Yale NewHaven Health
Bridgeport Hospital

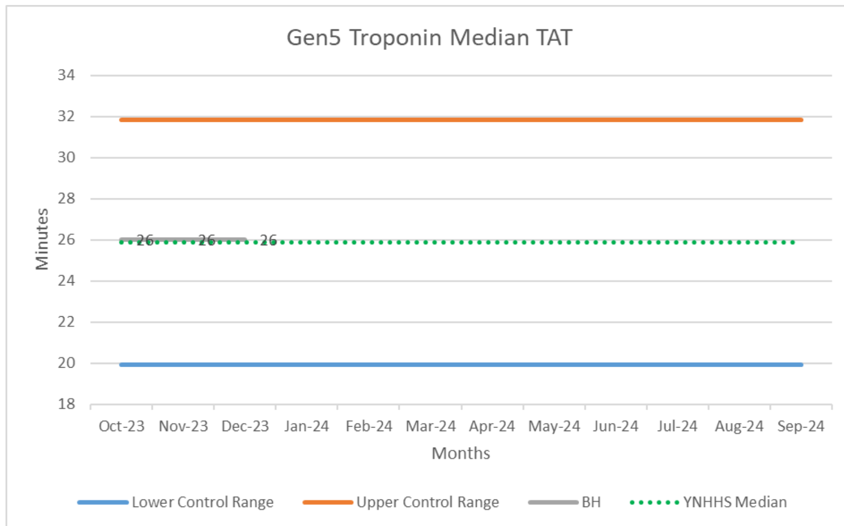
Laboratory Medicine – December 2023

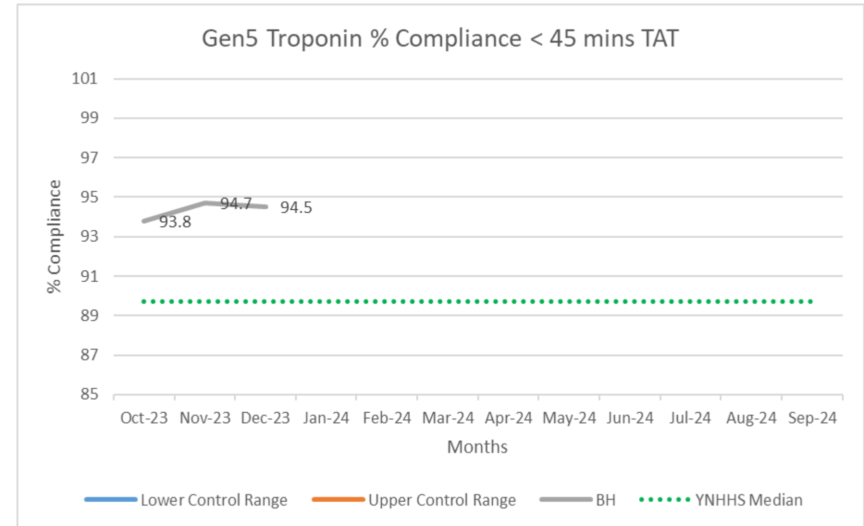
January 31, 2024

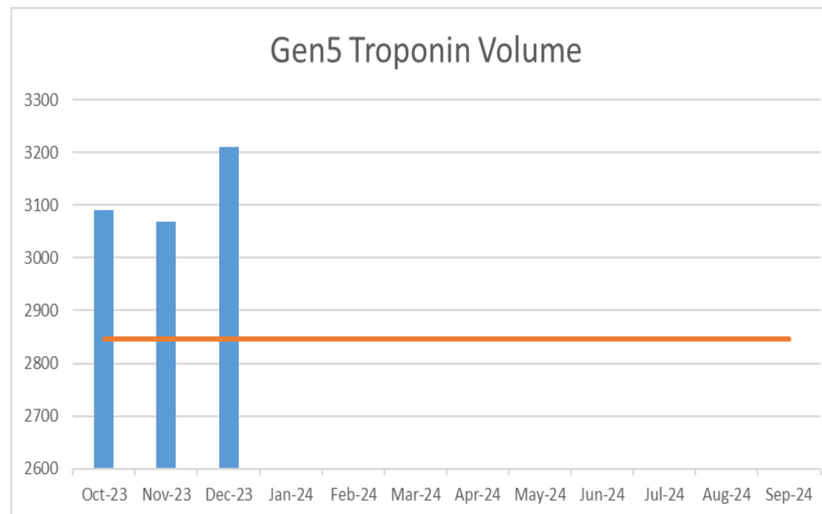
Bridgeport and Milford Campuses Turnaround Time Goals

- 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

Bridgeport Campus – Gen 5 Troponin TAT

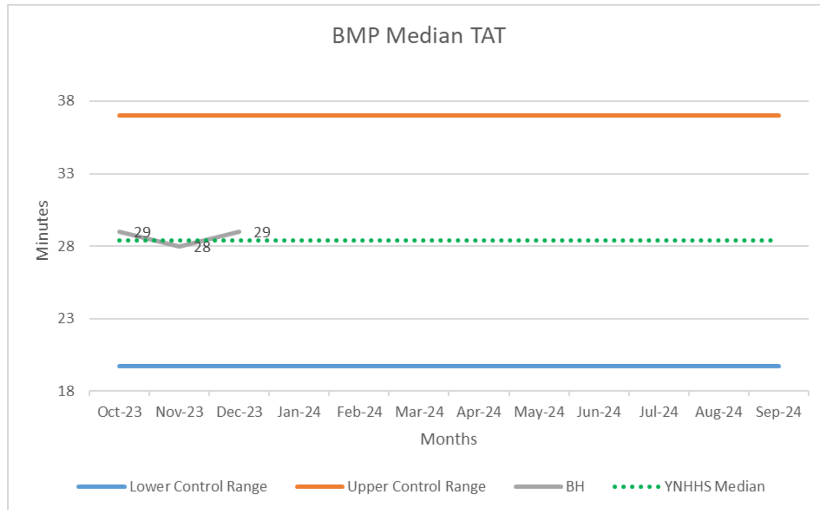


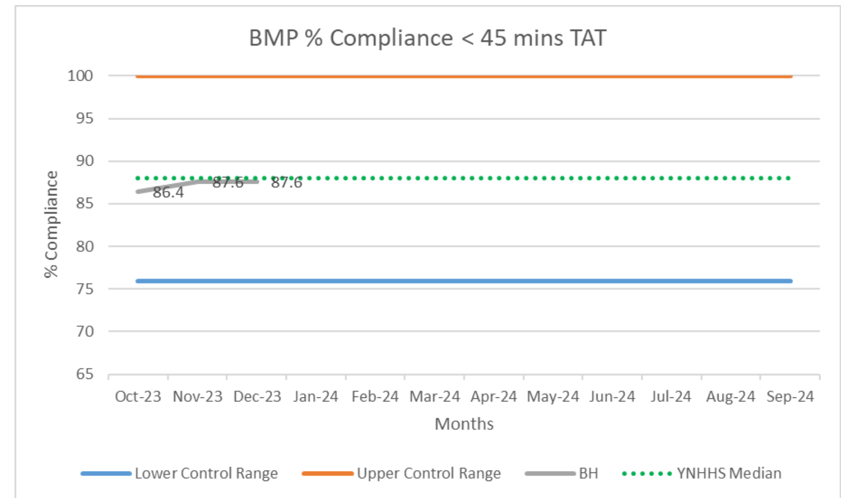


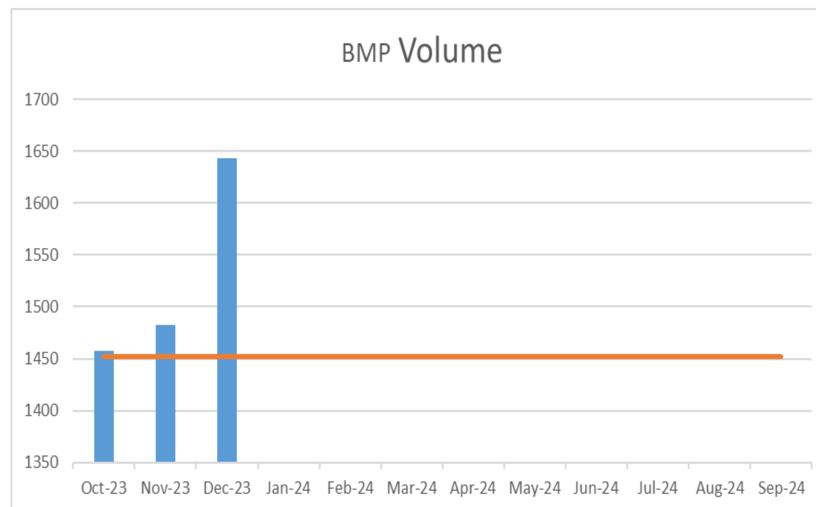


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – Basic Metabolic Panel (BMP) ED TAT

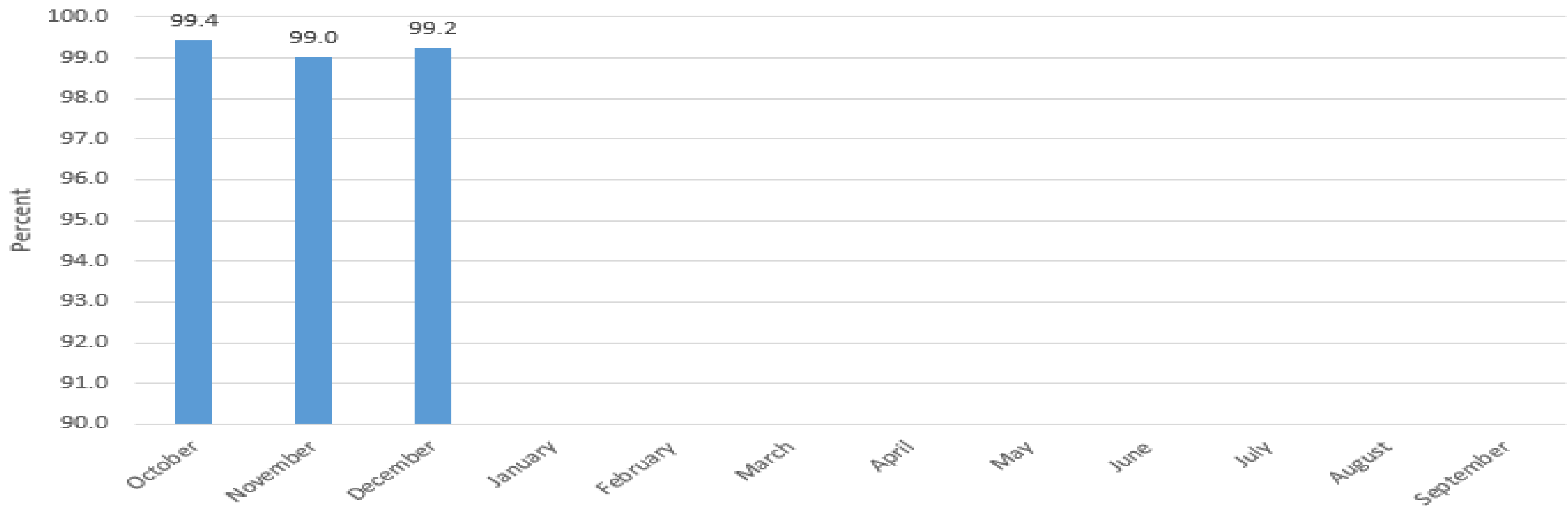






Yale NewHaven Health
Bridgeport Hospital

Chemistry



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
n	1386	1504	1684									
#compliant	1378	1490	1671									
#noncompliant	8	15	13									

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
no name	2	4	4									
no full name	1	3	2									
no credentials	5	6	5									
incorrect docum.		1										
incorrect person		1	1									
not called			1									

no name: tech must backspace the field and enter correct name

Each outlier was addressed with individual tech.

Chemistry

FY 2024 Quantiferon Indeterminate Rate

Percent

20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0

October	November	December	January	February	March	April	May	June	July	August	September
2.3	2.1	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
N	266	237	200									
indeterminate	6	5	3									

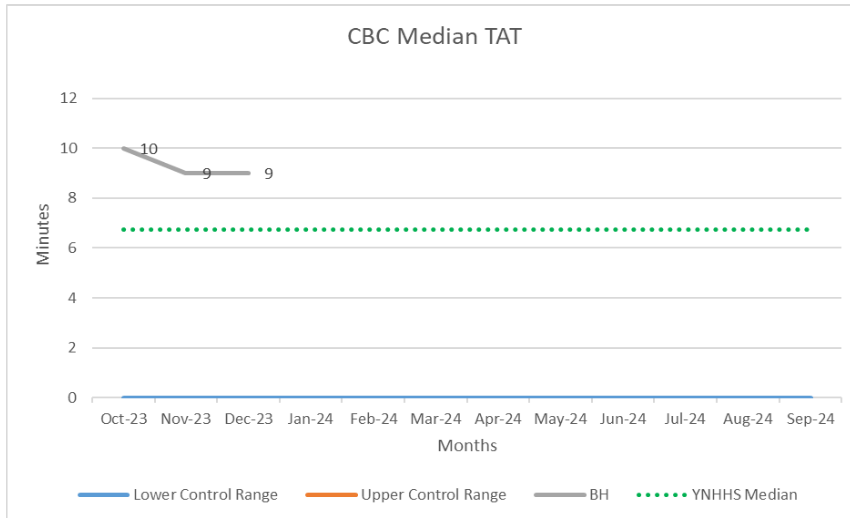
Chemistry

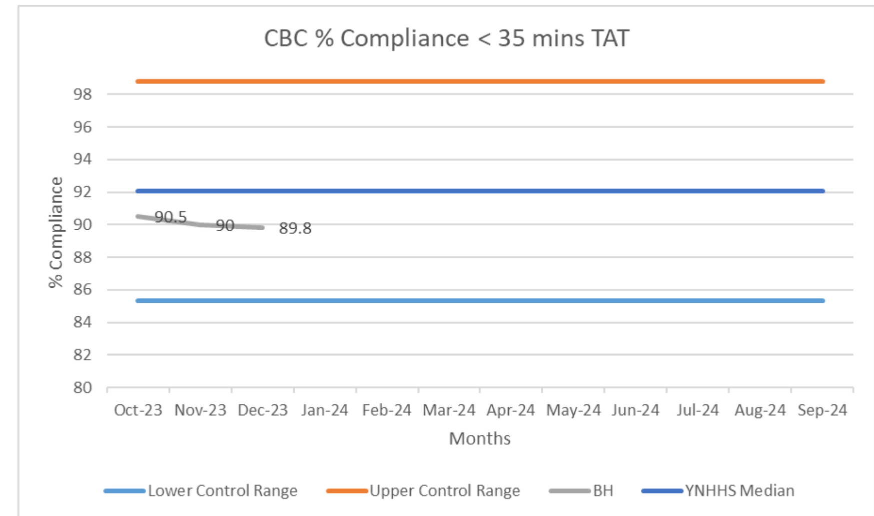
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
redraws	57	31	61									
rate %	19.4	14.2	24.0									

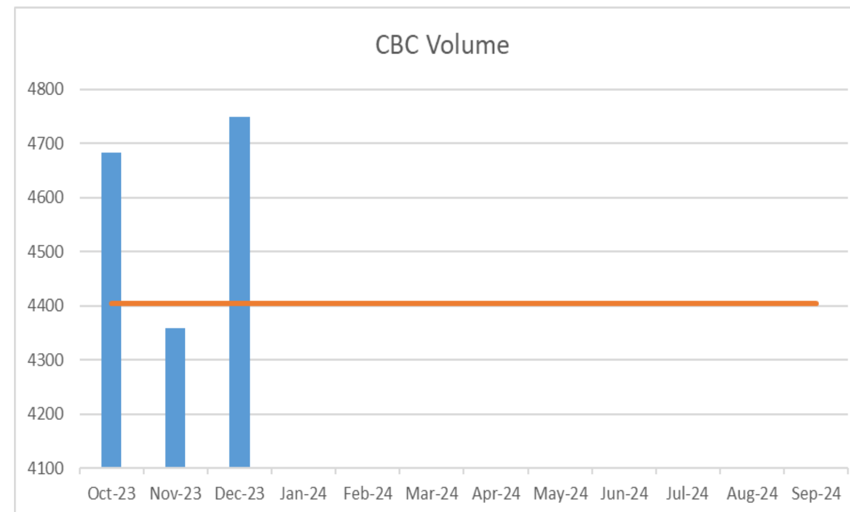
hemolyzed	44	26	48									
QNS	10	3	7									
overfilled	2	0	4									
other	1	2	2									

Other = 2 on same day, canceled by CP "Unacceptable for testing"

Bridgeport Campus – Complete Blood Count (CBC) ED TAT

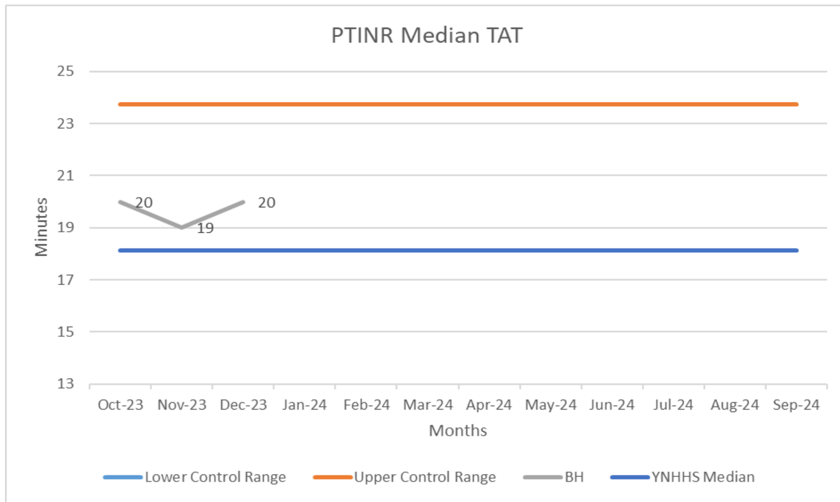


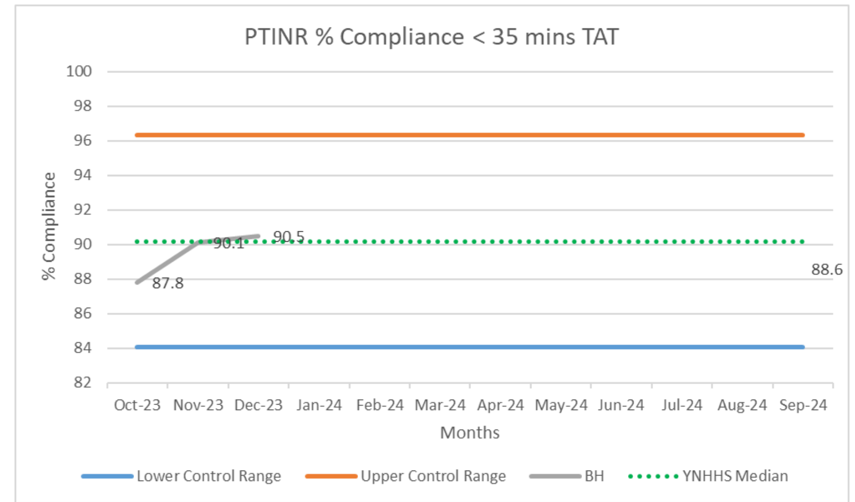


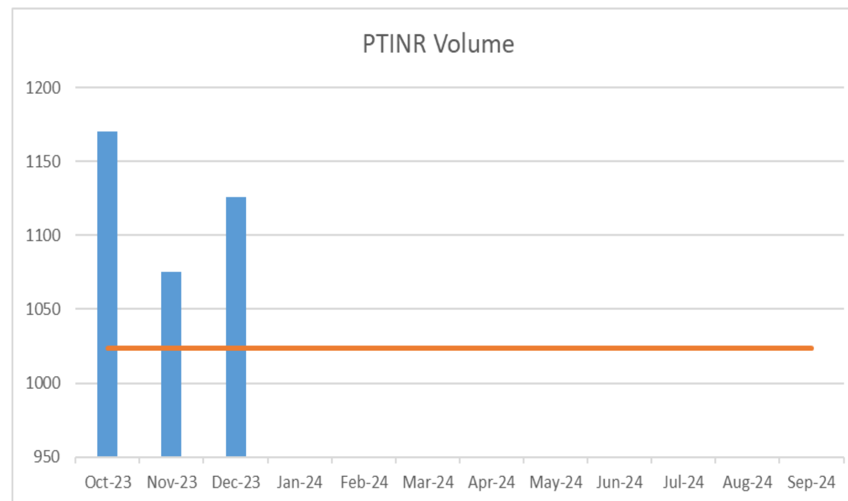


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – PTINR ED TAT

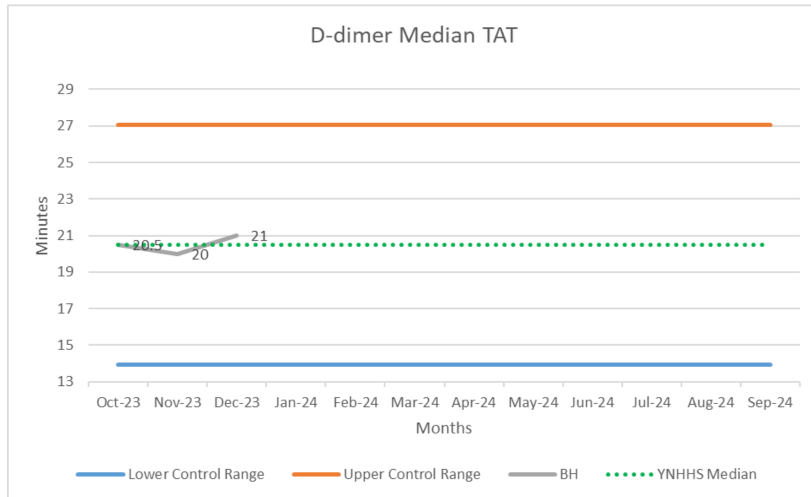


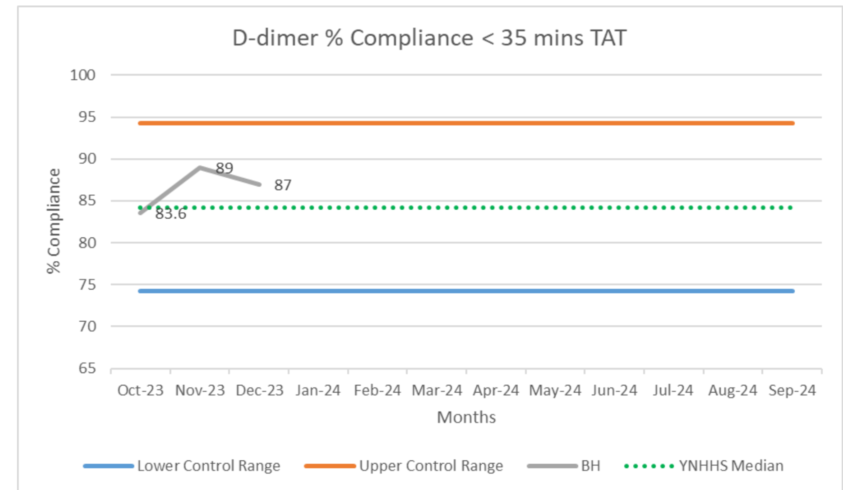


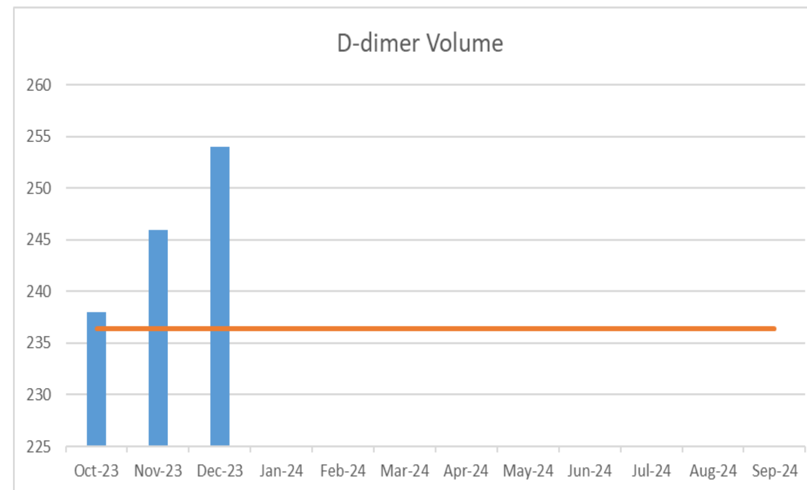


Yale NewHaven Health
Bridgeport Hospital

Bridgeport Campus – D-dimer ED TAT







Yale NewHaven Health
Bridgeport Hospital

Aspect of Care

Body Fluid /Cytology comparison
Expected Threshold-100%

101%
100%
99%
98%
97%
96%
95%
94%
93%

96% 100% 98%

Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

	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	170									
cytology ordered	69	62	80									
# of fluid diffs that did not correlate	3	0	2									
# of fluids correlated	66	62	78									
Threshold achieved	96%	100%	98%									
Expected	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Action/ Outcome	Dr. Minerowicz reviewed. One slide with suspicious cells.		Both fluids - suspicious for malignancy. Dr. Minerowicz to review									

Aspect of Care

CORRECTED REPORTS

% correct Documentation

120%
100%
80%
60%
40%
20%
0%

Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
corrected appended results	11	10	7									
incorrect documentation	5	0	1									
correct documetation	6	10	6									
% correct	55%	100%	86%	#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.		1 corrected result not communicated. Spoke to individual tech									

Aspect of Care

CRITICAL CALL COMPLIANCE

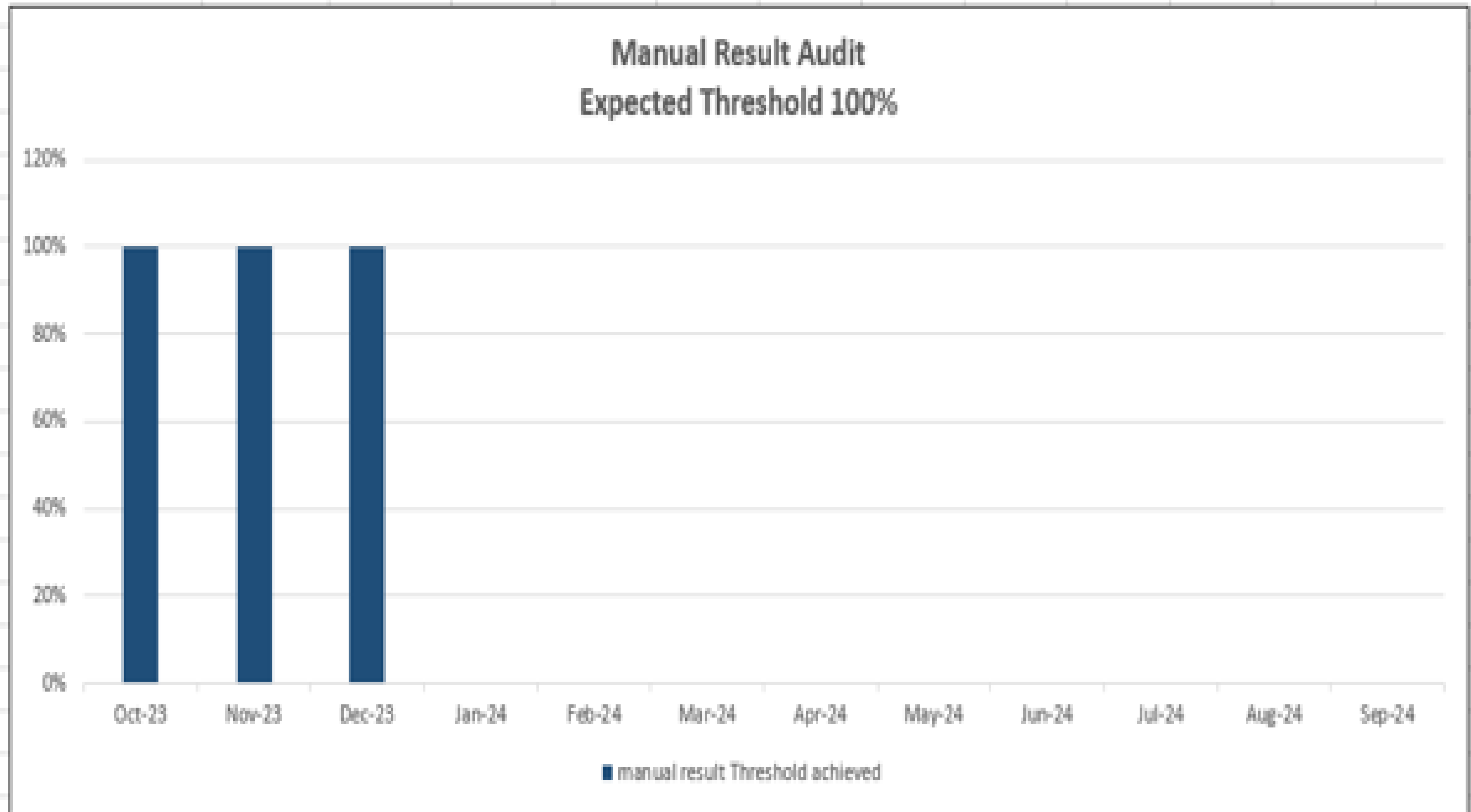
120.0
100.0
80.0
60.0
40.0
20.0
0.0

Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24

coag CBC

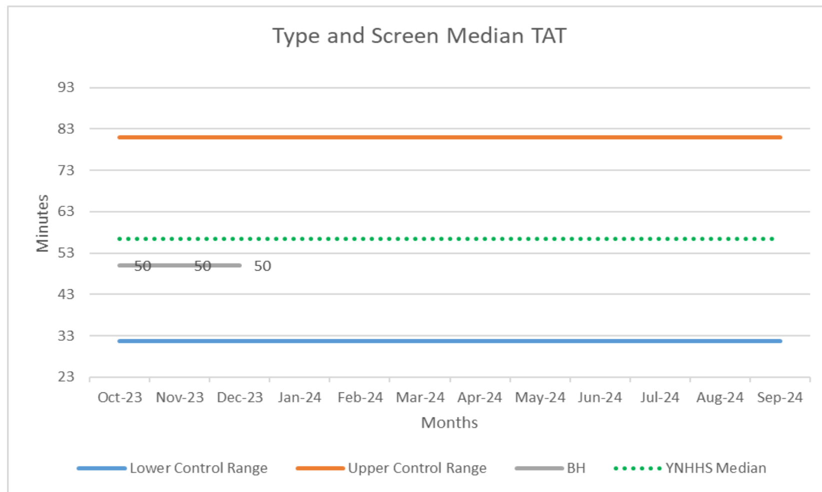
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total Calls	138	564	486									
compliant	128	558	480									
CBC Critical audit	20											
compliant	20											
% compliant	92.8	98.9	98.8	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
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	2-no credentials. Same Tech-counselled 4 last initial only. Same tech. Tech counselled.									

