Yale NewHaven Health Bridgeport Hospital

Laboratory Medicine – November 2023

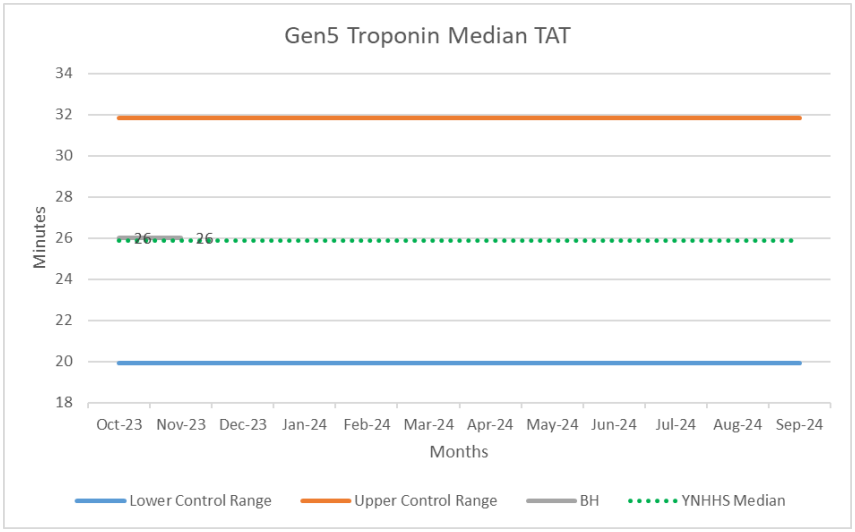
December 29, 2023

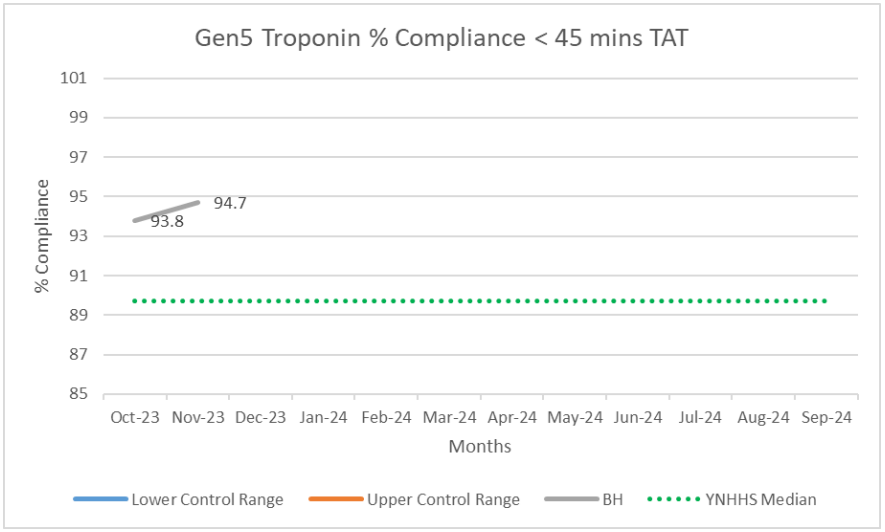
Bridgeport and Milford Campuses Turnaround Time Goals

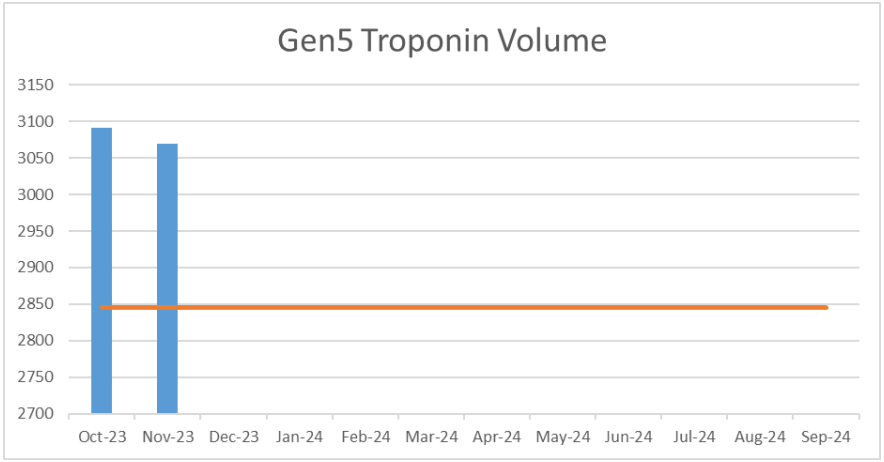
- Mean determined from median TAT across the Yale New Haven Health System delivery networks
  - Bridgeport and Milford Campuses – Bridgeport Hospital, Greenwich Hospital, Lawrence Memorial Hospital, Westerly Hospital, St. Raphael and York Street Campus – Yale New Haven Hospital and Shoreline Medical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

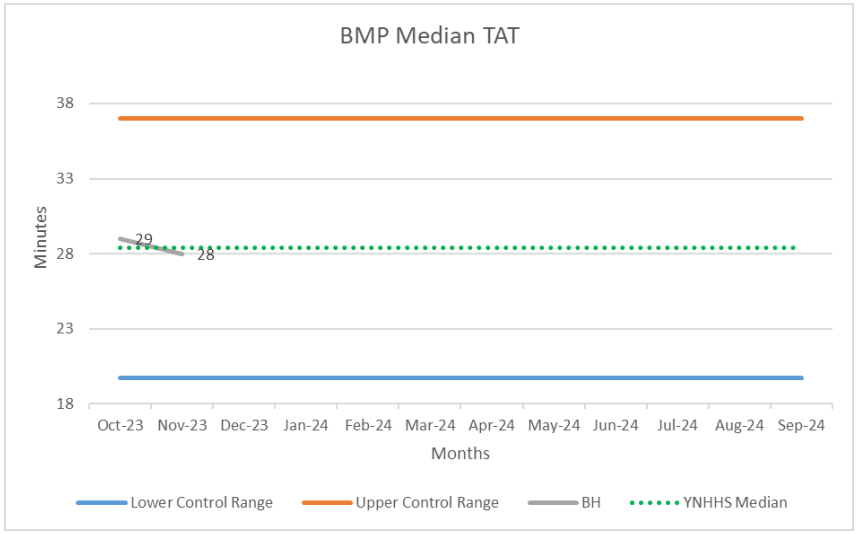


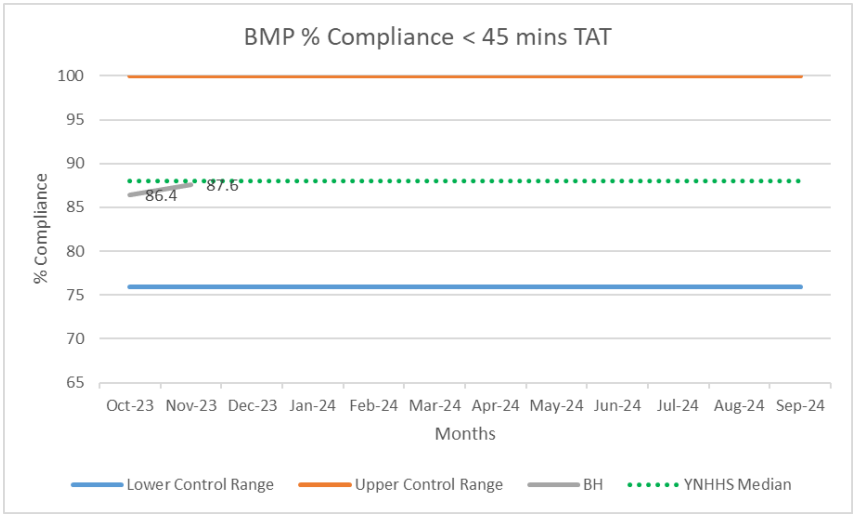


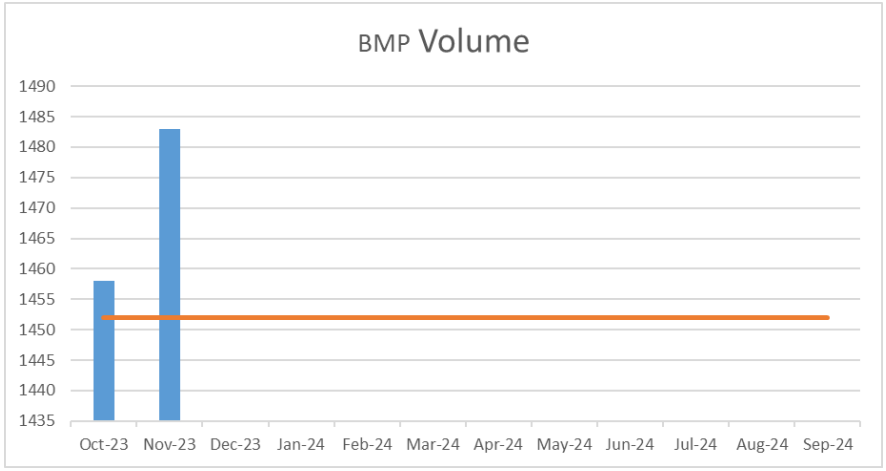


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT

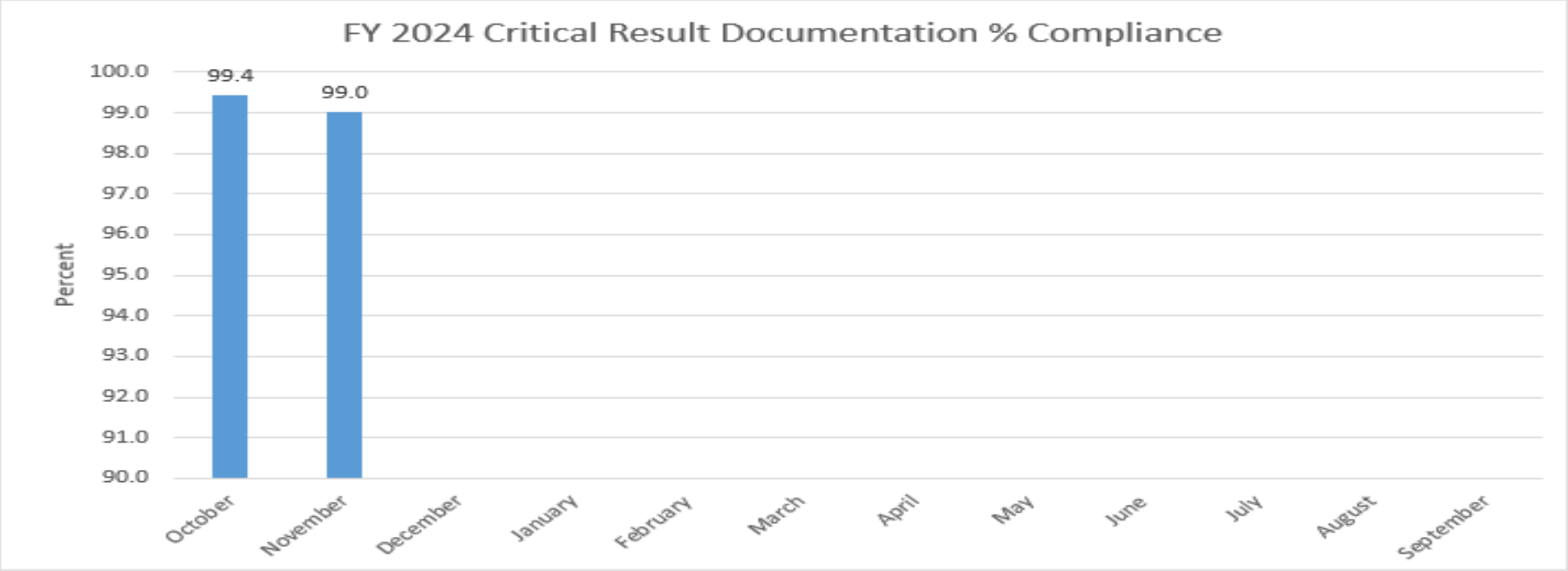






Yale NewHaven Health
Bridgeport Hospital

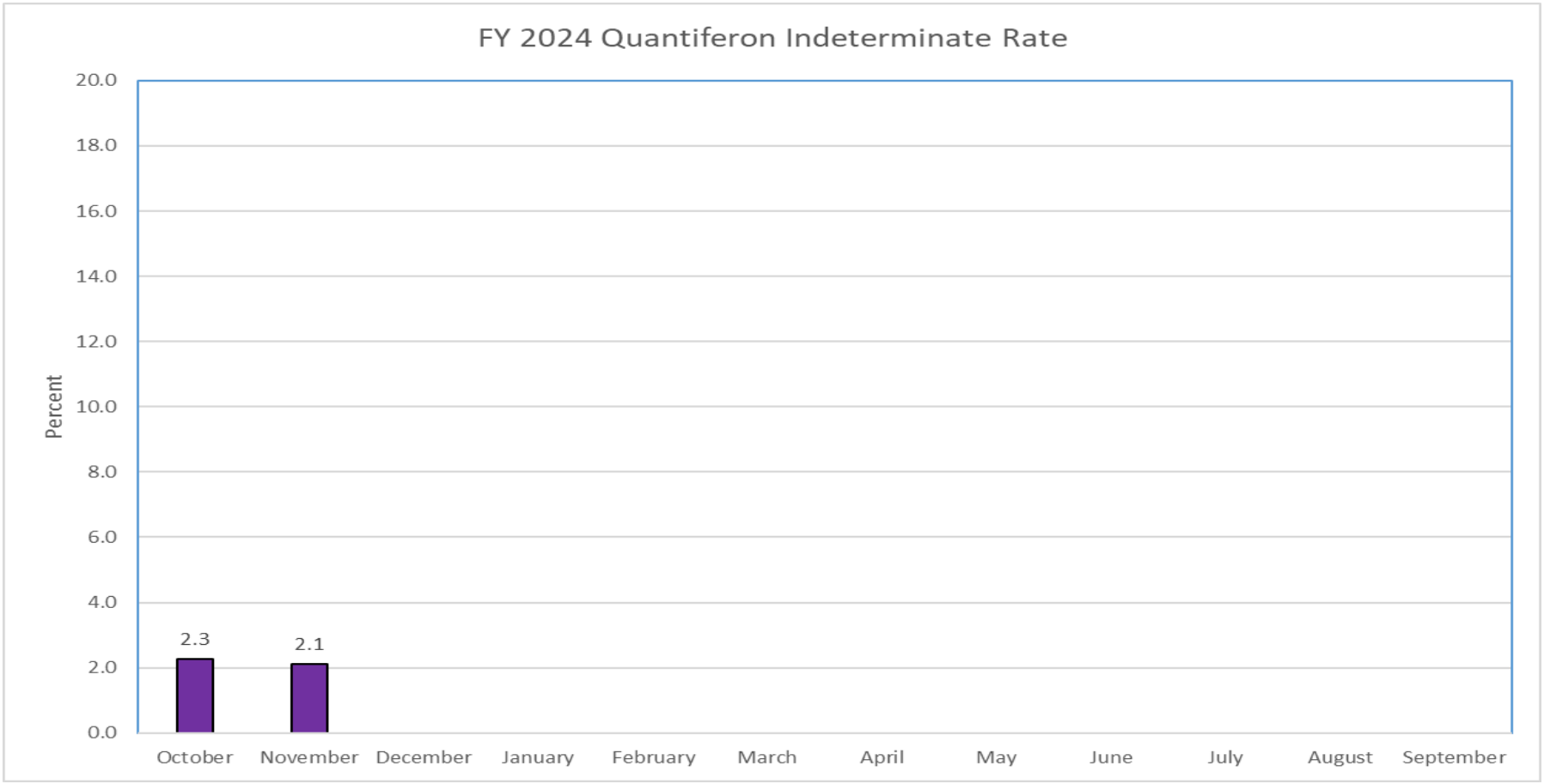
Chemistry



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
n	1386	1504										
#compliant	1378	1490										
#noncompliant	8	15										
no name	2	4										
no full name	1	3										
no credentials	5	6										
incorrect docum.		1										
incorrect person		1										

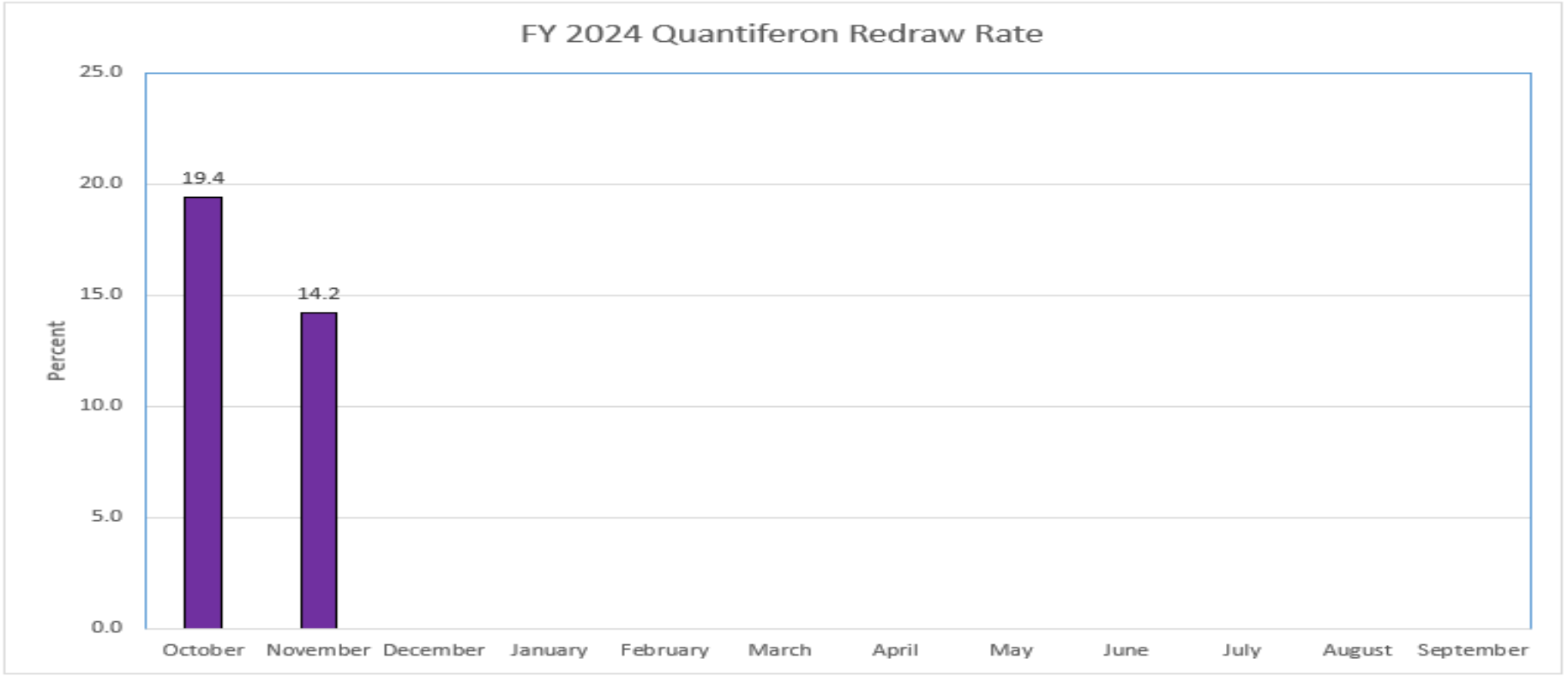
no name: tech must backspace the field and enter correct name
Each outlier was addressed with individual tech.

Chemistry



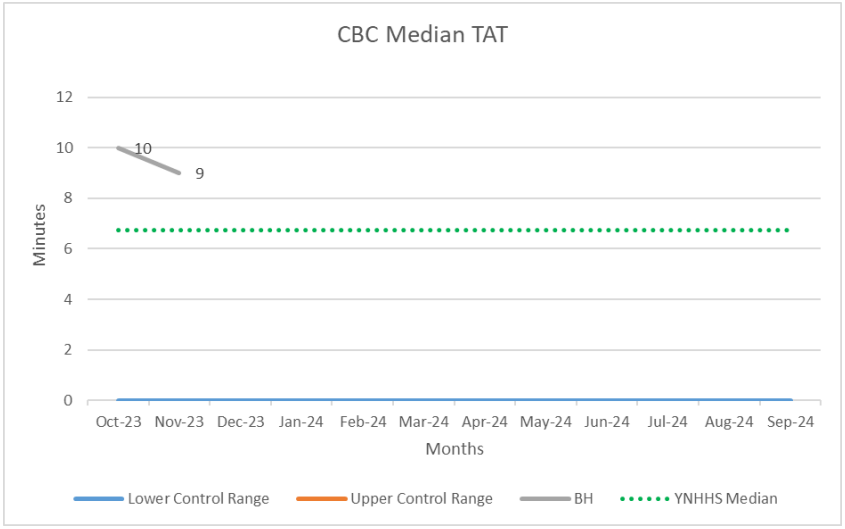
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
N	266	237										
indeterminate	6	5										

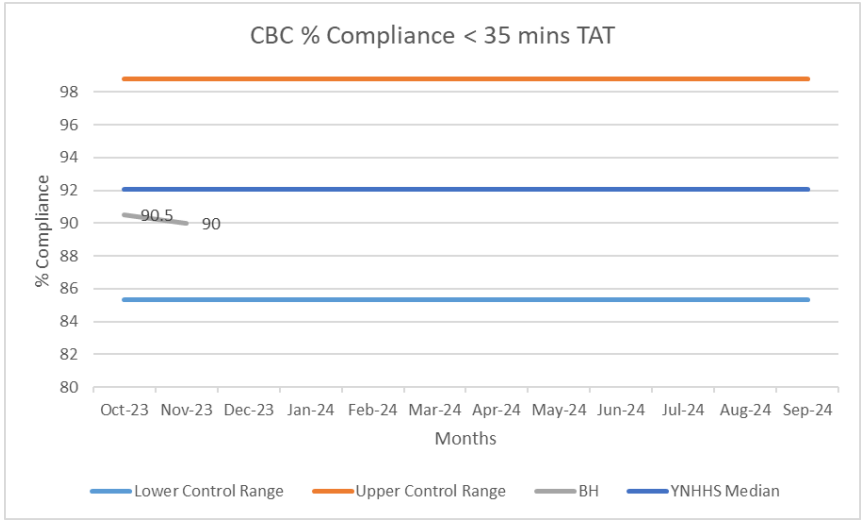
Chemistry

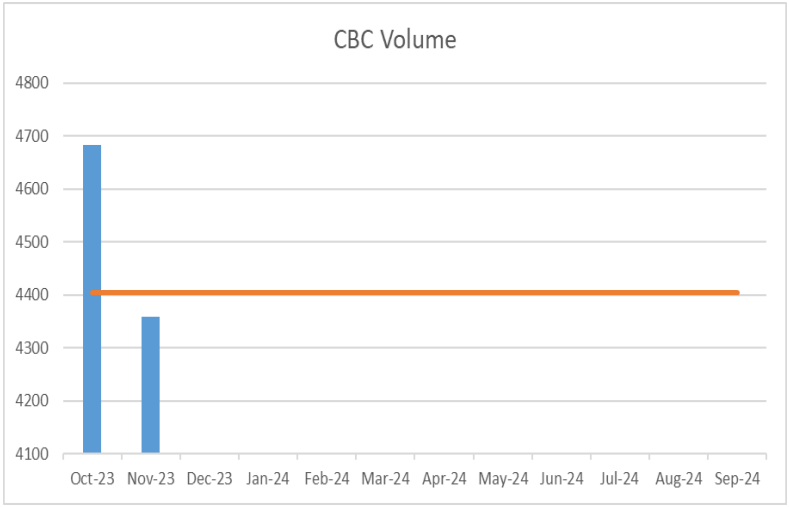


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
redraws	57	31										
rate %	19.4	14.2										
hemolyzed	44	26										
QNS	10	3										
overfilled	2	0										
other	1	2										

Bridgeport Campus – Complete Blood Count (CBC) ED TAT

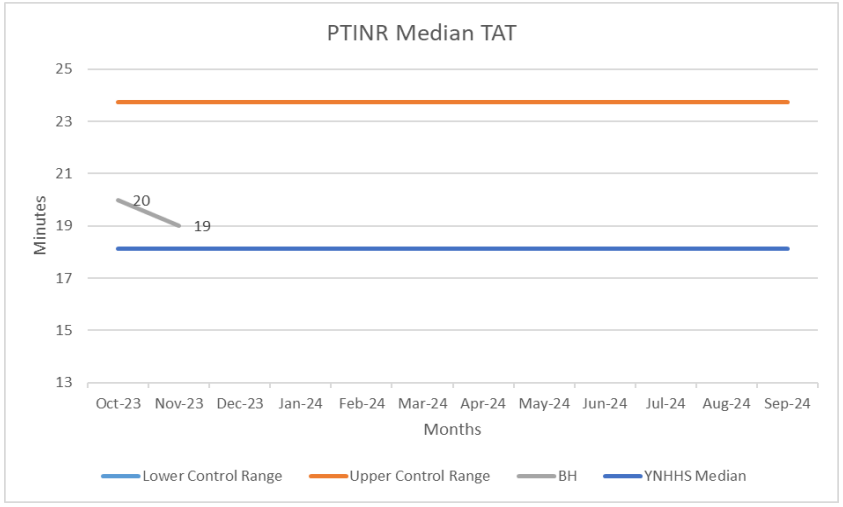


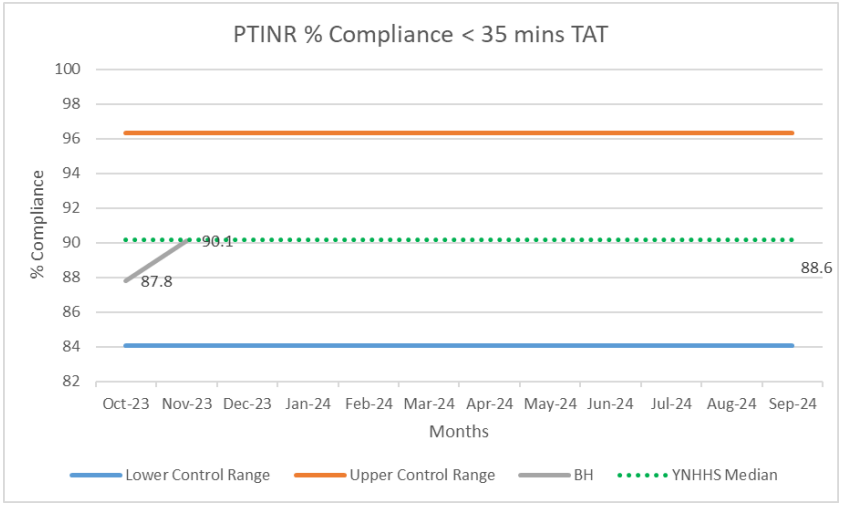


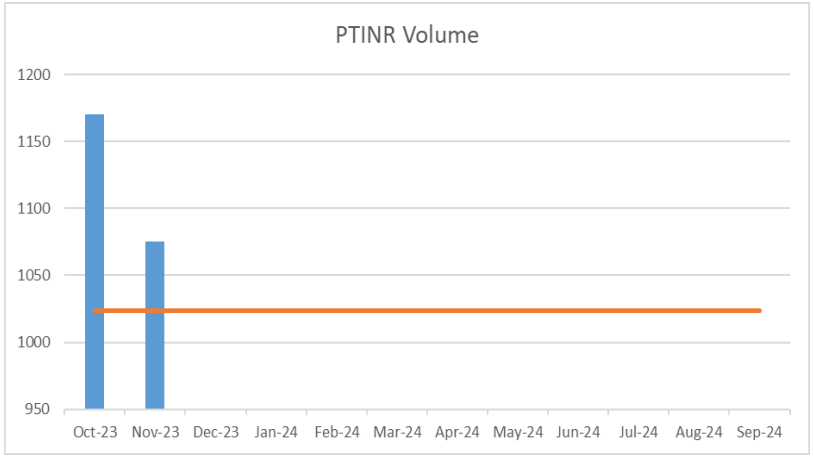


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – PTINR ED TAT

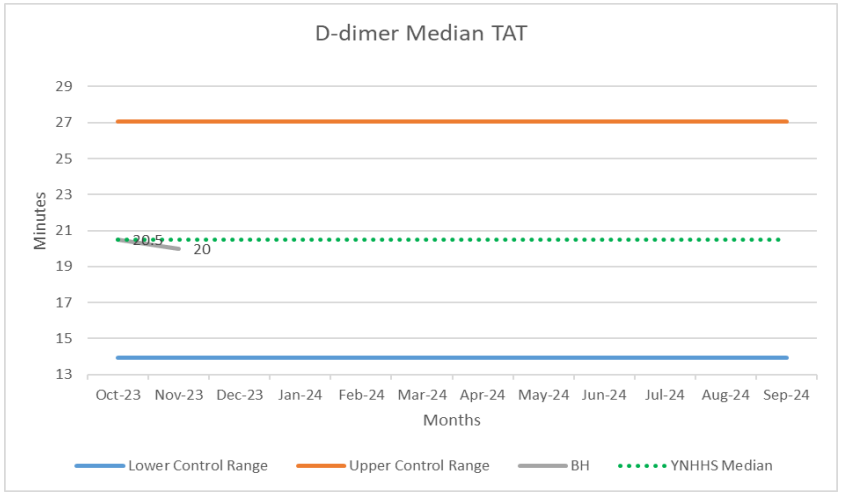


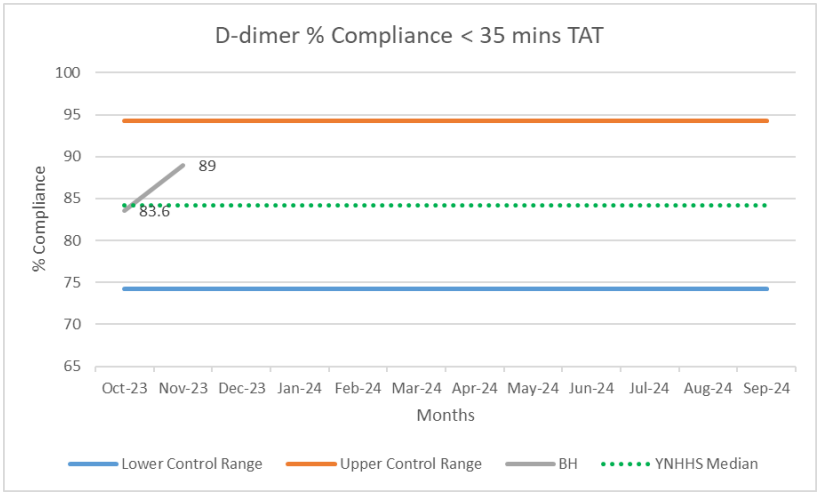


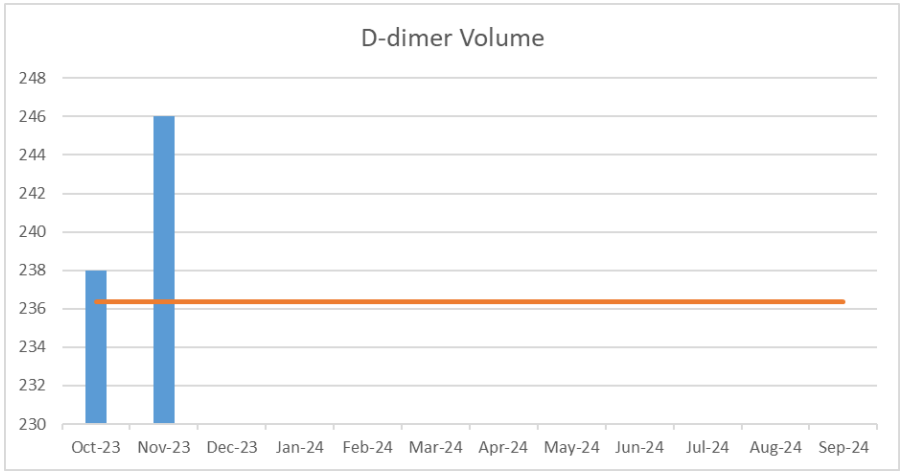


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – D-dimer ED TAT

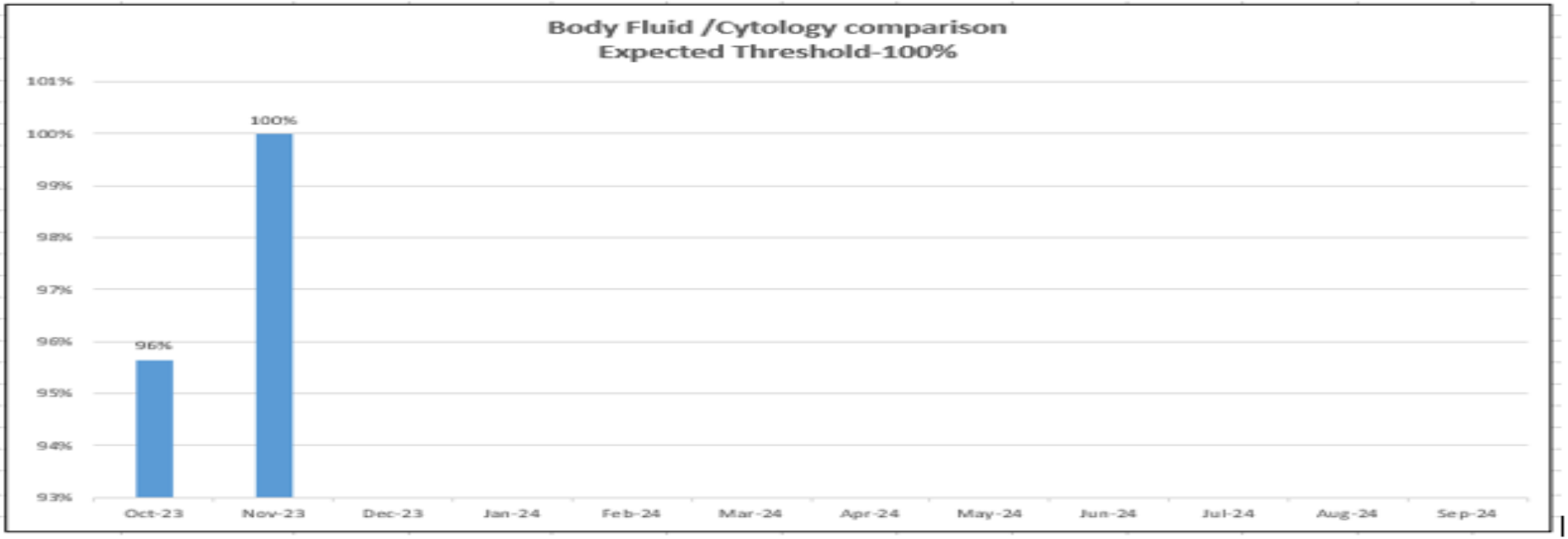






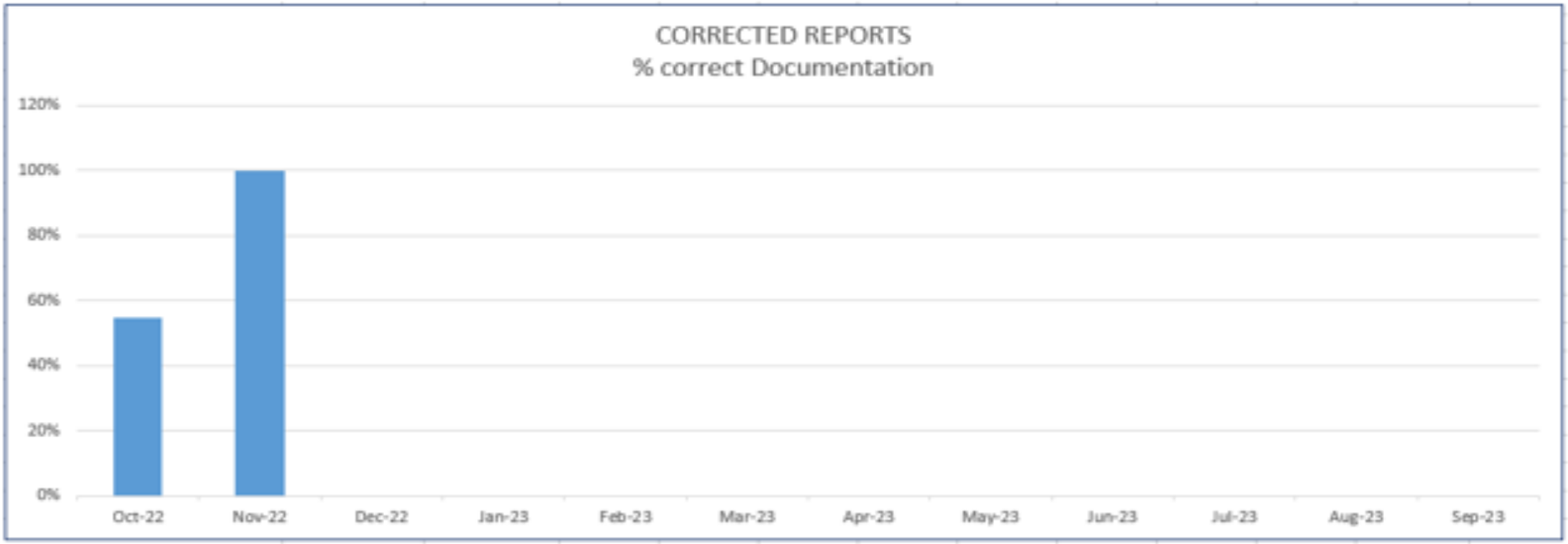
Yale NewHaven Health Bridgeport Hospital

