Yale NewHaven Health Bridgeport Hospital

Laboratory Medicine – October 2023

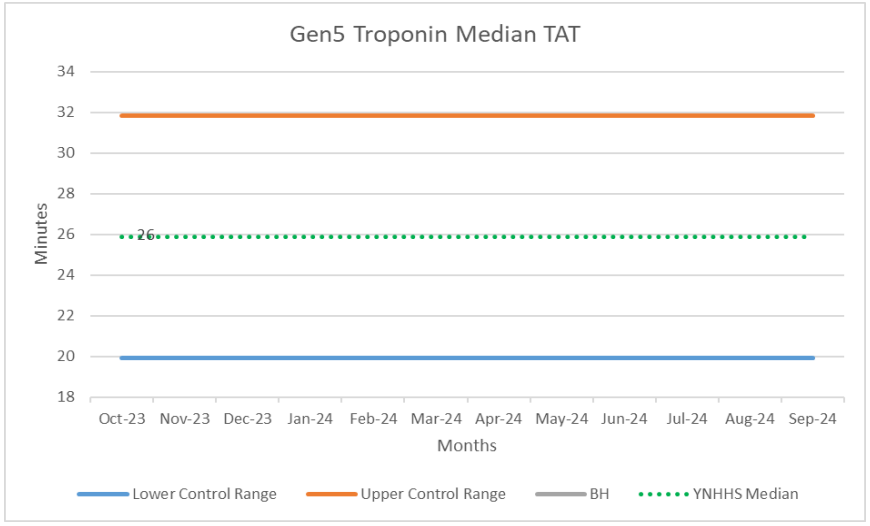
November 28, 2023

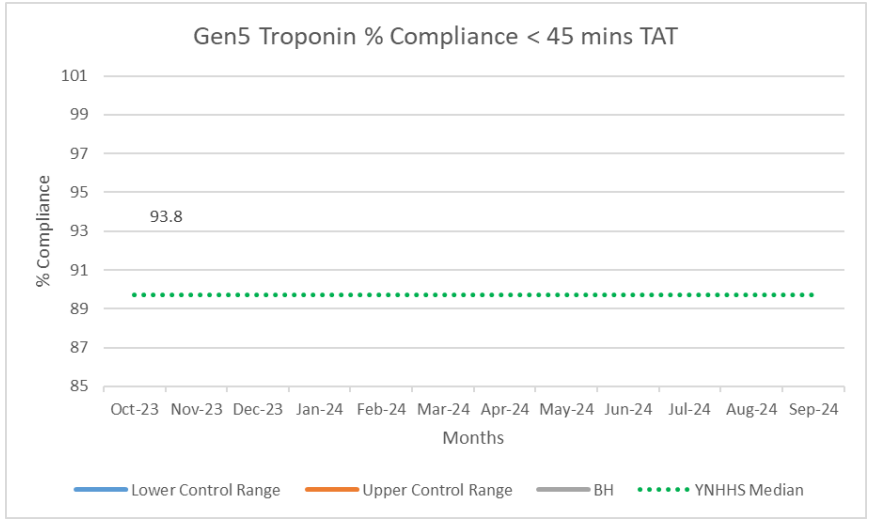
Bridgeport and Milford Campuses Turnaround Time Goals

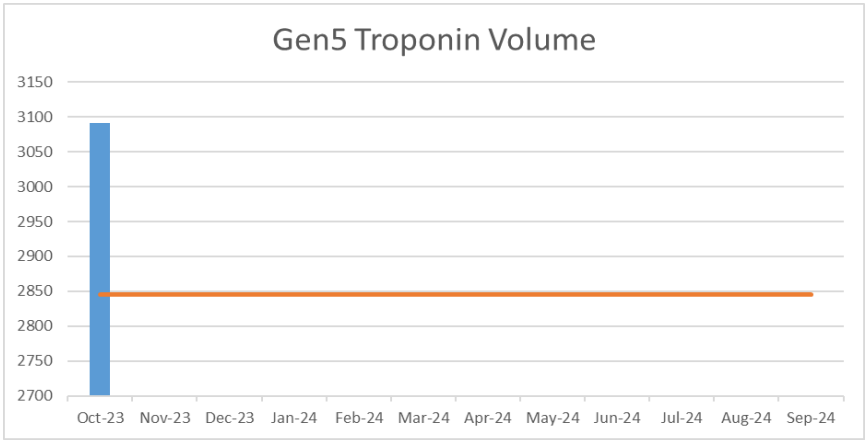
- Mean determined from median TAT across the Yale New Haven Health System delivery networks
  - Bridgeport and Milford Campuses – Bridgeport Hospital, Greenwich Hospital, Lawrence Memorial Hospital, Westerly Hospital, St. Raphael and York Street Campus – Yale New Haven Hospital and Shoreline Medical 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 – Gen 5 Troponin TAT

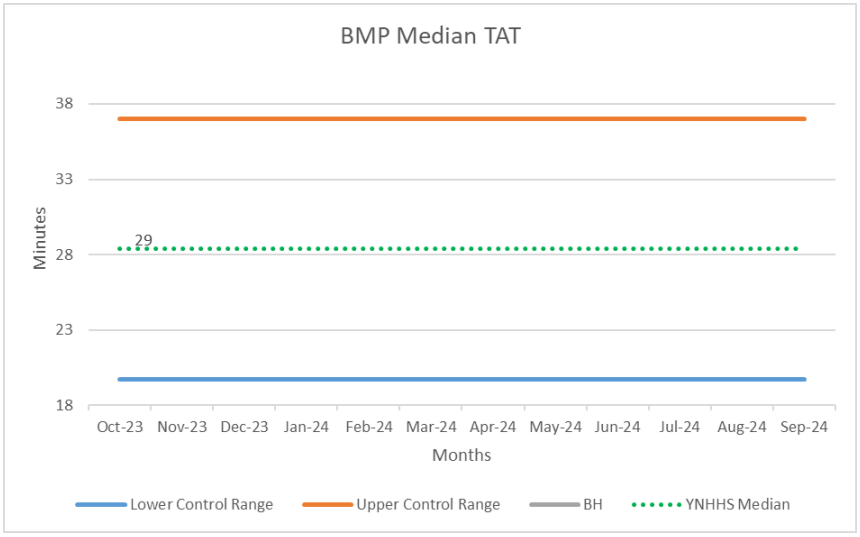


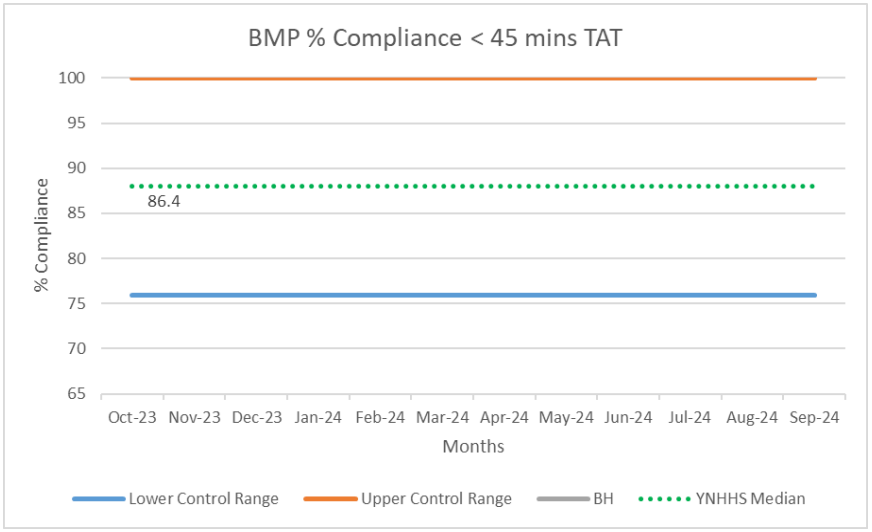


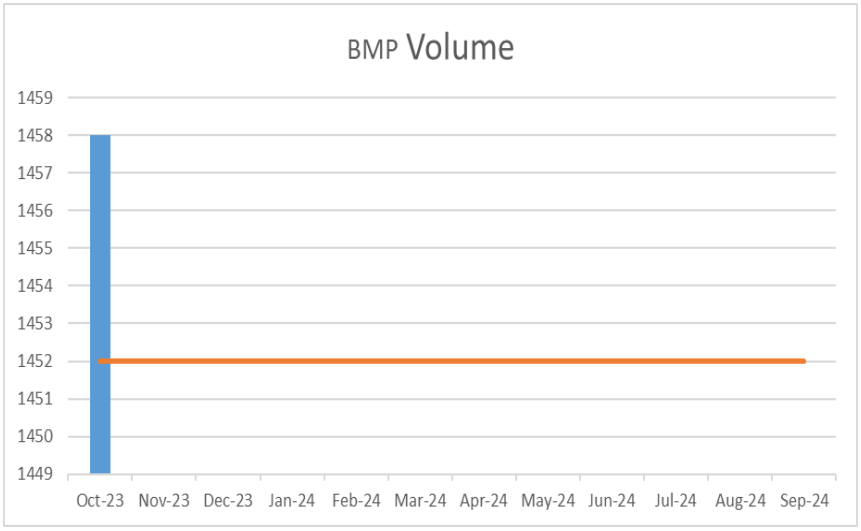


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT

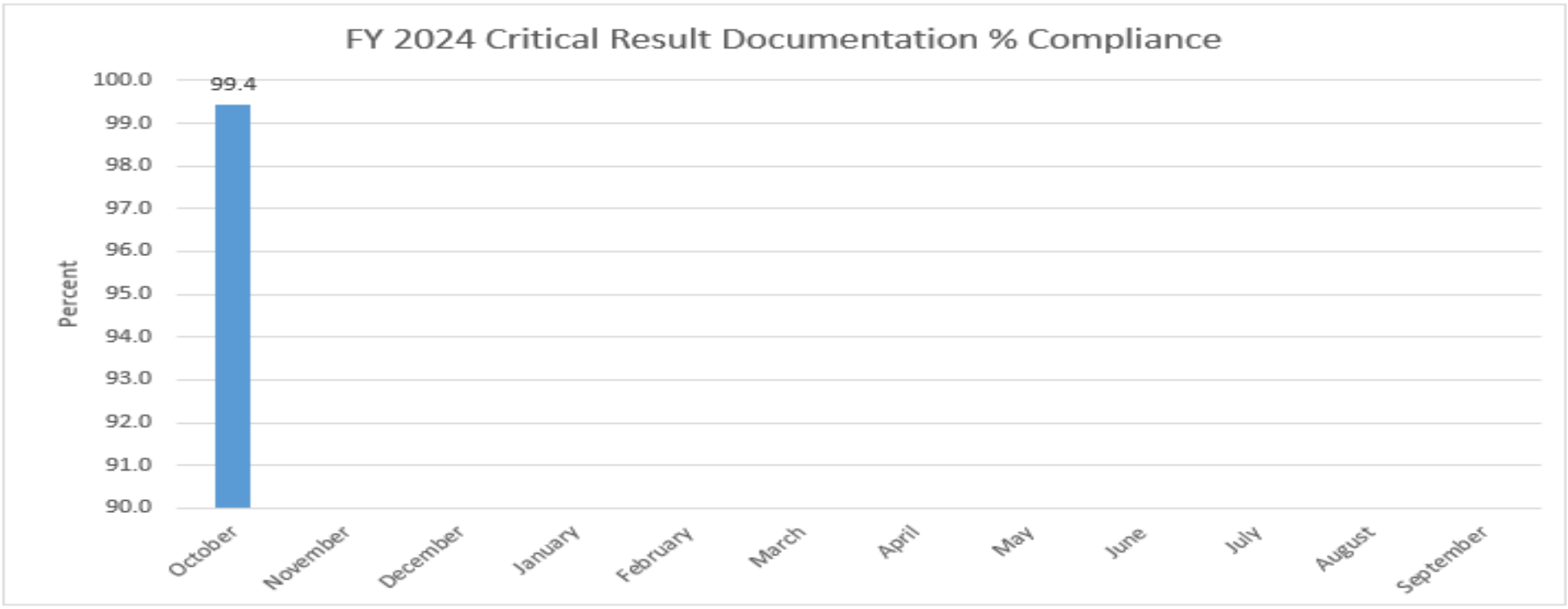






Yale NewHaven Health
Bridgeport Hospital

Chemistry

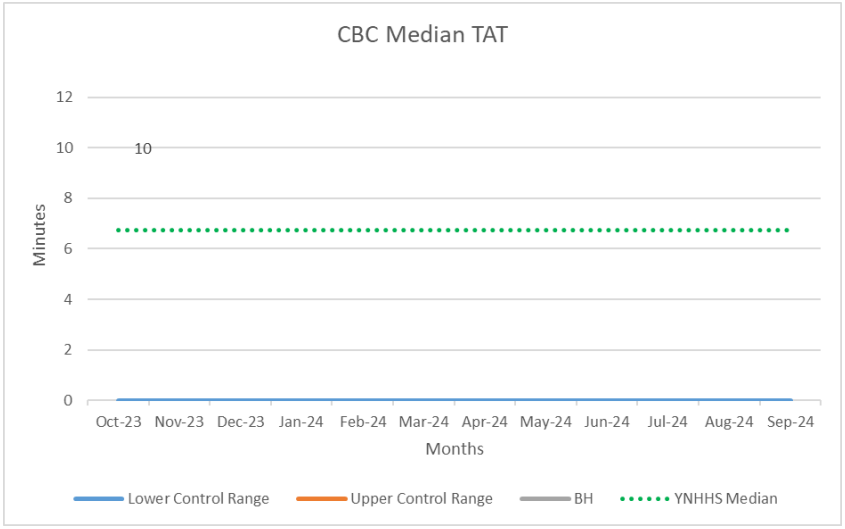


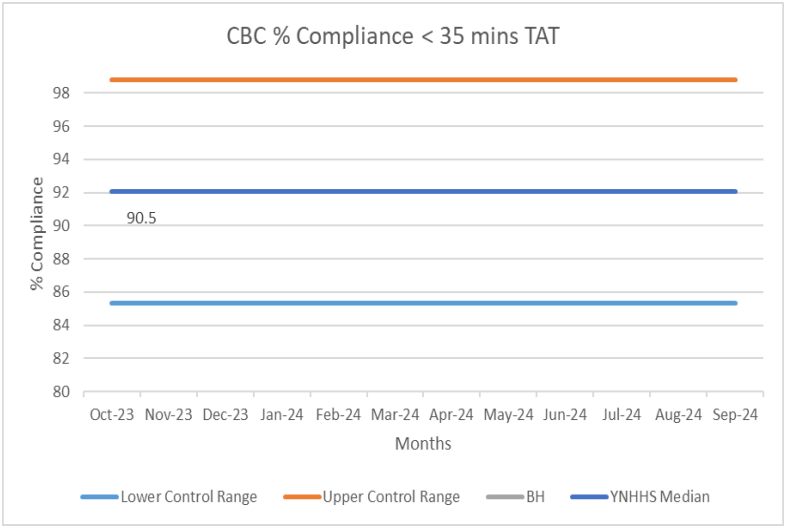
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
n	1386											
#compliant	1378											
#noncompliant	8											

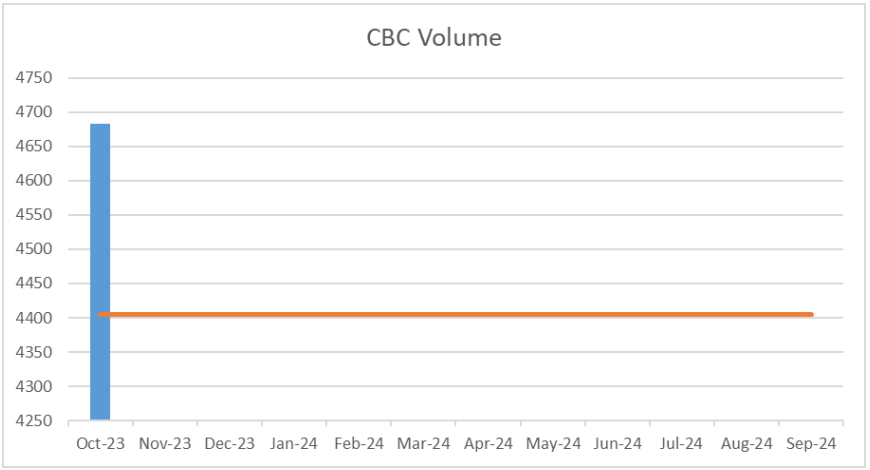
no name	2											
no full name	1											
no credentials	5											

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

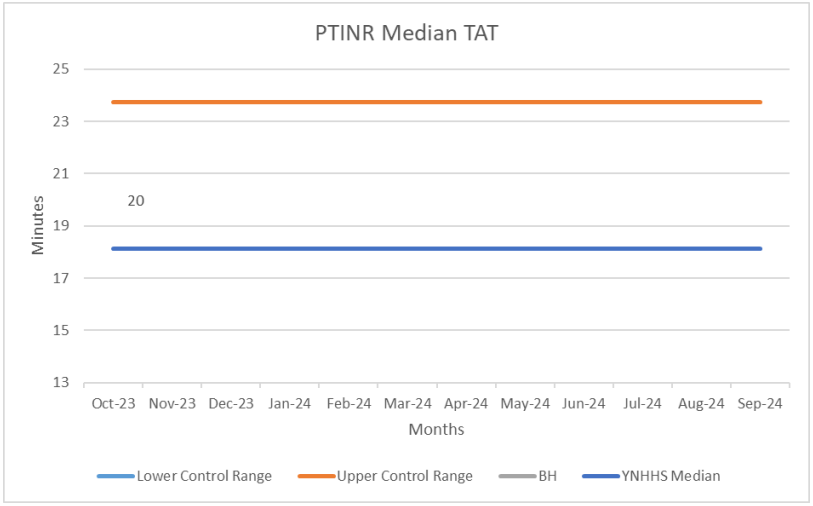


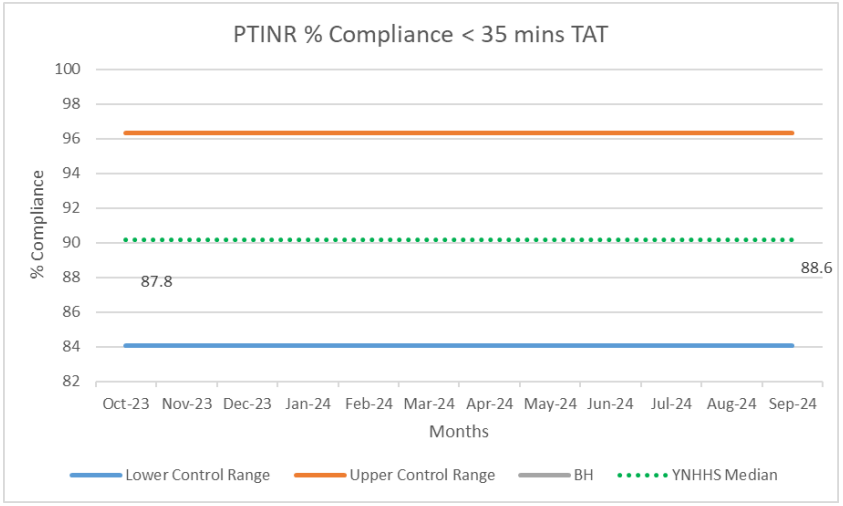


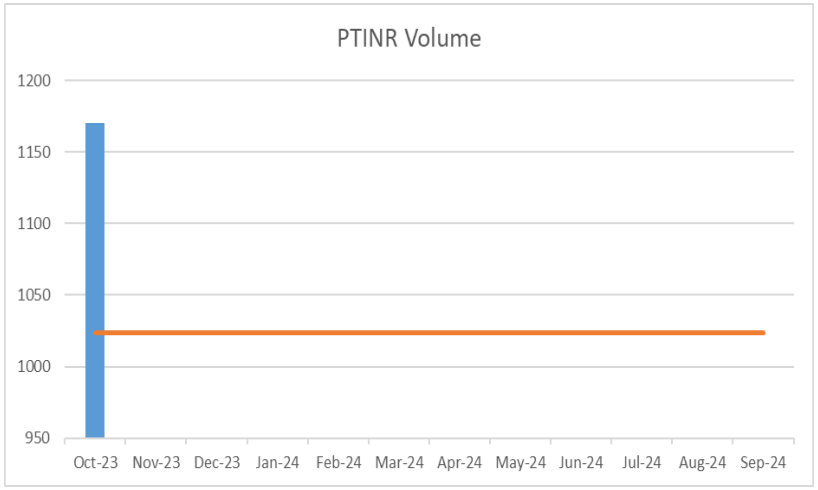


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – PTINR ED TAT

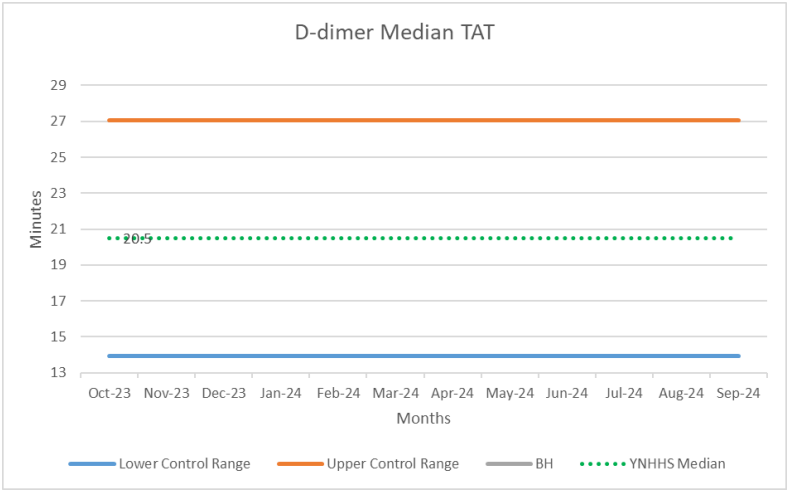


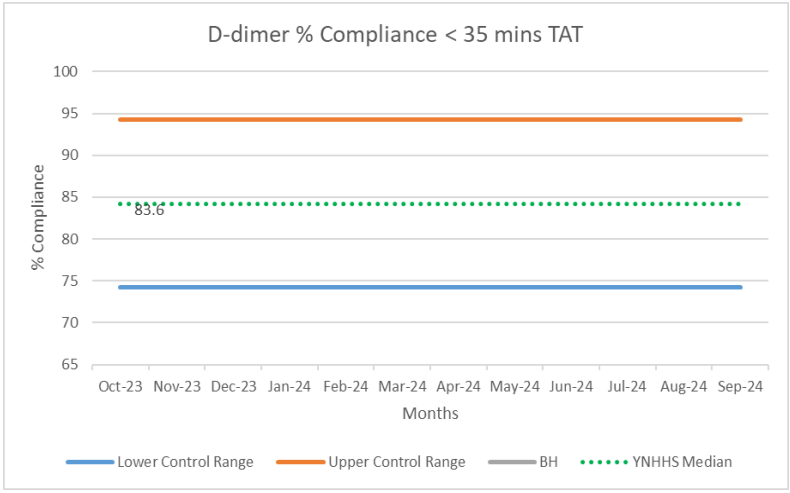


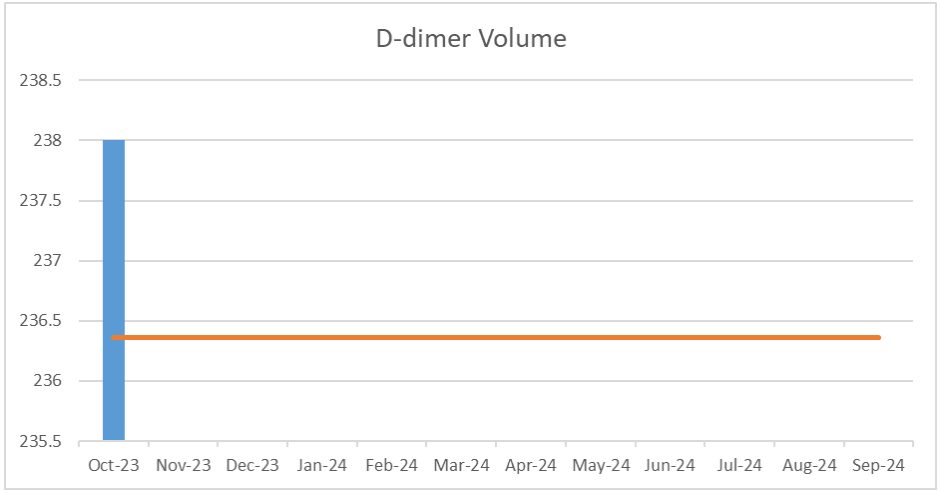


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – D-dimer ED TAT

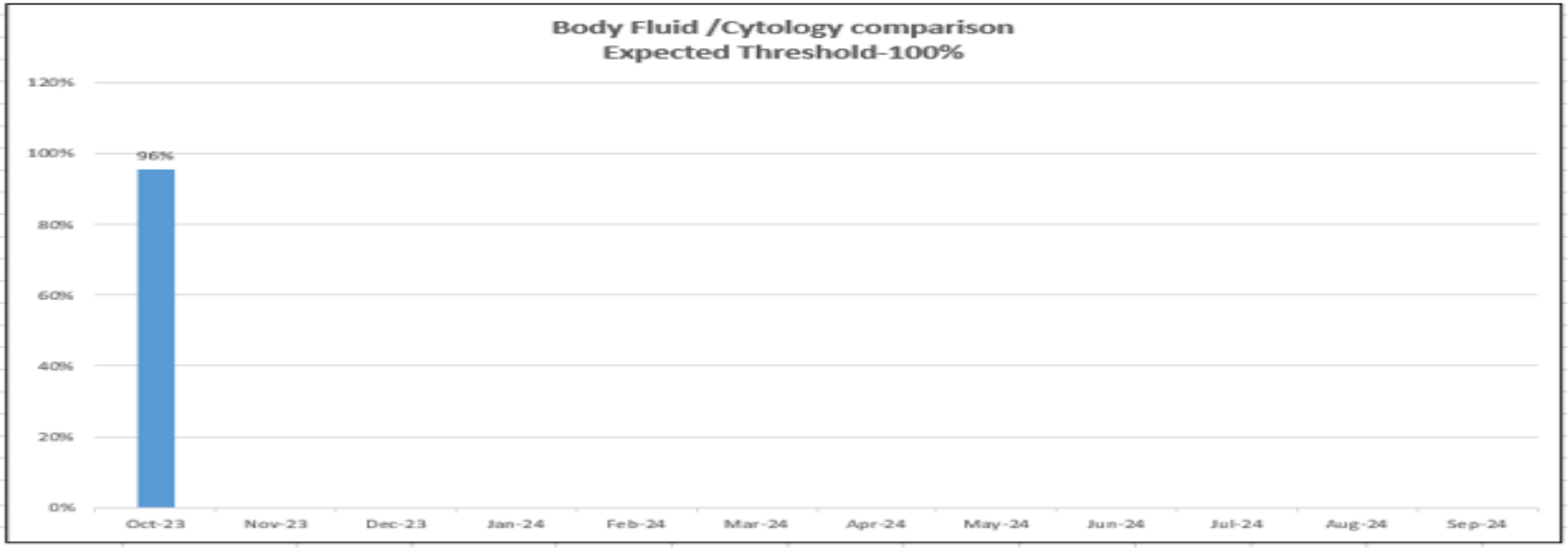






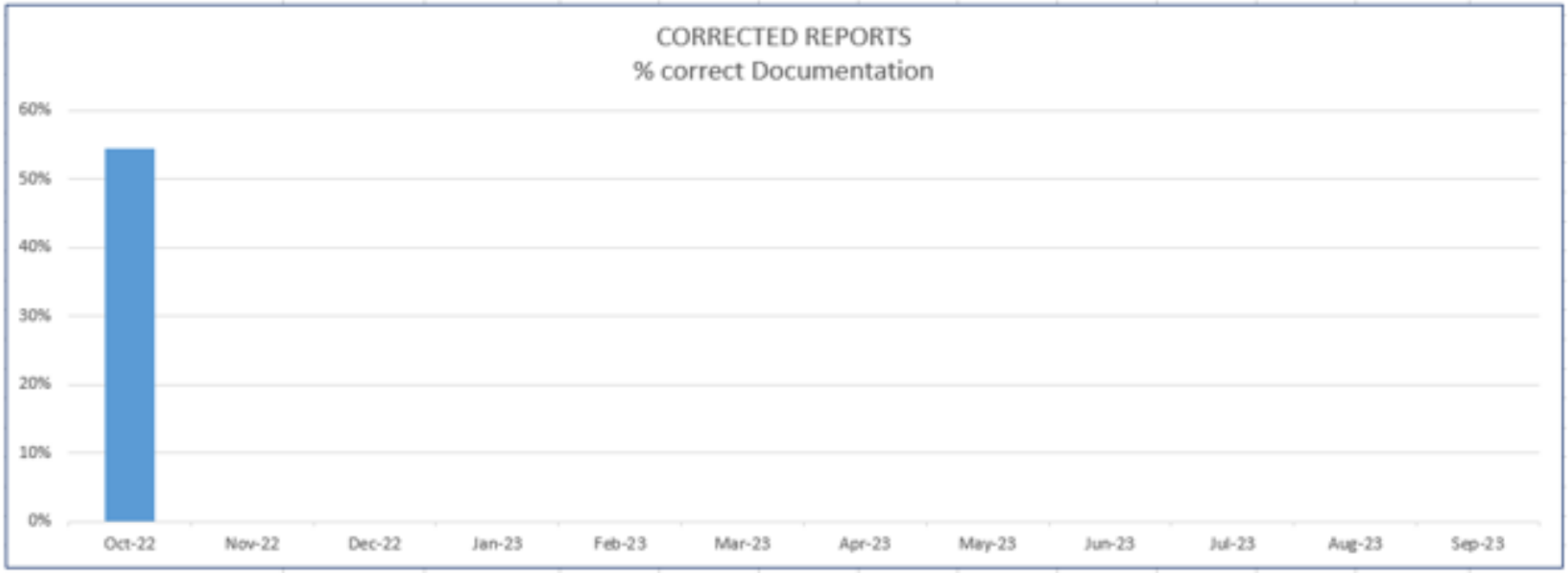
Yale NewHaven Health
Bridgeport Hospital

Aspect of Care



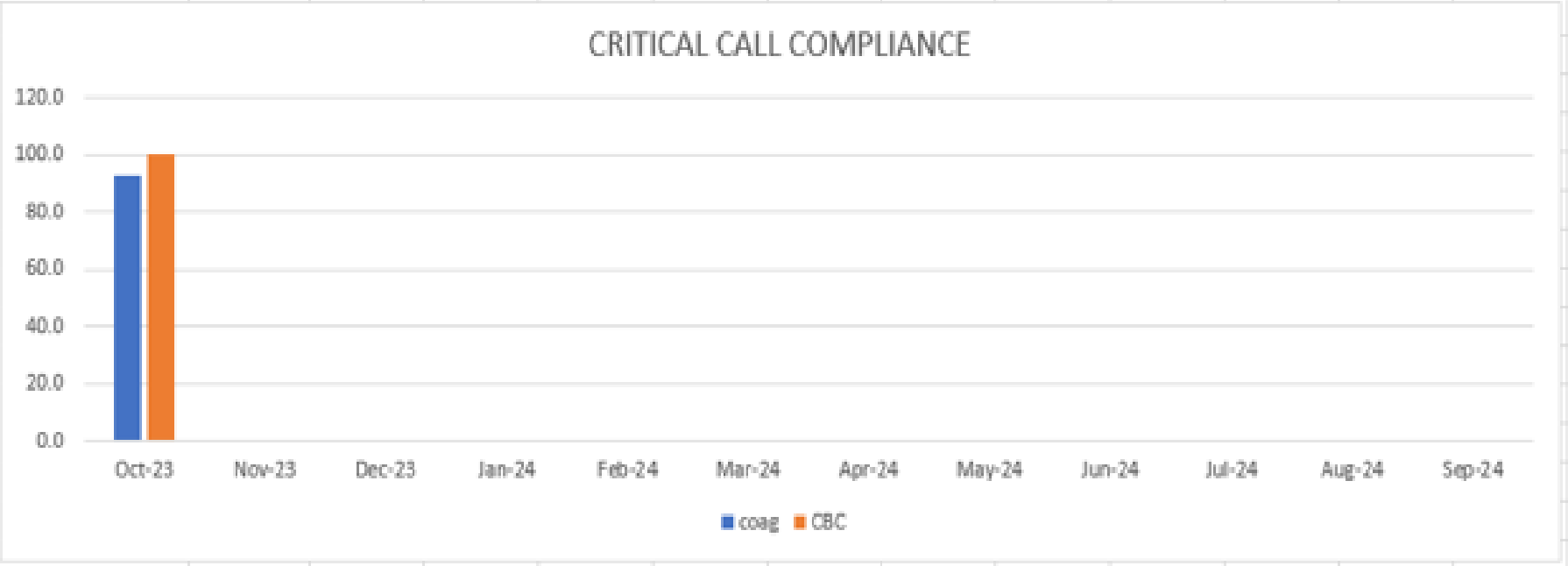
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total # of Fluids	160											
cytology ordered	69											
# of fluid diffs that did not correlate	3											
# of fluids correlated	66											
Threshold achieved	96%											
Expected	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Action/ Outcome	Dr. Mincrowicz reviewed. One slide with suspicious cells.											