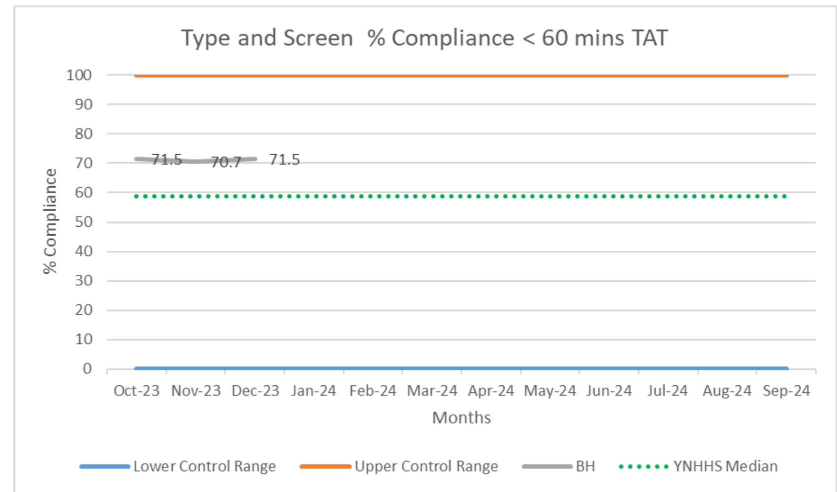
Aspect of Care

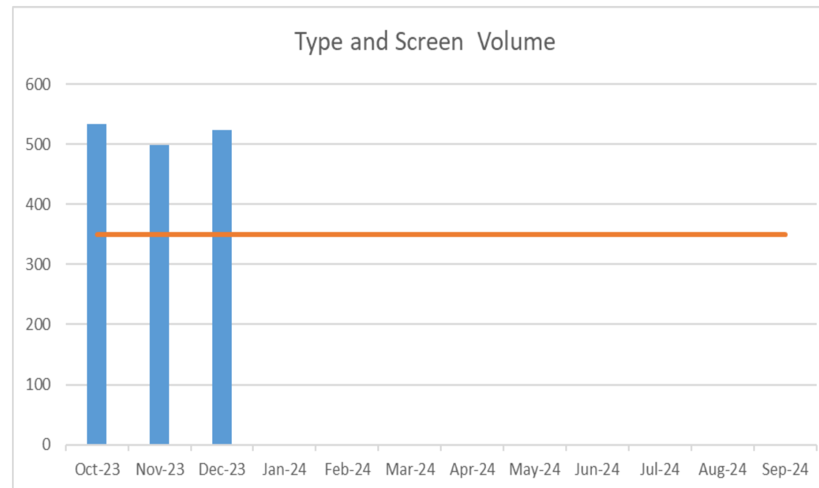


N=30

Bridgeport Campus – Type and Screen ED TAT







Yale NewHaven Health
Bridgeport Hospital

Yale NewHaven Health

QA Report: Department Pathology

1/16/2023

Bridgeport Hospital and Milford Campus

Laboratory Blood Bank

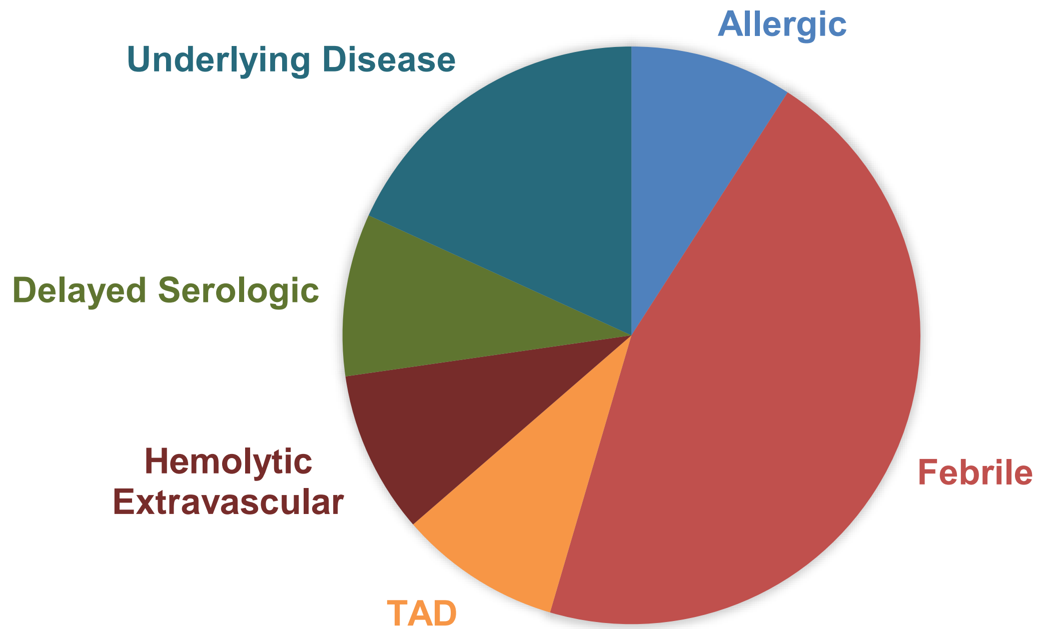
Edward Snyder MD, Christine Minerowicz MD, Lisa Krause, Melissa Morales, Teodorico Lee, Laura Buhlmann

Bridgeport Hospital Transfusion Reactions FY24

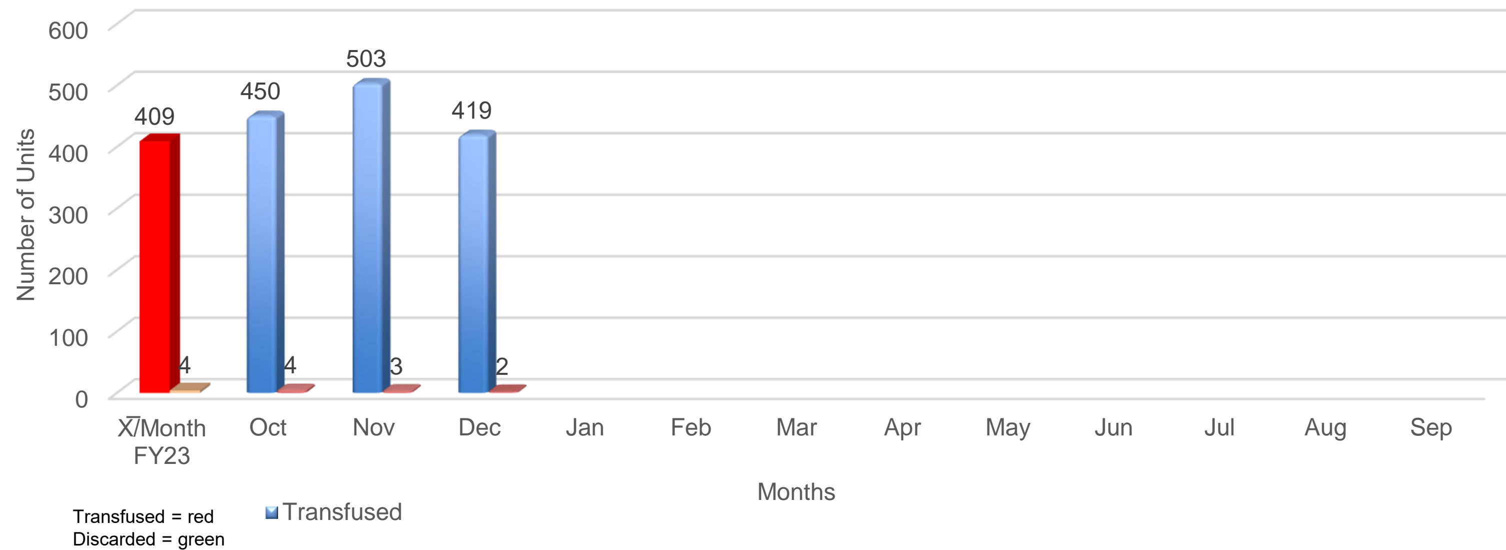
Months	Total	Allergic	Febrile	Anaphy	TACO	TRALI	TAD	Hemolytic Intravascular	Hemolytic Extravascular	Delayed Serologic	Septic	Underlying Disease
	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH
Oct	6	0	2	0	0	0	1	0	1	1	0	1
Nov	4	1	2	0	0	0	0	0	0	0	0	1
Dec	1	0	1	0	0	0	0	0	0	0	0	0
Jan	0											
Feb	0											
Mar	0											
Apr	0											
May	0											
Jun	0											
Jul	0											
Aug	0											
Sep	0											
Total	11	1	5	0	0	0	1	0	1	1	0	2

Yale NewHaven Health
Bridgeport Hospital

BRIDGEPORT HOSPITAL TRANSFUSION REACTIONS FY24
OCT – DEC



Bridgeport Hospital



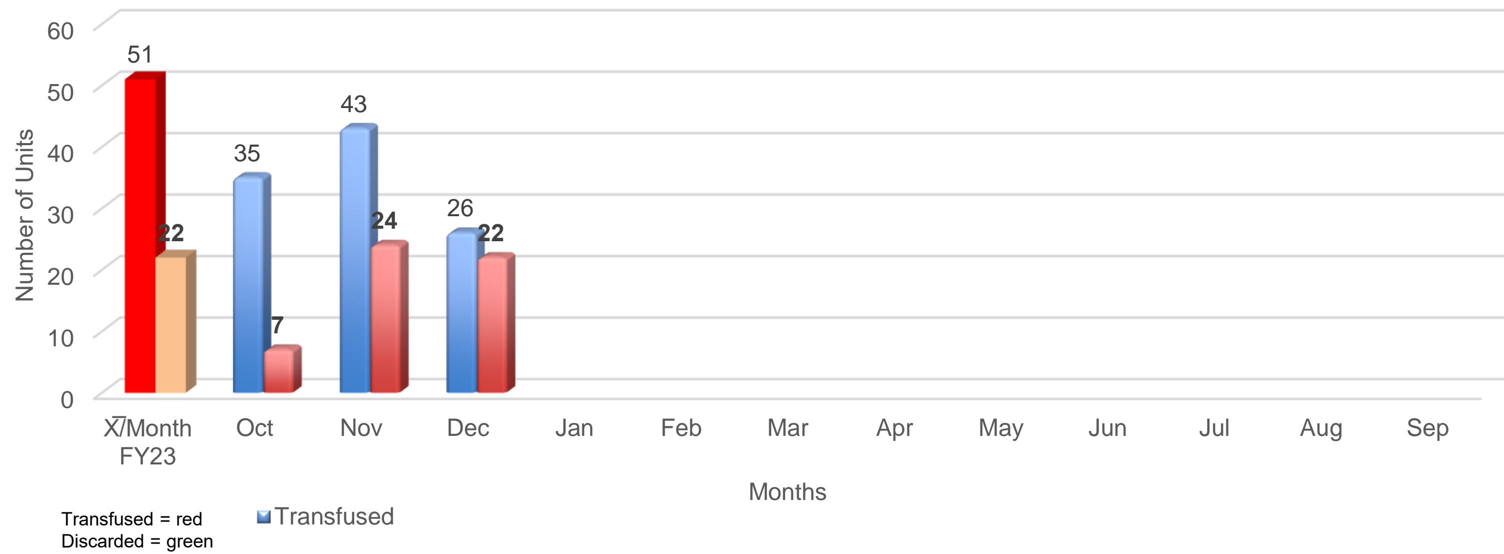
Bridgeport Hospital Blood Bank - FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	Mean ± SD	Total Amount
Transfused	450	503	419										1372	457 ± 42	$364,266.00
Discarded	4	3	2										9	3 ± 1	$1,593.00
Expired*	0	1	0										1	0.3 ± 1	$0.00
Wasted**	4	2	2										8	3 ± 1	$1,593.00
% Discarded	0.88%	0.59%	0.48%												
Total	454	506	421	0	0	0	0	0	0	0	0	0	1381	460 ± 43	$366,655.50

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



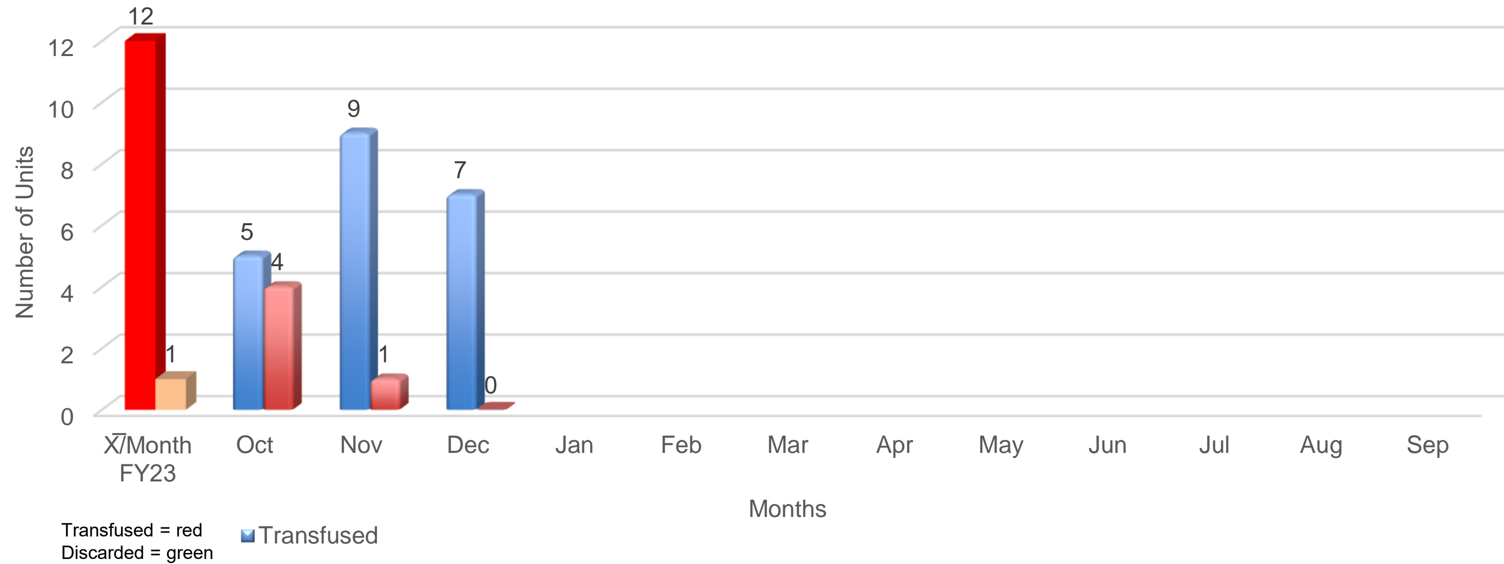
Bridgeport Hospital Blood Bank - FY24

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	Mean ± SD	Total Amount
Transfused	35	43	26										104	35 ± 9	$4,044.56
Discarded	7	24	22										53	18 ± 9	$2,061.17
Expired*	0	0	0										0	0 ± 0	$0.00
Wasted**	7	24	26										57	19 ± 10	$2,216.73
% Discarded	17%	36%	46%												
Total	42	67	48										157	52 ± 13	$6,105.73

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



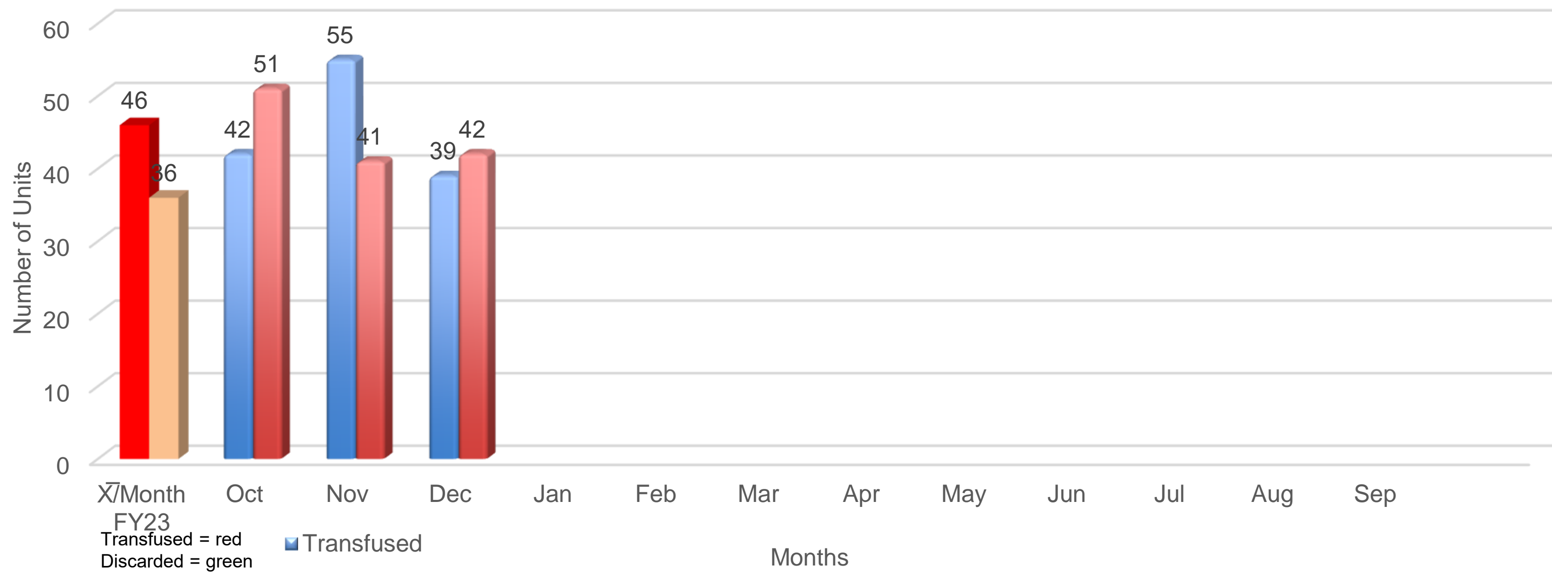
Bridgeport Hospital Blood Bank - FY24

Cryo

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	Mean ± SD	Total Amount
Transfused	5	9	7										21	7 ± 2	$6,961.50
Discarded	4	1	0										5	2 ± 2	$1,657.50
Expired	2	1	0										3	1 ± 1	$994.50
Wasted	2	0	0										2	1 ± 1	$663.00
% Discarded	44%	10%	0%												
Total	9	10	7										26	9 ± 2	$8,619.00

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

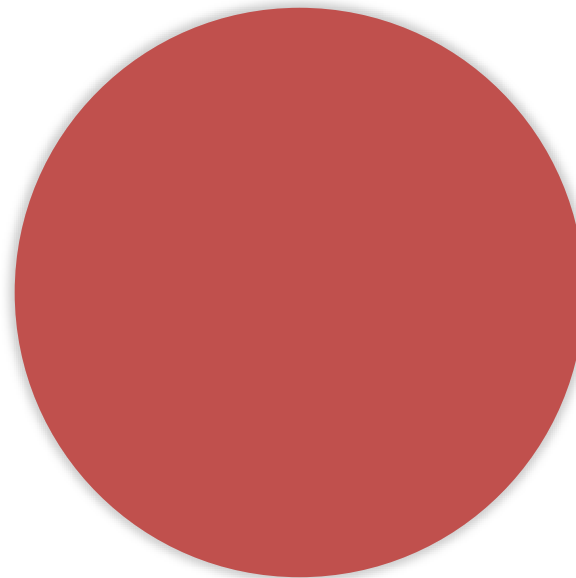
FY24

BH Platelet Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Total	Mean ± SD	Total Amount
Total	93	96	81										270	90±8	**$181,799.10**
Transfused	42	55	39										136	45±9	**$91,572.88**
Discarded	51	41	42										134	45±6	**$90,226.22**
Expired	51	41	42										134	45±6	**$90,226.22**
Wasted	0	0	0										0	0±0	**$0.00**
% Discarded	55%	43%	52%												

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

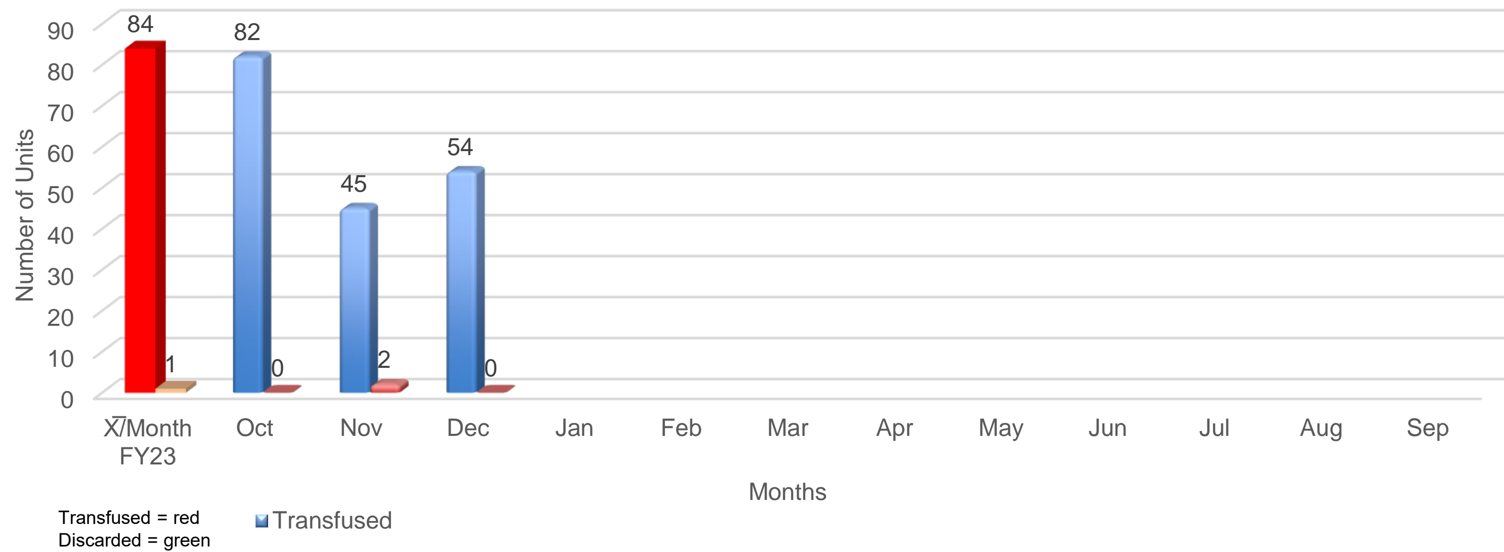
MILFORD HOSPITAL TRANSFUSION REACTIONS
FY24
OCT – DEC



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	0	0	0	0	0	0	0	0	0	0	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



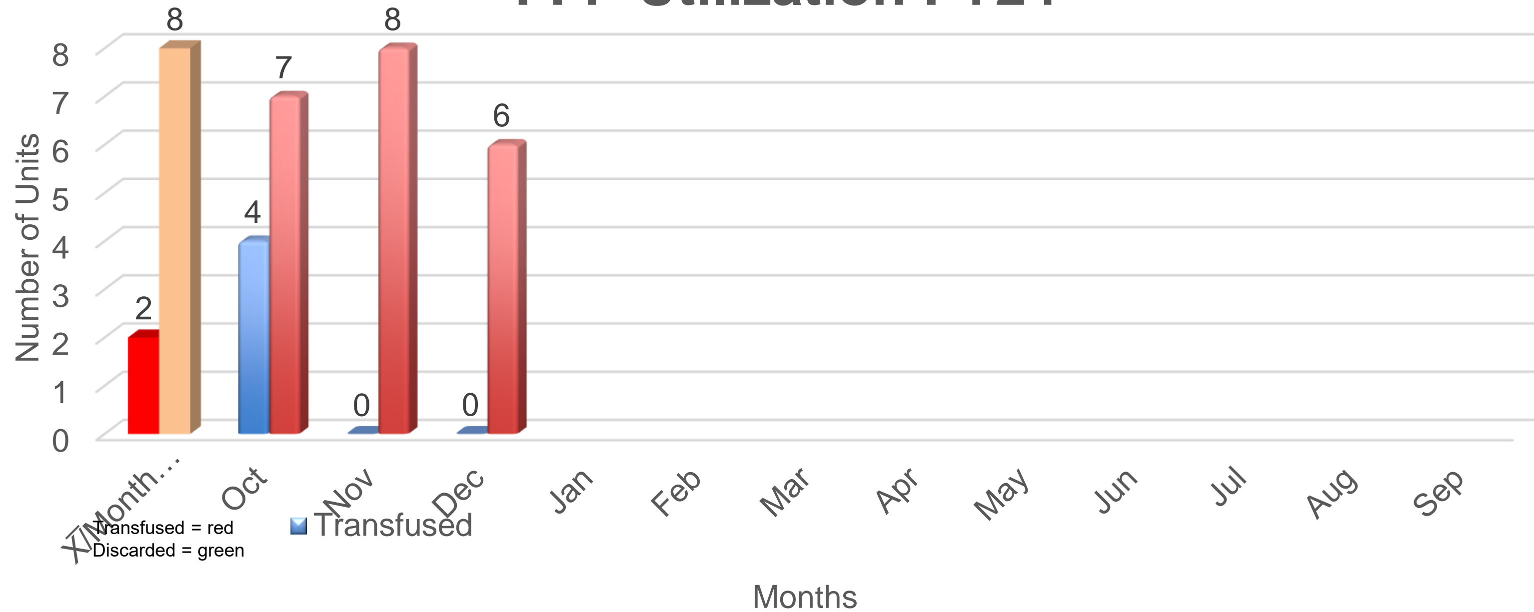
Milford Hospital Blood Bank FY24

RBC Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	Mean ± SD	Total Amount
Transfused	82	45	54										181	60 ± 19	$48,055.50
Discarded	0	2	0										2	1 ± 1	$531.00
Expired	0	1	0										1	0.3 ± 1	$265.50
Wasted	0	1	0										1	0.3 ± 1	$265.50
% Discarded	0%	4%	0%												
Total	82	47	54										183	61 ± 19	$48,586.50

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

FFP Utilization

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	Mean ± SD	Total Amount
Transfused	4	0	0										4	1±2	$155.56
Discarded	7	8	6										21	7±1	$816.69
Expired	0	8	6										14	5±4	$544.46
Wasted	7	0	0										7	2±4	$272.23
% Discarded	64%	100%	100%												
Total	11	8	6										25	8±3	$972.25

