

Objective/Purpose

The goal of the Quality Management Program (QMP) is to establish leadership structure throughout the path of quality workflow that enables Johns Hopkins Hospital to provide high quality laboratory services. Johns Hopkins QMP is designed to promote quality and patient safety through risk reduction and continuous process improvement. This includes development of a program that provides for the continuous monitoring and evaluation of patient care activities within the Department of Pathology in collaboration with Johns Hopkins Medicine for the purpose of improving outcomes. Laboratory performance is evaluated in pursuit of these goals. The Quality Management Program is designed to communicate the detail and relationship of the Department of Pathology's Quality Initiatives as they relate to the larger institution.

Quality management is the continuing process whereby the laboratory ensures quality, maintains compliance with applicable laws, regulations and institutional policies, and pursues quality improvement activities. This QMP provides for continuous cross-functional and departmental monitoring and evaluation of patient care activities within the Johns Hopkins Department of Pathology and Johns Hopkins Medicine. Monitoring includes pre-analytic, analytic, and post analytic processes. The Department of Pathology focuses on quality and patient safety. Each laboratory/division is responsible for scheduling and holding informational meetings in order to review quality improvement initiatives, patient safety activities, documentation quality and other clinical matters of the lab area.

Committee involvement in hospital –wide quality committees, as specified in the hospital Medical Staff Bylaws, demonstrates integration and collaboration of laboratory and hospital through the laboratory quality management structure. Selected members of the Department of Pathology participate in committees as either permanent or ad hoc members. Other selected members of the department work with clinical departments to solve problems, improve systems, or fulfill specific strategic initiatives. Key committees within The Department of Pathology include the Laboratory Advisory, Performance Improvement, Pathology Administrative Team, Compliance, Credentials, Education Advisory, Pathology Data Systems Steering, Human Resources and Outreach Testing Committees. The following sections outline the framework from which the Department of Pathology operates.

SECTION I

Laboratory Personnel and Hierarchy/Structure

The Laboratory Director in Chief, Deputy Directors, Division Directors and Administrators/Managers, oversee the management of quality and patient safety within the Department of Pathology. The clinical laboratories/divisions are organized into 7 administrative groups, each managed by an Administrator or Manager who reports to his/her Lab Directors/Administrators. Each division is lead by a Laboratory Director designee for that discipline. The duties are delineated by the Laboratory Director in Chief.

Chief of Service/The Laboratory Director in Chief is responsible for the overall operation and administration of the Department of Pathology, including employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately, and proficiently, and for ensuring compliance with the applicable regulations. He/she directs the implementation of a safe laboratory environment in compliance with good laboratory practice and applicable regulations. The Laboratory Director in Chief, appointed by the Medical Board, is involved in the design, implementation and oversight of the Quality Management System (QMS) and the Quality Management Program (QMP). Johns Hopkins Department of Pathology Director in Chief annually reviews the QMS and the QMP. The Laboratory Director in Chief reports progress and summaries of Safety, Quality Improvement and Compliance Strategies in the Annual Planning Meeting to Johns Hopkins Medicine Senior Management.

(See Appendix A for Director duties)

The Laboratory Director in Chief delegates responsibility to Deputy Directors, Lab Directors and Lab Managers for the operation and administration of their Clinical and Anatomic Laboratories. The Laboratory Director in Chief is ultimately responsible for overseeing the design and implementation of quality improvement activities within the Department of Pathology that are both intra and interdepartmental in approach. He/she is additionally responsible for the quality of the in vitro laboratory and pathology testing performed for patient care in the Hospital. The Laboratory Director in Chief may delegate the performance of such activities to the Physician Advisor and will ensure these responsibilities are met. The Laboratory Director in Chief delegates responsibility for coordinating risk management and performance improvement activities to the Physician Advisor.

The Physician Advisor is a qualified professional with appropriate clinical training and experience whose responsibilities include the implementation, coordination and maintenance of the quality improvement (QI) program within the department. He/she oversees the design and implementation of quality improvement and patient safety activities and ensures integration of QI activities with other hospital departments. The Physician Advisor represents the Department of Pathology at Clinical Quality Improvement Committee meetings and reviews performance measurements, reports of occurrence, and other identified indicators to determine if a quality or patient safety issue requires further peer review. As set forth in the Medical Staff Bylaws the duties of the Physician Advisor are:

- Chair Departmental Quality Improvement Committee
- Serve on the Department Credentials Committee
- Serve on the Hospital Clinical Quality Improvement Committee
- Coordinate patient safety and quality improvement activities including, as appropriate, quality assurance/quality improvement, medical staff monitoring functions, credentialing, medical record documentation, drug usage evaluation, infection control, surgical and invasive procedures reviews, blood usage evaluation, utilization reviews and utilization of critical pathways.
- Manage department risk management activities
- Monitor department compliance with regulatory requirements
- Regularly report to Laboratory Director in Chief concerning activities and issues pertaining to areas of responsibility as outlined above

- Identify a designee to serve during absences
- Other responsibilities as defined by the Laboratory Director in Chief

Laboratory Director Designees are qualified professionals with appropriate clinical training and experience and are responsible for the clinical and technical direction of patient care provided by their laboratory discipline. The qualified designees approve and or review discipline specific Quality Plans (QP) developed by the Laboratory Managers, Laboratory Supervisors, Quality Assurance Technologist and or Lead Technologists. Quality monitors are also reviewed and approved on an annual basis in conjunction with the Supervisors, Quality Assurance Technologists and or Lead Technologist. Quality monitors may be developed as needed if an issue is discovered or reported. Laboratory Director Designees report to hospital and or department committees as required or necessary.

Other duties include:

- Approve/review the quality assurance program in their laboratory division. Define the laboratory's performance criteria for quality control, proficiency testing and reporting of results
- Approve policies and procedures on a regular basis
- Oversee assay development and evaluation, equipment selection, referral of testing
- Ensure regulatory compliance, technical education and competency of laboratory staff
- Document review of proficiency testing by signing attestation statements and survey results
- Provide education programs, planning, research and development appropriate to the needs of the laboratory

Department Administrators / Laboratory Managers of each area are qualified professionals with appropriate education and experience; in conjunction with the Laboratory Director in Chief, Lab Directors and Administrators, they are responsible for the administrative and technical direction of laboratory services provided by their laboratory or laboratories. The administrators and or managers ensure the development of an appropriate quality assurance plan and assist in the selection of QI monitors. They determine how quality and safety information is communicated to the staff and encourage staff to report quality and safety concerns.

Their shared responsibilities include:

- Budgetary and financial management
- Quality assurance, risk management and safety
- Program development and business planning
- Staff competencies, education and training
- Materials and equipment management
- Facility design and maintenance

Supervisor, QA Technologist or Technical Specialist, in conjunction with Laboratory Directors and Laboratory Managers define the QI monitors for the year and prepare and review the QA monitoring reports and/or annual quality summaries. They collect data, report department measures to the

Pathology PIC, prepare any other summaries required by the department and participate in interdepartmental performance improvement activities, as needed.

Additionally, they perform the following duties:

- Review monthly quality control (QC) documents, and documentation of any problems.
- Review proficiency testing results.
- Ensure that PT samples are tested in the same manner as patient samples
- Ensure that all PT failures are identified, investigated, corrected and documented.
- Solve interdepartmental Quality Assurance (QA) and Patient Care problems.
- The Supervisor, Quality Assurance Technologist or Technical Specialist is responsible for establishing a system for identifying, correcting and documenting internal and external department problems. The Supervisor, Quality Assurance Technologist or Technical Specialist documents problem solving methods and preventive actions taken. Ensures performance improvement activities are executed per departmental plan.
- Implement and maintain a comprehensive employee orientation, training and competency program. May perform annual personnel performance evaluations.
- Ensure policy and procedure manuals are current and followed by staff. The Faculty Laboratory Directors may designate the Supervisors, Quality Assurance Technologists or Technical Specialists as the authorized reviewer of unchanged policies.

Lead Medical Technologist

- Solve quality assurance problems within their areas of expertise
- Review monthly preventive maintenance (PM) documentation and bring problems to the supervisor's attention.
- Review various computer generated reports to assure that documented problems have been handled correctly.
- Review abnormalities, outliers, or other problems with quality control logs, preventive maintenance logs or other reporting formats assigned for review.
- Implement established policies and procedures for the area.
- Communicate and resolve issues that arise between shifts
- Assist in writing and implementing policies and procedures.

