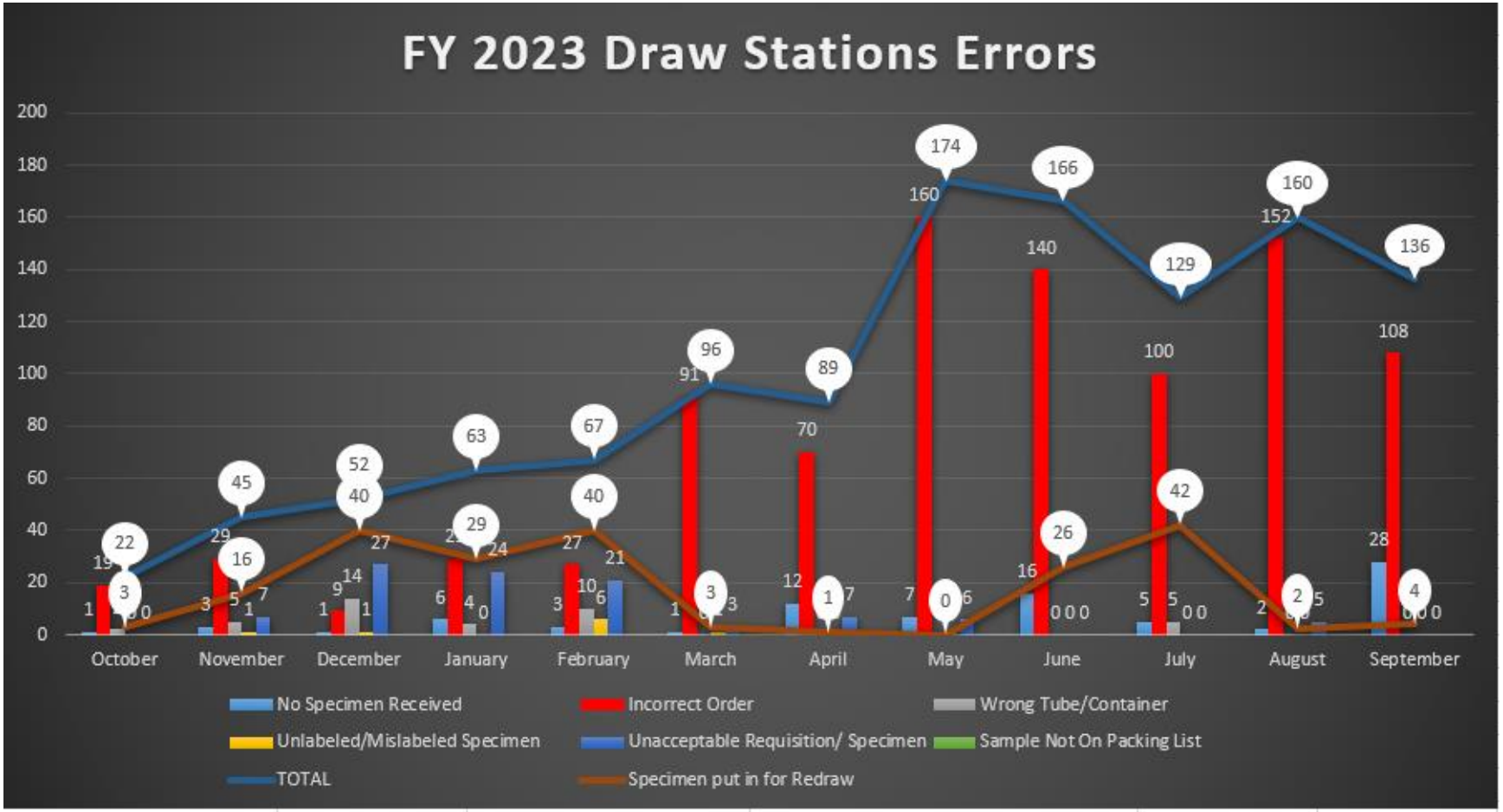
Micro Molecular Statistics

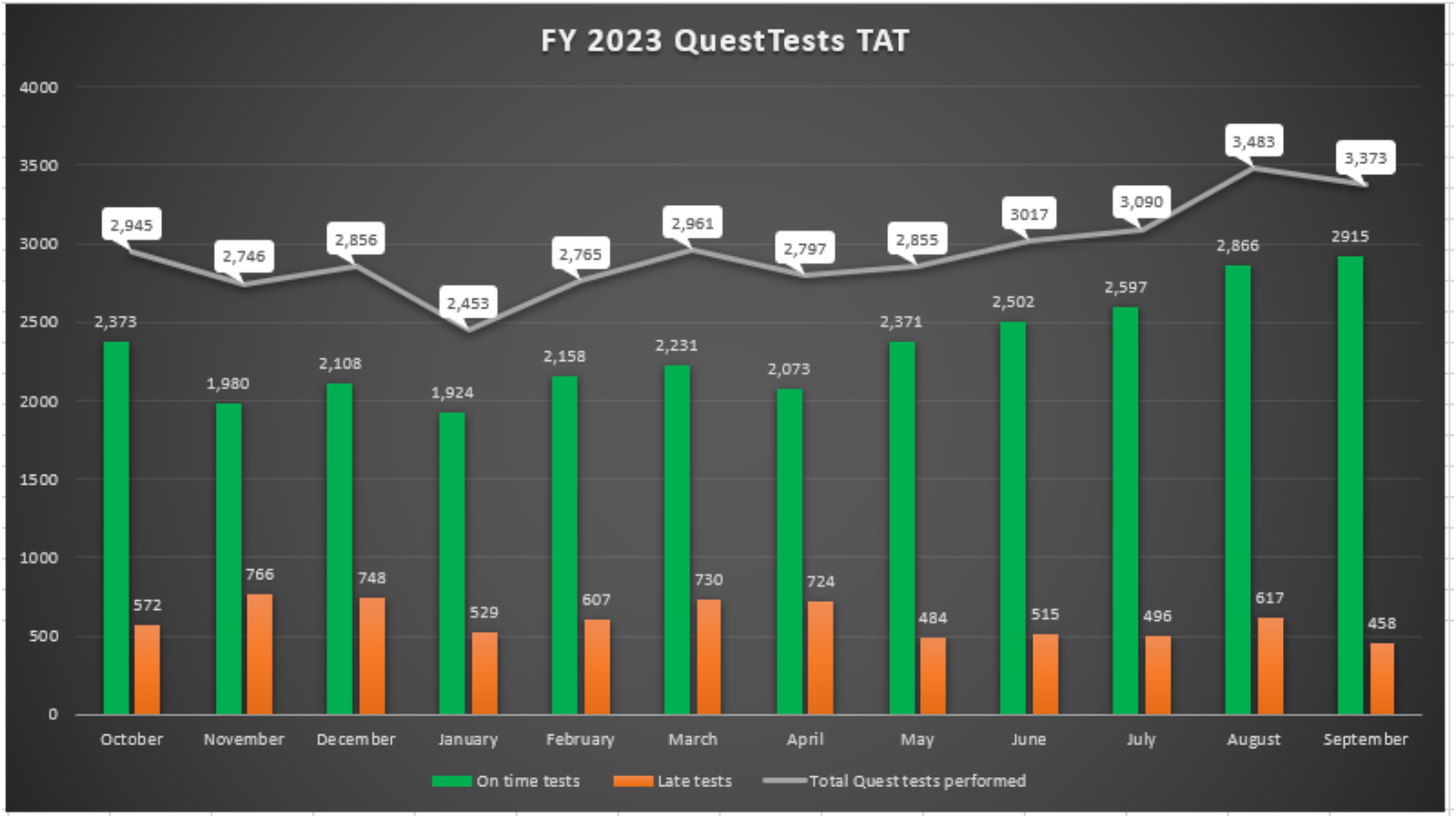
Date	Tests	Sample size	Positive Count	% Positivity	Lower Limit	Upper Limit	Environment Monitoring	Epidemiological Trends	Evaluation Notes
Sep-23	C. difficile Assay	143	29	20.30%	15%	31%	Negative	None	None
Sep-23	Chlamydia trachomatis, NAAT	475	21	4.40%	2%	7%	Negative	None	None
Sep-23	GBS PCR Pen Allergic	25	6	24.00%	0%	47%	Negative	None	None
Sep-23	GBS PCR Pen NonAllergic	63	15	23.80%	15%	33%	Negative	None	None
Sep-23	Group A Strep PCR	428	51	11.90%	1%	27%	Negative	None	None
Sep-23	Influenza A/B RNA, NAAT	763	2	0.30%	0%	19%	Negative	None	None
Sep-23	Influenza/RSV by RT-PCR	1,617	18	1.10%	0%	16%	Negative	None	None
Sep-23	MRSA Colonization Status	420	61	14.50%	5%	18%	Negative	None	None
Sep-23	MRSA/SAUR Blood PCR	27	12	44.40%	15%	52%	Negative	None	None
Sep-23	MTB w/rflx Rifampin PCR	6	0	0.00%	0%	80%	Negative	None	None
Sep-23	N. gonorrhoeae, NAAT	475	9	1.90%	1%	3%	Negative	None	None
Sep-23	Resp Virus PCR Panel	83	14	16.90%	3%	52%	Negative	None	None
Sep-23	SARS CoV-2 (COVID-19) RNA	2,799	388	13.90%	0%	20%	Negative	None	None
Sep-23	Stool Pathogens PCR	134	5	3.70%	0%	21%	Negative	None	None

FY2023 Draw Station Errors



NewHaven Health
Bridgeport Hospital

Quest TAT



The TAT calculations include
accessions that have been through the "test in question" process, or tests that have been corrected, repeated, reflexed, confirmed, or added on after the original order.

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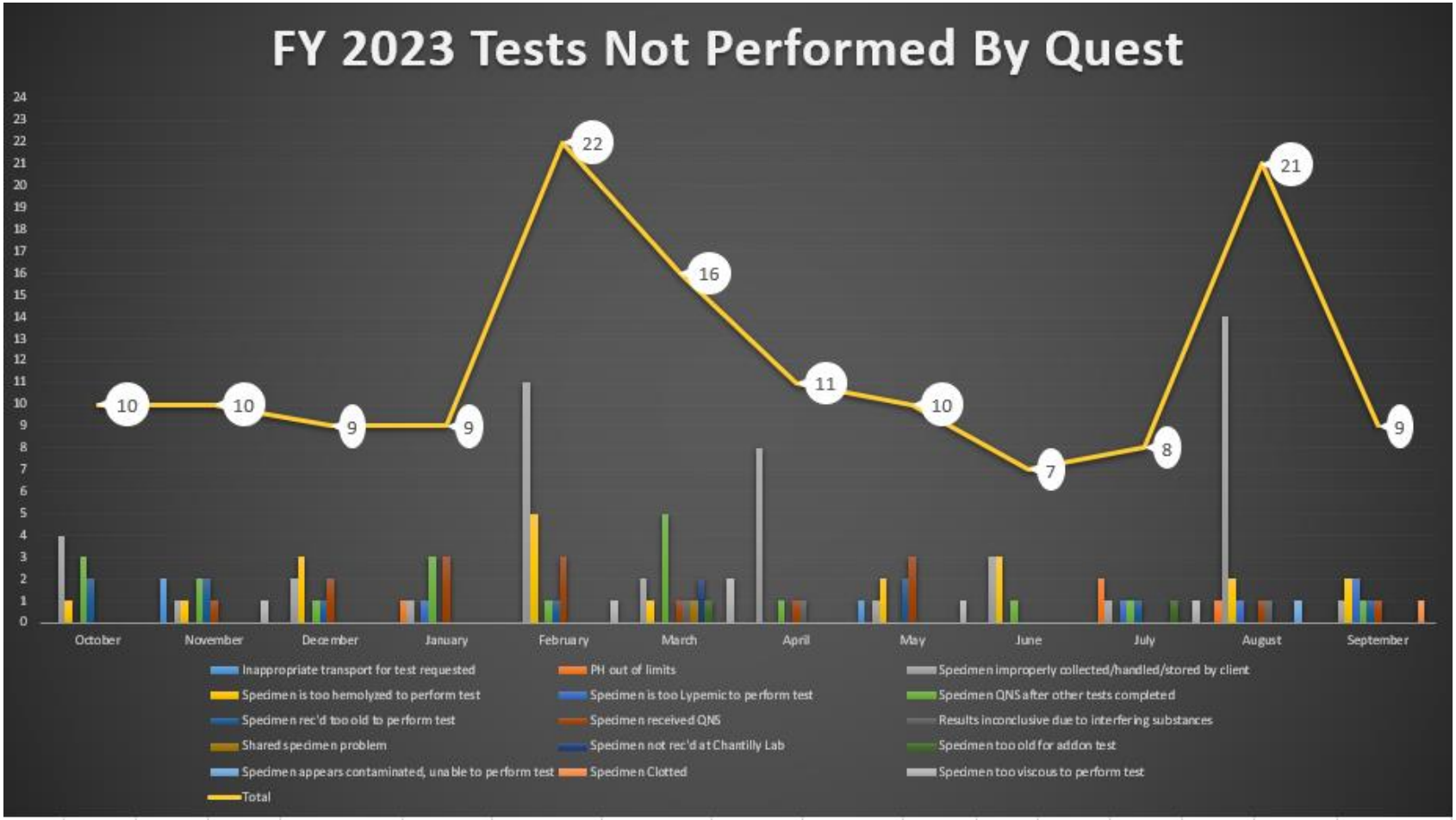
Bridgeport Hospital