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

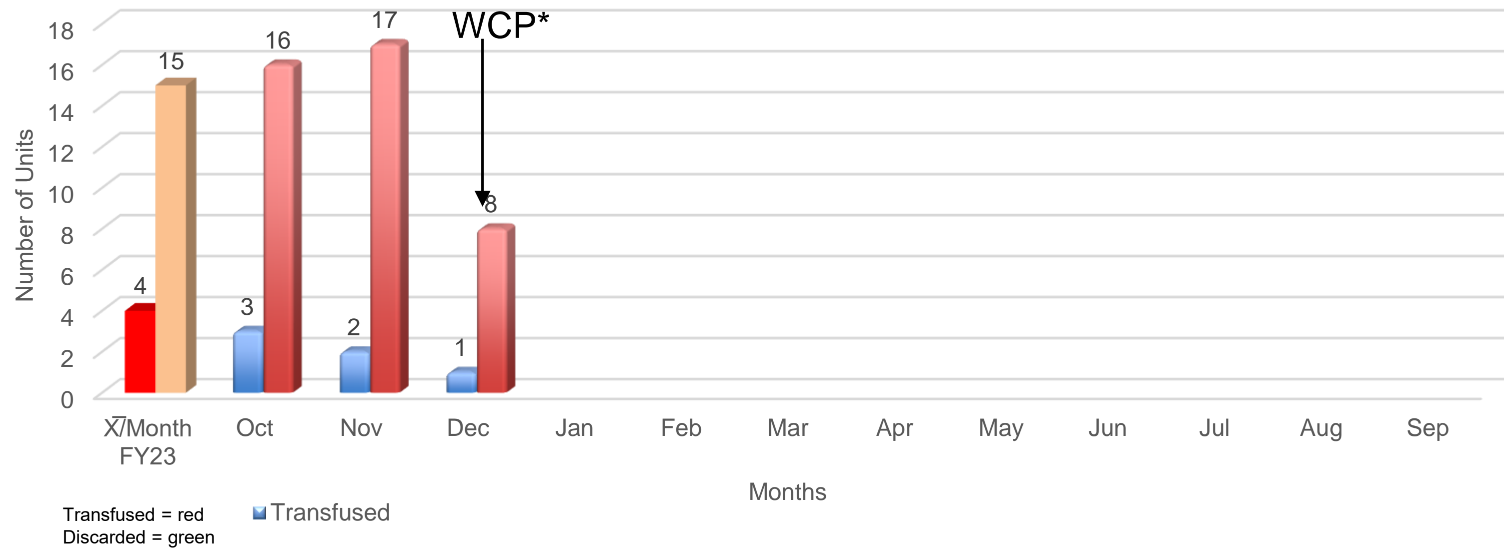
Milford Hospital Blood Bank FY24

Cryo Utilization

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

WCP
*

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Mean ± SD	Total	Total Amount
Total	**19**	**19**	**9**										**16 ± 6**	**47**	**$31,646.51**
Transfused	**3**	**2**	**1**										**2 ± 1**	**6**	**$4,039.98**
Discarded	**16**	**17**	**8**										**14 ± 5**	**41**	**$27,606.53**
Expired	**16**	**17**	**8**										**14 ± 5**	**41**	**$27,606.53**
Wasted	**0**	**0**	**0**										**0 ± 0**	**0**	**$0.00**
% Discarded	**84.21%**	**89.47%**	**88.89%**												

WCP* = Wastage Control Program
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	1										1 LQC run 2 days late on one of the instruments. All patient results documented correctly.
Incorrectly documented Urine POC Pregnancy Internal QC	0 errors	7 Volume = 1442	7 Volume = 1309	9 Volume = 1132										Email sent to 9 staff that have not previously had an issue. One was from a non-designated unit so this was also addressed with the Assistant Manager.
# of i-STAT codes / # of cartridges run		17 / 459	29/393	22/388										2of the iSTATs produced 8 instrument codes and needed to be conditioned. 3 of the codes were environmental from the burn room. No staff issues.
i-STAT Quality Check Codes	<5.0%	3.7%	7.4%	5.7%										

Yale NewHaven Health

CRSQ Report Out

Committee of Regulatory, Safety, & Quality

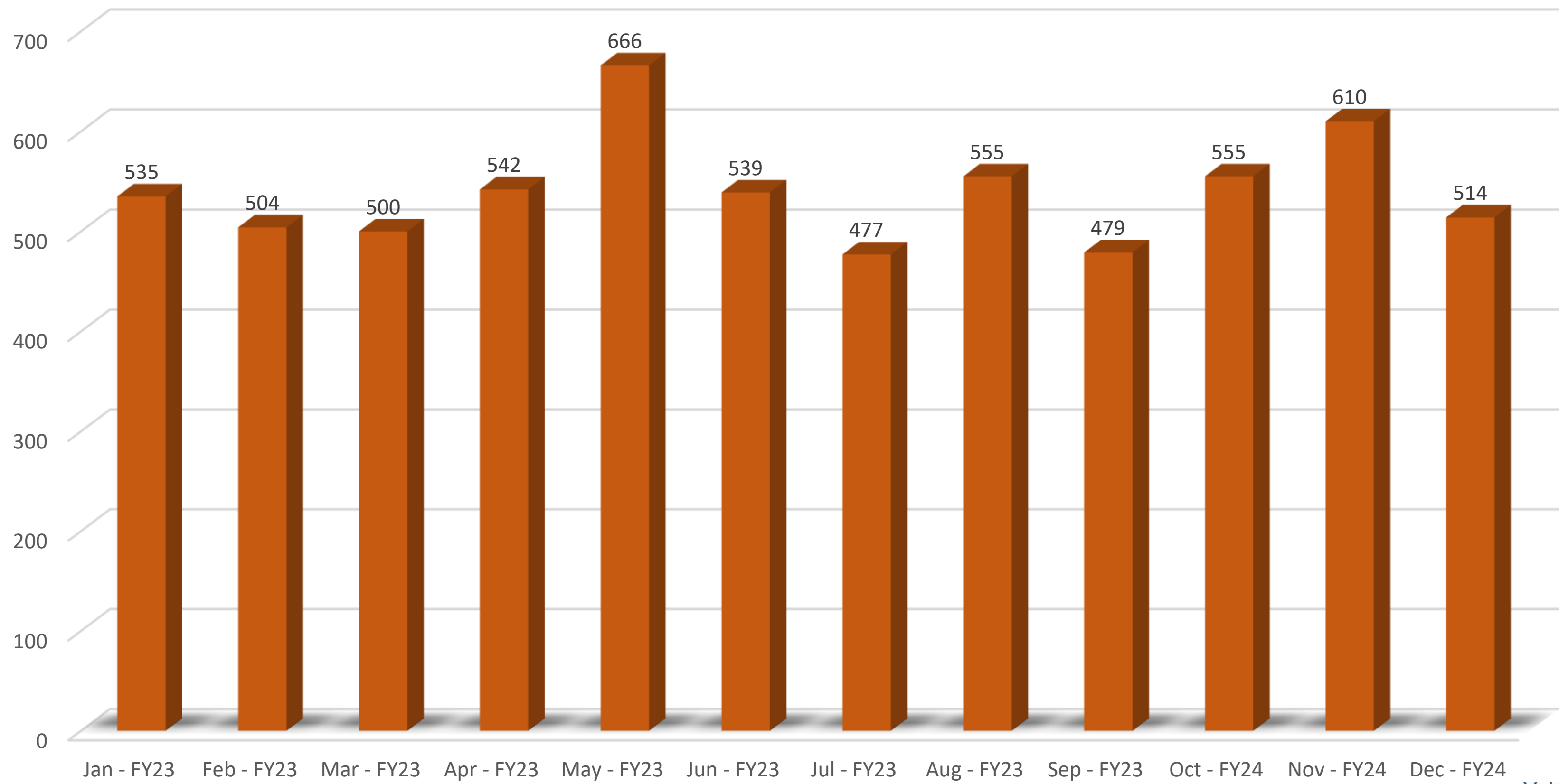
1/12/2023

Bridgeport Hospital

Laboratory Blood Bank

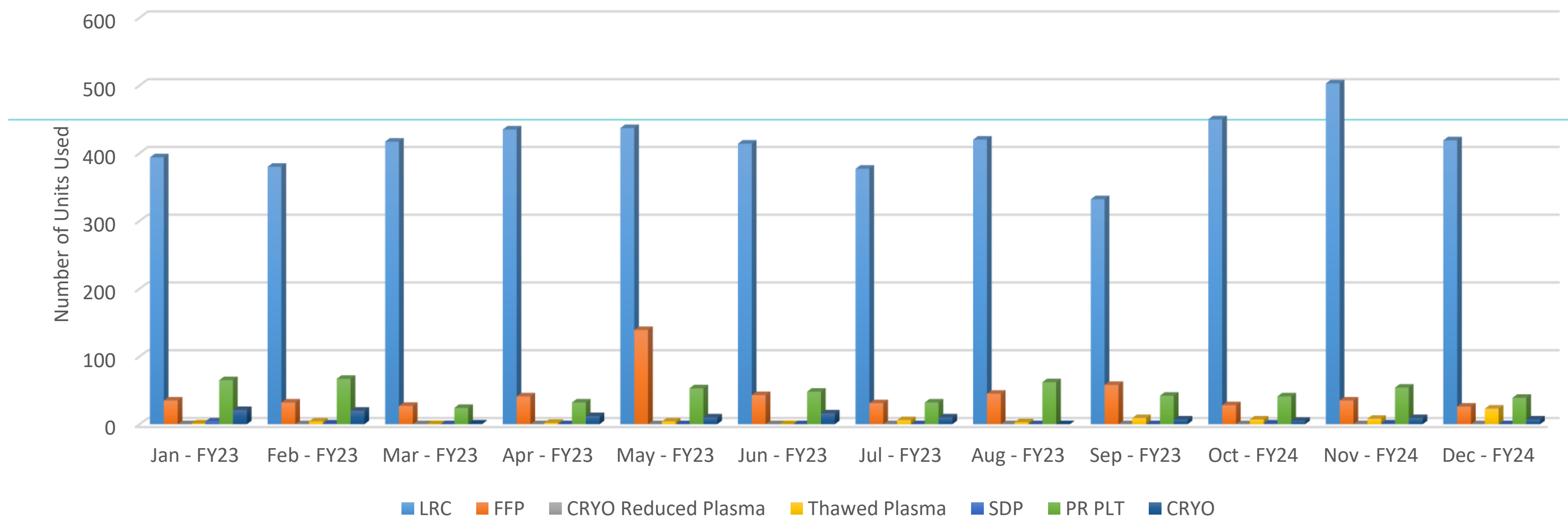
Edward Snyder MD, Christine Minerowicz MD, Lisa Krause, Melissa Morales, Teodorico Lee, Laura Buhlmann

PI.01.01.01 EP6



Yale NewHaven Health
Bridgeport Hospital

Transfused Blood Products By Component - BH

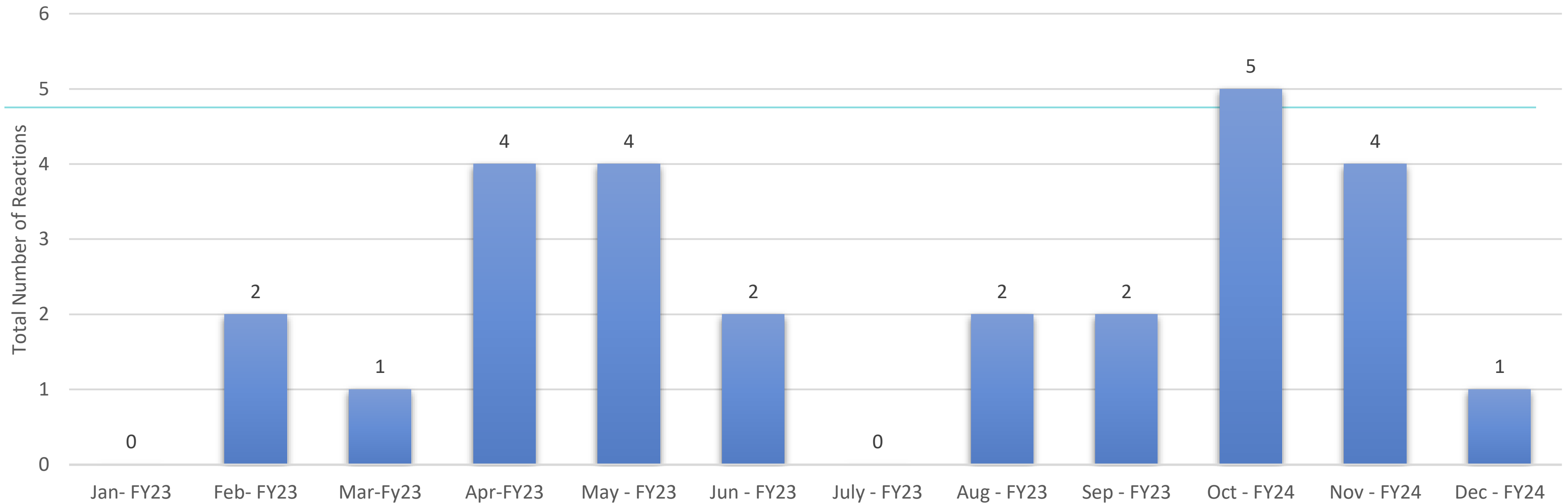


	Total Products	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	Total Plasma	SDP	PR PLT	Total Platelets	CRYO
Jan - FY23	535	394	35	0	1	36	4	65	69	21
Feb - FY23	504	380	32	0	4	36	1	67	68	20
Mar - FY23	500	417	27	0	0	27	0	24	24	1
Apr - FY23	542	435	41	0	2	43	0	32	32	12
May - FY23	666	437	139	0	4	143	0	53	53	10
Jun - FY23	539	414	43	0	0	43	0	48	48	16
Jul - FY23	477	377	31	0	6	37	0	32	32	10
Aug - FY23	555	420	45	0	3	48	0	62	62	0
Sep - FY23	479	332	58	0	9	67	0	42	42	7
Oct - FY24	555	450	28	0	7	35	1	41	42	5
Nov - FY24	610	503	35	0	8	43	1	54	55	9
Dec - FY24	514	419	26	0	23	49	0	39	39	7

PI.01.01.01 EP6

Yale NewHaven Health Bridgeport Hospital

Total Transfusion Reactions - BH

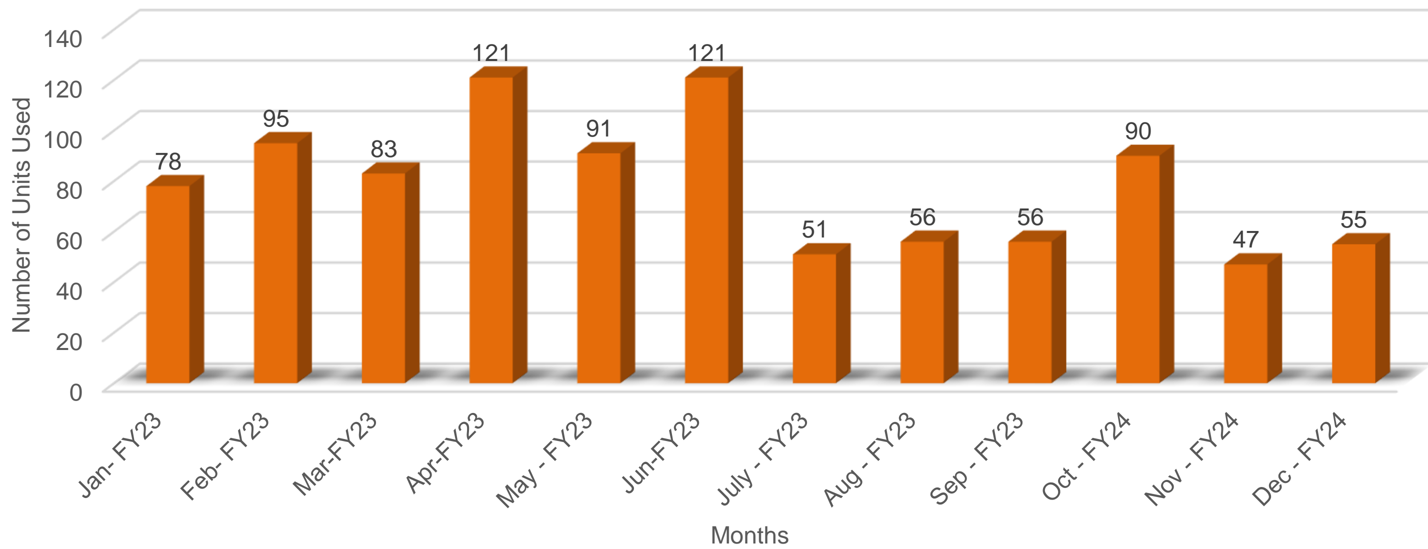


	Allergic	Febrile	Anaphylactic	TACO	TRALI	TAD	Septic	Hemolytic	Underlying Disease	Total
Jan- FY23	0	0	0	0	0	0	0	0	0	0
Feb- FY23	0	0	0	0	0	0	0	1	1	2
Mar-Fy23	0	1	0	0	0	0	0	0	0	1
Apr-FY23	1	2	0	1	0	0	0	0	0	4
May - FY23	1	1	0	0	0	0	0	0	2	4
Jun - FY23	0	0	0	0	0	0	0	0	2	2
July - FY23	0	0	0	0	0	0	0	0	0	0
Aug - FY23	0	2	0	0	0	0	0	0	0	2
Sep - FY23	1	1	0	0	0	0	0	0	0	2
Oct - FY24	0	2	0	0	0	1	0	0	2	5
Nov - FY24	1	2	0	0	0	0	0	0	1	4
Dec - FY24	0	1	0	0	0	0	0	0	0	1

PI.01.01.01 EP7

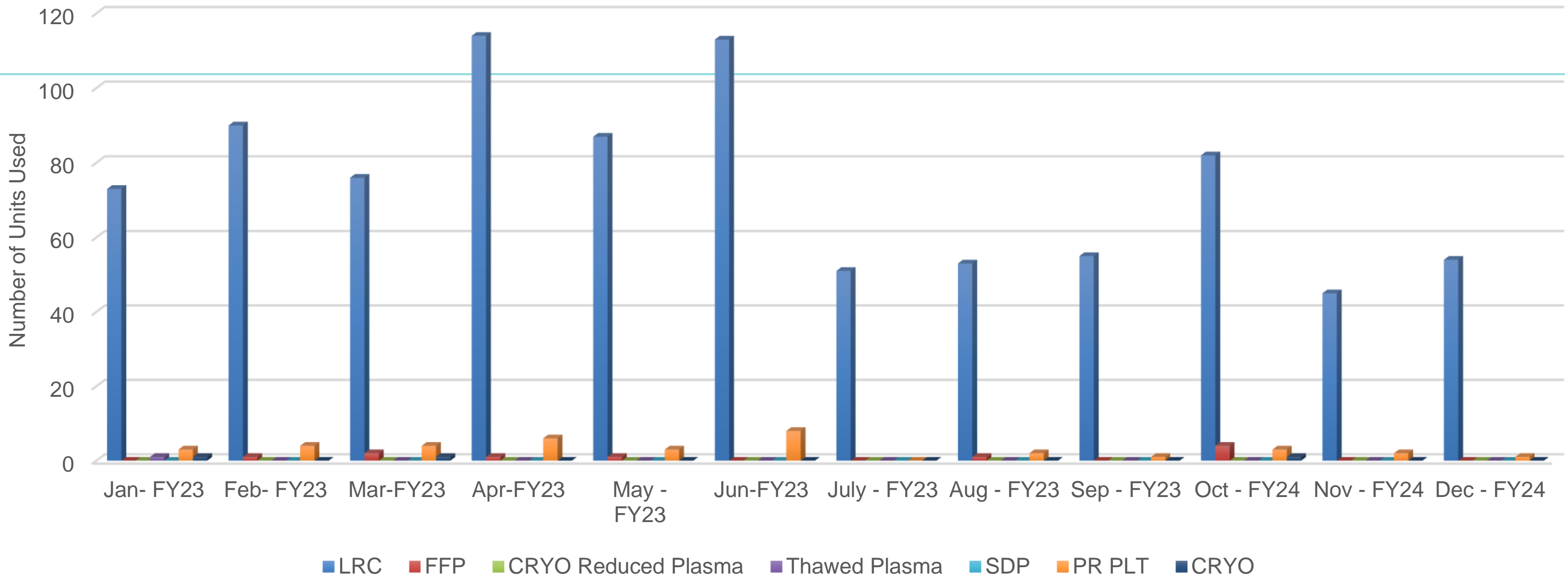
Yale NewHaven Health
Bridgeport Hospital

PI.01.01.01 EP6



Yale NewHaven Health
Bridgeport Hospital

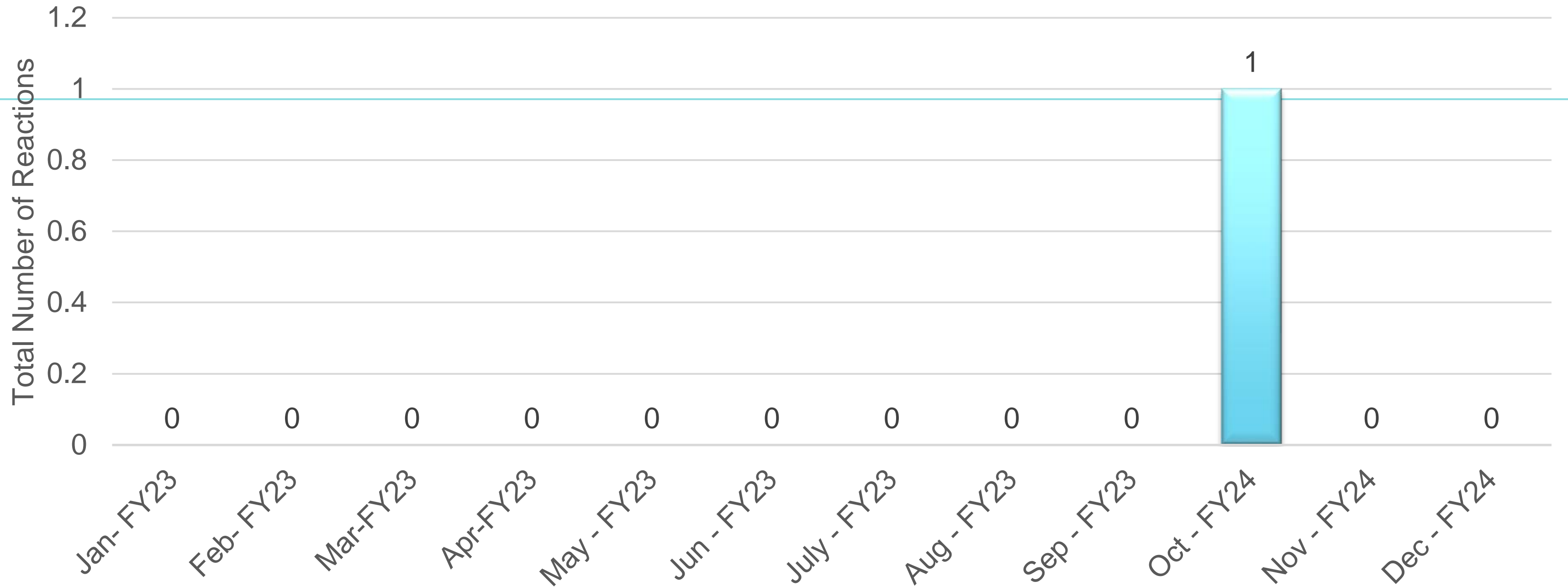
Transfused Blood Products By Component - MC



	Total Products	LRC	FFP	CRYO Reduced Plasma	Thawed Plasma	Total Plasma	SDP	PR PLT	Total Platelets	CRYO
Jan- FY23	78	73	0	0	1	1	0	3	3	1
Feb- FY23	95	90	1	0	0	1	0	4	4	0
Mar-FY23	83	76	2	0	0	2	0	4	4	1
Apr-FY23	121	114	1	0	0	1	0	6	6	0
May - FY23	91	87	1	0	0	1	0	3	3	0
Jun-FY23	121	113	0	0	0	0	0	8	8	0
July - FY23	51	51	0	0	0	0	0	0	0	0
Aug - FY23	56	53	1	0	0	1	0	2	2	0
Sep - FY23	56	55	0	0	0	0	0	1	1	0
Oct - FY24	90	82	4	0	0	4	0	3	3	1
Nov - FY24	47	45	0	0	0	0	0	2	2	0
Dec - FY24	55	54	0	0	0	0	0	1	1	0

Yale NewHaven Health Bridgeport Hospital

PI.01.01.01 EP6



	Allergic	Febrile	Anaphylactic	TACO	TRALI	TAD	Septic	Hemolytic	Underlying Diesease	Total
Jan- FY23	0	0	0	0	0	0	0	0	0	0
Feb- FY23	0	0	0	0	0	0	0	0	0	0
Mar-FY23	0	0	0	0	0	0	0	0	0	0
Apr-FY23	0	0	0	0	0	0	0	0	0	0
May - FY23	0	0	0	0	0	0	0	0	0	0
Jun - FY23	0	0	0	0	0	0	0	0	0	0
July - FY23	0	0	0	0	0	0	0	0	0	0
Aug - FY23	0	0	0	0	0	0	0	0	0	0
Sep - FY23	0	0	0	0	0	0	0	0	0	0
Oct - FY24	0	1	0	0	0	0	0	0	0	1
Nov - FY24	0	0	0	0	0	0	0	0	0	0
Dec - FY24	0	0	0	0	0	0	0	0	0	0

PI.01.01.01 EP7

Yale NewHaven Health
Bridgeport Hospital

Performance Improvement Plan

Lab Outreach Pre-Analytical Quality Indicator Monthly Review

December 2023

Average Wait Times

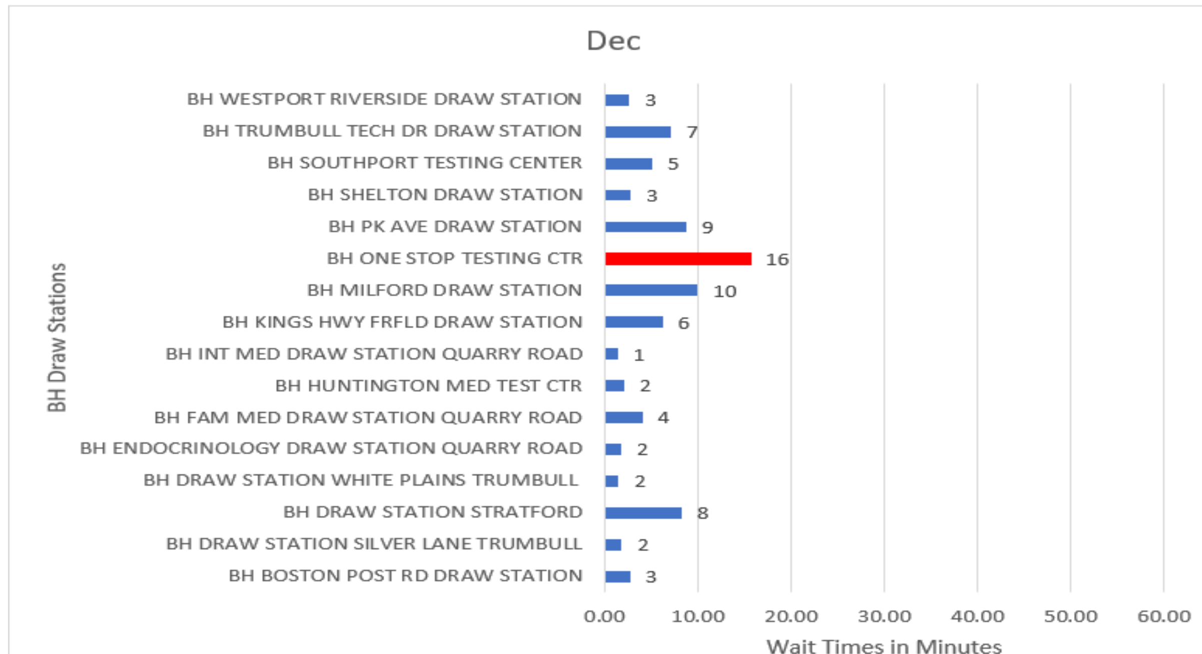
Section	**Lab Outreach/Phlebotomy**
Phase	**Pre-Analytical**
Title	**Average Wait Times**
Objective	**Calculate the average times from patient check-in/registration to the point of specimen collection for each DN. This metric ensures patient satisfaction and monitors phlebotomists' productivity in each 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.