Aspect of Care



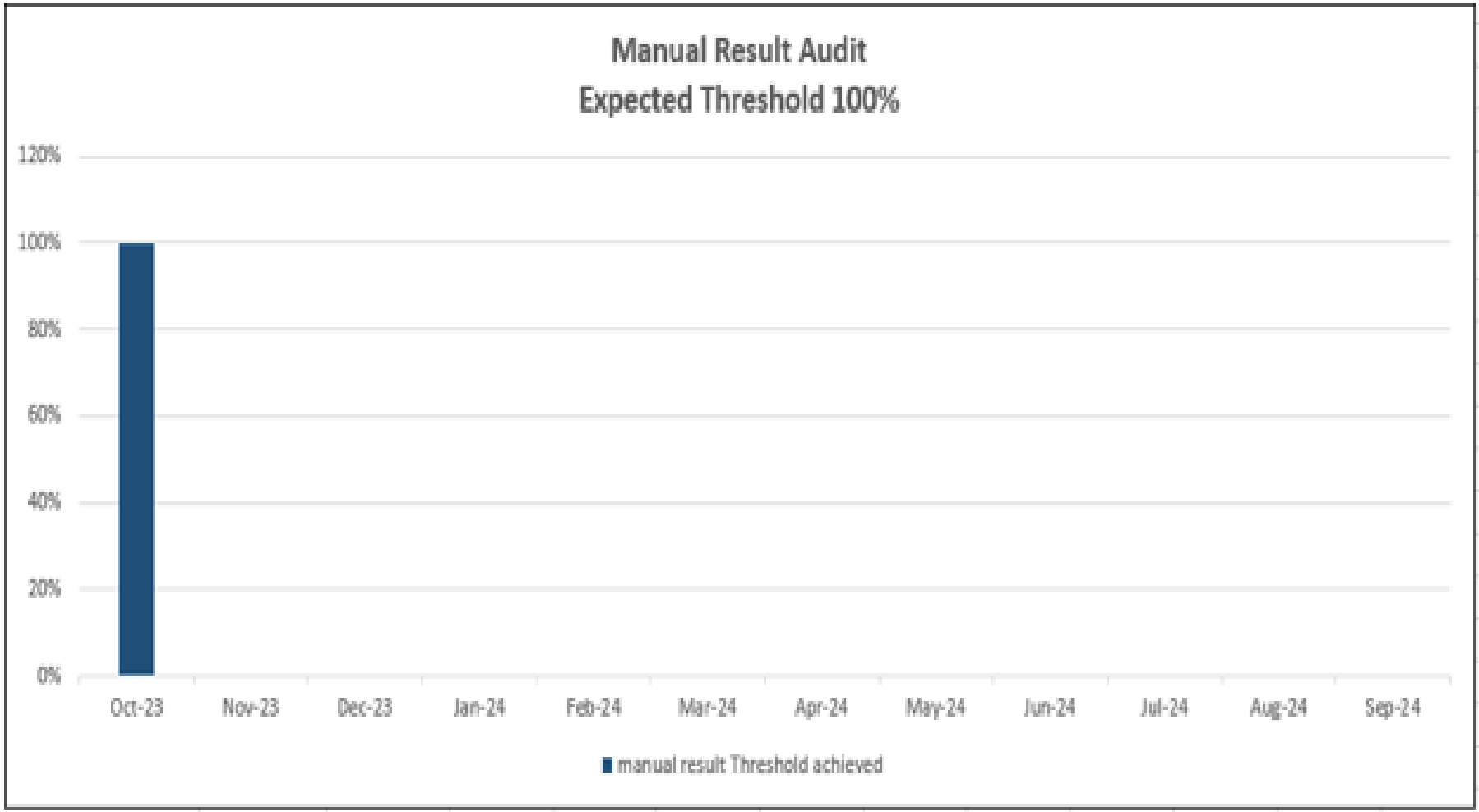
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
corrected appended results	11											
incorrect documentation	5											
correct documetation	6											
% correct	55%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Action/outcome:	adressed in the November staff meeting. The incorrect documentation was on color changes with Urines and fluids.											

Aspect of Care



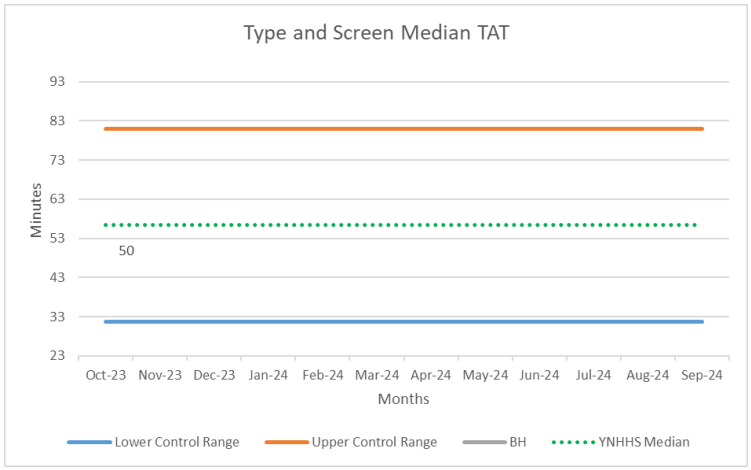
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total #coag Calls	138											
compliant	128											
CBC Critical audit	20											
compliant	20											
Coag	92.8	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
CBC	100	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	2-no credentials. 8-improper comm log.											

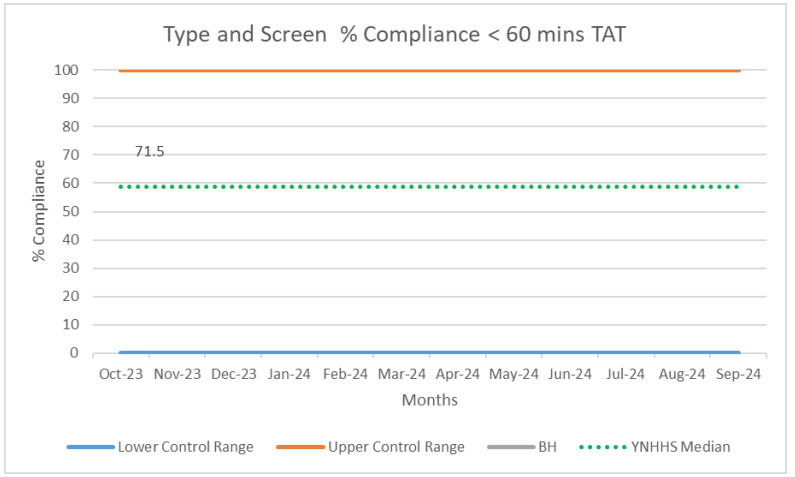
Aspect of Care

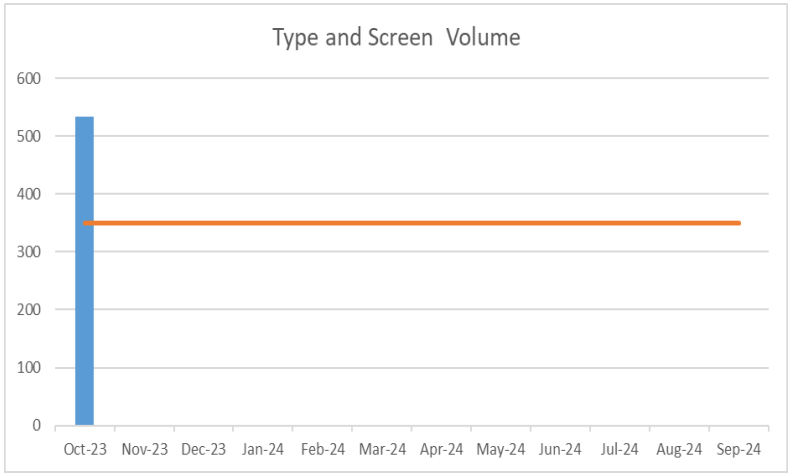


N=30 results audited.

Bridgeport Campus – Type and Screen ED TAT







Yale NewHaven Health
Bridgeport Hospital

Bridgeport Hospital Transfusion Reactions FY24

Months	Total	Allergic	Febrile	Anaphy	TACO	TRALI	TAD	Hemolytic Intravascular	Hemolytic extravascular	Delayed Serological	Septic	Underlying Disease
	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH
Oct	6	0	2	0	0	0	1	0	1	1	0	1
Nov	0											
Dec	0											
Jan	0											
Feb	0											
Mar	0											
Apr	0											
May	0											
Jun	0											
Jul	0											
Aug	0											
Sep	0											
Total	6	0	2	0	0	0	1	0	1	1	0	1

Yale NewHaven Health Bridgeport Hospital

Bridgeport Hospital

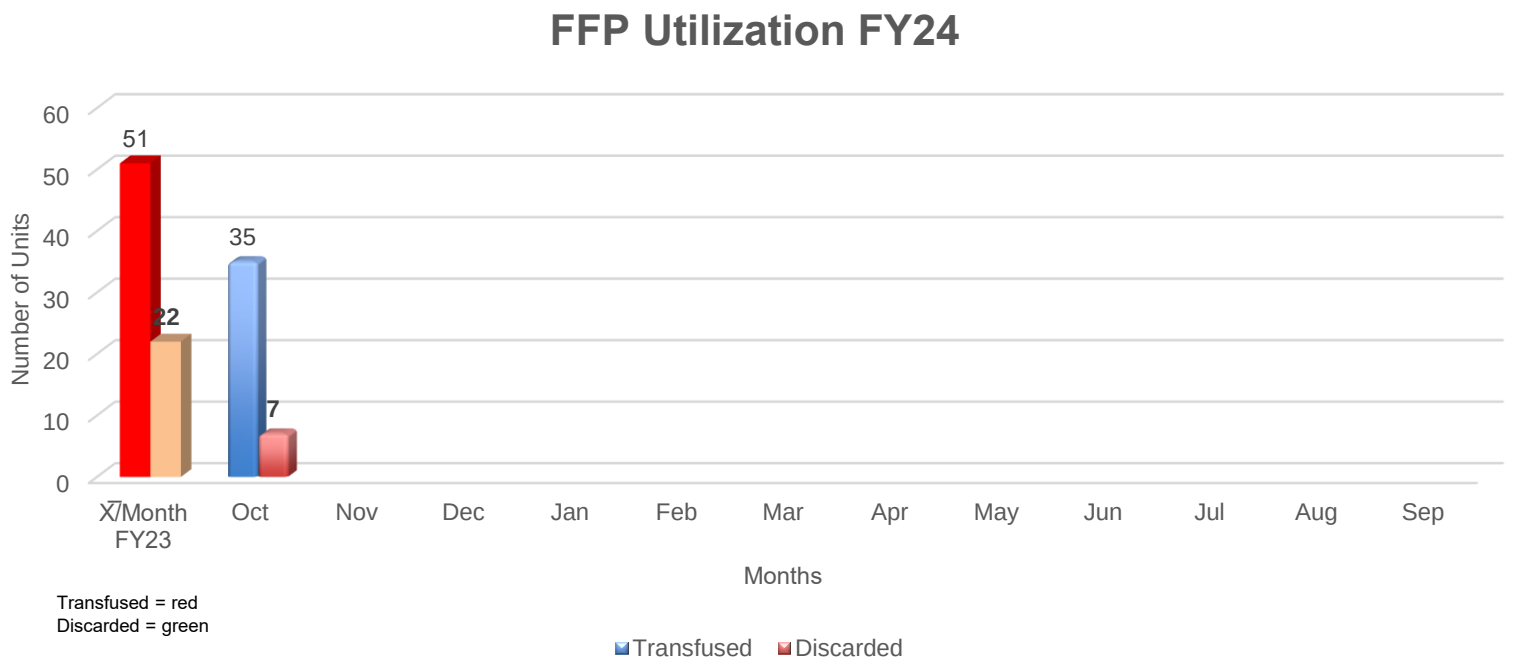
Bridgeport Hospital Blood Bank - FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfused	**450**													**450**	**$119,475.00**
Discarded	**4**													**4**	**$1,062.00**
Expired	**0**													**0**	**$0.00**
Wasted	**4**													**4**	**$1,062.00**
Total	**454**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**454**	**$120,537.00**

Discarded = Expired + 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 Hospital



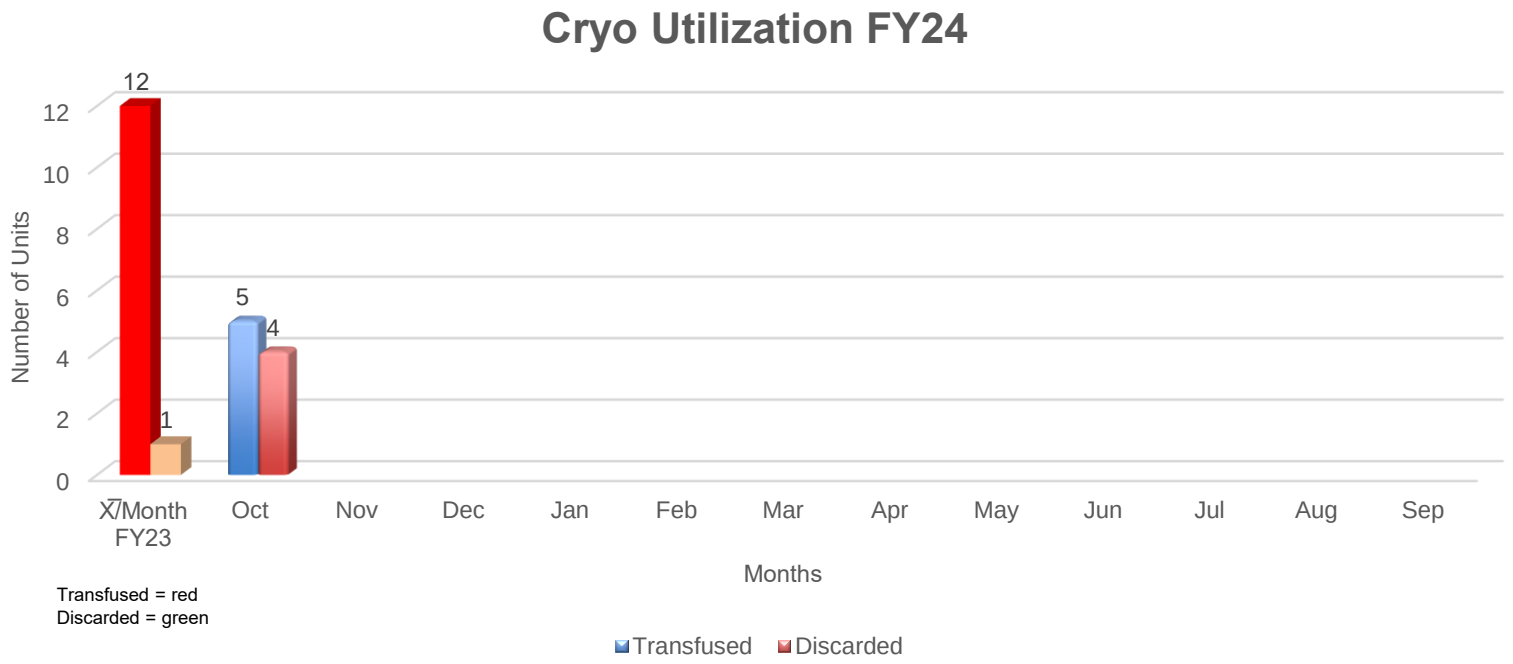
Bridgeport Hospital Blood Bank - FY24

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfused	35													35	$1,361.15
Discarded	7													7	$272.23
Expired*	0													0	$0.00
Wasted**	7													7	$272.23
Total	42	0	0	0	0	0	0	0	0	0	0	0		42	$1,633.38

Discarded = Expired + 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 Hospital



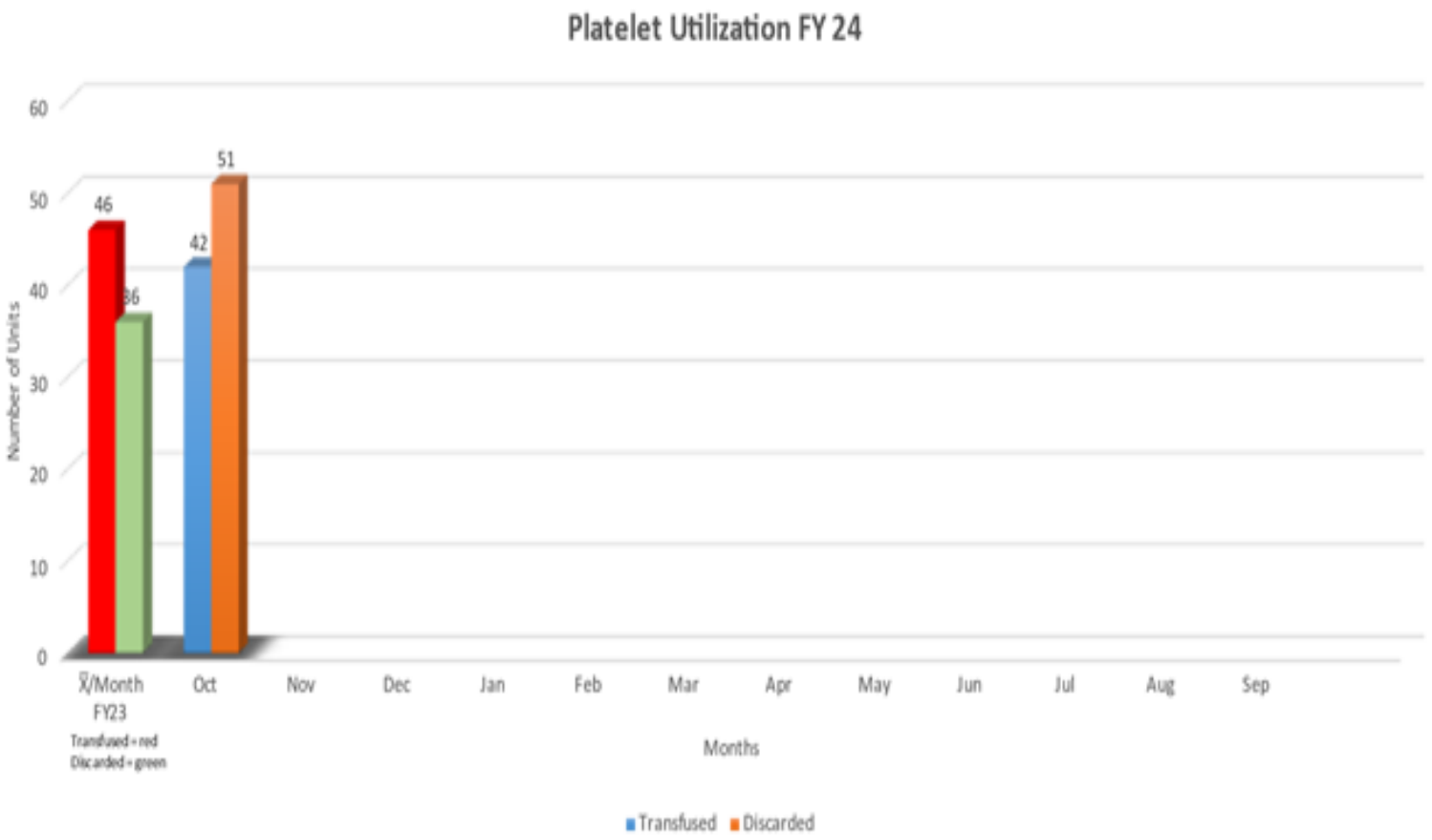
Bridgeport Hospital Blood Bank - FY24

Cryo

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfused	5													5	$1,657.50
Discarded	4													4	$1,326.00
Expired	2													2	$663.00
Wasted	2												0±0	2	$663.00
Total	13													13	$4,309.50

Discarded = Expired + 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 Hospital



Bridgeport Hospital Blood Bank

FY24

Platelet Utilization

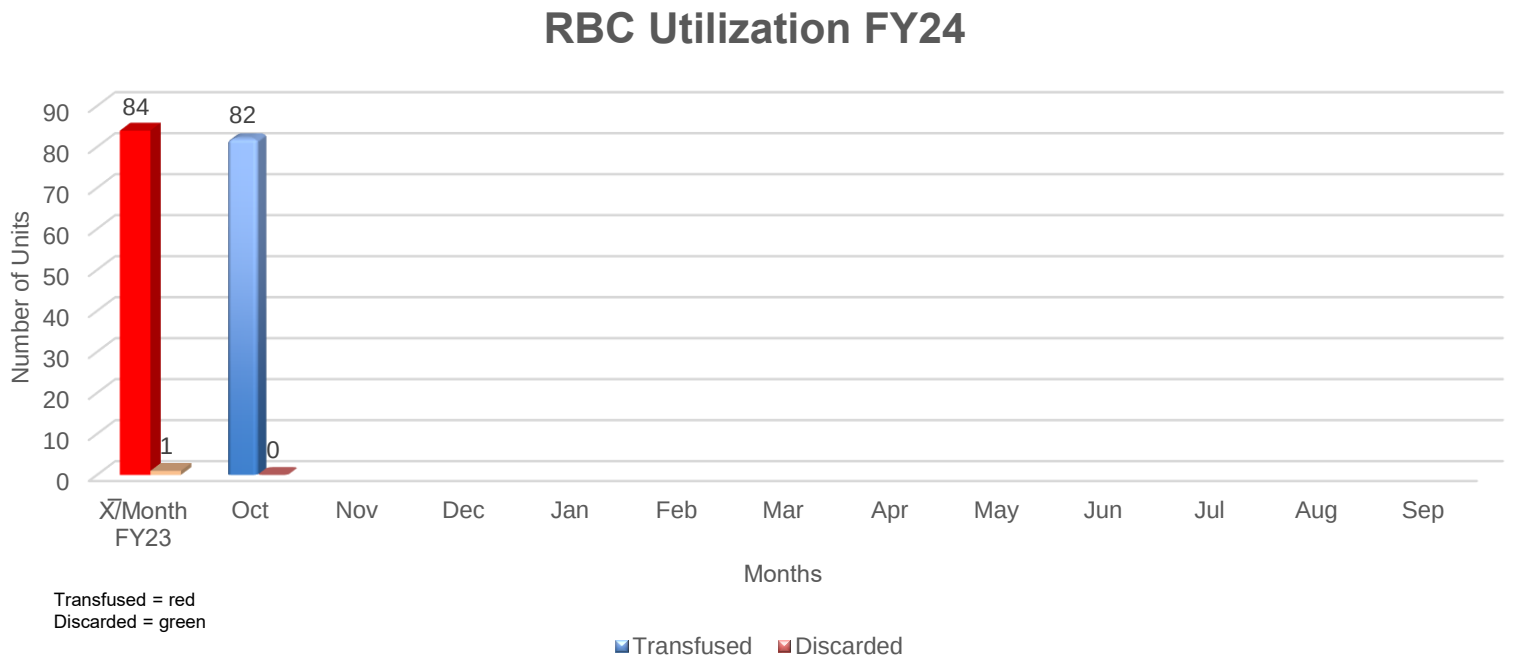
	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Mean ± SD	Total	Total Amount
Total	93	0	0	0	0	0	0	0	0	0	0	0		93	**$62,619.69**
Transfused	42													42	**$28,279.86**
Discarded	51													51	**$34,339.83**
Expired	51													51	**$34,339.83**
Wasted	0												0±0	0	**$0.00**
% Discarded	55%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
Day 6 extended transfused															

Discarded = Expired + 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

Milford Hospital Transfusion Reactions FY24

Months	Total	Allergic	Febrile	Anaphy	TACO	TRALI	TAD	Hemolytic Intravascular	Hemolytic extravascular	Delayed Serological	Septic	Underlying Disease
	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Oct	1	0	1	0	0	0	0	0	0	0	0	0
Nov	0											
Dec	0											
Jan	0											
Feb	0											
Mar	0											
Apr	0											
May	0											
Jun	0											
Jul	0											
Aug	0											
Sep	0											
Total	1	0	1	0	0	0	0	0	0	0	0	0

Milford Hospital



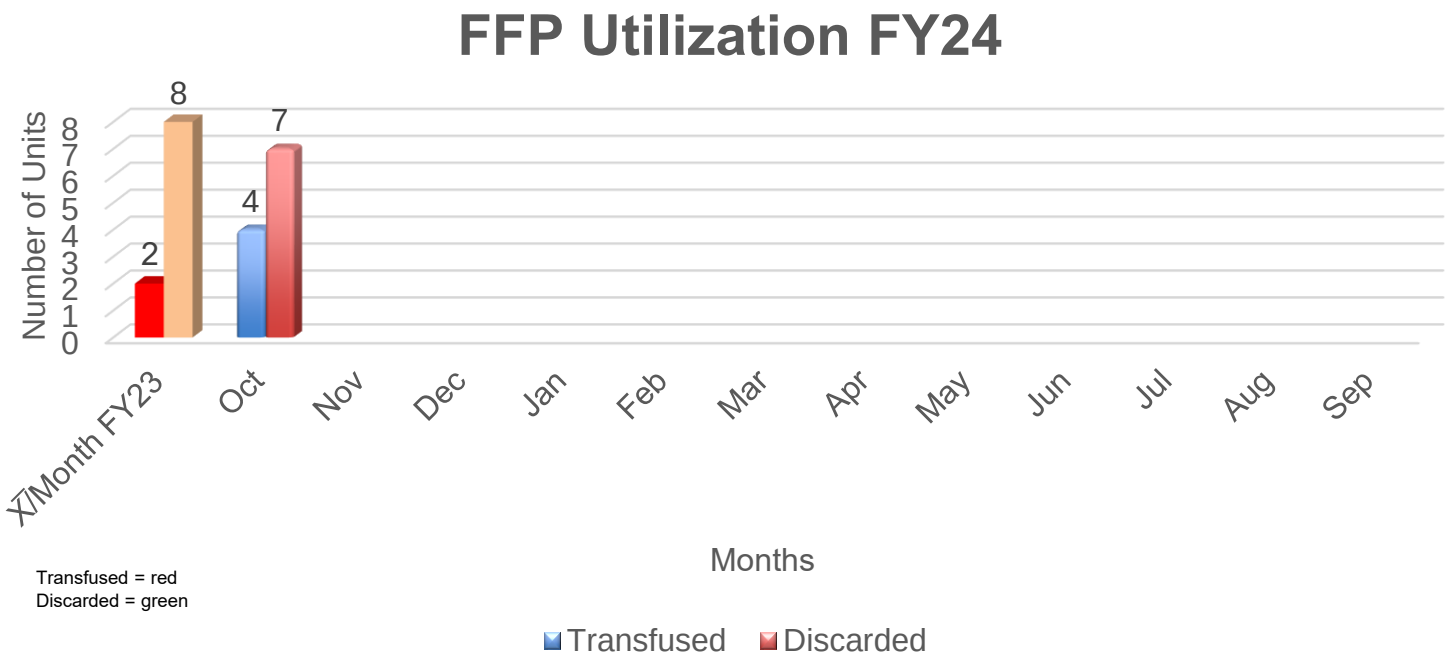
Milford Hospital Blood Bank FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfused	**82**													**82**	**$21,771.00**
Discarded	**0**													**0**	**$0.00**
***Expired**	**0**													**0**	**$0.00**
****Wasted**	**0**													**0**	**$0.00**
Total	**82**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**82**	**$21,771.00**

Discarded = Expired + 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

Milford Hospital



Transfused = red
Discarded = green

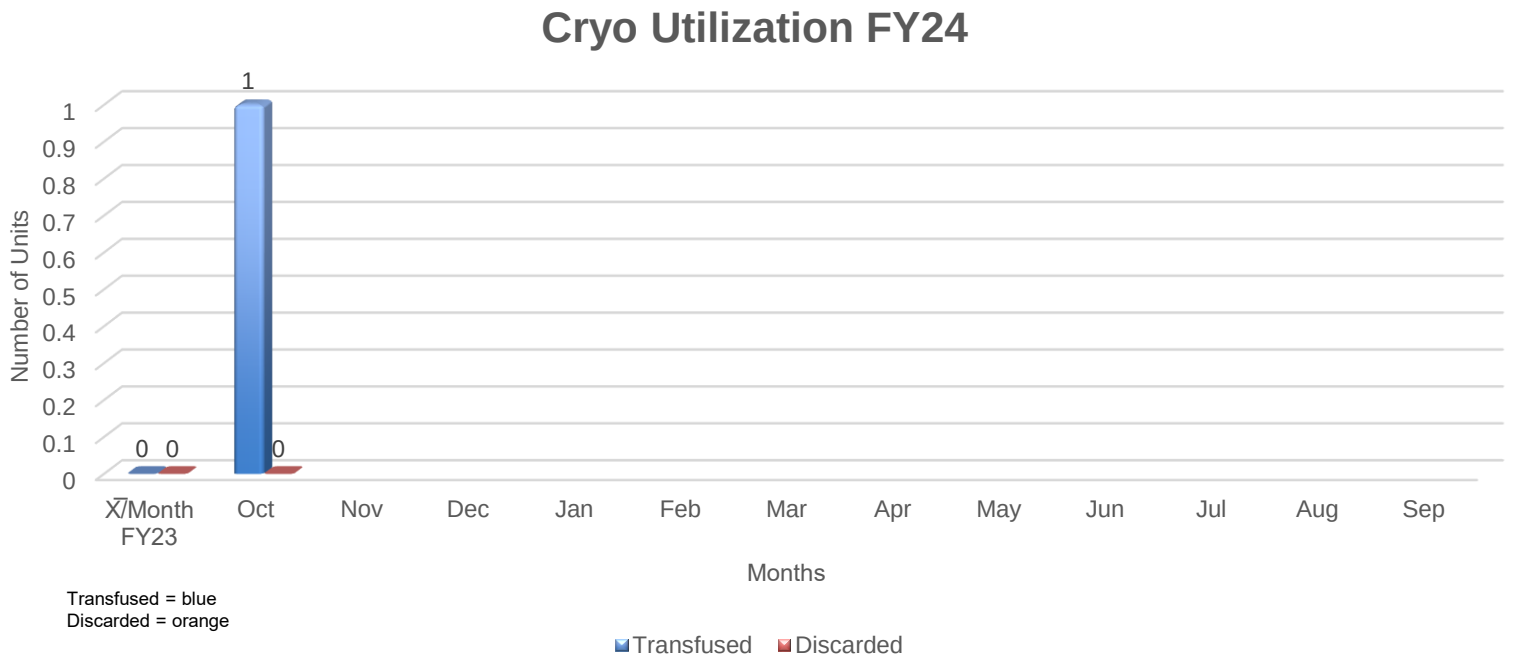
Milford Hospital Blood Bank FY24

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfused	**4**													**4**	**$155.56**
Discarded	**7**													**7**	**$272.23**
Expired	**0**													**0**	**$0.00**
Wasted	**7**													**7**	**$272.23**
Total	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**11**	**$427.79**