Aspect of Care



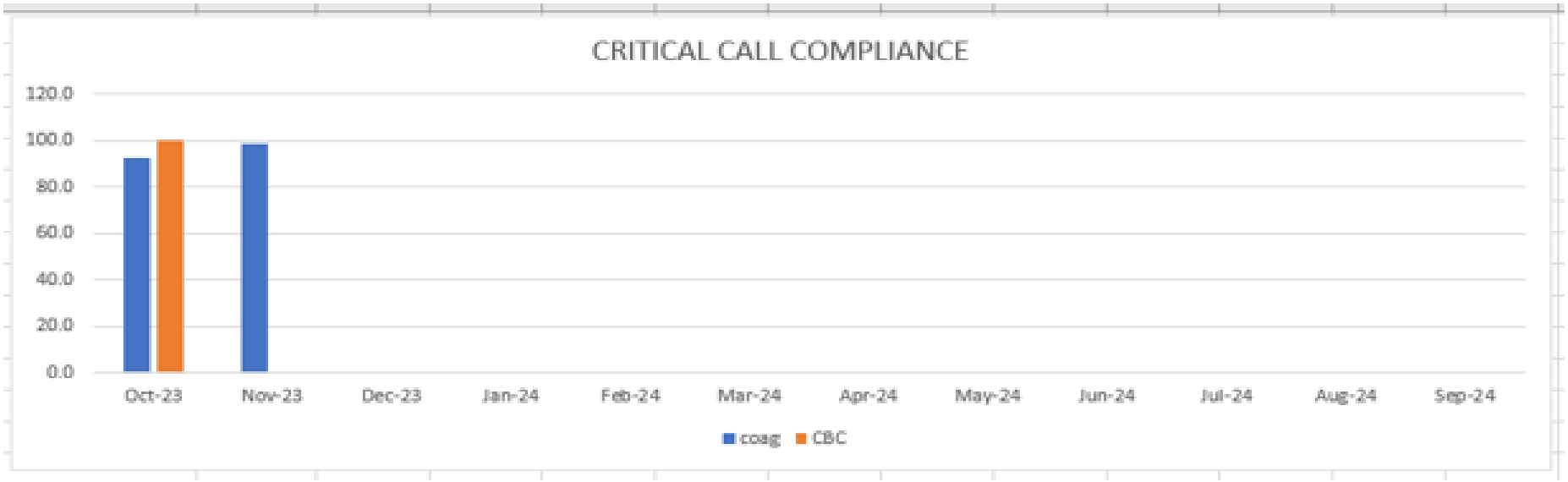
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total # of Fluids	160	138										
cytology ordered	69	62										
# of fluid diffs that did not correlate	3	0										
# of fluids correlated	66	62										
Threshold achieved	96%	100%										
Expected	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Action/ Outcome	Dr. Minerowicz reviewed. One slide with suspicious cells.											

Aspect of Care



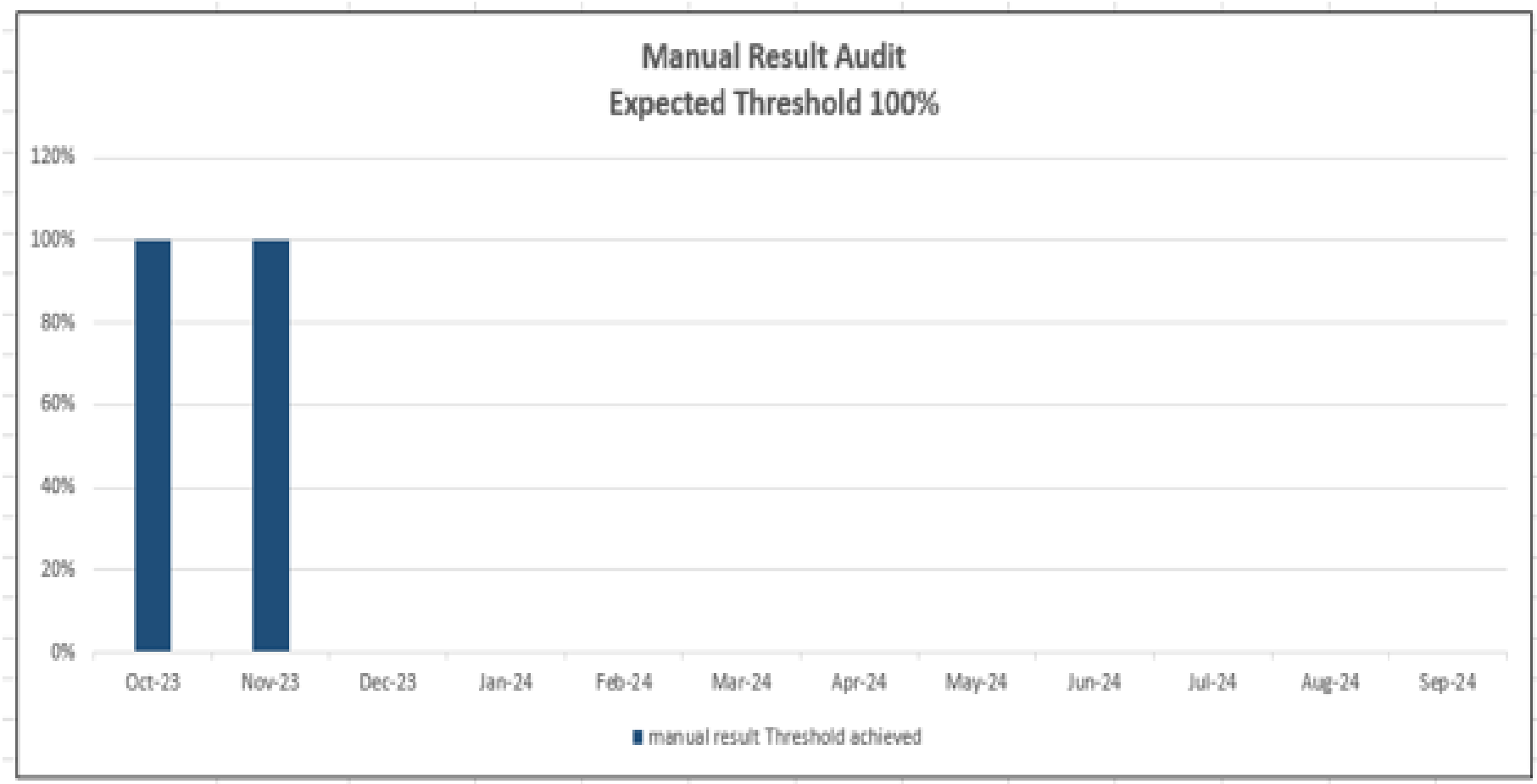
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
corrected appended results	11	10										
incorrect documentation	5	0										
correct documetation	6	10										
% correct	55%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Target	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



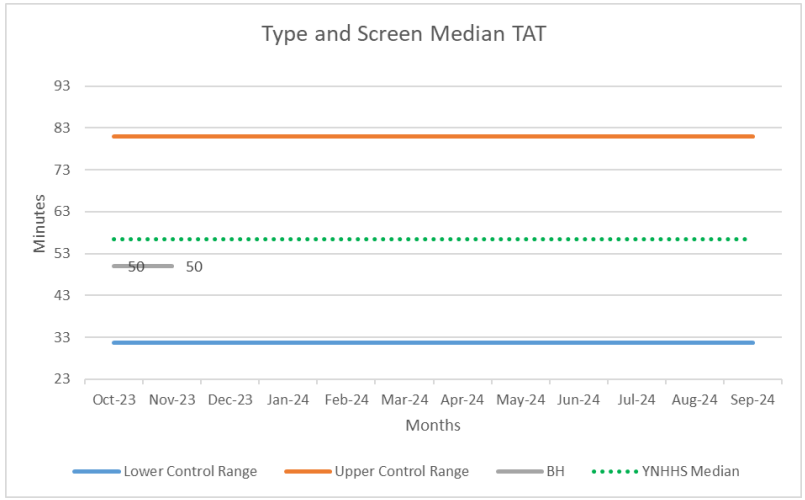
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total Calls	138	564										
compliant	128	558										
CBC Critical audit	20											
compliant	20											
% compliant	92.8	98.9	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
CBC	100											
	2-no credentials. 8-improper comm log.	1 improper documnetation. 1 no call(previous critical but we call all PTT. 4 improper comm log										

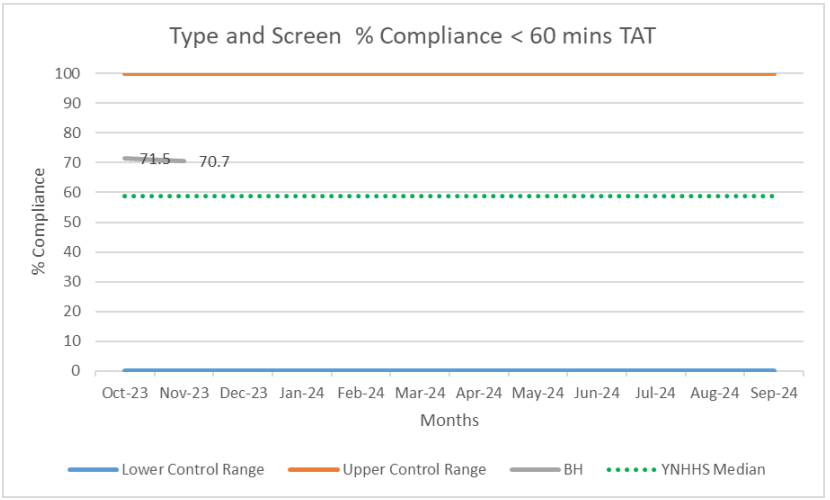
Aspect of Care

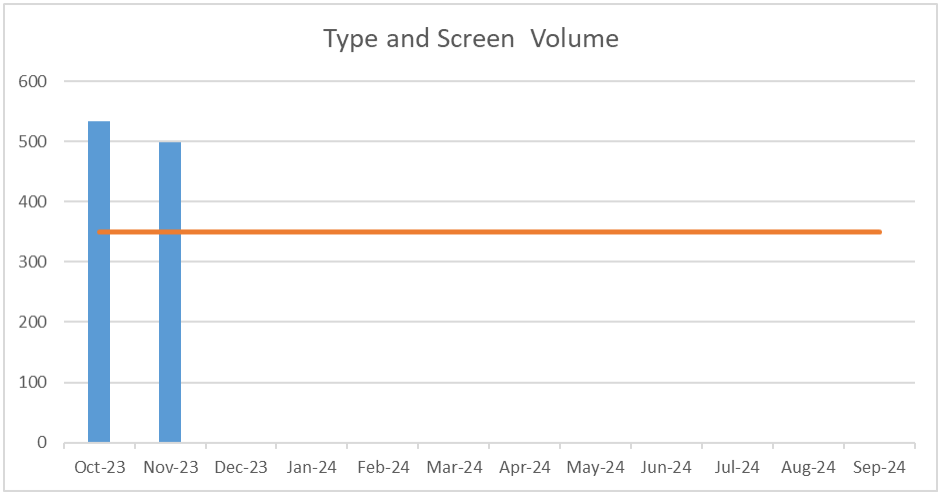


Sample size = 30

Bridgeport Campus – Type and Screen ED TAT







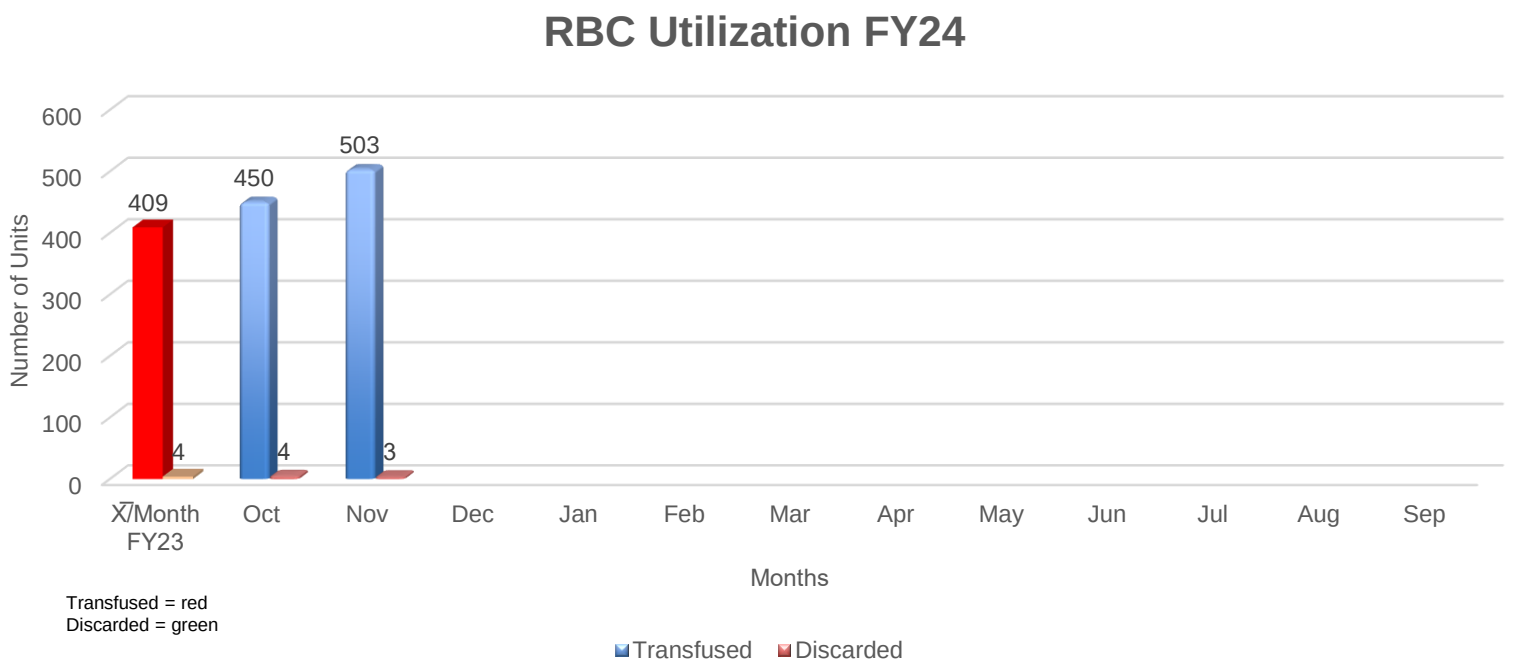
Yale NewHaven Health Bridgeport Hospital

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



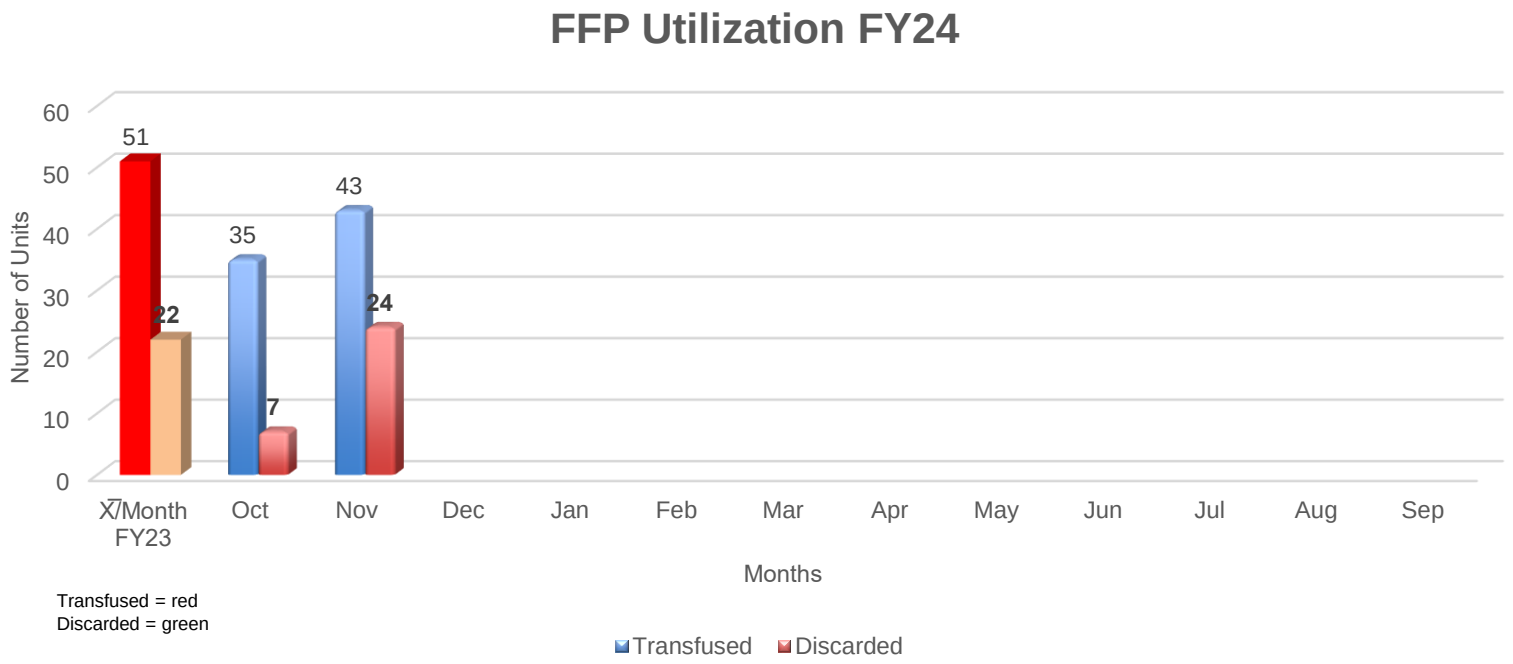
Bridgeport Hospital Blood Bank - FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfusion	**450**	**503**												**953**	**$253,021.50**
Discarded	**4**	**3**												**7**	**$1,062.00**
Expired	**0**	**1**												**1**	**$0.00**
Wasted	**4**	**2**												**6**	**$1,062.00**
Total	**454**	**506**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**960**	**$254,880.00**

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



Transfused = red
Discarded = green

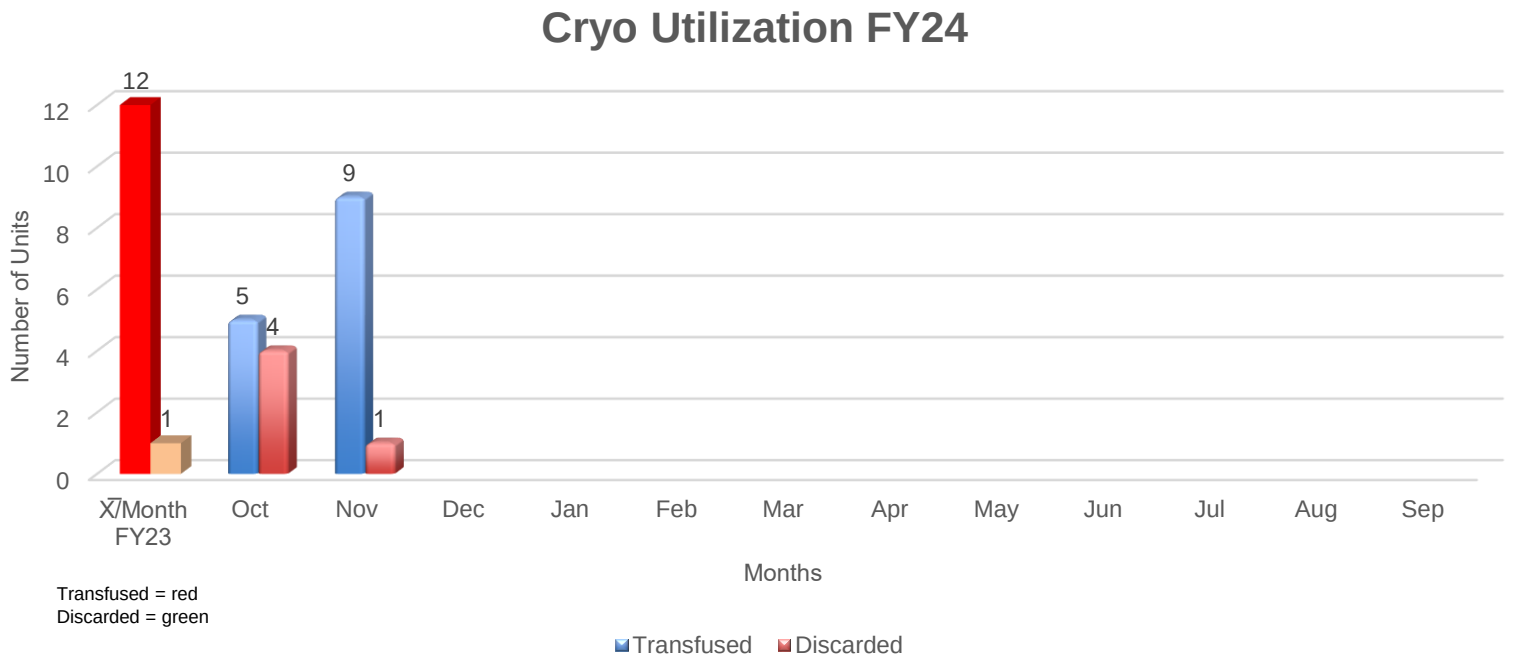
Bridgeport Hospital Blood Bank - FY24

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfusion	35	43												78	$3,033.42
Discarded	7	8												15	$583.35
Expired*	0	8												8	$311.12
Wasted**	7	0												7	$272.23
Total	42	51	0	0	0	0	0	0	0	0	0	0		93	$3,616.77

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



Transfused = red
Discarded = green

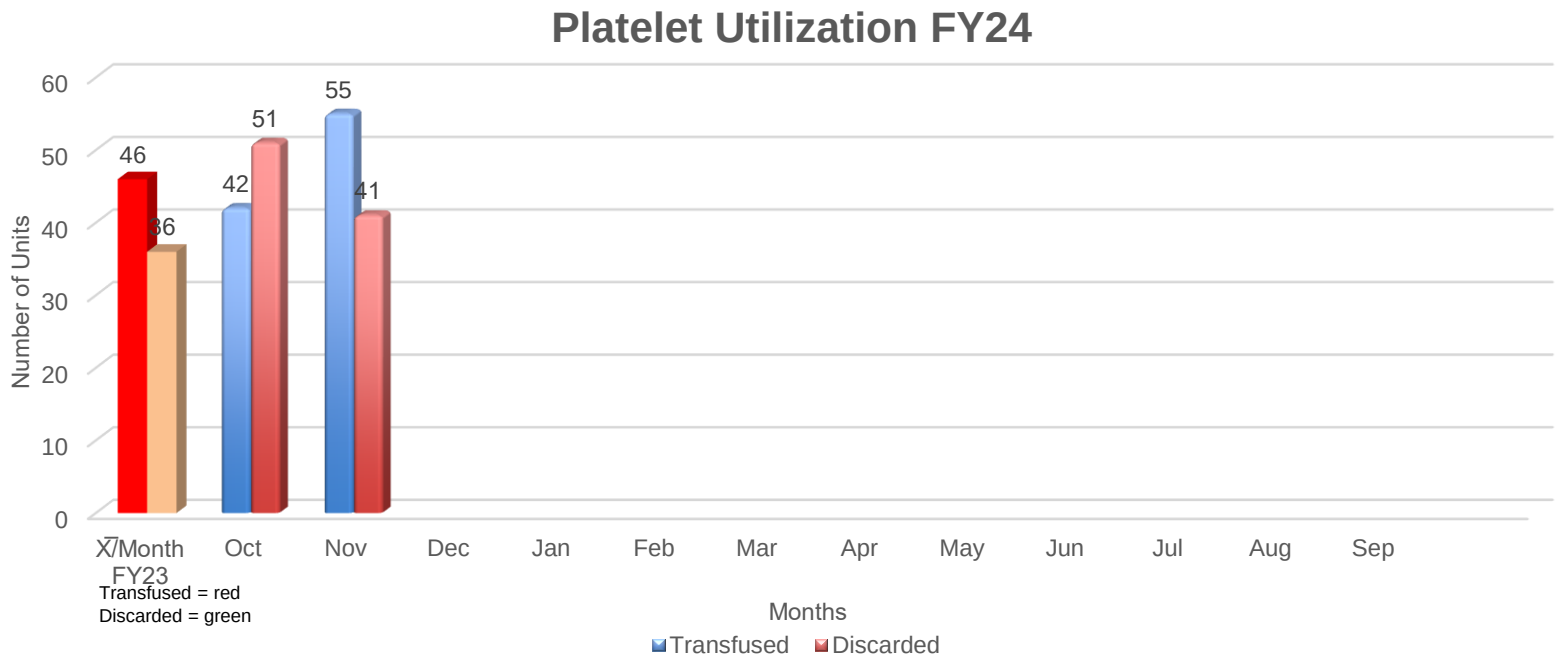
Bridgeport Hospital Blood Bank - FY24

Cryo

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfusion	5	9												14	$4,641.00
Discarded	4	1												5	$1,657.50
Expired	2	1												3	$994.50
Wasted	2	0											0±0	2	$663.00
Total	9	10												19	$6,298.50

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

BH Platelet Utilization

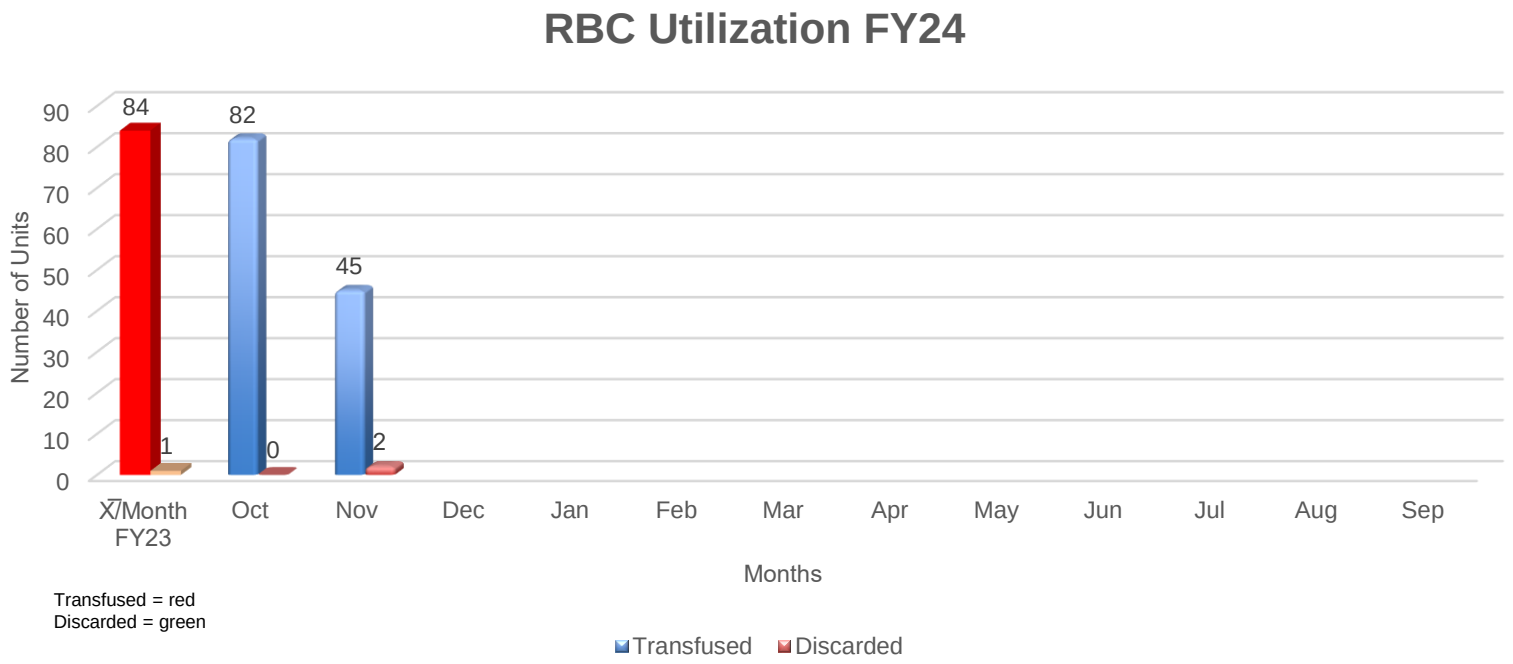
	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Mean ± SD	Total	Total Amount
Total	93	96	0	0	0	0	0	0	0	0	0	0		189	**$127,259.37**
Transfusion	42	55												97	**$65,313.01**
Discarded	51	41												92	**$61,946.36**
Expired	51	41												92	**$61,946.36**
Wasted	0	0												0	**$0.00**
% Discarded	55%	43%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
Discarded/Day	1.65	1.37	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1±0		**$261.31**

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**	0	0	0	0	0	0	0	0	0	0	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