December: Overall goal for the month was met. In December, BH draw stations averaged 5 minutes wait-time overall. Majority of locations were able to maintain wait times less than 10 minutes. BH One Stop had its lowest average wait time since March.



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.

December: Overall goal for the month was met. Across the BH locations 16 boxes of butterfly needles were ordered, 4 boxes less than the previous month resulting in 8% butterfly usage rate.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Butterfly Needles	1019	800	800	1000	800	600	1400	800	1100	1200	1000	800
Total Number of Patient Draws	9302	9223	10958	8888	9996	9910	9024	10056	9897	10601	10275	9960
ALL DRAW STATIONS	**11%**	**9%**	**7%**	**11%**	**8%**	**6%**	**16%**	**8%**	**11%**	**11%**	**10%**	**8%**

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%.

December: Overall goal for the month was met. Across all the BH draw stations the cancel/redraw rate is 2.8%.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
BH BOSTON POST RD MILFORD D.S.	1.3%	2.5%	8.3%	4.9%	4.0%	3.5%	1.8%	1.4%	0.8%	1.1%	1.9%	2.1%
BH SILVER LANE D.S. TRUMBULL	3.1%	2.6%	2.6%	6.6%	3.0%	3.4%	0.5%	4.1%	2.4%	2.5%	2.7%	5.5%
BH STRATFORD D.S.	1.9%	1.7%	1.2%	3.2%	4.0%	2.1%	3.0%	0.0%	0.5%	1.2%	2.5%	2.1%
BH WHITE PLAINS D.S. TRUMBULL	1.0%	4.7%	2.0%	5.8%	4.8%	2.9%	1.5%	1.7%	2.3%	3.6%	4.3%	6.1%
BH ENDO. D.S. QUARRY ROAD	2.6%	4.1%	3.9%	1.2%	7.7%	4.2%	0.6%	0.9%	1.5%	0.9%	0.8%	1.5%
BH FAM MED D.S. QUARRY ROAD	2.5%	4.3%	2.7%	1.2%	4.3%	4.5%	5.0%	3.8%	5.9%	3.1%	4.9%	3.7%
BH HUNTINGTON D.S.	2.9%	4.9%	3.8%	3.4%	6.7%	12.5%	2.8%	7.4%	7.4%	3.7%	2.4%	2.3%
BH INT MED D.S. QUARRY ROAD	4.4%	6.8%	6.7%	9.0%	7.9%	10.0%	6.8%	4.9%	4.8%	4.4%	5.7%	2.8%
BH KINGS HWY FRFLD D.S.	2.1%	4.9%	7.3%	8.1%	2.5%	2.5%	2.7%	2.9%	0.7%	1.8%	2.1%	2.5%
BH MILFORD D.S.	3.4%	3.8%	4.3%	3.9%	4.3%	1.6%	0.8%	0.2%	1.3%	1.1%	1.4%	4.3%
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%	4.1%
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%	3.4%
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%	1.9%
BH SOUTHPORT D.S.	3.0%	4.4%	3.6%	2.5%	8.9%	0.8%	1.5%	1.0%	3.7%	0.3%	0.0%	0.3%
BH TRUMBULL TECH DR D.S.	2.3%	3.3%	3.1%	7.2%	4.7%	5.2%	10.1%	3.8%	1.8%	2.5%	6.4%	1.5%
BH WESTPORT RIVERSIDE D. S	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%	1.0%	2.8%	0.3%	2.3%	0.4%
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%	2.8%

Centrifuge Compliance

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

Summary

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.

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

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

Patient Satisfactory Survey

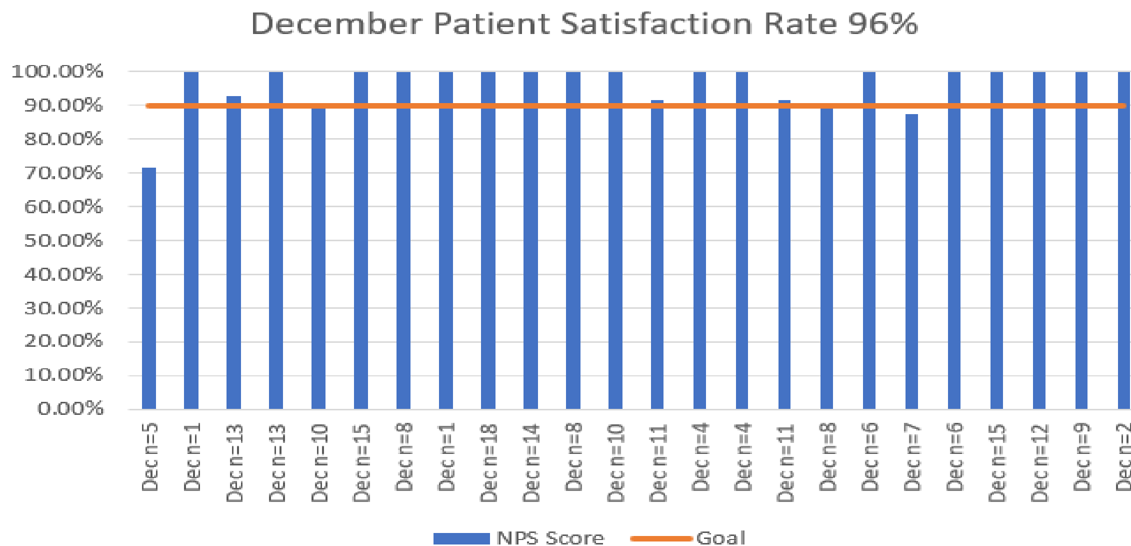
Section	Lab Outreach/Phlebotomy
Phase	Pre-Analytical
Title	Patient Satisfactory Survey
Objective	Achieving high levels of satisfaction is directly dependent on the high-quality patient care provided by phlebotomists in draw stations. In order to find out the pain-points of patients, whether there's any 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.

December: Overall goal for the month was met. Across 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 98% 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.

December: Overall goal for the month was met. For the month of December, the # providers transcribed 97/97, sum of tests transcribed correctly 304/306 and # of requisitions scanned in EPIC 95/95.

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

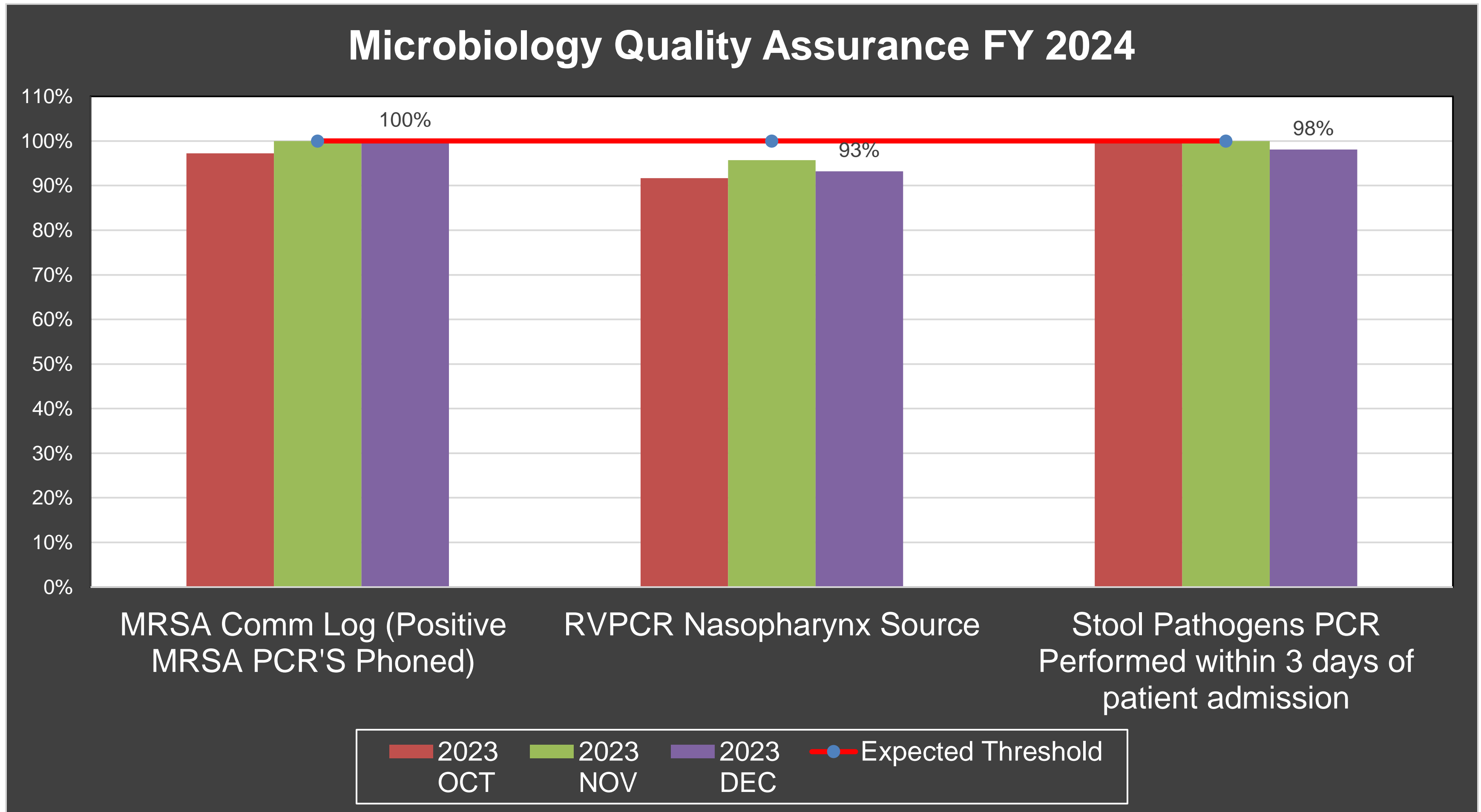
Yale NewHaven Health
Bridgeport Hospital

FY 2024 QA

Microbiology and Central Processing

January 2024

Microbiology Quality Measures 2024



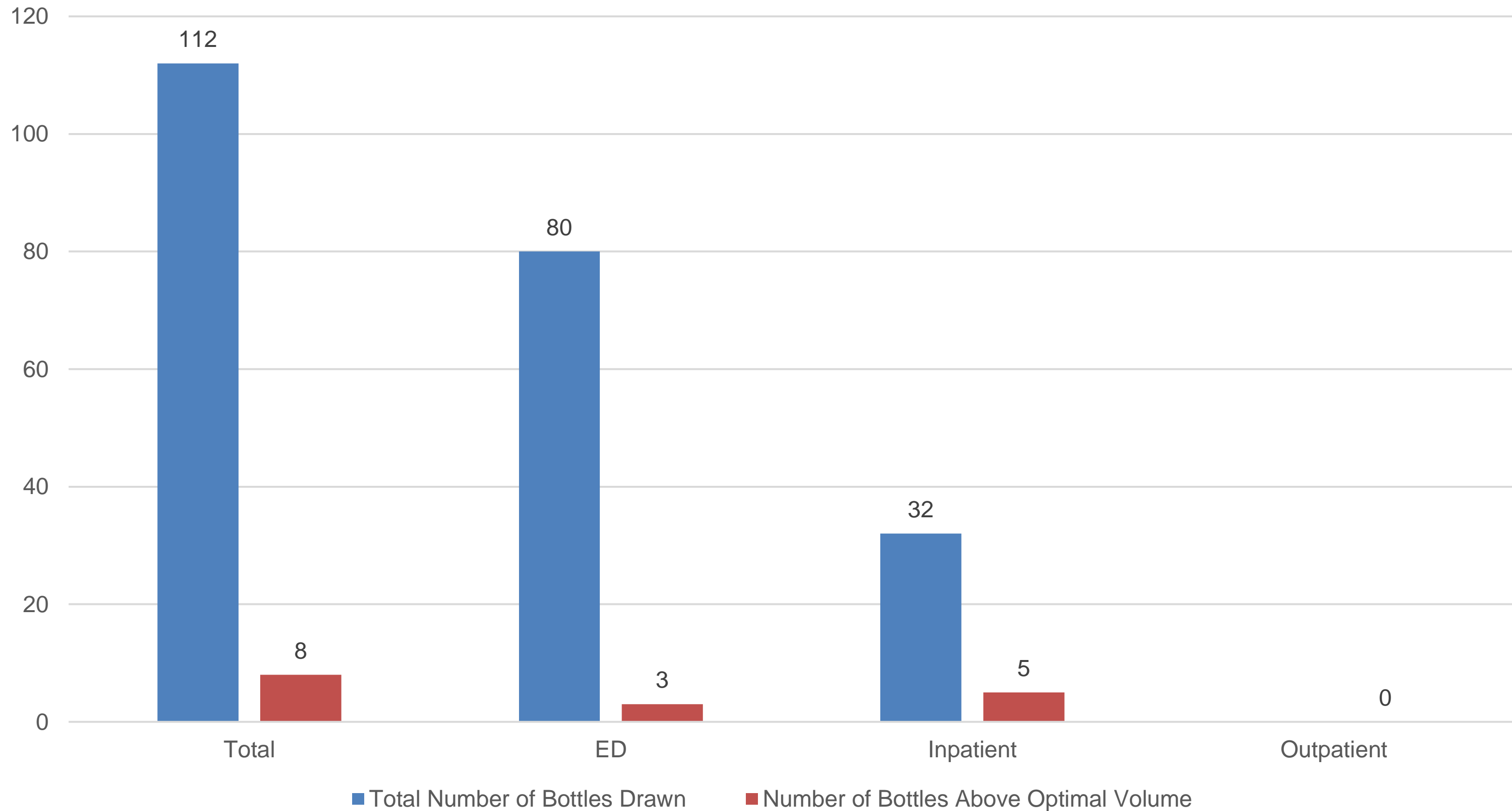
Yale NewHaven Health
Bridgeport Hospital

Microbiology Test Volumes

2023 Total Volume	October	November	December	January	February	March	April	May	June	July	August	Sept
MRSA	445	372	399									
MRSA Positive	36	52	48									
RVP	195	235	227									
Stool	138	126	144									
Stool Admitted	40	45	52									
Errors	0	1	1									

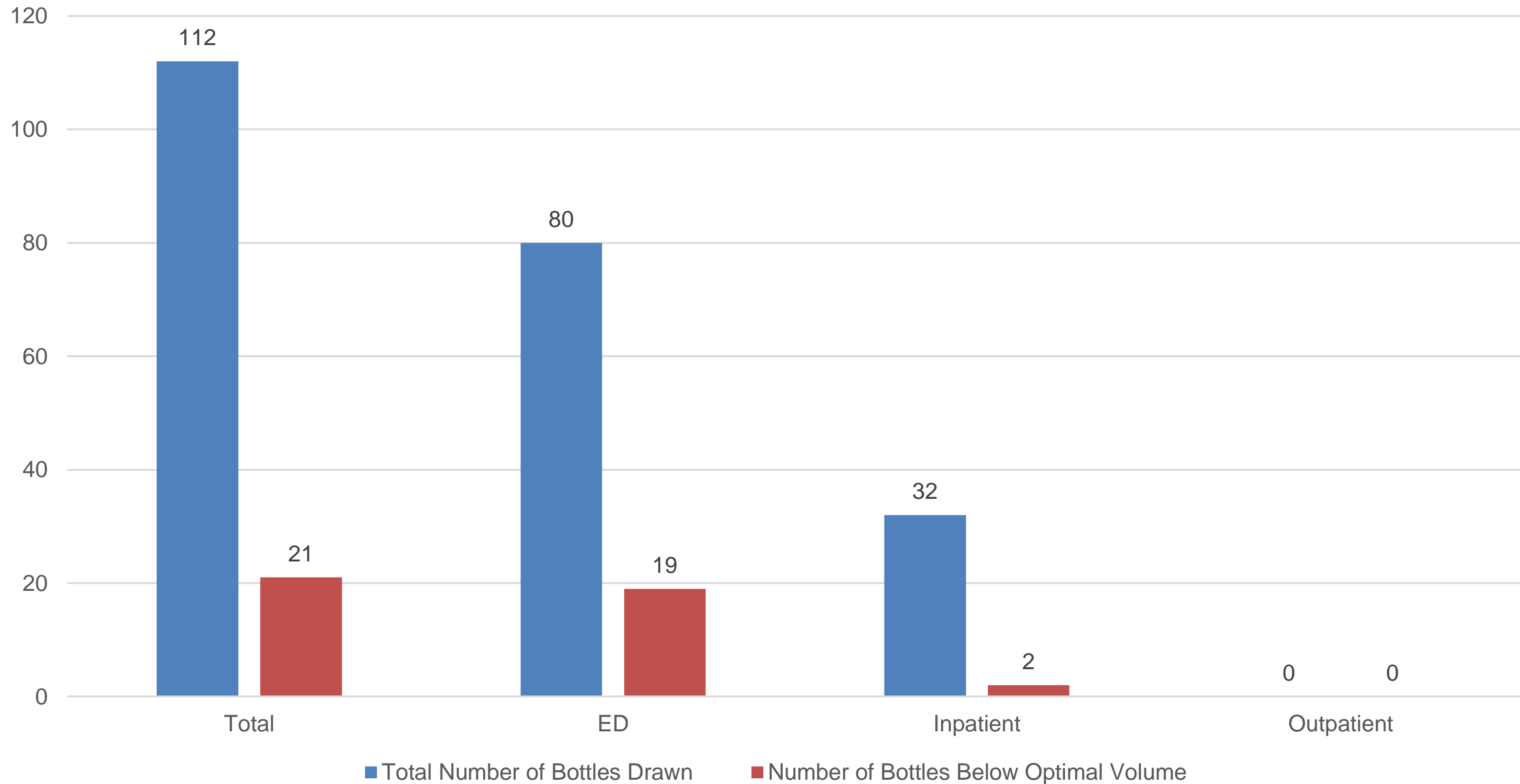
NewHaven Health
Bridgeport Hospital

Blood Culture Bottle Volumes – Above Optimal volume



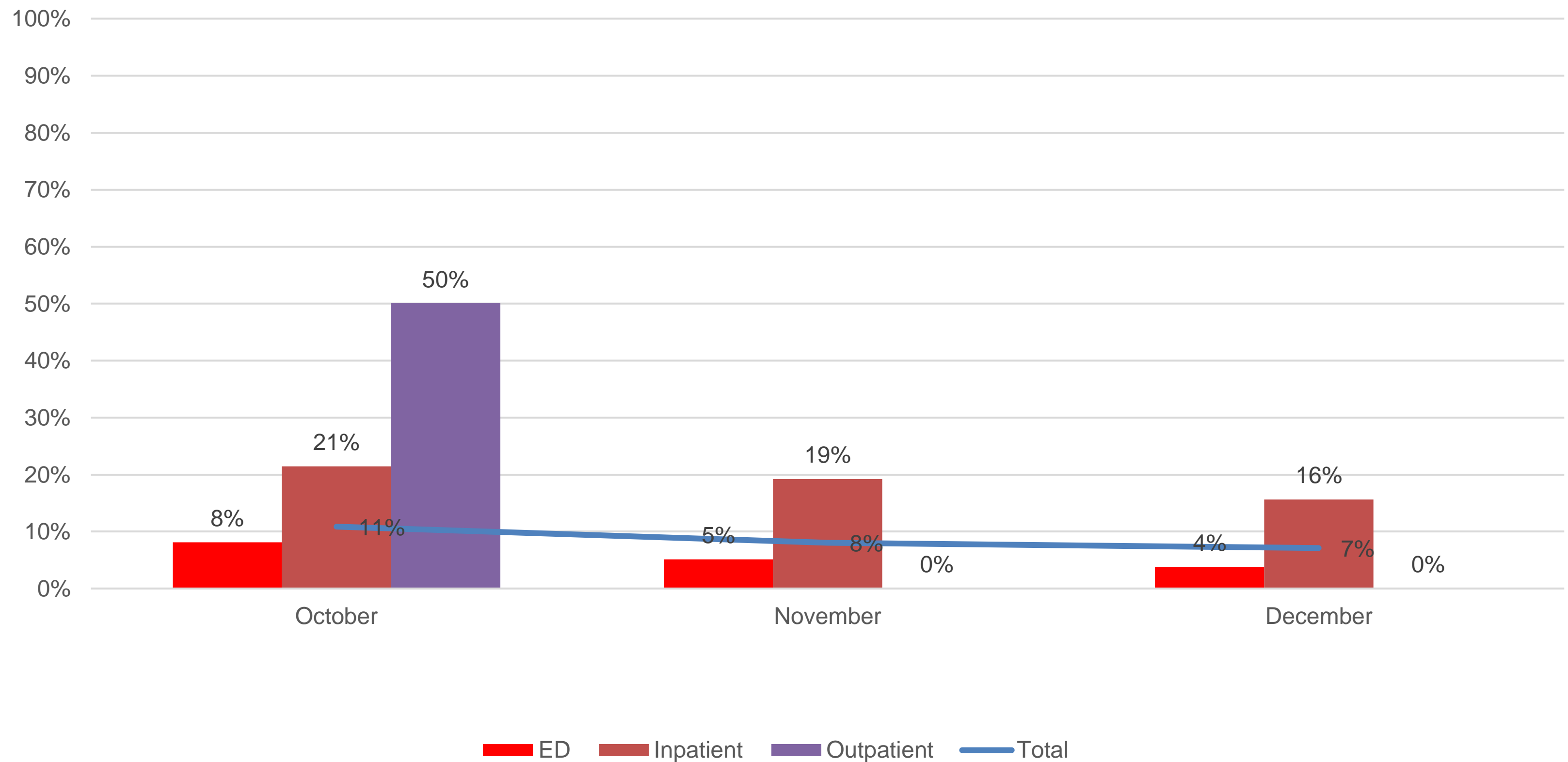
Yale NewHaven Health
Bridgeport Hospital

Blood Culture Bottle Volumes – Below Optimal volume



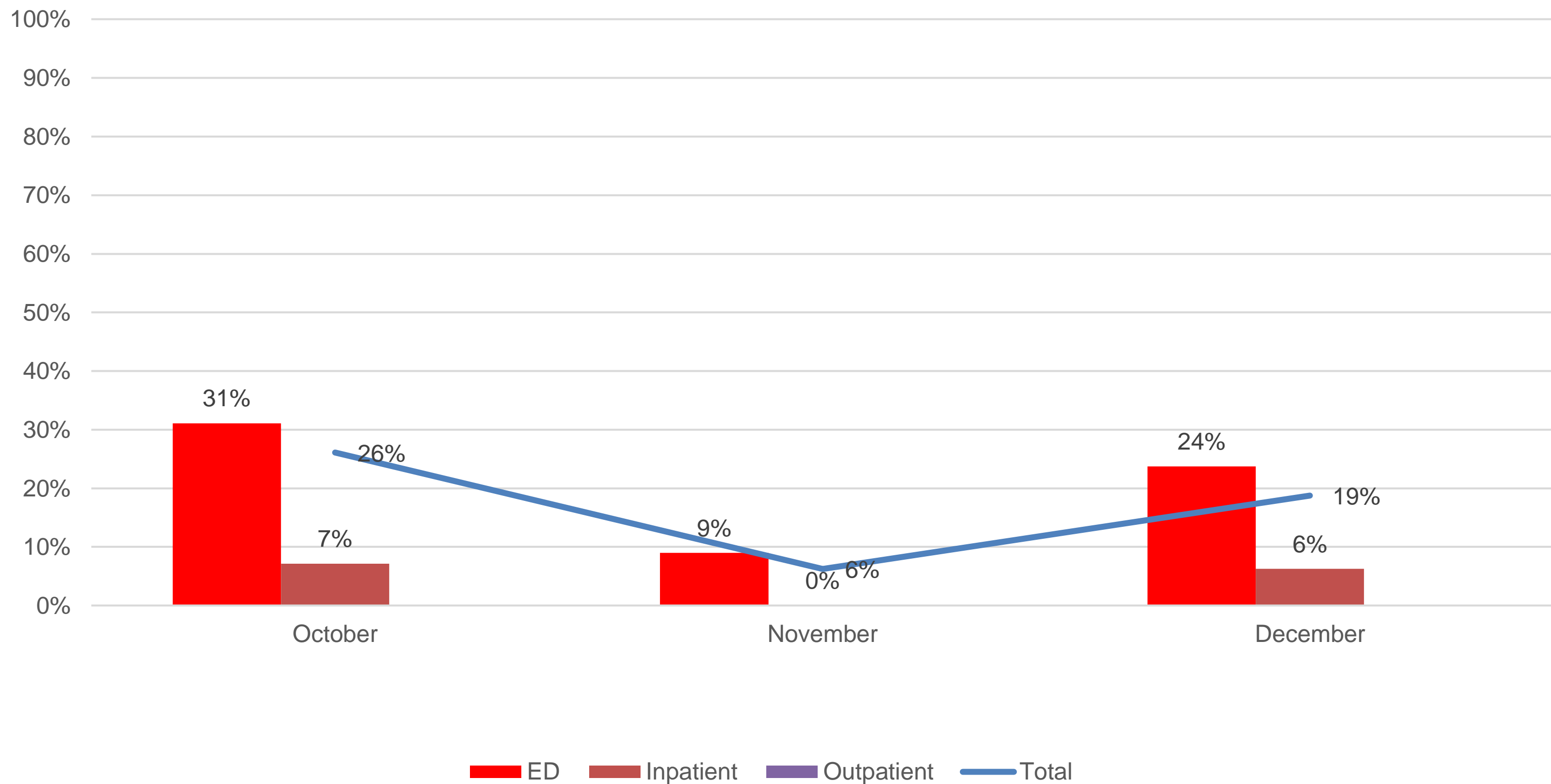
Yale NewHaven Health Bridgeport Hospital

FY 2024 Blood Culture Volume Above Optimal Range



Yale NewHaven Health Bridgeport Hospital

FY 2024 Blood Culture Volume Below Optimal Range



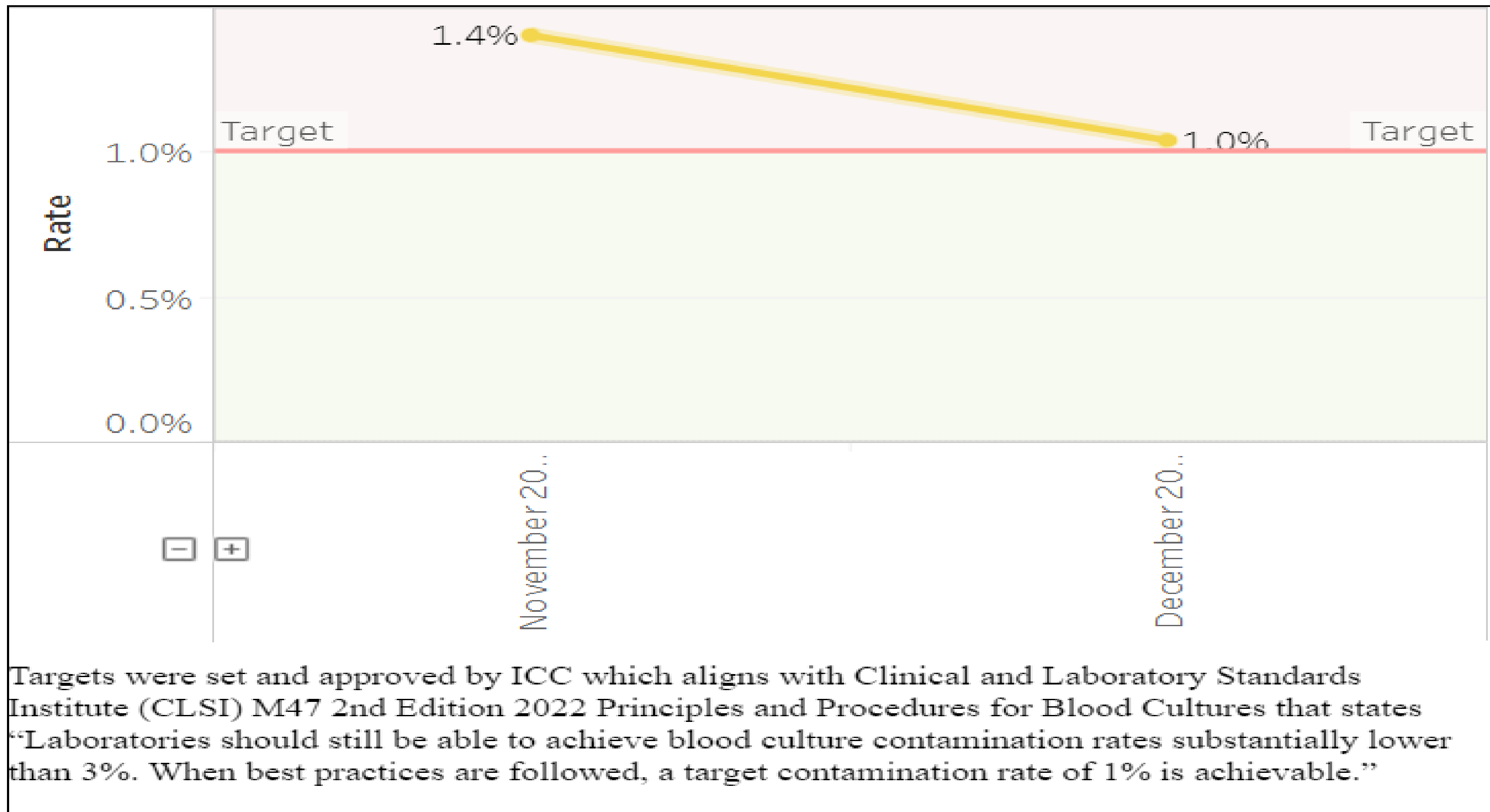
Yale NewHaven Health
Bridgeport Hospital