Discarded = Expired + 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

Milford Hospital



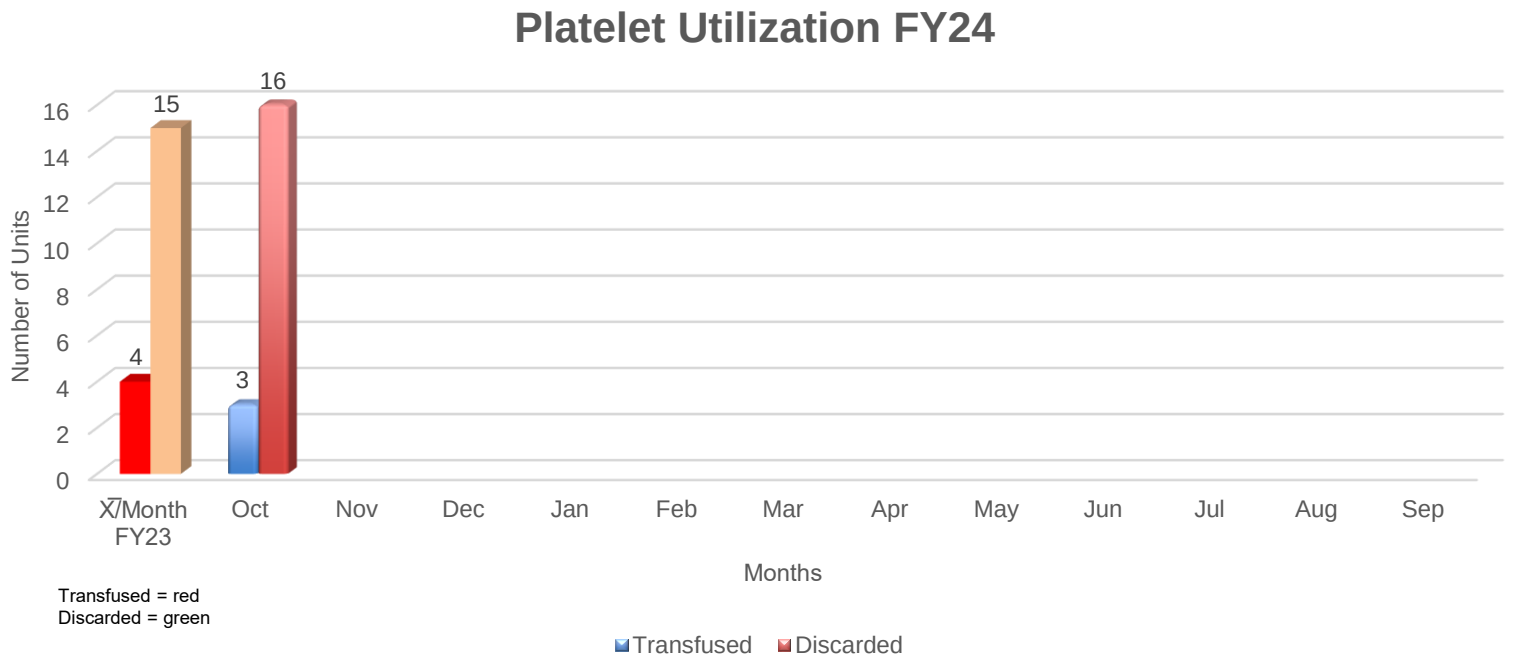
Milford Hospital Blood Bank FY24

Cryo Utilization

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

Discarded = Expired + 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

Milford Hospital



Transfused = red
Discarded = green

Milford Hospital Blood Bank FY24

Platelet Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Total	19	0	0	0	0	0	0	0	0	0	0	0		19	$12,793.27
Transfused	3													3	$2,019.99
Discarded	16													16	$10,773.28
Expired	16													16	$10,773.28
Wasted	0													0	$0.00
% Discarded	84.21%	#DIV/0!	#DIV/0!	80%	85%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
Day 6 extended transfused															

Discarded = Expired + 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 – 2023 Point of Care Performance Report Summary

MONTH	Threshold	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Incorrect or undocumented Patient / LQC Results for Avoximeter	0 errors	2												1 LQC was not performed on Monday - Reminder for all staff during their department huddle to do this on both instruments. 1 out of 3 results for one patient was not documented - reviewed with the monitor
Incorrectly documented Urine POC Pregnancy Internal QC	0 errors	7												Total volume is slightly up from last month and the errors are continuing to show a decreasing trend. Email sent to 4 staff.
# of i-STAT codes / # of cartridges run		17 / 459												Below Threshold 2 staff had multiple codes during difficult cases. No codes during other cases.
i-STAT Quality Check Codes	<5.0%	3.7%												

Yale NewHaven Health

CRSQ Report Out

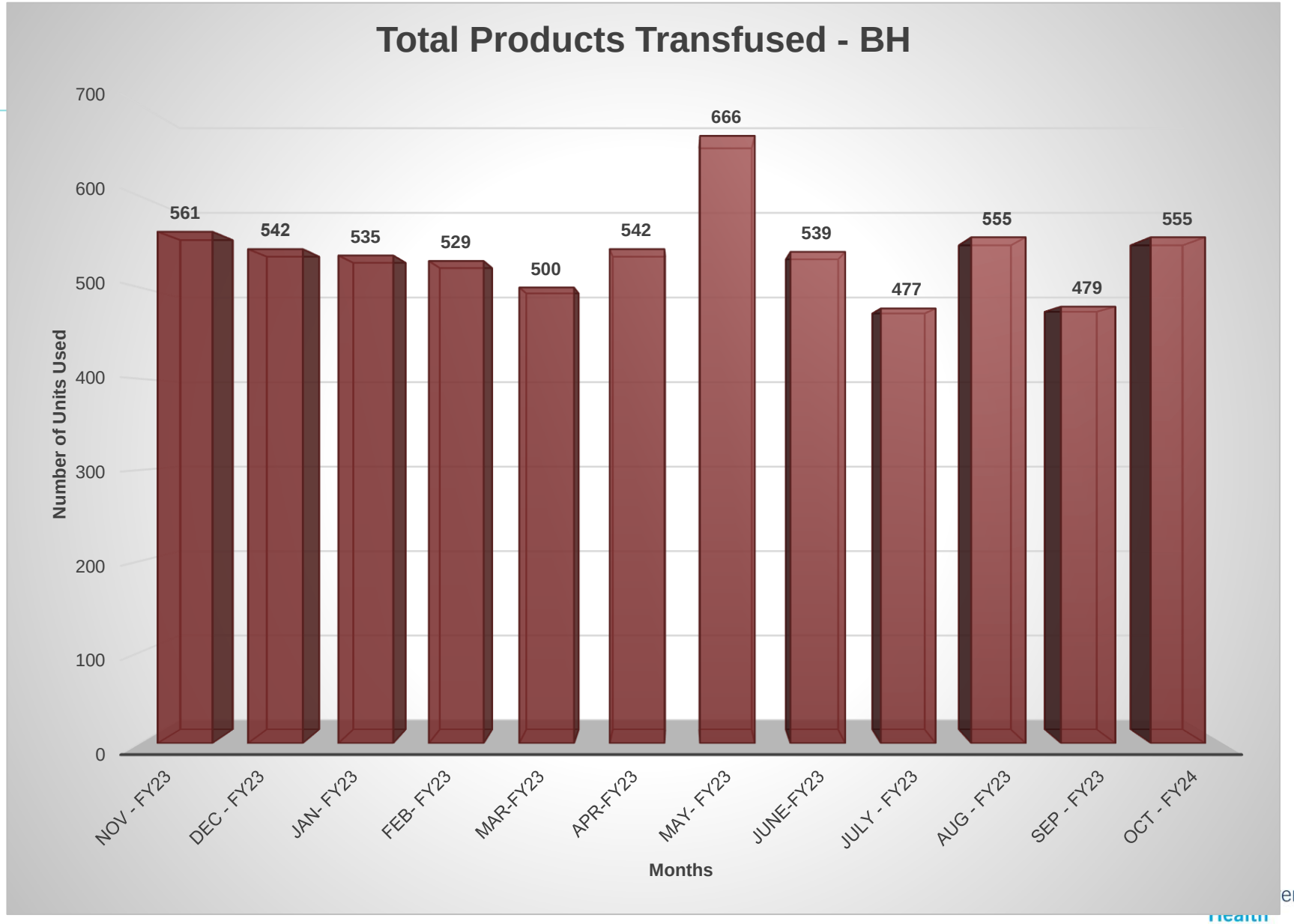
Committee of Regulatory, Safety, & Quality

10/06/2023

Bridgeport Hospital

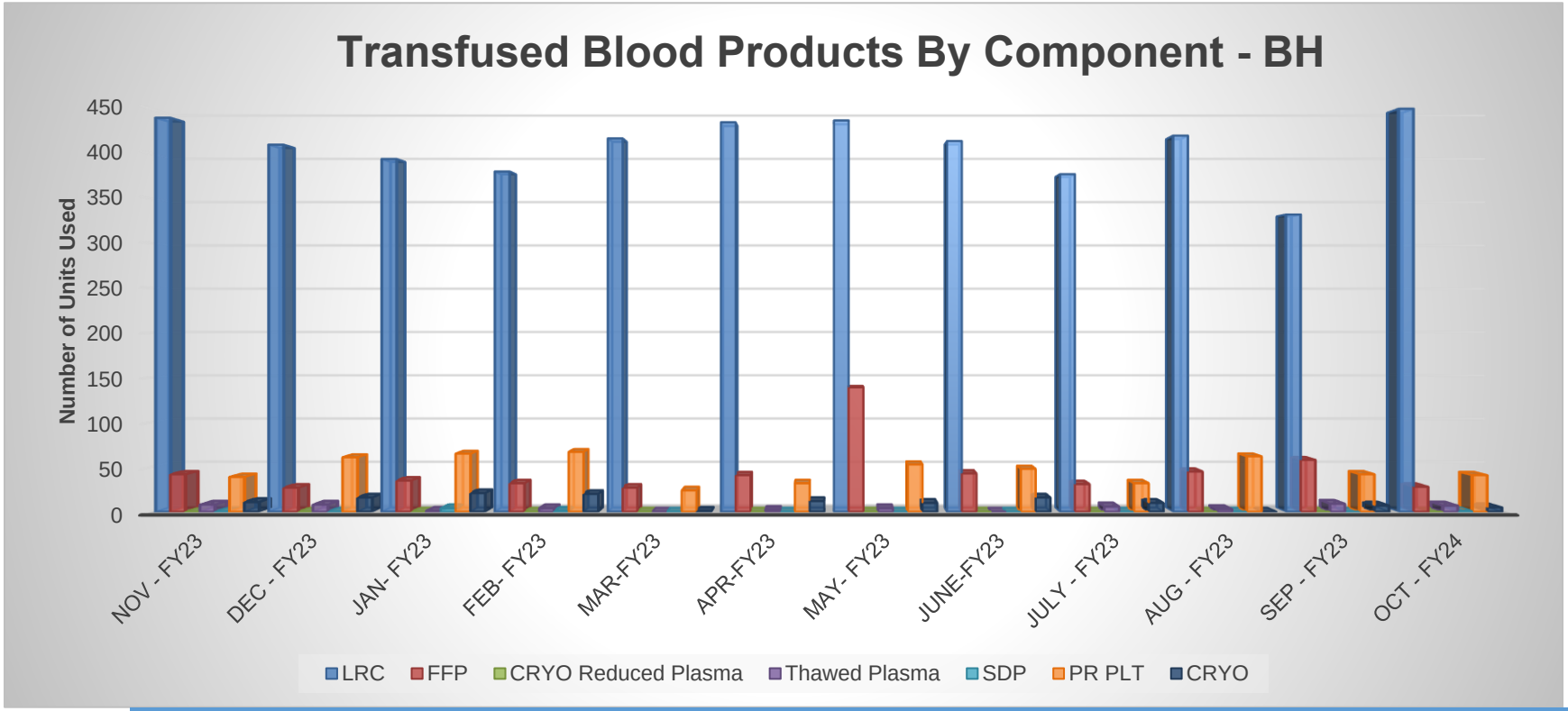
Laboratory Blood Bank

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



PI.01.01.01 EP6

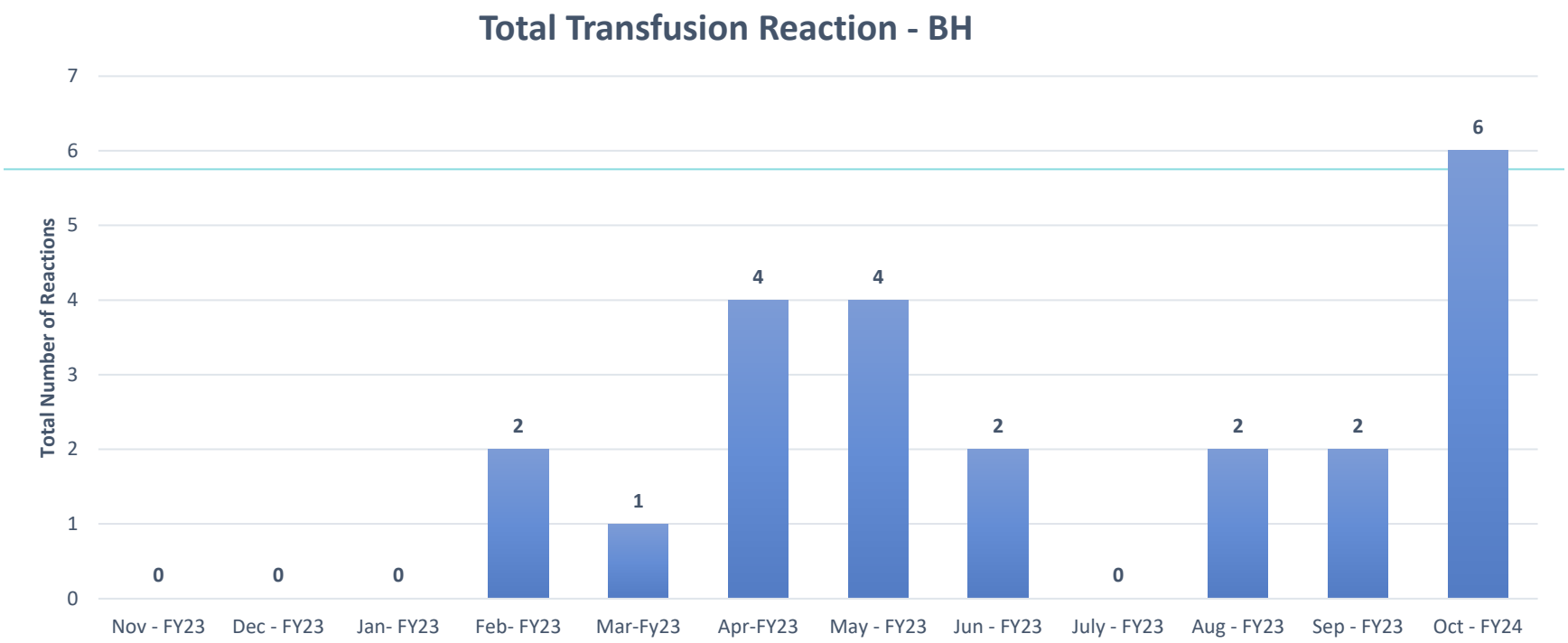
Bridgeport Hospital



	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO	Total Products	Total Plasma	Total Platelets
Nov - FY23	440	42	0	8	0	39	11	561	50	39
Dec - FY23	410	27	0	8	0	61	16	542	35	61
Jan- FY23	394	35	0	1	4	65	21	535	36	65
feb- FY23	380	32	0	4	1	67	20			
Mar-FY23	417	27	0	0	0	24	1	500	27	24
Apr-FY23	435	41	0	2	0	32	12	542	43	32
May- FY23	437	139	0	4	0	53	10	666	143	54
June-FY23	414	43	0	0	0	48	16	539	43	48
July - FY23	377	31	0	6	0	32	10	477	37	32
Aug - FY23	420	45	0	3	0	62	0	555	48	62
Sep - FY23	332	58	0	9	0	42	7	479	8	42
Oct - FY24	450	28	0	7	1	41	5	555	35	42

PI.01.01.01 EP6

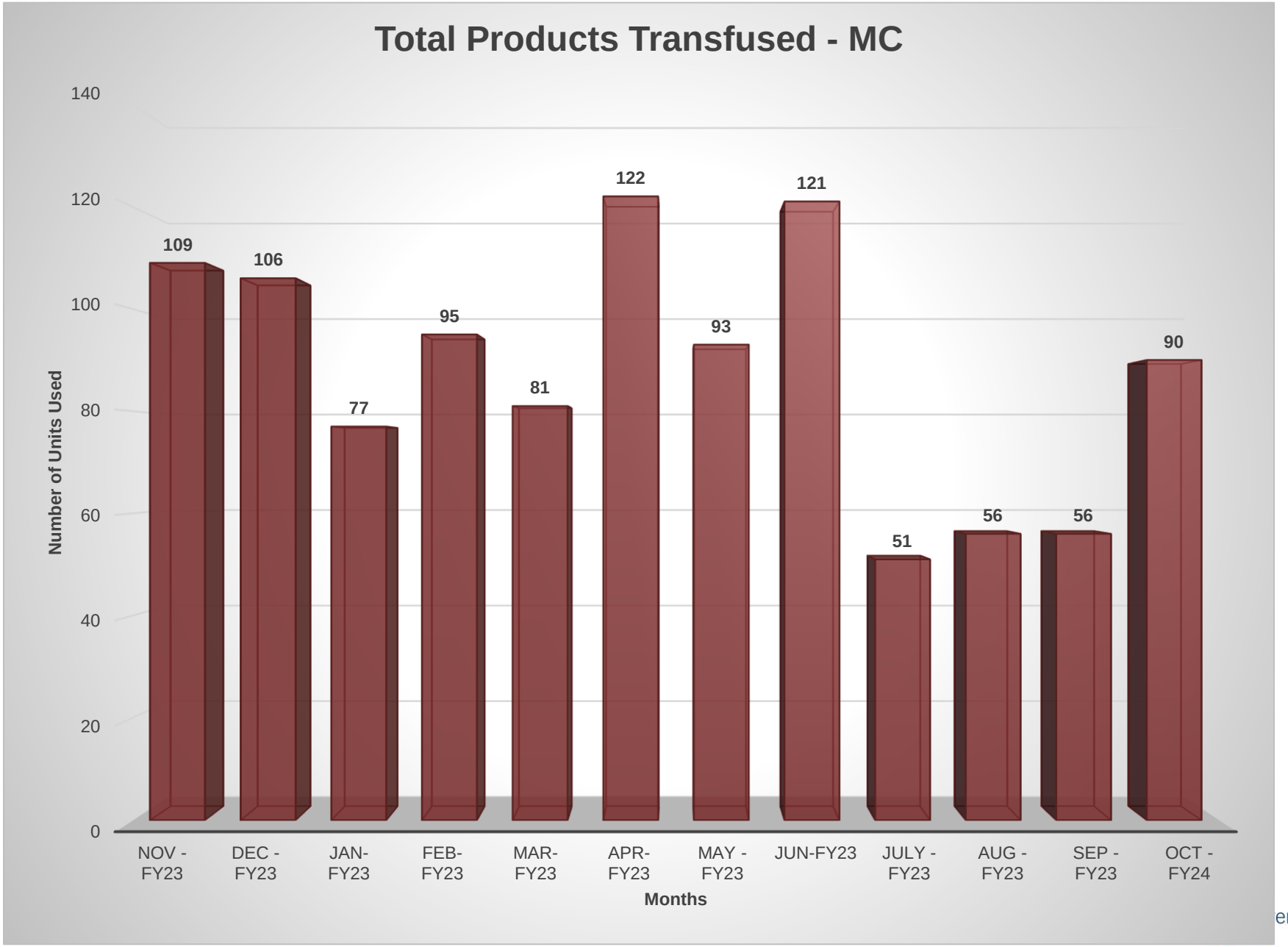
Yale NewHaven Health Bridgeport Hospital



	Allergic	Febrile	Anaphylactic	Taco	Trali	Hemolytic	Other	Total
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
Oct - FY24	0	2	0	0	0	0	3	6

PI.01.01.01 EP7

Yale NewHaven Health Bridgeport Hospital



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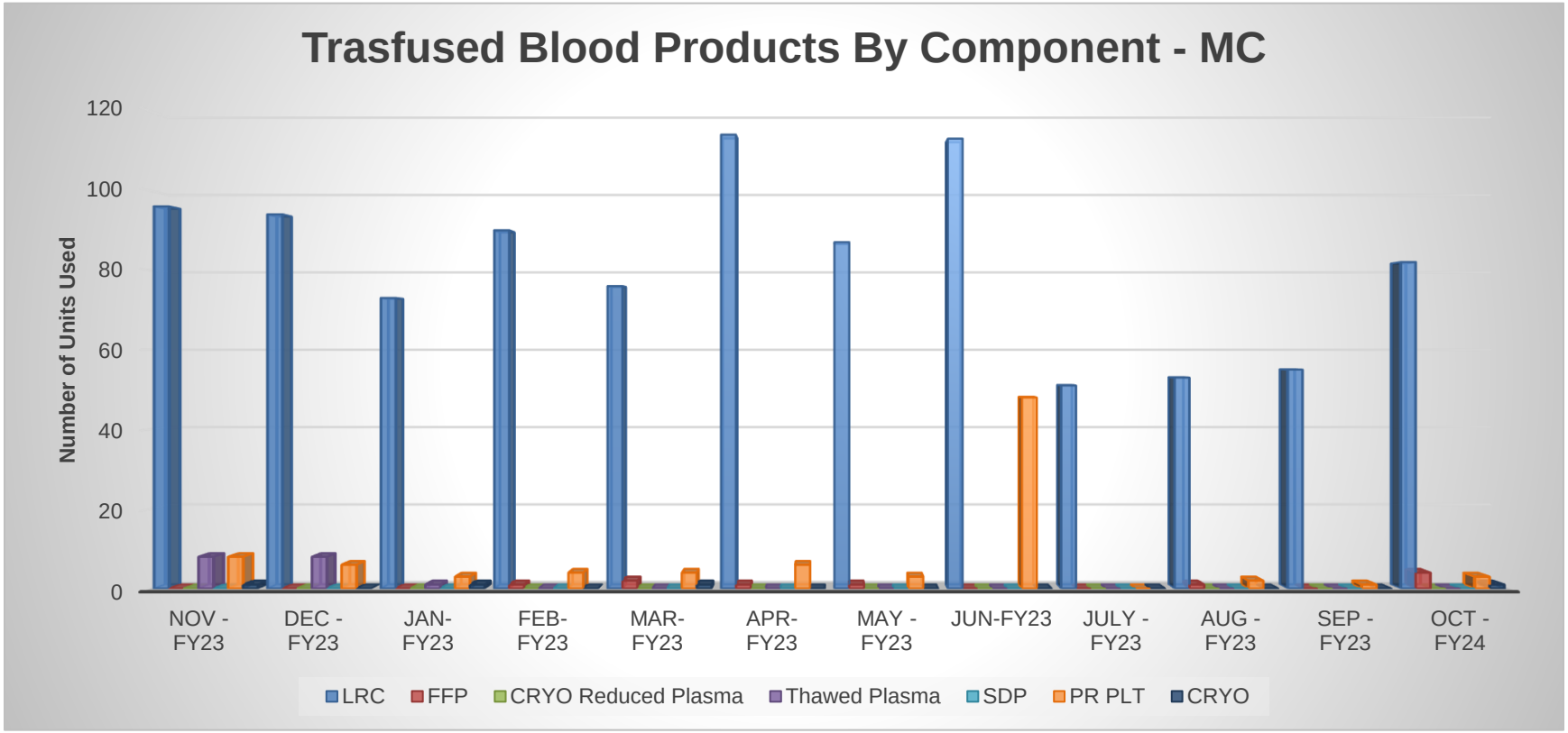
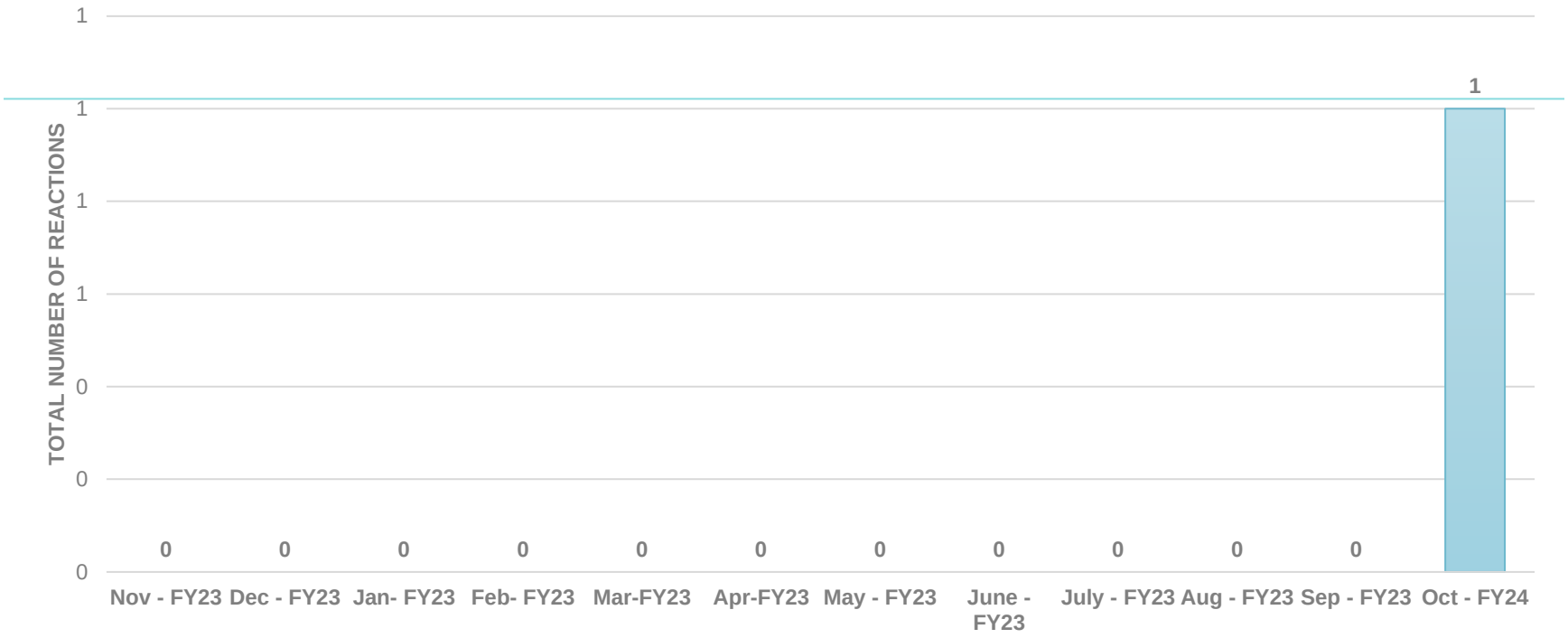


	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO	Total Products	Total Plasma	Total Platelets
Nov - FY23	96	0	0	8	0	8	1	109	4	8
Dec - FY23	94	0	0	8	0	6	0	106	6	6
Jan- FY23	73	0	0	1	0	3	1	77	0	3
Feb- FY23	90	1	0	0	0	4	0	95	1	4
Mar-FY23	76	2	0	0	0	4	1	81	0	4
Apr-FY23	114	1	0	0	0	6	0			
May - FY23	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
Oct - FY24	82	4	0	0	0	3	1	90	4	3

Yale NewHaven Health Bridgeport Hospital

PI.01.01.01 EP6

Total Transfusion Reaction - MC



	Allergic	Febrile	Anaphylactic	Taco	Trali	Hemolytic	Other	Total
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
Oct - FY24	0	1	0	0	0	0	0	1

PI.01.01.01 EP7

Yale NewHaven Health Bridgeport Hospital

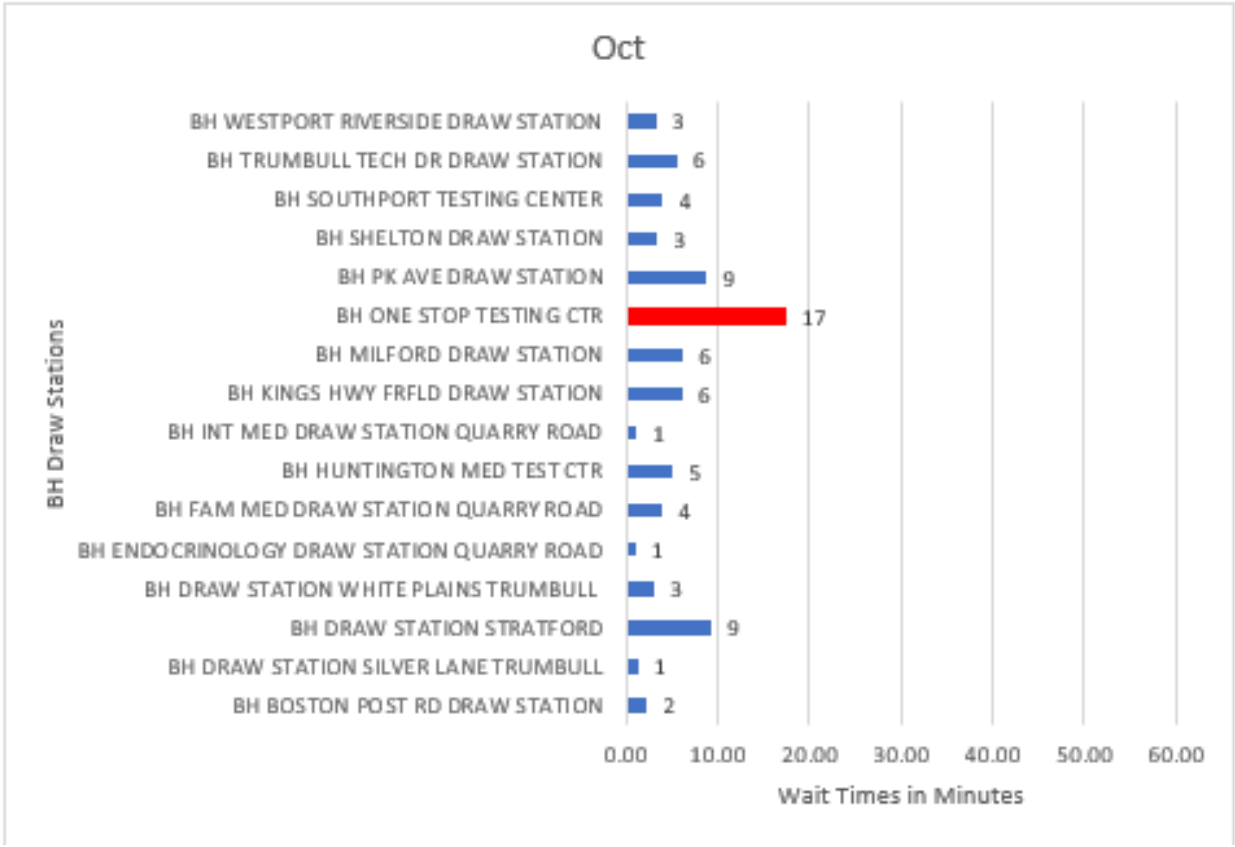
Performance Improvement Plan

Lab Outreach Pre-Analytical Quality Indicator Monthly Review

October 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.**


Oct
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
3
6
4
3
9
17
6
6
1
5
4
1
3
9
1
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 it's 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.

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

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.
October: Overall goal met for the month. Across the BH locations 24 boxes of butterfly needles were ordered, this month there was a significant increase in blood draws therefore the percentage of usage remained at 11% as the previous month.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Number of Butterfly Needles	1019	800	800	1000	800	600	1400	800	1100	1200
Total Number of Patient Draws	9302	9223	10958	8888	9996	9910	9024	10056	9897	10601
ALL DRAW STATIONS	11%	9%	7%	11%	8%	6%	16%	8%	11%	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.

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.