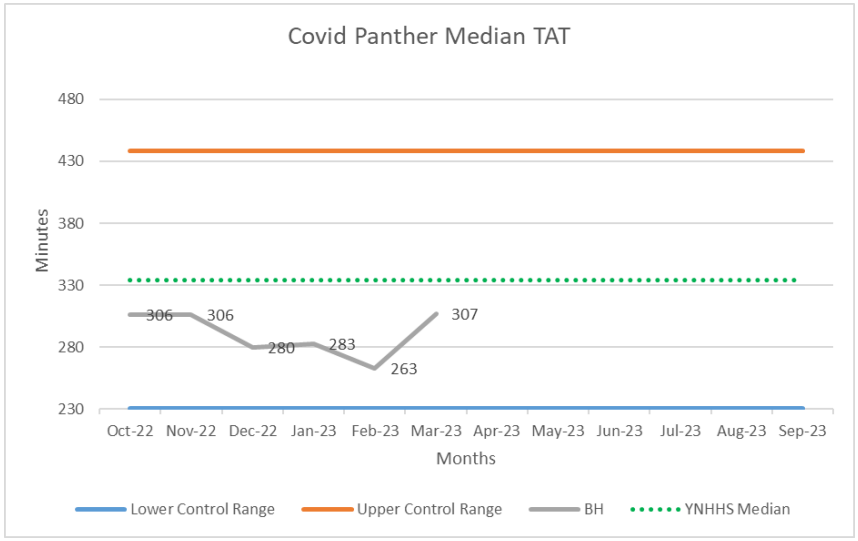
Quest Rejected Tests

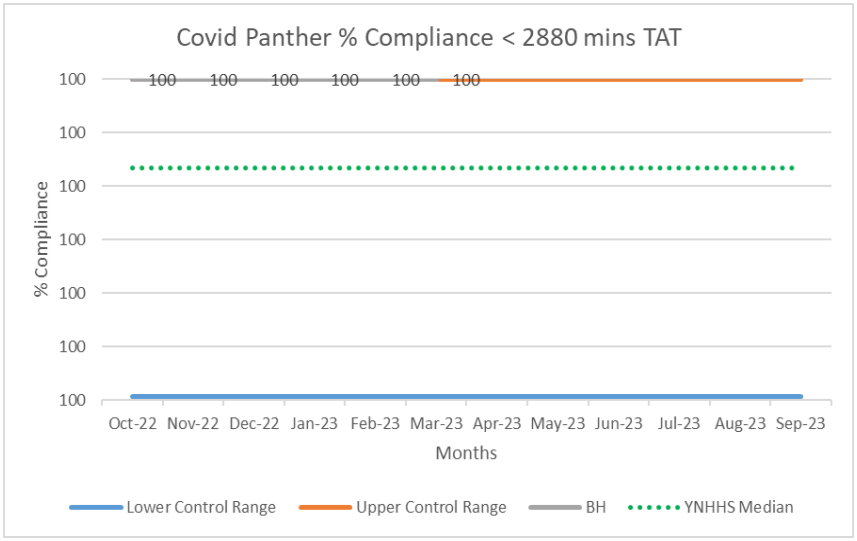


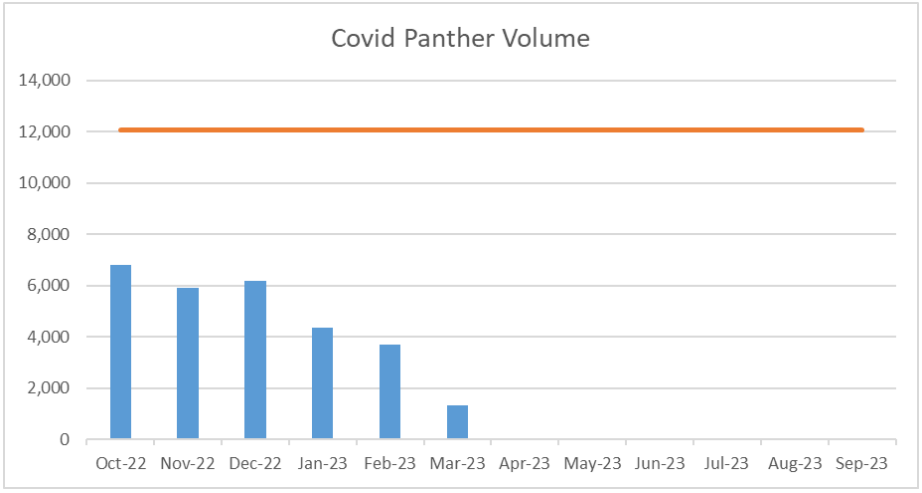
NewHaven Health Bridgeport Hospital

Bridgeport Campus – COVID-19 Panther

This has been discontinued







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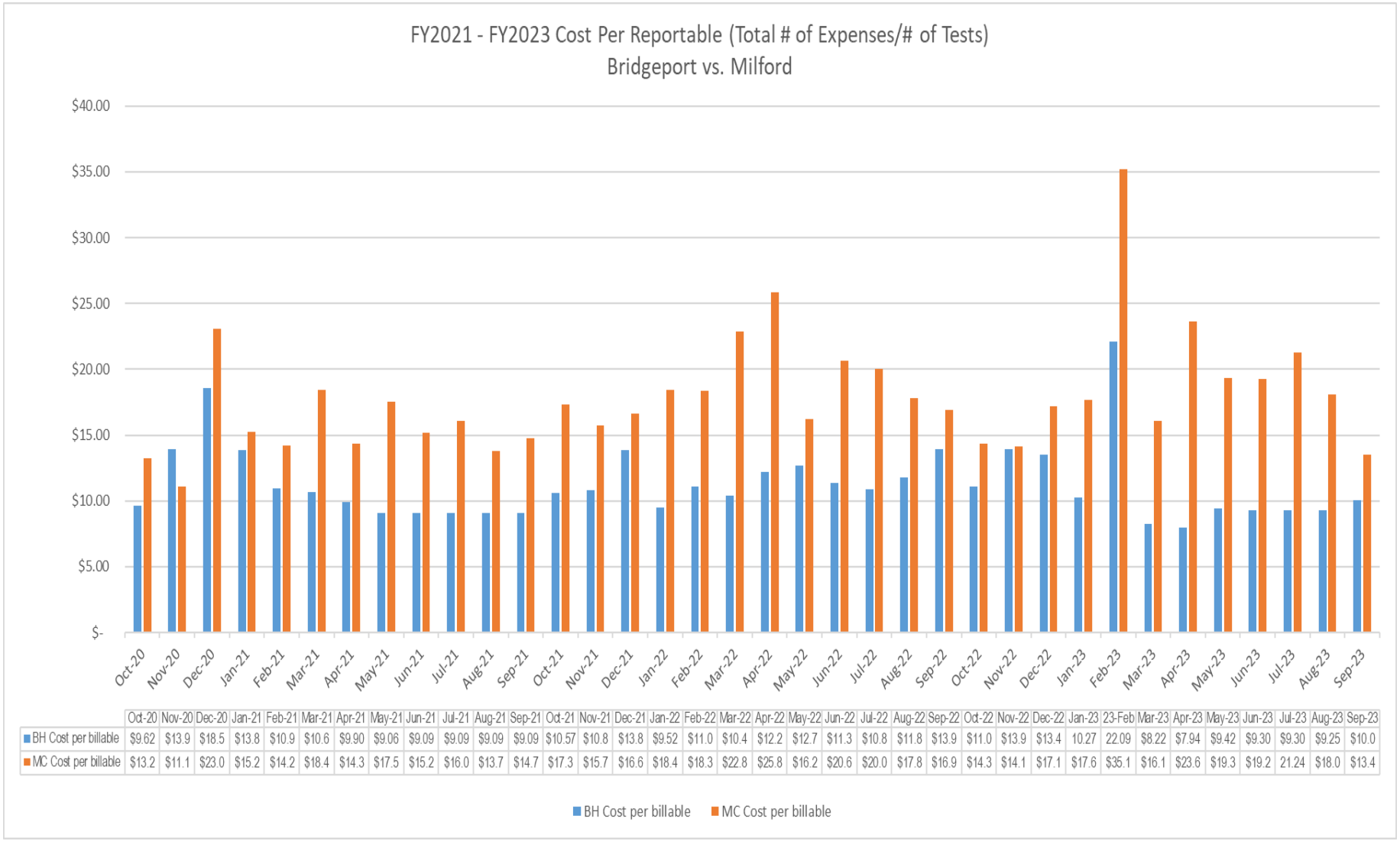
Bridgeport Hospital

Cost Per Billable

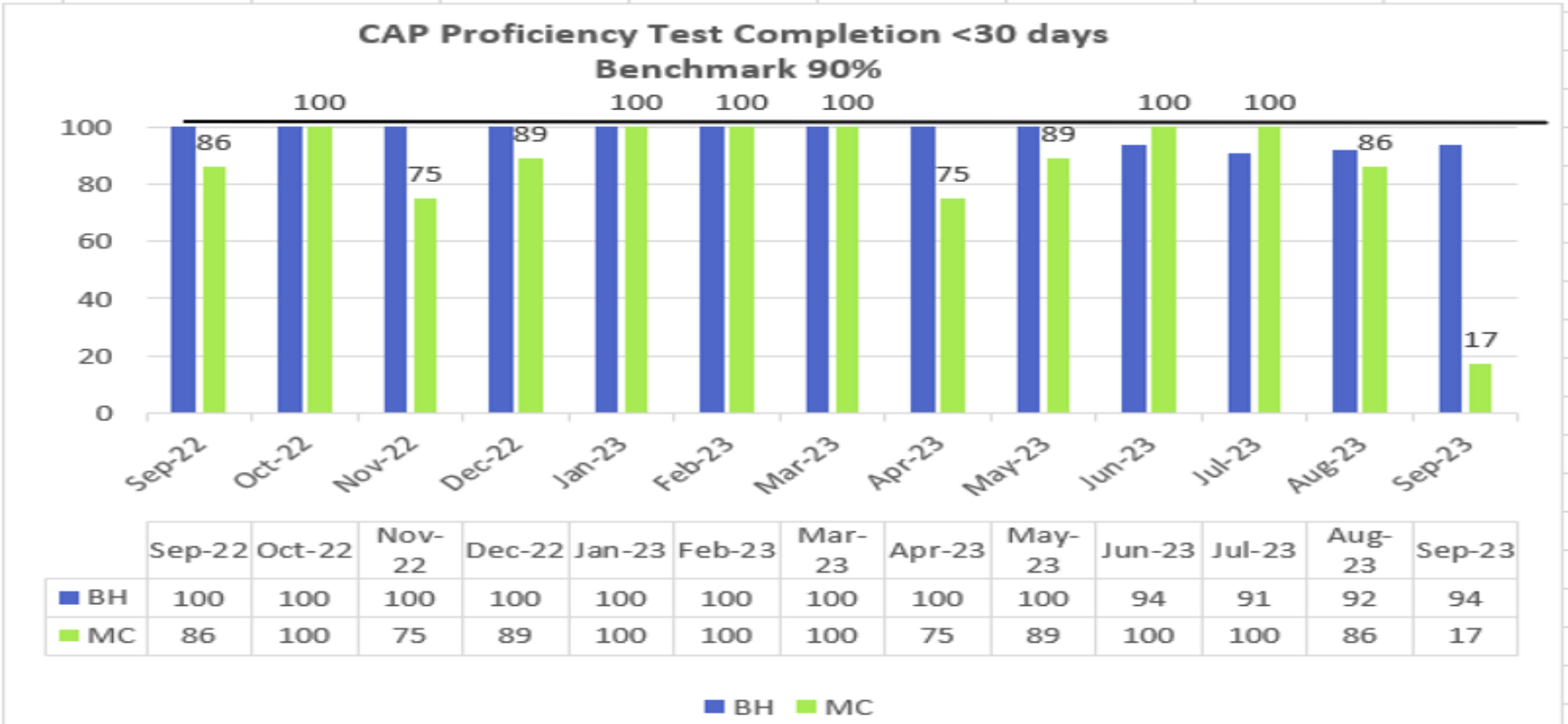


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	23-Feb	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH Cost per billable	$9.62	$13.9	$18.5	$13.8	$10.9	$10.6	$9.90	$9.06	$9.09	$9.09	$9.09	$9.09	$10.57	$10.8	$13.8	$9.52	$11.0	$10.4	$12.2	$12.7	$11.3	$10.8	$11.8	$13.9	$11.0	$13.9	$13.4	10.27	22.09	$8.22	$7.94	$9.42	$9.30	$9.30	$9.25	$10.0
MC Cost per billable	$13.2	$11.1	$23.0	$15.2	$14.2	$18.4	$14.3	$17.5	$15.2	$16.0	$13.7	$14.7	$17.3	$15.7	$16.6	$18.4	$18.3	$22.8	$25.8	$16.2	$20.6	$20.0	$17.8	$16.9	$14.3	$14.1	$17.1	$17.6	$35.1	$16.1	$23.6	$19.3	$19.2	21.24	$18.0	$13.4

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 MC	94% (17/18 surveys) 17% (1/6 surveys)	92% 86%	None	BH met benchmark, MC needs to improve on this QM.	Lab management and administration



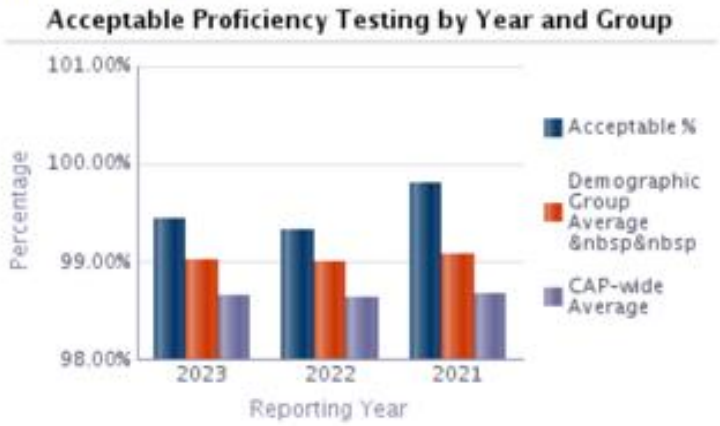
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH	100	100	100	100	100	100	100	100	100	94	91	92	94
MC	86	100	75	89	100	100	100	75	89	100	100	86	17

Laboratory General – Bridgeport
Proficiency Testing Performance Target 98%

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
BH	164/168	97.6%	99.5%	Slightly below threshold, unsatisfactory survey being investigated with corrective action	None required for benchmark-all surveys satisfactory. Each section investigates failed/unsatisfactory performances.