Micro Molecular Statistics

Date	Tests	Sample size	Positive Count	% Positivity	Lower Limit	Upper Limit	Environment Monitoring	Epidemiological Trends	Evaluation Notes
Dec-23	C. difficile Assay	141	26	18%	15%	27%	Negative	None	None
Dec-23	GBS PCR Pen Allergic	2	0	0%	0%	46%	Negative	None	Inhouse testing stopped 12/5/23
Dec-23	GBS PCR Pen NonAllergic	17	5	29%	16%	33%	Negative	None	Inhouse testing stopped 12/5/23
Dec-23	Group A Strep PCR	717	115	16%	2%	26%	Negative	None	None
Dec-23	Influenza A/B RNA, NAAT	327	32	10%	0%	19%	Negative	None	None
Dec-23	Influenza/RSV by RT-PCR	4,631	1,015	22%	0%	18%	Negative	Seasonal Spike in both Flu and RSV	None
Dec-23	MRSA Colonization Status	370	48	13%	5%	18%	Negative	None	None
Dec-23	MRSA/SAUR Blood PCR	22	7	32%	15%	51%	Negative	None	None
Dec-23	MTB w/rflx Rifampin PCR	3	0	0%	0%	78%	Negative	None	None
Dec-23	Resp Virus PCR Panel	135	25	19%	2%	51%	Negative	None	None
Dec-23	Respiratory Virus PCR Panel	170	18	11%	4%	33%	Negative	None	None
Dec-23	SARS CoV-2 (COVID-19) RNA	5,303	800	15%	0%	20%	Negative	None	None
Dec-23	Stool Pathogens PCR	125	28	22%	0%	22%	Negative	None	None

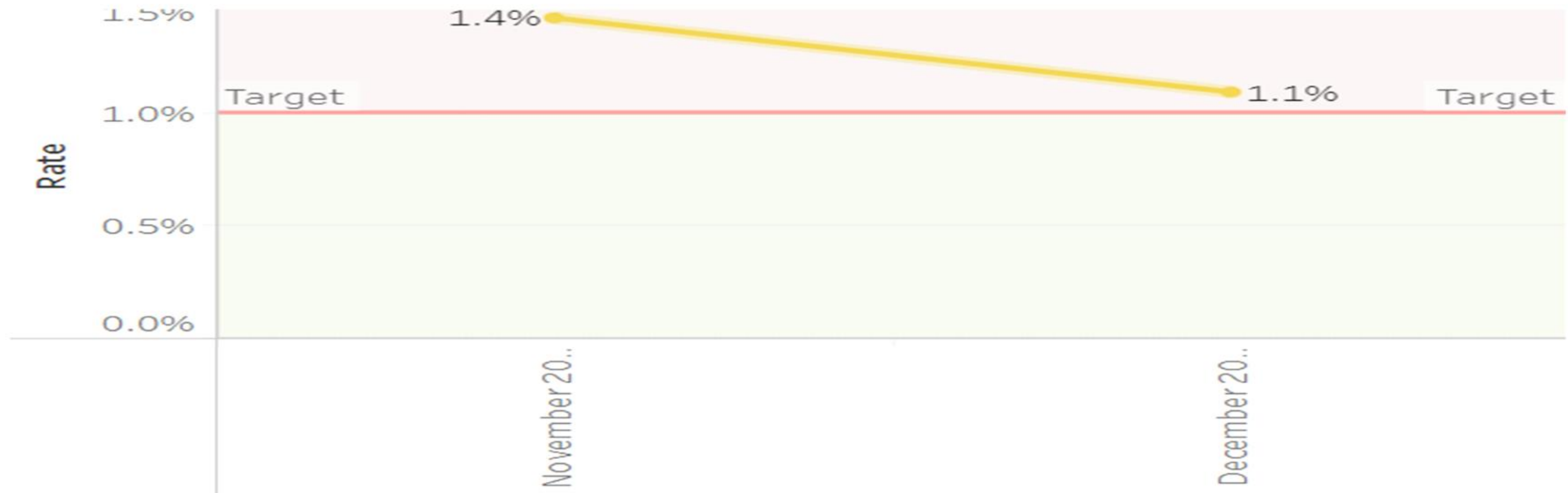
Yale NewHaven Health
Bridgeport Hospital

BH & MC Blood Culture contamination rate



NewHaven Health
Bridgeport Hospital

Blood Contamination rate—BH

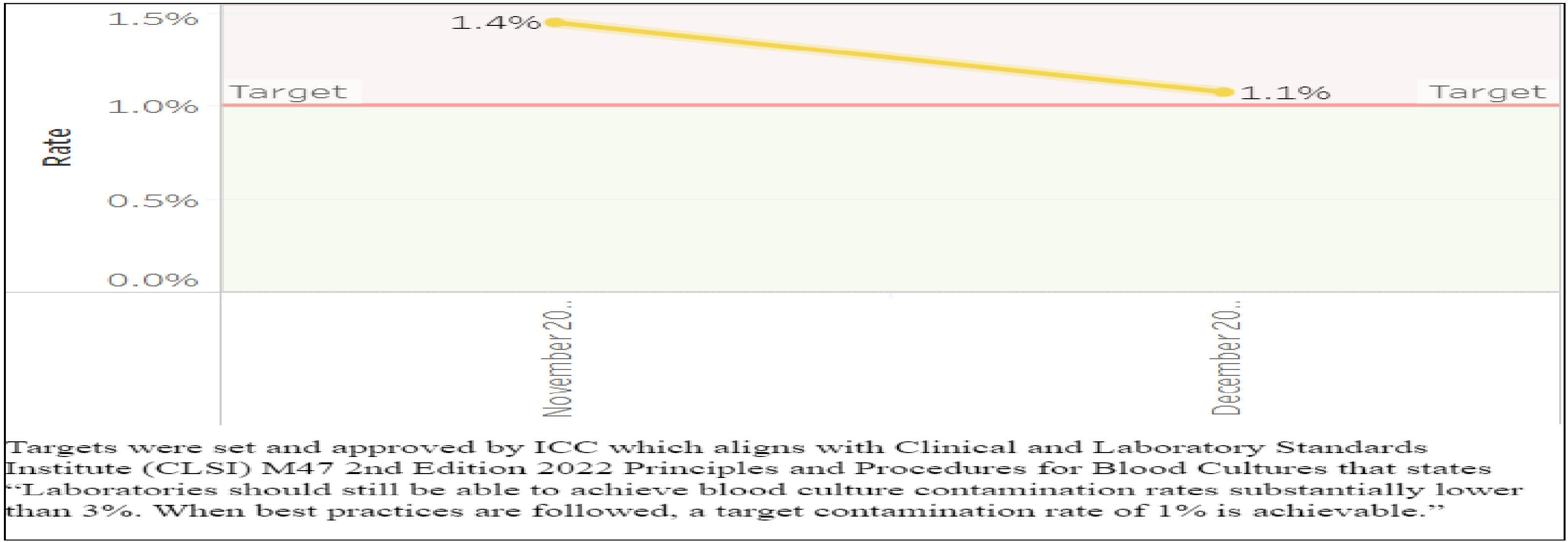


Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	December 2..	932	10	1.1%
		Inpatient	BH NORTHEAST 7	December 2..	26	1	3.8%
			BH NORTHWEST 7	December 2..	30	1	3.3%
			BH SURGICAL INTENSIVE C..	December 2..	36	1	2.8%
			BH WEST TOWER 10	December 2..	38	1	2.6%
Grand Total					1,062	14	1.3%

Yale NewHaven Health
Bridgeport Hospital

Blood Culture Contamination Rate—BH ED

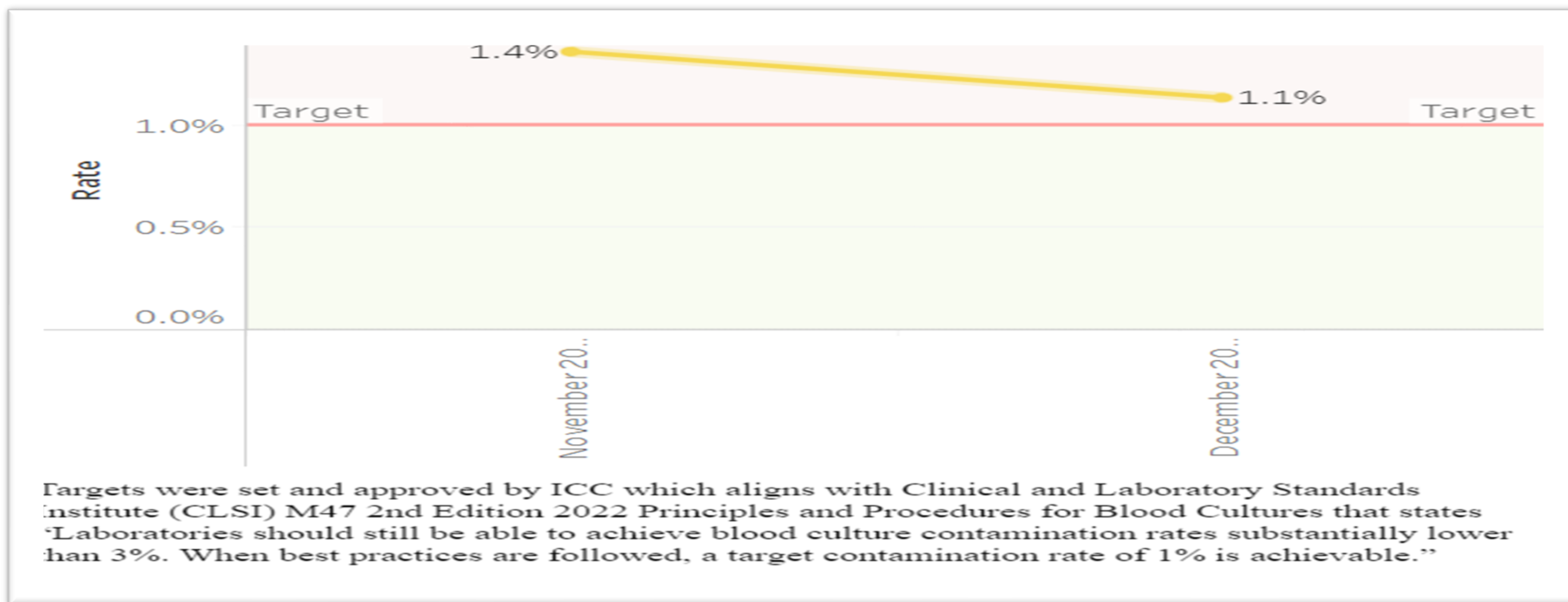


Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	BH	Emergency ..	BH EMERGENCY DEPARTM..	December 2..	932	10	1.1%
Grand Total					932	10	1.1%

YaleNewHaven Health
Bridgeport Hospital

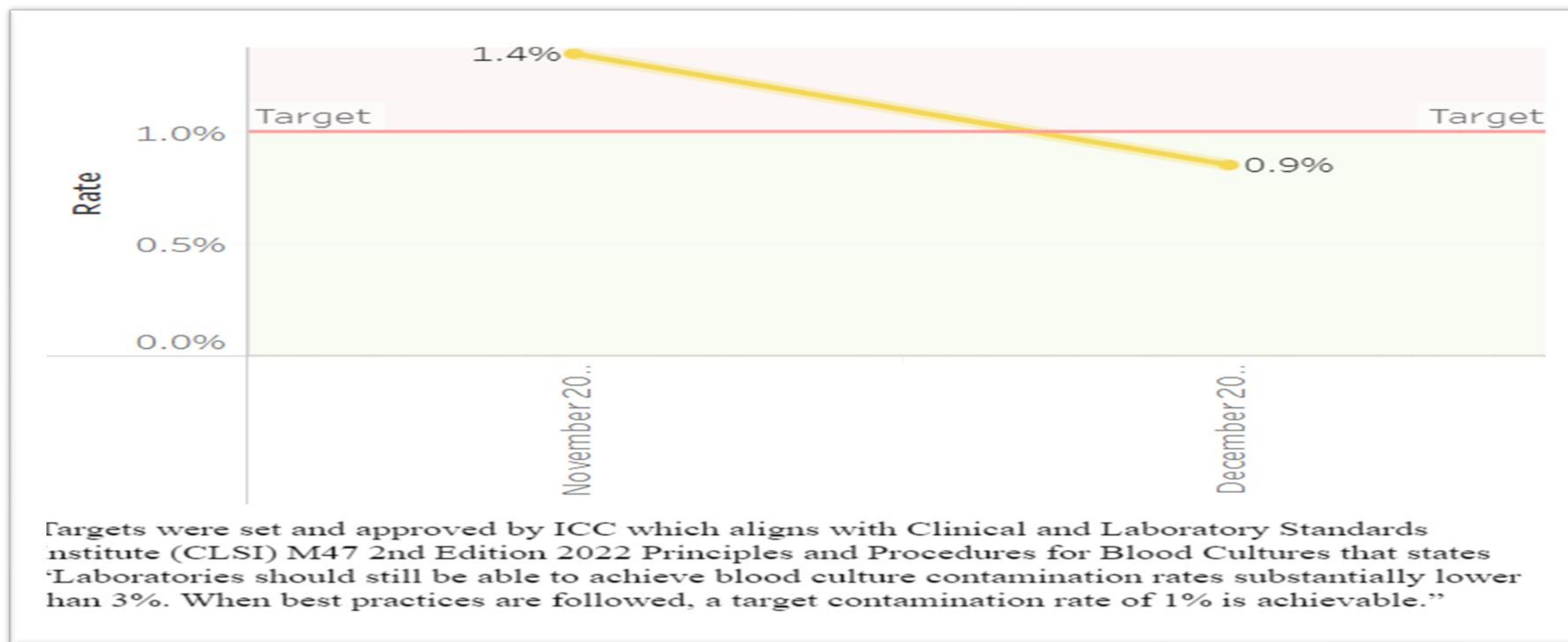
Blood Culture Contamination Rate—all other units



Inpatient	BH NORTHEAST 7	December 2..	26	1	3.8%
	BH NORTHWEST 7	December 2..	30	1	3.3%
	BH SURGICAL INTENSIVE C..	December 2..	36	1	2.8%
	BH WEST TOWER 10	December 2..	38	1	2.6%

Yale NewHaven Health
Bridgeport Hospital

Blood Culture Contamination Rate—MC



Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	December 2..	299	3	1.0%
Grand Total					299	3	1.0%

Yale NewHaven Health Bridgeport Hospital

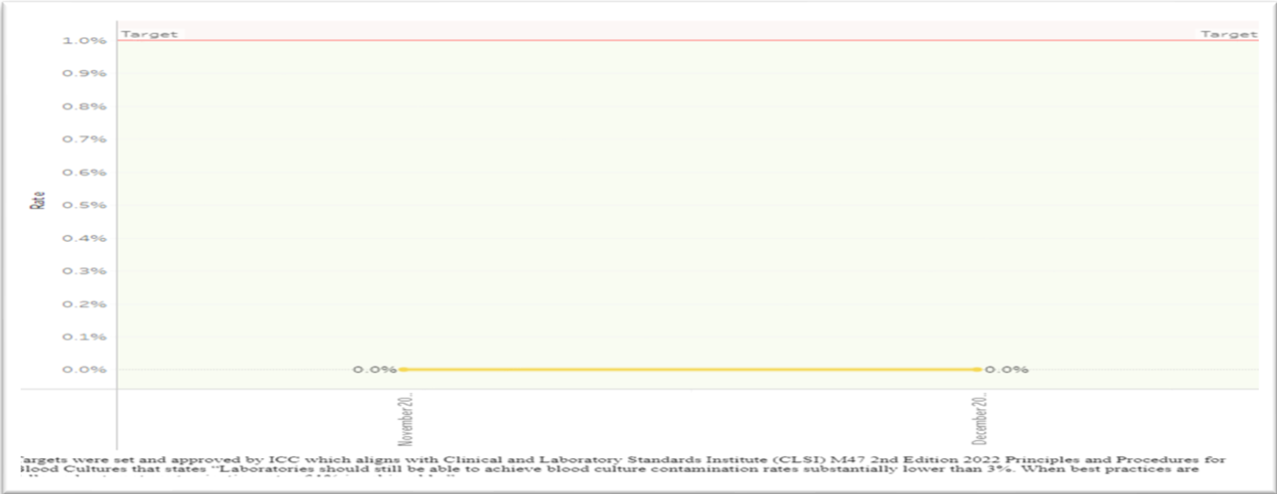
Blood Culture Contamination Rate—MC ED

Unit Rate

DN	Campus	Specialty	Department Name	Month of Collected	Specimen Count	Cont Count	Rate
BH/MC	MC	Emergency ..	MC EMERGENCY DEPART..	December 2..	299	3	1.0%
Grand Total					299	3	1.0%

Yale NewHaven Health
Bridgeport Hospital

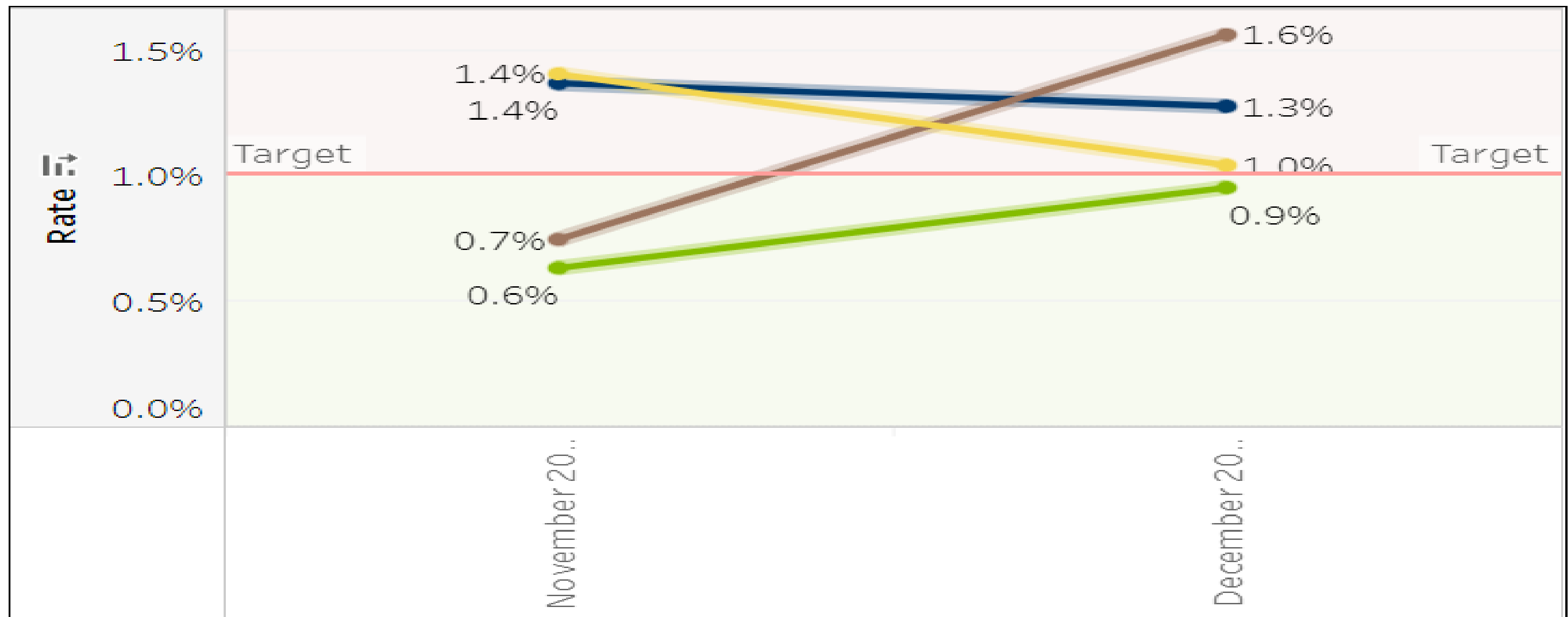
Blood Culture Contamination Rate—all other units



Inpatient	MC ICU	December 2..	15	0	0.0
	MC MAIN LAB	December 2..	7	0	0.0
	MC MEMORIAL 3 WEST	December 2..	20	0	0.0
	MC ONE STOP TESTING CTR	December 2..	1	0	0.0
	MC RESPIRATORY THERAPY	December 2..	2	0	0.0
	MC SOUTH 3	December 2..	4	0	0.0

Yale NewHaven Health
Bridgeport Hospital

Blood Culture Contamination Rate DN's Comparison

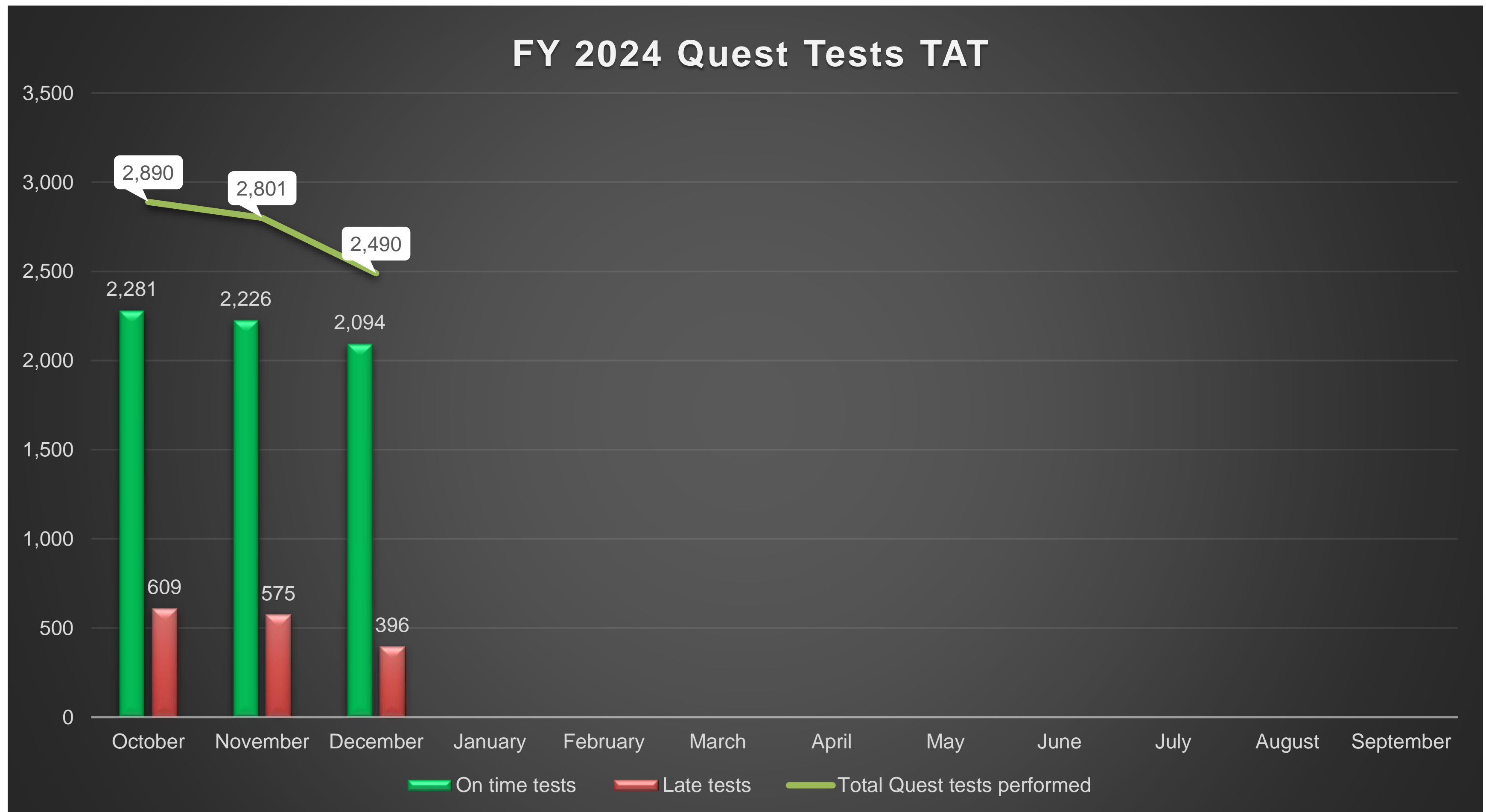


Targets were set and approved by ICC which aligns with Clinical and Laboratory Standards Institute (CLSI) M47 2nd Edition 2022 Principles and Procedures for Blood Cultures that states "Laboratories should still be able to achieve blood culture contamination rates substantially lower than 3%. When best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

YNHH
LMH/WH
BH/MC
GH

Yale NewHaven Health
Bridgeport Hospital

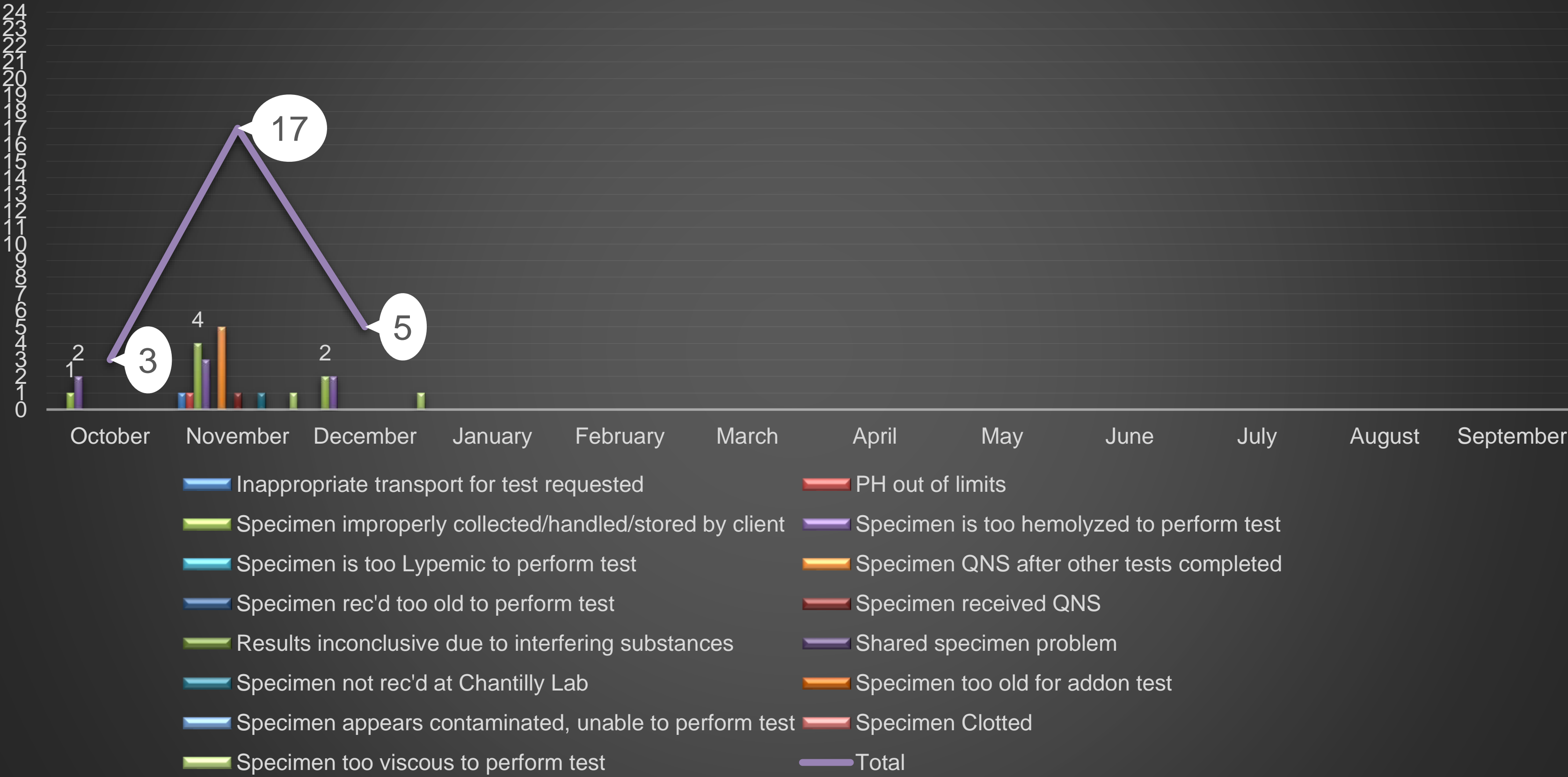
Quest TAT



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.