October: Overall goal for the month was met. Across all the BH draw stations the cancel/redraw rate is at 2.2% the lowest it has been all year. This is a 0.6% decrease from the previous month.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
BH BOSTON POST RD DRAW STATION	1.3%	2.5%	8.3%	4.9%	4.0%	3.5%	1.8%	1.4%	0.8%	1.1%
BH DRAW STATION SILVER LANE TRUMBULL	3.1%	2.6%	2.6%	6.6%	3.0%	3.4%	0.5%	4.1%	2.4%	2.5%
BH DRAW STATION STRATFORD	1.9%	1.7%	1.2%	3.2%	4.0%	2.1%	3.0%	0.0%	0.5%	1.2%
BH DRAW STATION WHITE PLAINS TRUMBULL	1.0%	4.7%	2.0%	5.8%	4.8%	2.9%	1.5%	1.7%	2.3%	3.6%
BH ENDOCRINOLOGY DRAW STATION QUARRY ROAD	2.6%	4.1%	3.9%	1.2%	7.7%	4.2%	0.6%	0.9%	1.5%	0.9%
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%	3.1%
BH HUNTINGTON MED TEST CTR	2.9%	4.9%	3.8%	3.4%	6.7%	12.5%	2.8%	7.4%	7.4%	3.7%
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%	4.4%
BH KINGS HWY FRFLD DRAW STATION	2.1%	4.9%	7.3%	8.1%	2.5%	2.5%	2.7%	2.9%	0.7%	1.8%
BH MILFORD DRAW STATION	3.4%	3.8%	4.3%	3.9%	4.3%	1.6%	0.8%	0.2%	1.3%	1.1%
BH ONE STOP TESTING CTR	7.2%	7.1%	6.8%	11.3%	11.7%	13.0%	4.4%	5.2%	6.3%	4.9%
BH PK AVE DRAW STATION	4.6%	7.2%	9.4%	9.4%	10.4%	9.8%	2.9%	2.1%	1.7%	1.7%
BH SHELTON DRAW STATION	1.8%	2.4%	2.2%	4.2%	2.3%	3.4%	3.2%	2.9%	0.6%	2.6%
BH SOUTHPORT TESTING CENTER	3.0%	4.4%	3.6%	2.5%	8.9%	0.8%	1.5%	1.0%	3.7%	0.3%
BH TRUMBULL TECH DR DRAW STATION	2.3%	3.3%	3.1%	7.2%	4.7%	5.2%	10.1%	3.8%	1.8%	2.5%
BH WESTPORT RIVERSIDE DRAW STATION	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%	1.0%	2.8%	0.3%
ALL DRAW STATION AVERAGE	3.0%	4.1%	4.2%	5.1%	5.4%	5.0%	3.4%	2.7%	2.8%	2.2%

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.

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

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Number of Compliant Centrifuges	19	19	19	19	19	19	20	20	20	20
Total Number of Centrifuges	19	19	19	19	19	19	20	20	20	20
ALL DRAW STATIONS	100%	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.

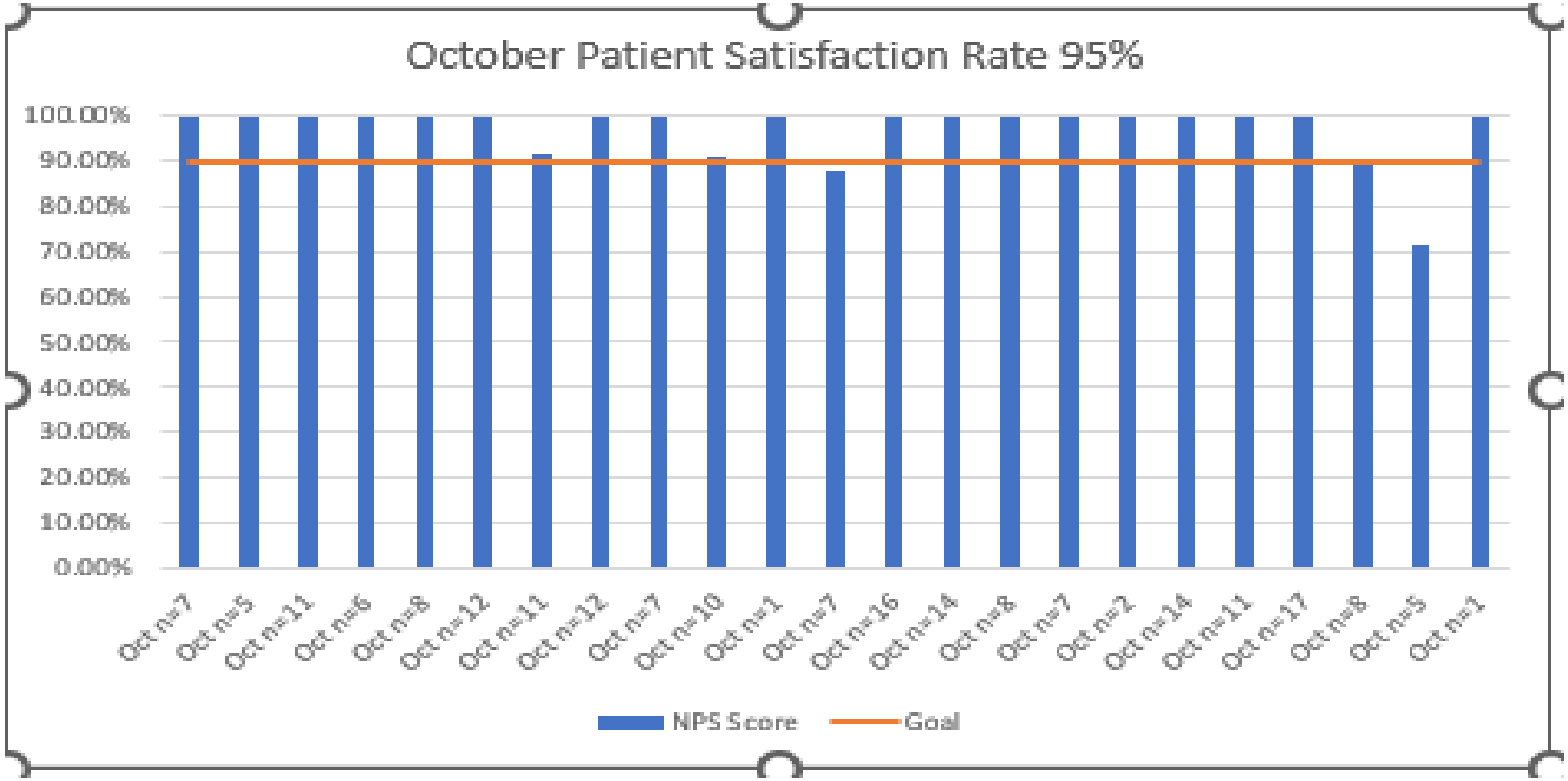
June: Overall goal for the month was not met. This month there was not a substantial amount of data from the surveys received. Across the BH draw station locations 87% of patients were likely to recommend our facilities to a friend, 100% of patients felt our facilities were neat and clean, and 100% of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

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


October Patient Satisfaction Rate 95%
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Oct n=7
Oct n=5
Oct n=11
Oct n=6
Oct n=8
Oct n=12
Oct n=11
Oct n=12
Oct n=7
Oct n=10
Oct n=1
Oct n=7
Oct n=16
Oct n=14
Oct n=8
Oct n=7
Oct n=2
Oct n=14
Oct n=11
Oct n=17
Oct n=8
Oct n=5
Oct n=1
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.

October: Overall goal for the month was met. For the month of October, the # of providers transcribed 110/110, sum of tests transcribed correctly 389/390 and # of requisitions scanned in EPIC 109/109.

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

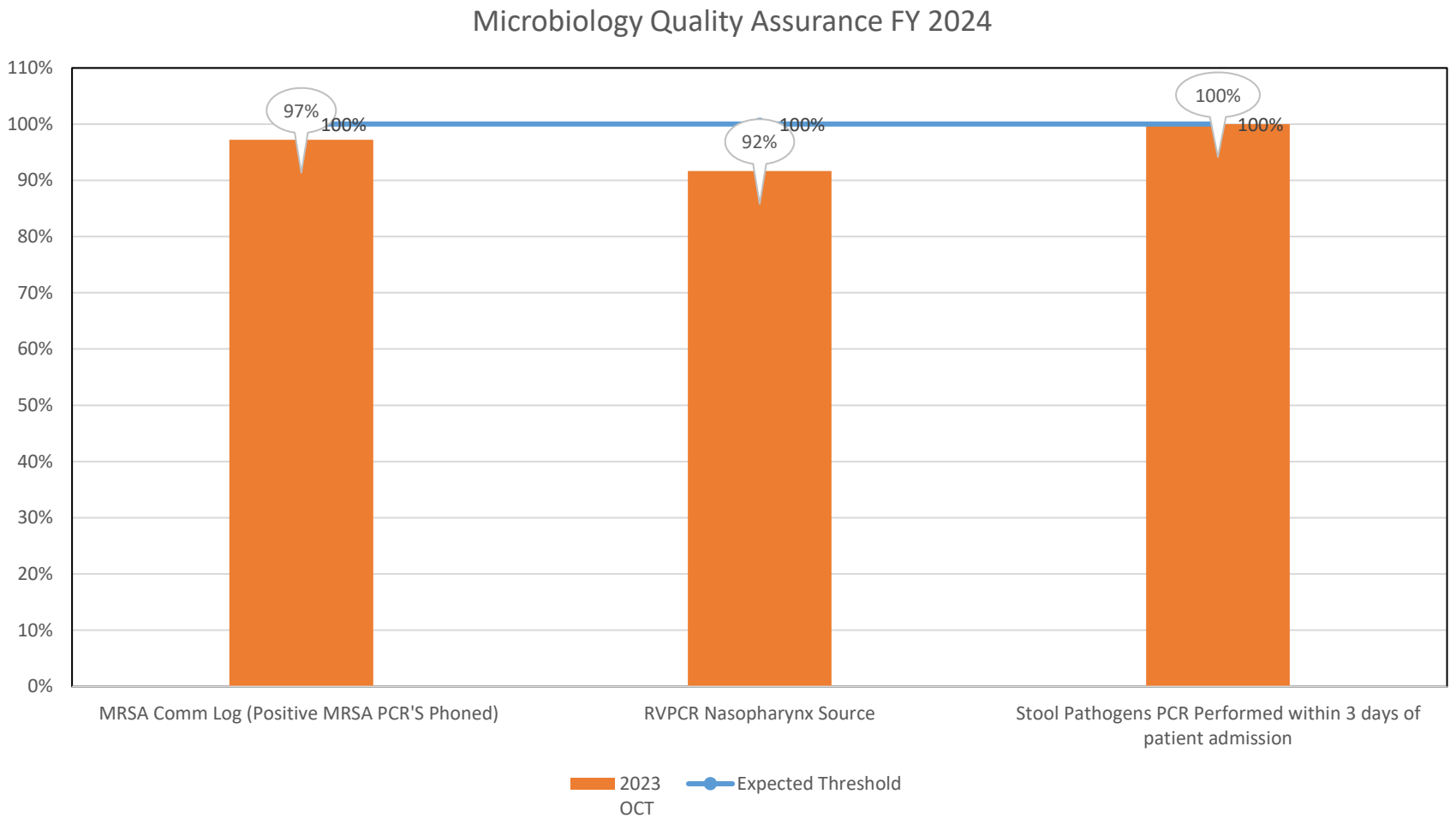
Yale NewHaven Health Bridgeport Hospital

FY 2024 QA

Microbiology and Central Processing

November 2023

Microbiology Quality Measures October 2023



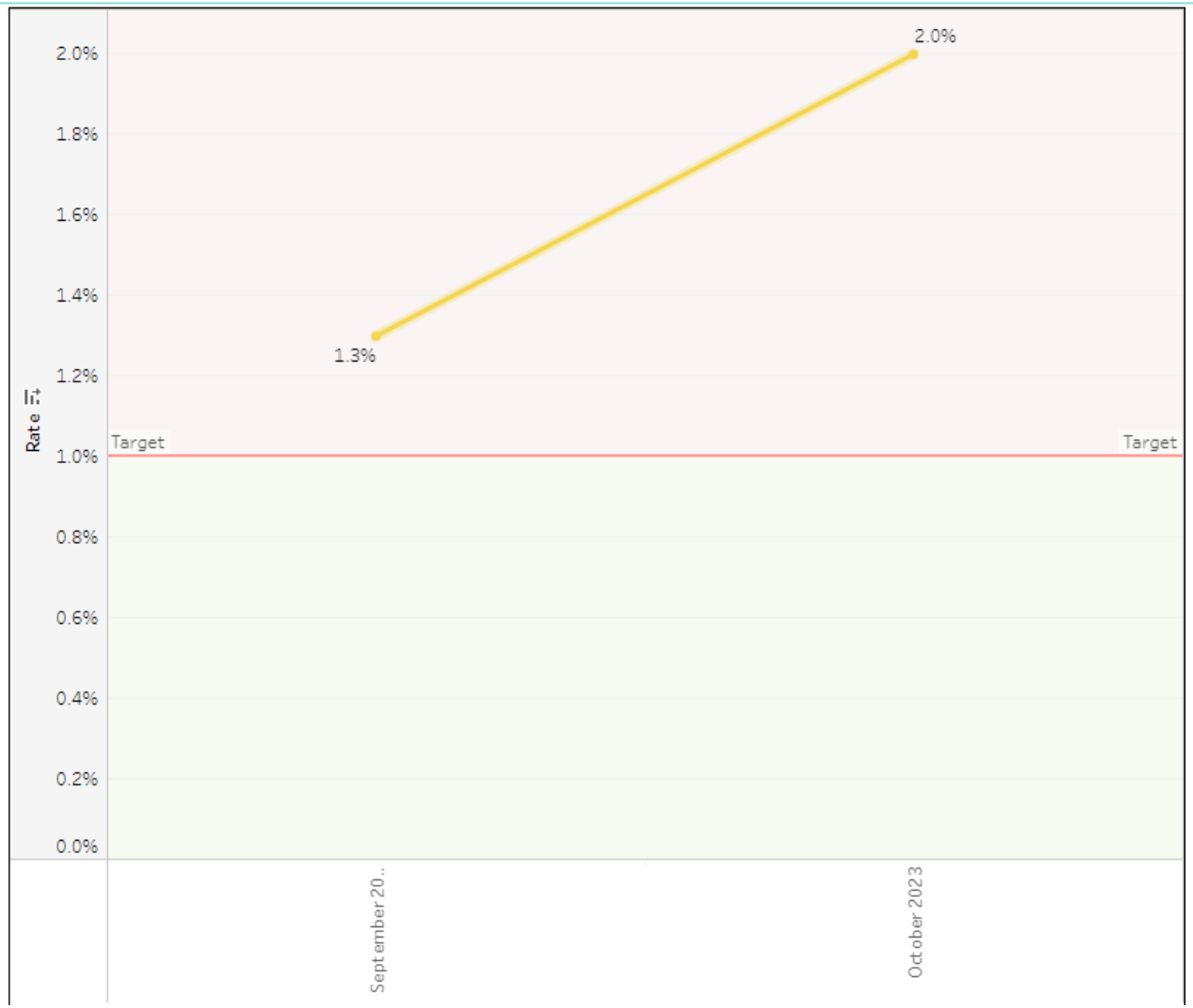
Yale NewHaven Health Bridgeport Hospital

Microbiology Test Volumes

2023 Total Volume	October	November	December	January	February	March	April	May	June
MRSA	445								
MRSA Positive	36								
RVP	195								
Stool	138								
Stool Admitted	40								
Errors	0								

Yale NewHaven Health Bridgeport Hospital

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

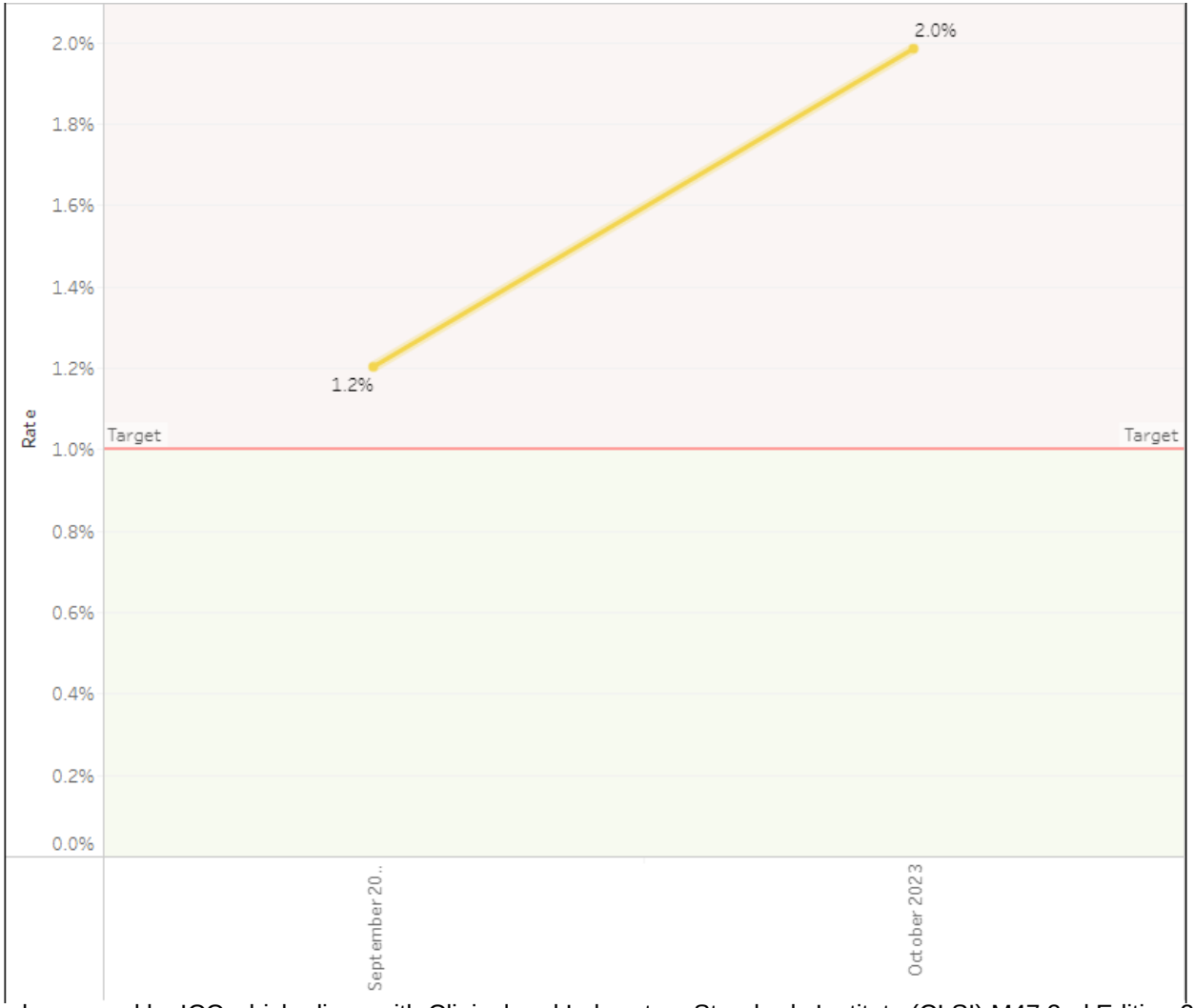
BH &MC Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	October 20..	819	13	1.6%
		Inpatient	BH EAST TOWER 8	October 20..	18	1	5.6%
			BH NORTHEAST 7	October 20..	31	1	3.2%
			BH NORTHEAST 10	October 20..	25	2	8.0%
			BH NORTHWEST 9	October 20..	27	2	7.4%
			BH SURGICAL INTENSIVE C..	October 20..	52	2	3.8%
			BH WEST TOWER 6	October 20..	25	1	4.0%
			BH WEST TOWER 7	October 20..	32	1	3.1%
			BH WOMENS CARE CENTE..	October 20..	2	1	50.0%
	MC	Emergency ..	MC EMERGENCY DEPART..	October 20..	328	8	2.4%
Grand Total					1,359	32	2.4%

Yale NewHaven Health Bridgeport Hospital

BH Blood Culture Contamination Rate



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Yale NewHaven Health Bridgeport Hospital

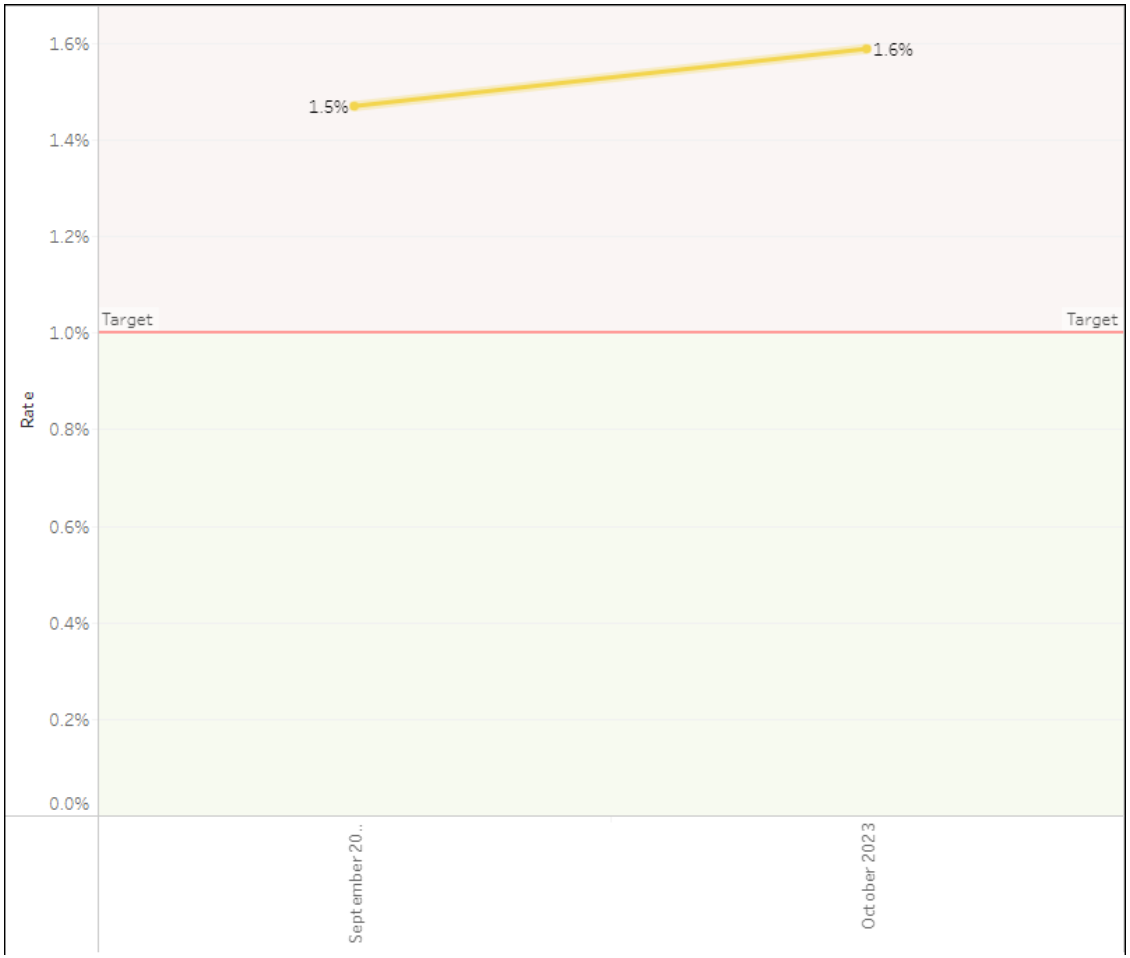
BH Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	October 20..	819	13	1.6%
		Inpatient	BH EAST TOWER 8	October 20..	18	1	5.6%
			BH NORTHEAST 7	October 20..	31	1	3.2%
			BH NORTHEAST 10	October 20..	25	2	8.0%
			BH NORTHWEST 9	October 20..	27	2	7.4%
			BH SURGICAL INTENSIVE C..	October 20..	52	2	3.8%
			BH WEST TOWER 6	October 20..	25	1	4.0%
			BH WEST TOWER 7	October 20..	32	1	3.1%
			BH WOMENS CARE CENTE..	October 20..	2	1	50.0%
Grand Total					1,031	24	2.3%

Yale NewHaven Health Bridgeport Hospital

BH 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	BH	Emergency ..	BH EMERGENCY DEPARTM..	October 20..	819	13	1.6%
Grand Total					819	13	1.6%

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.”

Yale NewHaven Health Bridgeport Hospital

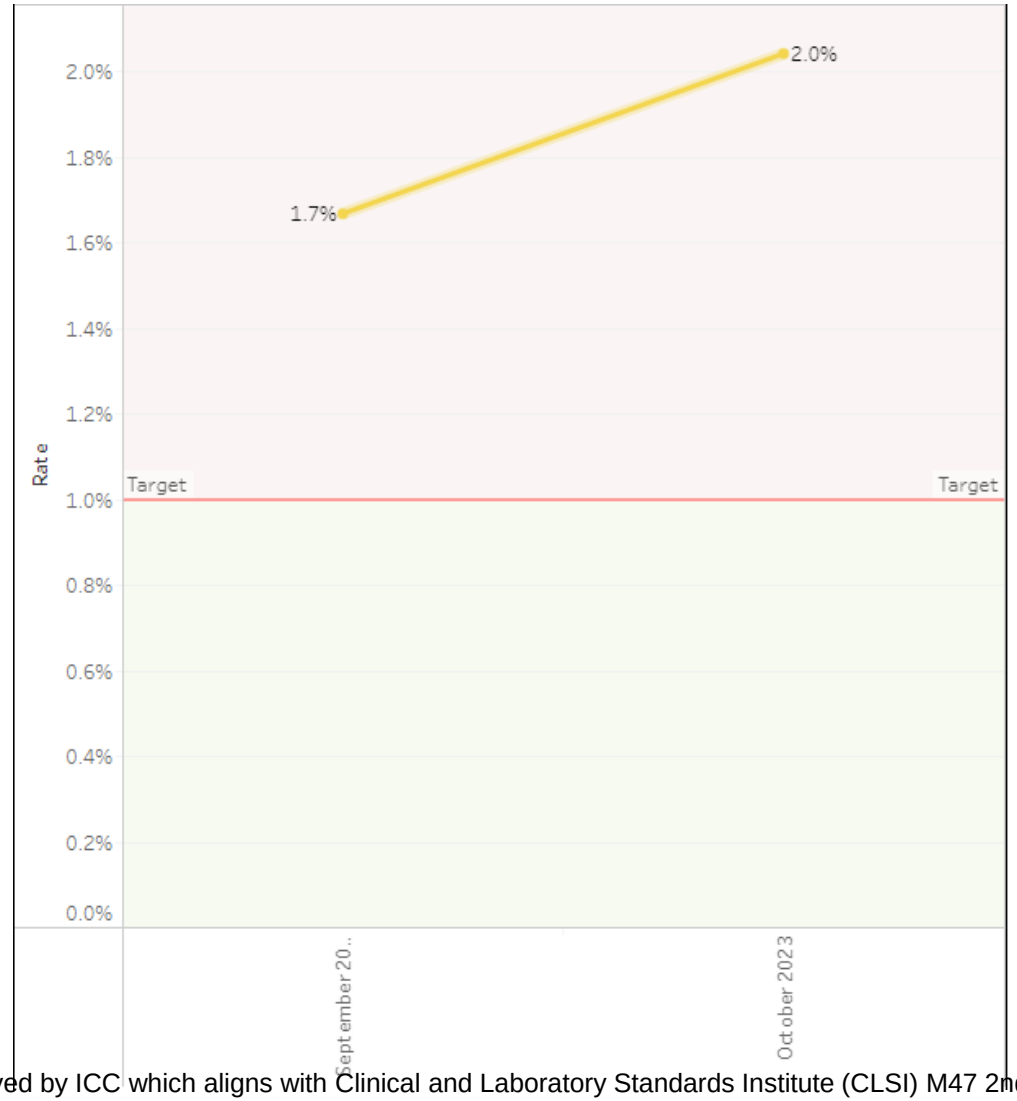
BH-All other units (excluding ED) Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Inpatient	BH EAST TOWER 8	October 20..	18	1	5.6%
			BH NORTHEAST 7	October 20..	31	1	3.2%
			BH NORTHEAST 10	October 20..	25	2	8.0%
			BH NORTHWEST 9	October 20..	27	2	7.4%
			BH SURGICAL INTENSIVE C..	October 20..	52	2	3.8%
			BH WEST TOWER 6	October 20..	25	1	4.0%
			BH WEST TOWER 7	October 20..	32	1	3.1%
			BH WOMENS CARE CENTE..	October 20..	2	1	50.0%
Grand Total					212	11	5.2%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate



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Yale NewHaven Health Bridgeport Hospital

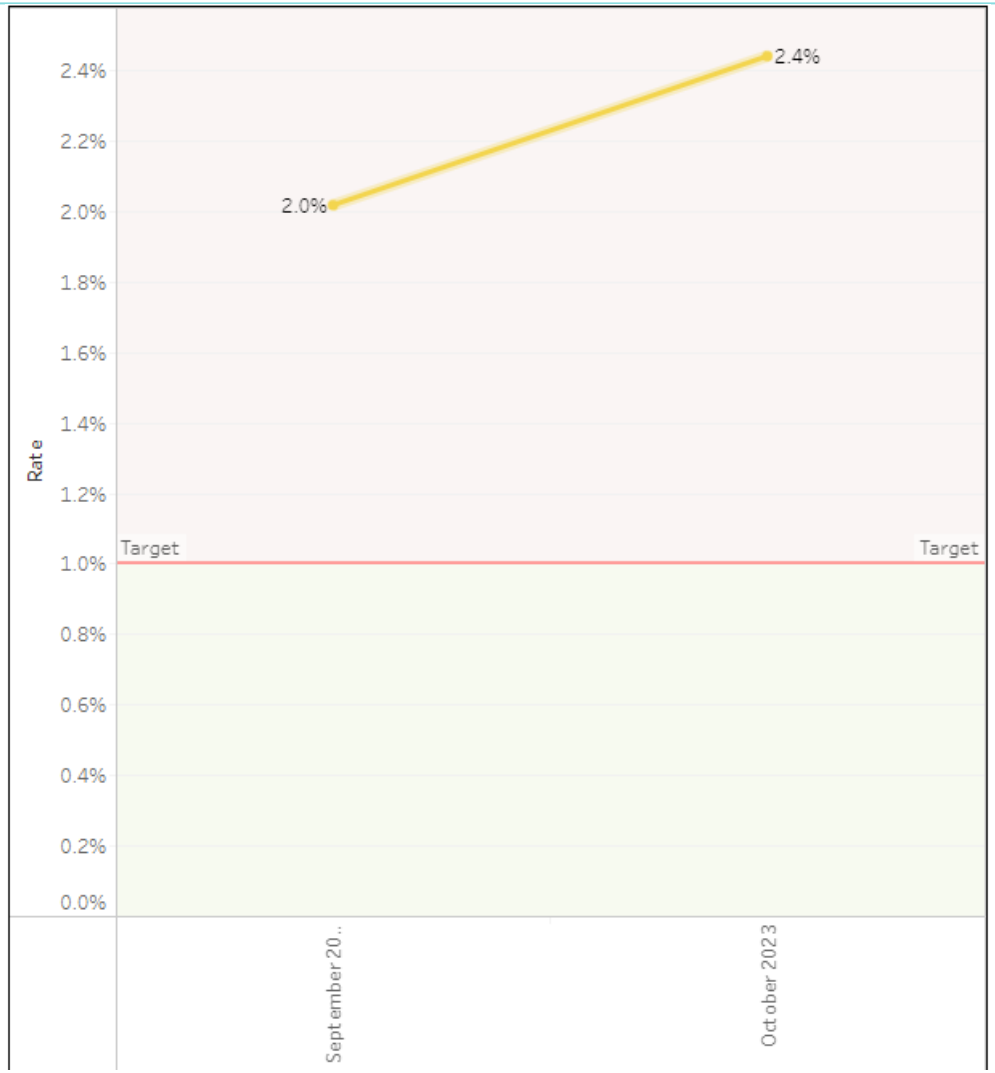
MC Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	October 20..	328	8	2.4%
Grand Total					328	8	2.4%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate(ED only)



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Yale NewHaven Health Bridgeport Hospital