Transfused = red
Discarded = green

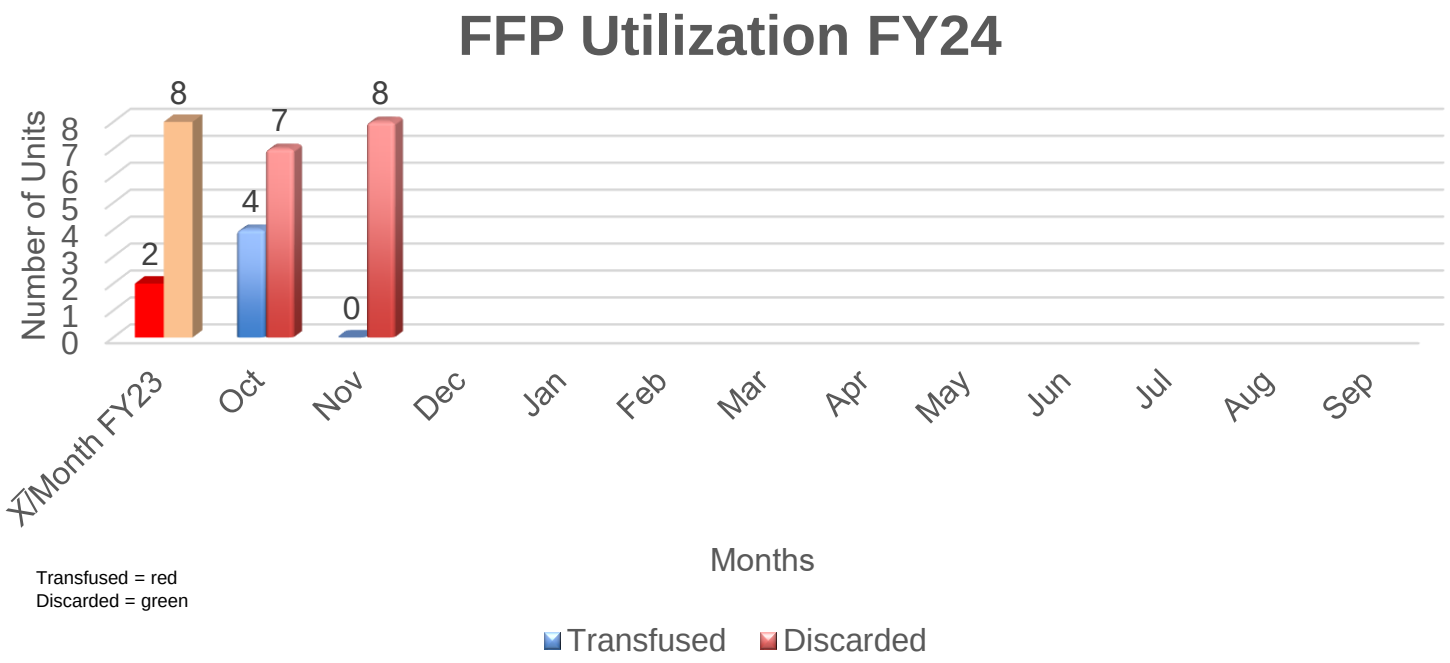
Milford Hospital Blood Bank FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfusion	**82**	**45**												**127**	**$33,718.50**
Discarded	**0**	**2**												**2**	**$531.00**
Expired	**0**	**1**												**1**	**$265.50**
Wasted	**0**	**1**												**1**	**$265.50**
Total	**82**	**47**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**129**	**$34,249.50**

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

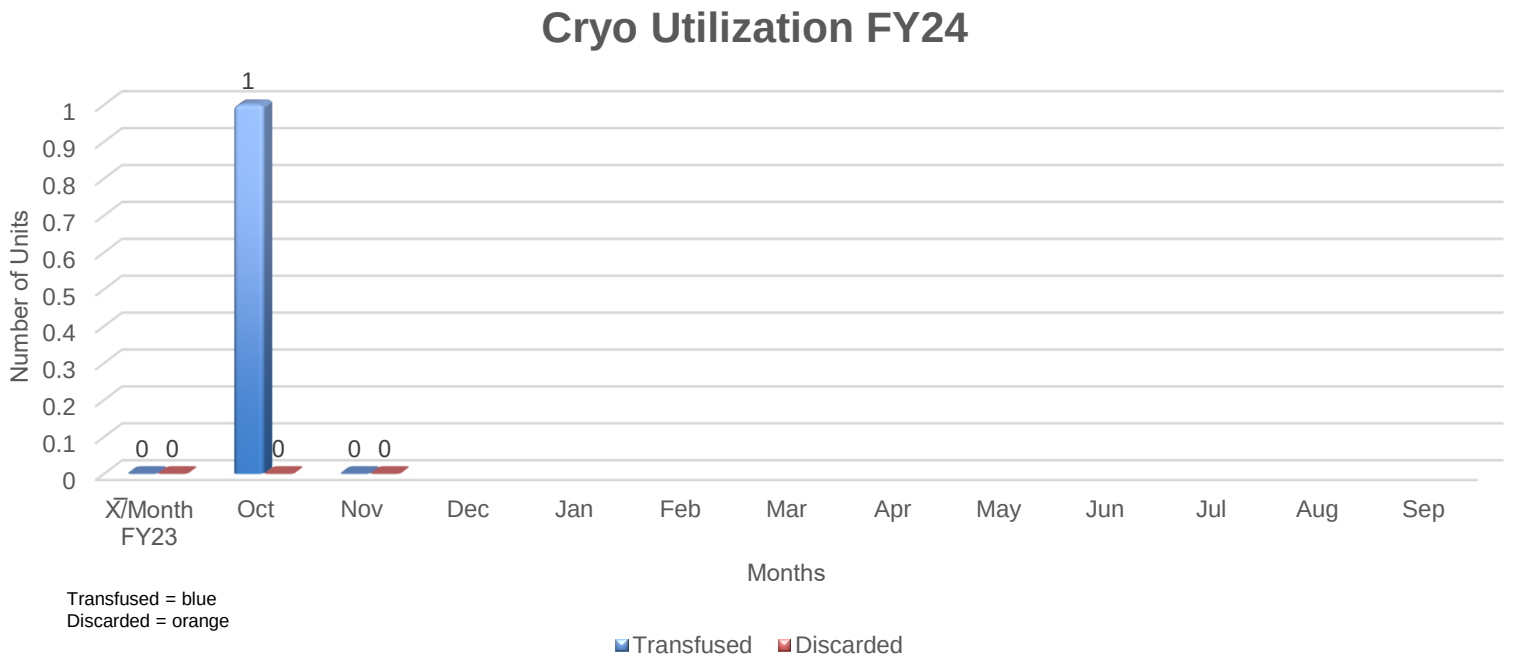
Milford Hospital Blood Bank FY24

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Transfusion	**4**	**0**											**2±2**	**4**	**$155.56**
Discarded	**7**	**8**											**8±10**	**15**	**$583.35**
Expired	**0**	**8**											**0±0**	**8**	**$311.12**
Wasted	**7**	**0**											**8±10**	**7**	**$272.23**
Total	**11**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10±9**	**19**	**$738.91**

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 = blue
Discarded = orange

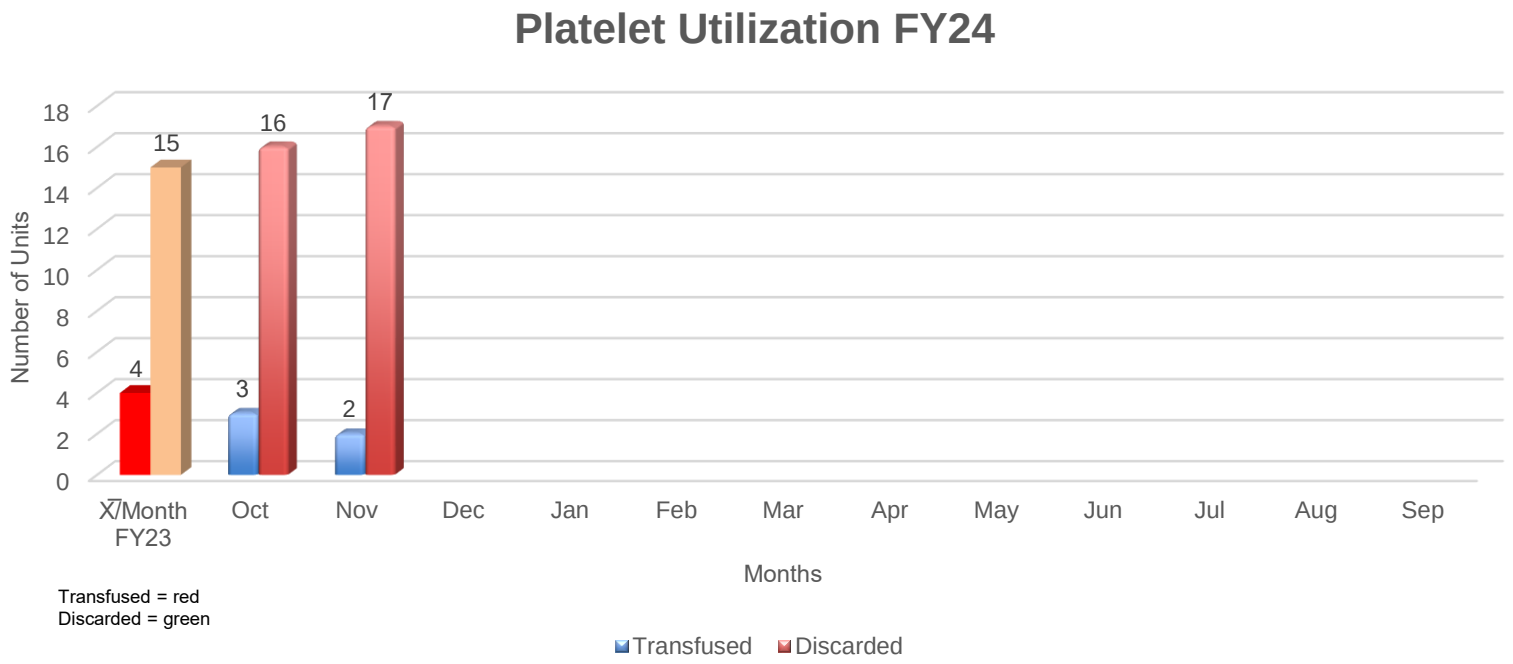
Milford Hospital Blood Bank FY24

Cryo Utilization

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



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	19	0	0	0	0	0	0	0	0	0	0		38	$25,586.54
Transfusion	3	2												5	$3,366.65
Discarded	16	17												33	$22,219.89
Expired	16	17												33	$22,219.89
Wasted	0	0												0	$0.00
% Discarded	84.21%	89.47%	#DIV/0!	80%	85%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
Discarded/Day	0.5161	0.5484	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000			$716.77

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	2											2 LQC not performed on schedule. An additional instrument was added. Asked manager to remind staff to run the QC on all 3 instruments at the same time. All patient results were properly documneted.
Incorrectly documented Urine POC Pregnancy Internal QC	0 errors	7 Volume = 1442	7 Volume = 1309											sent emails to 7 staff and met with 2 repeat staff to review documentation.
# of i-STAT codes / # of cartridges run		17 / 459	29/393											1 staff had 10 codes - reviewed cartridge filling and handling with her. All codes were on 1 burn patient so instructed her to make sure an adequate sample is obtained before attempting to run it.
i-STAT Quality Check Codes	<5.0%	3.7%	7.4%											

Yale NewHaven Health

CRSQ Report Out

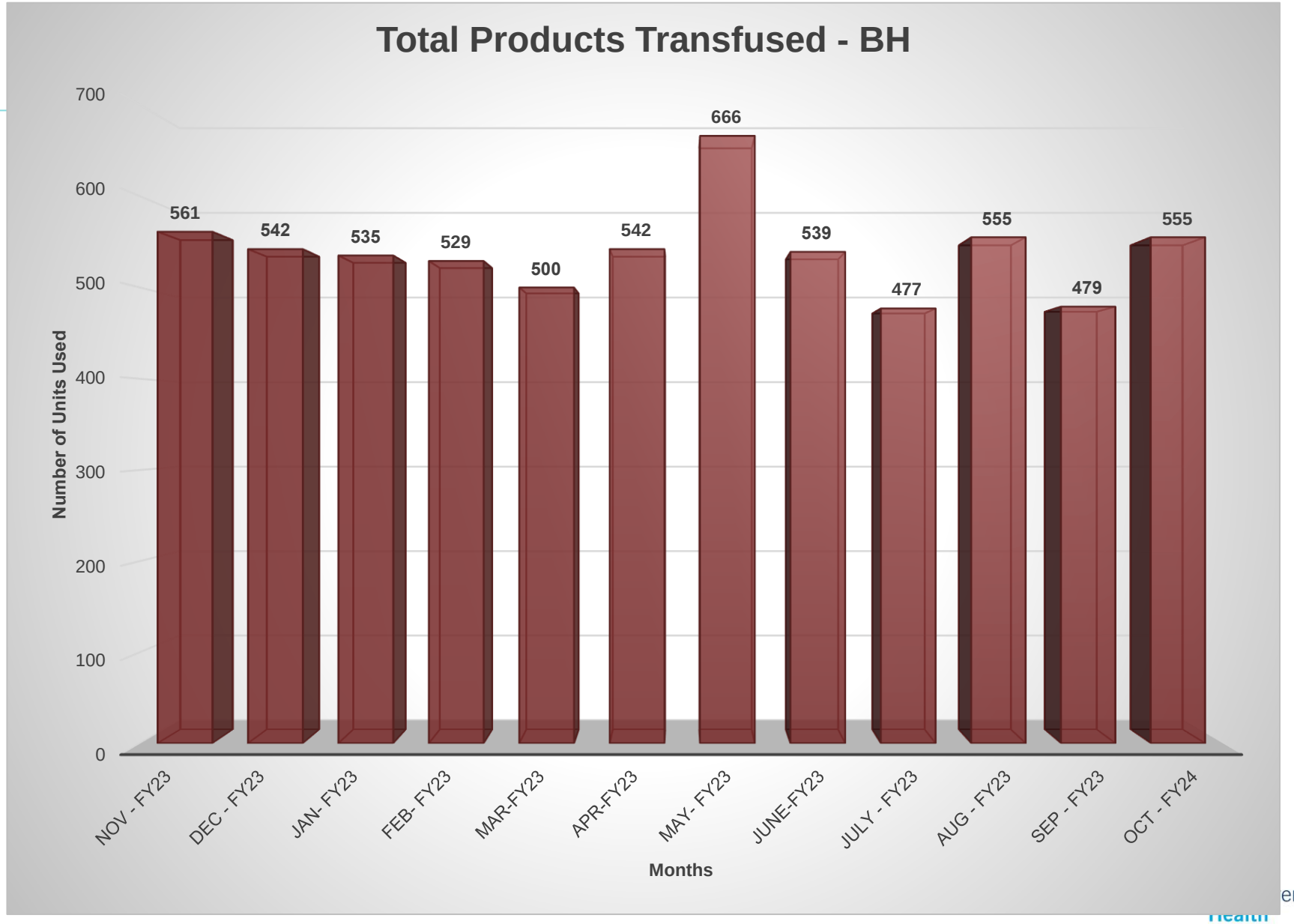
Committee of Regulatory, Safety, & Quality

10/06/2023

Bridgeport Hospital

Laboratory Blood Bank

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



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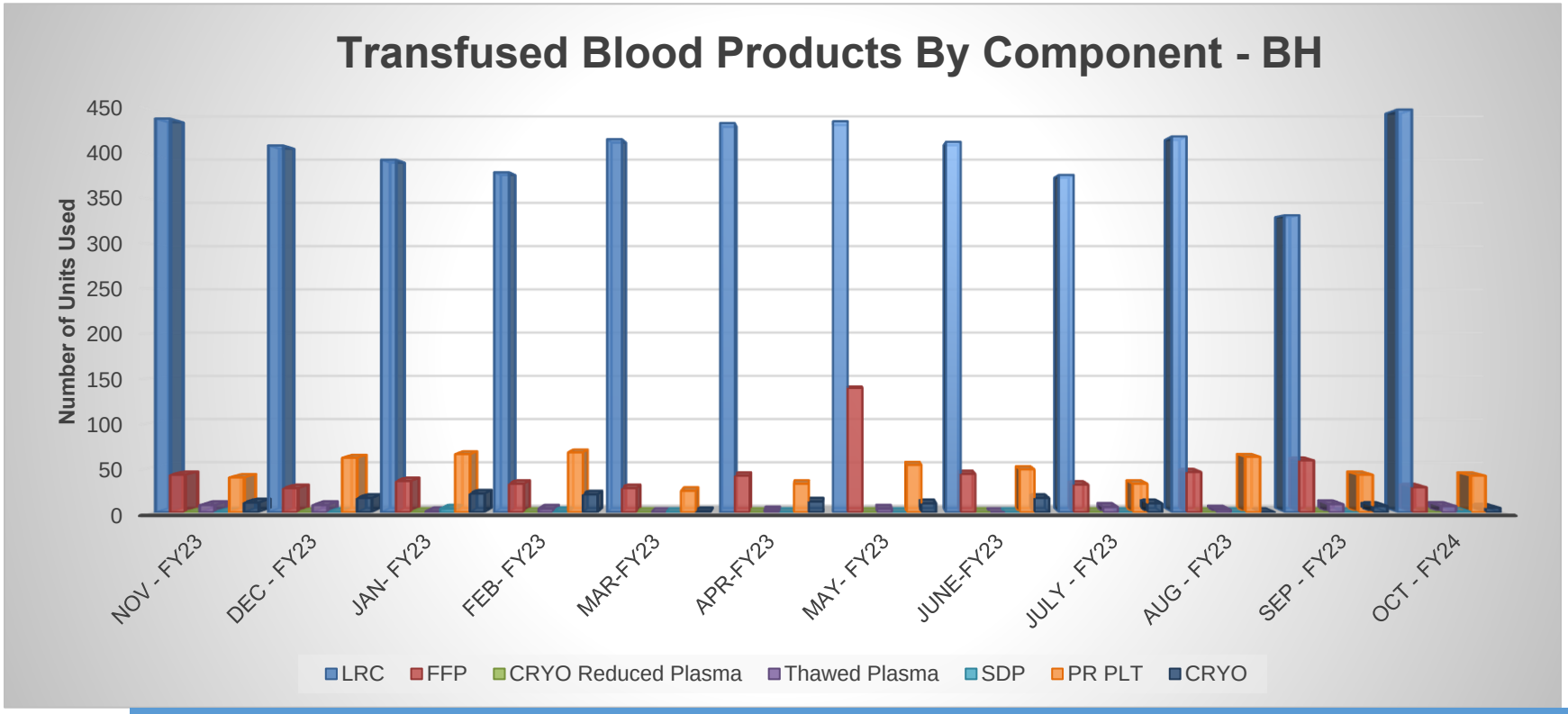
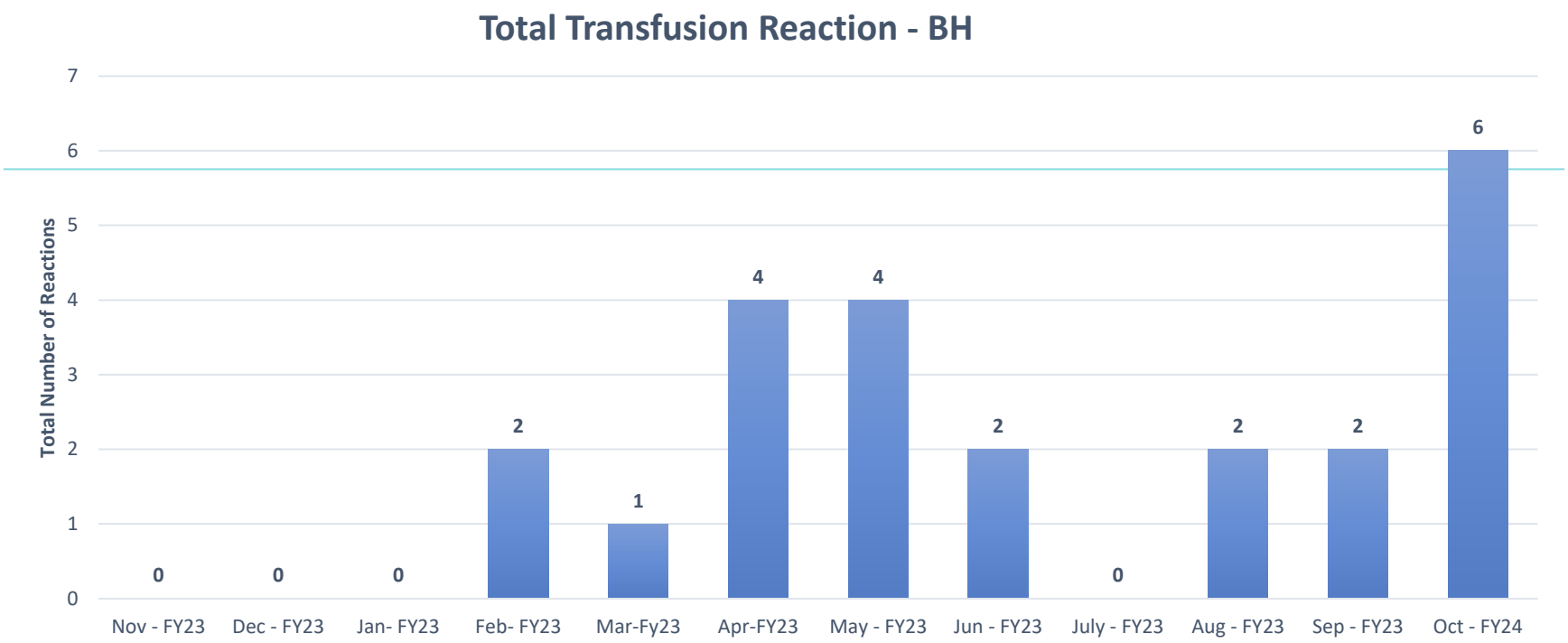


	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO	Total Products	Total Plasma	Total Platelets
Nov - FY23	440	42	0	8	0	39	11	561	50	39
Dec - FY23	410	27	0	8	0	61	16	542	35	61
Jan- FY23	394	35	0	1	4	65	21	535	36	65
feb- FY23	380	32	0	4	1	67	20			
Mar-FY23	417	27	0	0	0	24	1	500	27	24
Apr-FY23	435	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

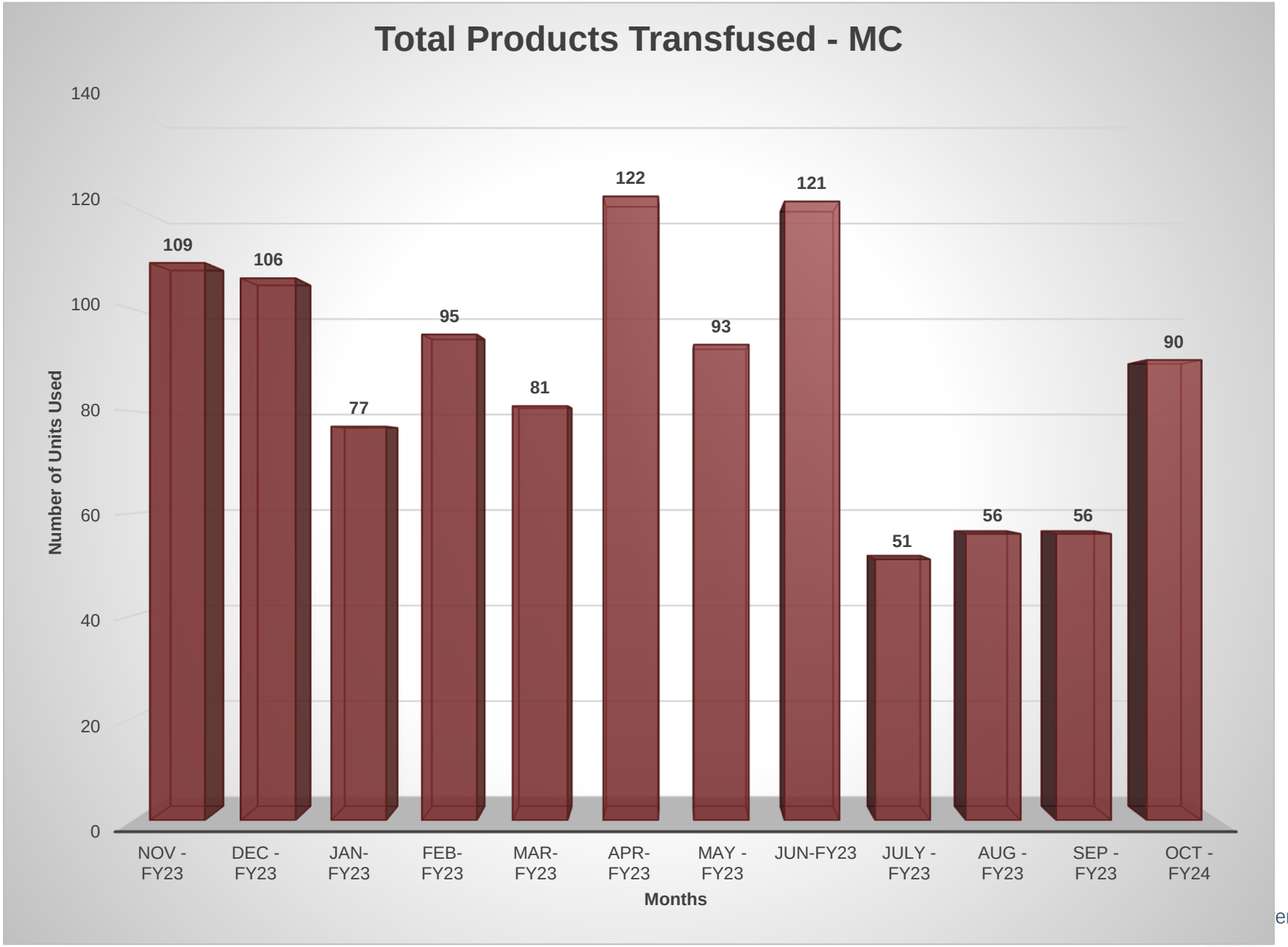
Yale NewHaven Health Bridgeport Hospital



	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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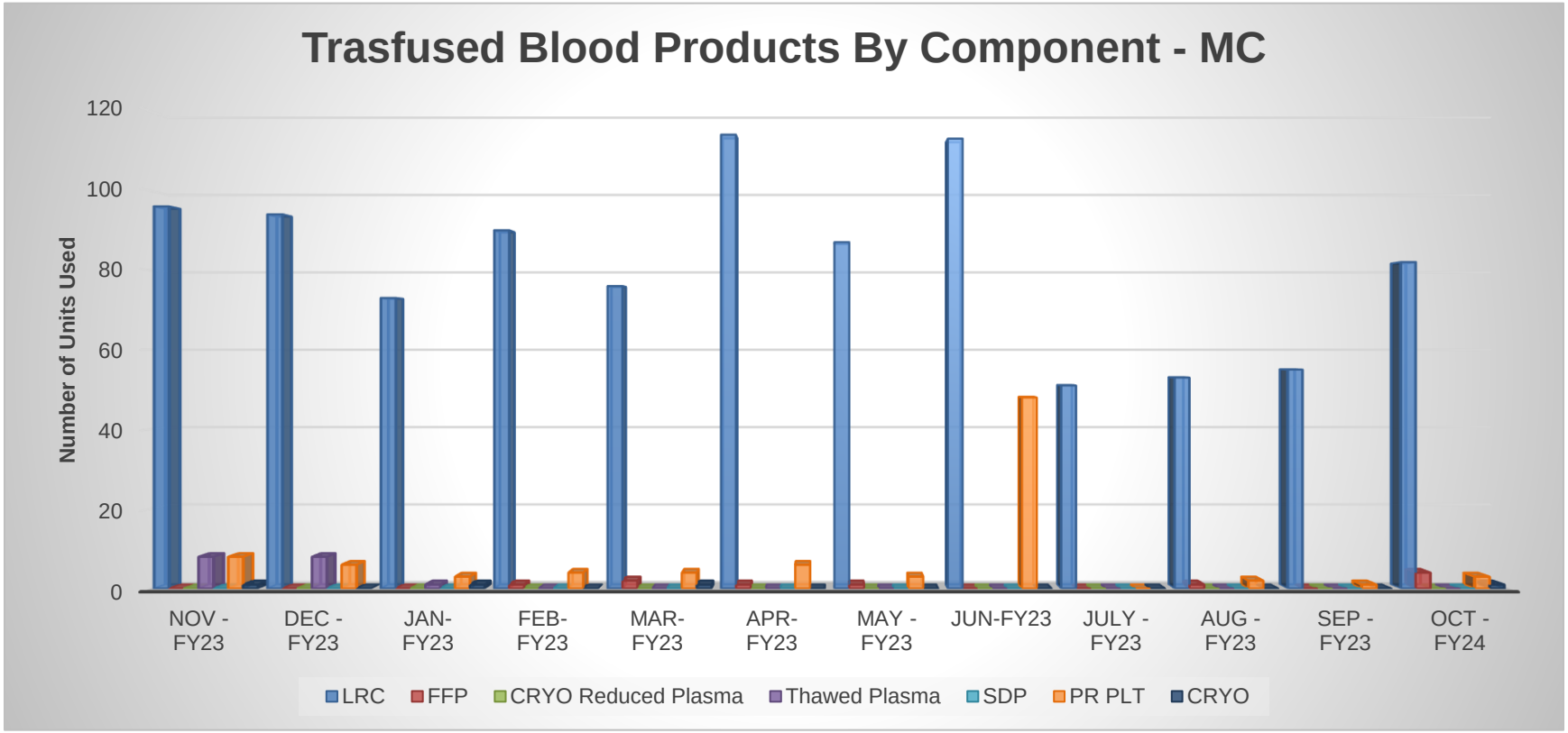
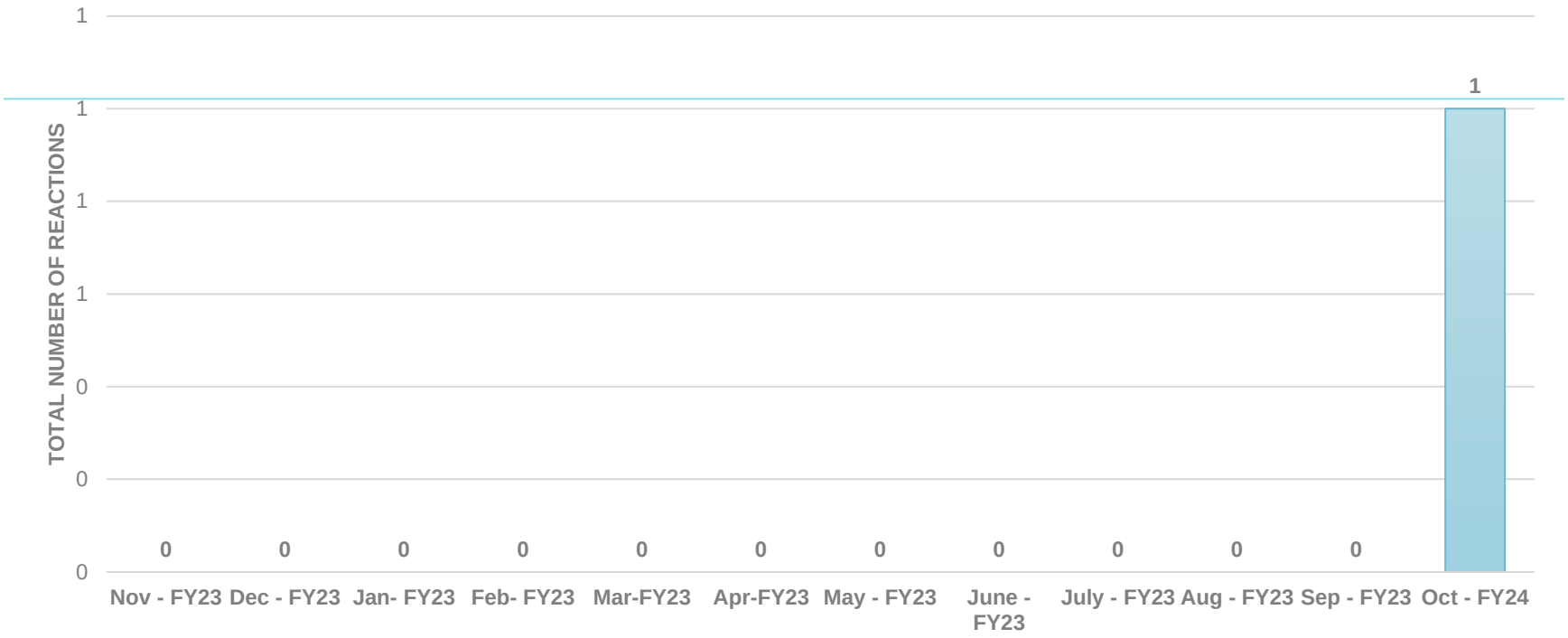


	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	SDP	PR PLT	CRYO	Total Products	Total Plasma	Total Platelets
Nov - FY23	96	0	0	8	0	8	1	109	4	8
Dec - FY23	94	0	0	8	0	6	0	106	6	6
Jan- FY23	73	0	0	1	0	3	1	77	0	3
Feb- FY23	90	1	0	0	0	4	0	95	1	4
Mar-FY23	76	2	0	0	0	4	1	81	0	4
Apr-FY23	114	1	0	0	0	6	0			
May - FY23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

November 2023

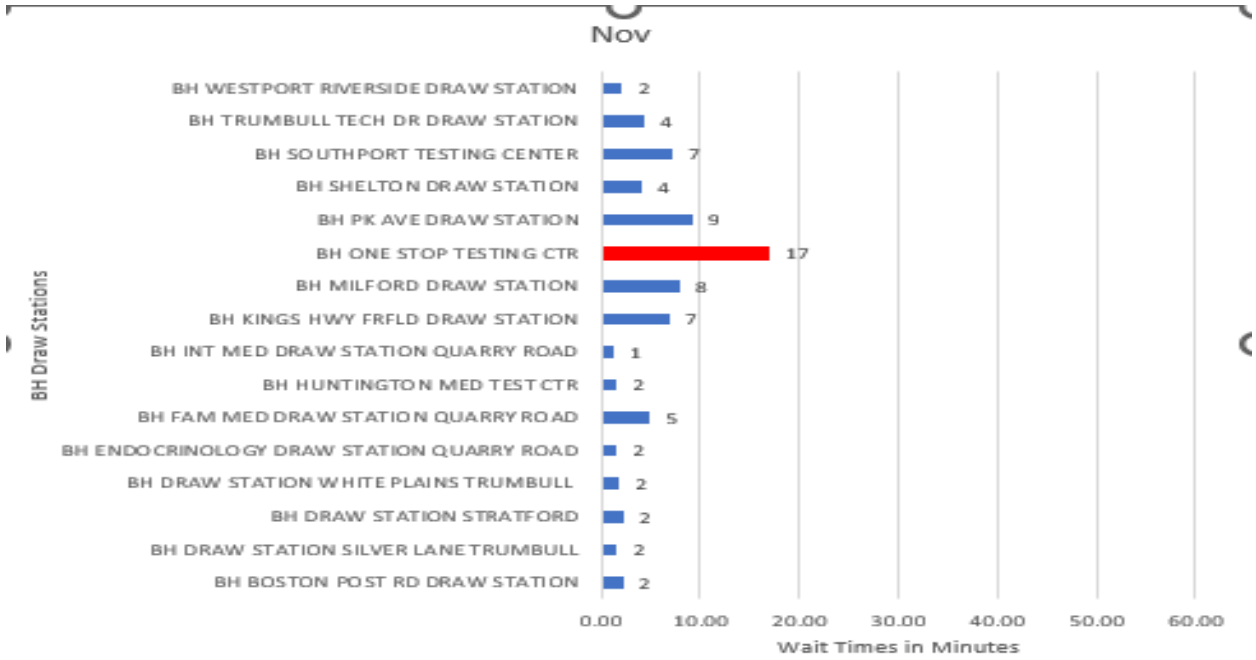
Average Wait Times

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.**

Summary:

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

November: Overall goal for the month was met. In November, BH draw stations averaged 5 minutes wait-time overall. All locations were able to maintain an average of 10 minutes wait-time. BH One Stop one of the busiest locations has a wait time of 17 minutes.