Proficiency Testing Performance Overview

Select View: Graph



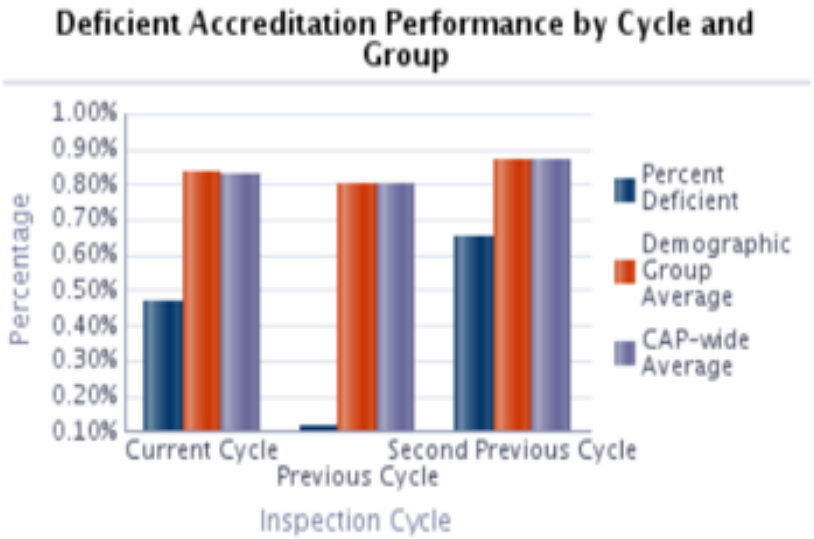
17	1	1	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.43%	99.02%	98.64%
2022	99.32%	99.00%	98.63%
2021	99.81%	99.06%	98.67%

Lab General

Accreditation Performance Overview

Accreditation Performance Overview BH



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

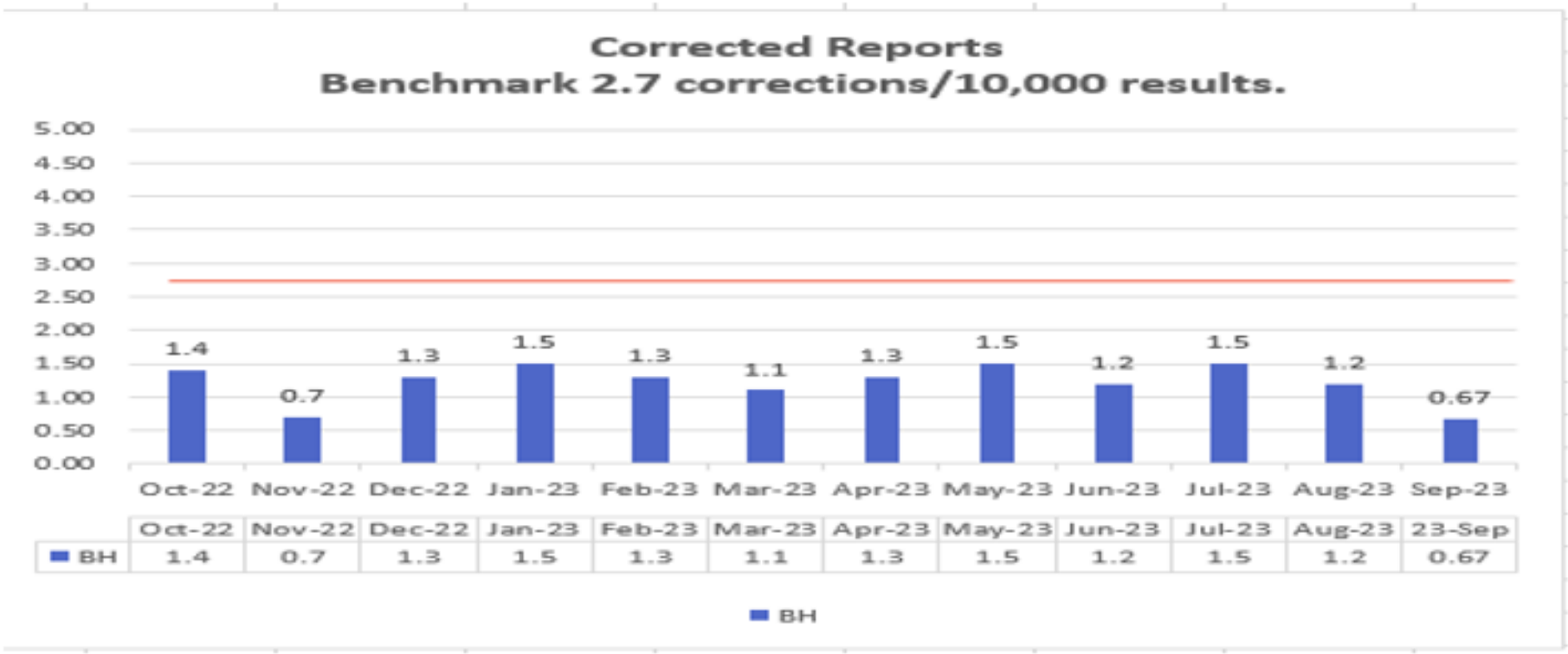
Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.47%	**0.84%**	0.82%
Previous Cycle	0.11%	**0.80%**	0.80%
Second Previous Cycle	0.65%	**0.86%**	0.87%

Lab General

BH Corrected Reports

Target <2.7/10,000 results

Quality Metric Corrected Reports	Sample size (tests)	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible
BC Lab Corrected reports	195,489 tests	0.67 (0.007%)	1.2 (0.012%)	Corrected reports can lead to adverse patient outcomes	None needed benchmark met	Laboratory administration



BH Non-Conforming Events**
(Department of Clinical Pathology only)

Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible Staff
Nonconforming events BH	**0**	195,489 Tests	0	0	None	None needed	Lab administration and management

MCBH Non-Conforming Events** (Department of Clinical Pathology only)

Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and 593follow-up	Responsible Staff
Nonconforming events MCBH	**0**	21,226 Tests	0	0	None	None needed	Lab administration and management

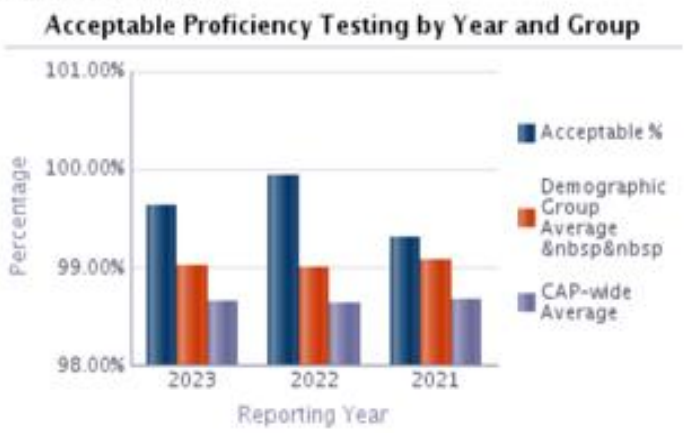
** Defiinition of Non Conforming events for this Quality Measure includes irreplaceable samples only

MCBH Proficiency Testing
Performance Target 98%

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
MCBH	19/19	100%	100%	None	

Proficiency Testing Performance Overview

Select View: Graph

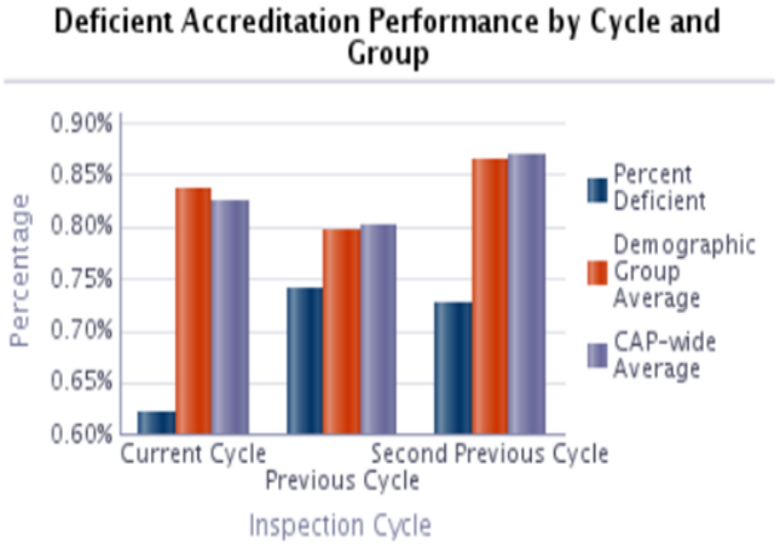


6	0	0	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.63%	99.02%	98.64%
2022	99.94%	99.00%	98.63%
2021	99.30%	99.06%	98.67%

MCBH Accreditation Performance Overview

Select View: Graph



Last Accreditation Decision	Date
Accredited	5/9/2022

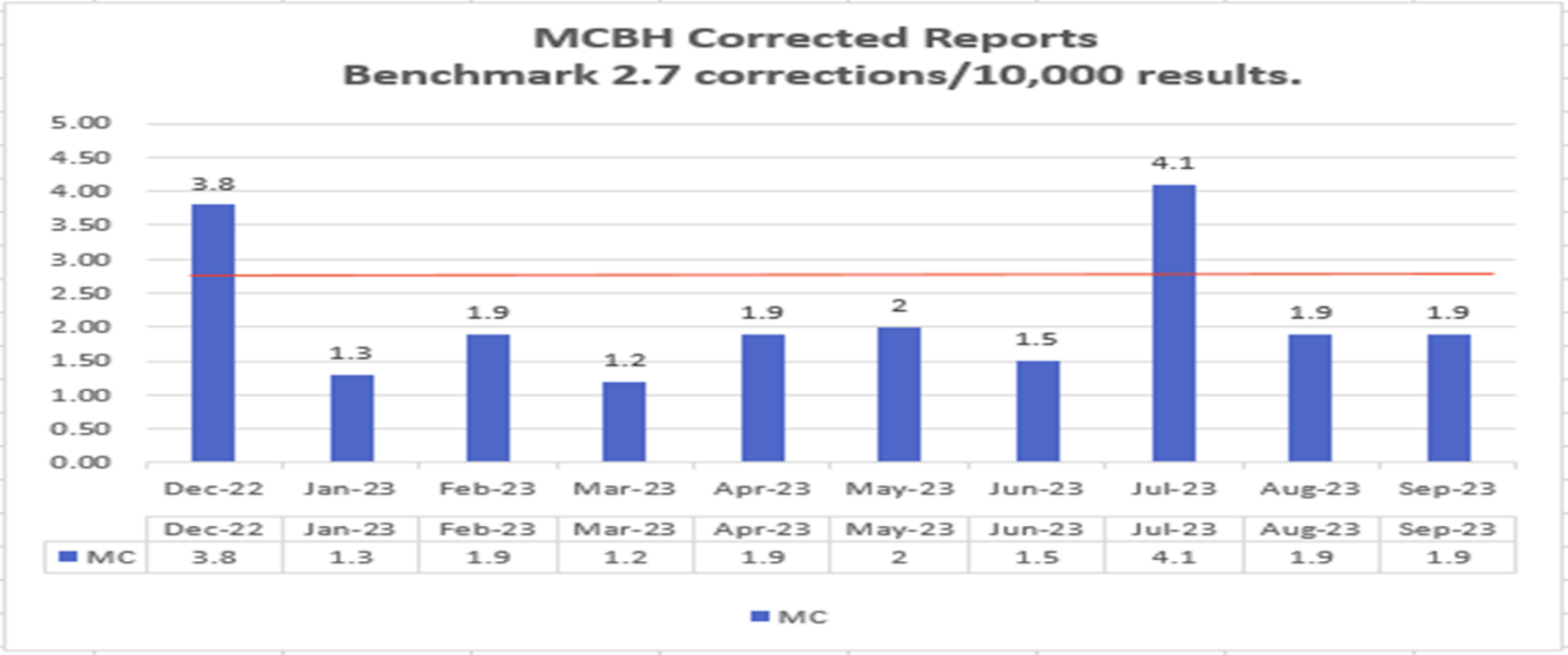
Current Cycle Inspection(s)			
Date	**Inspection Type**	**% Deficient**	**Recurring Deficiencies**
3/28/2022	Routine	0.62	0

Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.62%	**0.84%**	0.82%
Previous Cycle	0.74%	**0.80%**	0.80%
Second Previous Cycle	0.73%	**0.86%**	0.87%

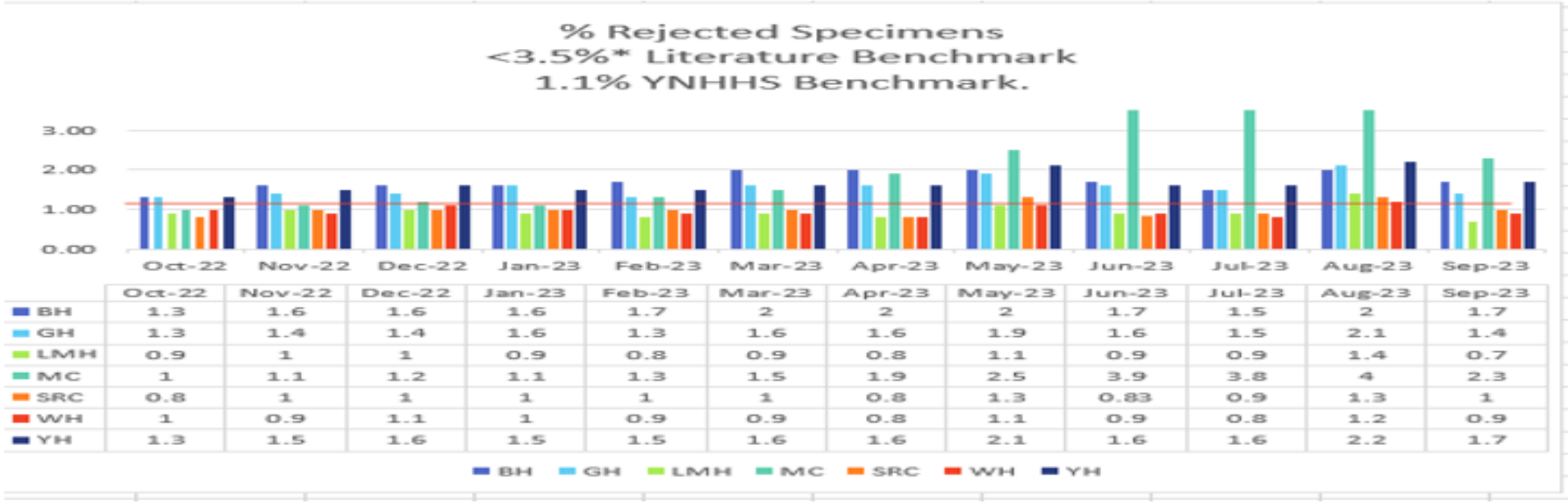
Yale NewHaven Health Bridgeport Hospital