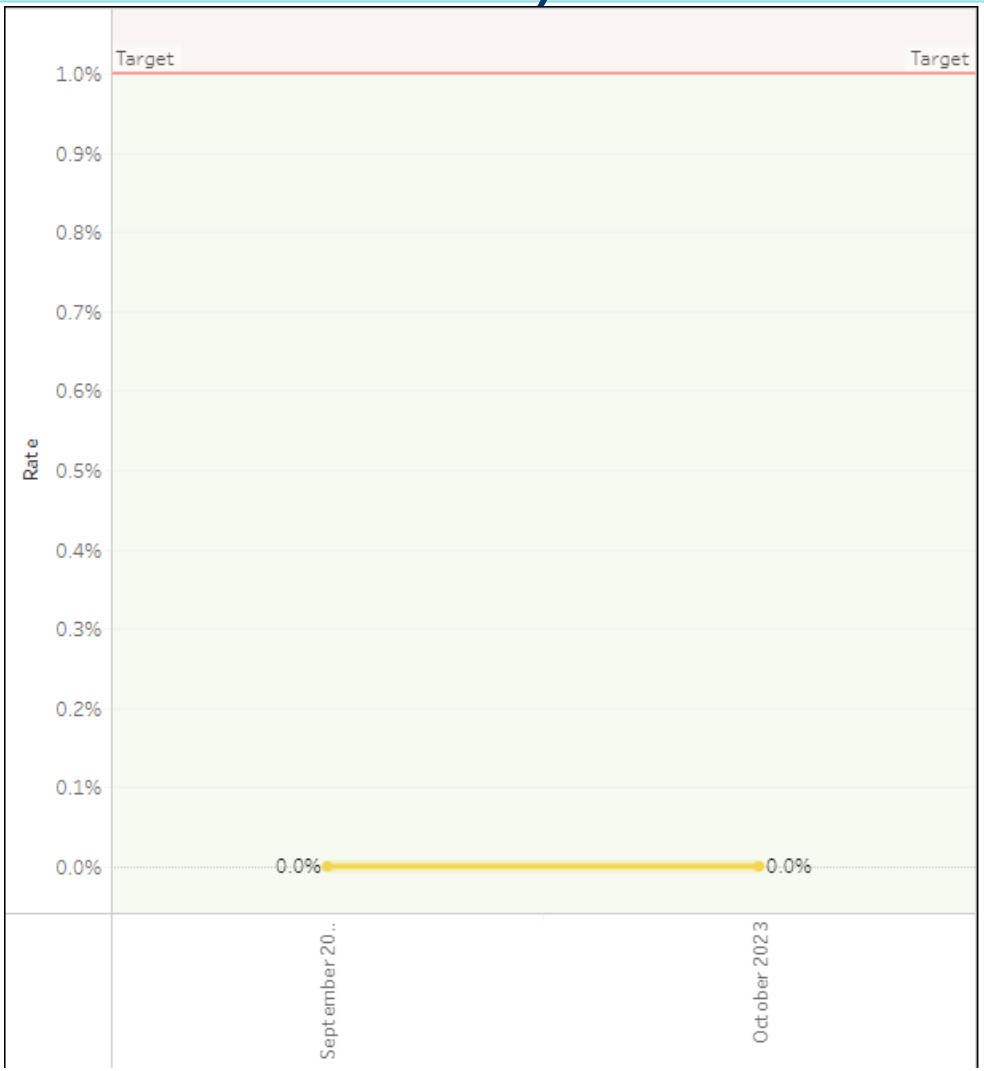
MC ED Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	October 20..	328	8	2.4%
Grand Total					328	8	2.4%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate (excluding ED)



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Yale NewHaven Health Bridgeport Hospital

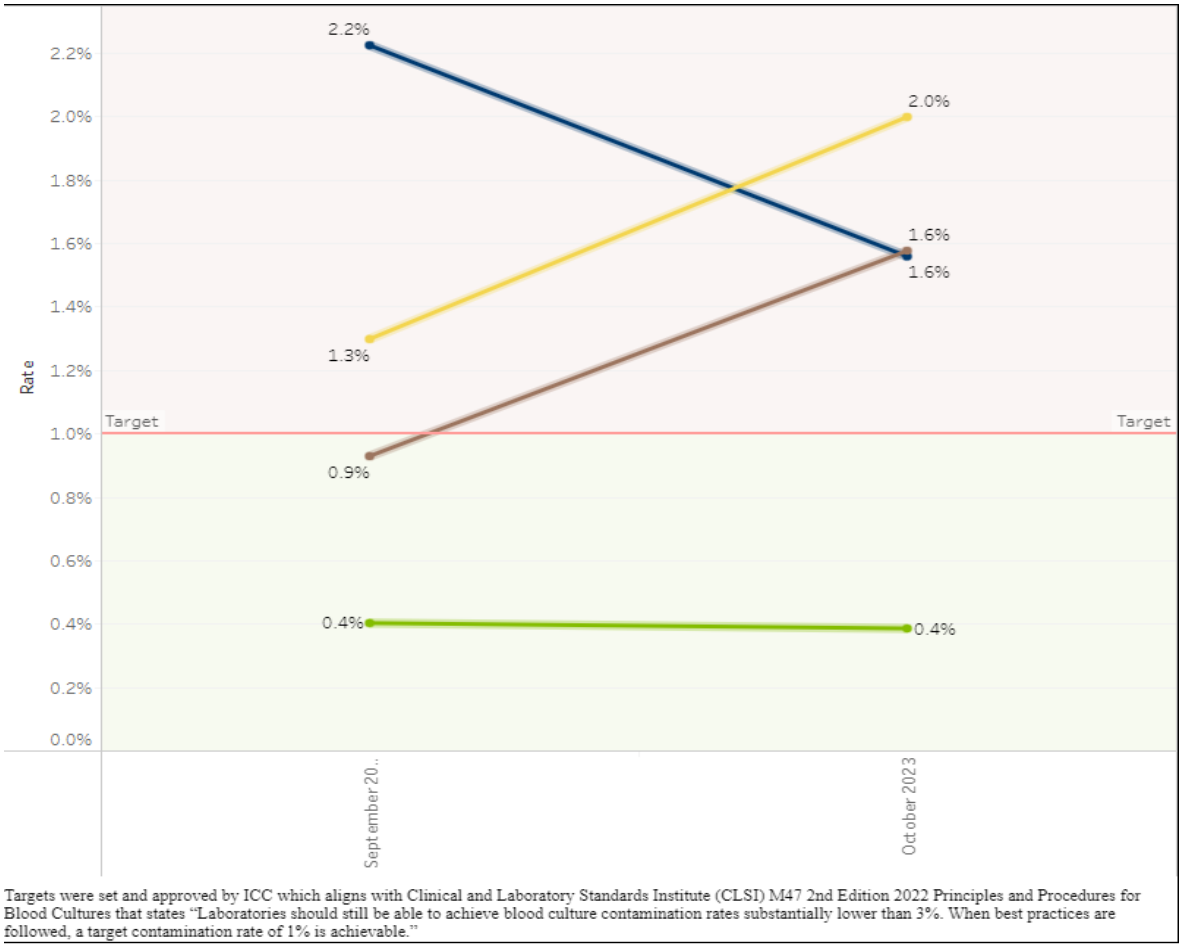
MC-All other units (excluding ED) Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Inpatient	MC EMERGENCY DEPART..	October 20..	2	0	0.0%
			MC ICU	October 20..	24	0	0.0%
			MC MAIN LAB	October 20..	7	0	0.0%
			MC MEMORIAL 3 WEST	October 20..	29	0	0.0%
			MC SOUTH 3	October 20..	2	0	0.0%
Grand Total					64	0	0.0%

Yale NewHaven Health Bridgeport Hospital

Blood culture Contamination Rate DNs Comparison



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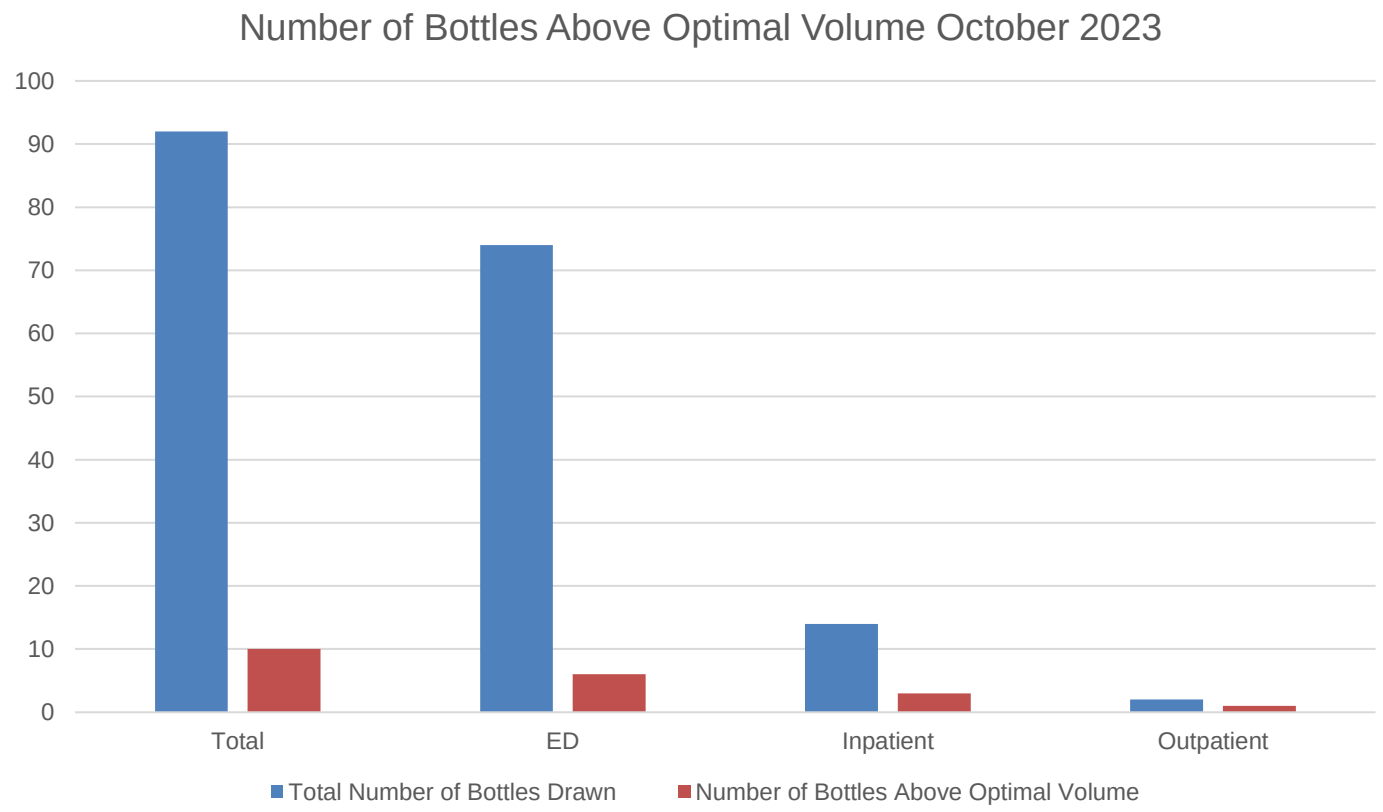
- BH/MC =2.0 %
- YNHH = 1.6%
- LMH/WH = 1.6%
- GH = 0.4 %

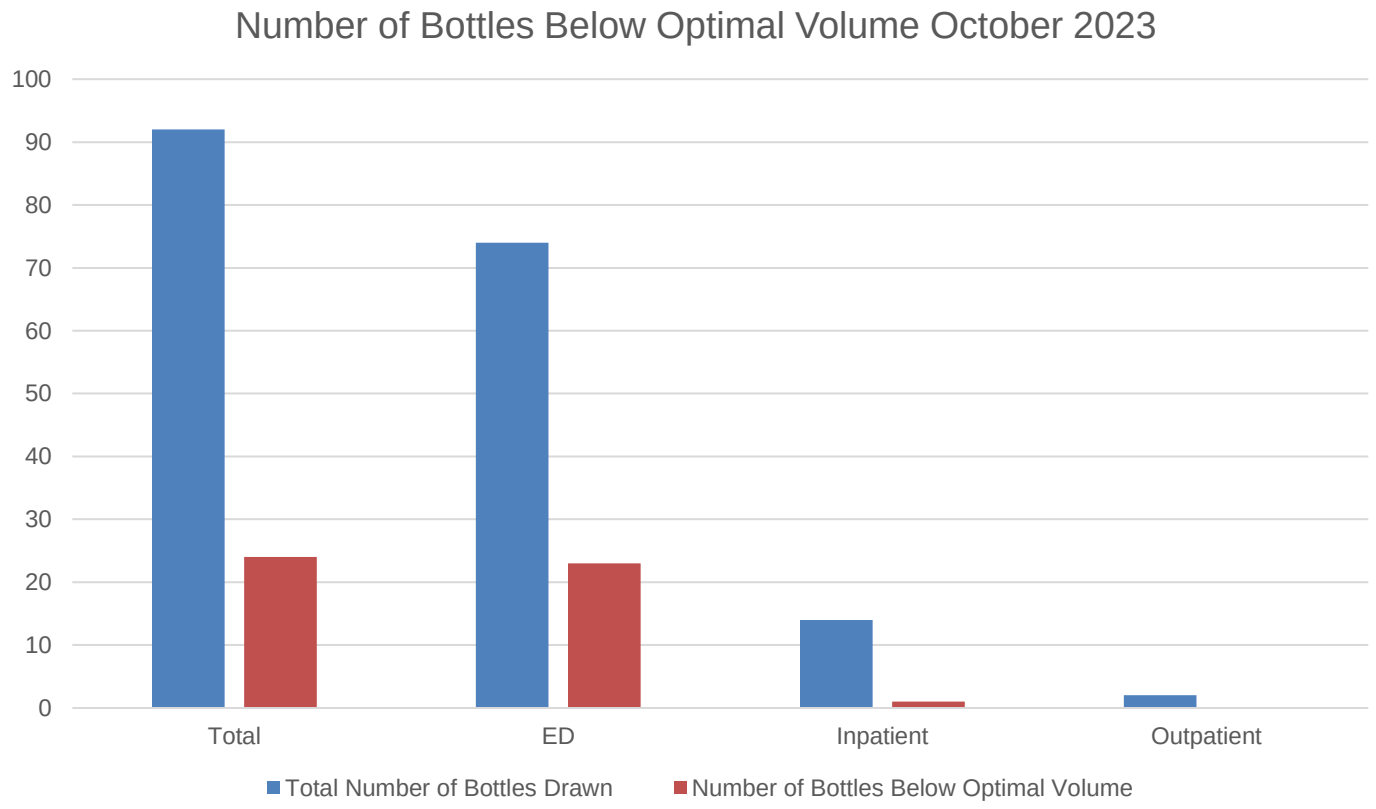
Yale NewHaven Health Bridgeport Hospital

Blood Culture Bottle Volumes – Above Optimal



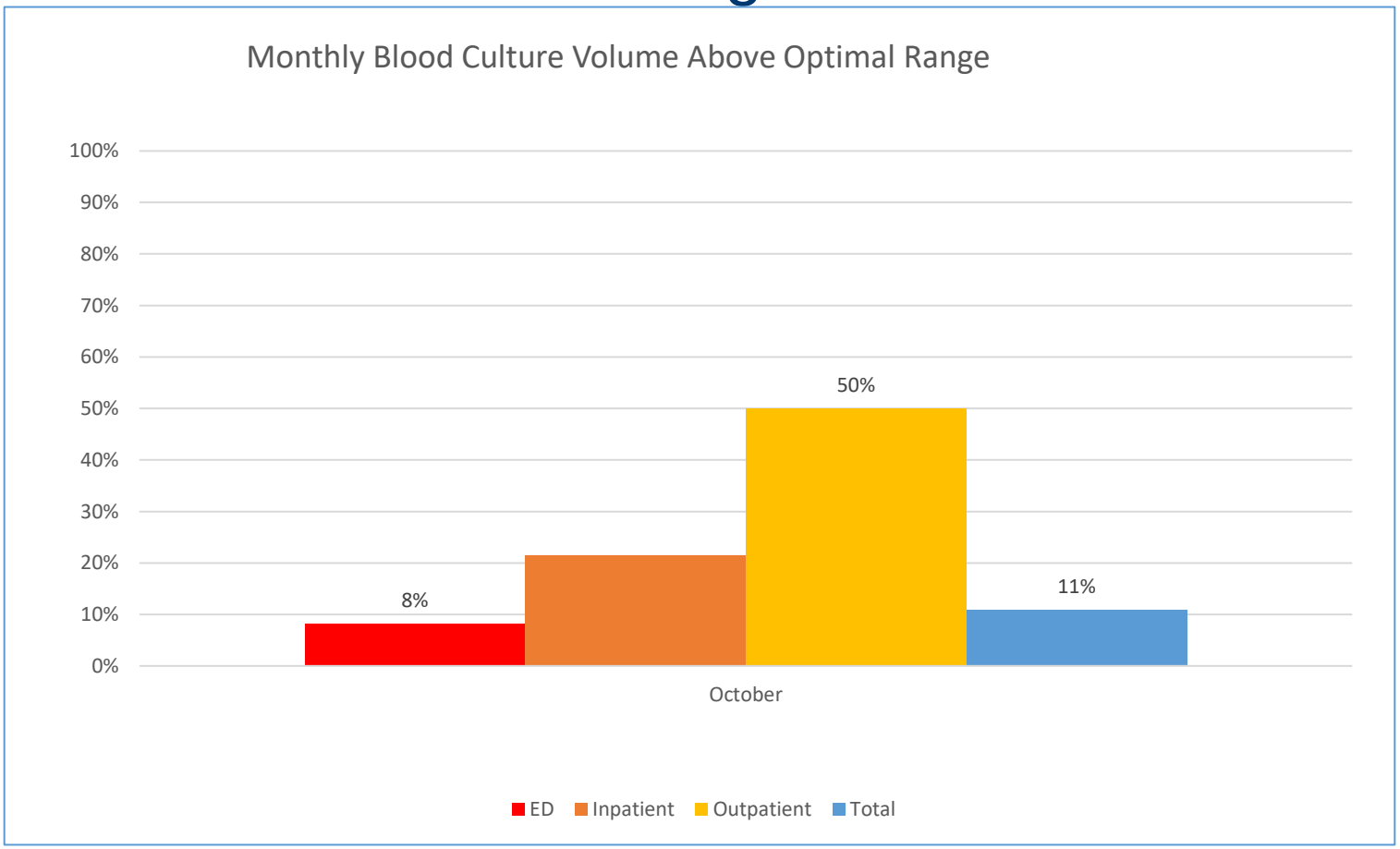
Yale NewHaven Health Bridgeport Hospital

Blood Culture Bottle Volumes – Below Optimal



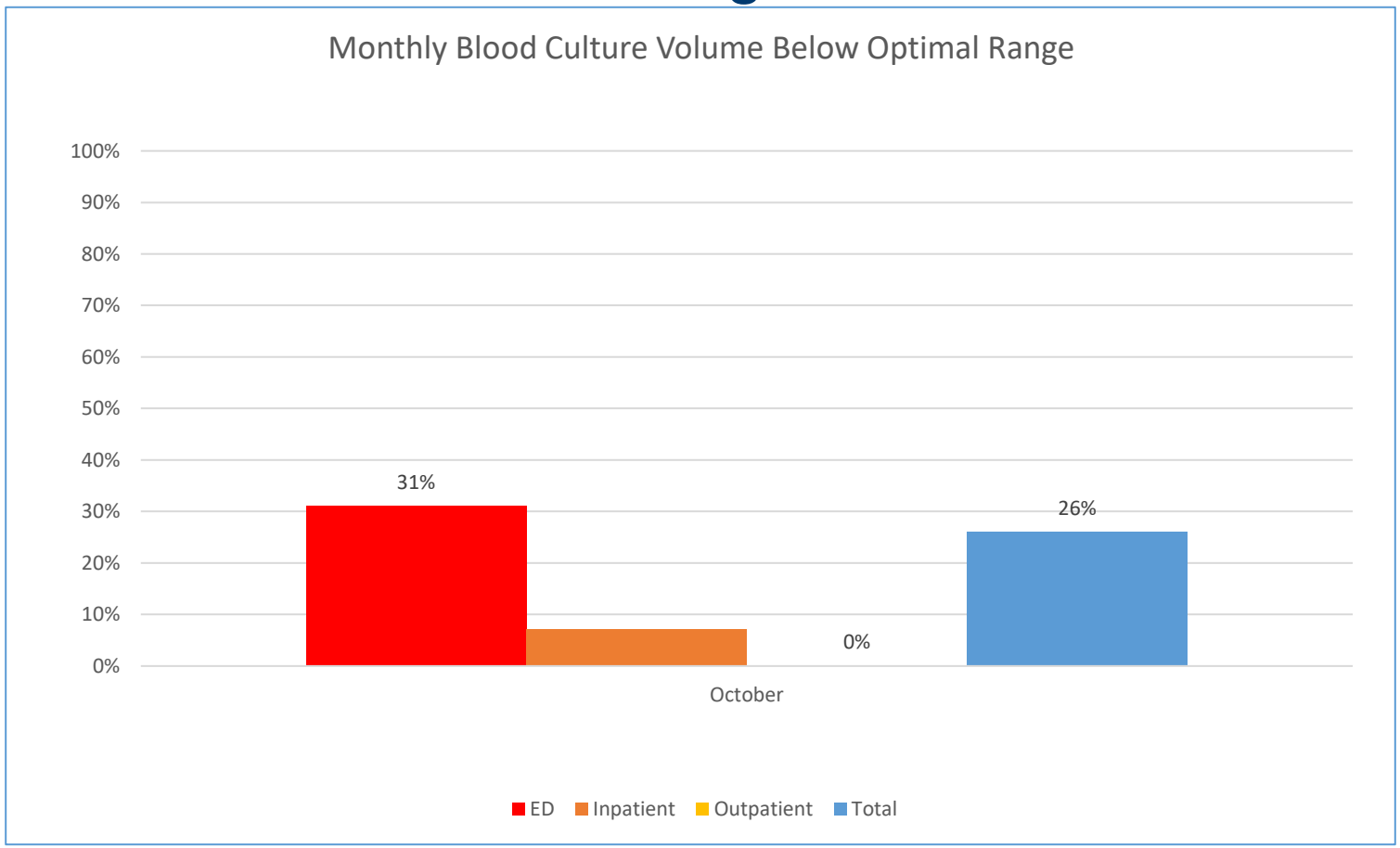
Yale NewHaven Health Bridgeport Hospital

FY 2024 Blood Culture Volume Above Optimal Range



Yale NewHaven Health Bridgeport Hospital

FY 2024 Blood Culture Volume Below Optimal Range



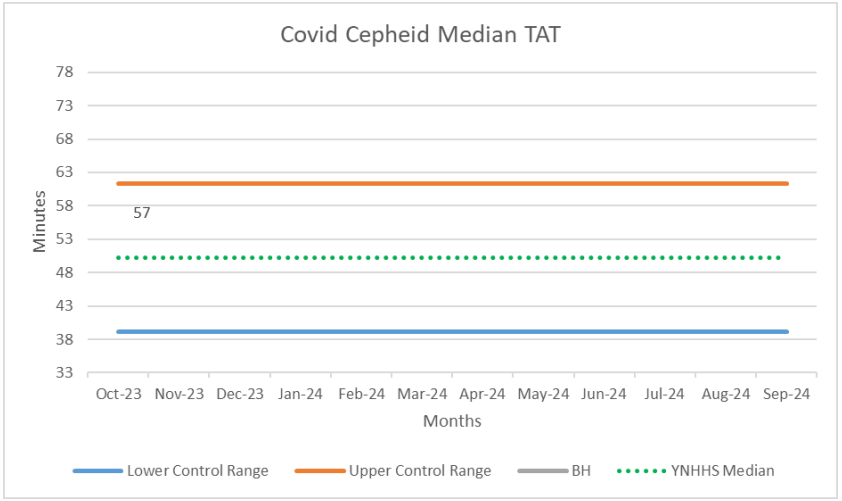
Yale NewHaven Health Bridgeport Hospital

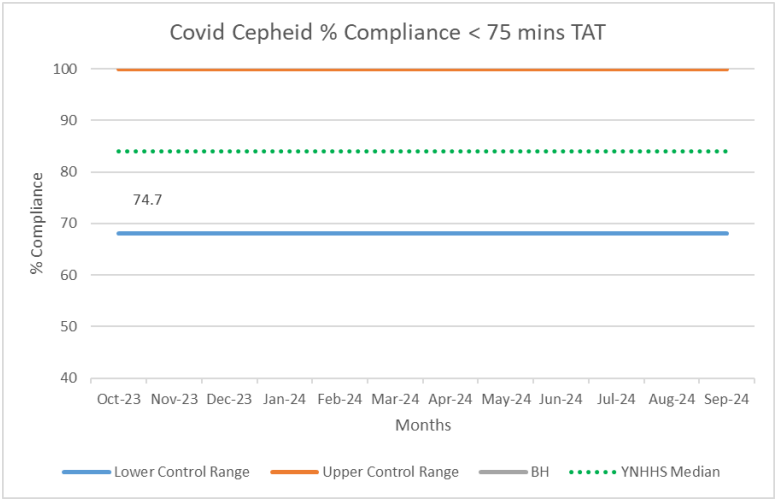
Micro Molecular Statistics

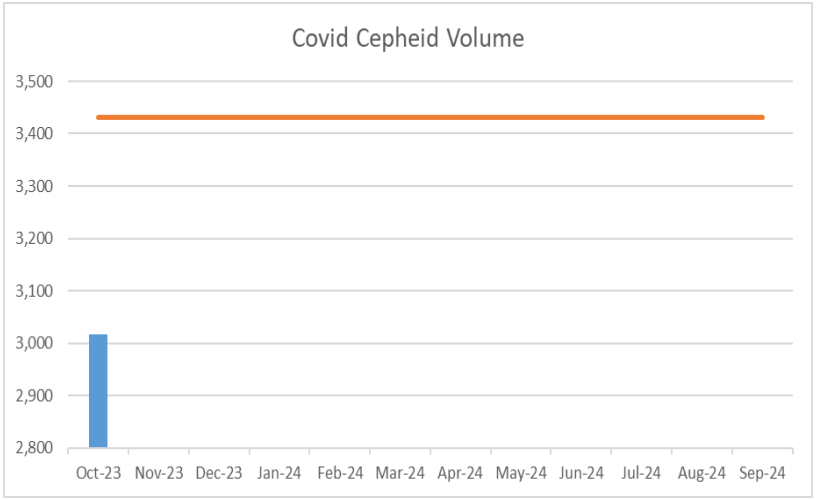
Date	Tests	Sample size	Positive Count	% Positivity	Lower Limit	Upper Limit	Environment Monitoring	Epidemiological Trends	Evaluation Notes
Oct-23	C. difficile Assay	128	24	18.80%	14%	29%	Negative	None	None
Oct-23	GBS PCR Pen Allergic	20	4	20.00%	0%	46%	Negative	None	None
Oct-23	GBS PCR Pen NonAllergic	88	21	23.90%	16%	33%	Negative	None	None
Oct-23	Group A Strep PCR	457	54	11.80%	1%	27%	Negative	None	None
Oct-23	Influenza A/B RNA, NAAT	732	8	1.10%	0%	19%	Negative	None	None
Oct-23	Influenza/RSV by RT-PCR	1,853	80	4.30%	0%	16%	Negative	None	None
Oct-23	MRSA Colonization Status	399	35	8.80%	5%	18%	Negative	None	None
Oct-23	MRSA/SAUR Blood PCR	33	9	27.30%	15%	52%	Negative	None	None
Oct-23	MTB w/rflx Rifampin PCR	4	0	0.00%	0%	79%	Negative	None	None
Oct-23	Resp Virus PCR Panel	146	25	17.10%	2%	52%	Negative	None	None
Oct-23	Respiratory Virus PCR Panel	136	34	25.00%	2%	52%	Negative	None	None
Oct-23	SARS CoV-2 (COVID-19) RNA	3,019	265	8.80%	0%	20%	Negative	None	None
Oct-23	Stool Pathogens PCR	100	7	7.00%	0%	21%	Negative	None	None

Yale NewHaven Health Bridgeport Hospital

Bridgeport Campus – COVID-19 Cepheid

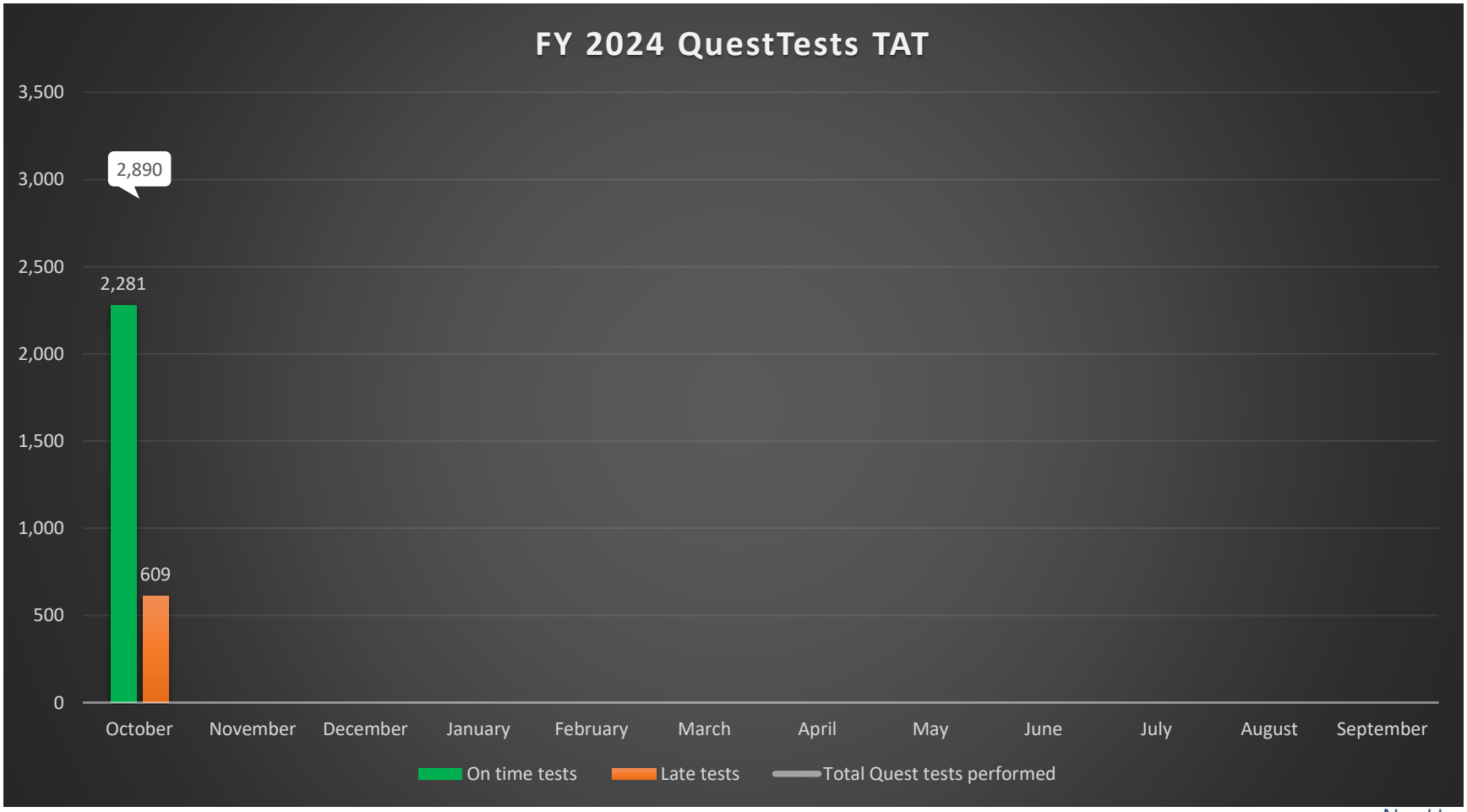






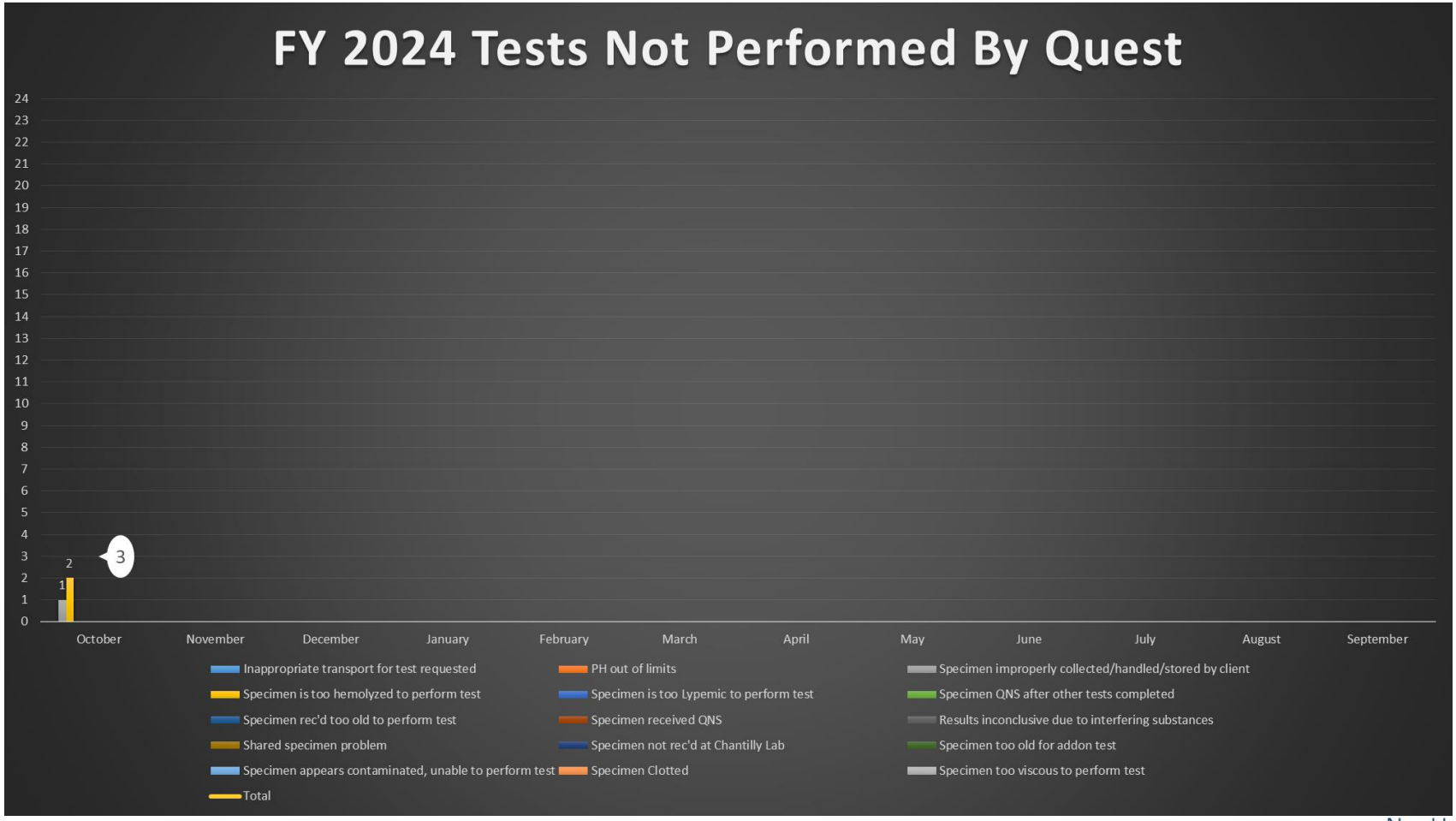
Yale NewHaven Health
Bridgeport Hospital