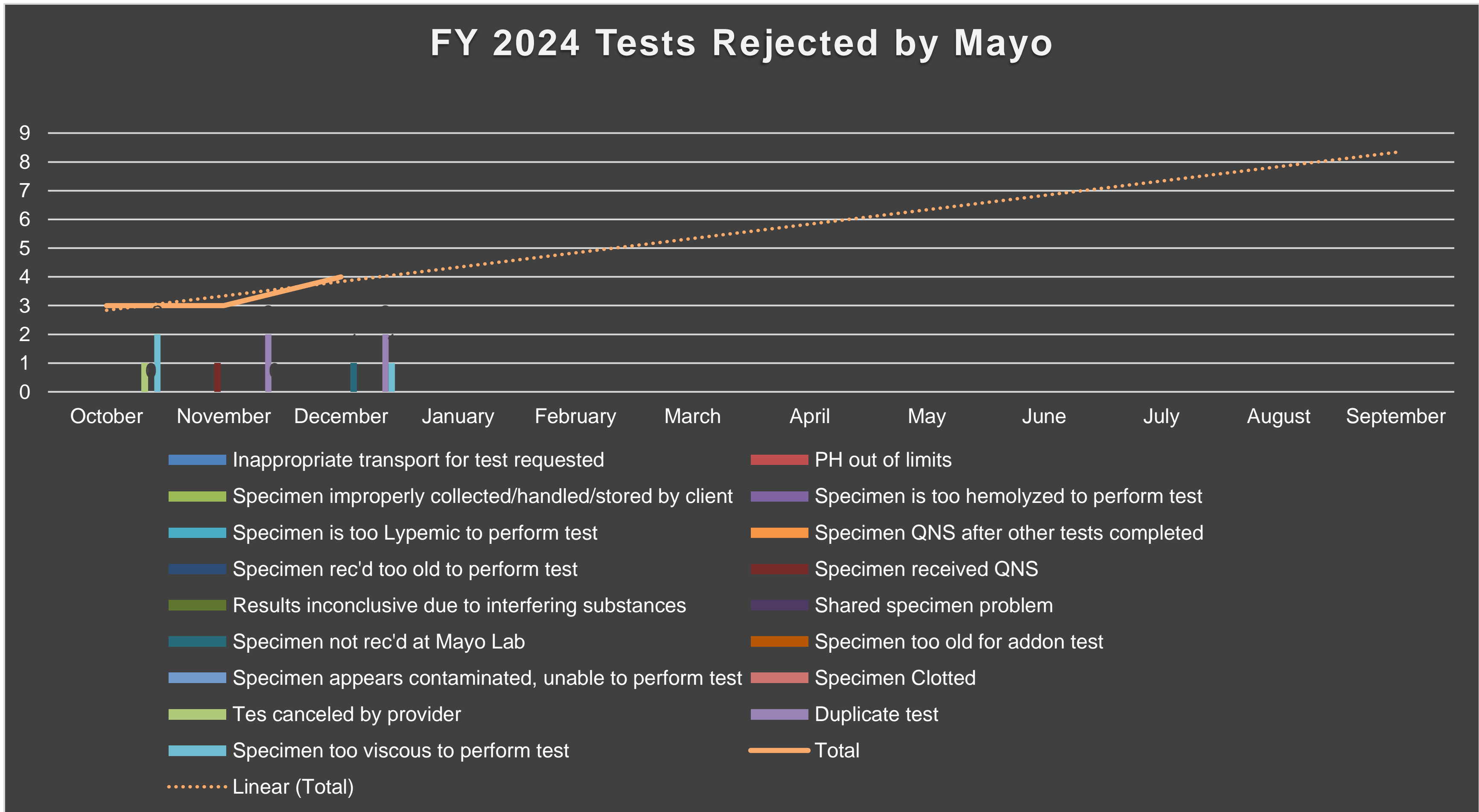
Yale NewHaven Health Bridgeport Hospital

Quest Rejected Tests



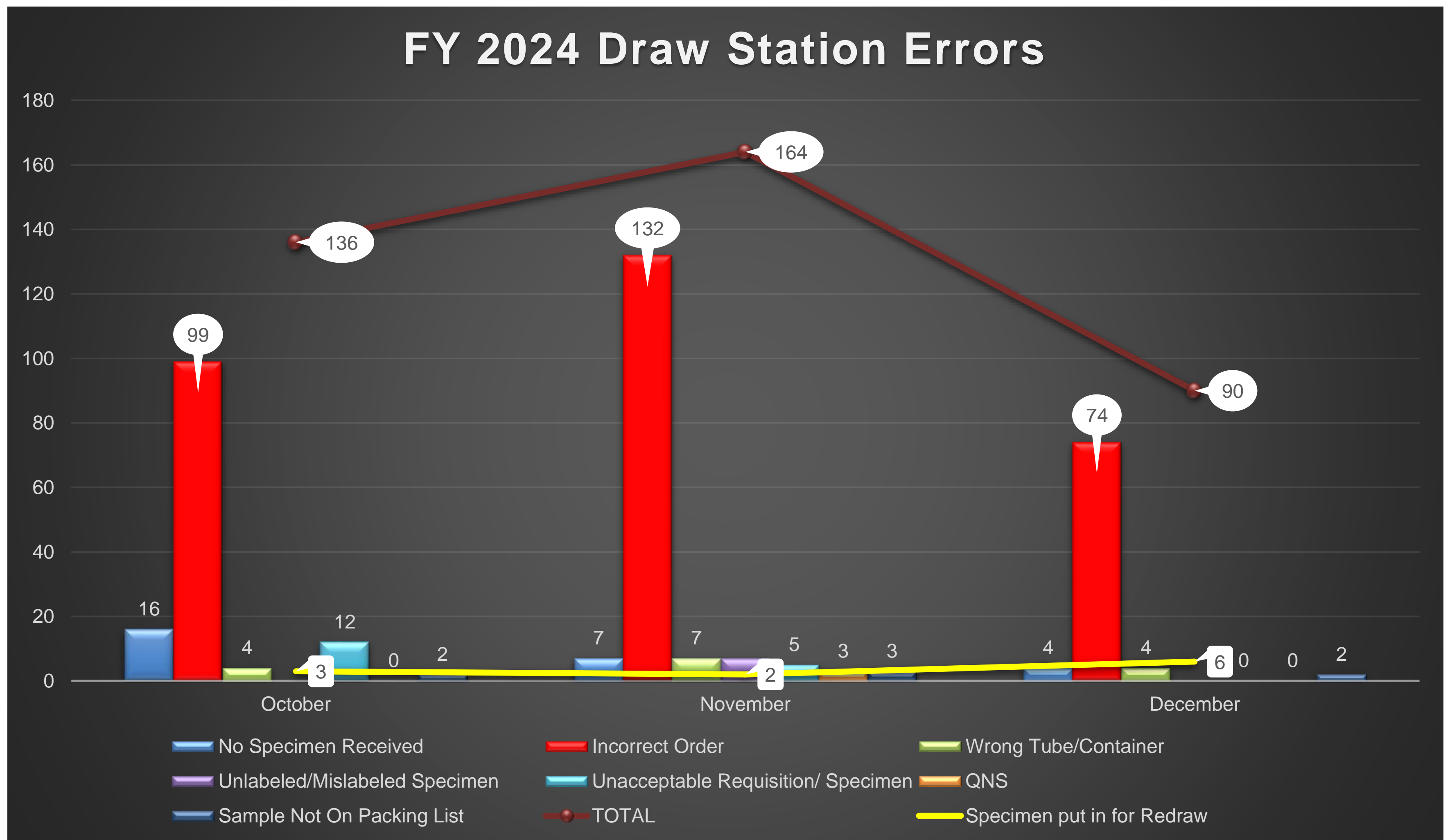
NewHaven Health
Bridgeport Hospital

Mayo Rejected Tests



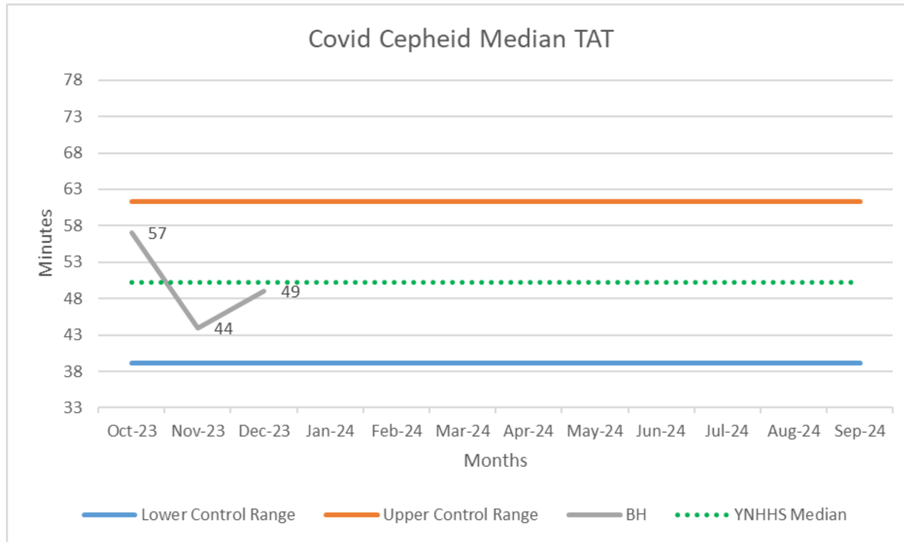
NewHaven Health
Bridgeport Hospital

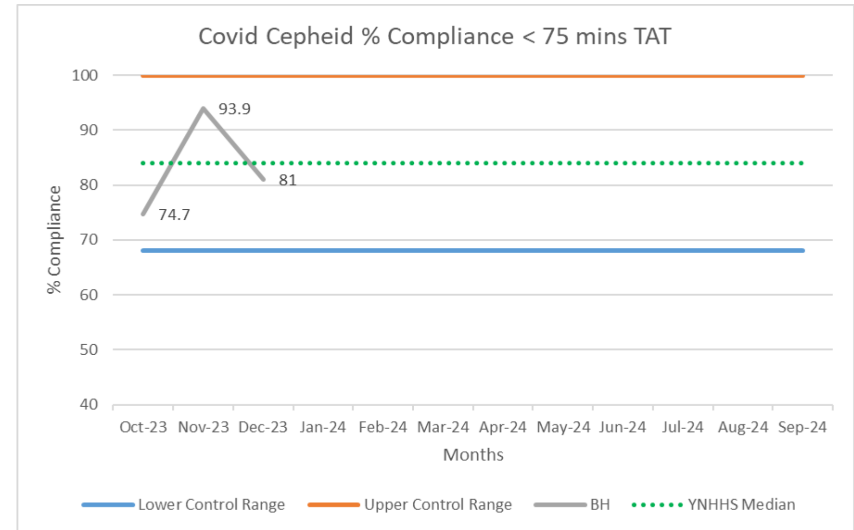
FY2024 Draw Station Errors

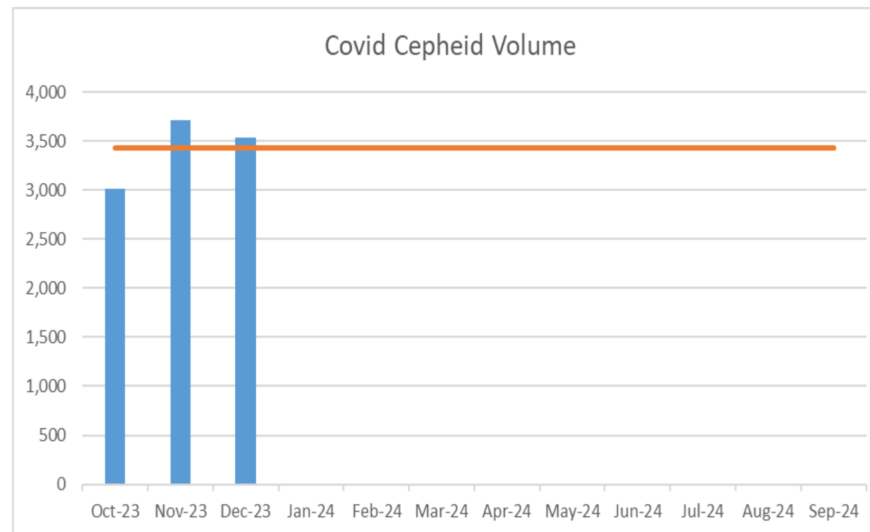


NewHaven Health
Bridgeport Hospital

Bridgeport Campus – COVID-19 Cepheid

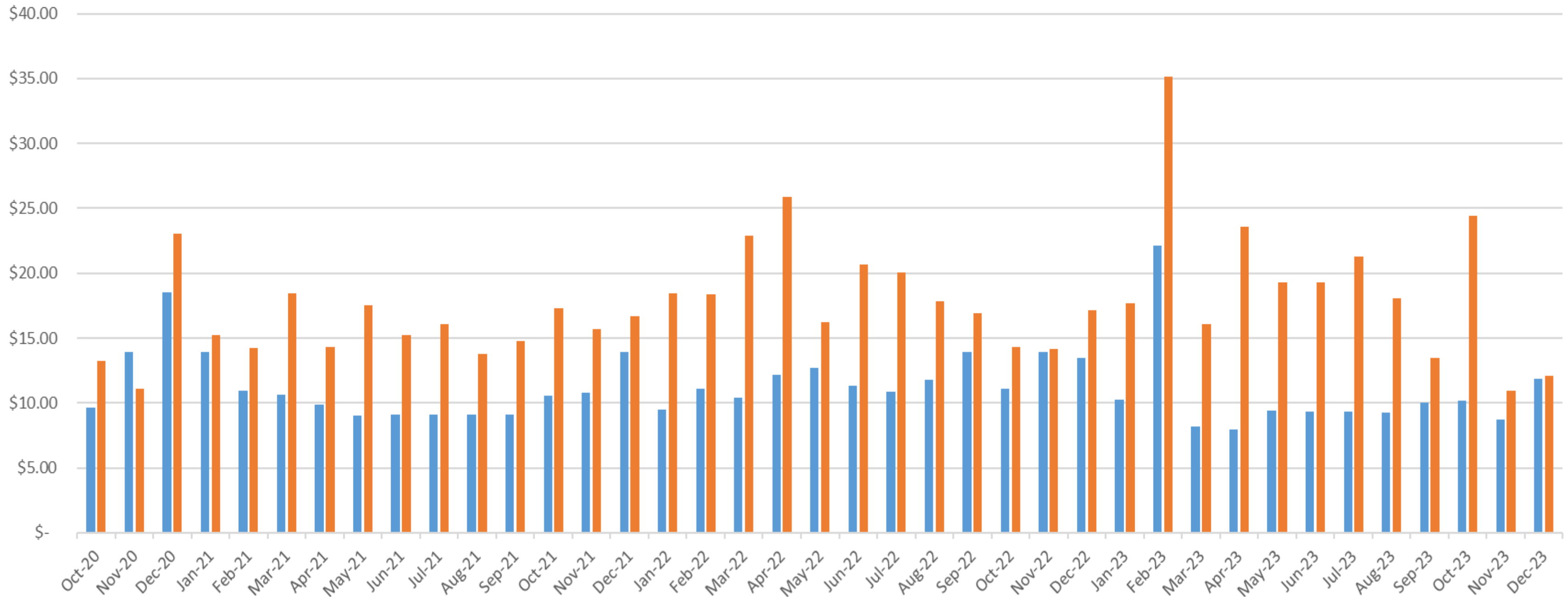






Yale NewHaven Health
Bridgeport Hospital

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
BH Cost per billable	$9.	$13	$18	$13	$10	$10	$9.	$9.	$9.	$9.	$9.	$9.	$10.	$10	$13	$9.	$11	$10	$12	$12
MC Cost per billable	$13	$11	$23	$15	$14	$18	$14	$17	$15	$16	$13	$14	$17	$15	$16	$18	$18	$22	$25	$16

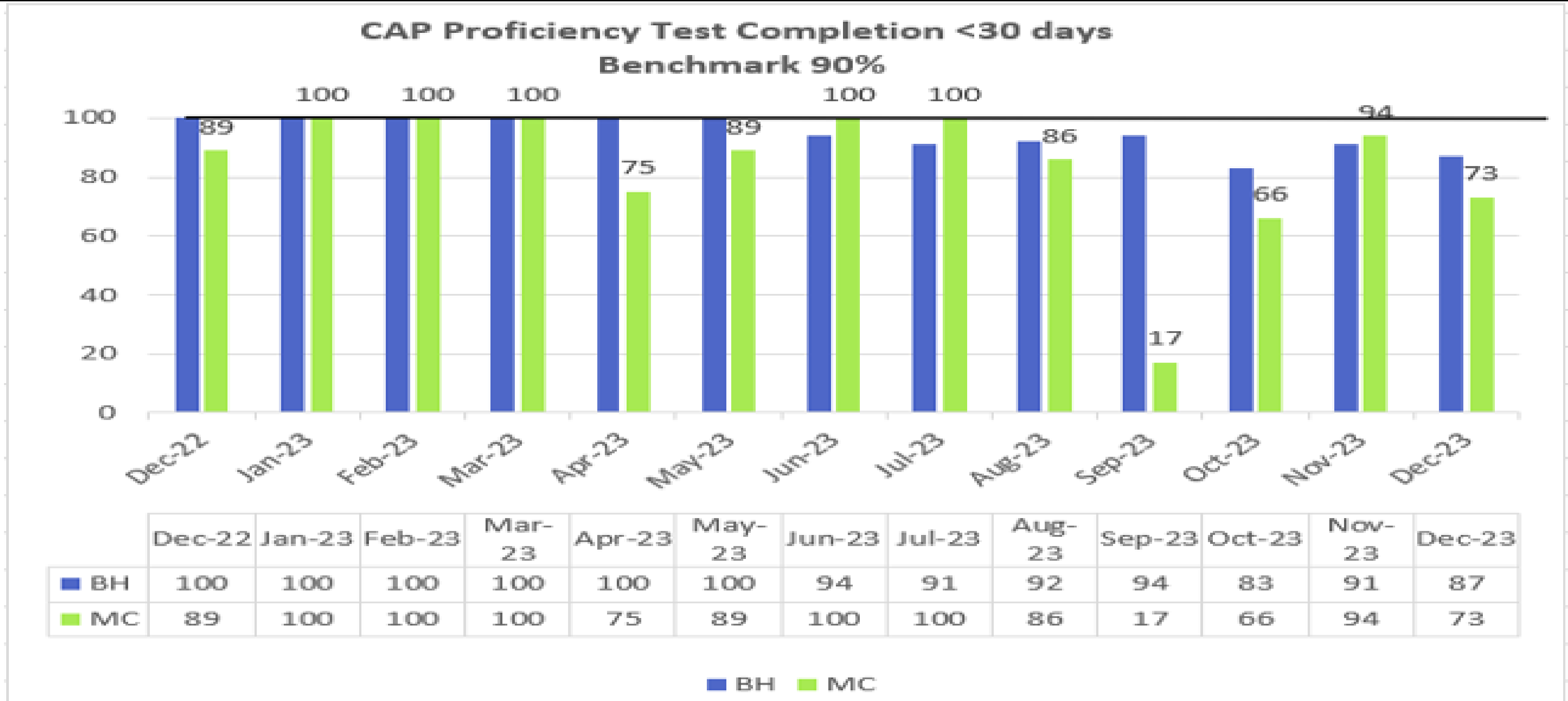
	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	23-Feb	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
BH Cost per billable	$11	$10	$11	$13	$11	$13	$13	10.3	22.1	$8.	$7.	$9.	$9.	$9.	$9.	$10	$10	$8.	$11
MC Cost per billable	$20	$20	$17	$16	$14	$14	$17	$17	$35	$16	$23	$19	$19	21.	$18	$13	$24	$10	$12

Yale NewHaven Health
Bridgeport Hospital

Lab General

BH CL07D0099572/CAP1191901
MCBH CL07D0097265/CAP 1189901

Quality Metric	Target	Sample size	Current performance	Previous month	Patient Impact	Corrective action and follow-up	Responsible
CAP PT Turnaround within 30 days	90%	BC MC	87% (26/30 surveys) 73% (8/11 surveys)	91% 94%	None	Both labs exceeded benchmark. No corrective actions required.	Lab management and administration

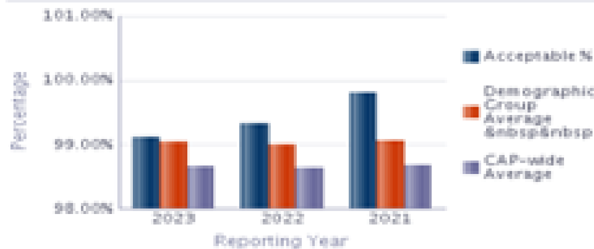


Bridgeport Proficiency Performance Testing Target 98% & Accreditation Overview

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
BH	330/337	98%	99%	None, benchmark met	all surveys satisfactory. None needed.

Proficiency Testing Performance Overview

Select View: Graph



19	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	99.11%	99.04%	98.65%
2022	99.32%	99.00%	98.63%
2021	99.81%	99.06%	98.67%

Accreditation Performance Overview

Select View: Data

Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.14%	0.85%	0.84%
Previous Cycle	0.47%	0.80%	0.79%
Second Previous Cycle	0.11%	0.86%	0.87%

Last Accreditation Decision	Date
Accredited	5/9/2022

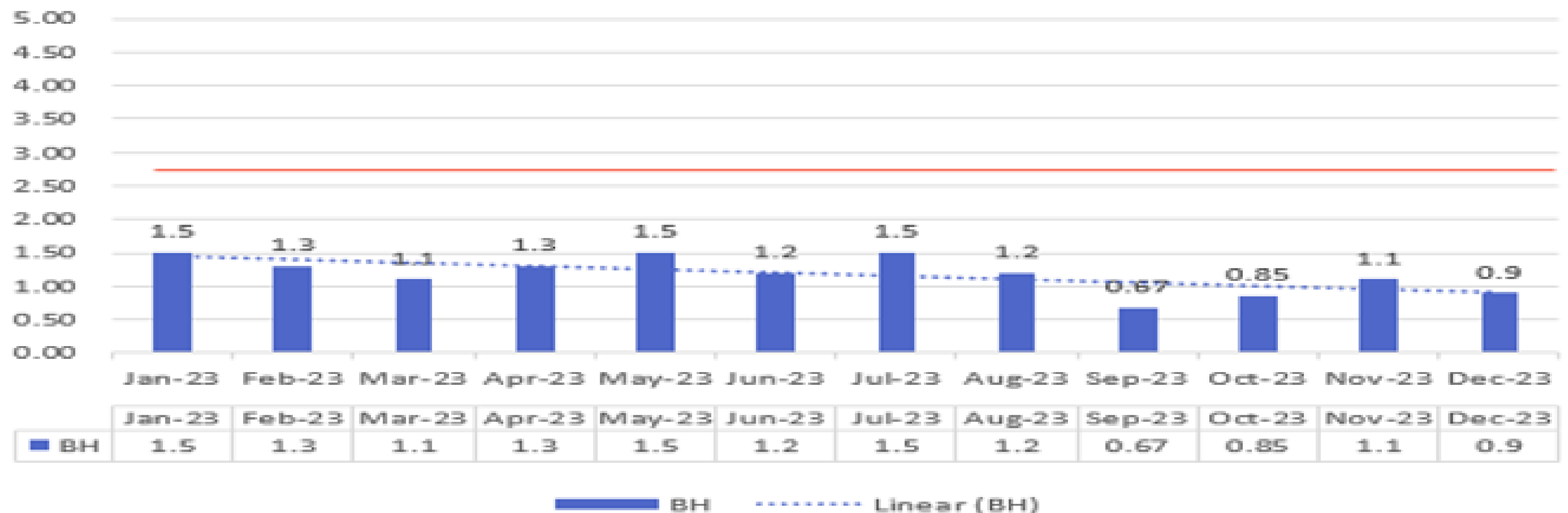
Current Cycle Inspection(s)			
Date	Inspection Type	% Deficient	Recurring Deficiencies
1/11/2024	Routine	0.14	0

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.	198,181 tests	0.9 (.009%)	1.1 (0.011%)	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**	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**	Tests	0	0	None	None needed	Lab administration and management

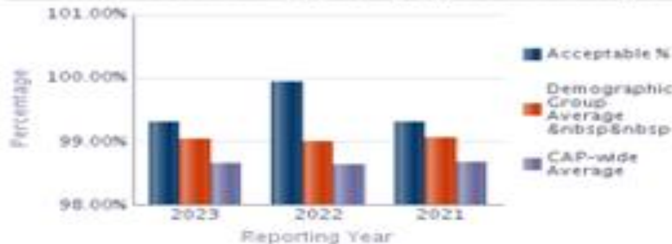
** Definition of Non Conforming events for this Quality Measure includes irreplaceable samples only

MCBH Proficiency Testing Target 98% & Accreditation Overview

Campus	Analytes	Performance	Previous Month	Patient impact	Corrective actions
MCBH	73/73	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	99.31%	99.04%	98.65%
2022	99.94%	99.00%	98.63%
2021	99.30%	99.06%	98.67%

Accreditation Performance Overview

Select View: Data

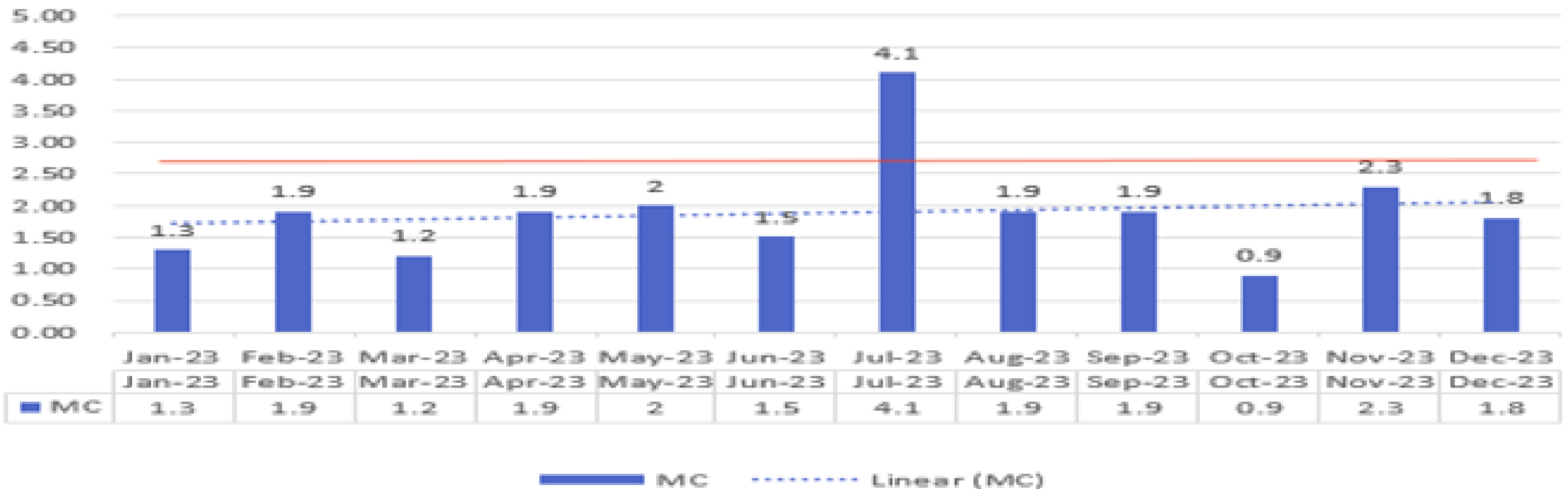
Period Name	Percent Deficient	Demographic Group Average	CAP-wide Average
Current Cycle	0.27%	0.85%	0.84%
Previous Cycle	0.62%	0.80%	0.79%
Second Previous Cycle	0.74%	0.86%	0.87%