MCBH Corrected Reports
Target <2.7/10,000 results

Quality Metric Corrected Reports	Sample size (tests)	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible
MCBC Lab Corrected reports	21,226 tests	1.9 (0.019%)	1.9 (0.019%)	Corrected reports can lead to adverse patient outcomes	None needed benchmark met but all corrected reports are reviewed with appropriate follow-up.	Laboratory administration

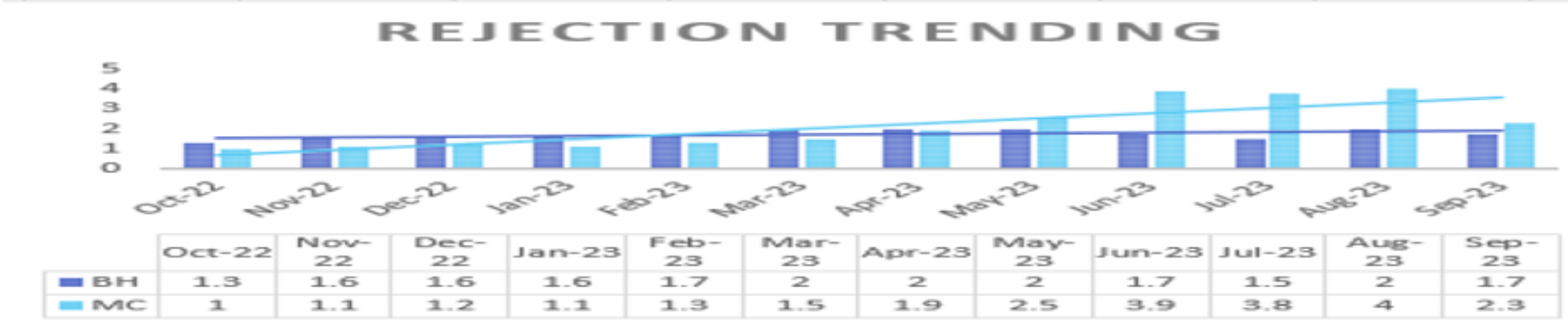


Laboratory General



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH	1.3	1.6	1.6	1.6	1.7	2	2	2	1.7	1.5	2	1.7
GH	1.3	1.4	1.4	1.6	1.3	1.6	1.6	1.9	1.6	1.5	2.1	1.4
LMH	0.9	1	1	0.9	0.8	0.9	0.8	1.1	0.9	0.9	1.4	0.7
MC	1	1.1	1.2	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3
SRC	0.8	1	1	1	1	1	0.8	1.3	0.83	0.9	1.3	1
WH	1	0.9	1.1	1	0.9	0.9	0.8	1.1	0.9	0.8	1.2	0.9
YH	1.3	1.5	1.6	1.5	1.5	1.6	1.6	2.1	1.6	1.6	2.2	1.7

*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



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH	1.3	1.6	1.6	1.6	1.7	2	2	2	1.7	1.5	2	1.7
MC	1	1.1	1.2	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3

** corrective actions to reduce MC redraw rate include BD came to observe blood collection techniques in late Sept. (hopefully improvement in Oct?). Hemolysis accounted for 38% of all redraws at Milford in Sept. and of the 38%, 95% collected by MC ED.

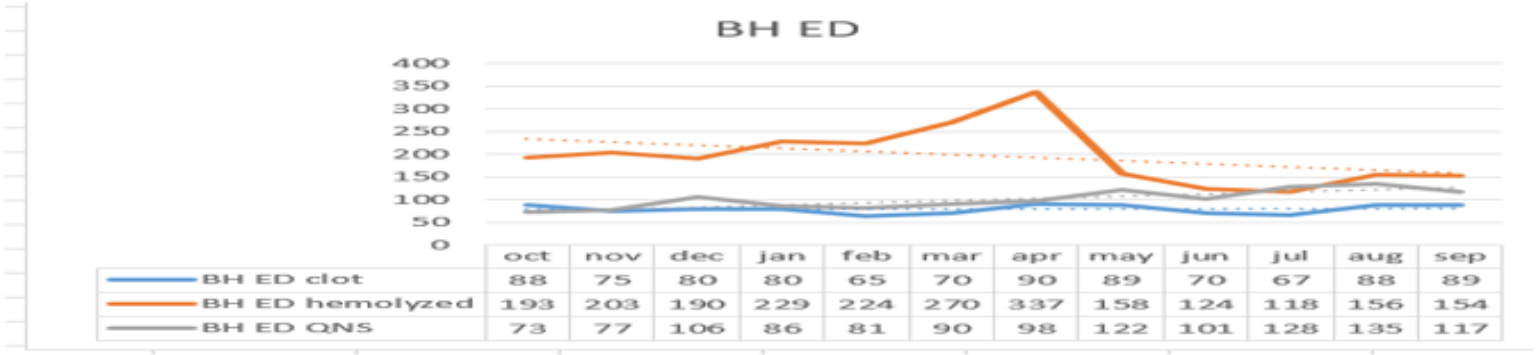
Laboratory General

Rejected Specimens by Classification (all BH collection locations)

	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
23-Feb	343	302	167	49	49	22
23-Mar	402	329	169	63	57	36
23-Apr	463	295	197	69	44	15
23-May	220	332	184	50	59	19
23-Jun	164	315	183	48	68	16
23-Jul	162	331	157	60	39	31
23-Aug	194	389	182	60	88	30
23-Sep	228	333	173	54	40	34

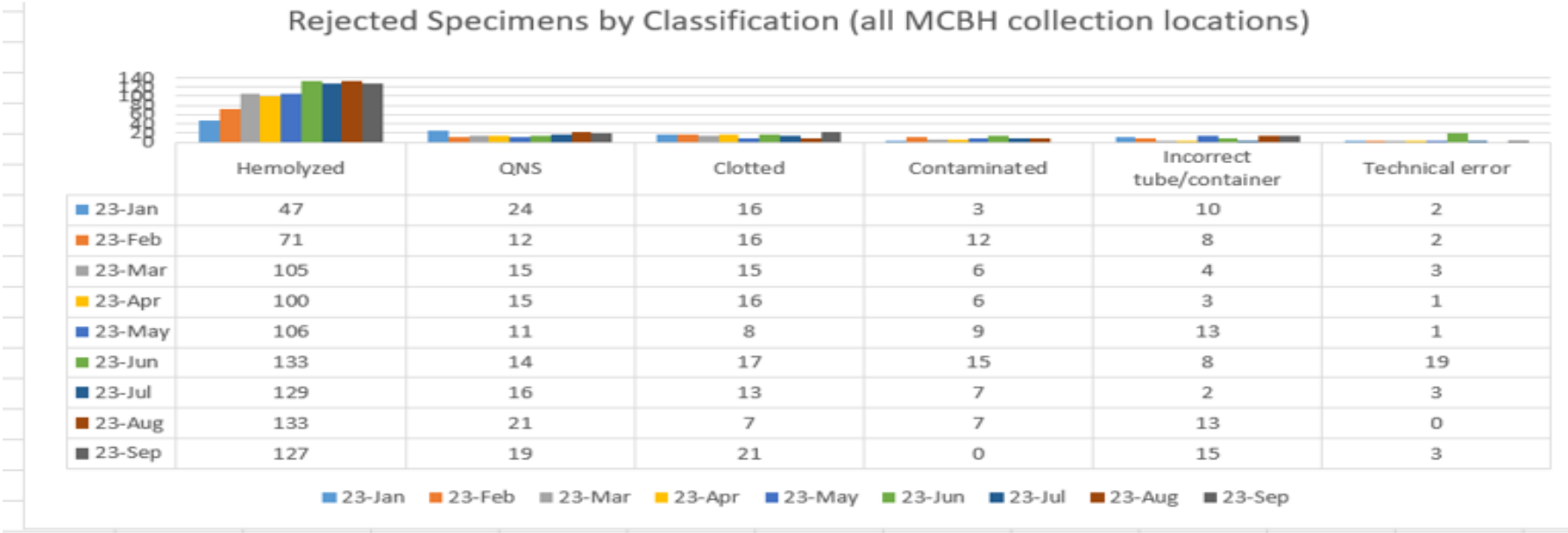
22-Oct 22-Nov 22-Dec 23-Jan 23-Feb 23-Mar 23-Apr 23-May 23-Jun 23-Jul 23-Aug 23-Sep

Top 3 Rejections-BH ED totals



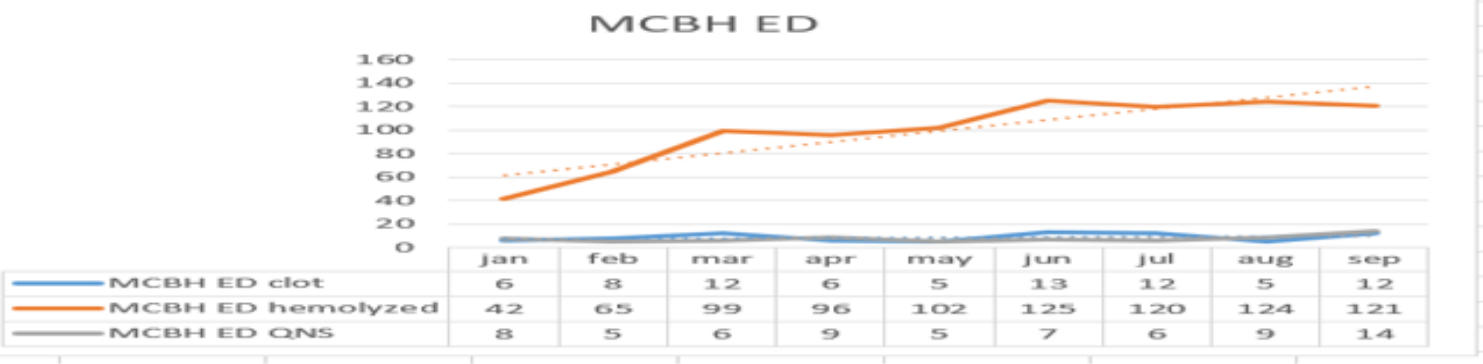
	oct	nov	dec	jan	feb	mar	apr	may	jun	jul	aug	sep
BH ED clot	88	75	80	80	65	70	90	89	70	67	88	89
BH ED hemolyzed	193	203	190	229	224	270	337	158	124	118	156	154
BH ED QNS	73	77	106	86	81	90	98	122	101	128	135	117

Laboratory General



	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
23-Jan	47	24	16	3	10	2
23-Feb	71	12	16	12	8	2
23-Mar	105	15	15	6	4	3
23-Apr	100	15	16	6	3	1
23-May	106	11	8	9	13	1
23-Jun	133	14	17	15	8	19
23-Jul	129	16	13	7	2	3
23-Aug	133	21	7	7	13	0
23-Sep	127	19	21	0	15	3

Top 3 Rejections-MCBH ED totals

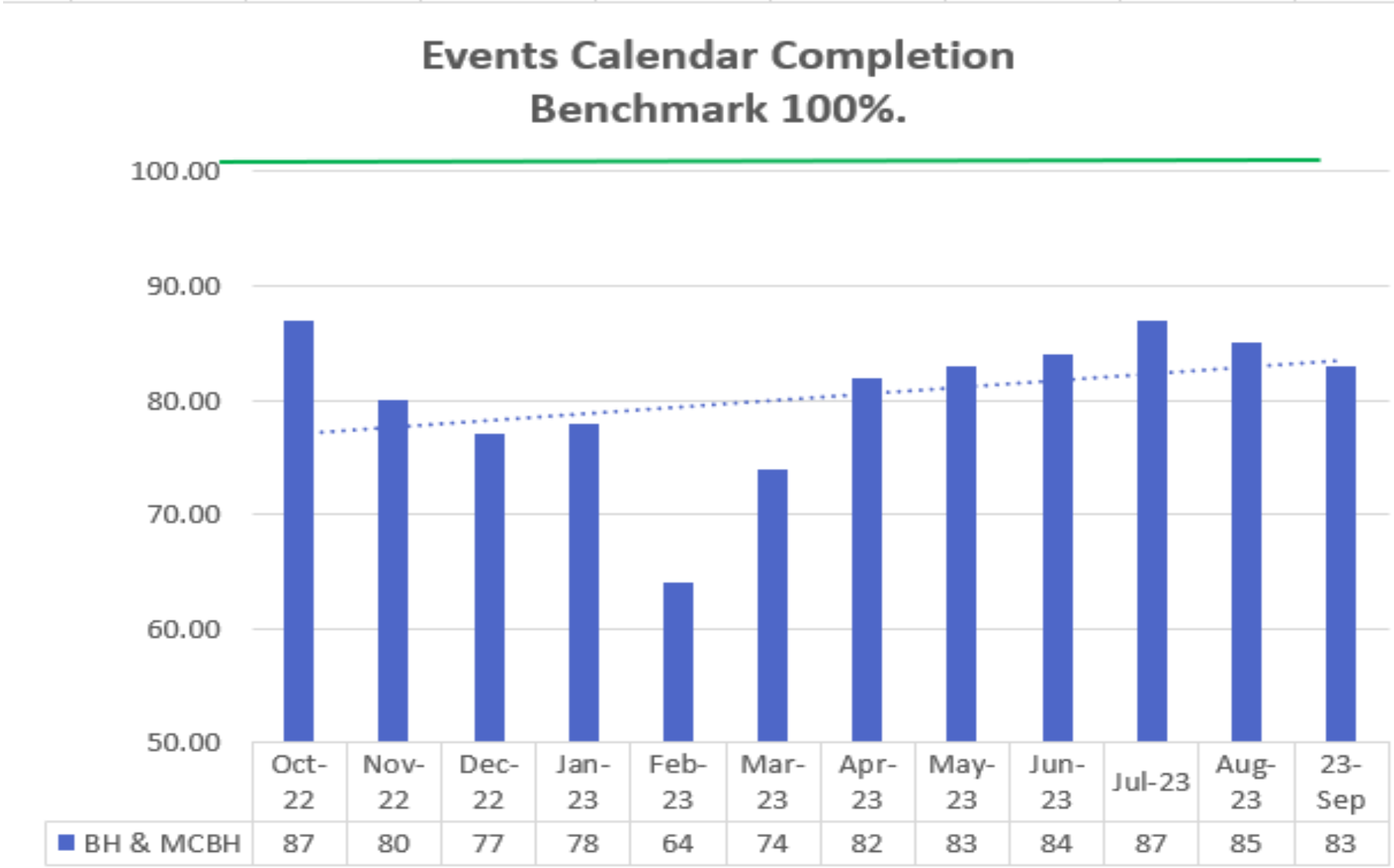


	jan	feb	mar	apr	may	jun	jul	aug	sep
MCBH ED clot	6	8	12	6	5	13	12	5	12
MCBH ED hemolyzed	42	65	99	96	102	125	120	124	121
MCBH ED QNS	8	5	6	9	5	7	6	9	14