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

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.

November: Overall goal for the month was met. Across the BH locations 20 boxes of butterfly needles were ordered, 4 boxes less than the previous month resulting in a 10% butterfly usage rate.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Number of Butterfly Needles	1019	800	800	1000	800	600	1400	800	1100	1200	1000
Total Number of Patient Draws	9302	9223	10958	8888	9996	9910	9024	10056	9897	10601	10275
ALL DRAW STATIONS	11%	9%	7%	11%	8%	6%	16%	8%	11%	11%	10%

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:

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.

November: Overall goal for the month was met. Across all the BH draw stations the cancel/redraw rate is 3.0%.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
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%	1.9%
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%	2.7%
BH DRAW STATION STRATFORD	1.9%	1.7%	1.2%	3.2%	4.0%	2.1%	3.0%	0.0%	0.5%	1.2%	2.5%
BH DRAW STATION WHITE PLAINS TRUMBULL	1.0%	4.7%	2.0%	5.8%	4.8%	2.9%	1.5%	1.7%	2.3%	3.6%	4.3%
BH ENDOCRINOLOGY DRAW STATION QUARRY ROAD	2.6%	4.1%	3.9%	1.2%	7.7%	4.2%	0.6%	0.9%	1.5%	0.9%	0.8%
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%	4.9%
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%	2.4%
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%	4.4%	5.7%
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%	2.1%
BH MILFORD DRAW STATION	3.4%	3.8%	4.3%	3.9%	4.3%	1.6%	0.8%	0.2%	1.3%	1.1%	1.4%
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%	5.6%
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%	2.5%
BH SHELTON DRAW STATION	1.8%	2.4%	2.2%	4.2%	2.3%	3.4%	3.2%	2.9%	0.6%	2.6%	1.8%
BH SOUTHPORT TESTING CENTER	3.0%	4.4%	3.6%	2.5%	8.9%	0.8%	1.5%	1.0%	3.7%	0.3%	0.0%
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%	6.4%
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%	2.3%
ALL DRAW STATION AVERAGE	3.0%	4.1%	4.2%	5.1%	5.4%	5.0%	3.4%	2.7%	2.8%	2.2%	3.0%

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

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

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

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

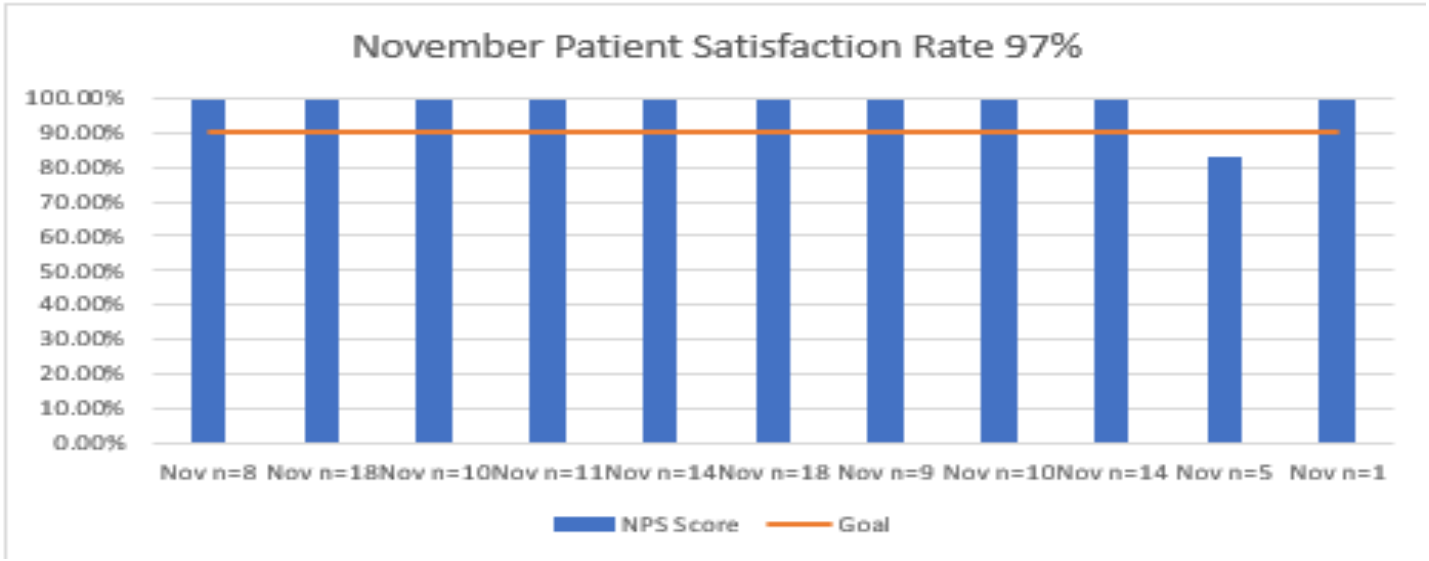
Patient Satisfactory Survey

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

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.

November: Overall goal for the month was met. Across BH draw station locations 97% 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.



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

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.

November: Overall goal for the month was met. For the month of November, the # of providers transcribed 104/104, sum of tests transcribed correctly 354/354 and # of requisitions scanned in EPIC 104/104.

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

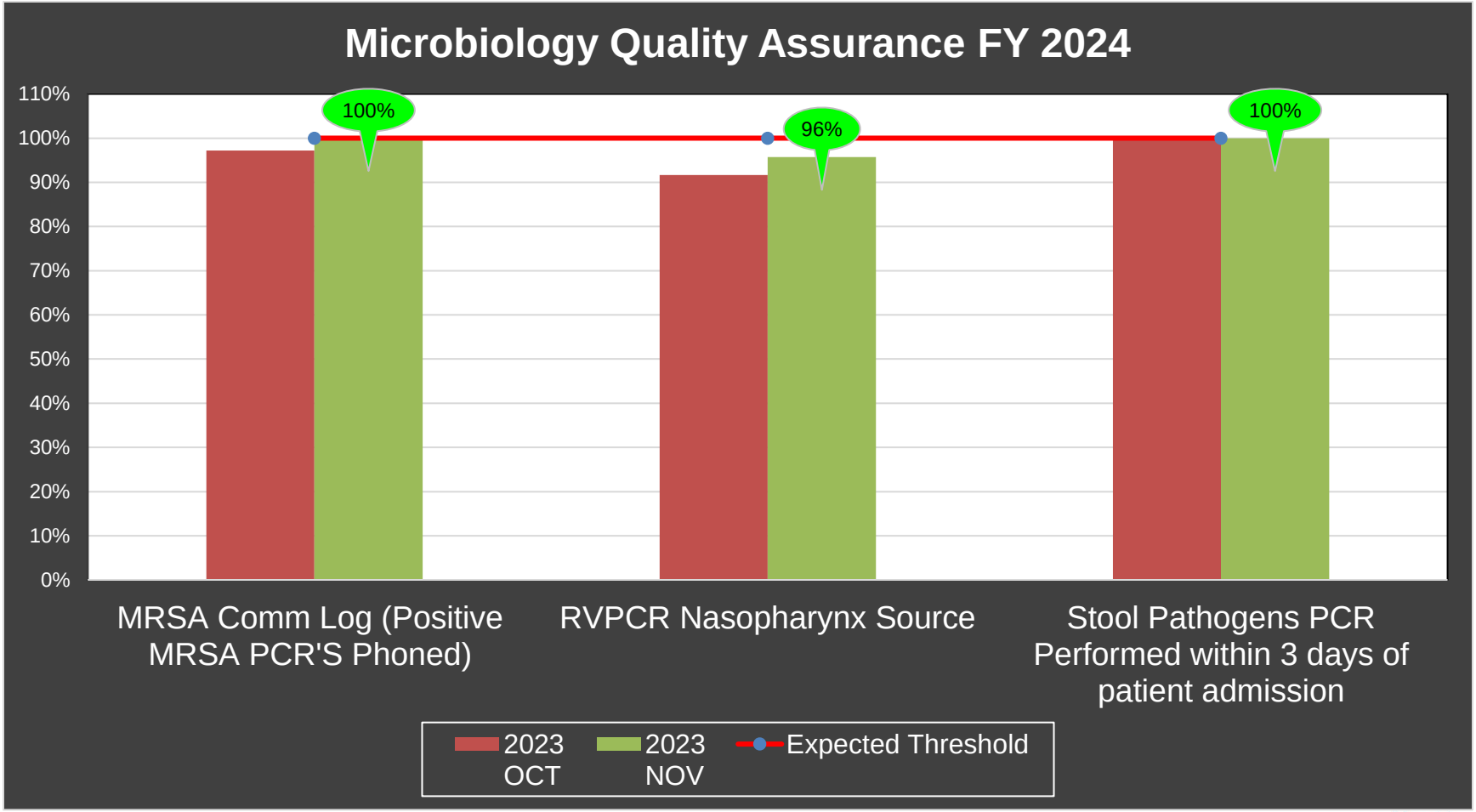
Yale NewHaven Health Bridgeport Hospital

FY 2024 QA

Microbiology and Central Processing

December 2023

Microbiology Quality Measures October 2023



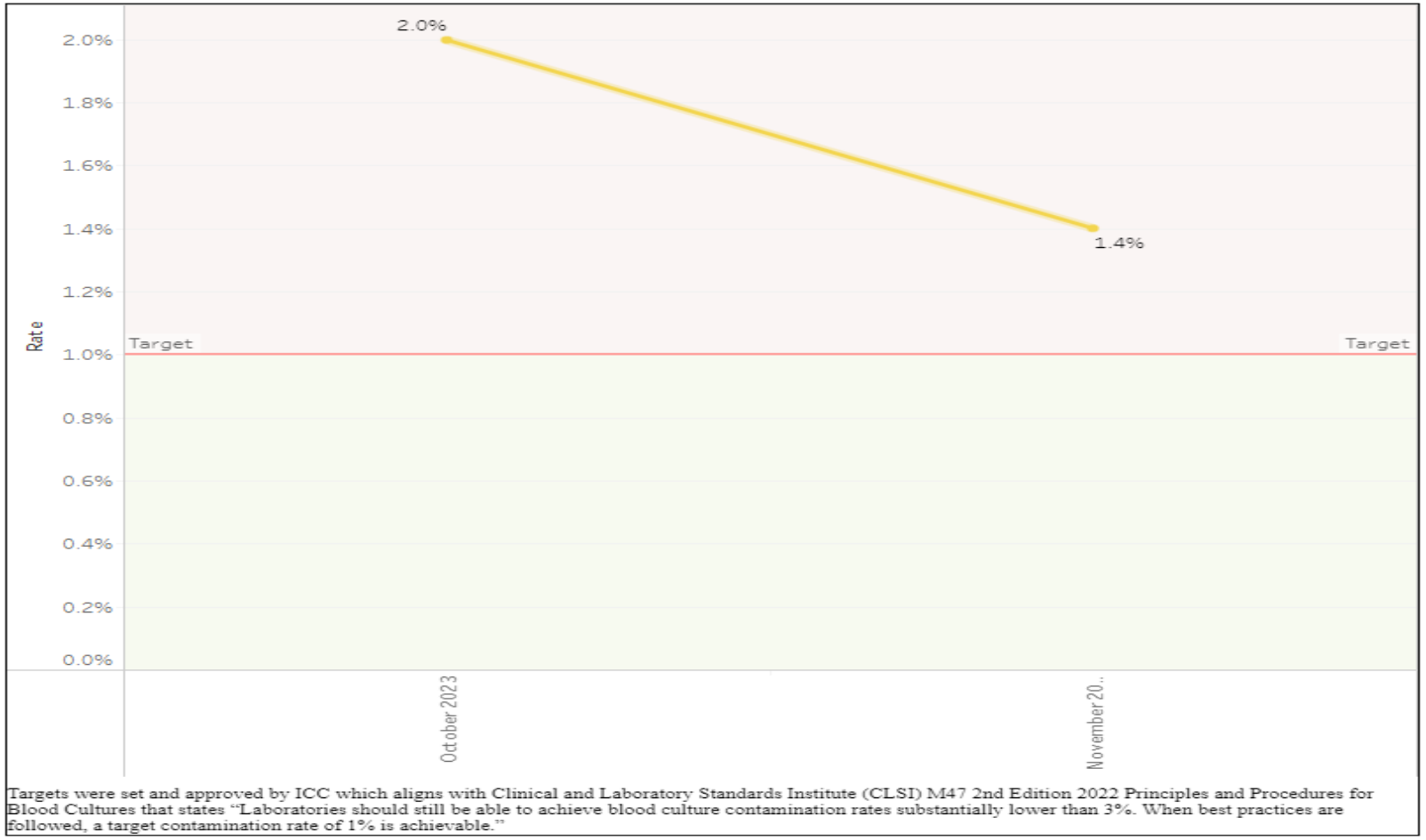
NewHaven Health Bridgeport Hospital

Microbiology Test Volumes

2023 Total Volume	October	November	December	January	February	March	April	May	June	July	August	Sept
MRSA	445	372										
MRSA Positive	36	52										
RVP	195	235										
Stool	138	126										
Stool Admitted	40	45										
Errors	0	1										

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

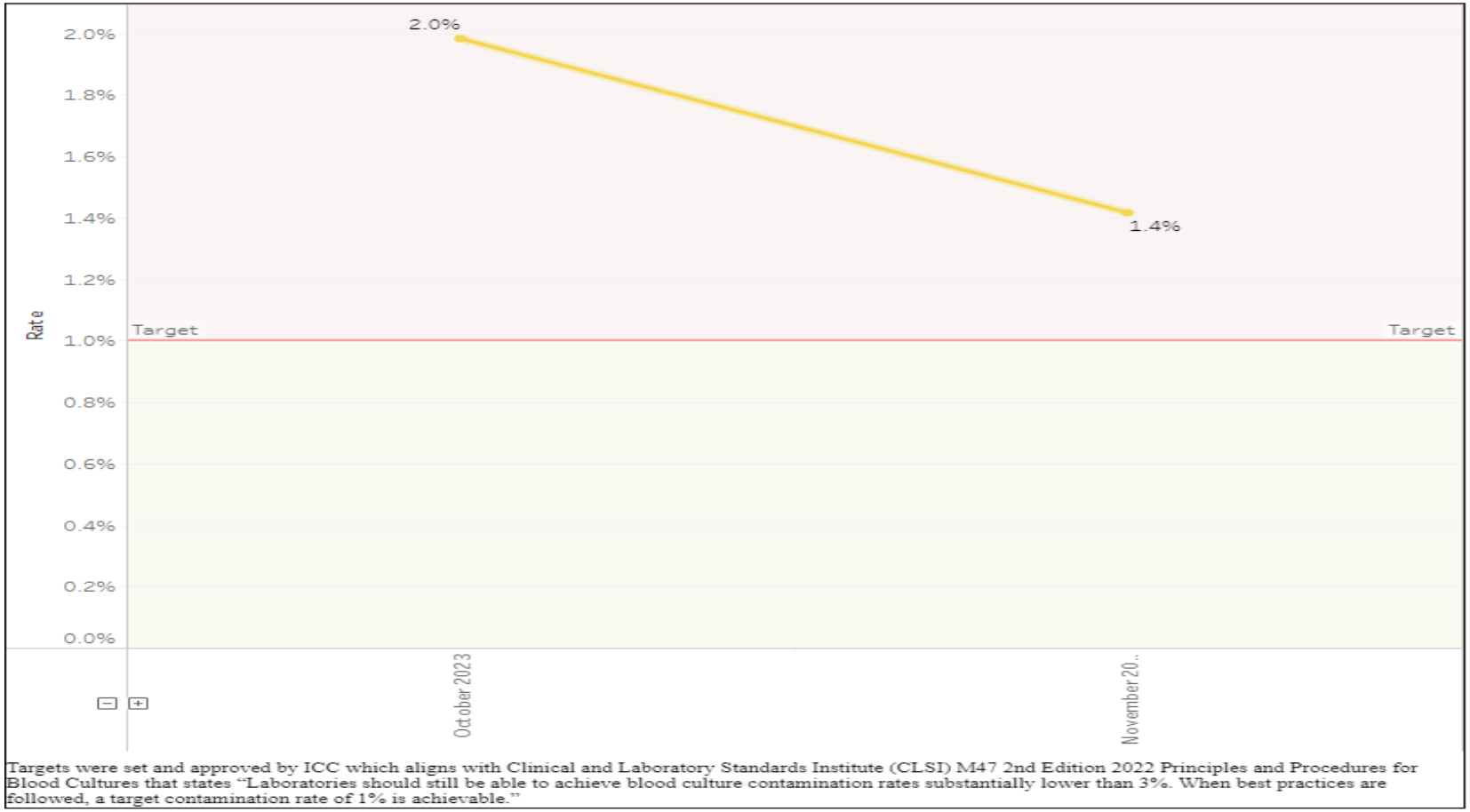
BH & MC Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	November ..	760	11	1.4%
		Inpatient	BH EAST TOWER 8	November ..	10	1	10.0%
			BH MED/CORONARY CARE ..	November ..	63	1	1.6%
			BH NORTHEAST 9	November ..	16	1	6.3%
			BH NORTHWEST 7	November ..	34	1	2.9%
			BH NORTHWEST 9	November ..	41	1	2.4%
	MC	Emergency ..	MC EMERGENCY DEPART..	November ..	305	5	1.6%
Grand Total					1,229	21	1.7%

Yale NewHaven Health Bridgeport Hospital

BH Blood Culture Contamination Rate



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Yale NewHaven Health Bridgeport Hospital

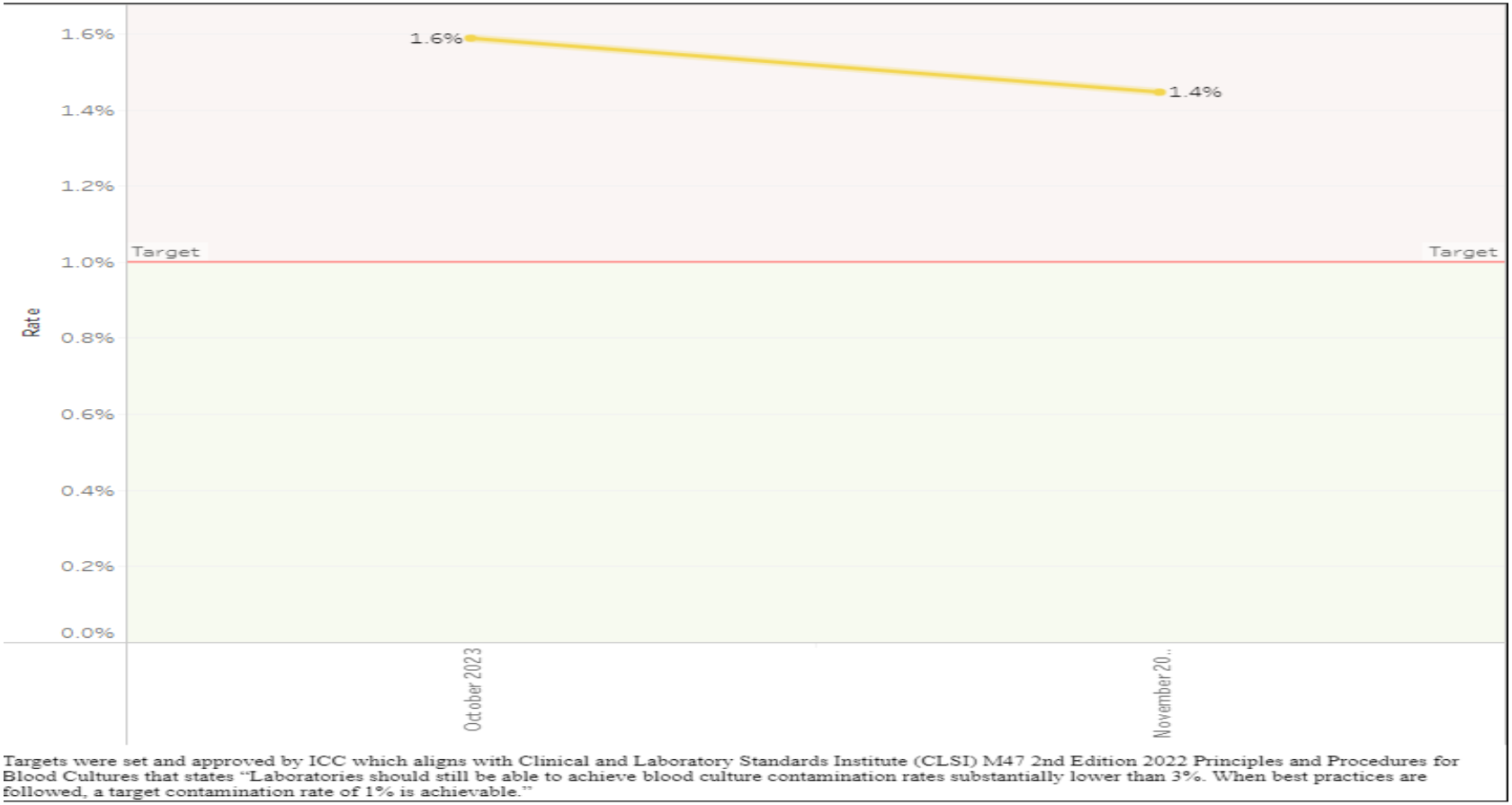
BH Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	November ..	760	11	1.4%
		Inpatient	BH EAST TOWER 8	November ..	10	1	10.0%
			BH MED/CORONARY CARE ..	November ..	63	1	1.6%
			BH NORTHEAST 9	November ..	16	1	6.3%
			BH NORTHWEST 7	November ..	34	1	2.9%
			BH NORTHWEST 9	November ..	41	1	2.4%
Grand Total					924	16	1.7%

Yale NewHaven Health Bridgeport Hospital

BH Blood Culture Contamination Rate(ED only)



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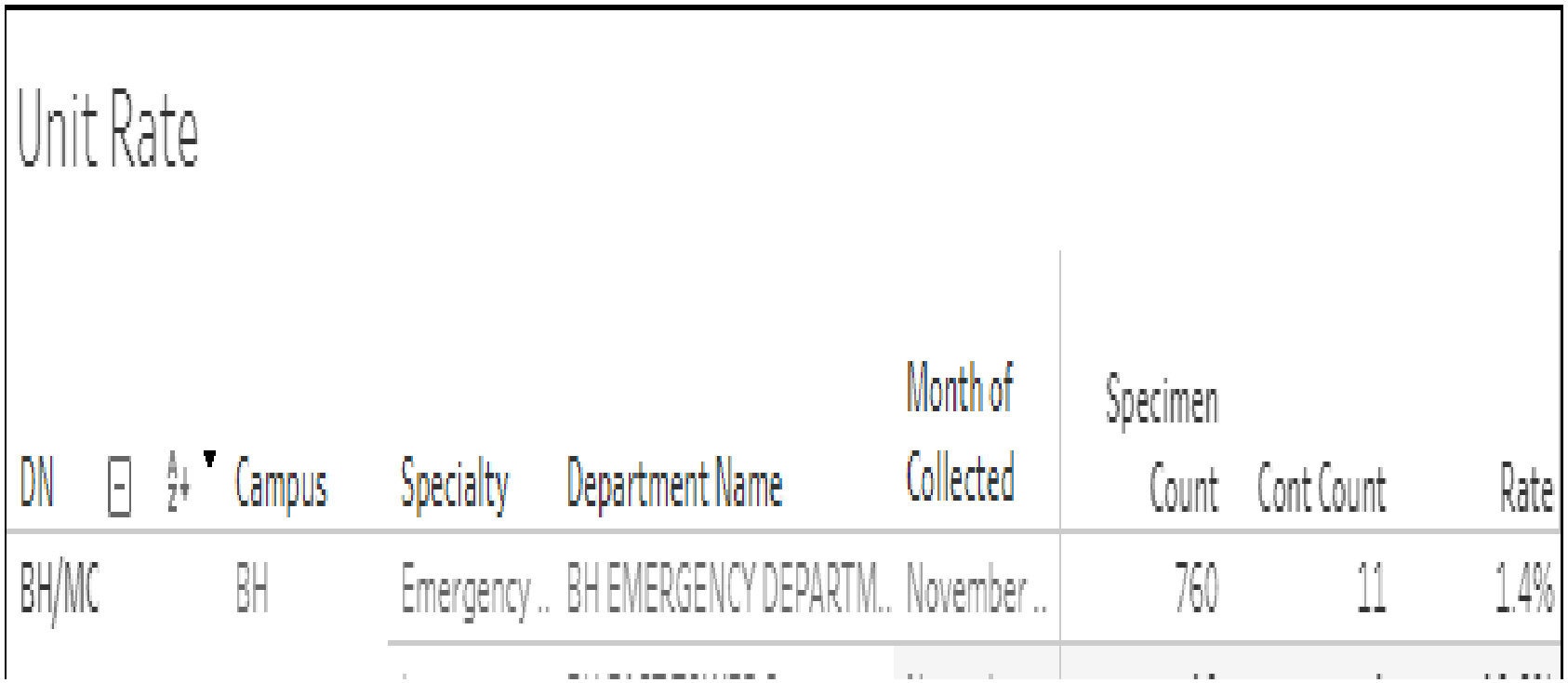
Yale NewHaven Health Bridgeport Hospital

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..	November ..	760	11	1.4%

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

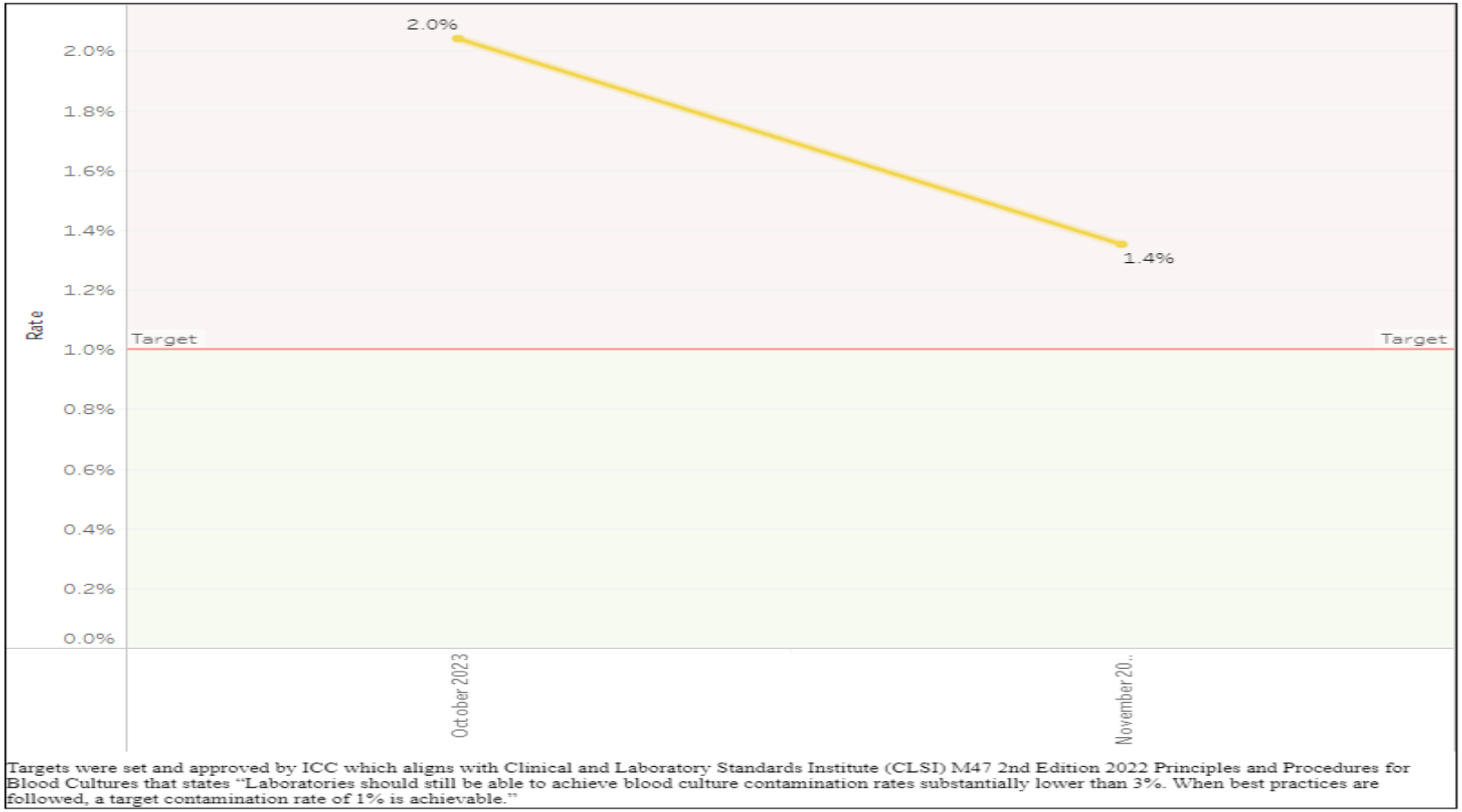
BH-All other units (excluding ED) Rate Breakdown

Unit Rate

DN	Campus	Speci⊟:y	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	November ..	760	11	1.4%
		Inpatient	BH EAST TOWER 8	November ..	10	1	10.0%
			BH MED/CORONARY CARE ..	November ..	63	1	1.6%
			BH NORTHEAST 9	November ..	16	1	6.3%
			BH NORTHWEST 7	November ..	34	1	2.9%
			BH NORTHWEST 9	November ..	41	1	2.4%
Grand Total					924	16	1.7%

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."

Yale NewHaven Health Bridgeport Hospital

MC Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	November ..