Quest TAT



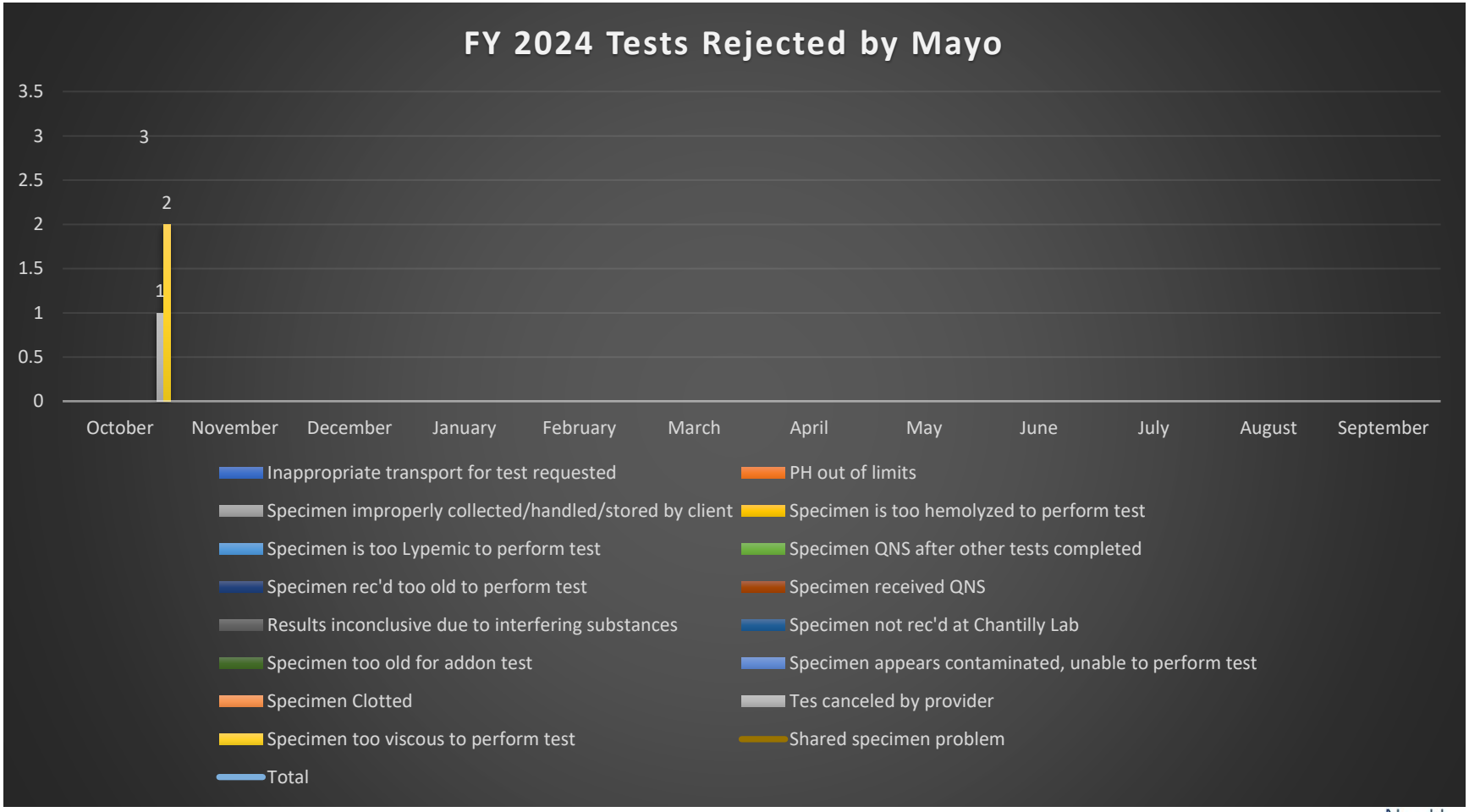
NewHaven Health Bridgeport Hospital

Quest Rejected Tests



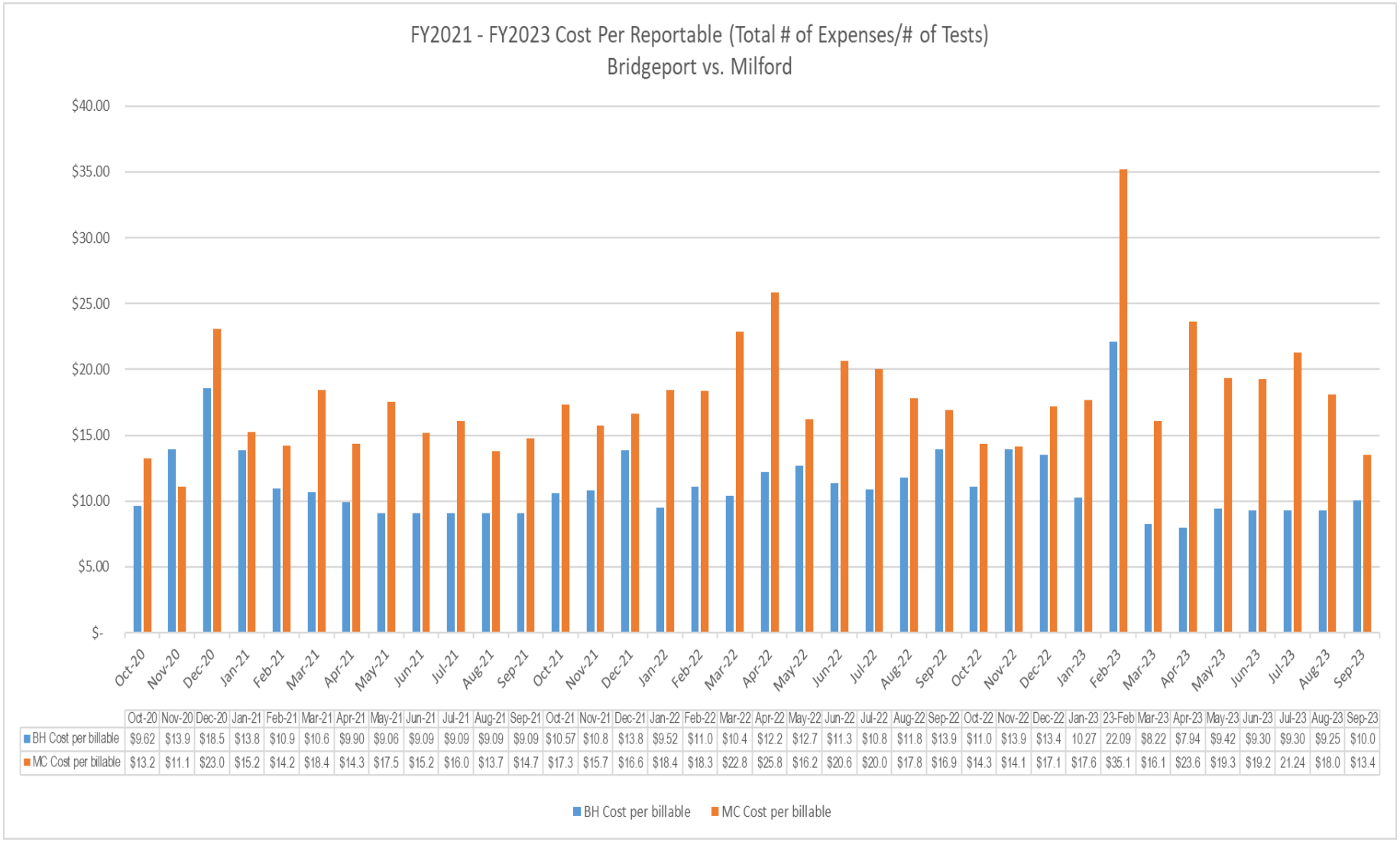
NewHaven Health Bridgeport Hospital

Mayo Rejected Tests



NewHaven Health
Bridgeport Hospital

Cost Per Billable – will be reported next month.

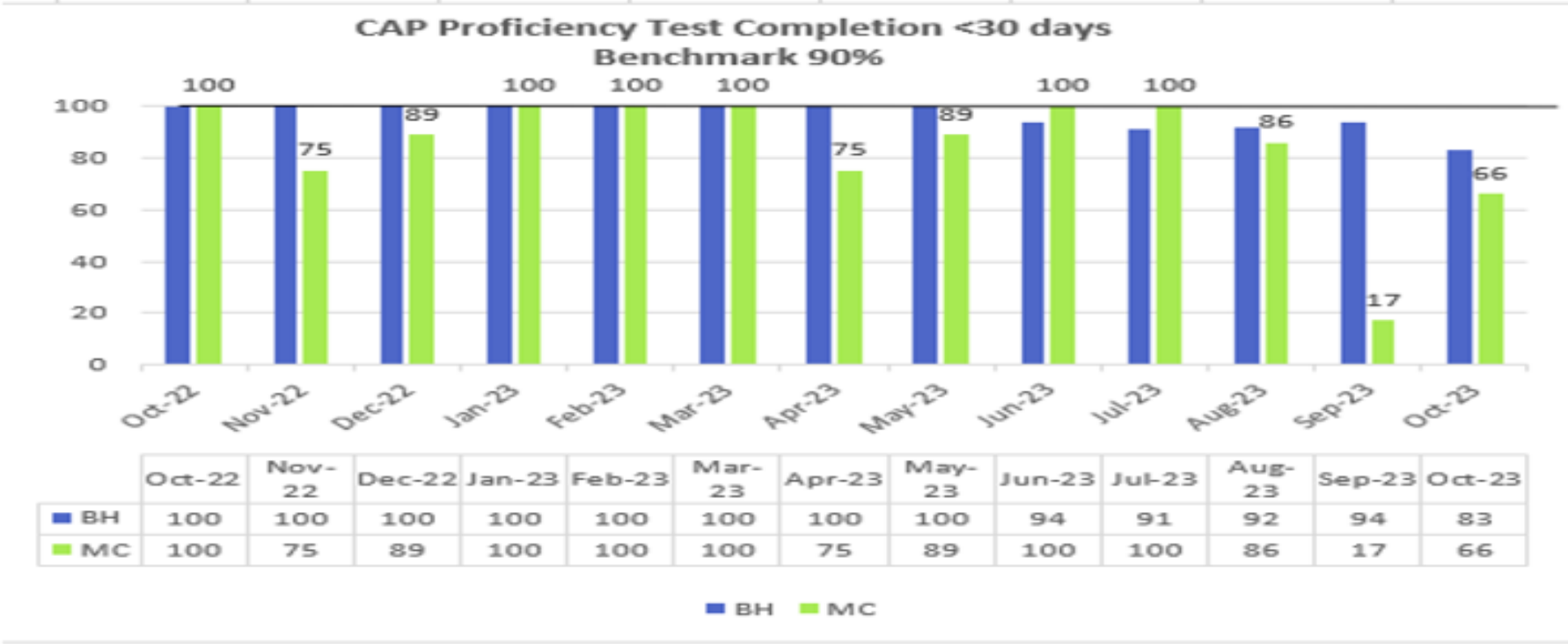


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	23-Feb	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BH Cost per billable	$9.62	$13.9	$18.5	$13.8	$10.9	$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	67% (2/3 surveys) 83% (15/18 surveys)	94% 17%	None	Both BH & MCBH did not meet target due to multiple analytes requiring investigations due to > 2 sdi or for unacceptable results.	Lab management and administration



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
BH	100	100	100	100	100	100	100	100	94	91	92	94	83
MC	100	75	89	100	100	100	75	89	100	100	86	17	66

Laboratory General – Bridgeport
Proficiency Testing Performance Target 98%

BH Proficiency Testing Performance Target 98%

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
BH	327/334	98%	97.6%	Bone, benchmark met	Unsatisfactory PT's are being investigated with corrective actions taken-all surveys satisfactory. Each section investigates failed/unsatisfactory performances.

Proficiency Testing Performance Overview

Select View: Graph

18	0	2	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

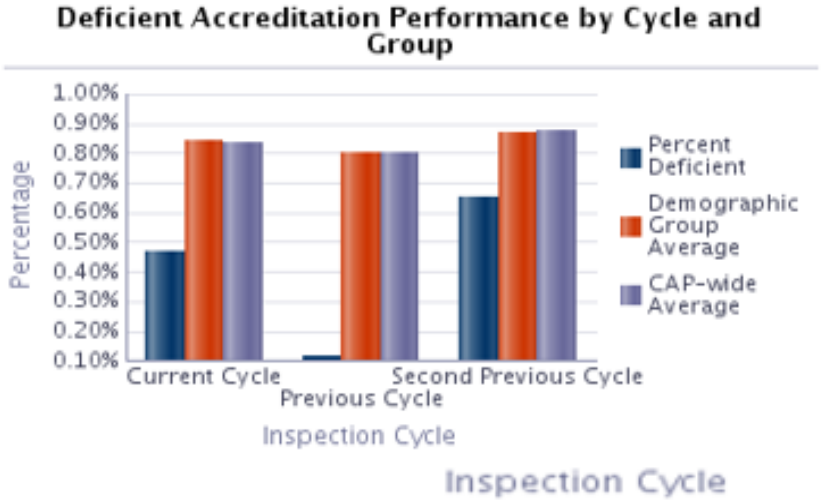
Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.21%	99.07%	98.72%
2022	99.32%	98.99%	98.63%
2021	99.81%	99.06%	98.67%

Lab General

Accreditation Performance Overview

Accreditation Performance Overview

Select View: Graph



Last Accreditation Decision	Date
Accredited	5/9/2022

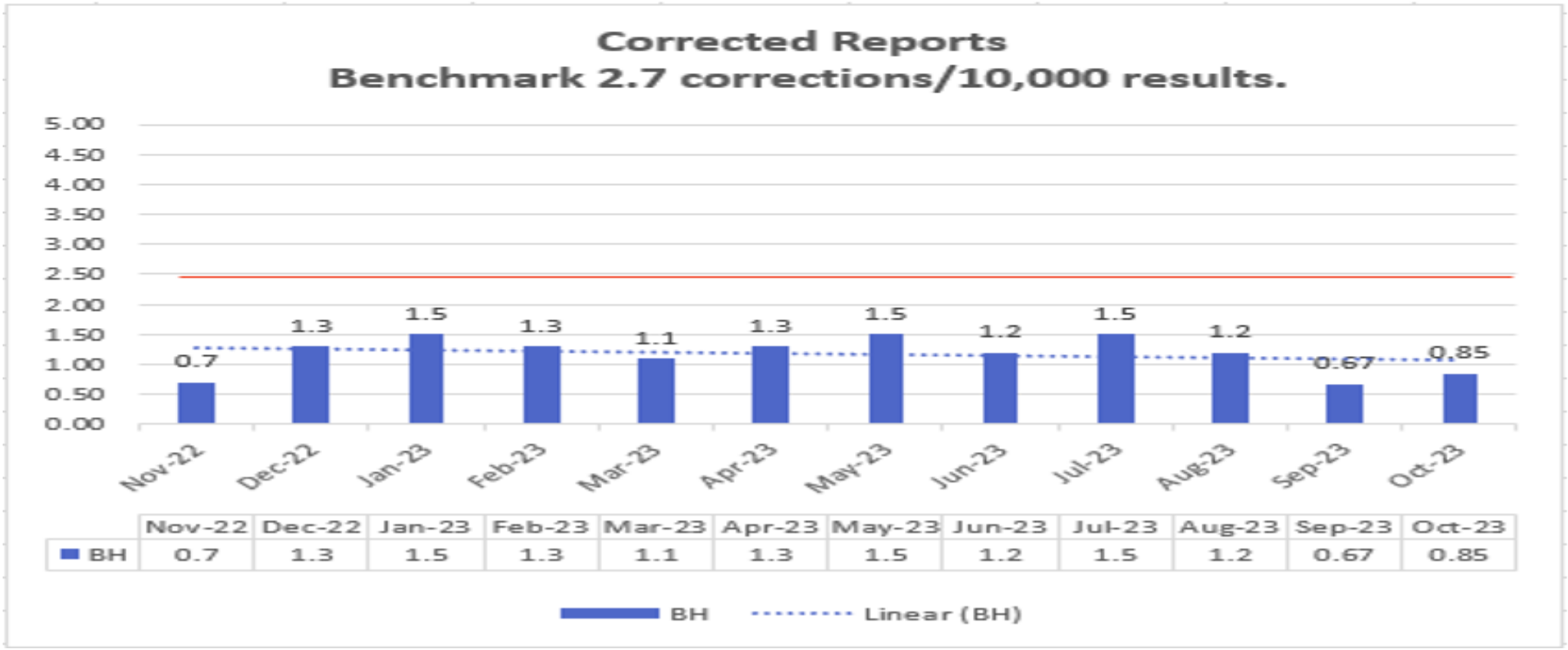
Current Cycle Inspection(s)			
Date	Inspection Type	% Deficient	Recurring Deficiencies
3/29/2022	Routine	0.47	1

Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.47%	0.84%	0.83%
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.	212,375 tests	0.85 (.008%)	0.67 (0.007%)	Corrected reports can lead to adverse patient outcomes	None needed benchmark met-but all corrections investigated with appropriate follow up with staff.	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	212,375 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	23,013 Tests	0	0	None	None needed	Lab administration and management

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

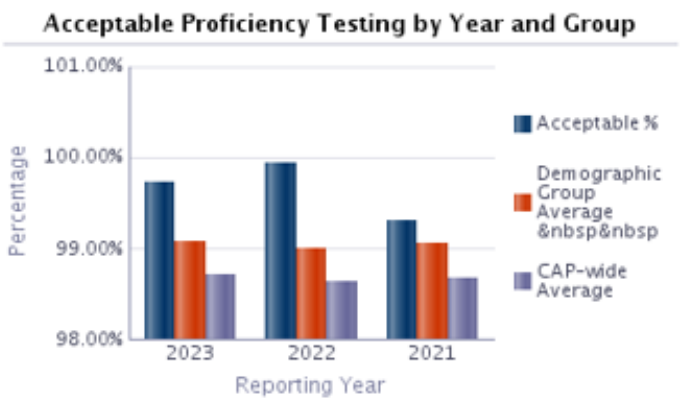
MCBH Proficiency Testing Performance Target 98%

MCBH Proficiency Testing Performance Target 98%

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
MCBH	178/178	100%	100%	None	None Needed

Proficiency Testing Performance Overview

Select View: Graph



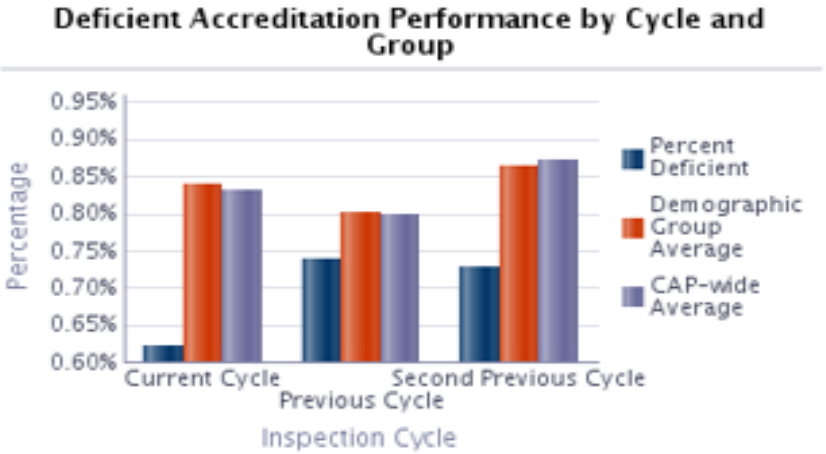
7	0	0	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.72%	99.07%	98.72%
2022	99.94%	98.99%	98.63%
2021	99.30%	99.06%	98.67%

MCBH Accreditation Performance Overview

Accreditation Performance Overview

Select View: Graph



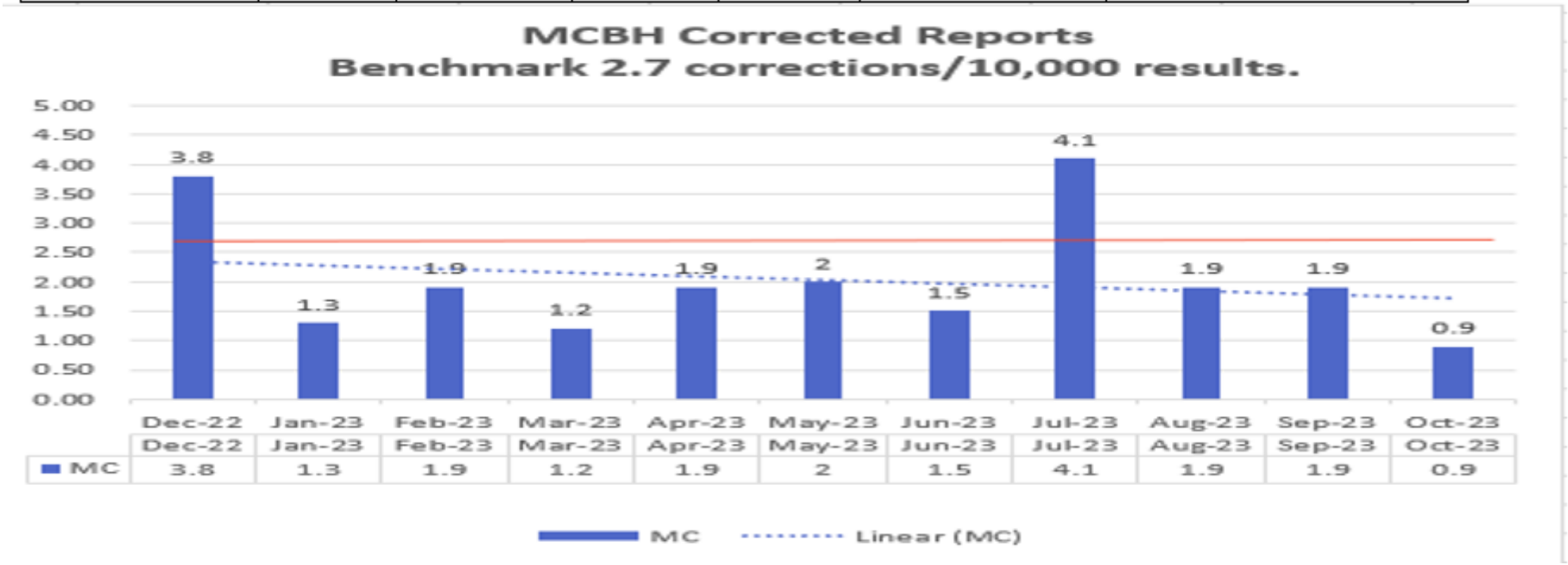
Last Accreditation Decision	Date
Accredited	5/9/2022

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

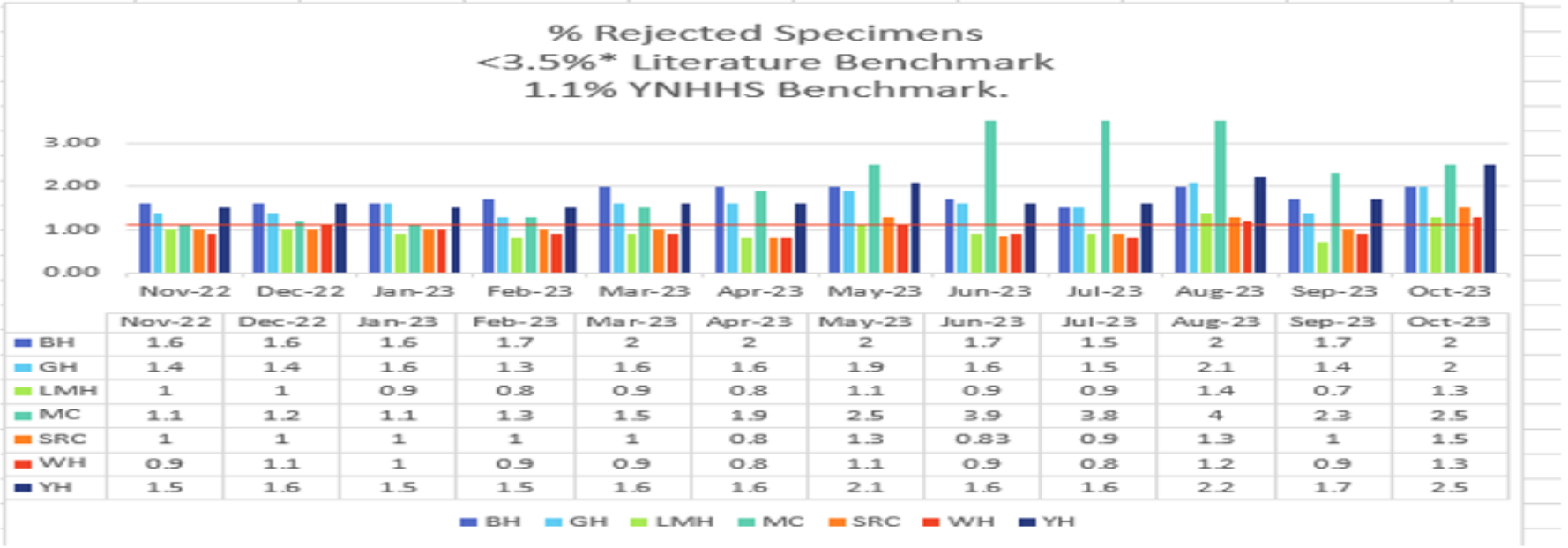
Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.62%	0.84%	0.83%
Previous Cycle	0.74%	0.80%	0.80%
Second Previous Cycle	0.73%	0.86%	0.87%

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.	23,013 tests	0.9 (0.009%)	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. Only 2 corrections in Oct. was scanning ABG's after verifying. Will continue to reinforce with staff the correct workflow.	Laboratory administration



Laboratory General



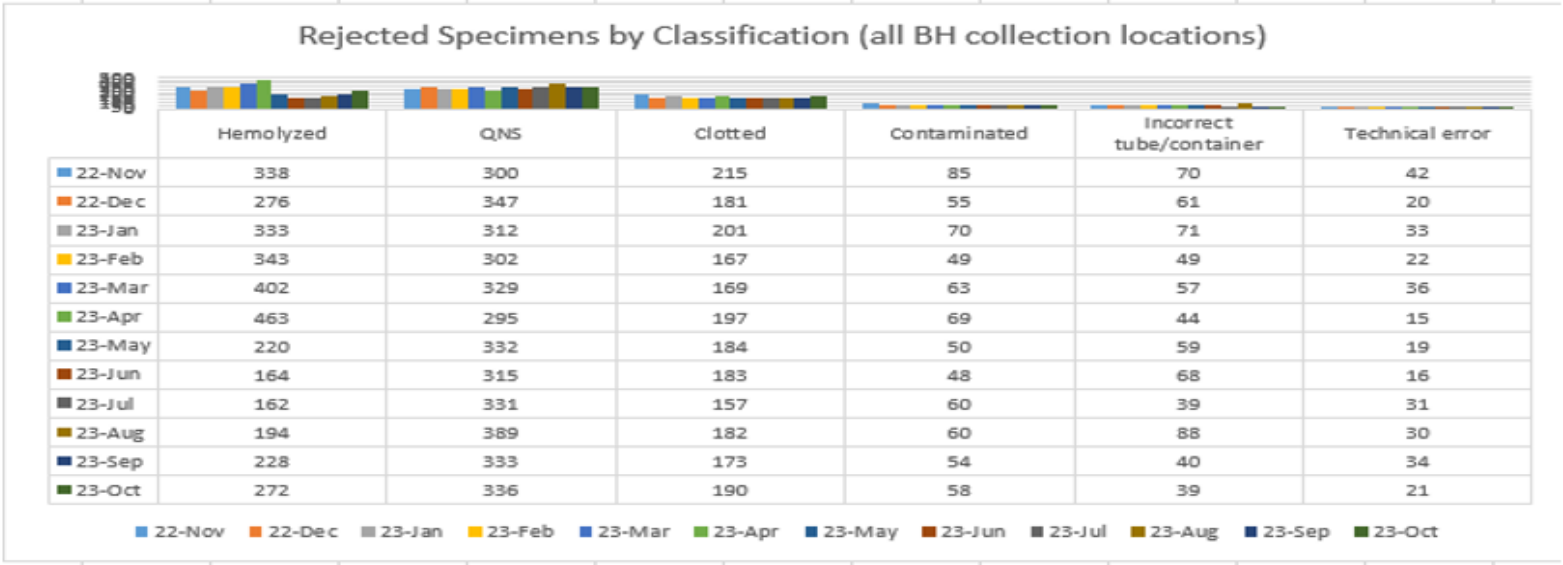
	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
BH	1.6	1.6	1.6	1.7	2	2	2	1.7	1.5	2	1.7	2
GH	1.4	1.4	1.6	1.3	1.6	1.6	1.9	1.6	1.5	2.1	1.4	2
LMH	1	1	0.9	0.8	0.9	0.8	1.1	0.9	0.9	1.4	0.7	1.3
MC	1.1	1.2	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3	2.5
SRC	1	1	1	1	1	0.8	1.3	0.83	0.9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

*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

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

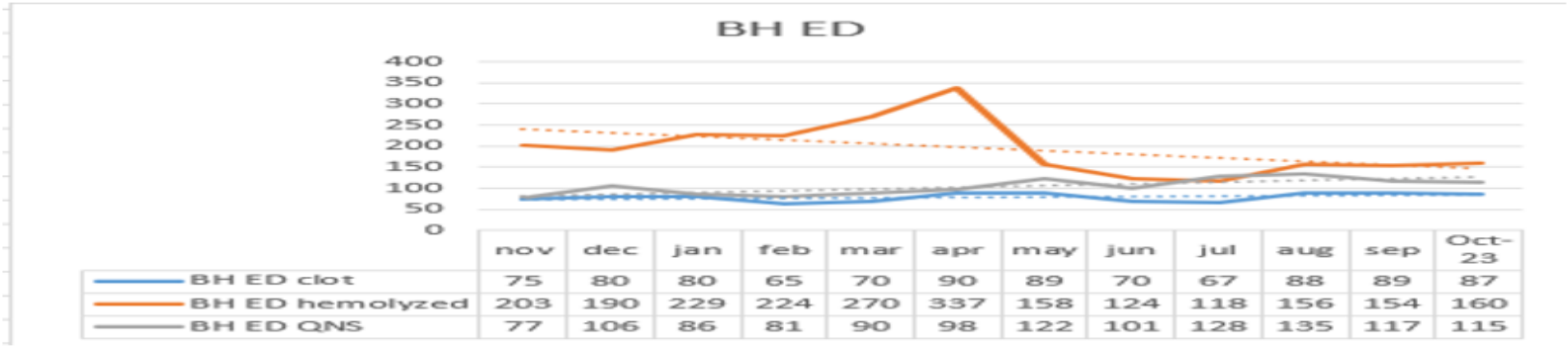
Laboratory General

** corrective actions to reduce MC redraw rate include BD came to observe blood collection techniques in late Sept. (Hemolysis accounted for 29% of all redraws at Milford in Oct. and of the 29%, 93% collected by MC ED (84 Chemistry samples, rest Heme & BB).