Laboratory General

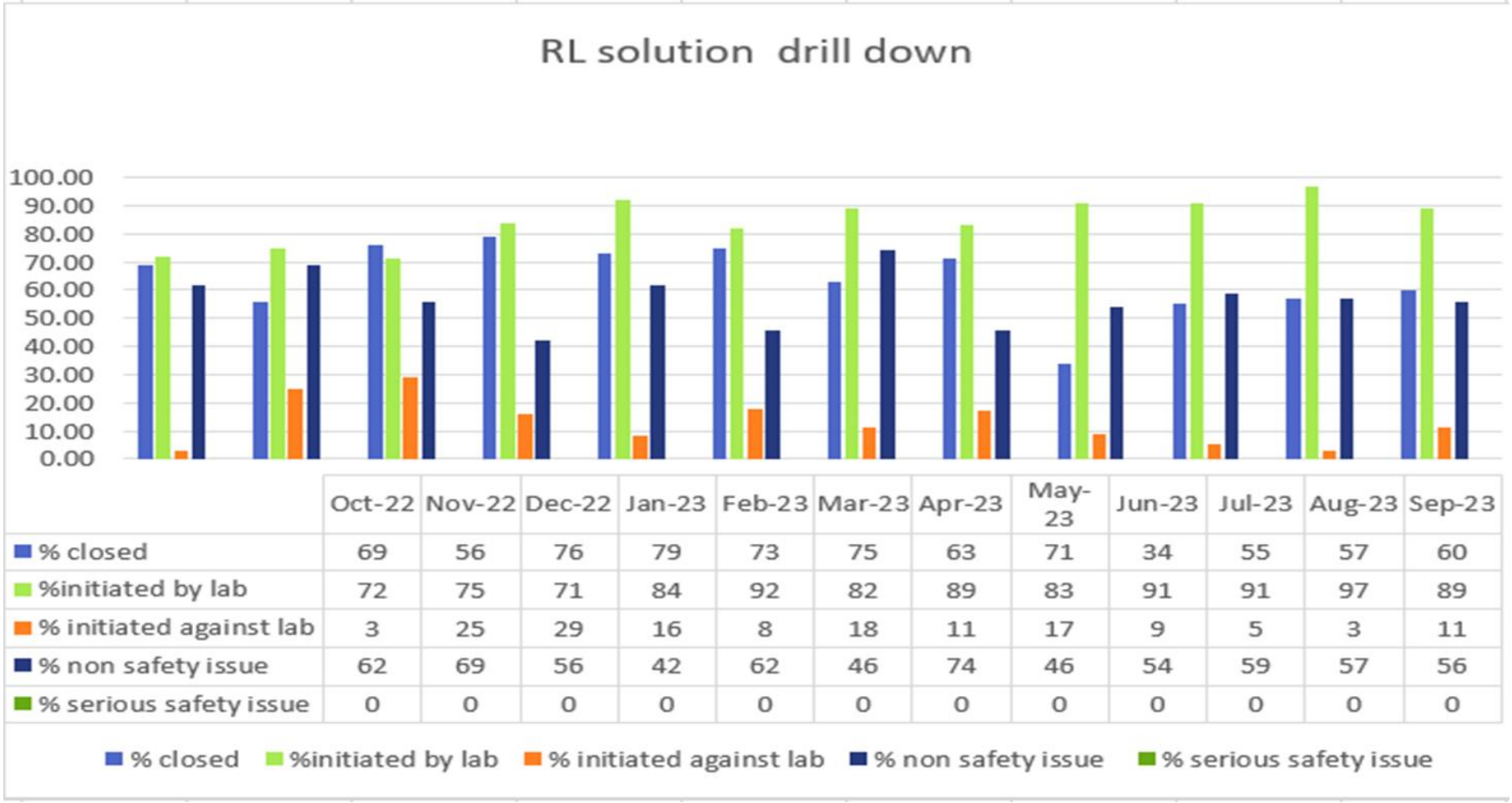
BH & MCBH Events Calendar Completion 87%

Benchmark 100% 39/41 Events Completed



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	23-Sep
BH & MCBH	87	80	77	78	64	74	82	83	84	87	85	83

Laboratory General
RL Solution Monitor

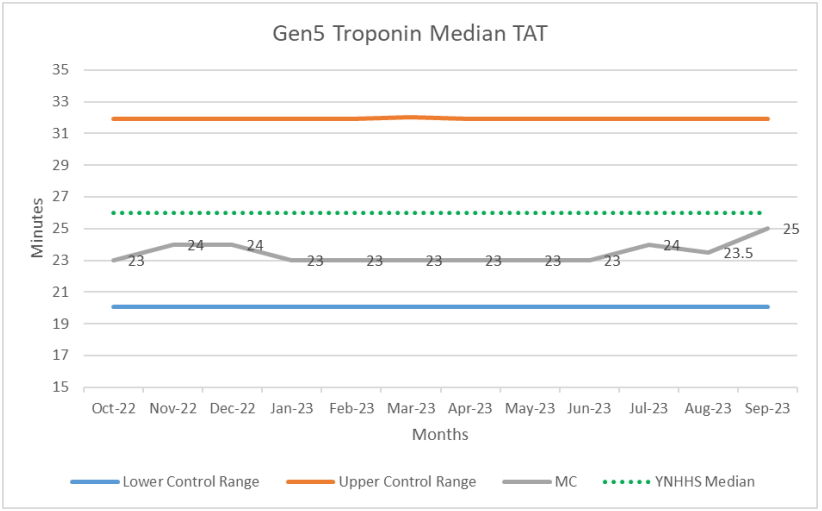


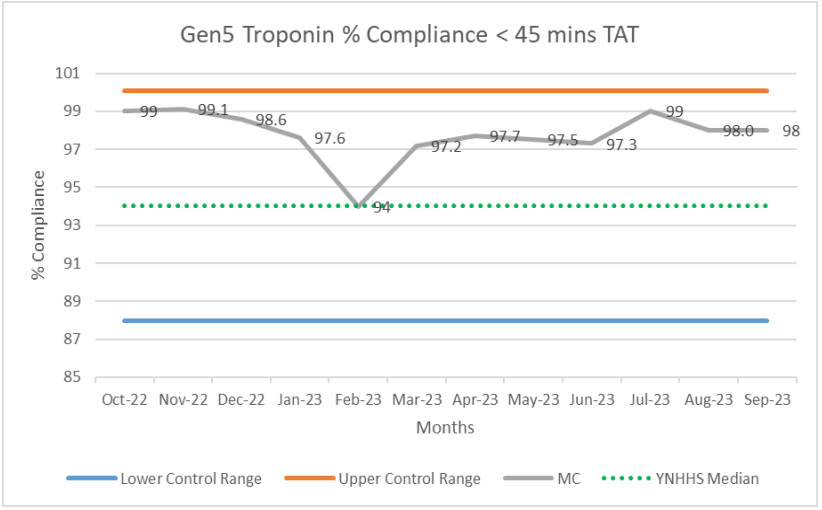
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
% closed	69	56	76	79	73	75	63	71	34	55	57	60
%initiated by lab	72	75	71	84	92	82	89	83	91	91	97	89
% initiated against lab	3	25	29	16	8	18	11	17	9	5	3	11
% non safety issue	62	69	56	42	62	46	74	46	54	59	57	56
% serious safety issue	0	0	0	0	0	0	0	0	0	0	0	0

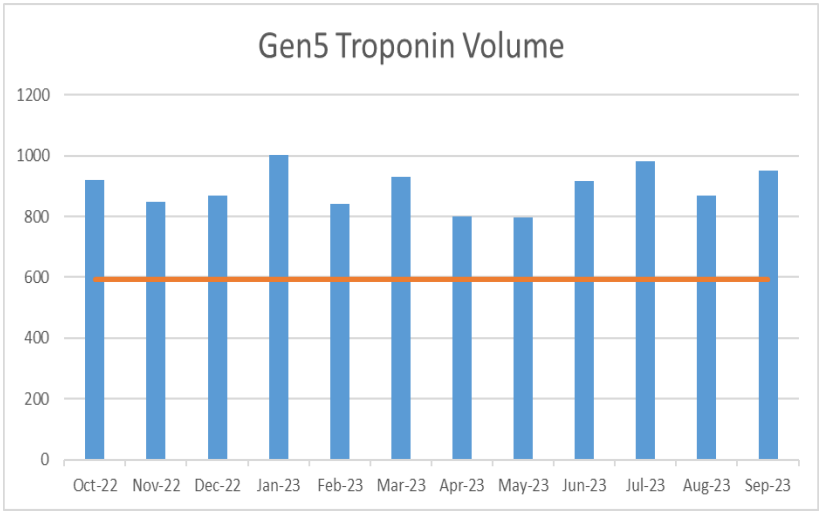
16/27 events closed, 10 are new & 1 in progress.
24 were lab initiated (2 vs. lab from Unit, 1 lab vs. lab)
No Serious Safety Events, rest barrier catches & PSE's.

Yale NewHaven Health Bridgeport Hospital

Milford Campus – Gen 5 Troponin TAT







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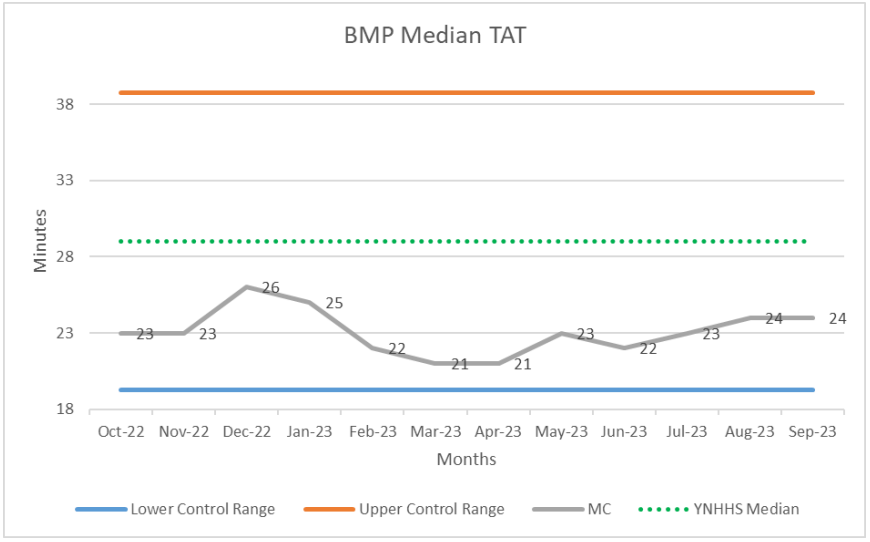
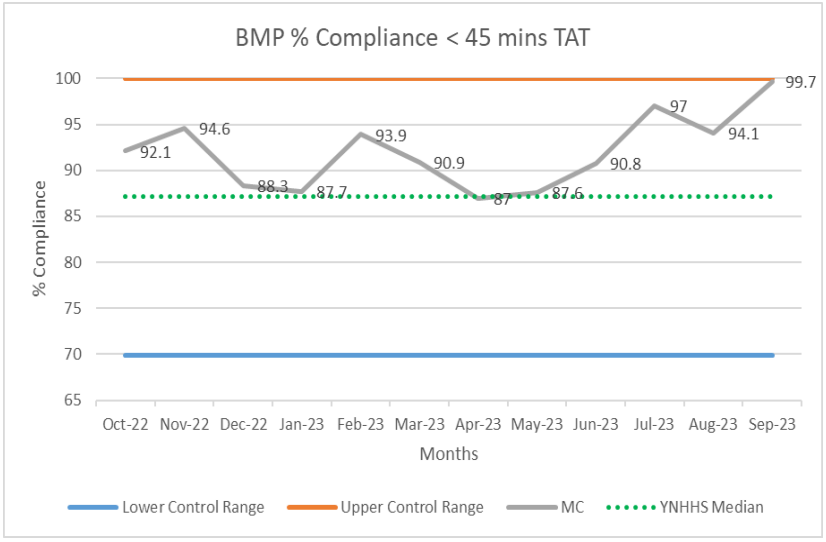
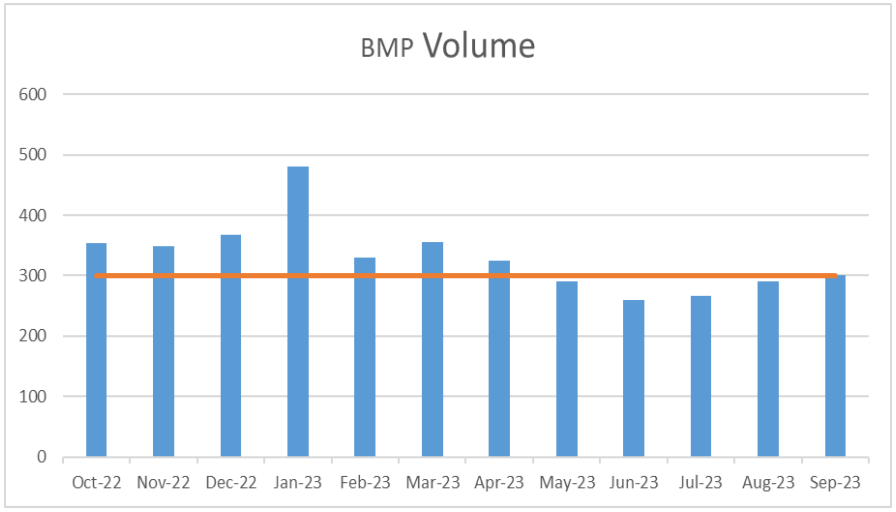
Milford Campus – Basic Metabolic Panel (BMP) ED TAT