Last Accreditation Decision	Date
Accredited	5/9/2022

Current Cycle Inspection(s)			
Date	Inspection Type	% Deficient	Recurring Deficiencies
1/12/2024	Routine	0.27	0

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.	22,662 tests	1.8 (.018%)	2.3 (.023%)	Corrected reports can lead to adverse patient outcomes	4 total lab corrections (1 manual, 3 UA color change) Techs reminded to be careful with manual entries and color change corrections can be prevented by cleaning the analyzer better.	Laboratory administration



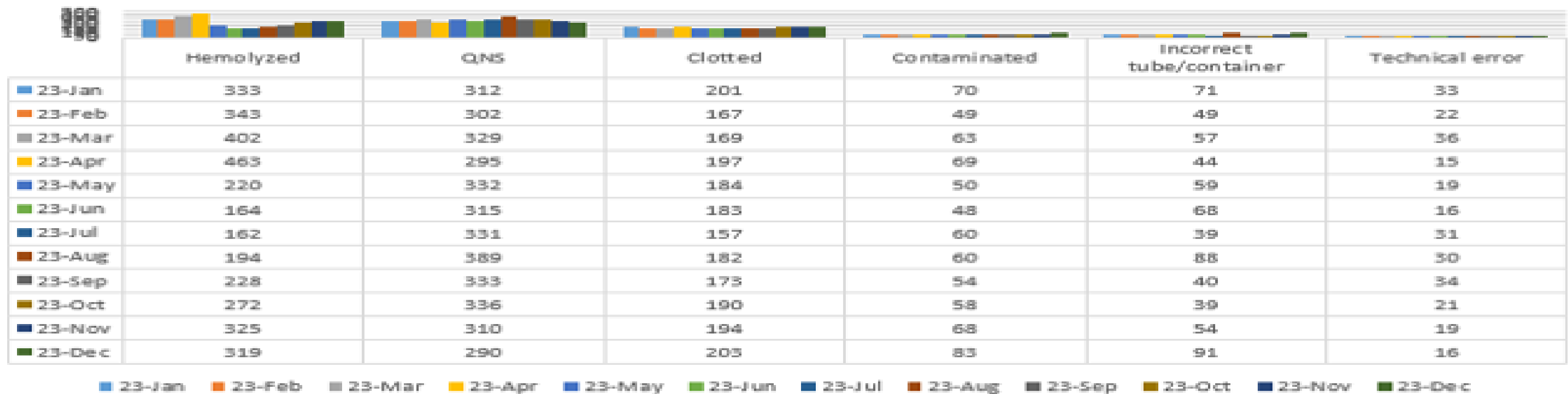
Laboratory General

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
BH	1.6	1.7	2	2	2	1.7	1.5	2	1.7	2	2.1	2.1
GH	1.6	1.3	1.6	1.6	1.9	1.6	1.5	2.1	1.4	2	2	2
LMH	0.9	0.8	0.9	0.8	1.1	0.9	0.9	1.4	0.7	1.3	1	1
MC	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3	2.5	3	5
SRC	1	1	1	0.8	1.3	0.83	0.9	1.3	1	1.5	1.3	1.2
WH	1	0.9	0.9	0.8	1.1	0.9	0.8	1.2	0.9	1.3	1	0.9
YH	1.5	1.5	1.6	1.6	2.1	1.6	1.6	2.2	1.7	2.5	2.3	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

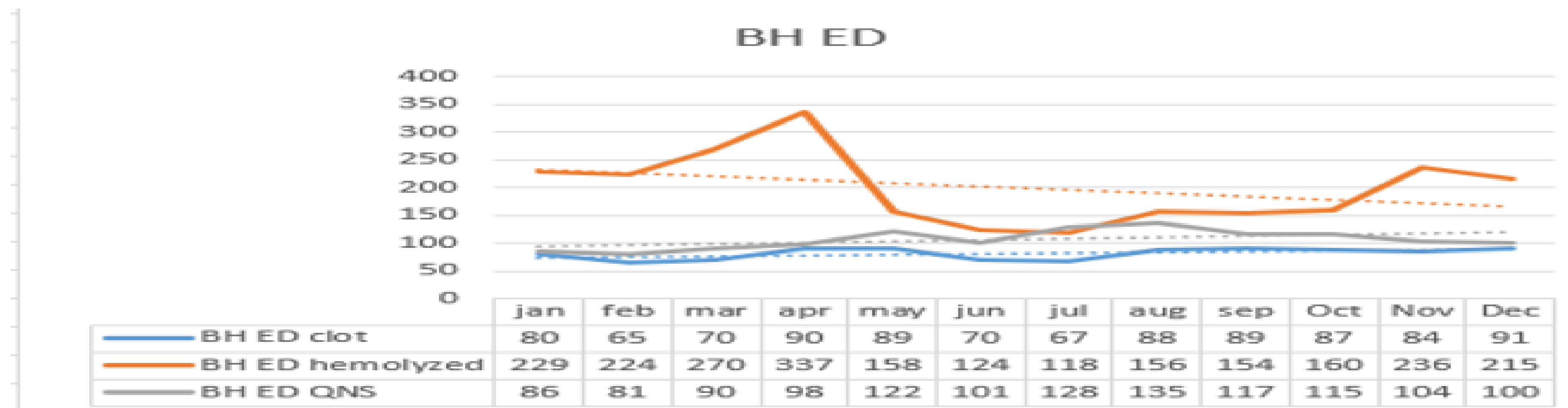
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
BH	1.6	1.7	2	2	2	1.7	1.5	2	1.7	2	2.1	2.1
MC	1.1	1.3	1.5	1.9	2.5	3.9	3.8	4	2.3	2.5	3	5

Laboratory General



	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
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
23-Dec	319	290	203	83	91	16

Top 3 Rejections-BH ED totals



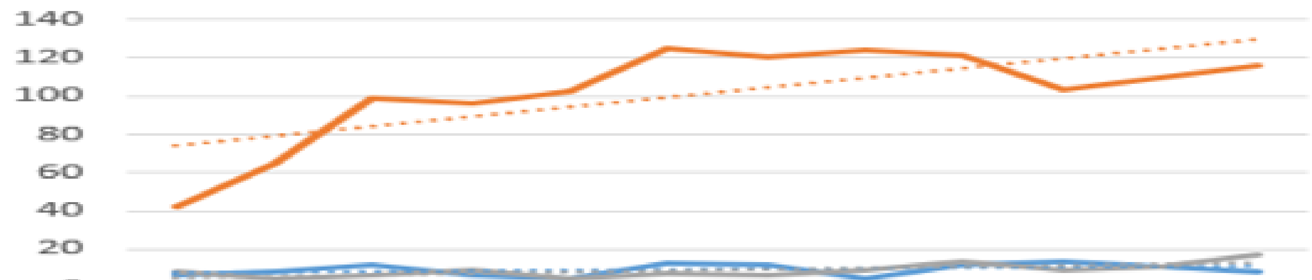
	jan	feb	mar	apr	may	jun	jul	aug	sep	Oct	Nov	Dec
BH ED clot	80	65	70	90	89	70	67	88	89	87	84	91
BH ED hemolyzed	229	224	270	337	158	124	118	156	154	160	236	215
BH ED QNS	86	81	90	98	122	101	128	135	117	115	104	100

Laboratory General

Rejected Specimens by Classification (all MCBH collection locations)

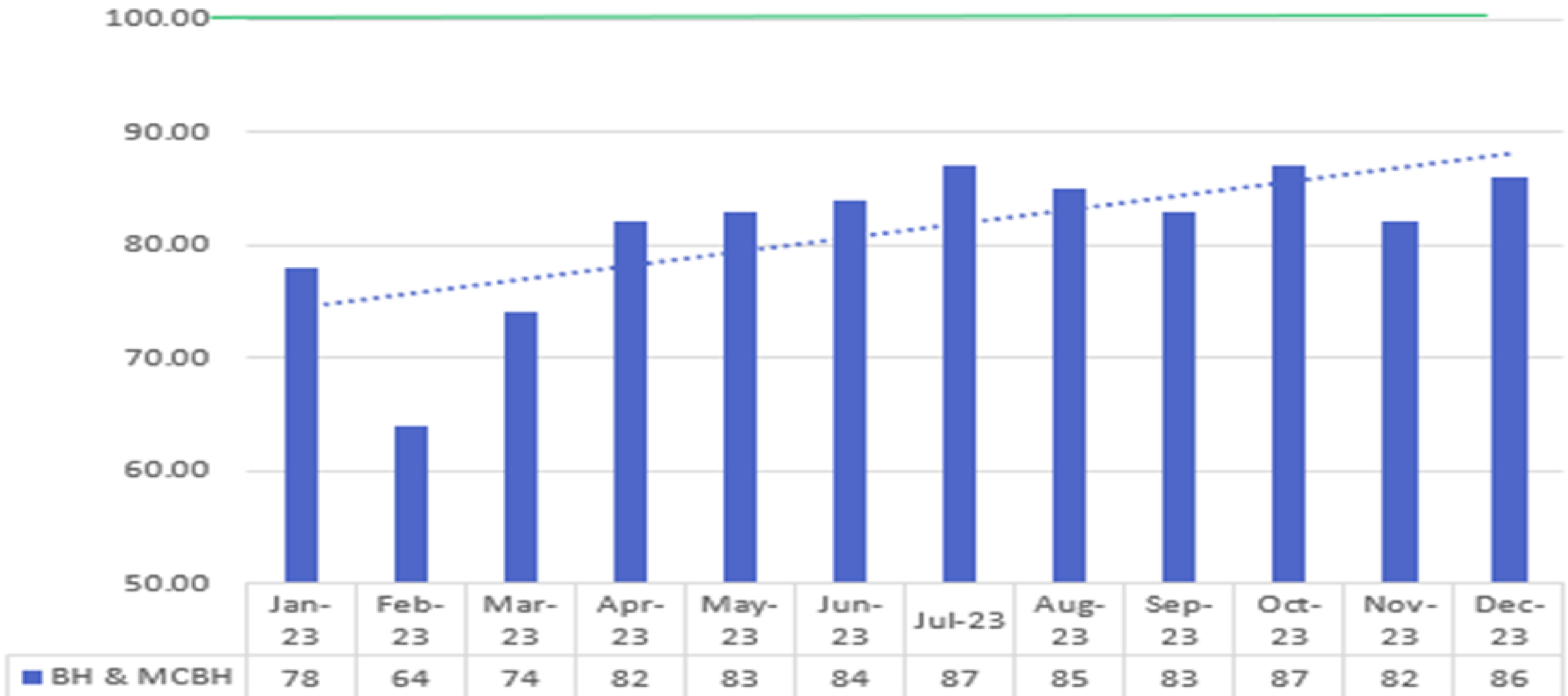
	Hemolyzed	QNS	Clotted	Contaminated	Incorrect tube/container	Technical error
23-Jan	47	24	16	3	10	2
23-Feb	71	12	16	12	8	2
23-Mar	105	15	15	6	4	3
23-Apr	100	15	16	6	3	1
23-May	106	11	8	9	13	1
23-Jun	133	14	17	15	8	19
23-Jul	129	16	13	7	2	3
23-Aug	133	21	7	7	13	0
23-Sep	127	19	21	0	15	3
23-Oct	111	19	21	8	10	0
23-Nov	120	21	15	8	15	1
23-Dec	125	24	12	1	5	0

Top 3 Rejections-MCBH ED totals



	jan	feb	mar	apr	may	jun	jul	aug	sep	oct	nov	dec
MCBH ED clot	6	8	12	6	5	13	12	5	12	14	11	8
MCBH ED hemolyzed	42	65	99	96	102	125	120	124	121	103	110	116
MCBH ED QNS	8	5	6	9	5	7	6	9	14	9	11	17

Laboratory General
BH & MCBH Events Calendar Completion 86%
Benchmark 100%

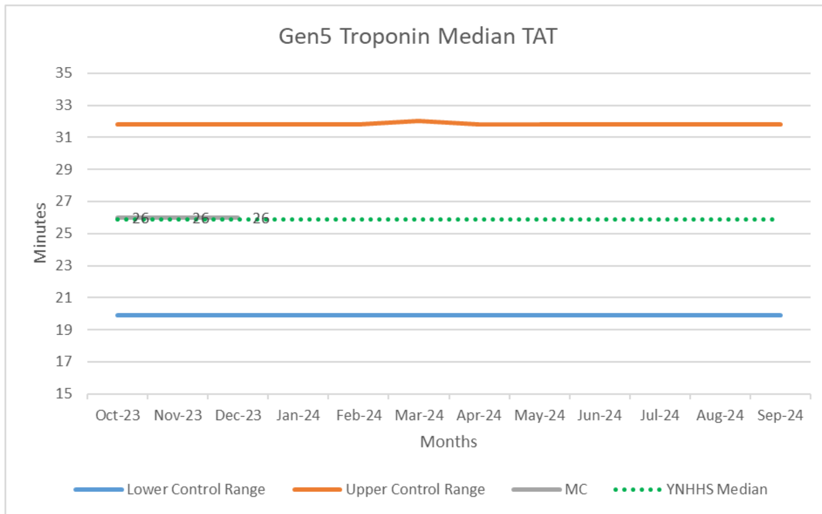


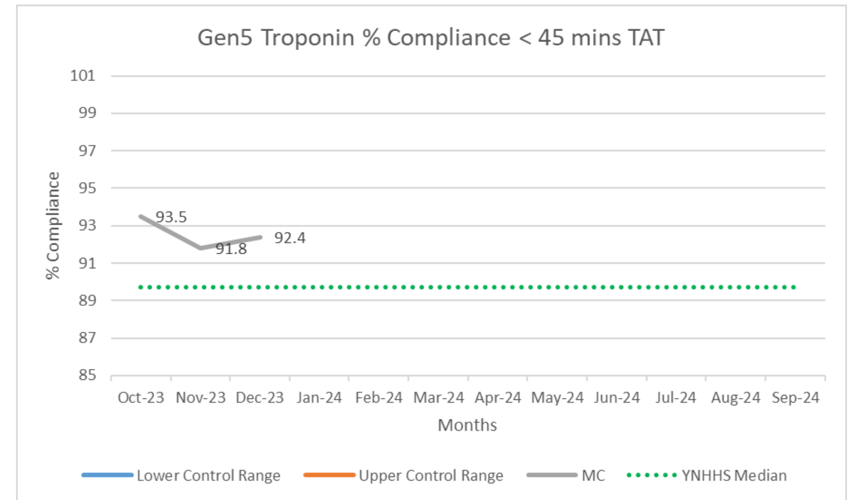
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
BH & MCBH	78	64	74	82	83	84	87	85	83	87	82	86

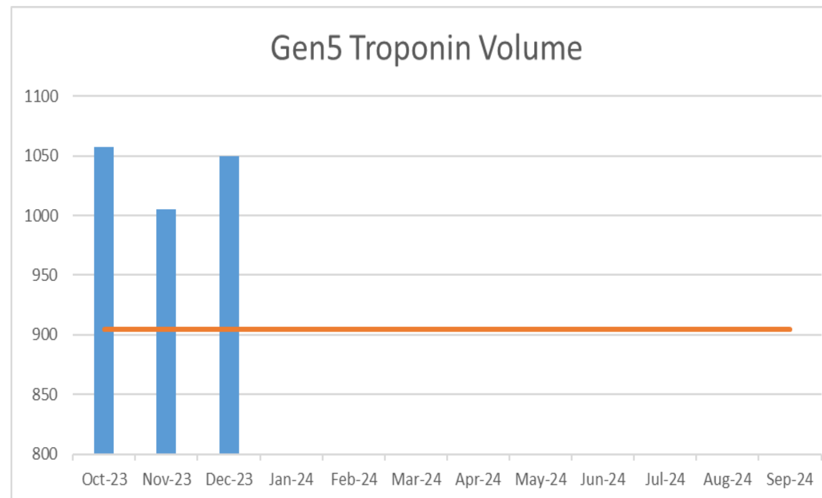
Overdue competencies/training on per diem employees.

Yale NewHaven Health
Bridgeport Hospital

Milford Campus – Gen 5 Troponin TAT

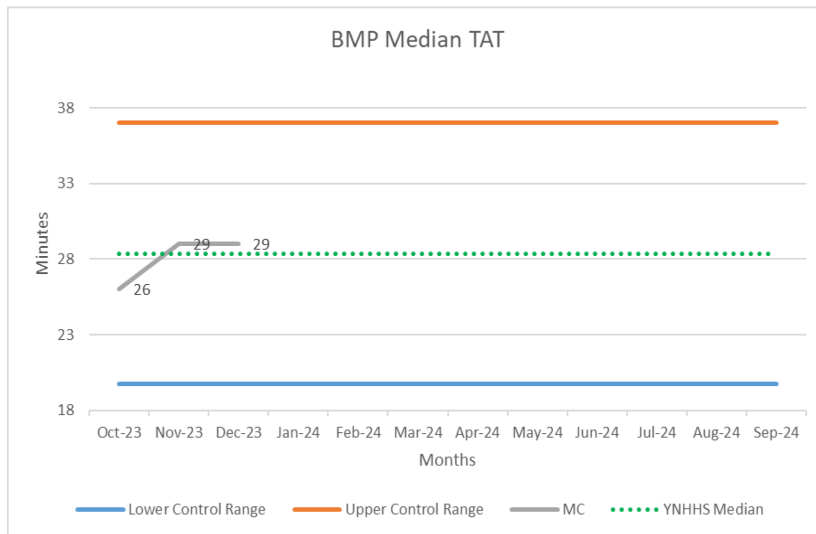


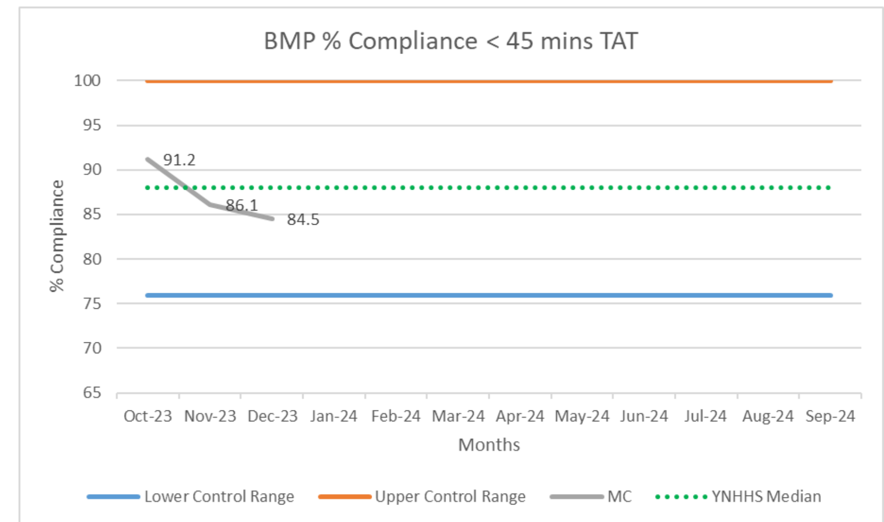


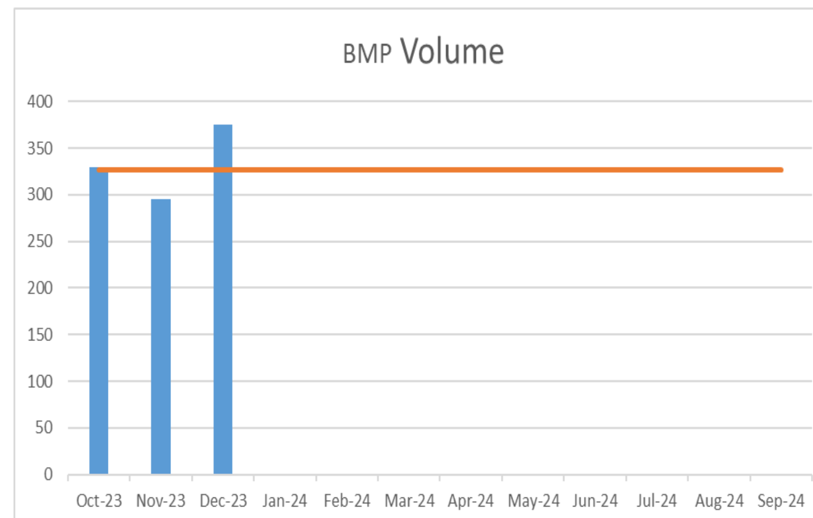


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – Basic Metabolic Panel (BMP) ED TAT

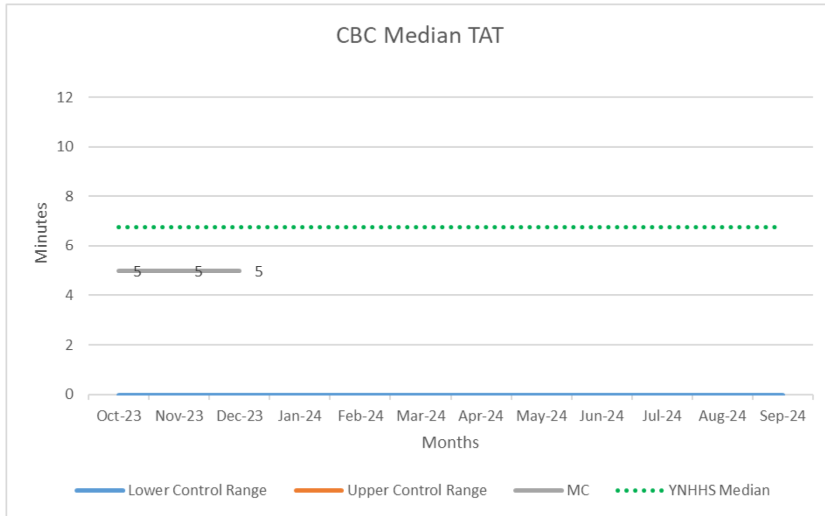


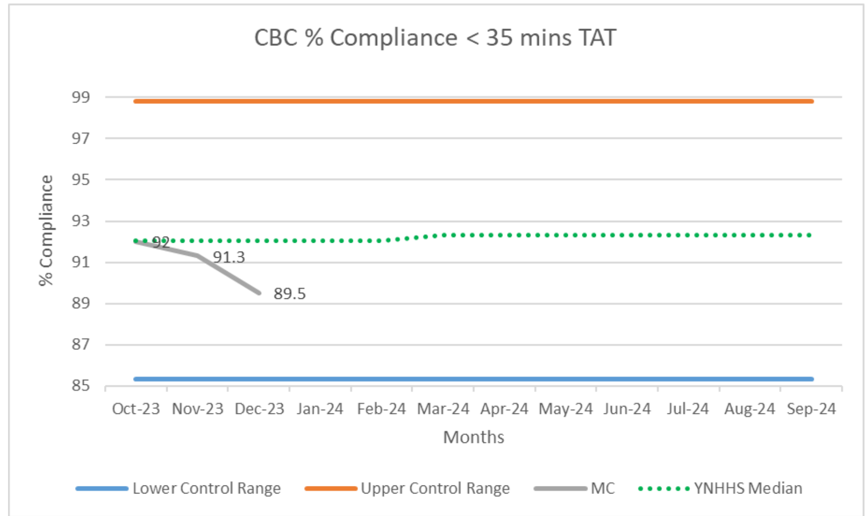


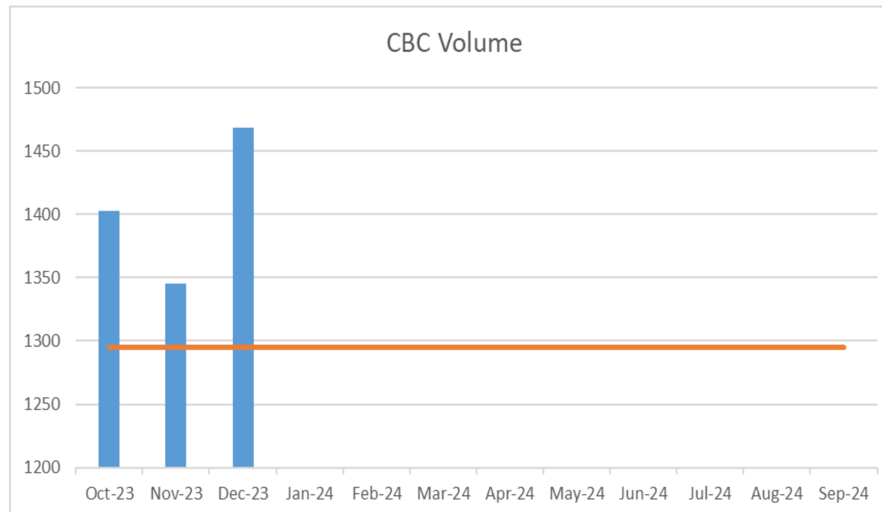


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – Complete Blood Count (CBC) ED TAT