Specimen Count	370
Cont Count	5
Rate	1.4%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate(ED only)

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

Yale NewHaven Health Bridgeport Hospital

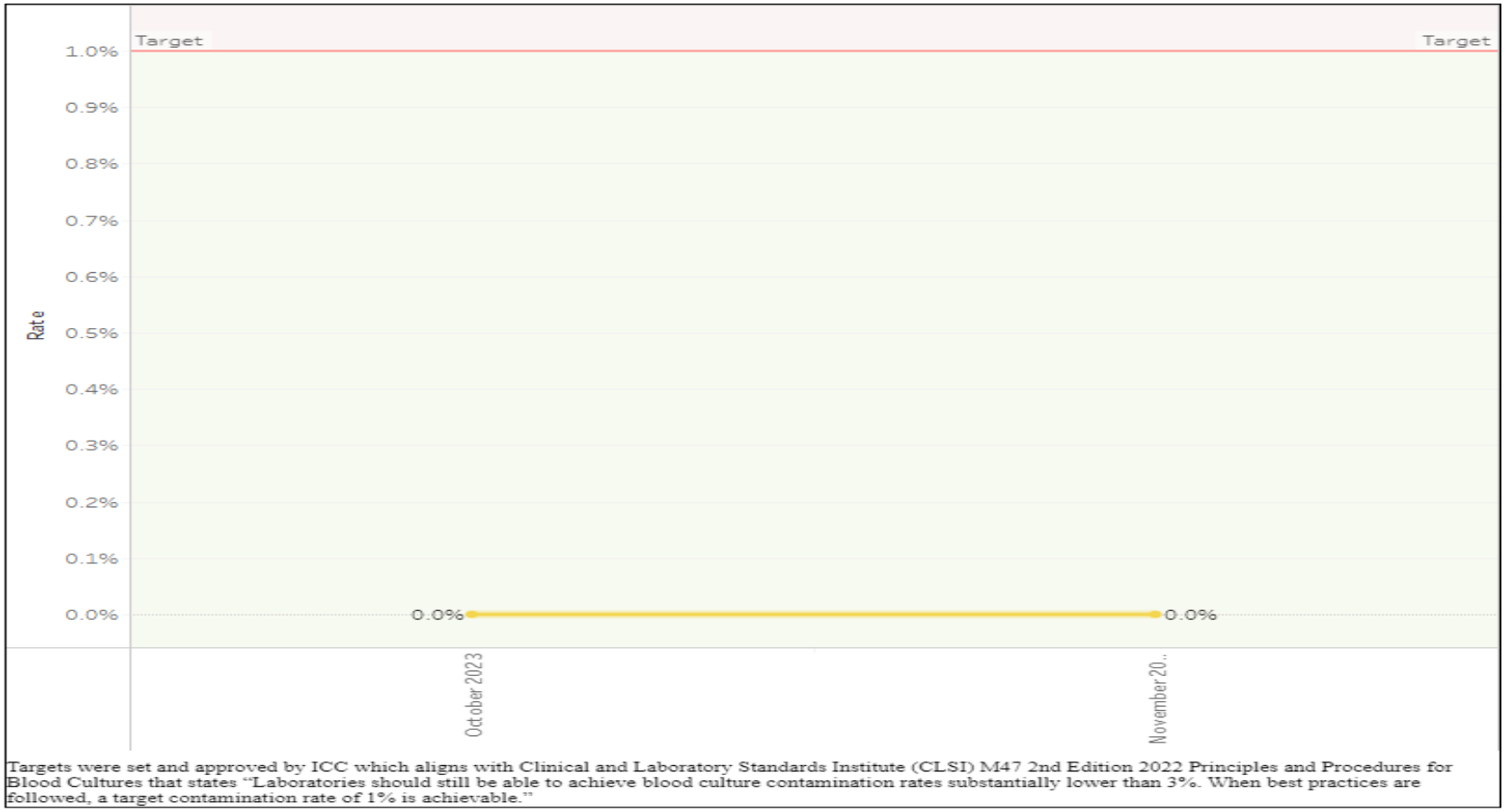
MC ED Unit Rate Breakdown

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	November ..	305	5	1.6%
Grand Total					305	5	1.6%

Yale NewHaven Health Bridgeport Hospital

MC Blood Culture Contamination Rate (excluding ED)



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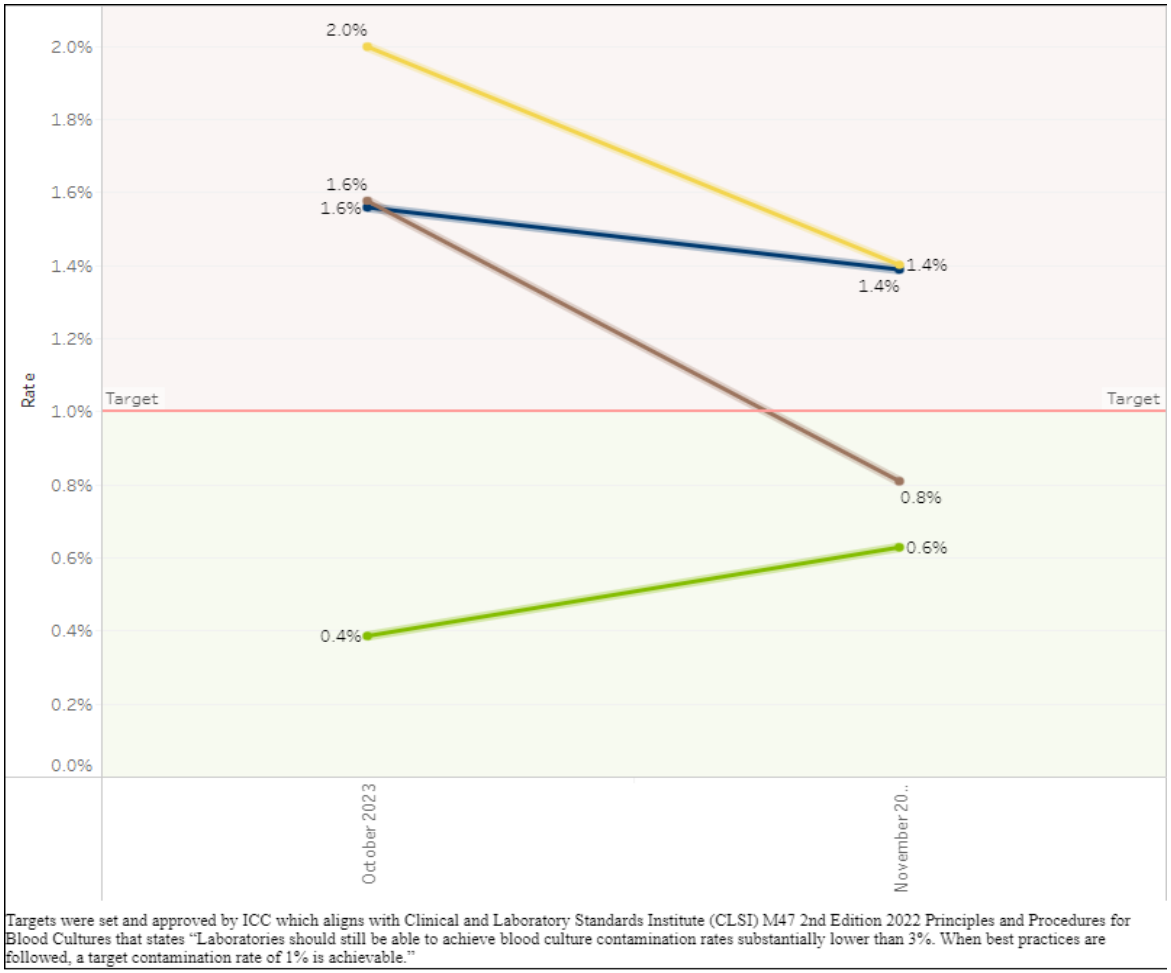
Yale NewHaven Health Bridgeport Hospital

Blood culture Contamination Rate DNs Comparison



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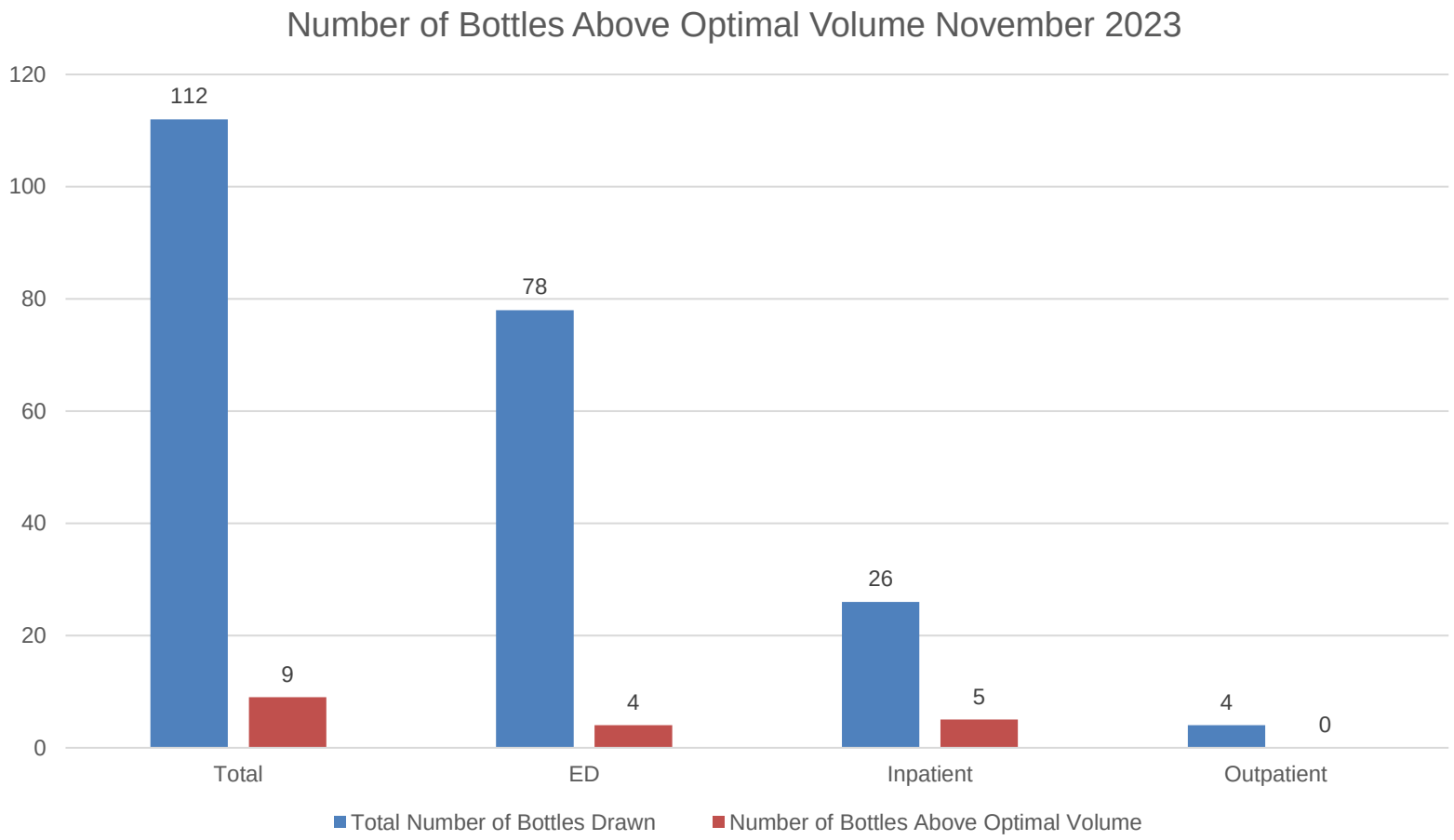
- BH/MC =1.4 %
- YNHH = 1.4%
- LMH/WH = 0.8%
- GH = 0.6 %

Yale NewHaven Health Bridgeport Hospital

Blood Culture Bottle Volumes – Above Optimal



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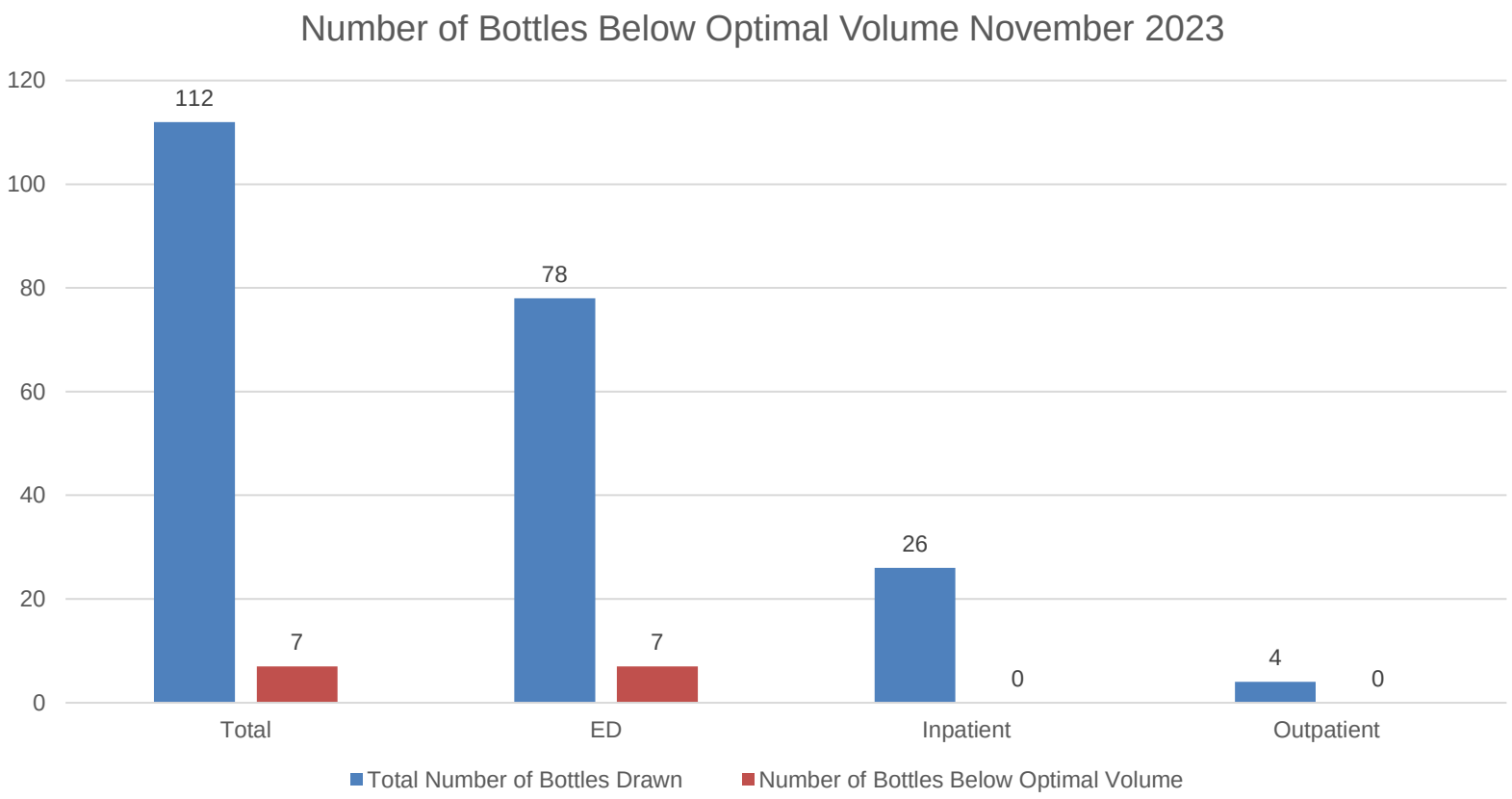
Blood Culture Bottle Volumes – Below Optimal



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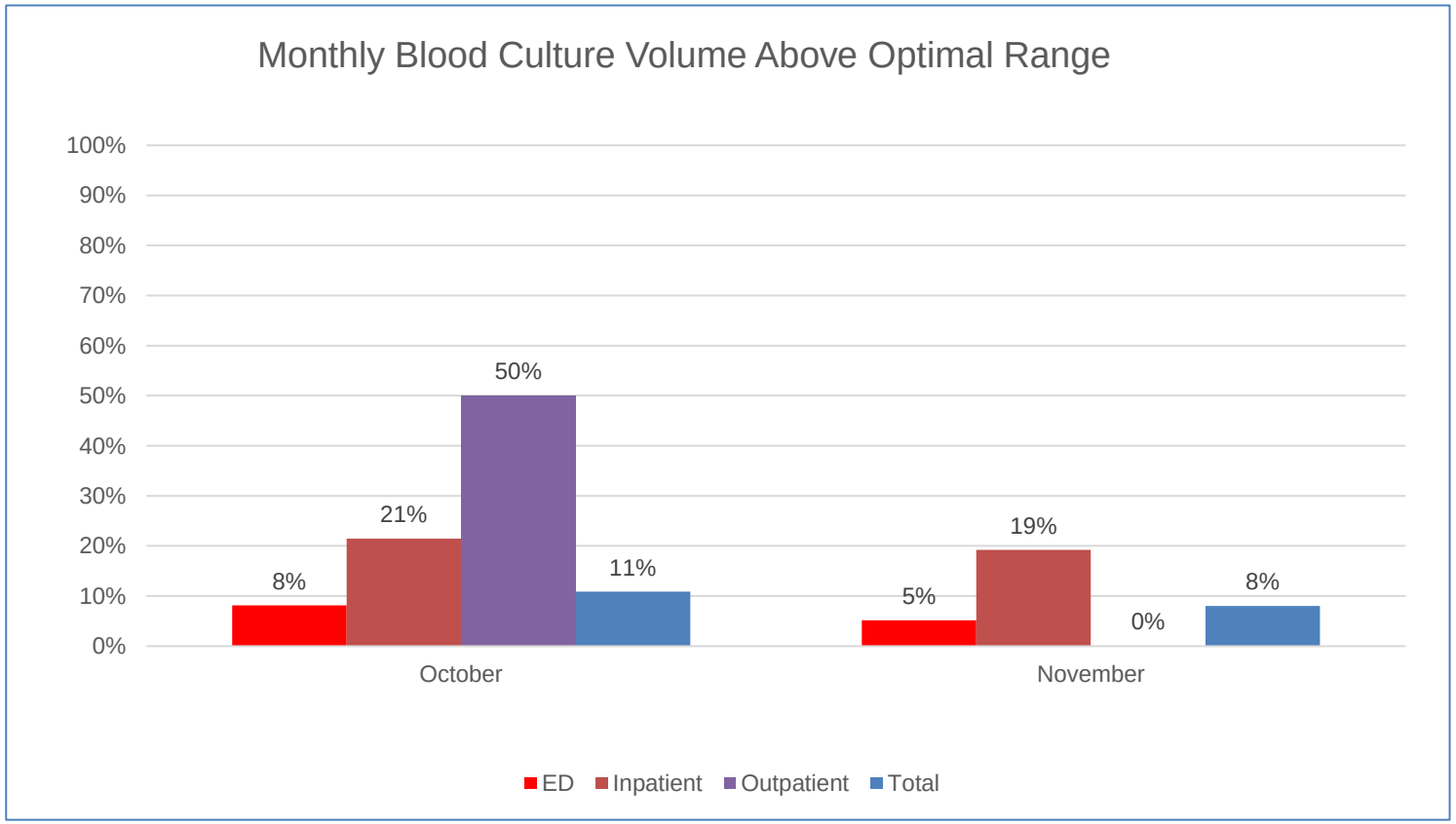
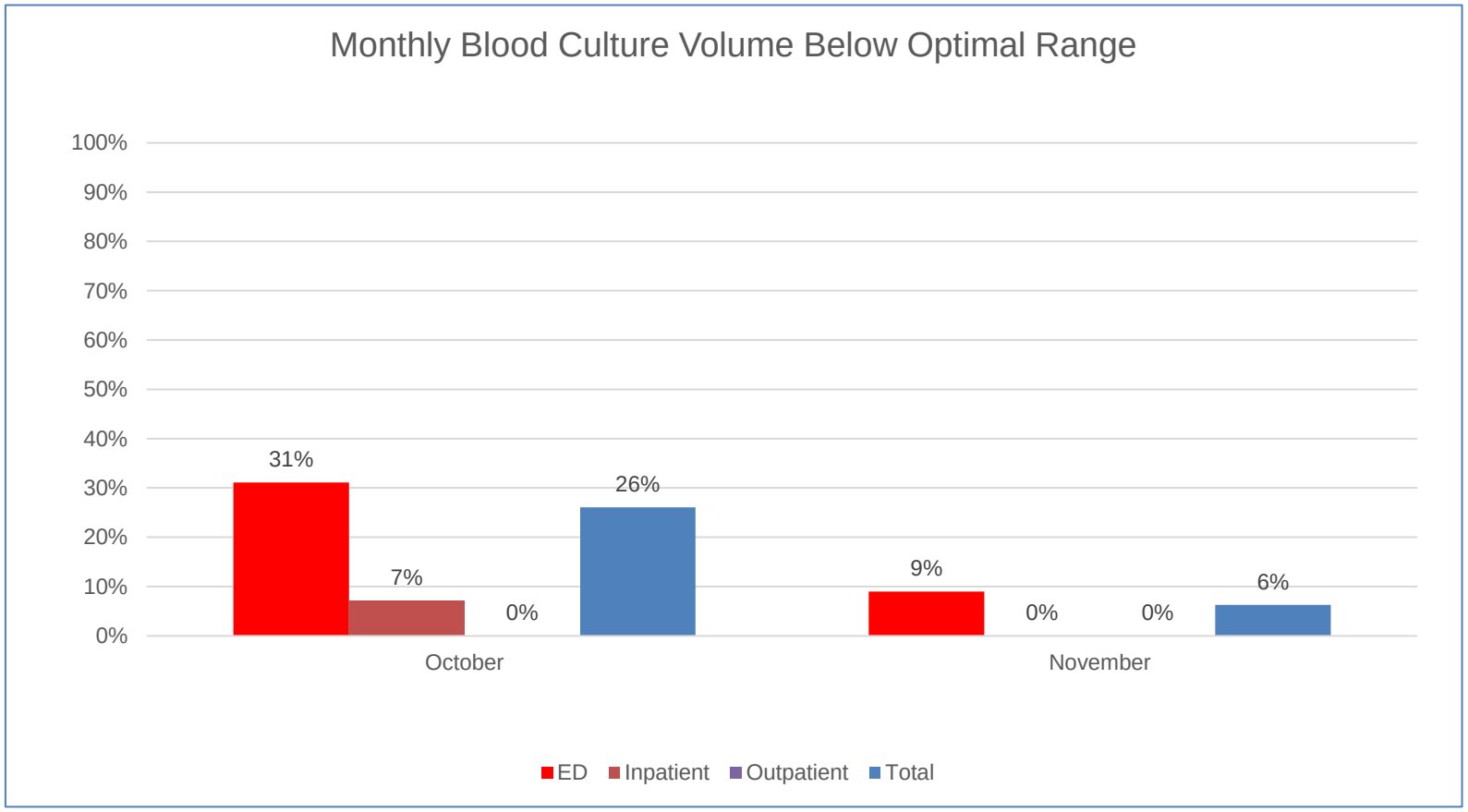
FY 2024 Blood Culture Volume Above Optimal Range



Yale NewHaven Health Bridgeport Hospital

FY 2024 Blood Culture Volume Below Optimal Range



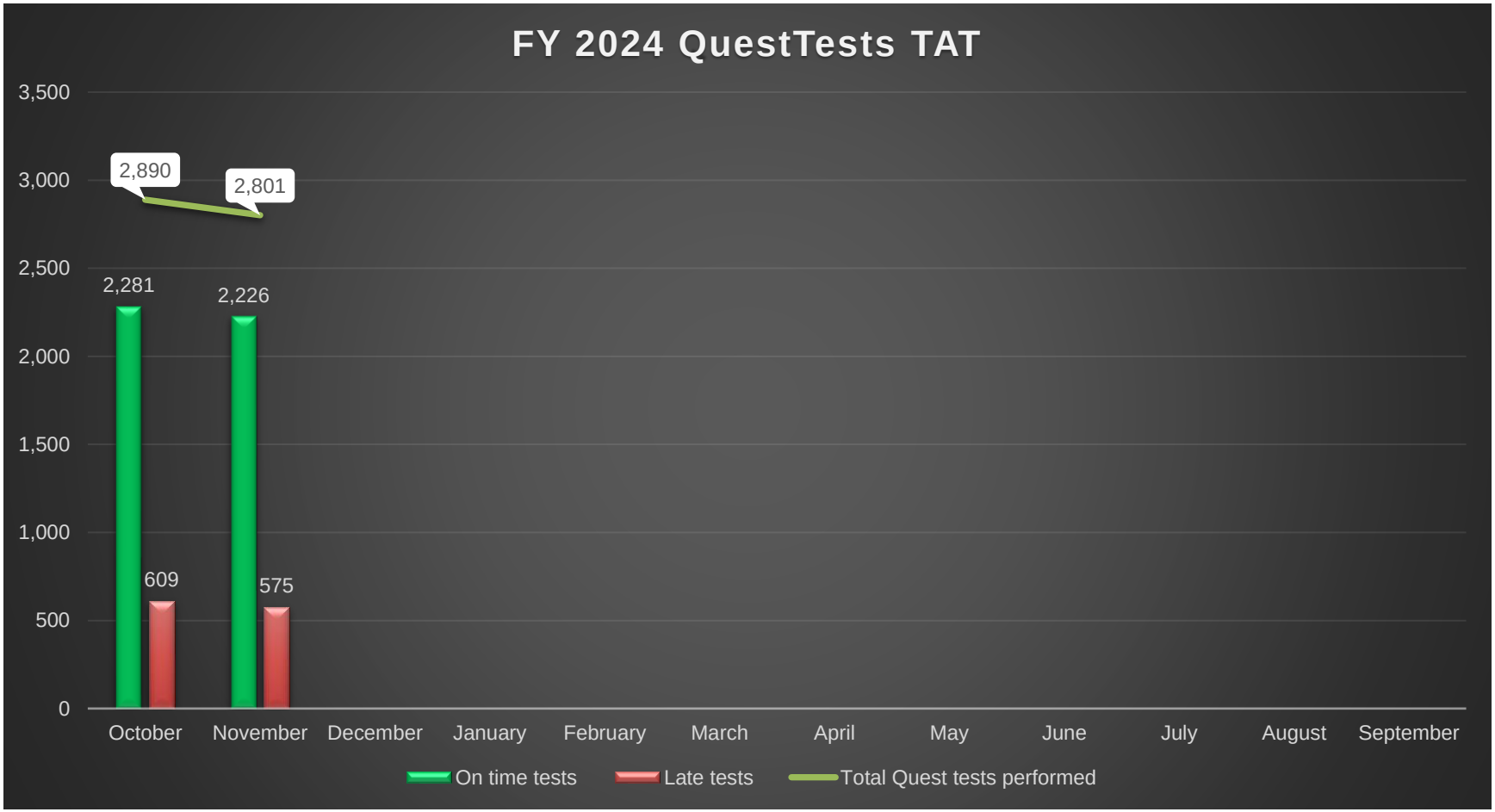
Yale NewHaven Health Bridgeport Hospital

Micro Molecular Statistics

Date	Tests	Sample size	Positive Count	% Positivity	Lower Limit	Upper Limit	Environment Monitoring	Epidemiological Trends	Evaluation Notes
Nov-23	C. difficile Assay	105	21	20.00%	15%	27%	Negative	None	None
Nov-23	GBS PCR Pen Allergic	8	2	25.00%	0%	46%	Negative	None	None
Nov-23	GBS PCR Pen NonAllergic	100	20	20.00%	16%	32%	Negative	None	None
Nov-23	Group A Strep PCR	547	84	15.40%	2%	26%	Negative	None	None
Nov-23	Influenza A/B RNA, NAAT	832	29	3.50%	0%	19%	Negative	None	None
Nov-23	Influenza/RSV by RT-PCR	2,524	400	15.80%	0%	17%	Negative	None	None
Nov-23	MRSA Colonization Status	338	51	15.10%	5%	18%	Negative	None	None
Nov-23	MRSA/SAUR Blood PCR	24	8	33.30%	15%	52%	Negative	None	None
Nov-23	MTB w/rflx Rifampin PCR	5	2	40.00%	0%	79%	Negative	None	None
Nov-23	Resp Virus PCR Panel	166	25	15.10%	2%	52%	Negative	None	None
Nov-23	Respiratory Virus PCR Panel	141	27	19.10%	14%	30%	Negative	None	None
Nov-23	SARS CoV-2 (COVID-19) RNA	3,716	335	9.00%	0%	20%	Negative	None	None
Nov-23	Stool Pathogens PCR	108	13	12.00%	0%	21%	Negative	None	None

Yale NewHaven Health Bridgeport Hospital

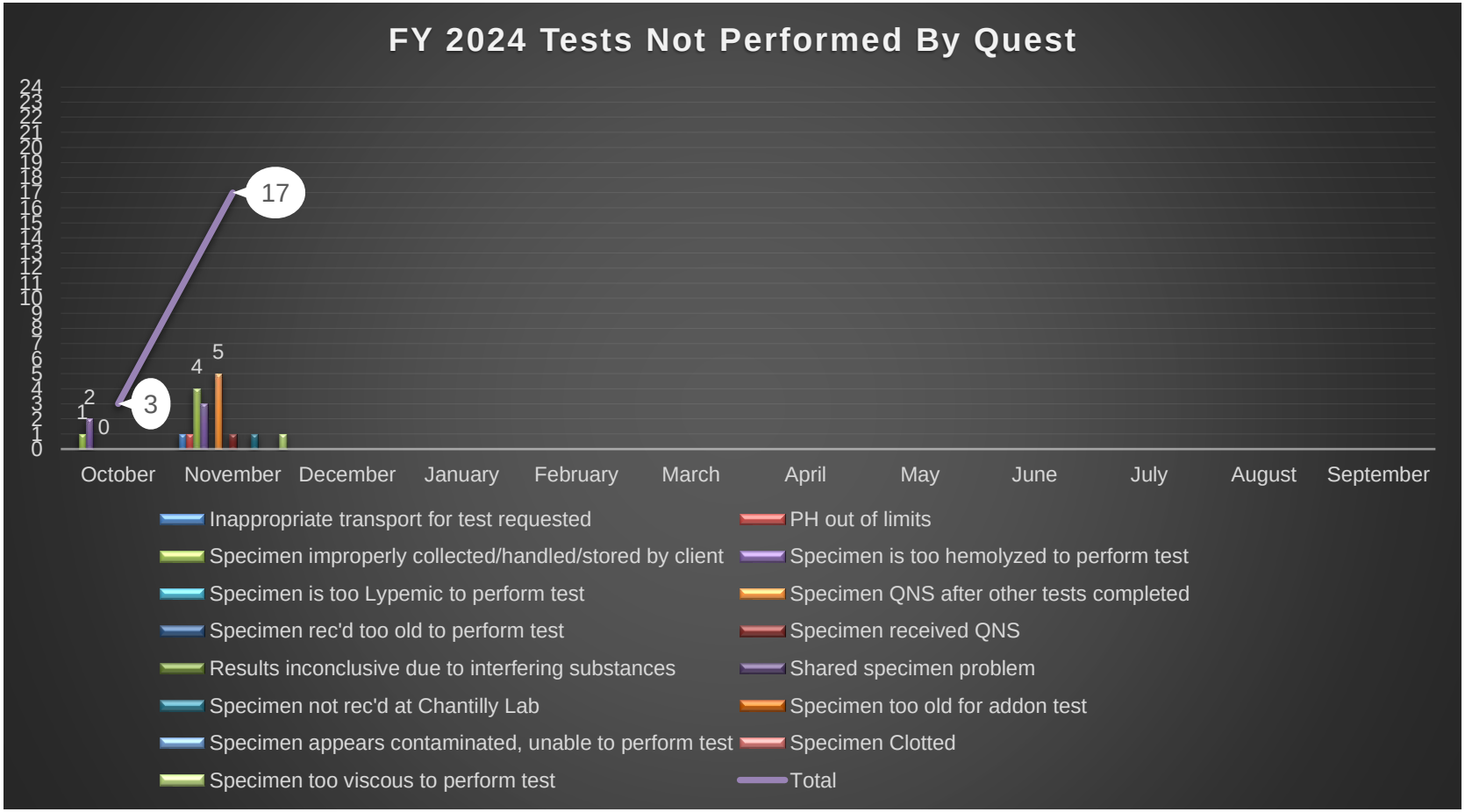
Quest TAT



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.