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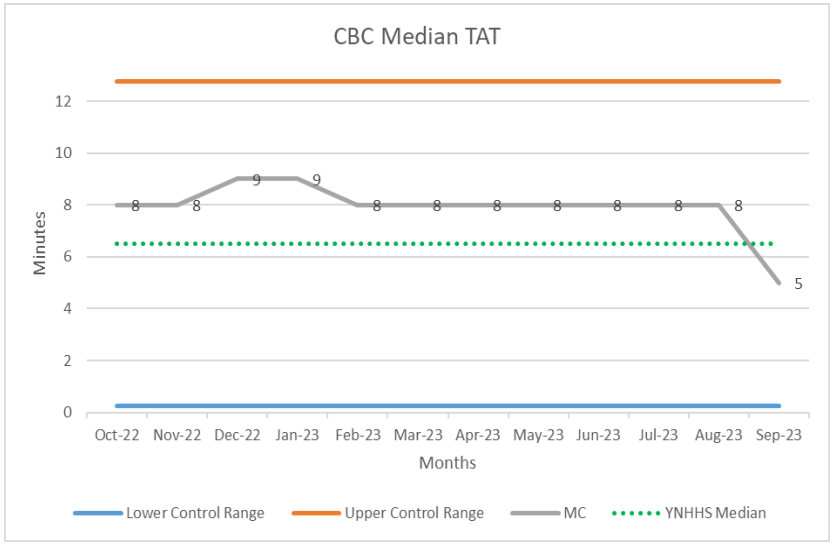
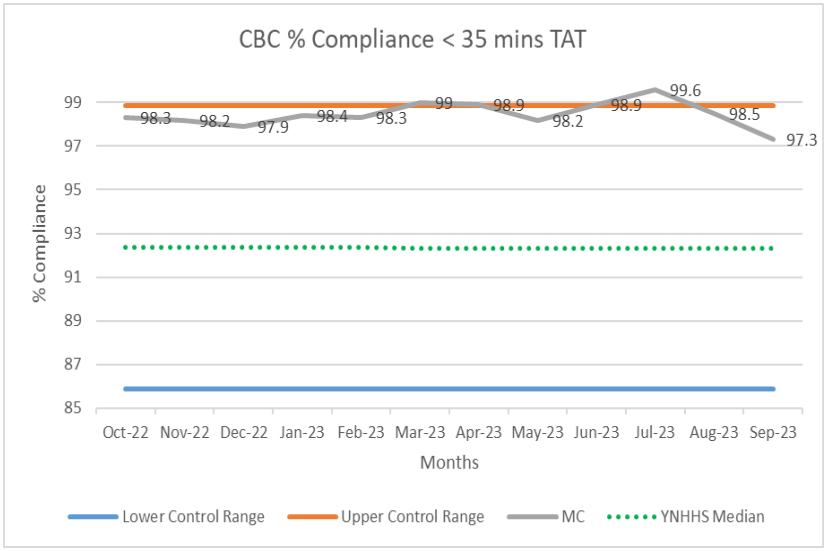
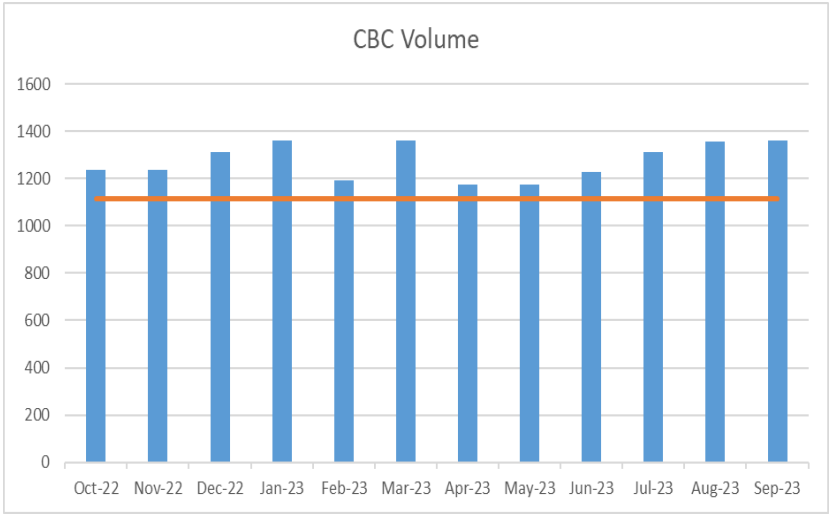
Milford Campus – Complete Blood Count (CBC) ED TAT







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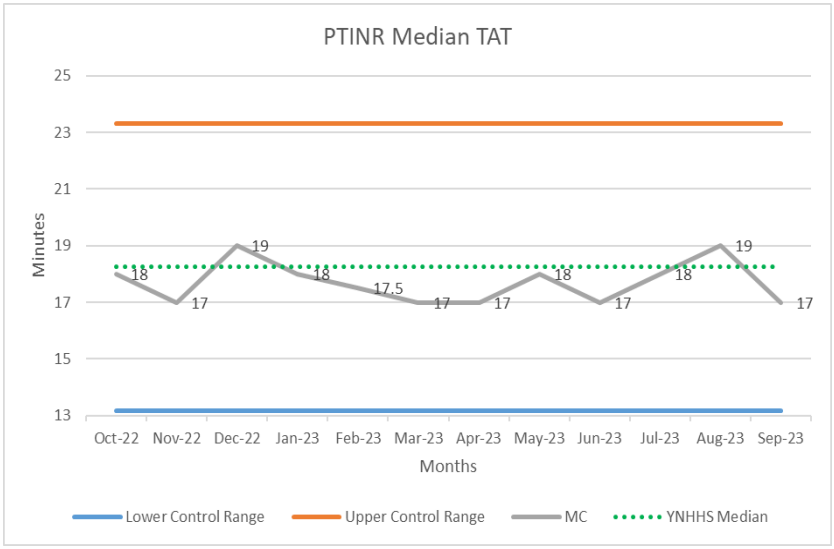
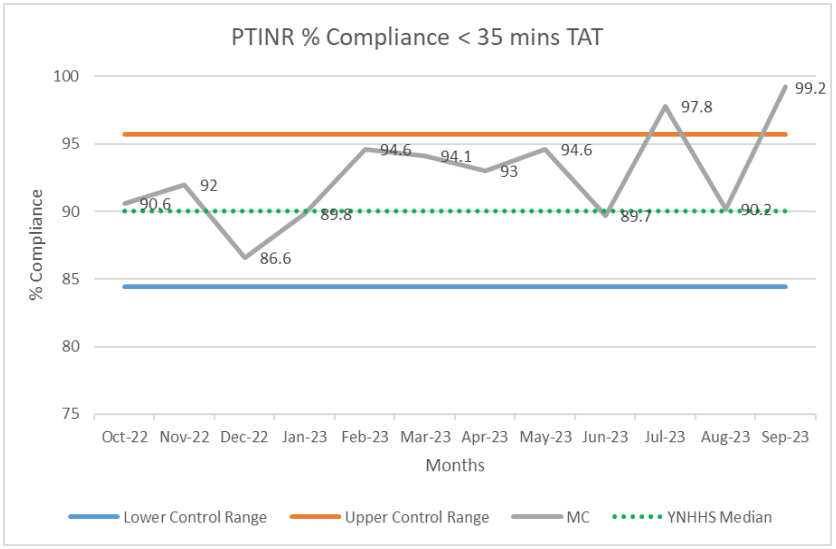
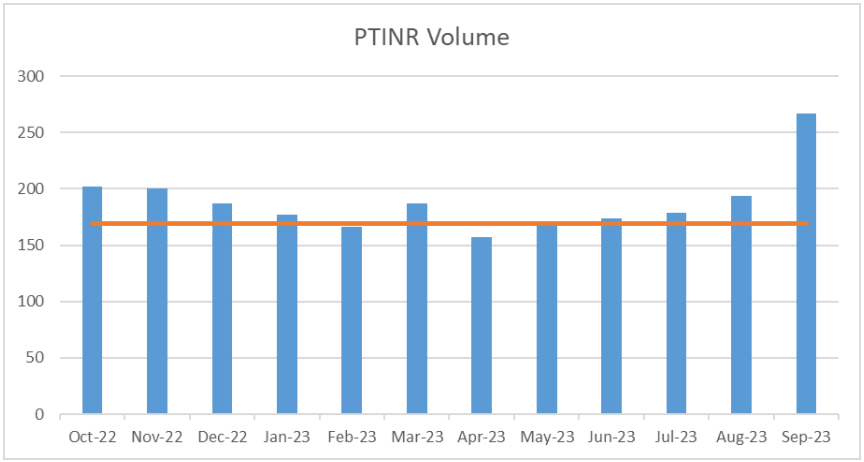
Milford Campus – PTINR ED TAT







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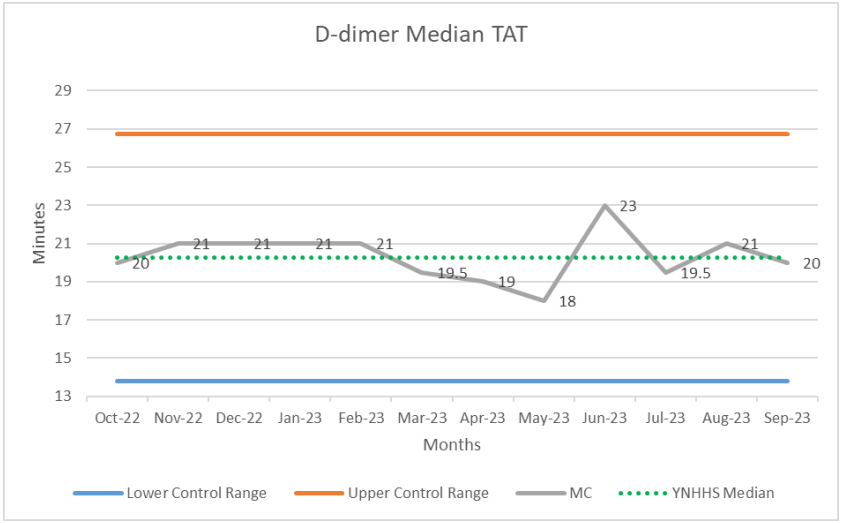
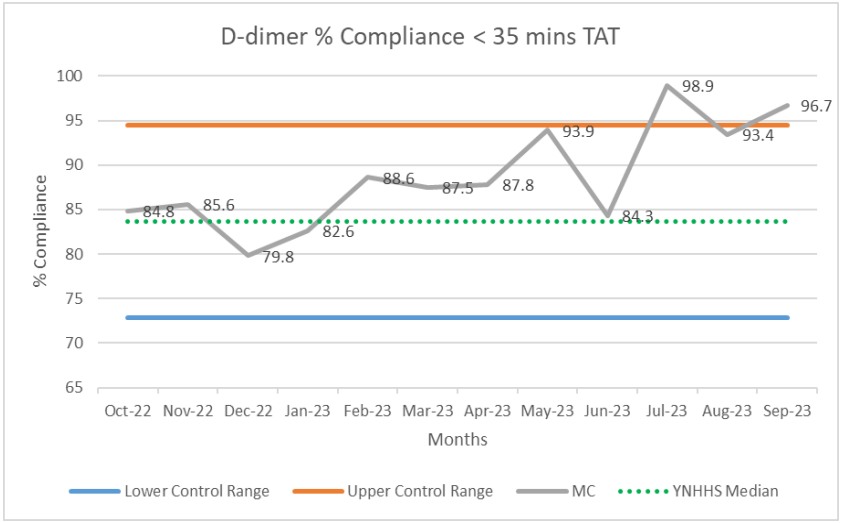
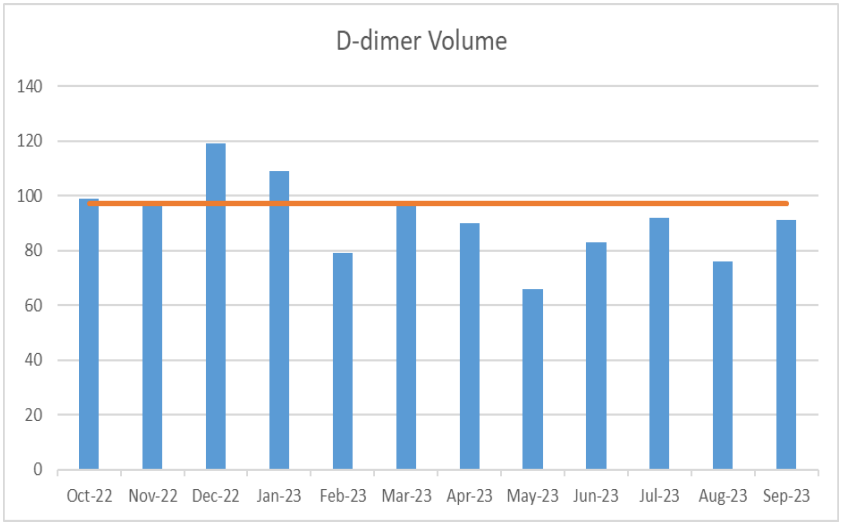
Milford Campus – D-dimer ED TAT