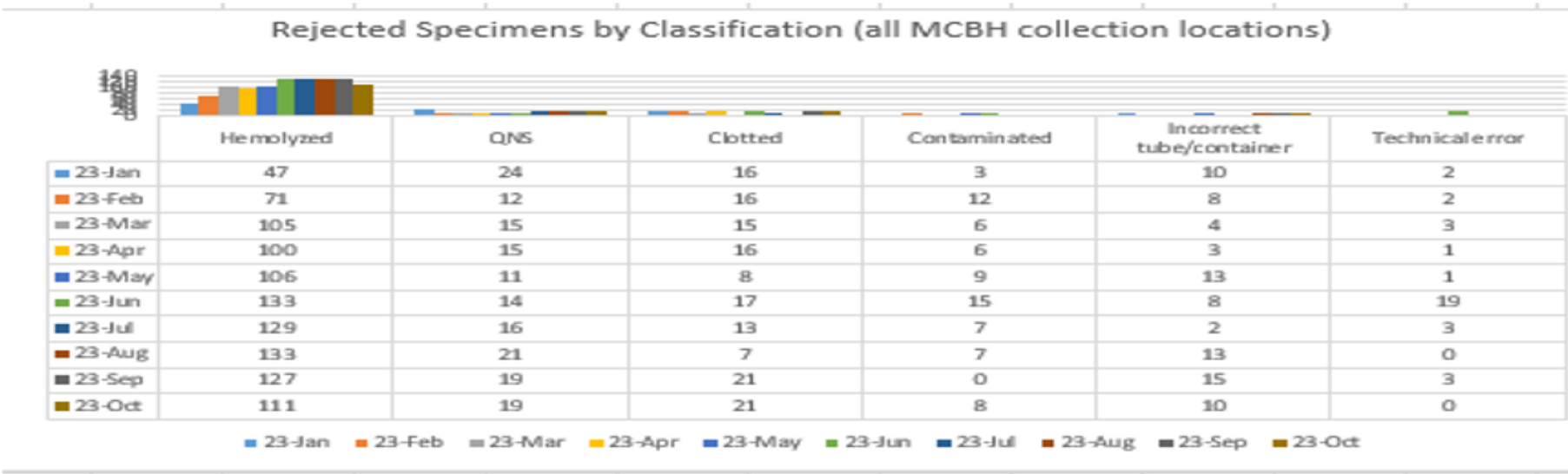
	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
22-Nov	338	300	215	85	70	42
22-Dec	276	347	181	55	61	20
23-Jan	333	312	201	70	71	33
23-Feb	343	302	167	49	49	22
23-Mar	402	329	169	63	57	36
23-Apr	463	295	197	69	44	15
23-May	220	332	184	50	59	19
23-Jun	164	315	183	48	68	16
23-Jul	162	331	157	60	39	31
23-Aug	194	389	182	60	88	30
23-Sep	228	333	173	54	40	34
23-Oct	272	336	190	58	39	21

Top 3 Rejections-BH ED totals



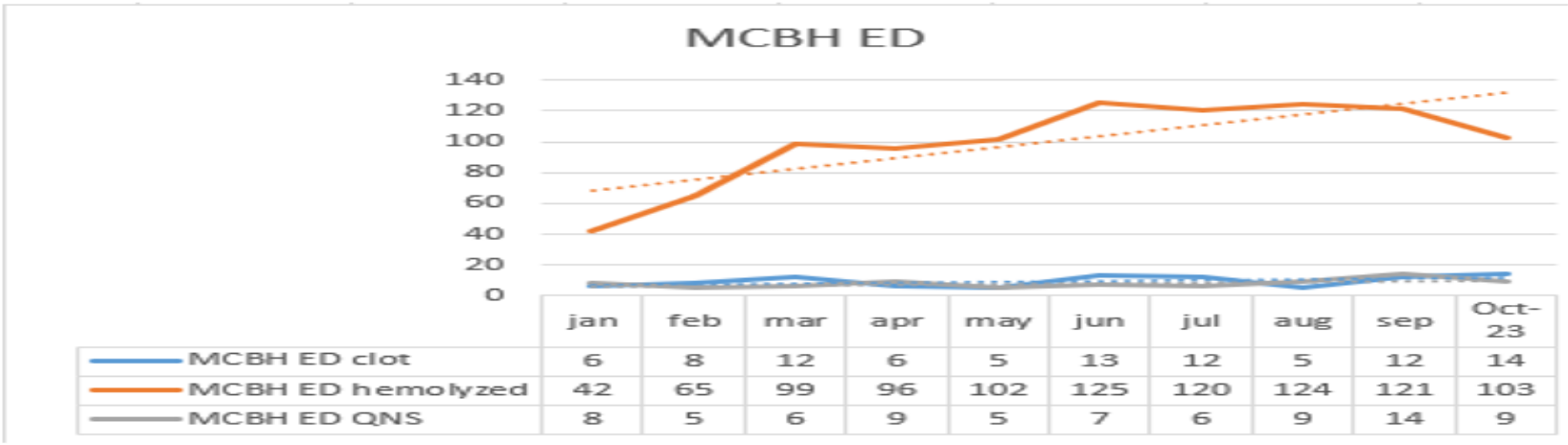
	nov	dec	jan	feb	mar	apr	may	jun	jul	aug	sep	Oct-23
BH ED clot	75	80	80	65	70	90	89	70	67	88	89	87
BH ED hemolyzed	203	190	229	224	270	337	158	124	118	156	154	160
BH ED QNS	77	106	86	81	90	98	122	101	128	135	117	115

Laboratory General



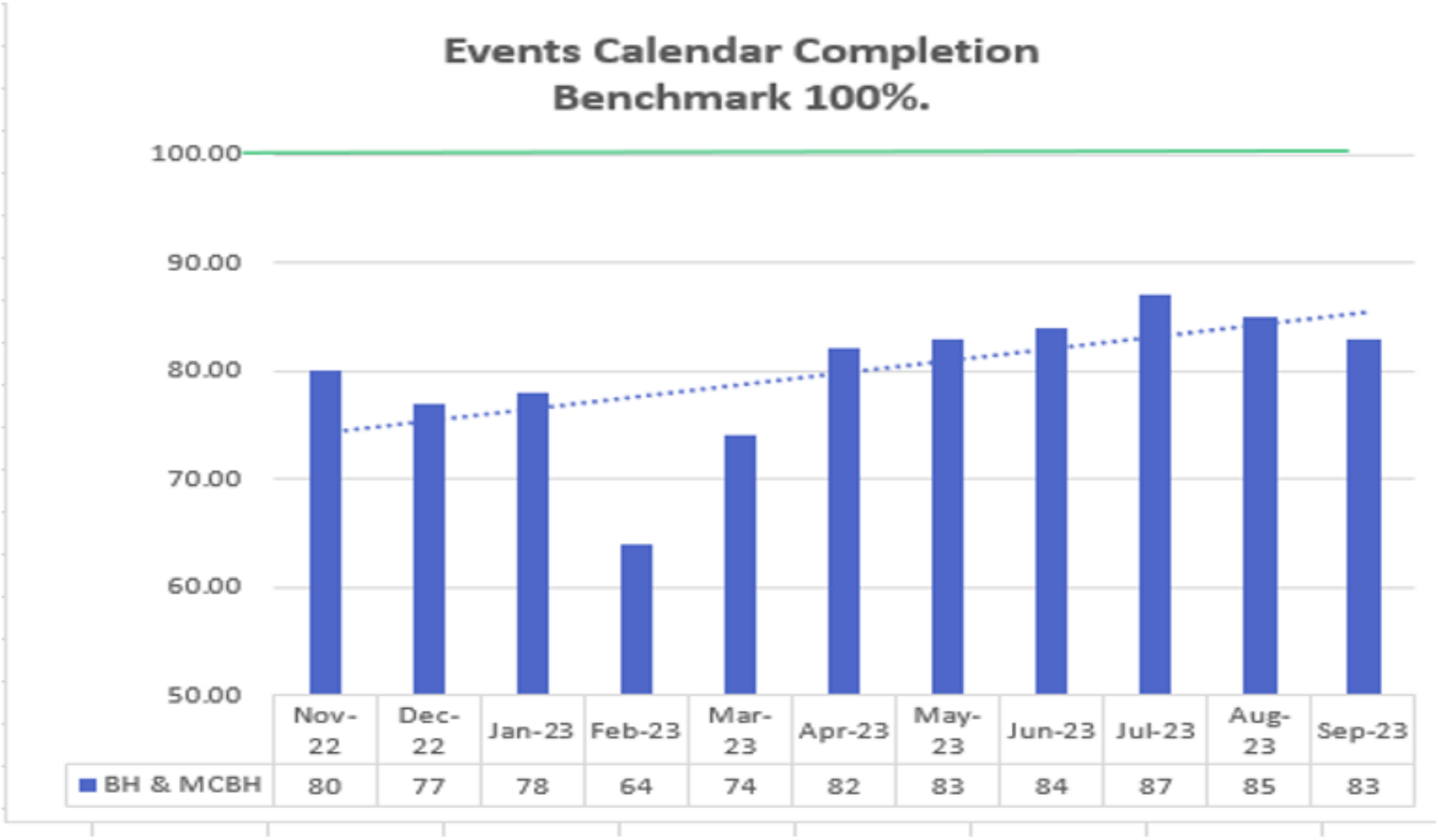
	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
23-Jan	47	24	16	3	10	2
23-Feb	71	12	16	12	8	2
23-Mar	105	15	15	6	4	3
23-Apr	100	15	16	6	3	1
23-May	106	11	8	9	13	1
23-Jun	133	14	17	15	8	19
23-Jul	129	16	13	7	2	3
23-Aug	133	21	7	7	13	0
23-Sep	127	19	21	0	15	3
23-Oct	111	19	21	8	10	0

Top 3 Rejections-MCBH ED totals



	jan	feb	mar	apr	may	jun	jul	aug	sep	Oct-23
MCBH ED clot	6	8	12	6	5	13	12	5	12	14
MCBH ED hemolyzed	42	65	99	96	102	125	120	124	121	103
MCBH ED QNS	8	5	6	9	5	7	6	9	14	9

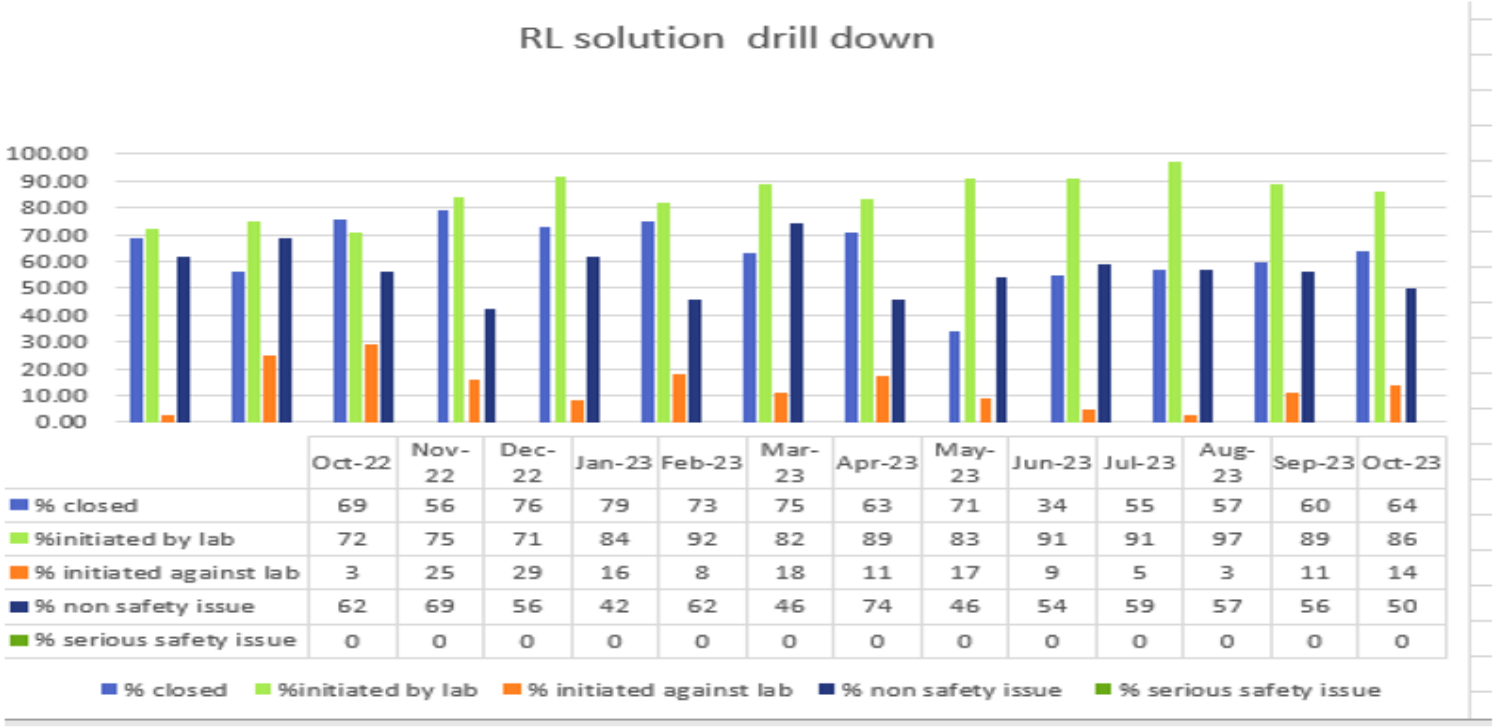
Laboratory General
BH & MCBH Events Calendar Completion 87%
Benchmark 100% 33/38 Events Completed



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

Overdue competencies/training on per diem employees, centrifuge training not completed on 3 employees.

Laboratory General
RL Solution Monitor

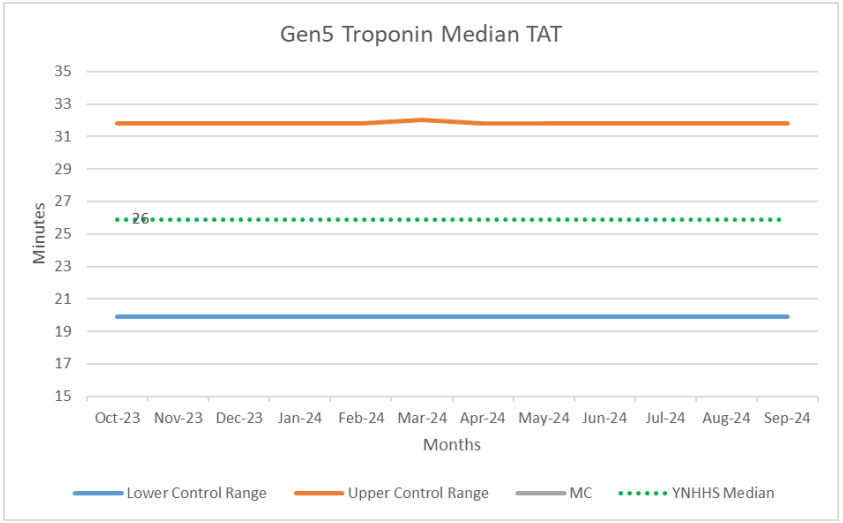


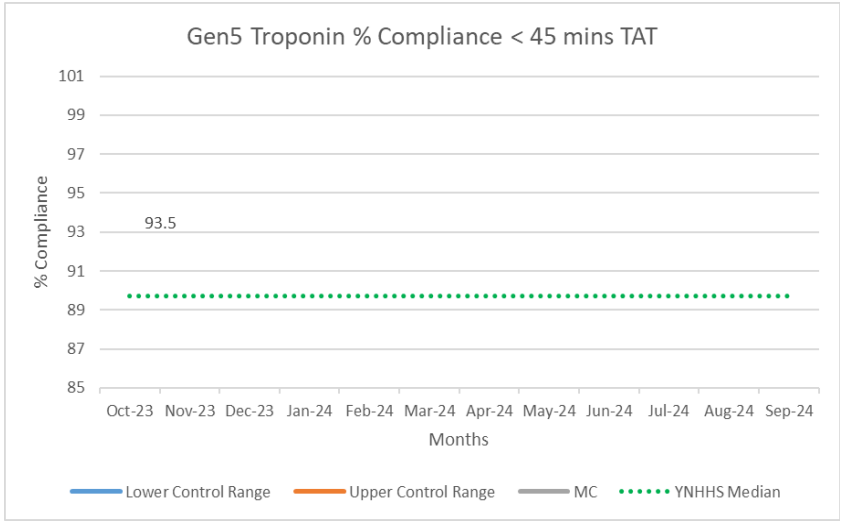
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
% closed	69	56	76	79	73	75	63	71	34	55	57	60	64
%initiated by lab	72	75	71	84	92	82	89	83	91	91	97	89	86
% initiated against lab	3	25	29	16	8	18	11	17	9	5	3	11	14
% non safety issue	62	69	56	42	62	46	74	46	54	59	57	56	50
% serious safety issue	0	0	0	0	0	0	0	0	0	0	0	0	0

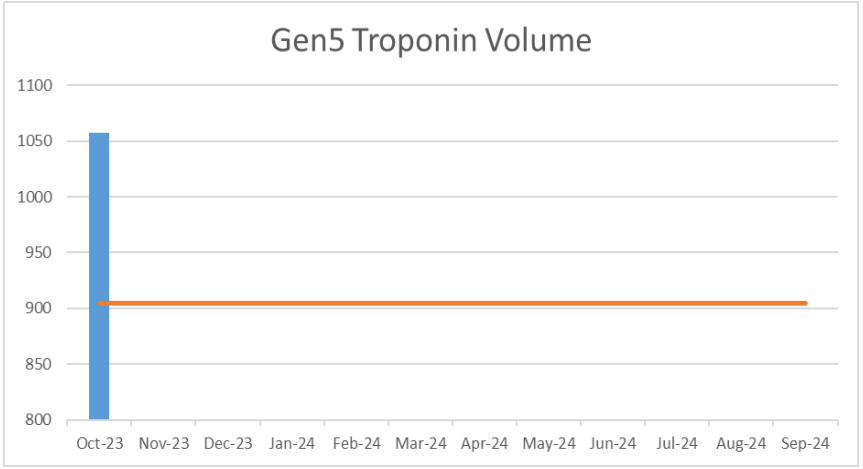
18/28 events closed, 9 are new & 1 in progress.
24 were lab initiated.
No Serious Safety Events, rest barrier catches & PSE's.

- **RL is being replaced by SAFER (1/1/2024). Please go in and make sure that all RL's are closed out. There are a lot that have not been followed up on and we have been asked to clear them out as soon as possible.**

Milford Campus – Gen 5 Troponin TAT







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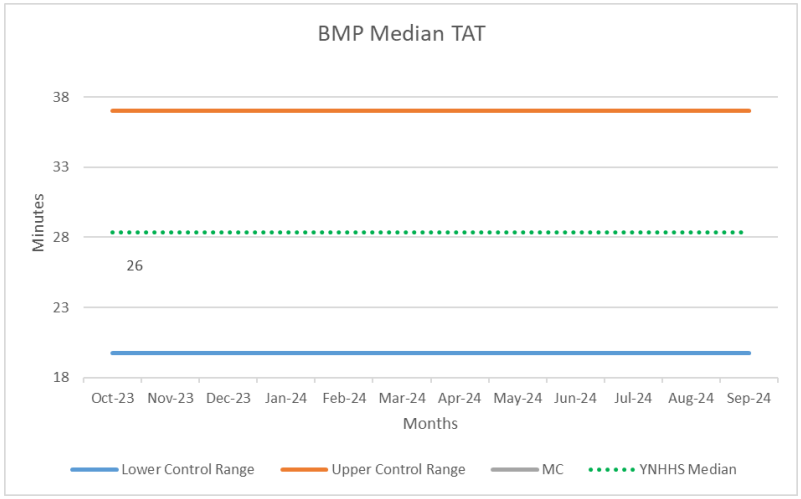
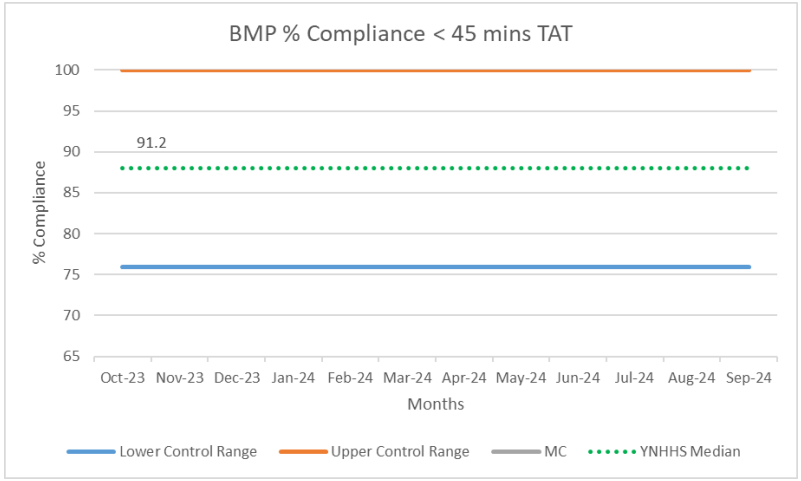
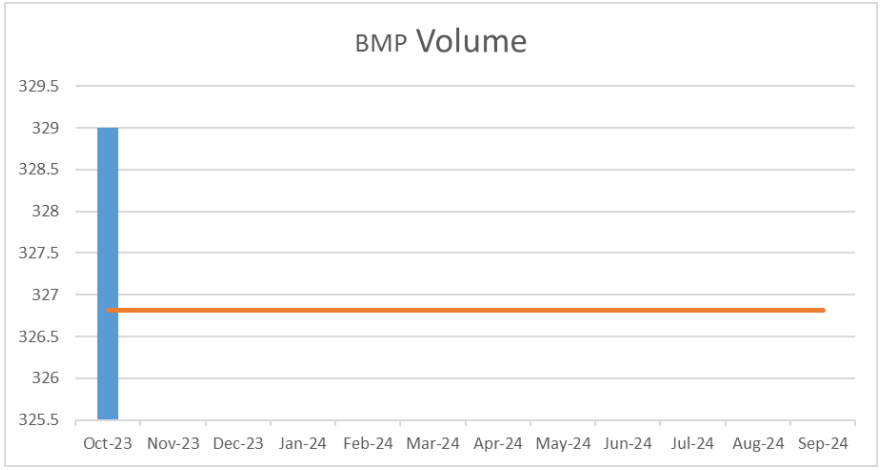
Bridgeport Hospital

Milford Campus – Basic Metabolic Panel (BMP) ED TAT







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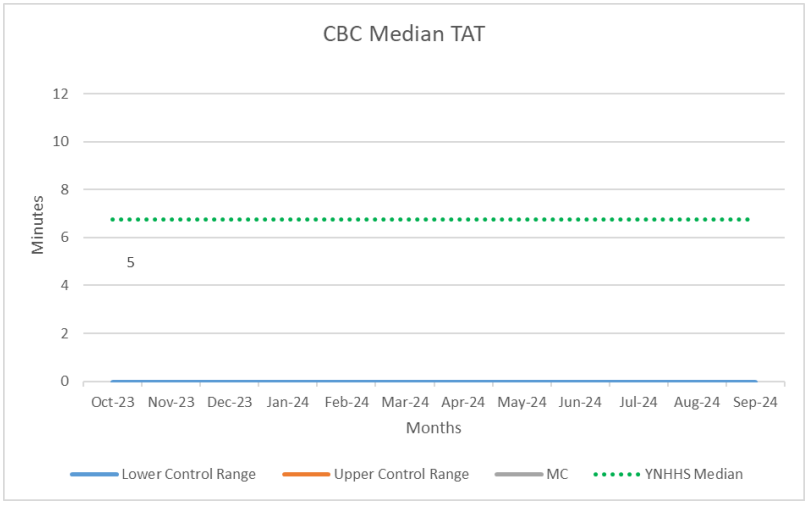
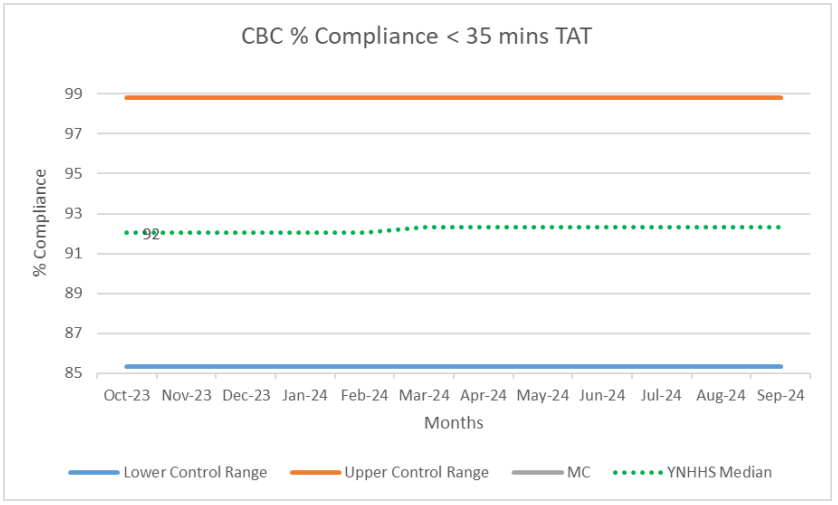
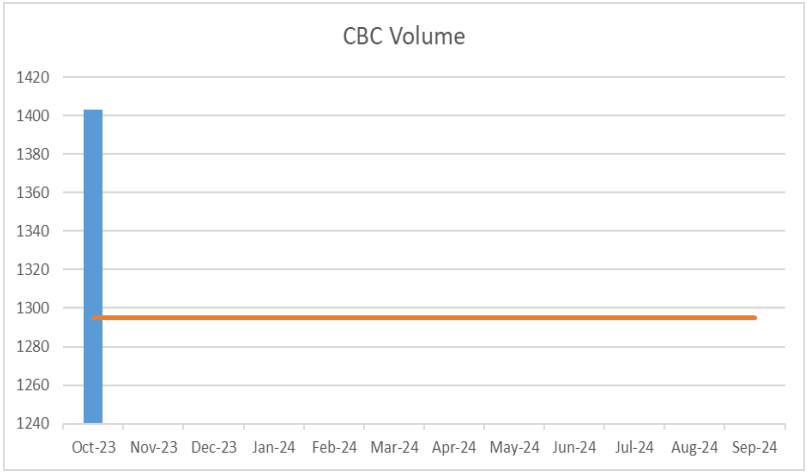
Milford Campus – Complete Blood Count (CBC) ED TAT







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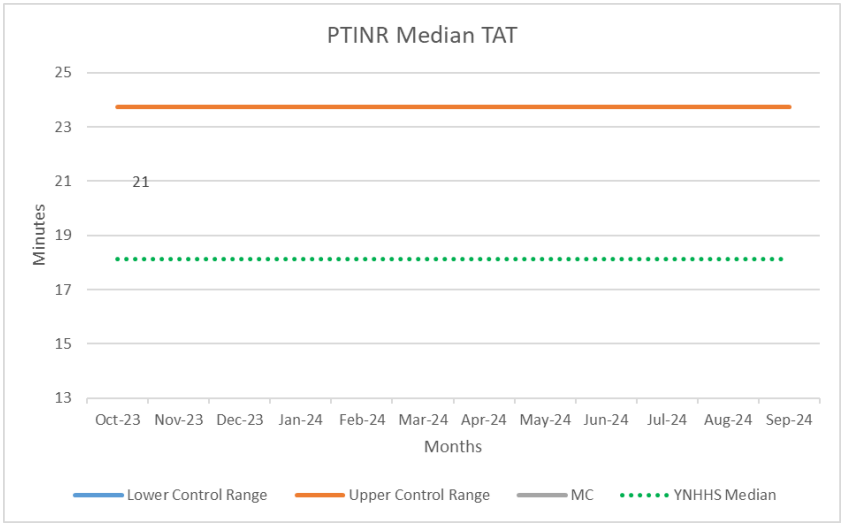
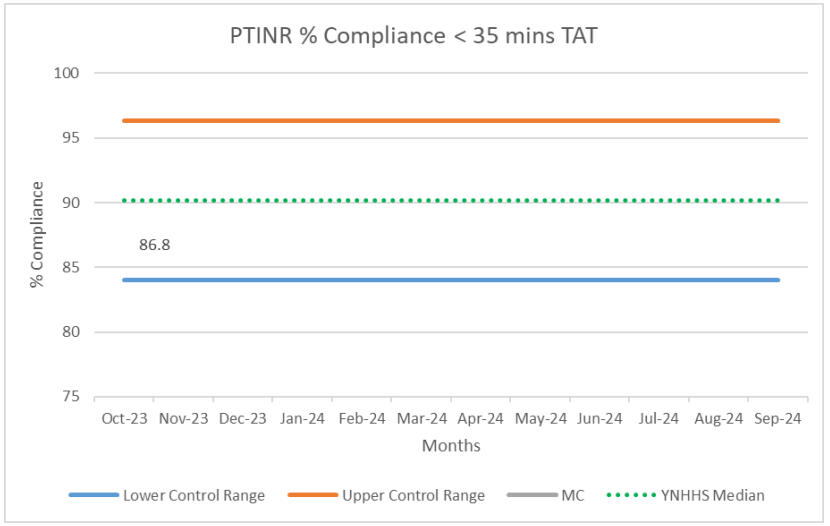
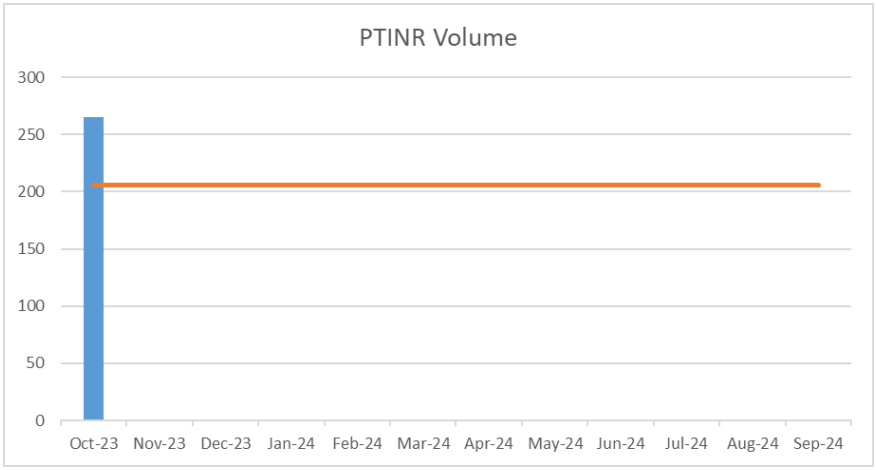
Bridgeport Hospital