Yale NewHaven Health Bridgeport Hospital

Quest Rejected Tests



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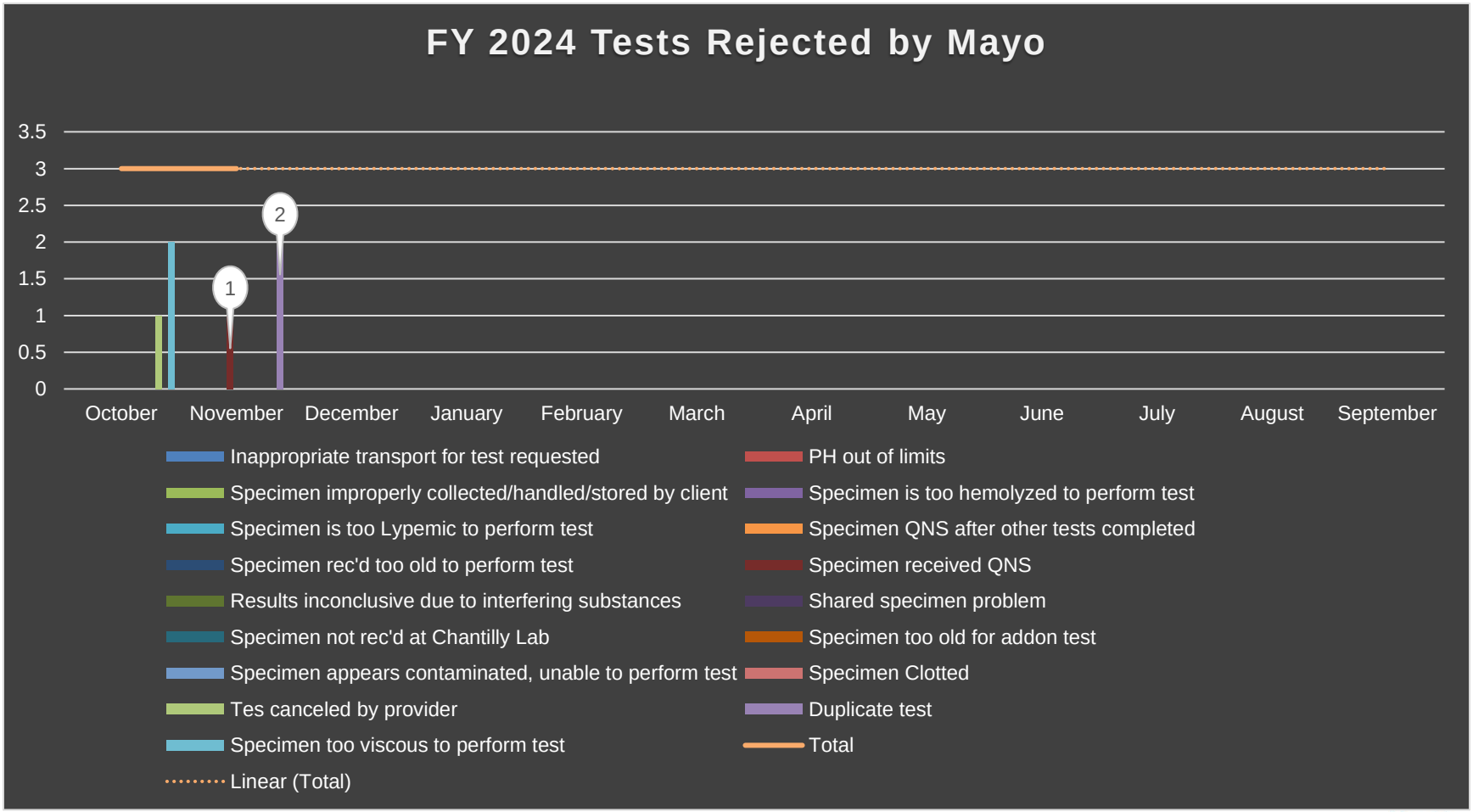
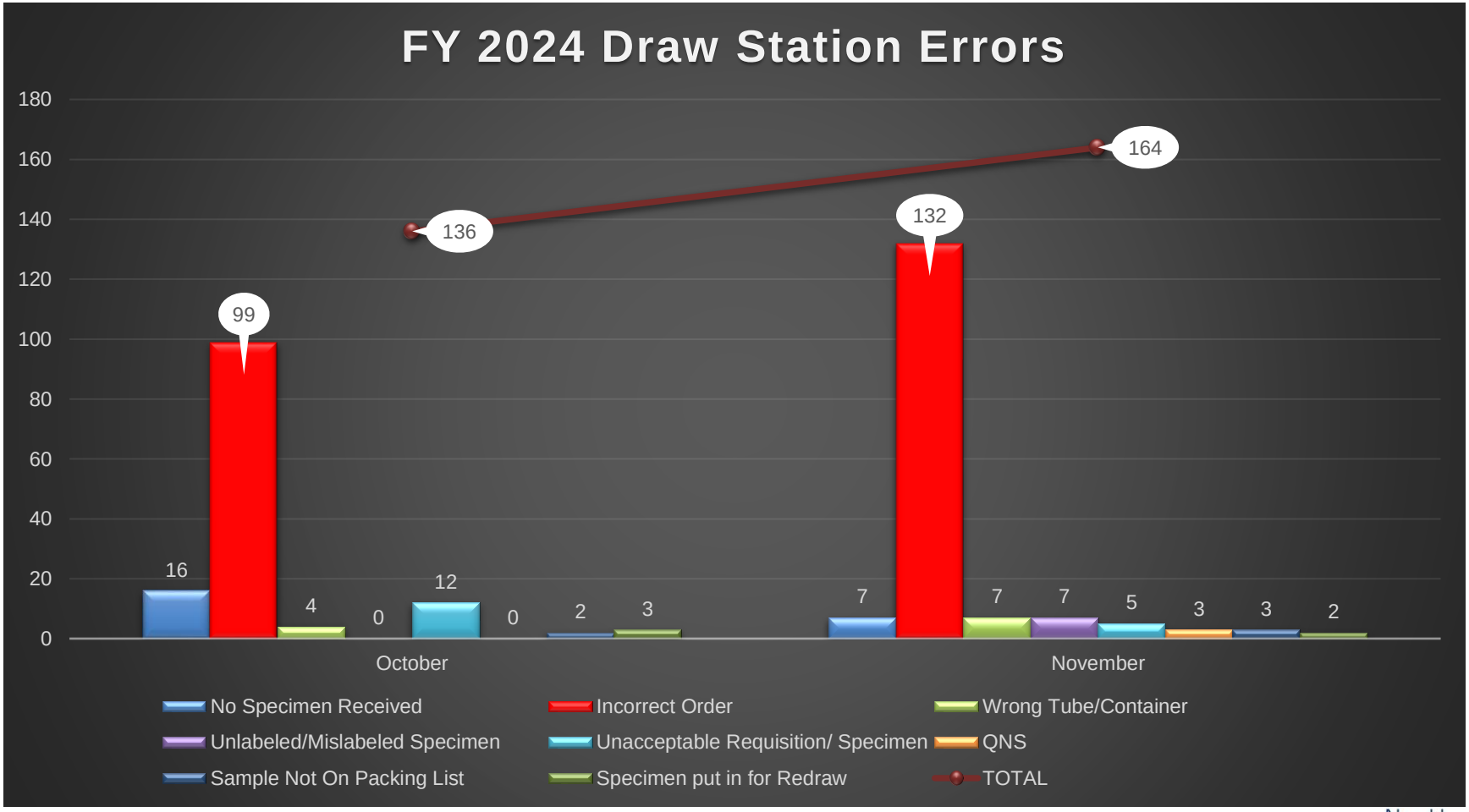
Mayo Rejected Tests



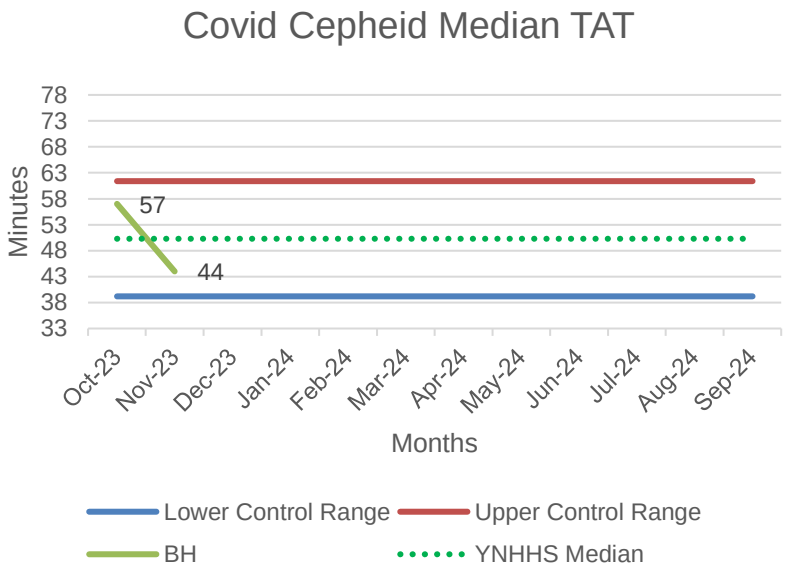
NewHaven Health Bridgeport Hospital

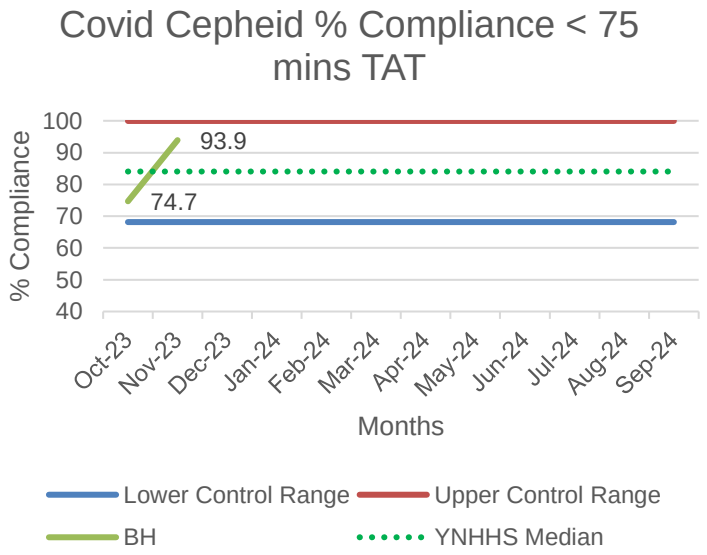
FY2024 Draw Station Errors

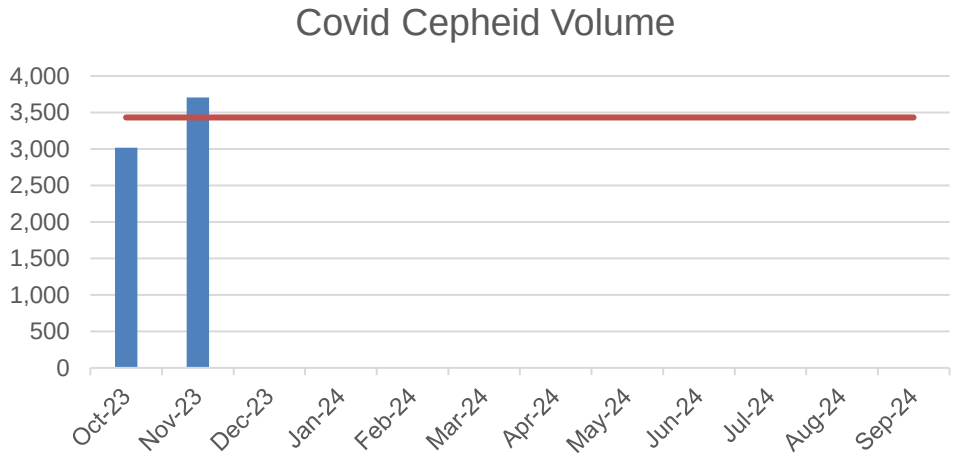


NewHaven Health Bridgeport Hospital

Bridgeport Campus – COVID-19 Cepheid

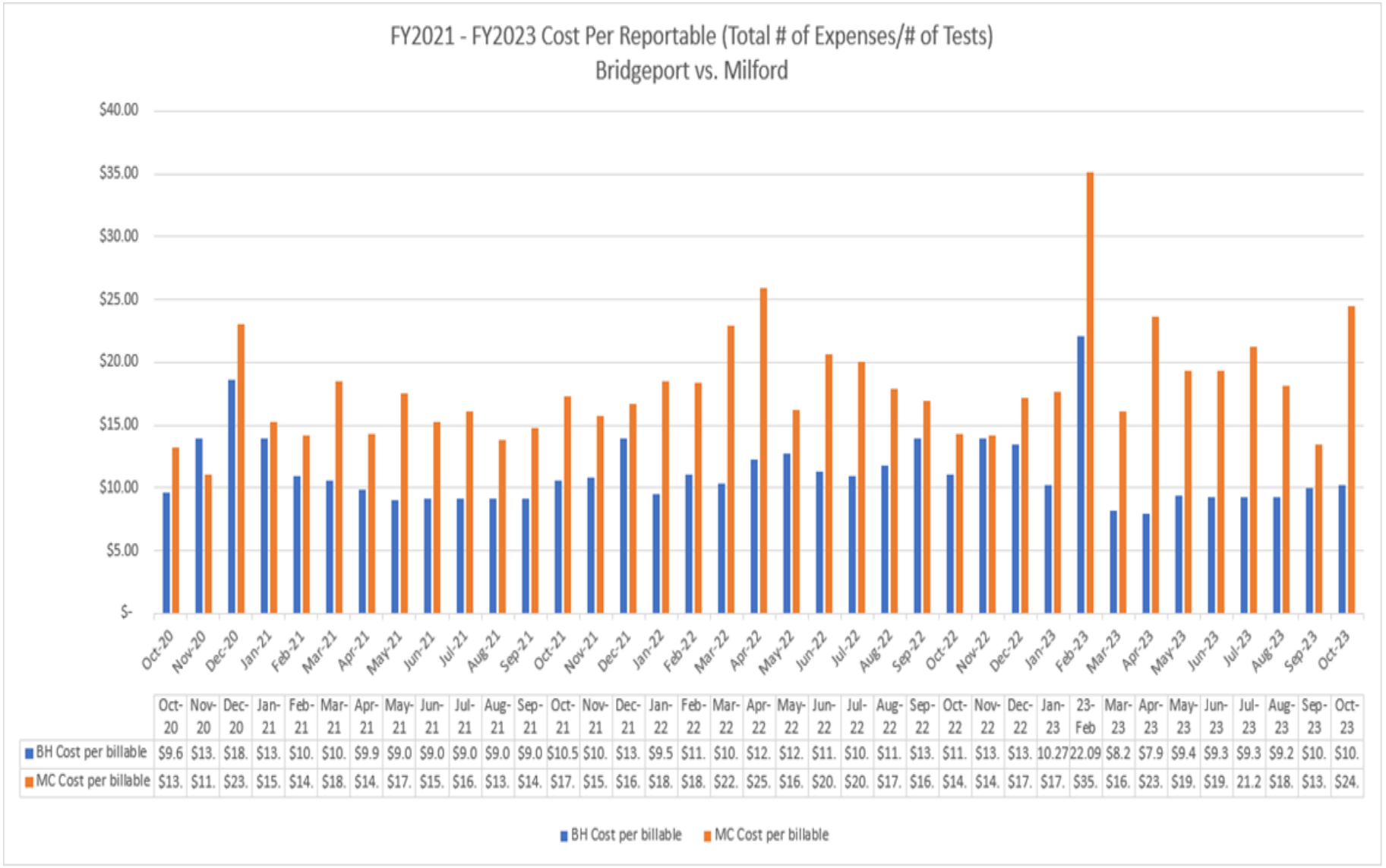






Yale NewHaven Health Bridgeport Hospital

Cost Per Billable

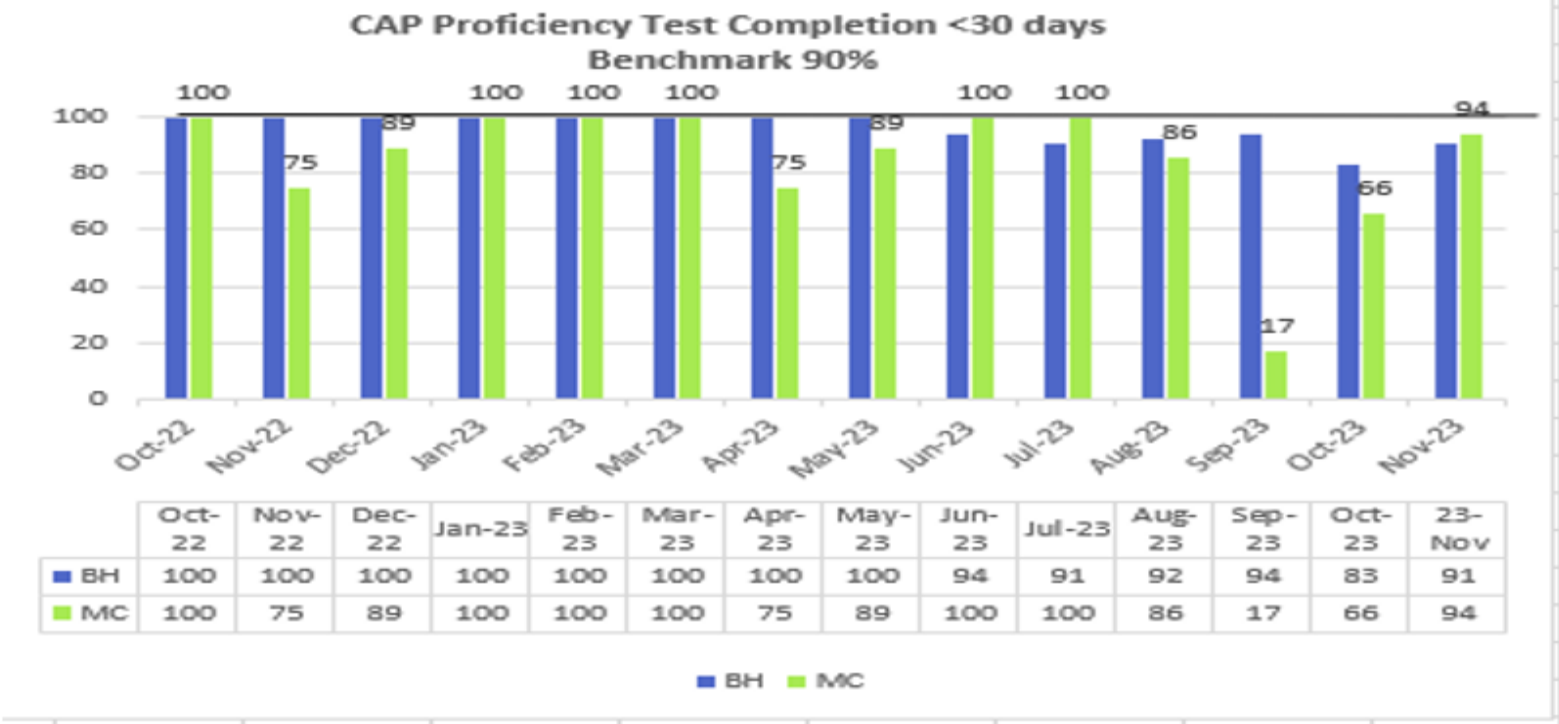


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	23-Feb	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
BH Cost per billable	$9.6	$13.	$18.	$13.	$10.	$10.	$9.9	$9.0	$9.0	$9.0	$9.0	$9.0	$10.5	$10.	$13.	$9.5	$11.	$10.	$12.	$12.	$11.	$10.	$11.	$13.	$11.	$13.	$13.	10.27	22.09	$8.2	$7.9	$9.4	$9.3	$9.3	$9.2	$10.	$10.
MC Cost per billable	$13.	$11.	$23.	$15.	$14.	$18.	$14.	$17.	$15.	$16.	$13.	$14.	$17.	$15.	$16.	$18.	$18.	$22.	$25.	$16.	$20.	$20.	$17.	$16.	$14.	$14.	$17.	$17.	$35.	$16.	$23.	$19.	$19.	21.2	$18.	$13.	$24.

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	91% (21/23 surveys) 94% (16/17 surveys)	67% 83%	None	Both labs exceeded benchmark. There were a couple of surveys that required extensive investigations. Will continue to monitor	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	23-Nov
BH	100	100	100	100	100	100	100	100	94	91	92	94	83	91
MC	100	75	89	100	100	100	75	89	100	100	86	17	66	94

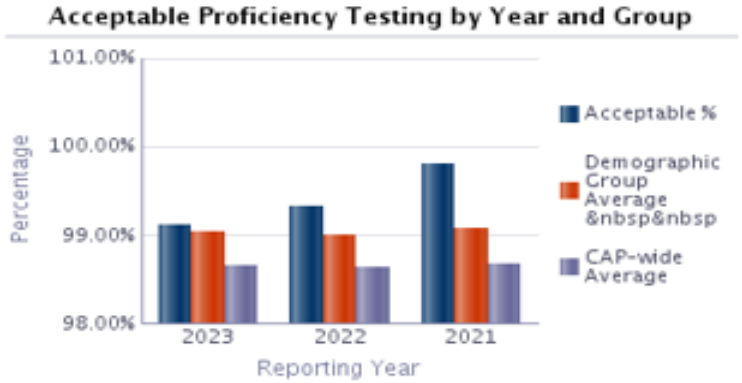
Yale NewHaven Health Bridgeport Hospital

Laboratory General – Bridgeport
Proficiency Testing Performance Target 98%

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
BH	327/334	99%	98%	Bone, benchmark met	Unsatisfactory PT's are being investigated with corrective actions -all surveys satisfactory. Each section investigates failed/unsatisfactory performances.

Proficiency Testing Performance Overview

Select View: Graph

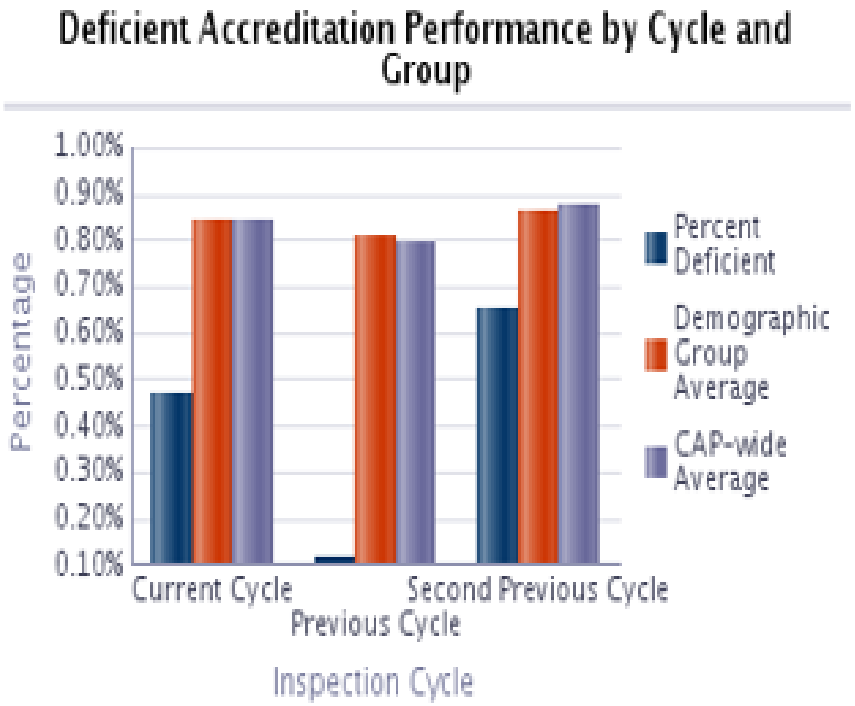


21	1	0	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.12%	99.04%	98.65%
2022	99.32%	99.00%	98.63%
2021	99.81%	99.06%	98.67%

Lab General

Accreditation Performance Overview



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

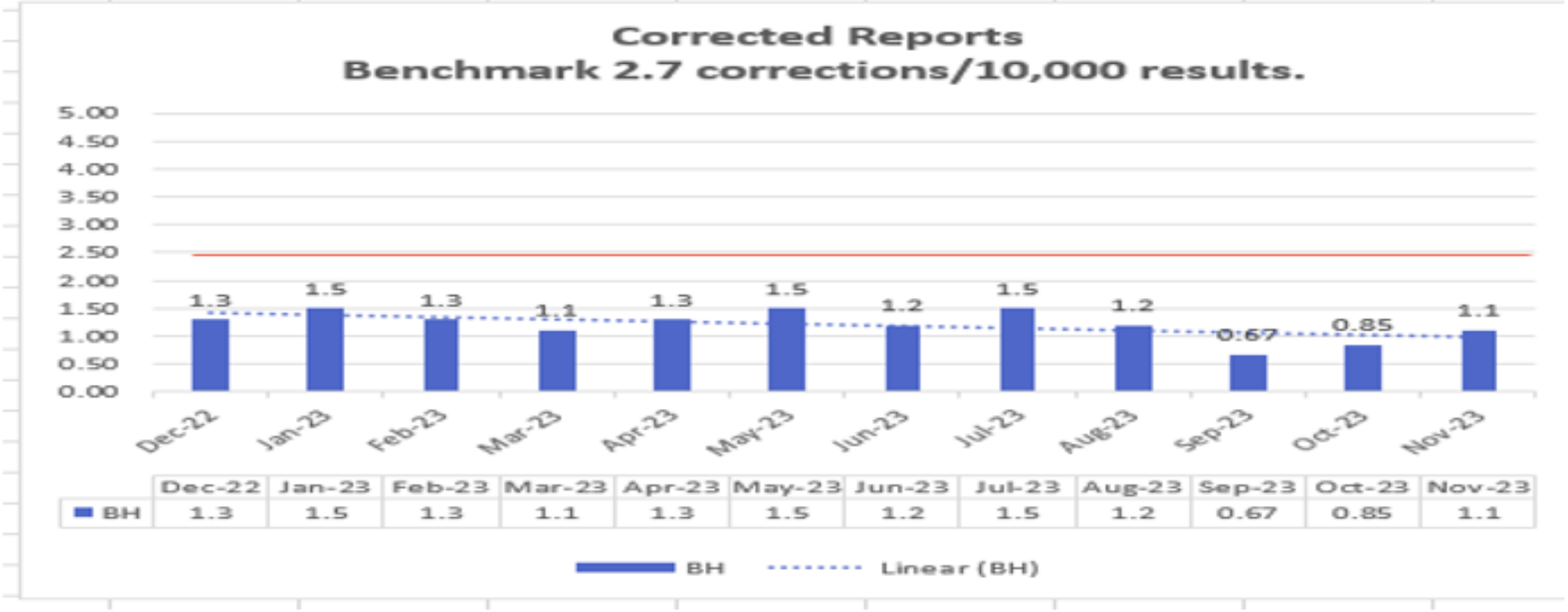
		Percent Deficient			Demographic Group Average			CAP-wide Average		
CAP #	Graph	Current Cycle	Previous Cycle	Second Previous Cycle	Current Cycle	Previous Cycle	Second Previous Cycle	Current Cycle	Previous Cycle	Second Previous Cycle
1191901		0.47%	0.11%	0.65%	0.84%	0.80%	0.86%	0.84%	0.79%	0.87%

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	200,625 tests	1.1 (.011%)	0.85 (0.008%)	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	200,625 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	22,201 Tests	0	0	None	None needed	Lab administration and management

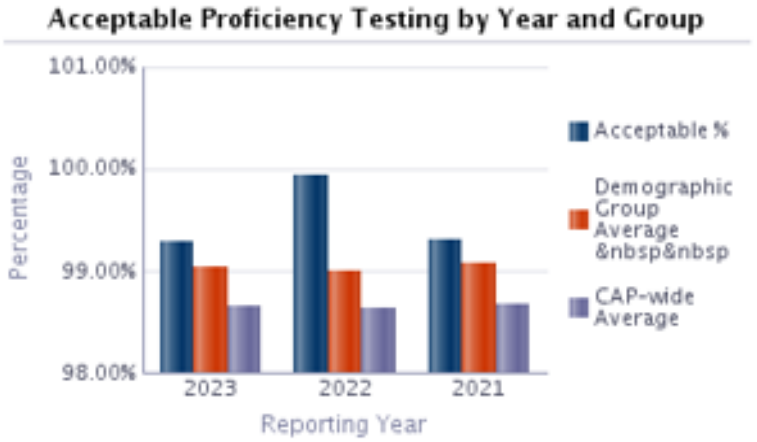
** Definition of Non Conforming events for this Quality Measure includes irreplaceable samples only

MCBH Proficiency Testing
Performance Target 98%

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

Proficiency Testing Performance Overview

Select View: Graph



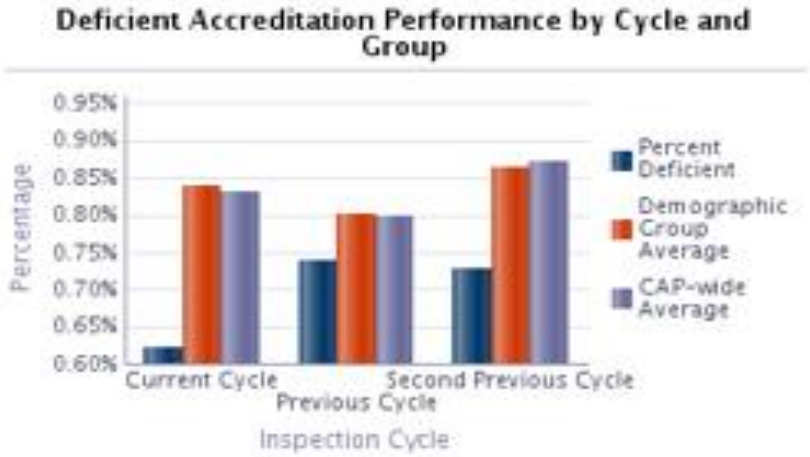
6	0	0	0	0
Mailings with New Evaluations	Mailings with Revised Evaluations	Analytes with Unsatisfactory PT	Analytes with Unsuccessful PT	Analytes with Repeat Unsuccessful PT

Reporting Year	Acceptable %	Demographic Group Average	CAP-wide Average
2023	99.29%	99.04%	98.65%
2022	99.94%	99.00%	98.63%
2021	99.30%	99.06%	98.67%

MCBH Accreditation Performance Overview

Accreditation Performance Overview

Select View: Graph



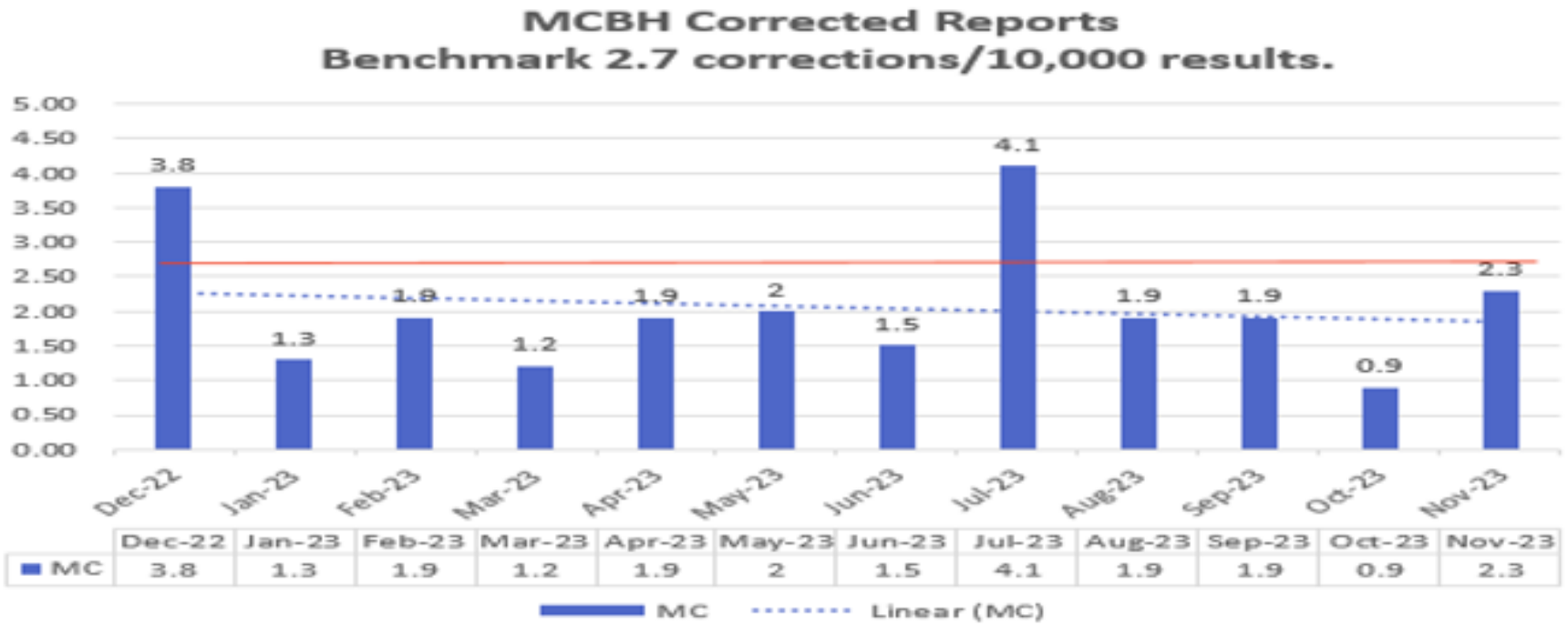
Last Accreditation Decision	Date
Accredited	5/9/2022

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

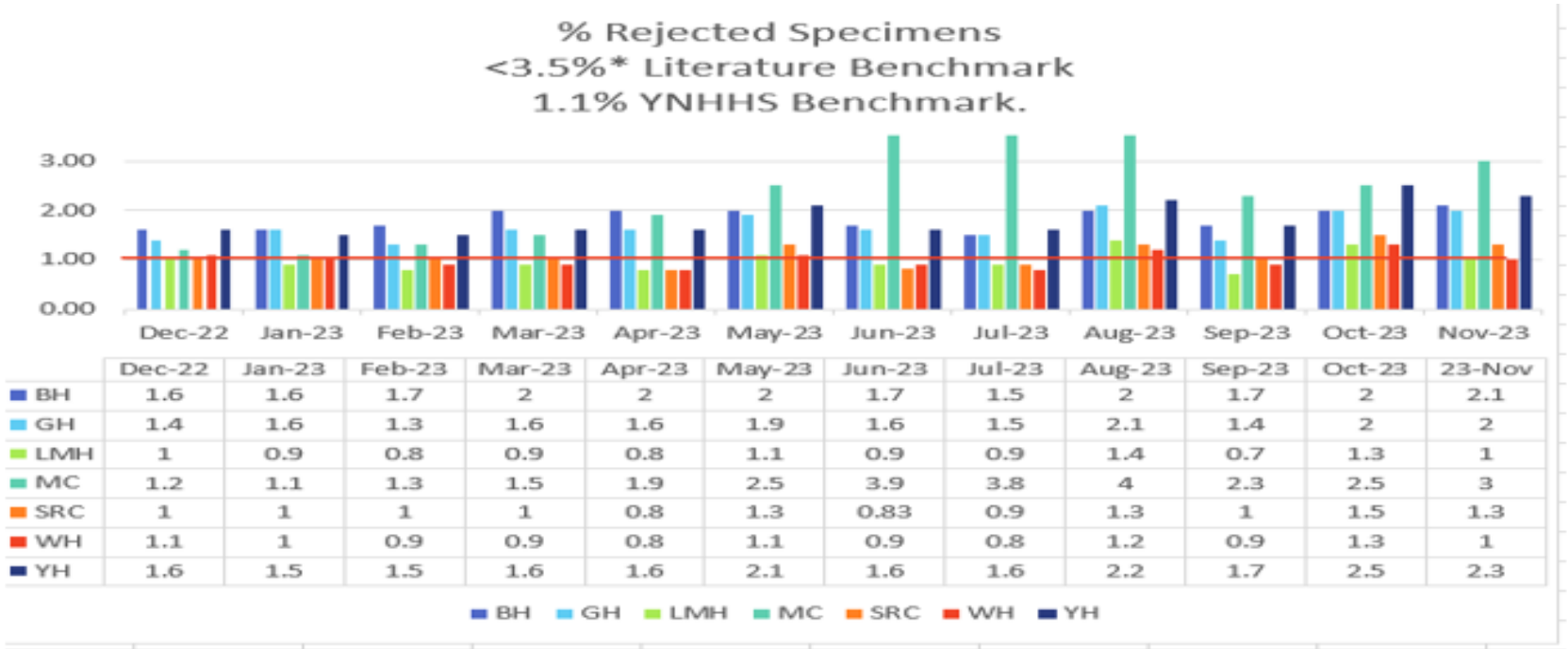
		Percent Deficient			Demographic Group Average			CAP-wide Average		
CAP #	Graph	Current Cycle	Previous Cycle	Second Previous Cycle	Current Cycle	Previous Cycle	Second Previous Cycle	Current Cycle	Previous Cycle	Second Previous Cycle
1189901		0.62%	0.74%	0.73%	0.84%	0.80%	0.86%	0.84%	0.79%	0.87%