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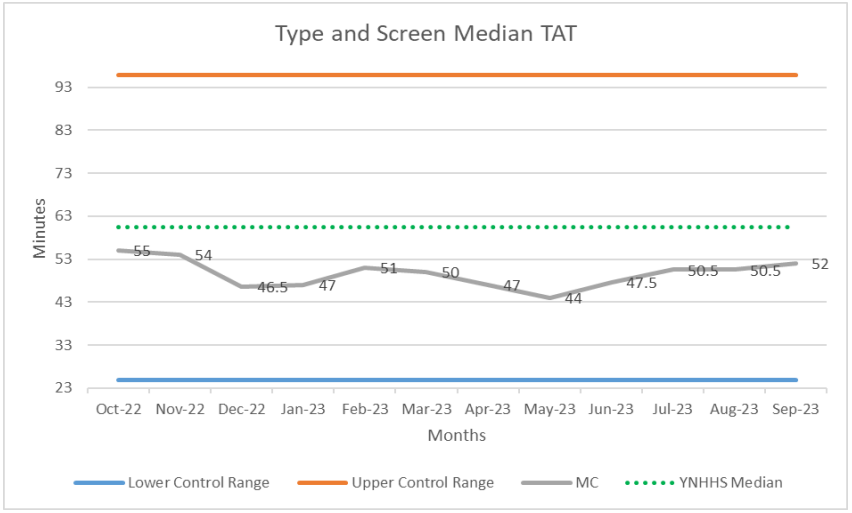
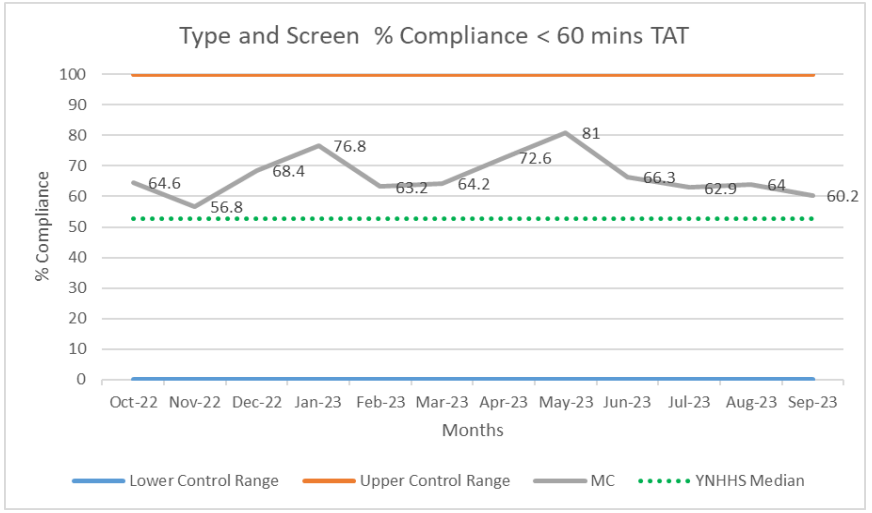
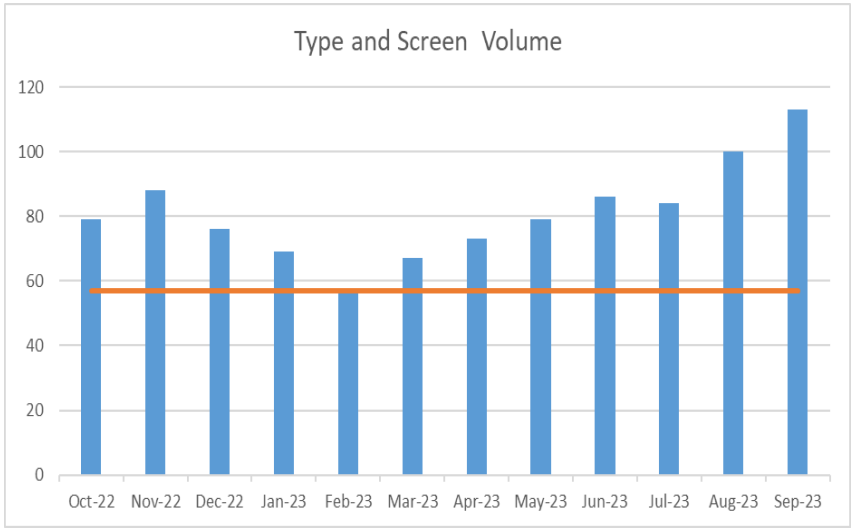
Bridgeport Hospital

Milford Campus – Type and Screen ED TAT







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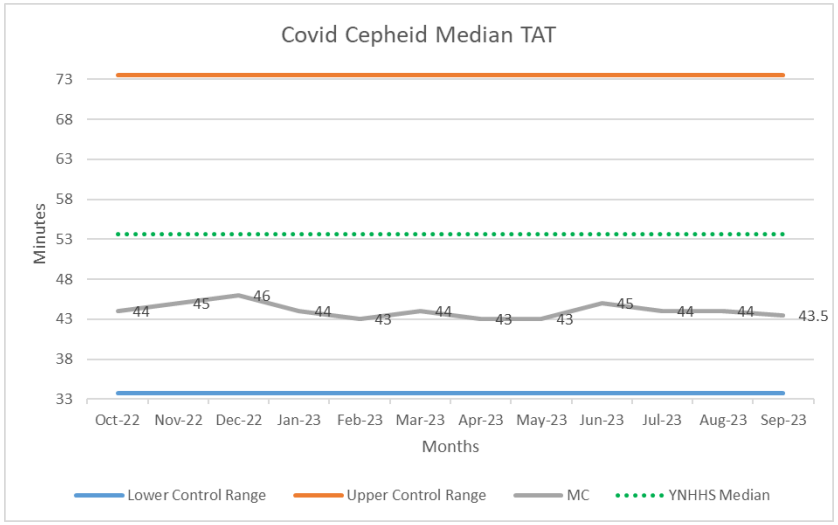
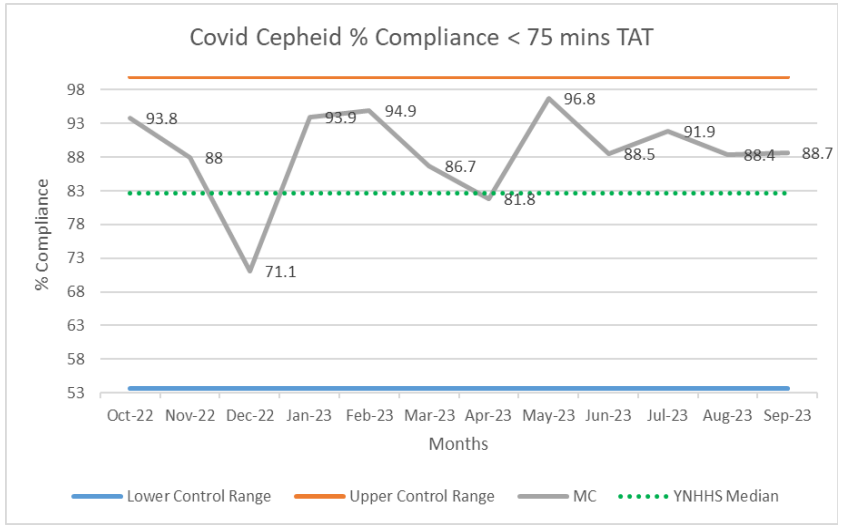
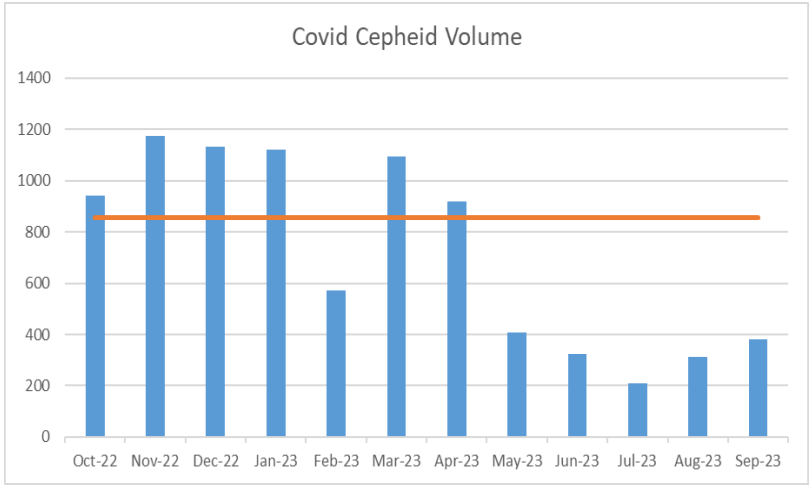
Bridgeport Hospital

Milford Campus – COVID Cepheid PCR ED TAT







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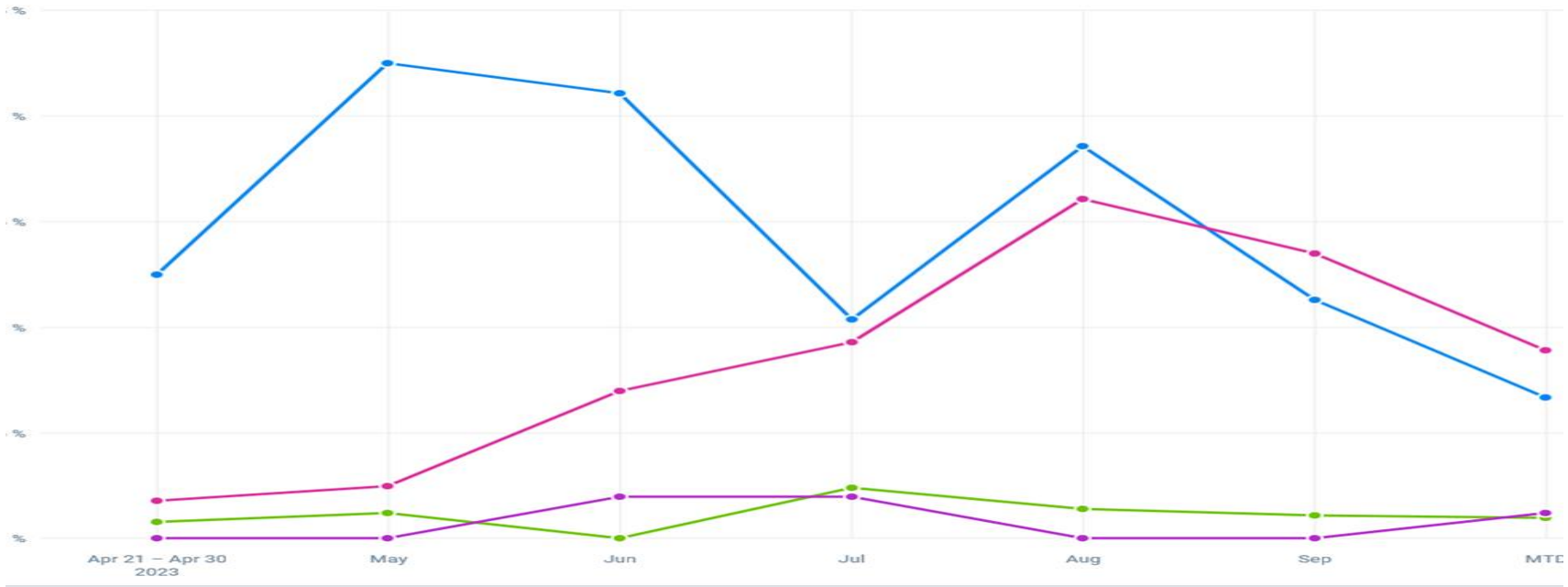
Milford Campus Molecular Dashboard



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

Date	Tests	% Positivity	Derived Baseline	Environment Monitoring	Physician Feedback	Epidemiological Trends	Evaluation Notes	Corrective Action (if needed)
Sep-23	SARS-CoV-2	13.50%	0-22%	Negative	None	None	None	None
Sep-23	Group A Strep	11.30%	0-19%	Negative	None	None	None	None
Sep-23	Flu A/B	0.00%	0-7%	Negative	None	None	None	None
Sep-23	Flu/RSV	1.10%	0-14%	Negative	None	None	None	None
Sep-23	C. diff toxin	11.40%	not established	Negative	None	None	None	None

- OF the 11.4% (4/35) positive C dif toxin by PCR, only 1 (2.9%) went on to have active infection confirmed.

Yale NewHaven Health Bridgeport Hospital

CRSQ Report Out

Committee of Regulatory, Safety, & Quality

September 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 *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. • We are currently at **88.5%** compliance as a department.
Key drivers *measureable processes impacting the outcome*	Decrease the time from result verification to communication log completion. • Increase performance of correct workflow (verify result first and then notify provider). • Timely communication of outpatient critical values
Interventions *actions/changes necessary to impact key drivers*	Standardize critical call list workflow • Provided re-education and tips and tricks for the correct workflow. • Identified a process to streamline outpatient critical calls (work with specific practices with known notification issues).
Results* *accomplishments, modifications, barriers*	Accomplishments • Nov 2022 had a 94.0% compliance (highest in the12 month period of Oct 2022-Sep 2023). • Inpatient compliance rate is 93.7%, Outpatient rate is 80.6% for last 12 months. • Department of Laboratory Medicine averages approximately 1500 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