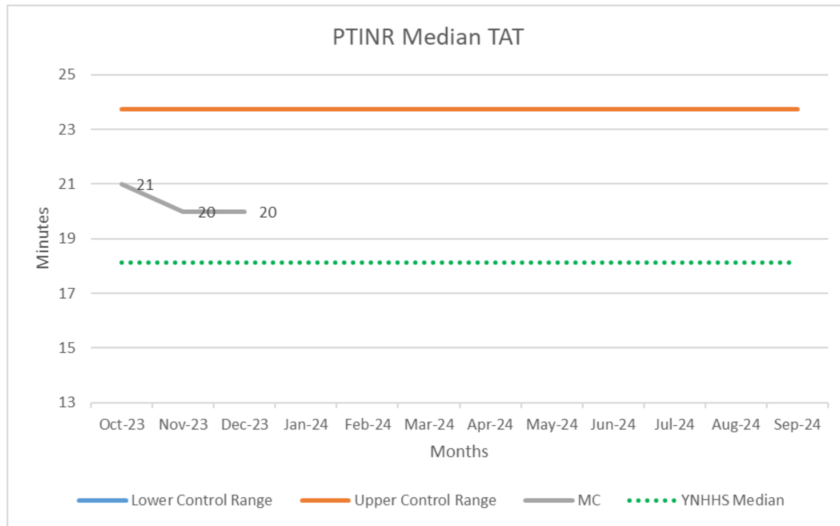


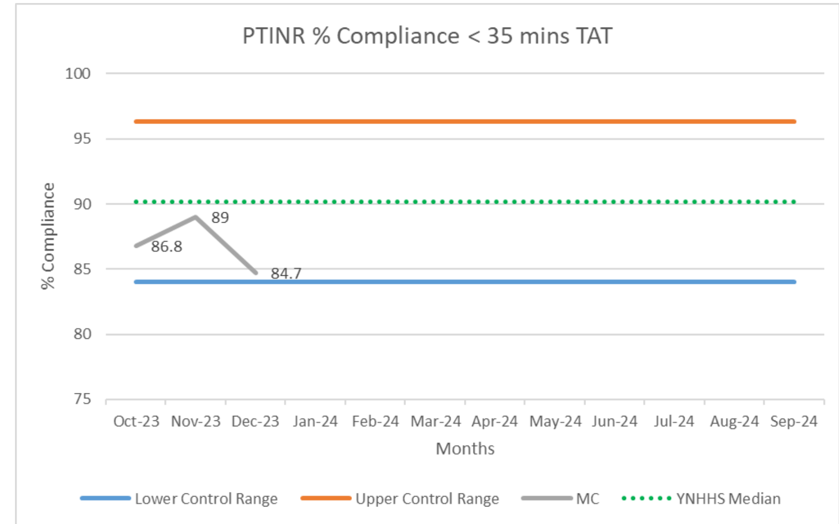


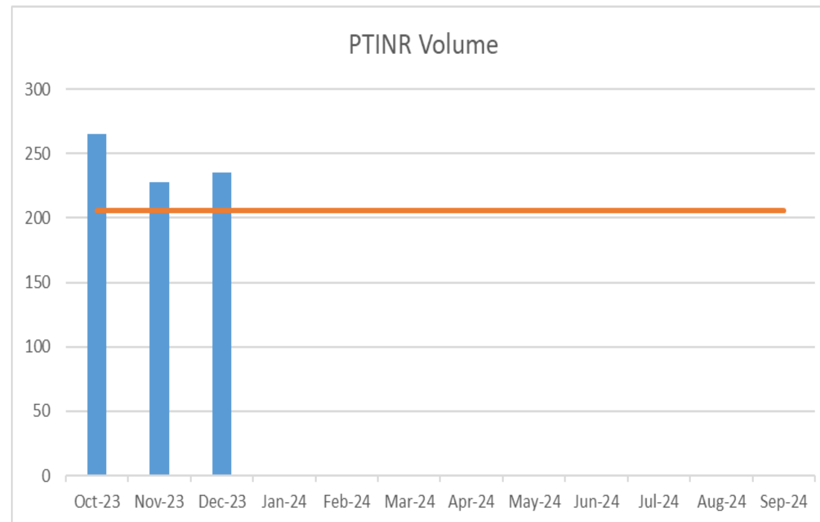


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – PTINR ED TAT

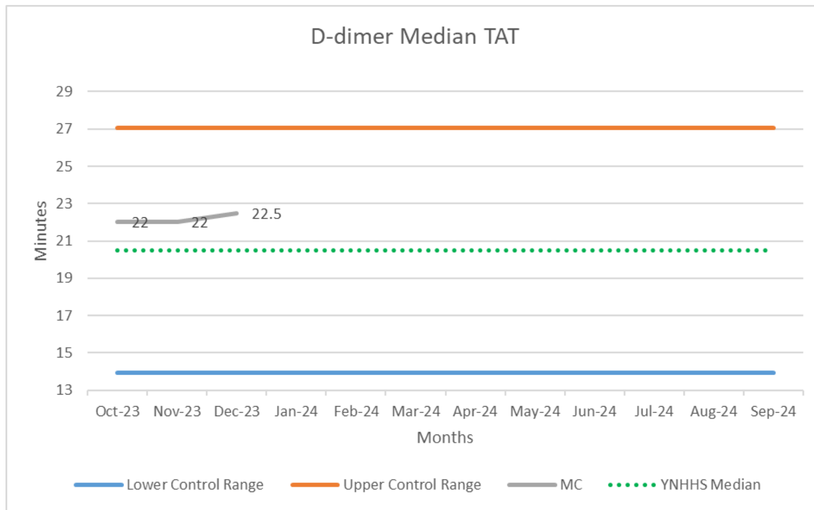


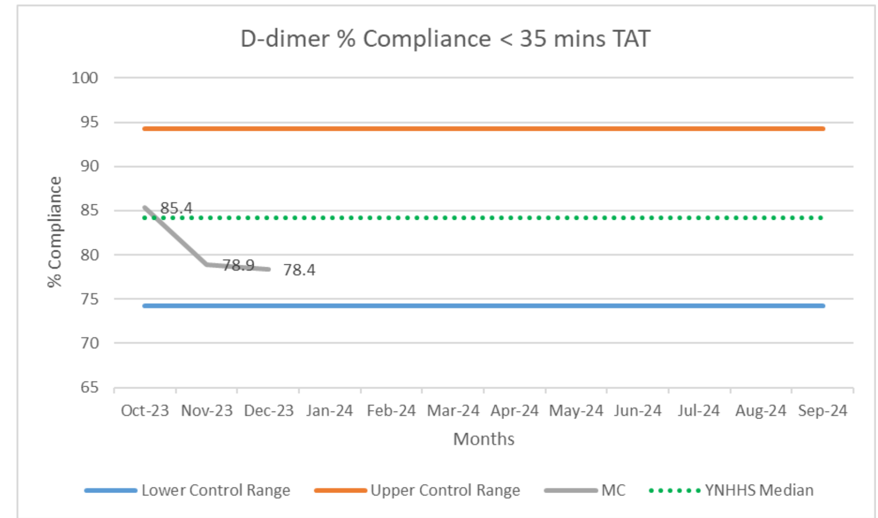


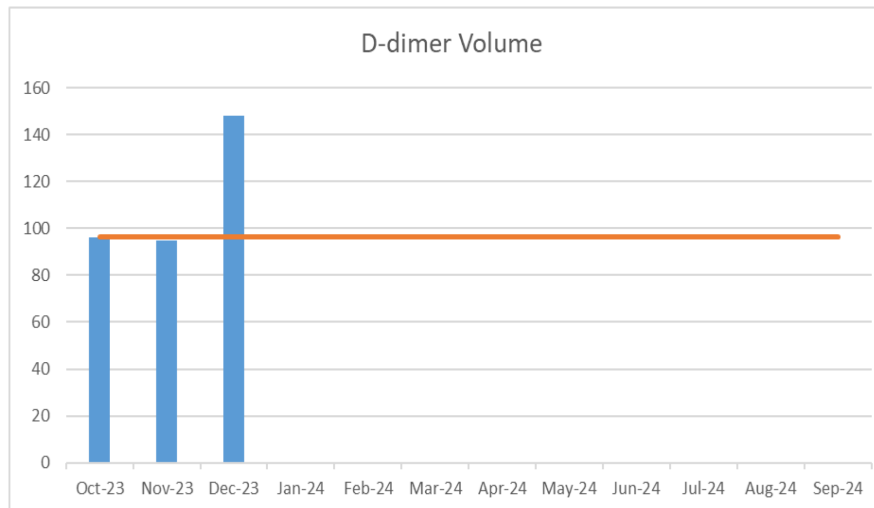


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – D-dimer ED TAT

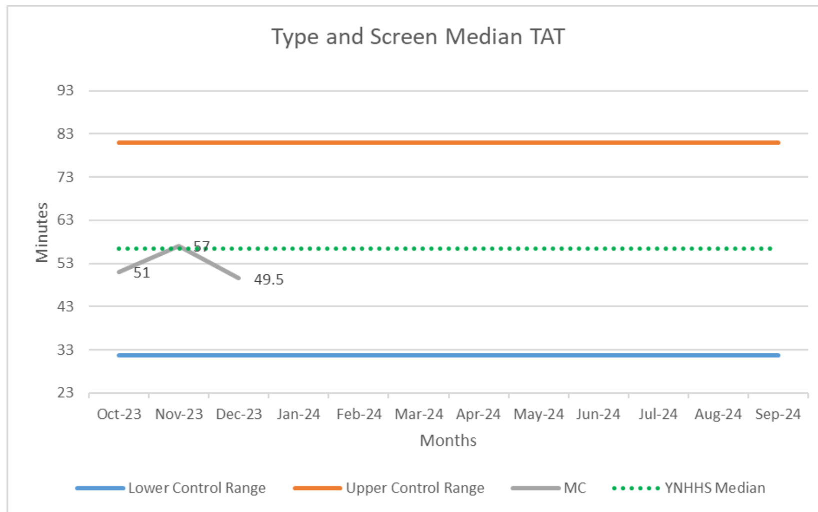


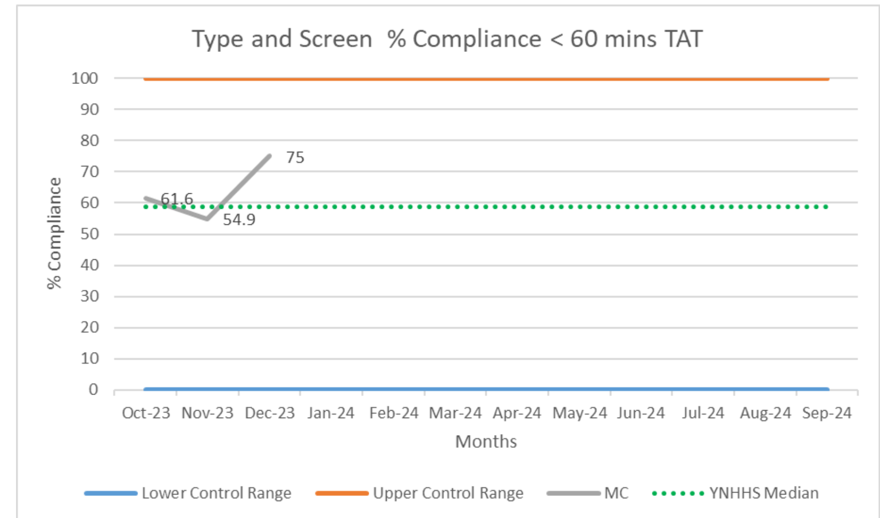


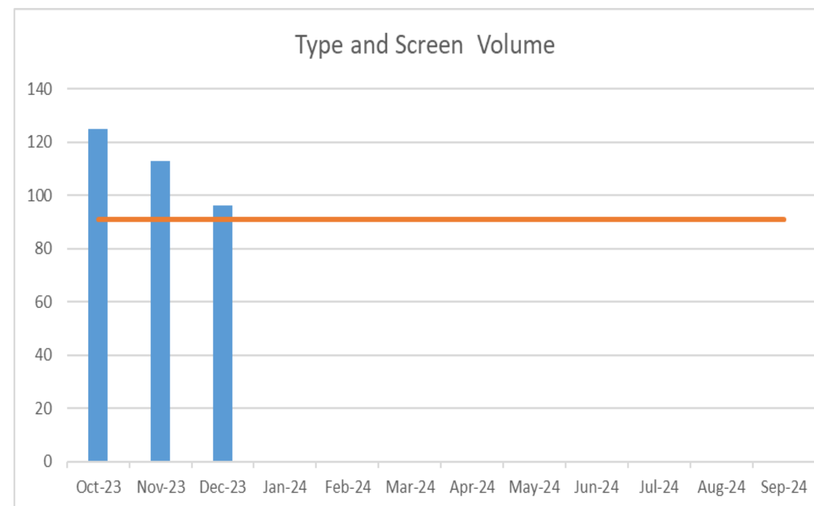


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – Type and Screen ED TAT

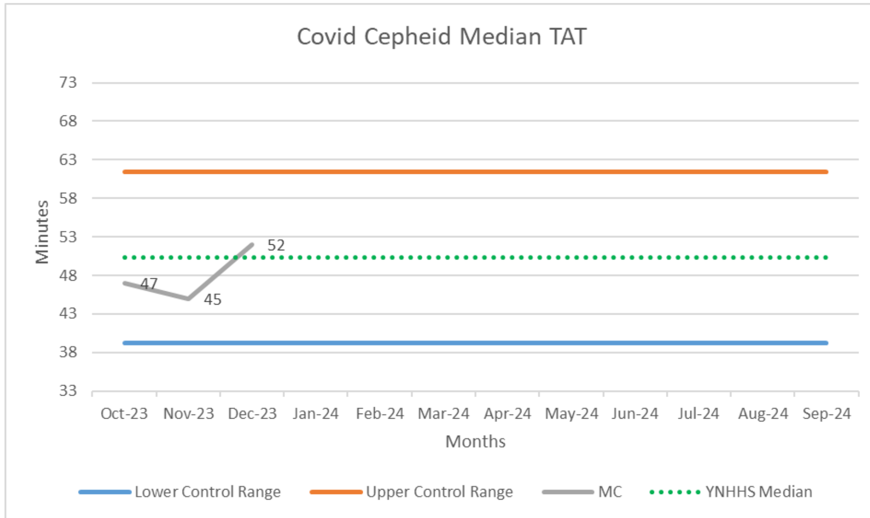


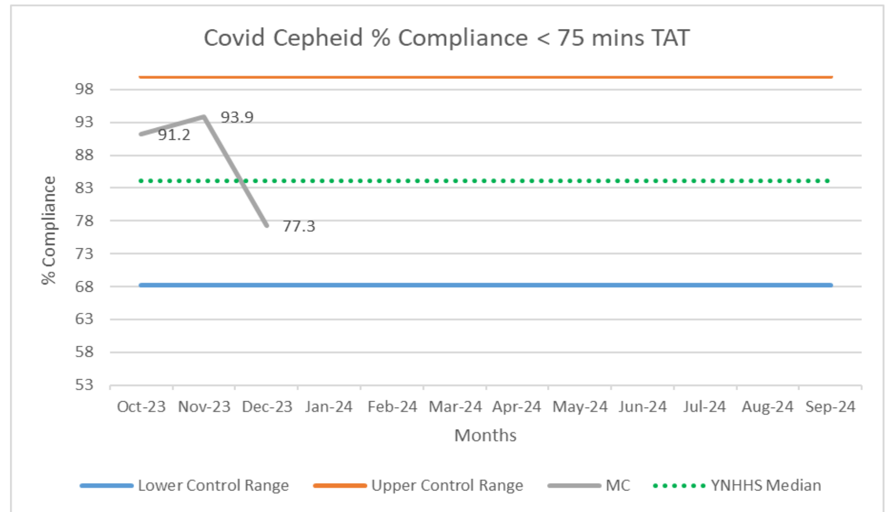


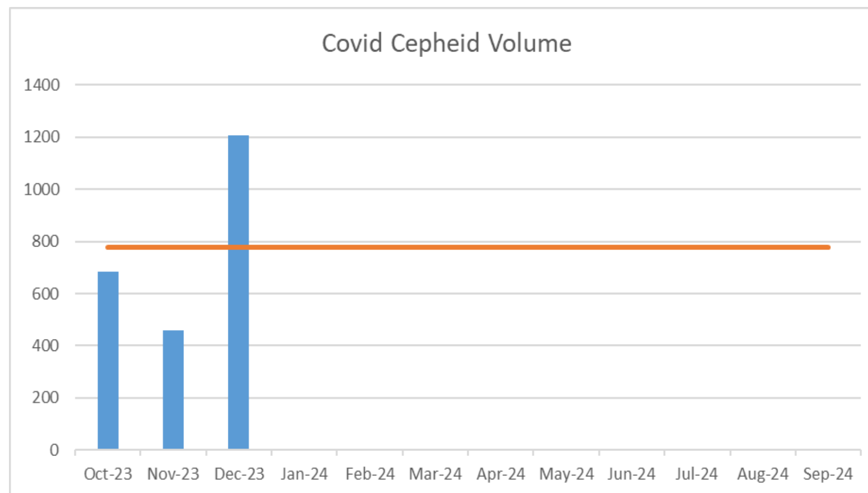


Yale NewHaven Health
Bridgeport Hospital

Milford Campus – COVID Cepheid PCR TAT

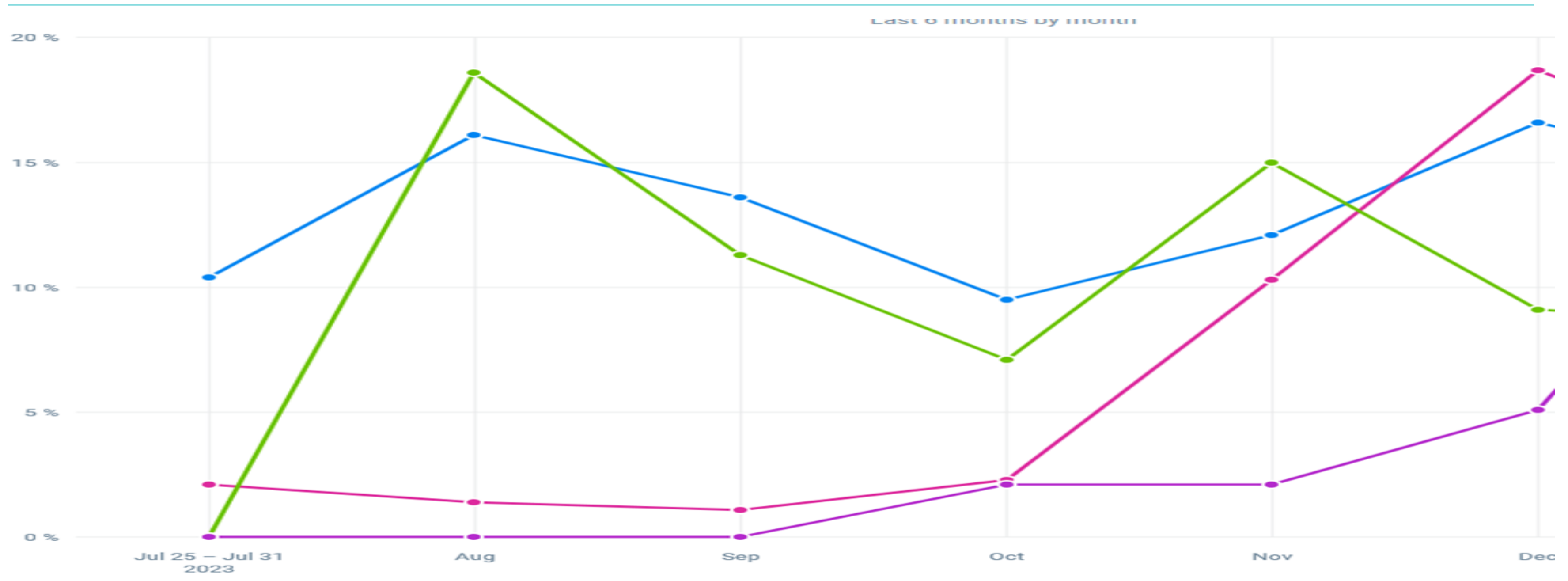






Yale NewHaven Health
Bridgeport Hospital

Milford Campus Molecular Dashboard



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

Date	Tests	% Positivity	Derived Baseline	Environment Monitoring	Physician Feedback	Epidemiological Trends	Evaluation Notes	Corrective Action (if needed)
Dec-23	SARS-CoV-2	16.60%	0-22%	Negative	None	post thanksgiving holiday period	None	None
Dec-23	Group A Strep	9.10%	0-19%	Negative	None	None	None	None
Dec-23	Flu A/B	18.70%	0-7%	Negative	None	flu season/holiday period	None	None
Dec-23	Flu/RSV	5.10%	0-14%	Negative	None	None	None	None
Dec-23	C. diff toxin	22.20%	not established	Negative	None	None	None	None

- OF the 22.2% positive C dif toxin by PCR, there were 3 confirmed active infections

Yale NewHaven Health
Bridgeport Hospital

MCBH Critical Result Calls & Documentation

Critical Result Call & Result Documentation % Compliance

Percent

100

80

Dec-23

	Dec-23
Called	100
Correctly documented	99

Axis Title

Called Correctly documented

	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov
n	230											
#compliant	228											
#noncompliant	2											
Notes	All called. 2 were phoned after comm log review by manager											

No name												
No full name	1											
No credentials	1											
Incorrect documentation												
Incorrect Person												

MCBH Corrected Report Calls & Documentation

	Dec-23
Called	100
Correctly documented	100

	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov
n	4											
#compliant	4											
#noncompliant	0											
Notes	3 UA color red to yellow, 1 manual entry											

No name	0											
No full name	0											
No credentials	0											
Incorrect documentation	0											
Incorrect Person	0											

Yale
NewHaven
Health
Bridgeport
Hospital

CRSQ Report Out

Committee of Regulatory, Safety, & Quality

December 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.

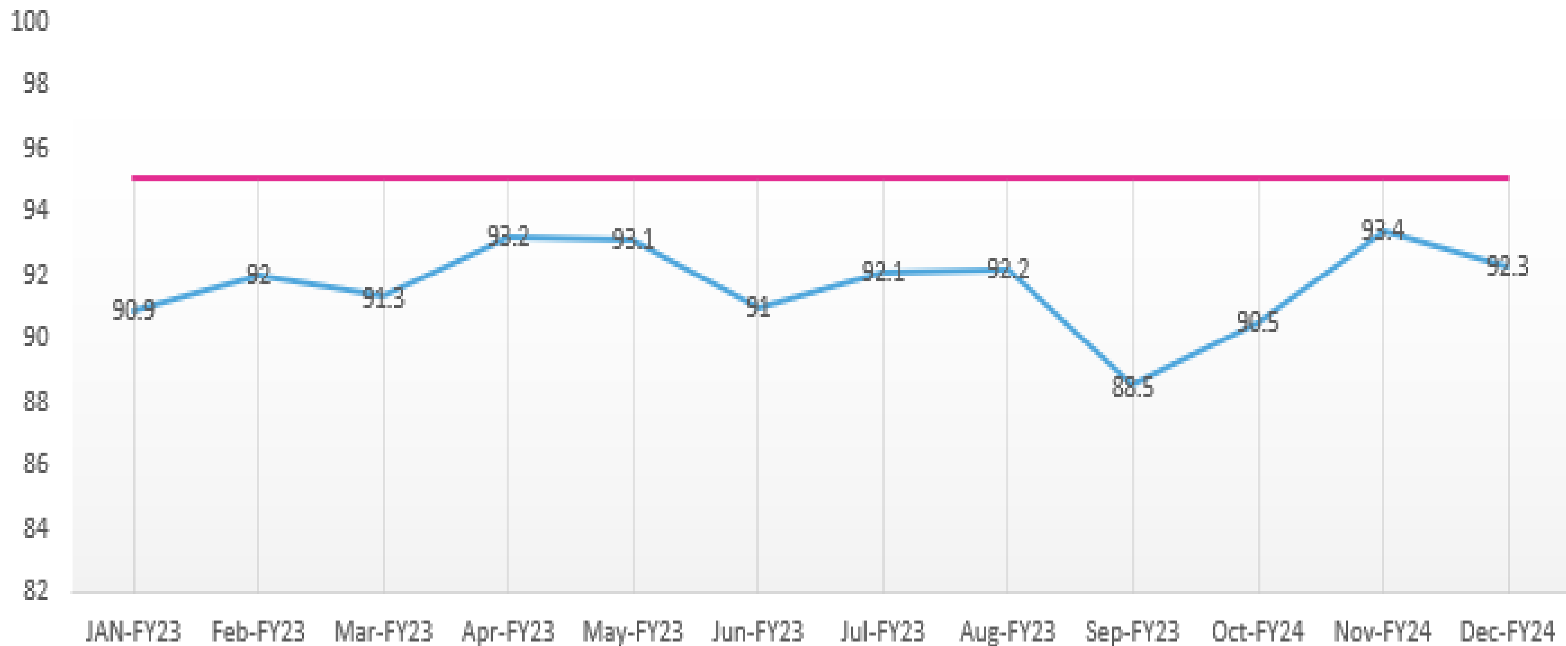
SMART Aim *Specific-Measureable-Actionable-Relevant-Timely*	Increase the critical result notification compliance with our 30-minute goal to 95% at Bridgeport Hospital The 30-minute time period is from the moment the critical value is final verified to the moment the communication log in Epic is completed. • We are currently at **92.3%** 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 • November 2023 has a 93.4% compliance (highest in the12 month period of Jan 2023-Dec 2023). • Inpatient compliance rate is 93.9%, Outpatient rate is 78.1% 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

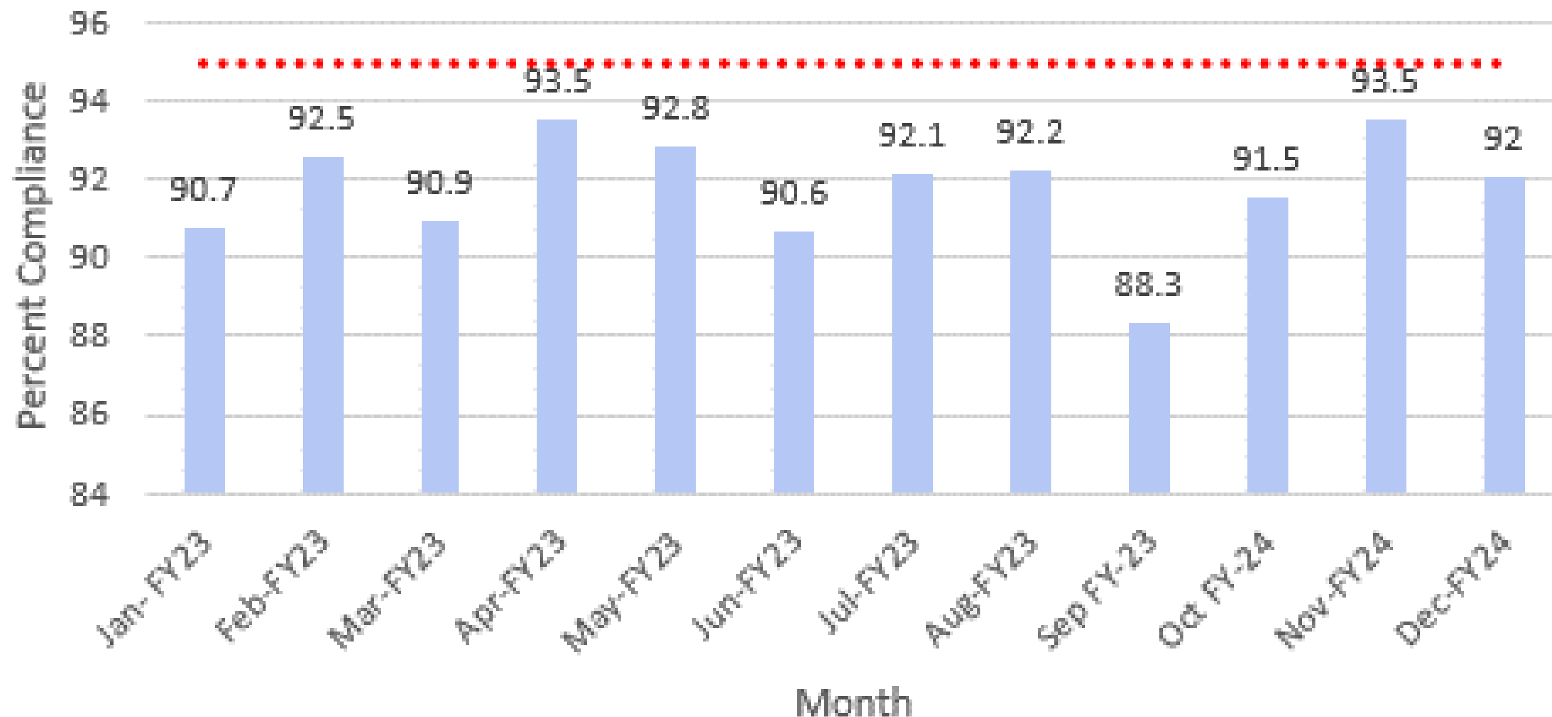
Bridgeport Hospital Department of Laboratory Medicine Critical Call Percent Compliance 91.8% (12 month cumulative) 12/1/2023-12/31/2023



Yale NewHaven Health
Bridgeport Hospital

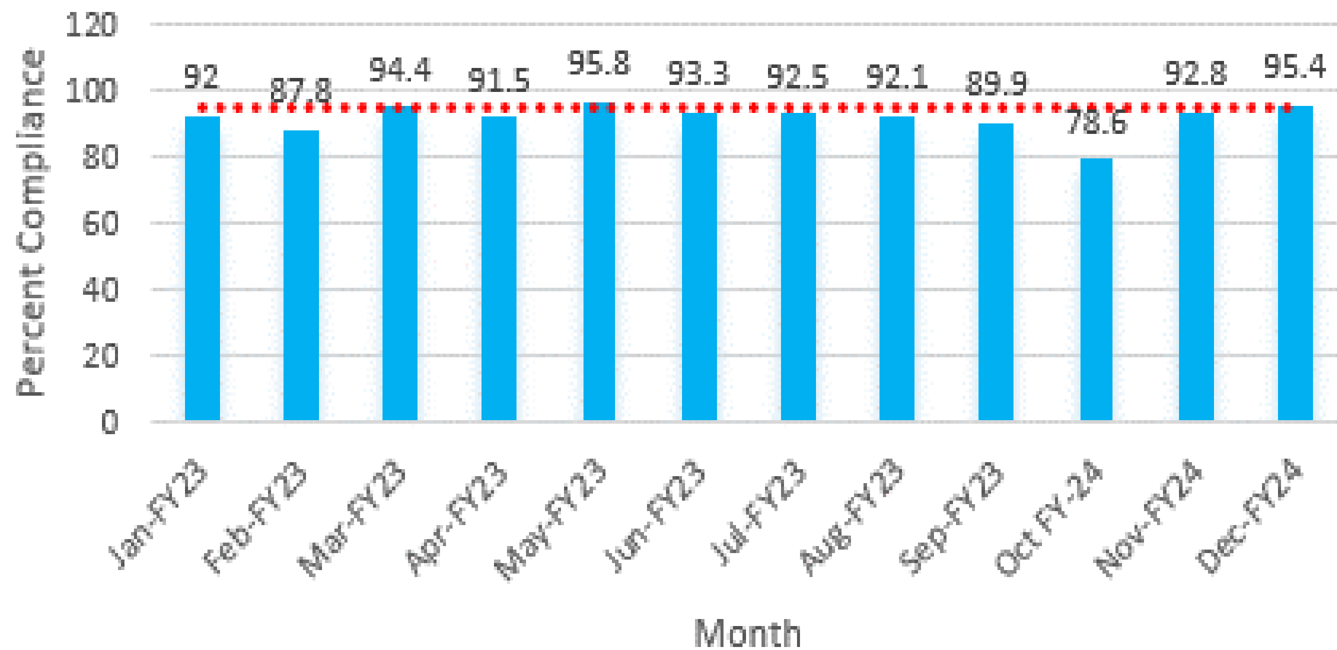
Bridgeport Campus Critical Call Percent Compliance 91.8%

1/1/2023- 12/31/2023



Yale NewHaven Health
Bridgeport Hospital

Milford Campus Critical Call Percent Compliance 91.4% 1/1/2023-12/31/2023



Yale NewHaven Health
Bridgeport Hospital