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	22,201 tests	2.3 (.023%)	0.9 (0.009%)	Corrected reports can lead to adverse patient outcomes	5 total lab corrections (2 manual, 2 UA color change & 1 BB) Techs reminded to be careful with manual entries and color change corrections can be prevented by cleaning the analyzer better.	Laboratory administration

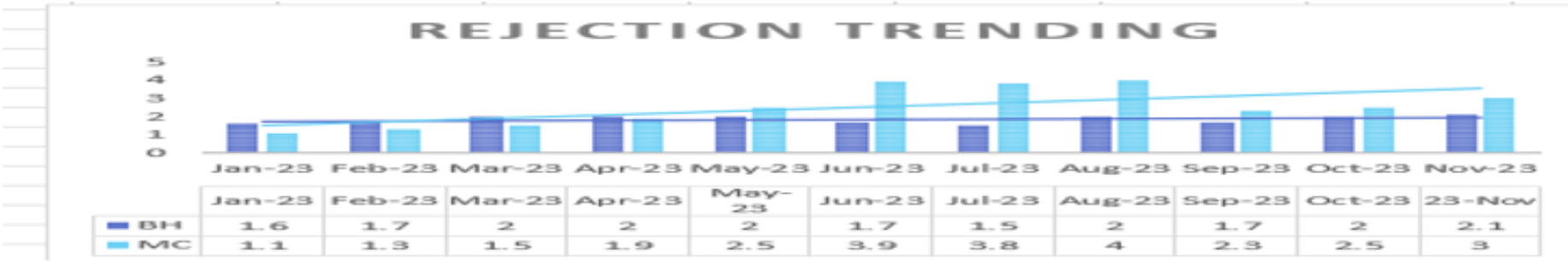


Laboratory General



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	23-Nov
BH	1.6	1.6	1.7	2	2	2	1.7	1.5	2	1.7	2	2.1
GH	1.4	1.6	1.3	1.6	1.6	1.9	1.6	1.5	2.1	1.4	2	2
LMH	1	0.9	0.8	0.9	0.8	1.1	0.9	0.9	1.4	0.7	1.3	1
MC	1.2	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3	2.5	3
SRC	1	1	1	1	0.8	1.3	0.83	0.9	1.3	1	1.5	1.3
WH	1.1	1	0.9	0.9	0.8	1.1	0.9	0.8	1.2	0.9	1.3	1
YH	1.6	1.5	1.5	1.6	1.6	2.1	1.6	1.6	2.2	1.7	2.5	2.3

*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



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	23-Nov
BH	1.6	1.7	2	2	2	1.7	1.5	2	1.7	2	2.1
MC	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3	2.5	3

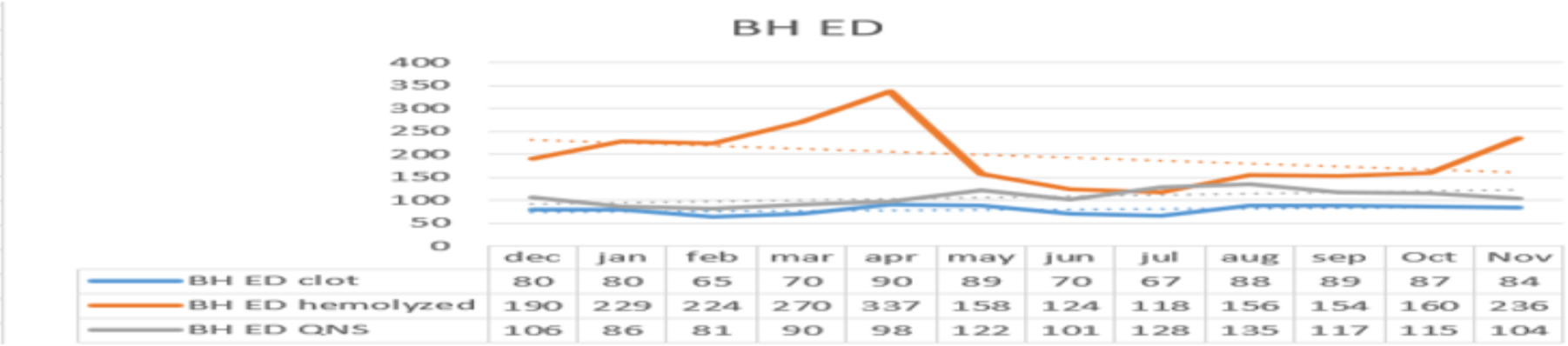
Laboratory General

Rejected Specimens by Classification (all BH collection locations)

	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
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
23-Nov	325	310	194	68	54	19

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

Top 3 Rejections-BH ED totals



	dec	jan	feb	mar	apr	may	jun	jul	aug	sep	Oct	Nov
BH ED clot	80	80	65	70	90	89	70	67	88	89	87	84
BH ED hemolyzed	190	229	224	270	337	158	124	118	156	154	160	236
BH ED QNS	106	86	81	90	98	122	101	128	135	117	115	104

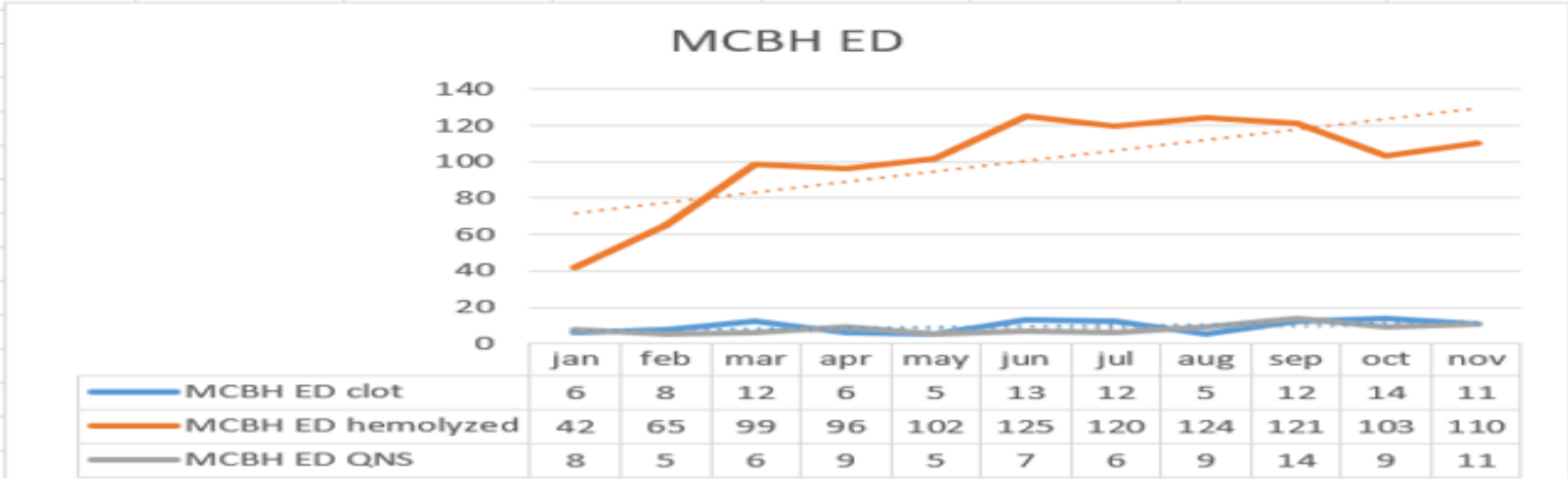
Laboratory General

Rejected Specimens by Classification (all MCBH collection locations)

	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
23-Nov	120	21	15	8	15	1

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

Top 3 Rejections-MCBH ED totals

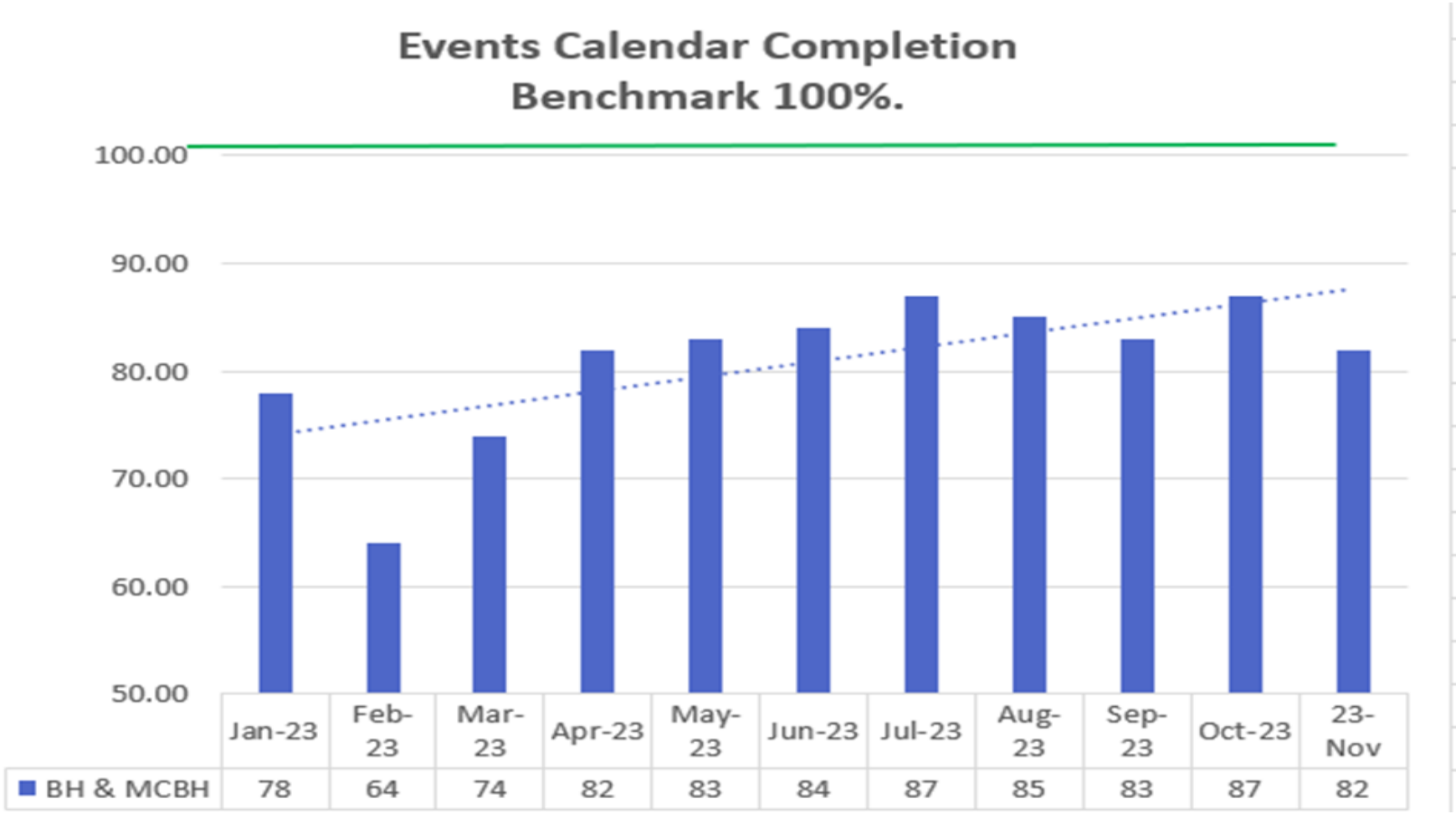


	jan	feb	mar	apr	may	jun	jul	aug	sep	oct	nov
MCBH ED clot	6	8	12	6	5	13	12	5	12	14	11
MCBH ED hemolyzed	42	65	99	96	102	125	120	124	121	103	110
MCBH ED QNS	8	5	6	9	5	7	6	9	14	9	11

Laboratory General

BH & MCBH Events Calendar Completion 82%

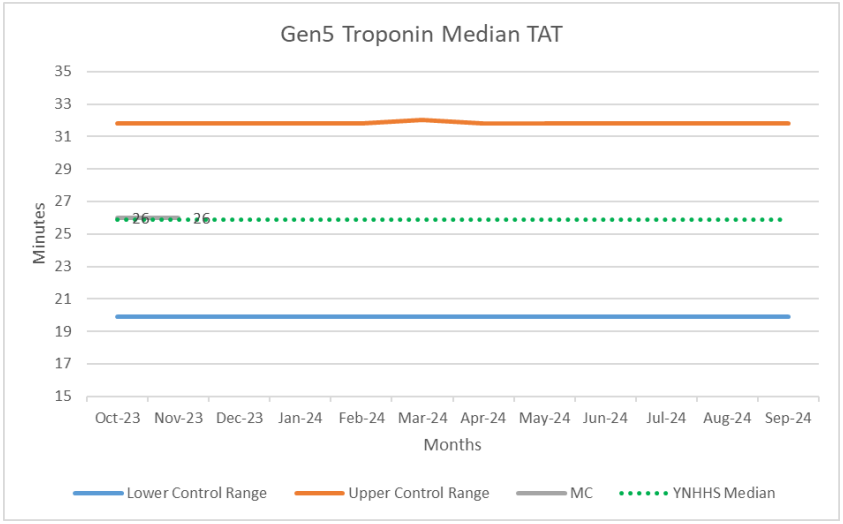
Benchmark 100% 9/11 Events Completed

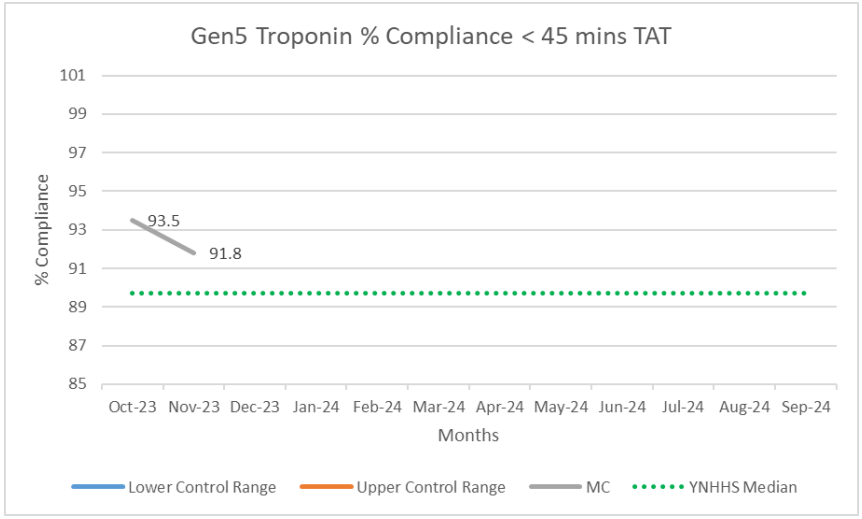


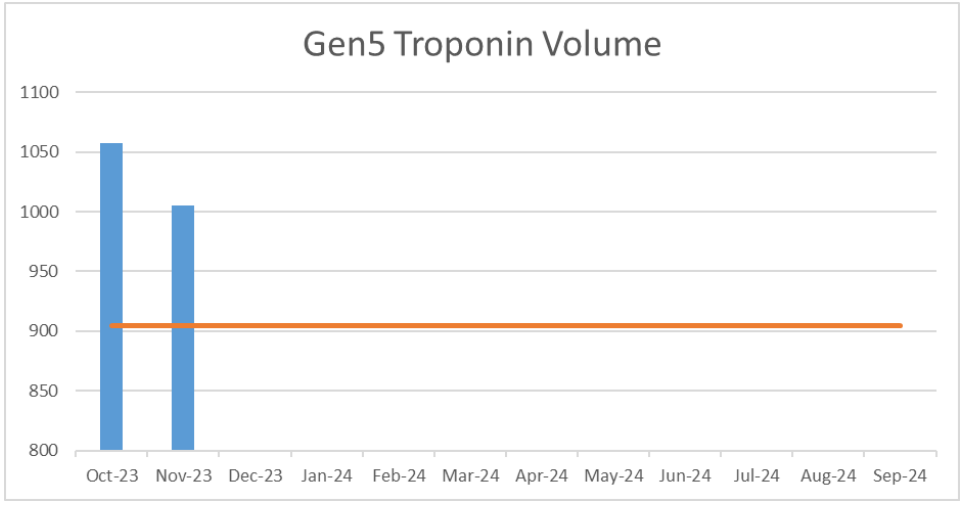
Overdue competencies/training on per diem employees.

Yale NewHaven Health Bridgeport Hospital

Milford Campus – Gen 5 Troponin TAT

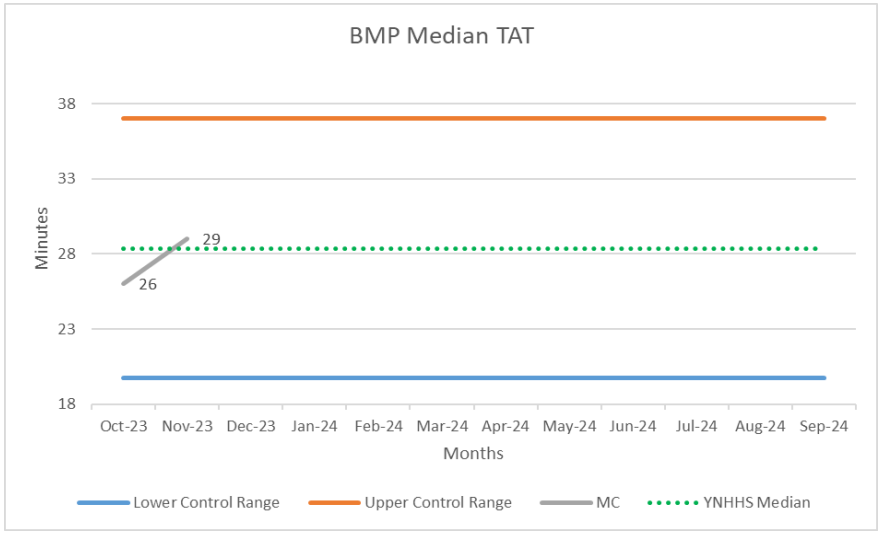


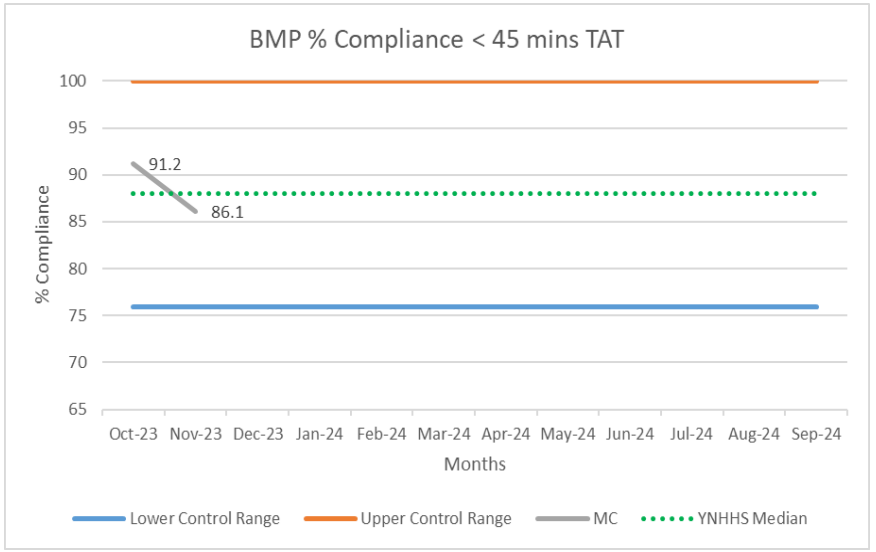


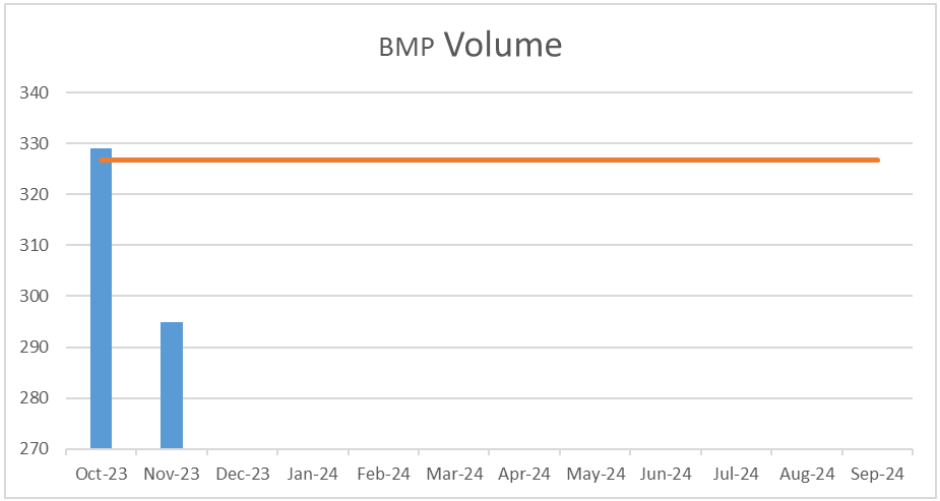


Yale NewHaven Health Bridgeport Hospital

Milford Campus – Basic Metabolic Panel (BMP) ED TAT







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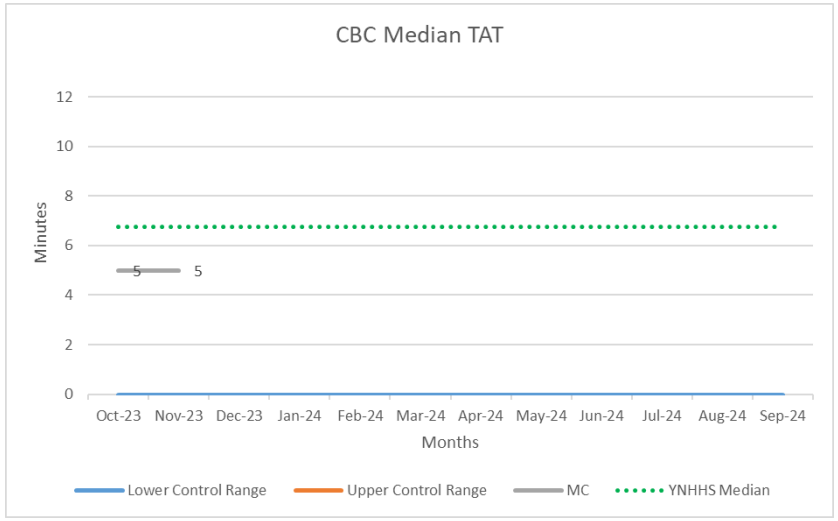
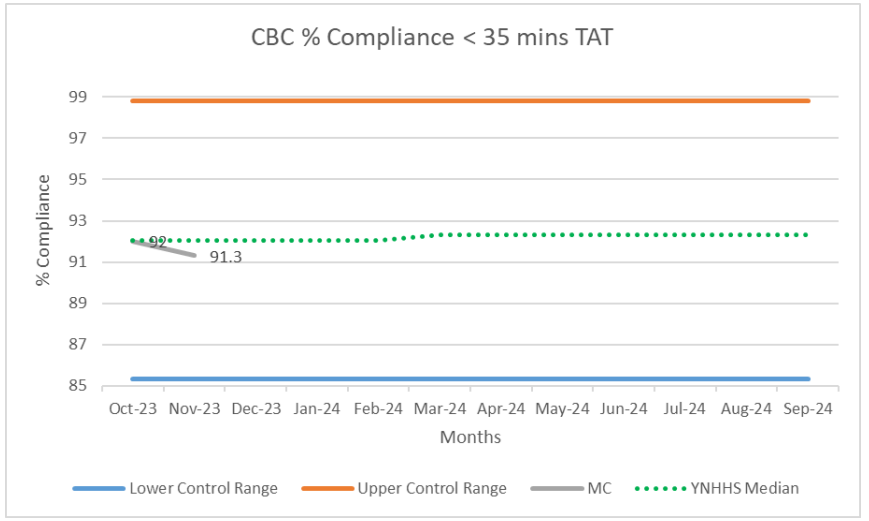
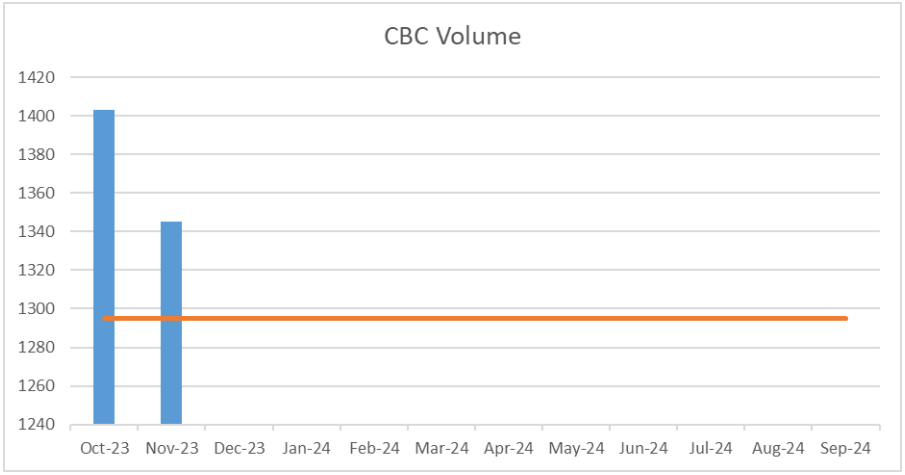
Bridgeport Hospital

Milford Campus – Complete Blood Count (CBC) ED TAT







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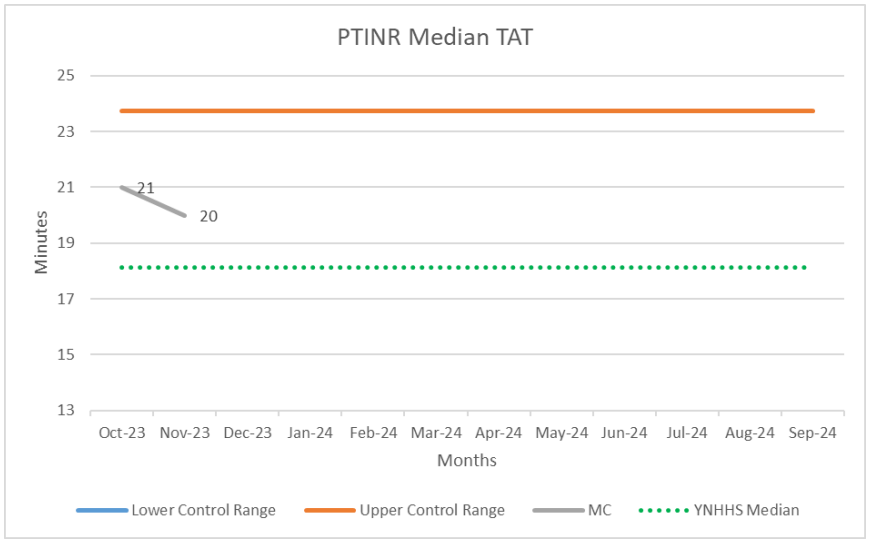
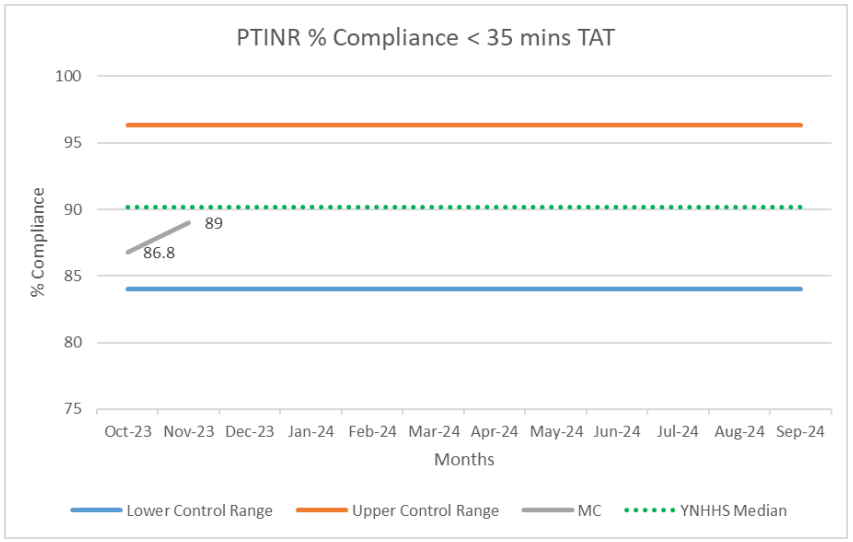
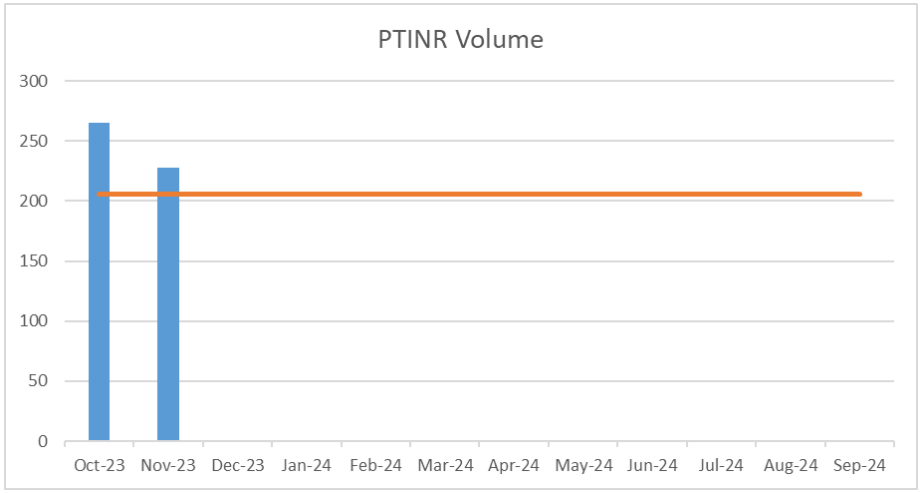
Milford Campus – PTINR ED TAT







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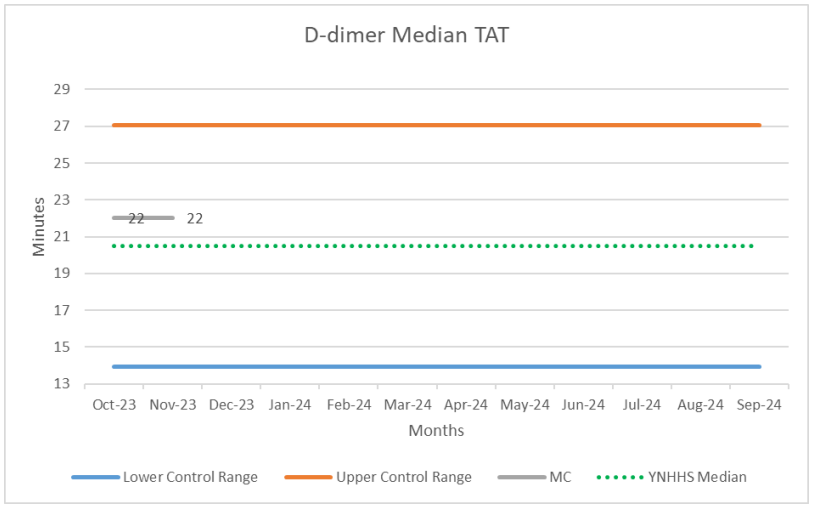
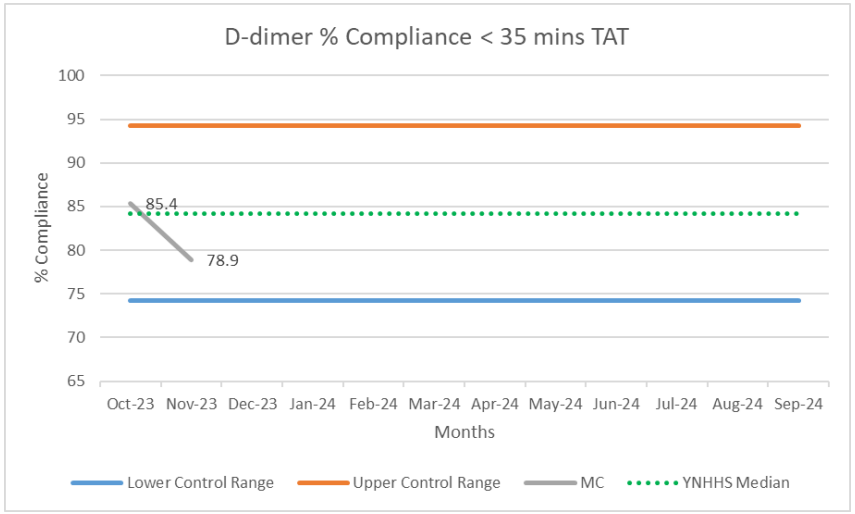
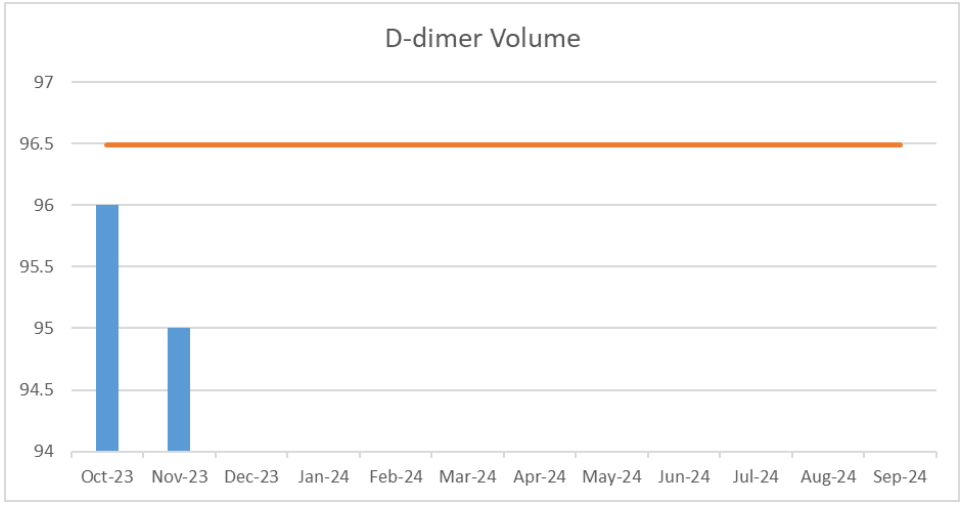
Milford Campus – D-dimer ED TAT