Milford Campus – PTINR ED TAT







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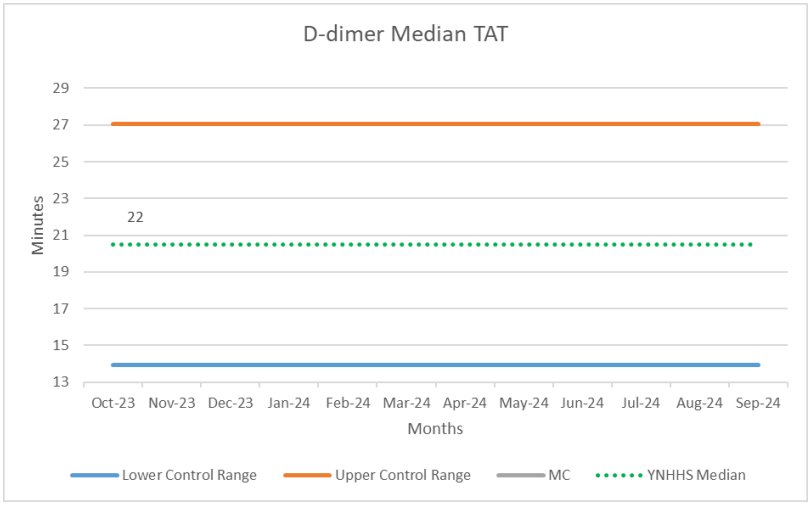
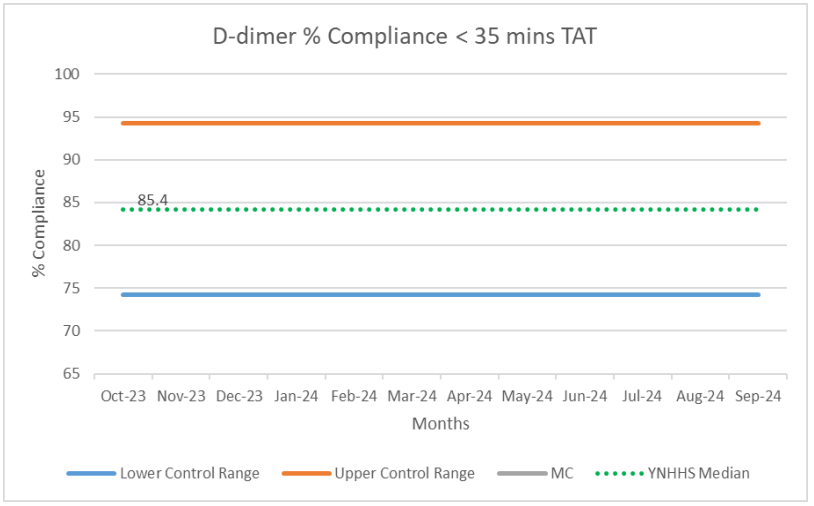
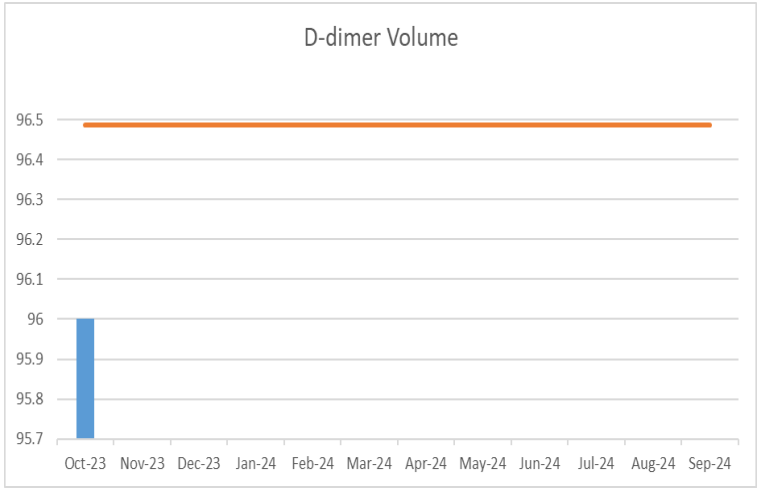
Milford Campus – D-dimer ED TAT







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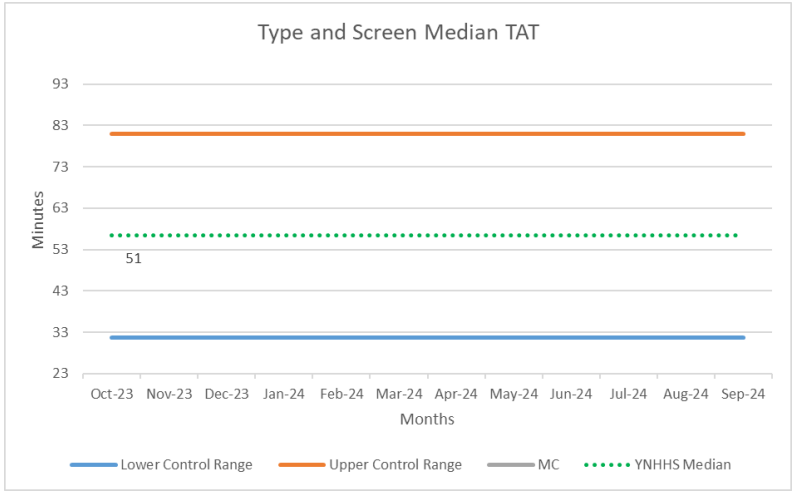
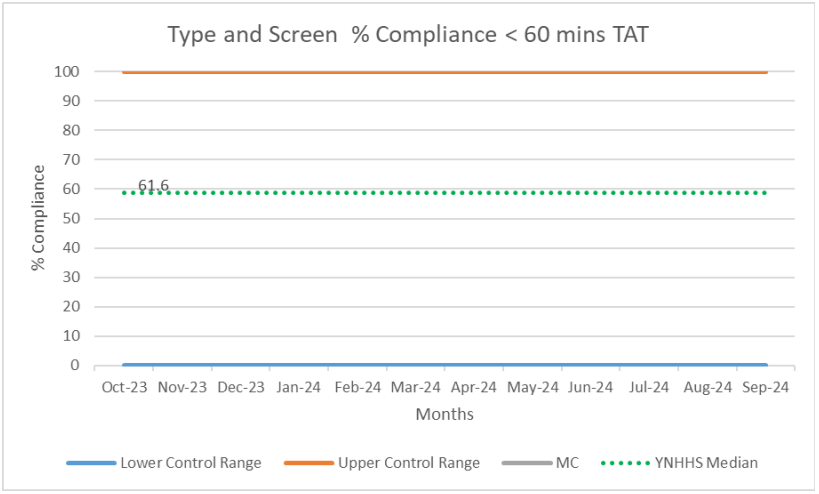
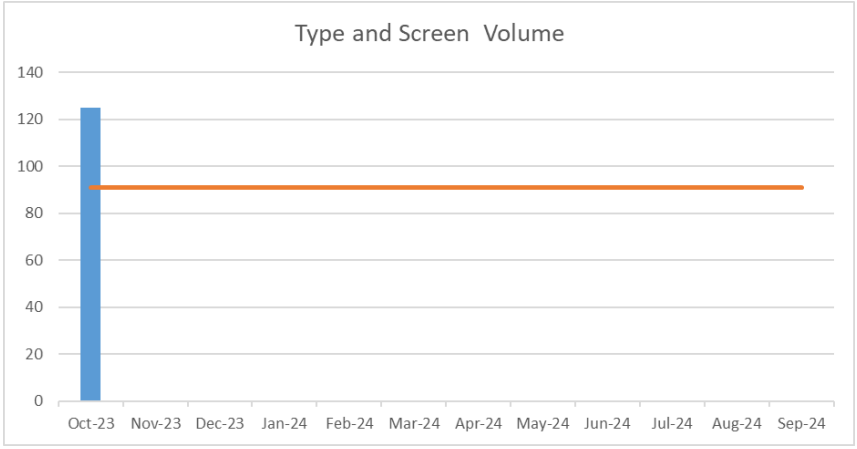
Milford Campus – Type and Screen ED TAT







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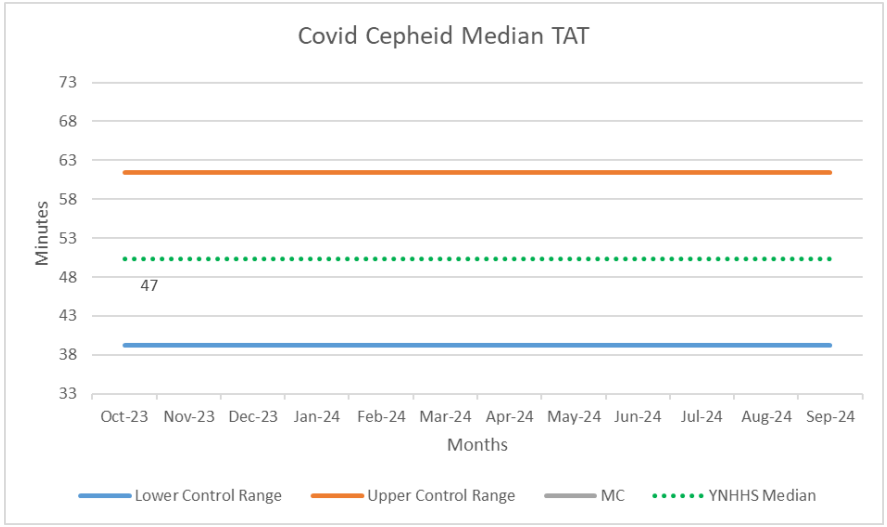
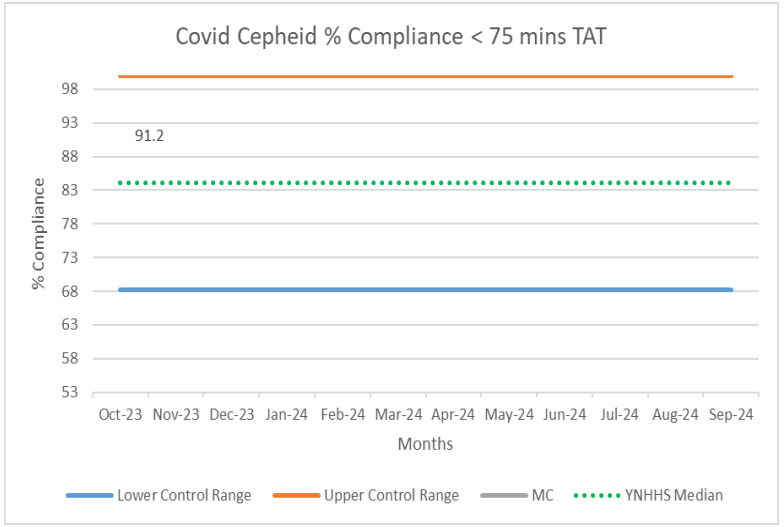
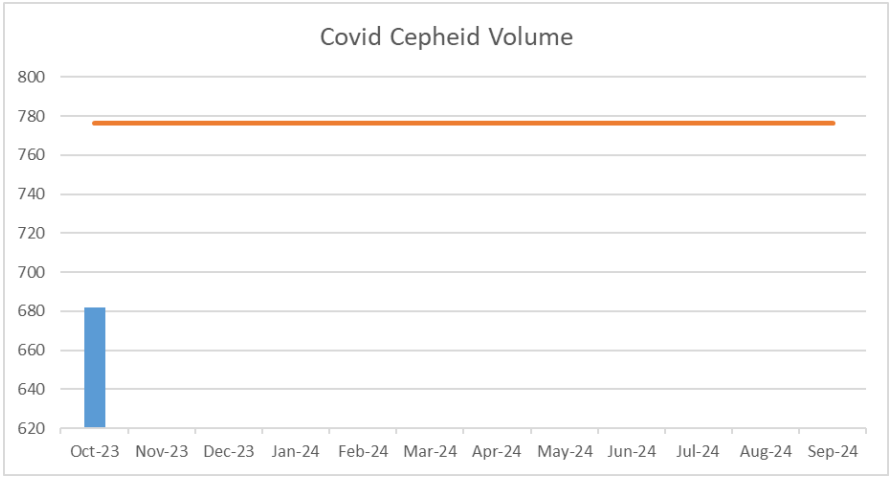
Milford Campus – COVID Cepheid PCR ED TAT







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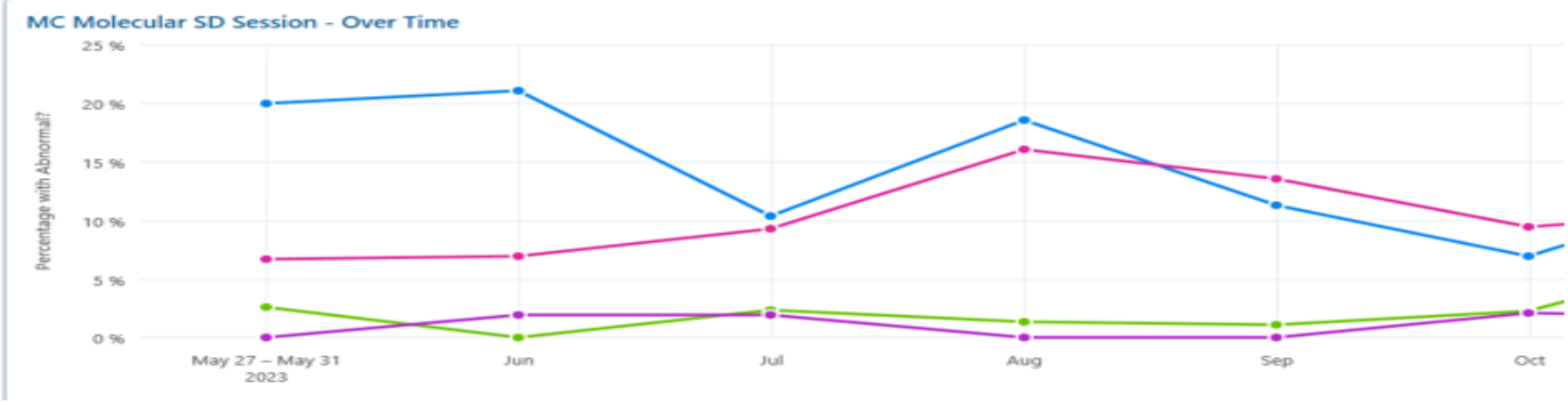
Milford Campus Molecular Dashboard



Date	Tests	% Positivity	Derived Baseline	Environment Monitoring	Physician Feedback	Epidemiological Trends	Evaluation Notes	Corrective Action (if needed)	
Oct-23	SARS-CoV-2	9.50%	0-22%	Negative	None	None	None	None	LB 11/26/2023
Oct-23	Group A Strep	7.00%	0-19%	Negative	None	None	None	None	LB 11/26/2023
Oct-23	Flu A/B	2.10%	0-7%	Negative	None	None	None	None	LB 11/26/2023
Oct-23	Flu/RSV	2.30%	0-14%	Negative	None	None	None	None	LB 11/26/2023
Oct-23	C. diff toxin	14.30%	not establishec	Negative	None	None	None	None	LB 11/26/2023

- OF the 14.3% positive C diff toxin by PCR, there were no active infections

Yale NewHaven Health Bridgeport Hospital

CRSQ Report Out

Committee of Regulatory, Safety, & Quality

October 2023

Bridgeport Hospital

Department of Laboratory Medicine

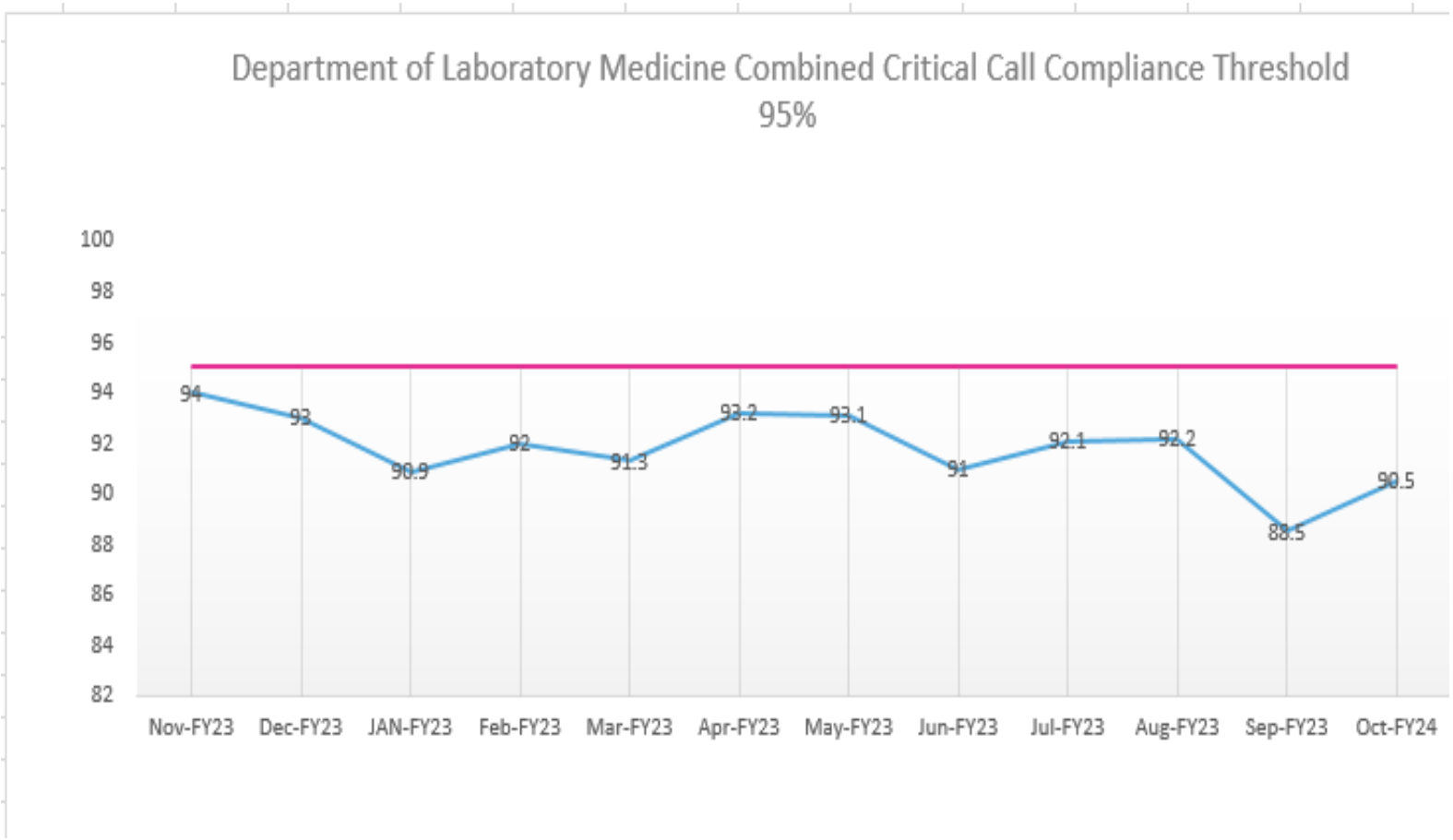
Teodorico Lee MPH, Christine Minerowicz M.D., Edward Snyder M.D.,
Laura Buhlmann M.S., Melissa Morales B.A.

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 **90.5%** 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 Nov 2022-Sep 2023). • Inpatient compliance rate is 93.6%, 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

Yale NewHaven Health Bridgeport Hospital

Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 91.5% (12 month cumulative) 11/1/2022-10/31/2023



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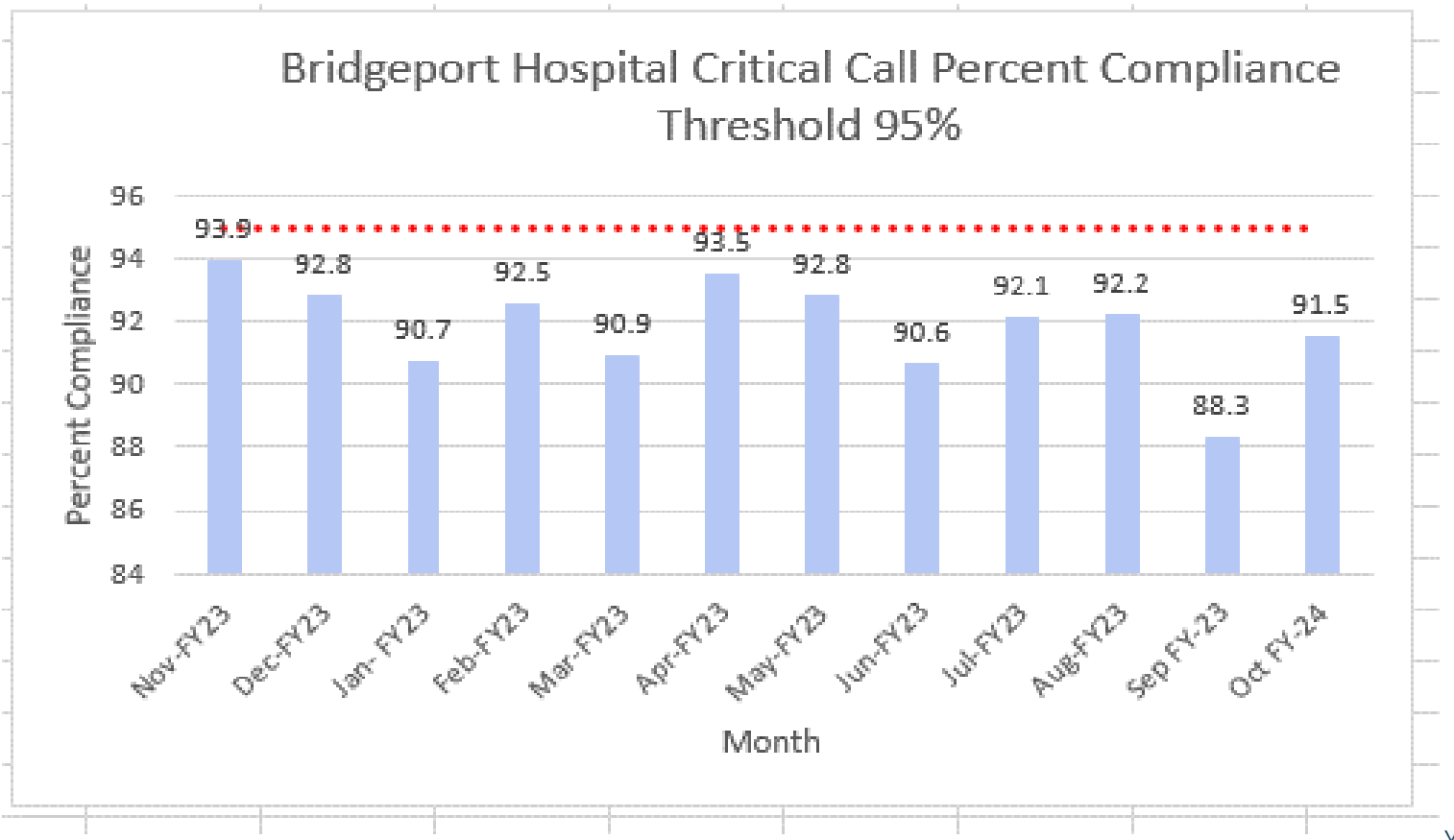
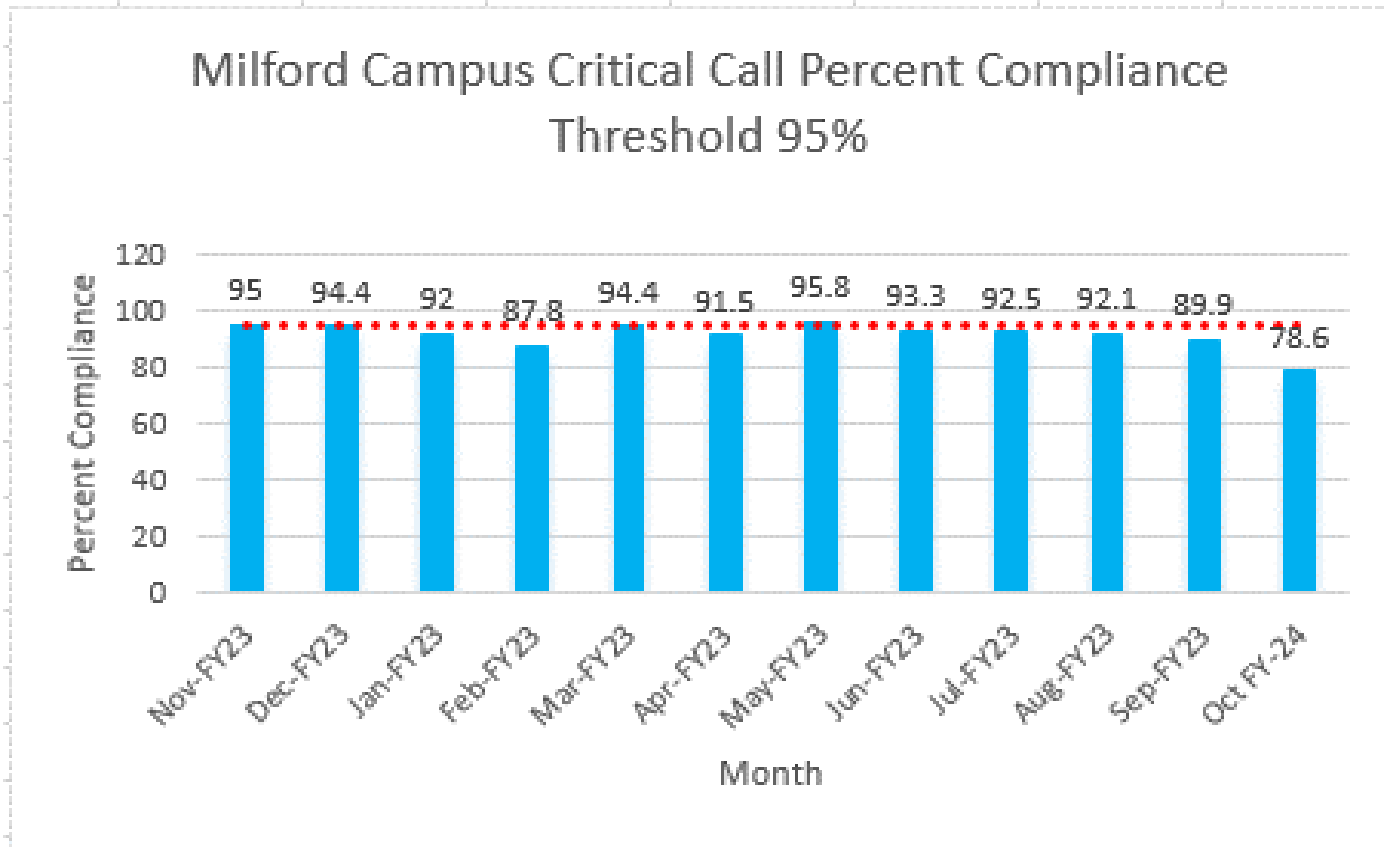
Bridgeport Campus Critical Call Percent Compliance 91.6%

11/1/2022- 10/31/2023



Yale NewHaven Health Bridgeport Hospital

Milford Campus Critical Call Percent Compliance 91.1%
11/1/2022-10/31/2023



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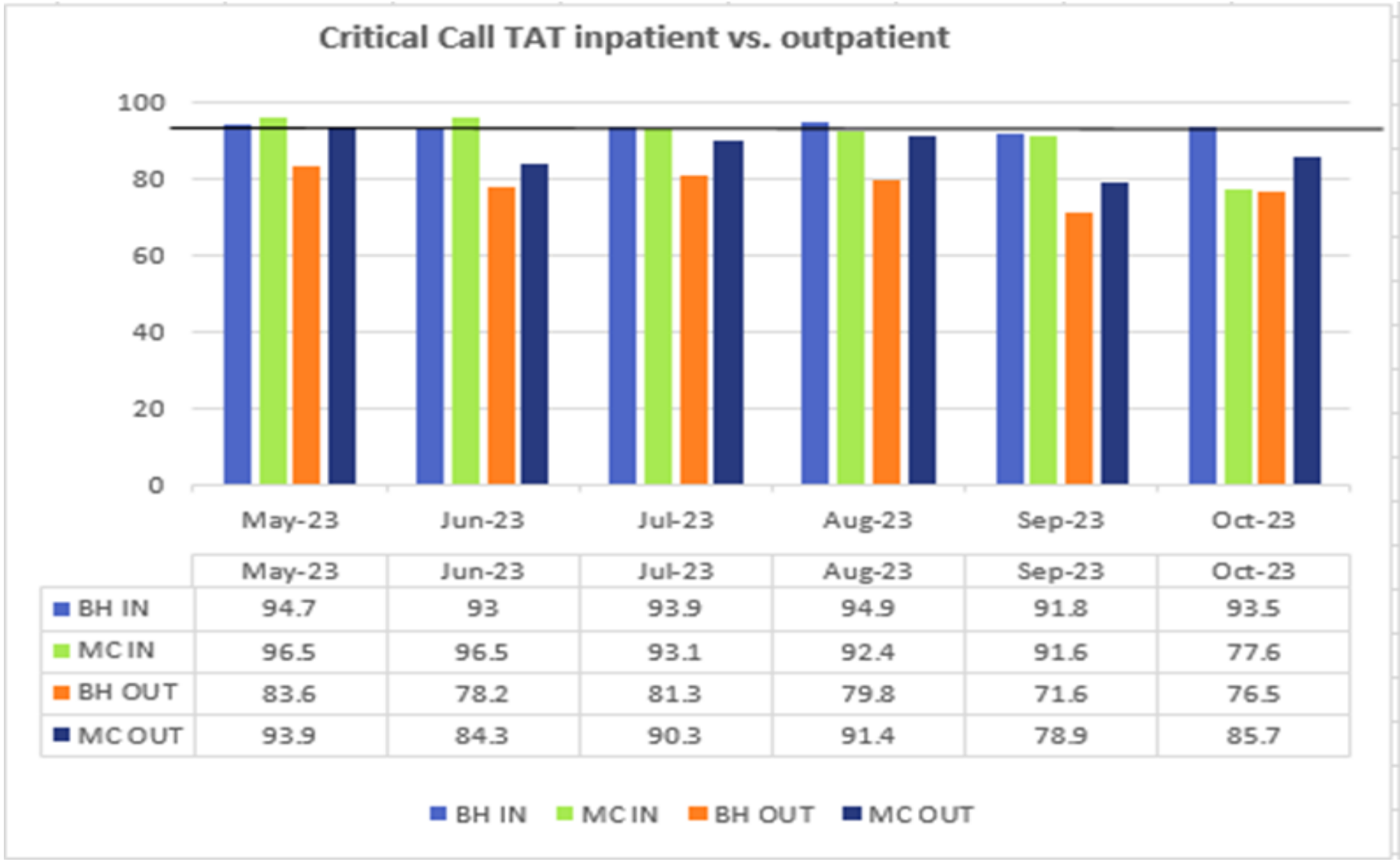
Critical Call TAT
Inpatient vs. Outpatient



	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
BH IN	94.7	93	93.9	94.9	91.8	93.5
MC IN	96.5	96.5	93.1	92.4	91.6	77.6
BH OUT	83.6	78.2	81.3	79.8	71.6	76.5
MC OUT	93.9	84.3	90.3	91.4	78.9	85.7