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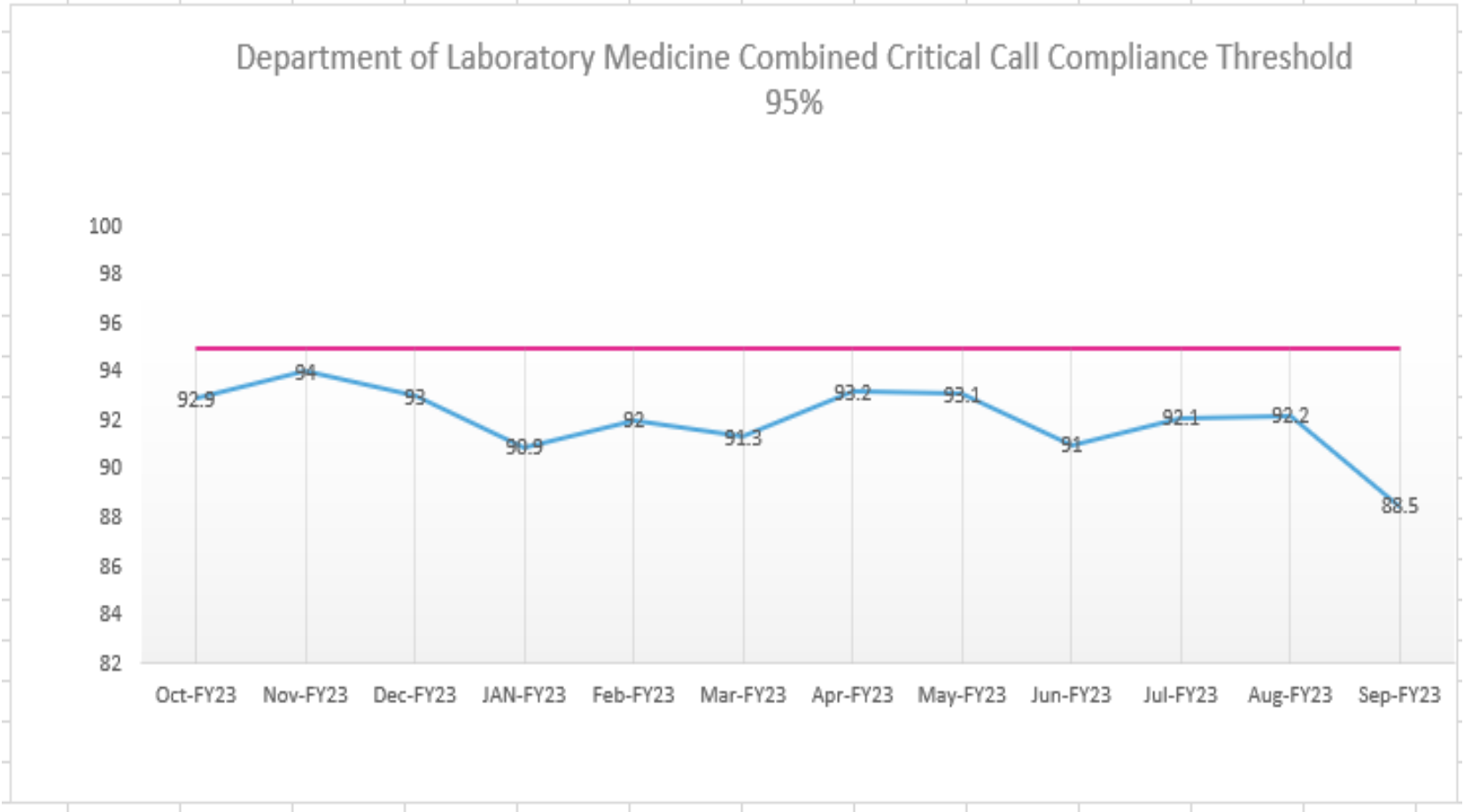
Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 91.6% (12 month cumulative) 10/1/2022-9/30/2023



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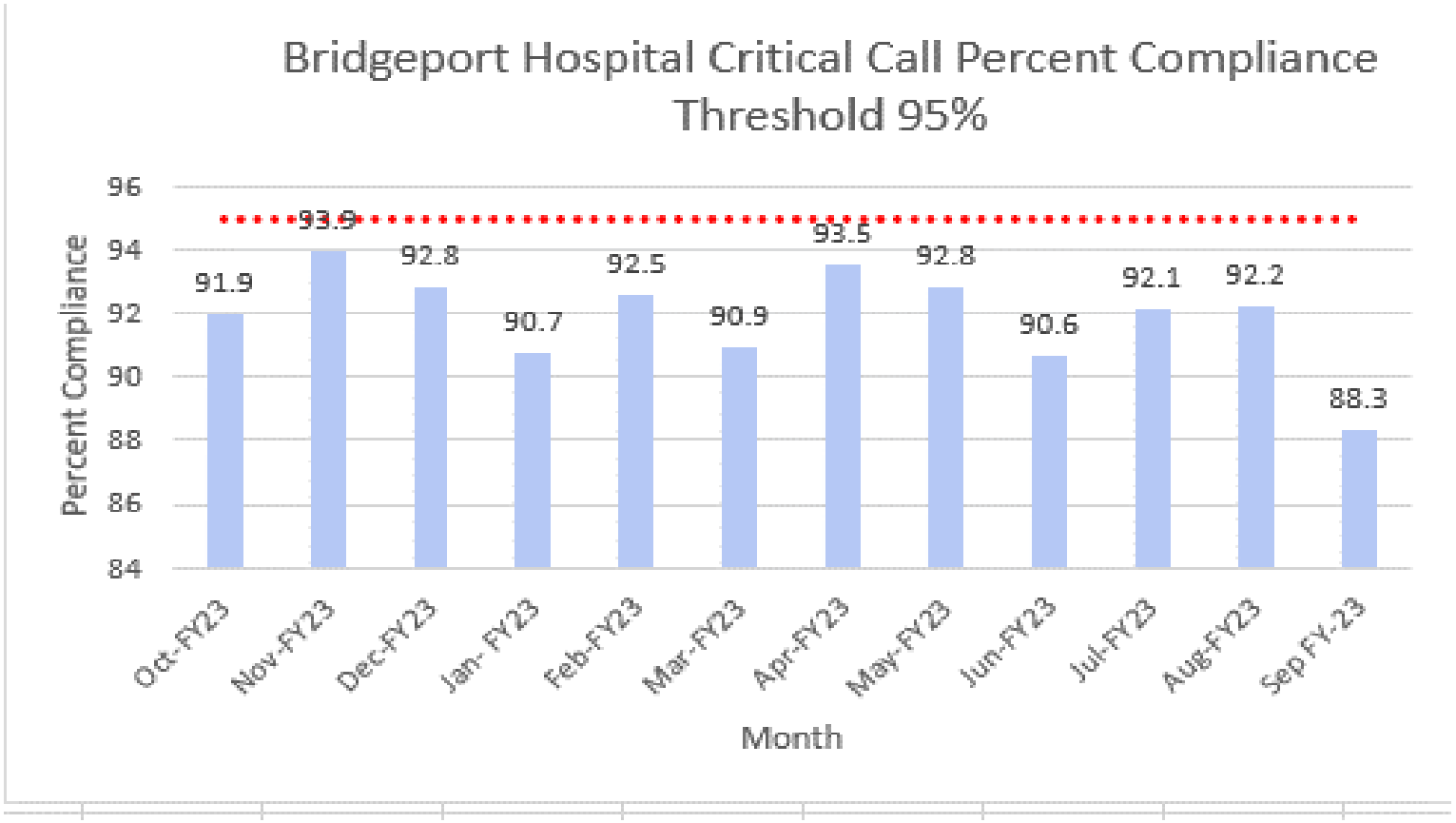
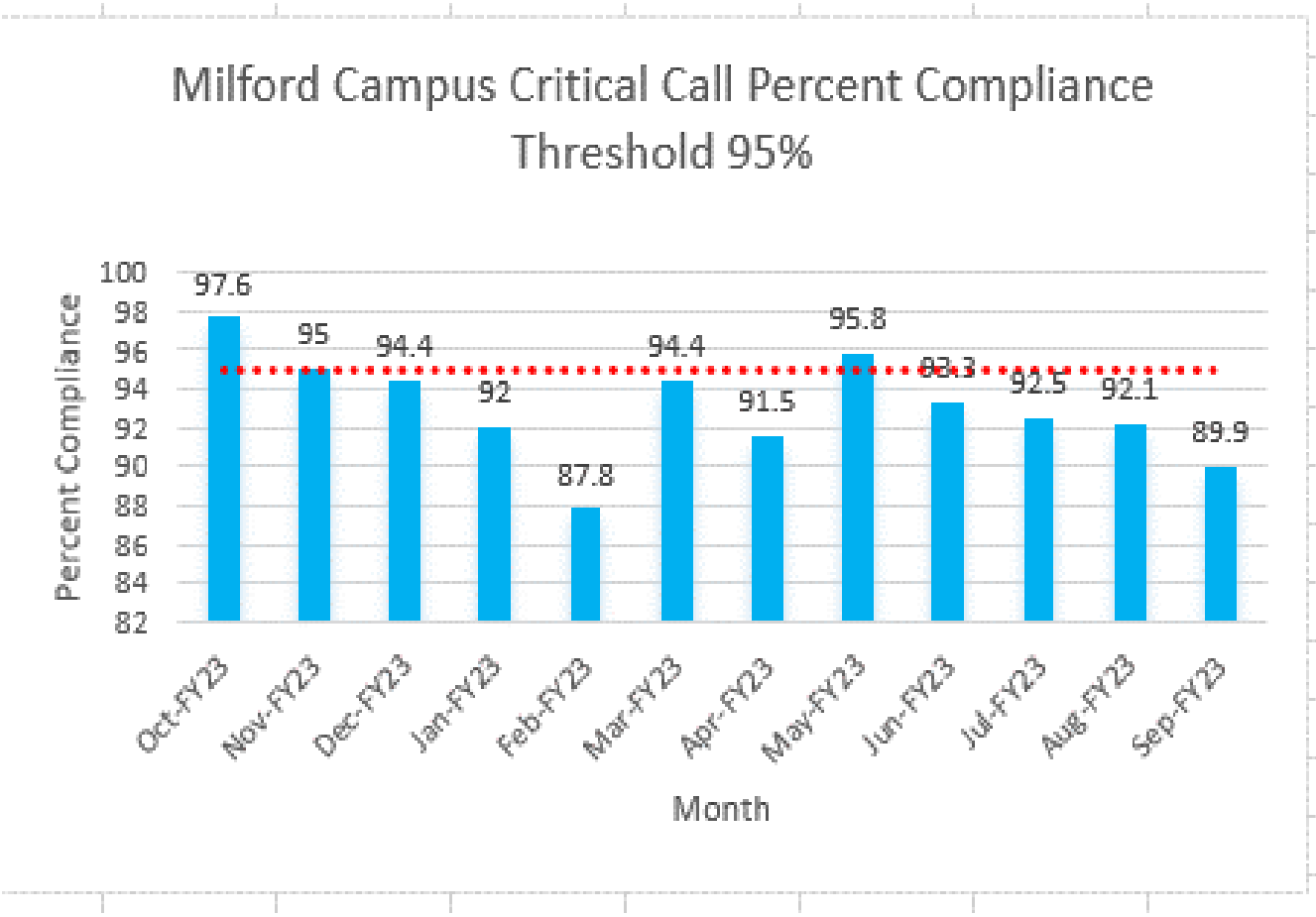
Bridgeport Campus Critical Call Percent Compliance 91.6%

10/1/2022- 9/30/2023



Yale NewHaven Health Bridgeport Hospital

Milford Campus Critical Call Percent Compliance 92.1% 9/1/2022-8/31/2023



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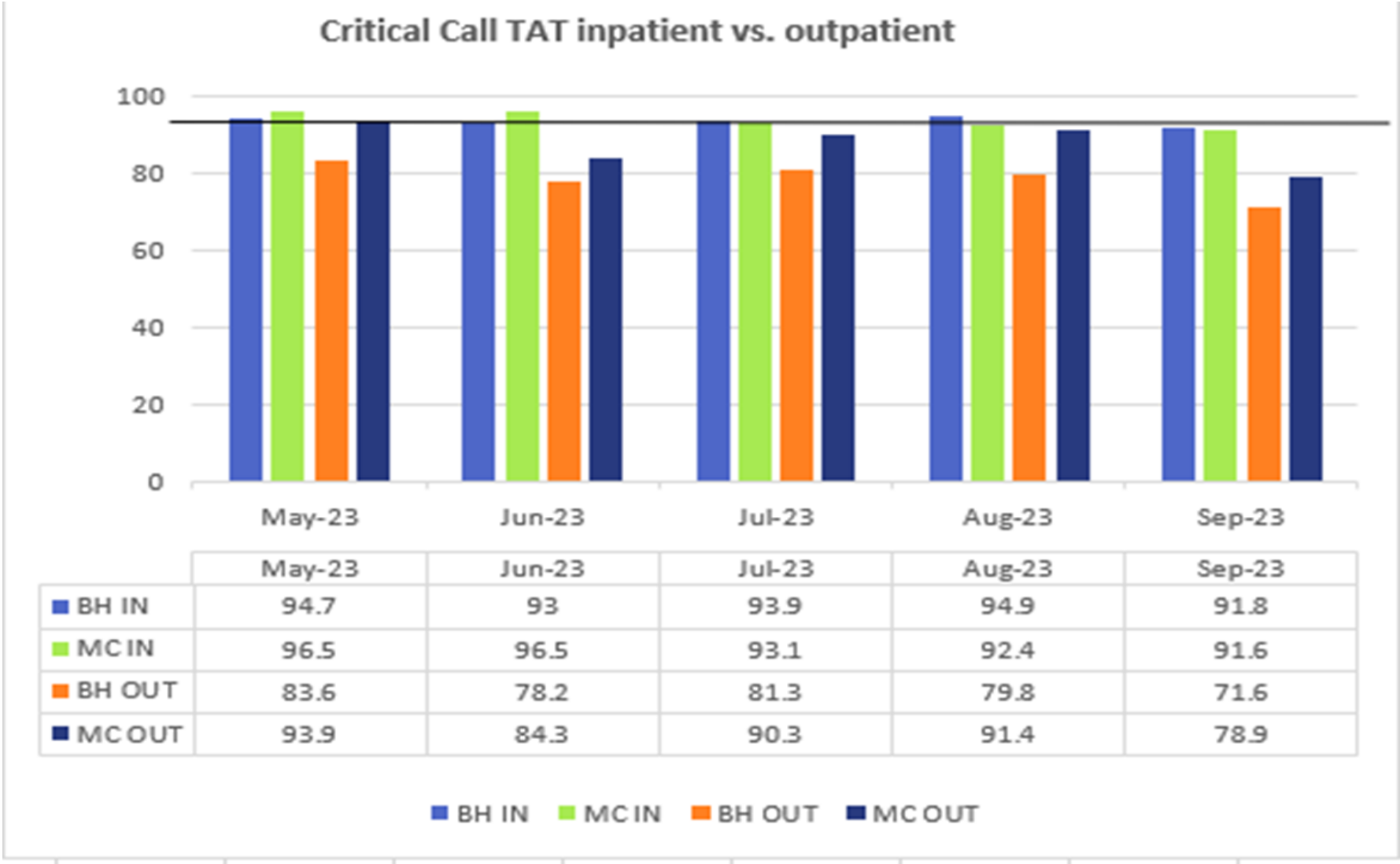
Critical Call TAT
Inpatient vs. Outpatient



	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH IN	94.7	93	93.9	94.9	91.8
MC IN	96.5	96.5	93.1	92.4	91.6
BH OUT	83.6	78.2	81.3	79.8	71.6
MC OUT	93.9	84.3	90.3	91.4	78.9