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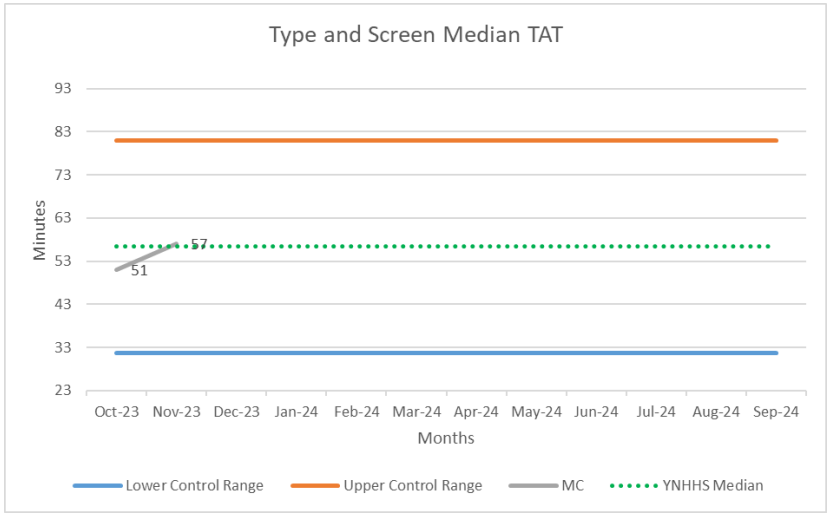
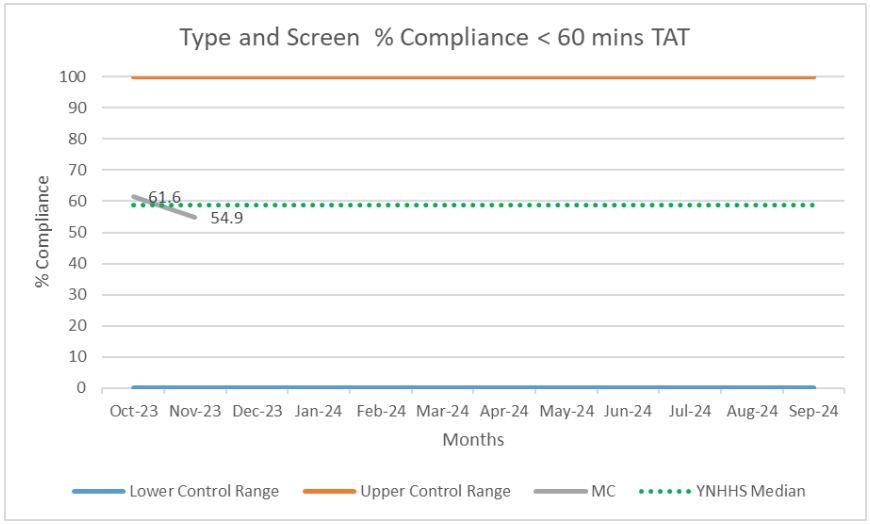
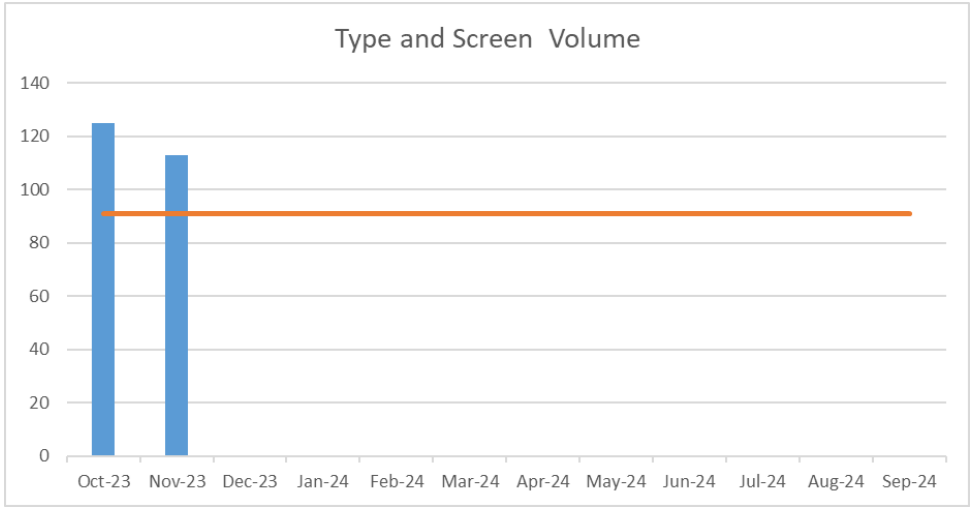
Milford Campus – Type and Screen ED TAT







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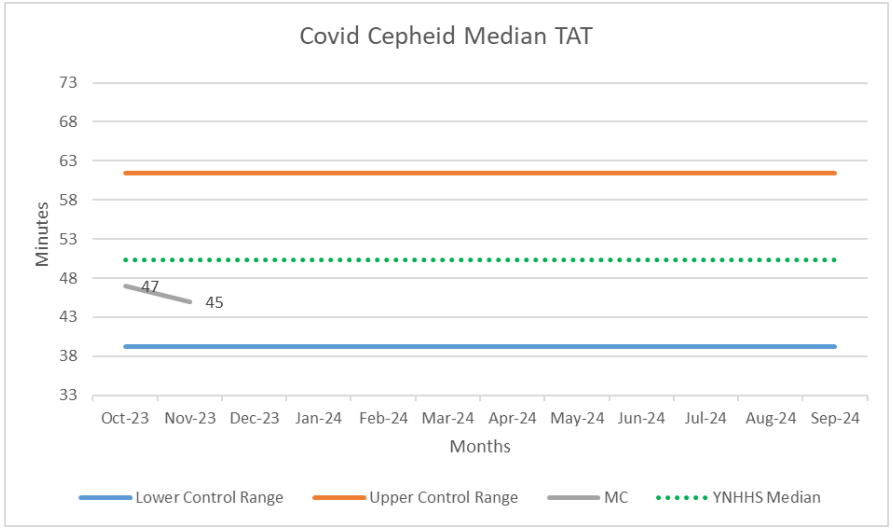
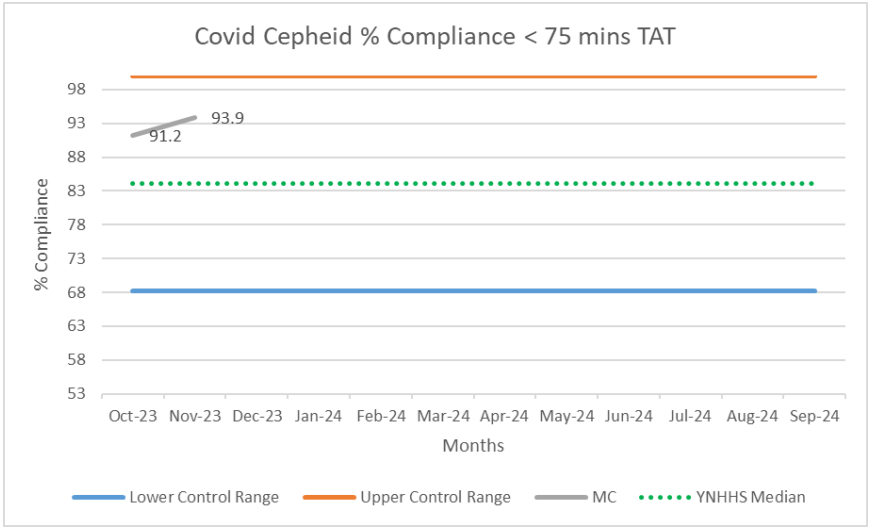
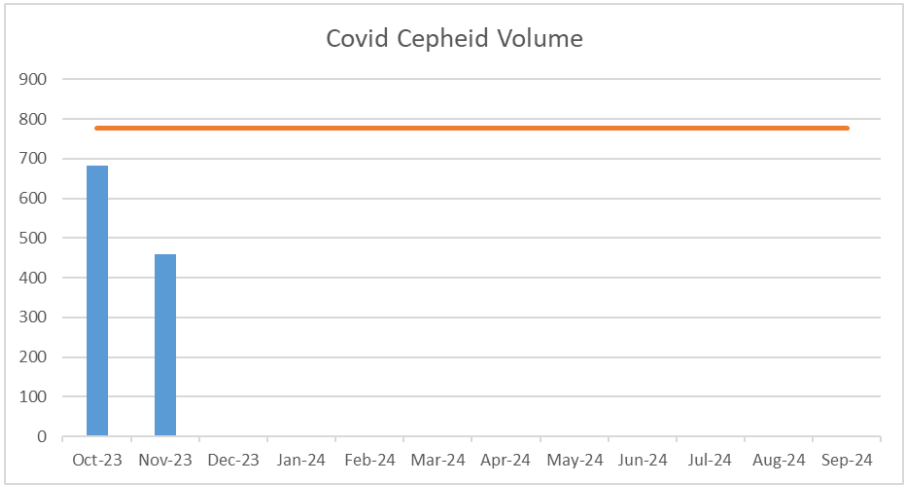
Milford Campus – COVID Cepheid PCR ED TAT







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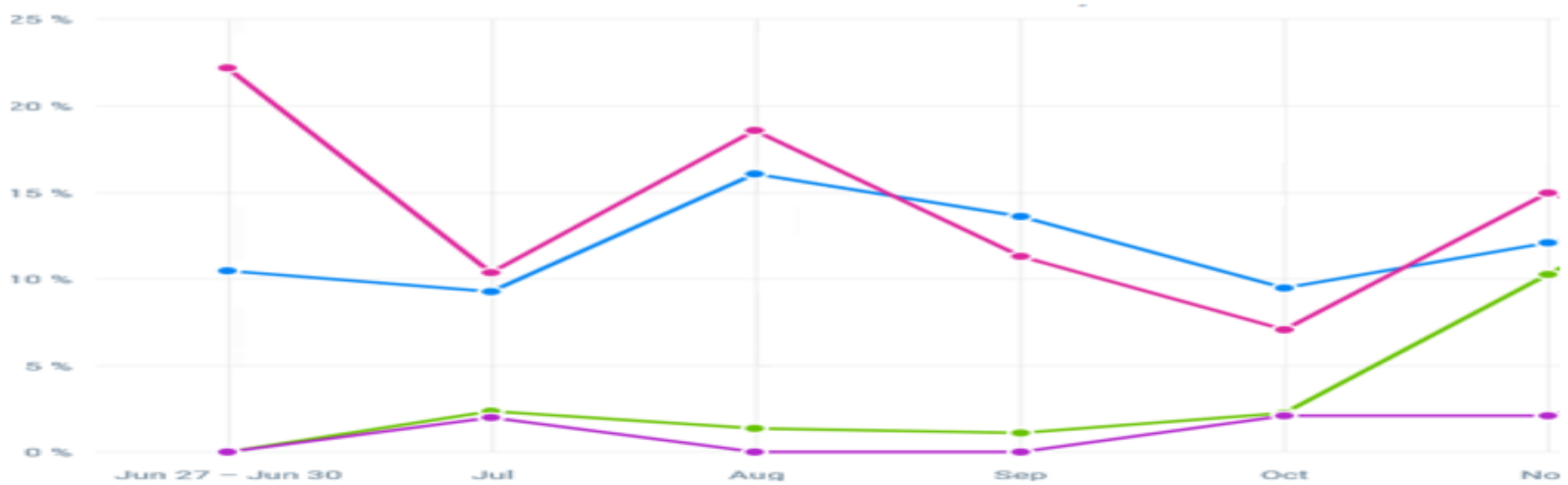
Milford Campus Molecular Dashboard



- SARS CoV-2 (COVID-19) RNA
- Group A Strep PCR
- 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)
Nov-23	SARS-CoV-2	12.10%	0-22%	Negative	None	None	None	None
Nov-23	Group A Strep	15.00%	0-19%	Negative	None	None	None	None
Nov-23	Flu A/B	2.10%	0-7%	Negative	None	None	None	None
Nov-23	Flu/RSV	10.30%	0-14%	Negative	None	None	None	None
Nov-23	C. diff toxin	16.70%	not established	Negative	None	None	None	None

- OF the 16.7% positive C dif toxin by PCR, there 2 confirmed active infections

CRSQ Report Out

Committee of Regulatory, Safety, & Quality

November 2023

Bridgeport Hospital

Department of Laboratory Medicine

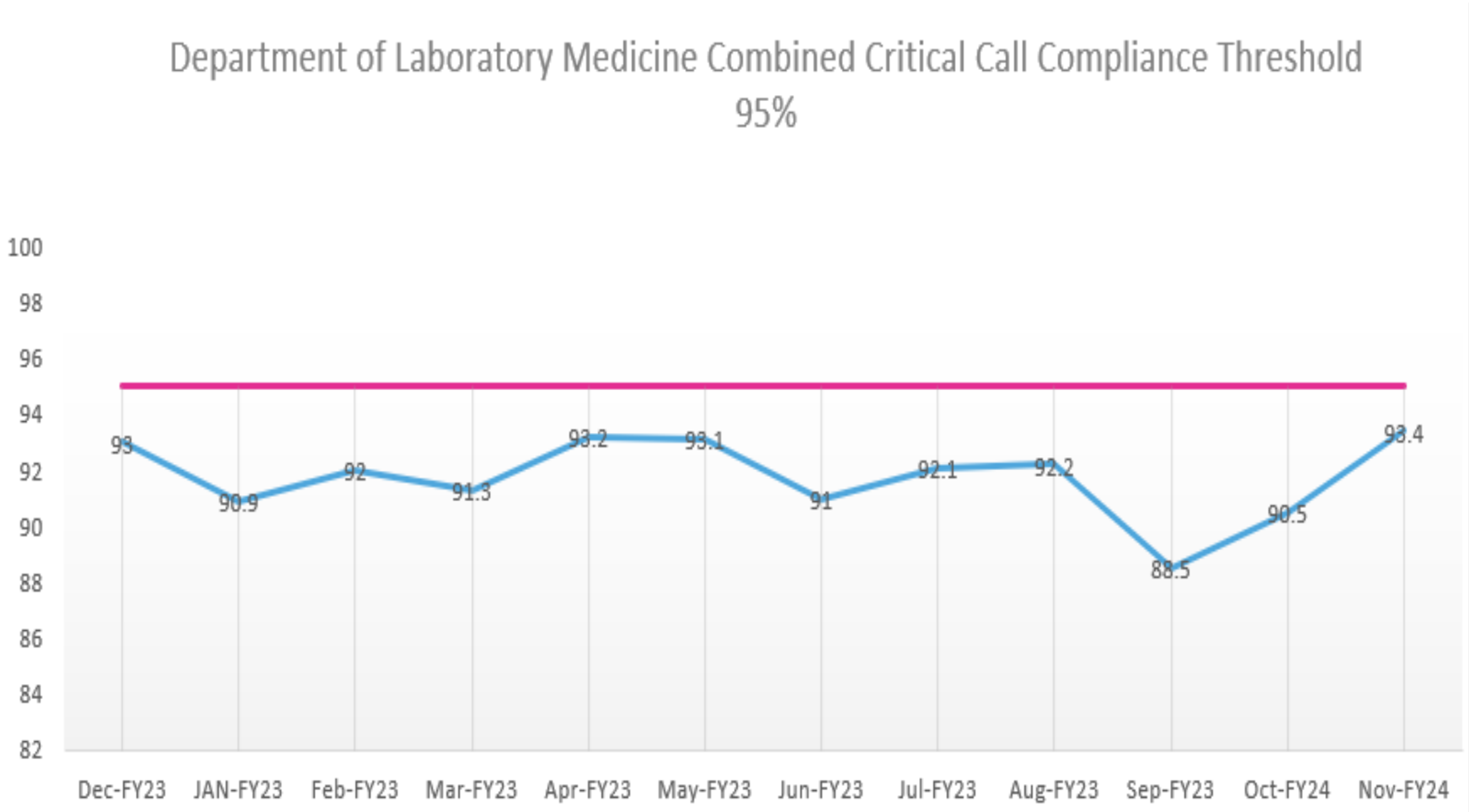
Teodorico Lee MPH, Christine Minerowicz M.D., Edward Snyder M.D.,
Laura Buhlmann M.S., Melissa Morales B.A.

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 **93.4%** 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 • December 2023 has a 93.4% compliance (highest in the12 month period of Dec 2022-Nov 2023). • Inpatient compliance rate is 93.7%, Outpatient rate is 80.4% 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

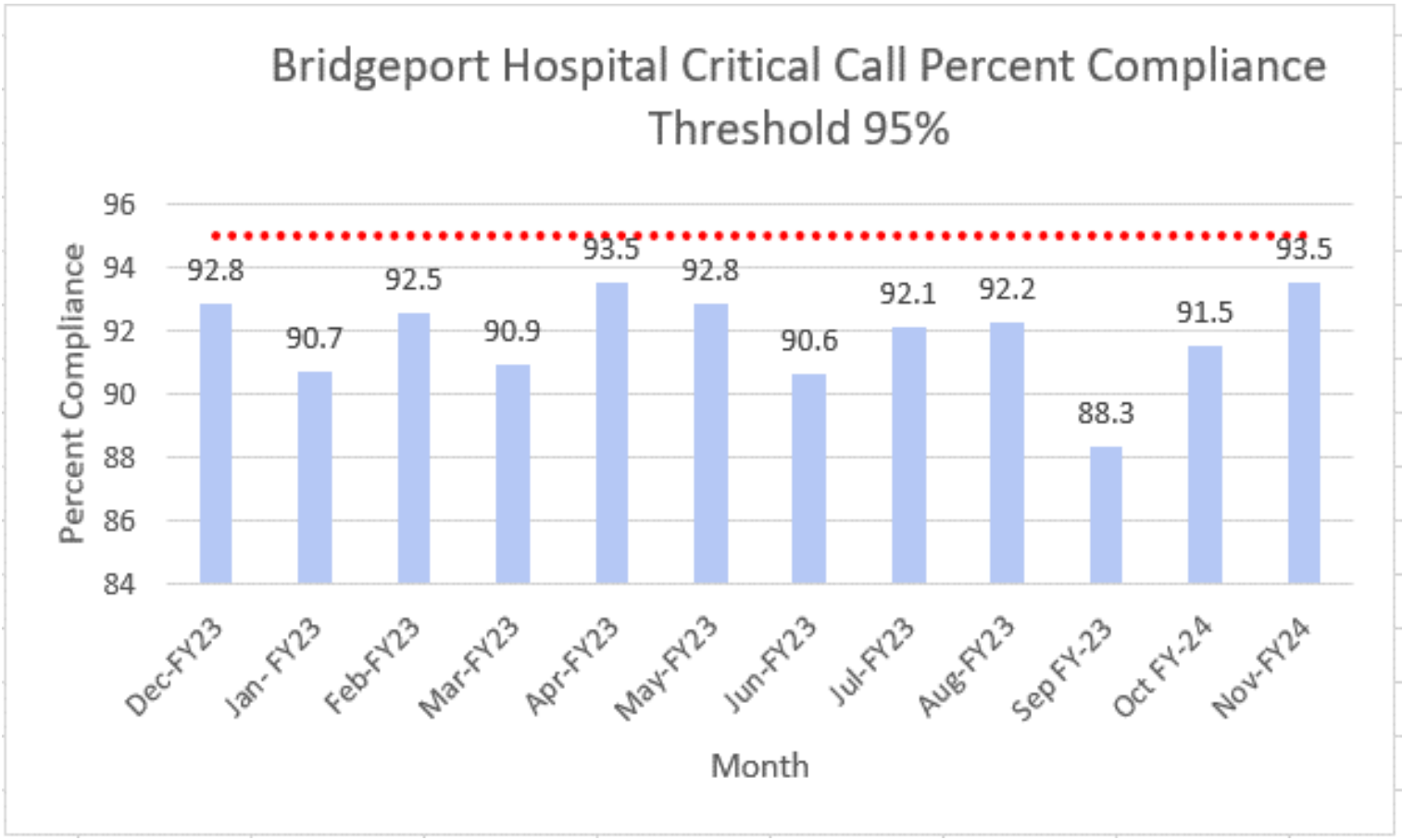
Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 91.6% (12 month cumulative) 12/1/2022-11/30/2023



NewHaven Health Bridgeport Hospital

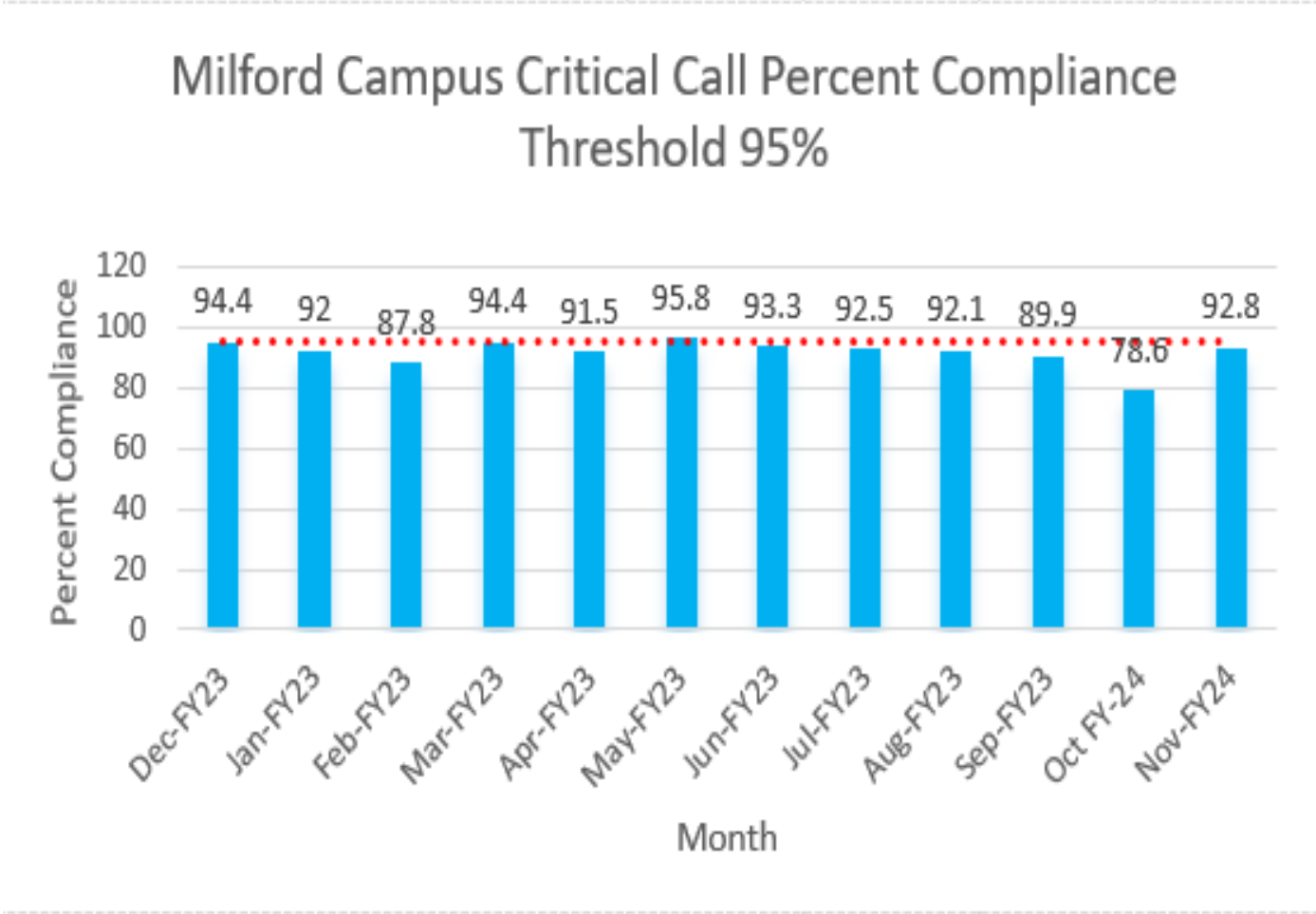
Bridgeport Campus Critical Call Percent Compliance 91.7%

12/1/2022- 11/30/2023



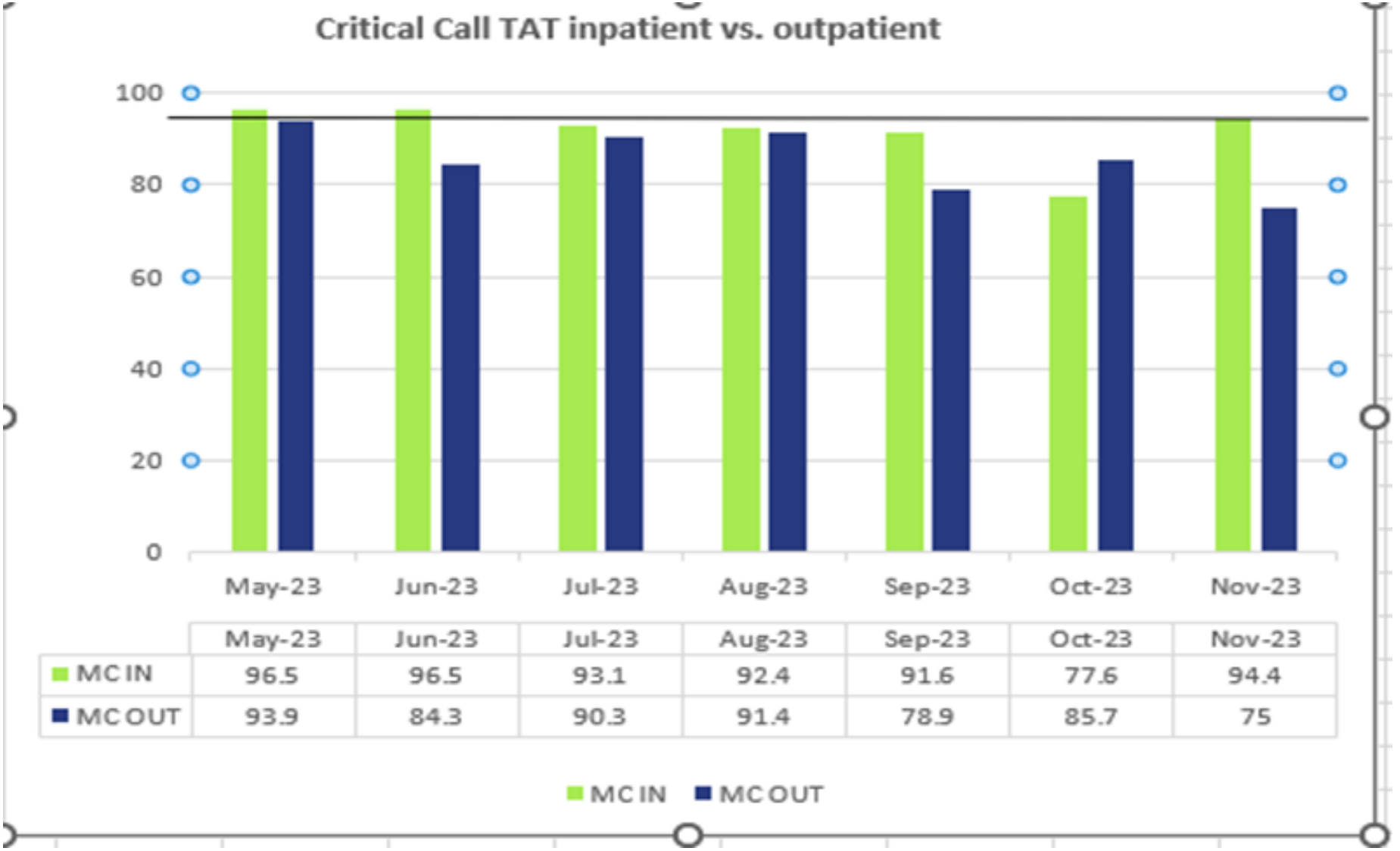
Yale NewHaven Health Bridgeport Hospital

Milford Campus Critical Call Percent Compliance 90.9%
12/1/2022-11/30/2023



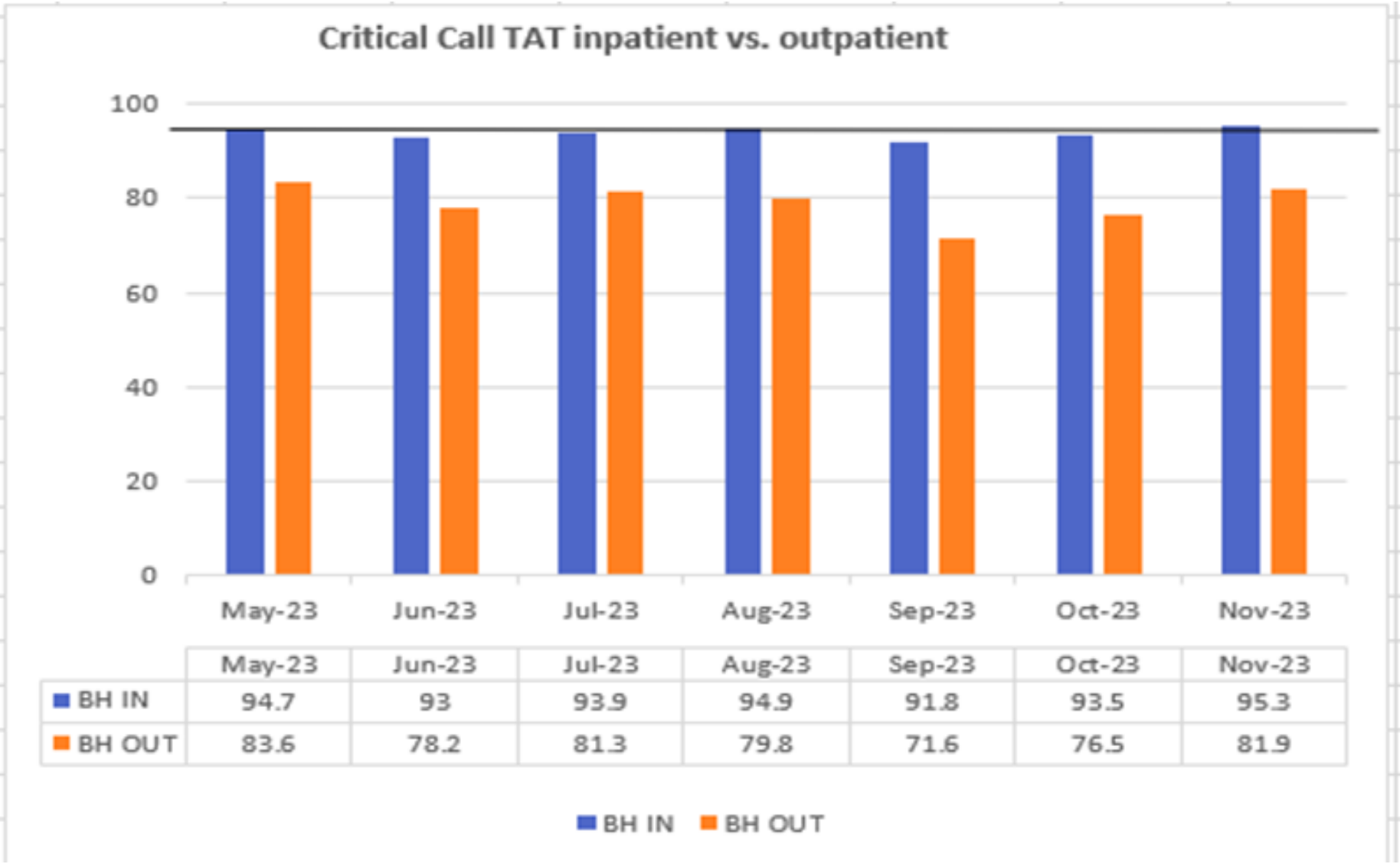
Yale NewHaven Health Bridgeport Hospital

Critical Call TAT
Inpatient vs. Outpatient



	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
MC IN	96.5	96.5	93.1	92.4	91.6	77.6	94.4
MC OUT	93.9	84.3	90.3	91.4	78.9	85.7	75

Critical Call TAT
Inpatient vs. Outpatient



	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
BH IN	94.7	93	93.9	94.9	91.8	93.5	95.3
BH OUT	83.6	78.2	81.3	79.8	71.6	76.5	81.9