Bench Technologist/Technicians

- Ensure that daily quality control is within expected ranges before proceeding with patient samples. Refer any unresolved problems to lead technologist or supervisor
- Identify opportunities for improvement, documenting problems arising on each shift
- Perform other functions as defined within their job description

SECTION II

Quality Infrastructure

Key cross-functional, departmental and interdepartmental committees:

JHH Department of Pathology is responsible for providing in vitro diagnostic services through its Pathology and Laboratory Medicine services. Additionally the Department is responsible for the quality of patient care laboratory and pathology services performed by all units providing information for patient care decision-making. It has oversight responsibility for Point of Care Testing performed by non-laboratory personnel. The Office of CQI Programs within the Department of Pathology performs the task of monitoring CQI activities/regulatory compliance of all patient care testing areas. The Department of Pathology participates in a variety of departmental and interdepartmental quality assurance improvement plans and initiatives. Collaborating with other hospital departments is pursued in order to improve patient health outcomes.

The Quality Improvement Council (QIC) is a cross-functional hospital committee that meets monthly. The Assistant Director of Quality Management represents the Department of Pathology on the JHH QIC. The council is the forum where safety, service and quality improvement leaders across the institution discuss related issues, set annual quality improvement priorities, and monitor progress toward these priorities. The council reports its progress to the Trustees via the Board of Trustees Quality Improvement Committee.

The hospital Clinical Quality Improvement Committee (CQIC) is a cross-functional committee that meets monthly. Members are comprised of departmental Physician Advisors who review identified performance measurements, policies and other quality, utilization or risk management issues. The Physician Advisor represents the Department of Pathology on the CQIC and reports pertinent information to the department. The committee assesses and makes recommendations related to intra and interdepartmental problems in quality assessment/quality improvement, risk management and utilization management. Improvement of patient care is addressed through review, discussion and support of departmental quality improvement programs.

The Laboratory Advisory Committee (LAC) is a cross-functional committee and meets monthly. The Deputy Director for Clinical Affairs chairs the LAC and the members are comprised of physicians, residents, nursing administration, pharmacy, laboratory directors and administrators.

As laid out by the Medical Bylaws the committee:

- Assists in the education of physicians and other staff on the appropriate use of laboratory services

- Provides recommendations to the Medical Board and Hospital Administration regarding improvement of pathology and laboratory services and their utilization.
- Advises the Department of Pathology on the scope, availability, and relevance of laboratory services, including selection of reference laboratory services.
- Periodically reviews reports pertaining to clinical department assessment of laboratory services in terms of factors such as quality, timeliness and responsiveness to problems and inquires
- Participates in the development and interpretation of quality assessment studies dealing with the appropriateness of test ordering the effectiveness of test utilization and interpretation, and correlation with quality improvement activities in the clinical departments
- Advises the Department of Pathology regarding written and electronic communications to medical, nursing, and other hospital staff
- Receives relevant information from operating divisions and central administration if the Department of Pathology
- Evaluates all critical pathways, order sets, and similar materials concerned with Pathology and Laboratory Medicine tests and procedures
- Serves as a resource for information or consultations for Johns Hopkins Medicine institutional Review Boards and requesting investigators regarding Pathology and Laboratory issues
- Monitors and develop policies regarding the activities of sales representatives for laboratory diagnostics and in vitro devices within the Hospital

The Surgical and Invasive Procedure Review Committee (SIPRC) is a cross-functional committee that meets at least quarterly. Members are comprised of physician representatives from each division of Anatomic Pathology, Dermatopathology and Eye Pathology. Representatives of anatomic pathology administration, nursing administration, clinical departments or divisions and quality improvement who evaluate cases that meet specific criteria for review are also members. A list of cases reviewed and findings are presented semiannually to appropriate Chiefs of Service and to the Vice President for Medical Affairs.

Duties and responsibilities:

- Evaluate cases with the following properties:
 - Cases in which the final diagnosis differs from the pre-operative diagnosis or from the diagnosis made from frozen section, and/or cytopathology
 - Cases in which the original pathological diagnosis has been changed
 - Cases in with specific diagnoses selected for periodic reviews of specific operative and invasive procedures
 - Surgical cases operated on at JHH following tissue diagnosis made elsewhere, for which pertinent slides have not been reviewed by JHH pathologists prior to the operation at JHH
 - Autopsy cases in which the post-mortem diagnosis differs significantly from the per-terminal diagnosis
- Each of the above cases found to merit review will a written report generated that will include documentation and explanation of any event in question and any response from the attending physician. The report will be submitted to the appropriate Physician Advisors for departmental review and action.
- Provide a list of cases reviewed and the findings semiannually to the appropriate Chiefs of Service and to the Vice President for Medical affairs.

- Report to the Clinical Quality Improvement Committee any identified systemic problems requiring institutional or multidisciplinary alerts or action

The Transfusion Practices Committee is a cross-functional committee that meets quarterly. Members are comprised of Director, Associate Director, Laboratory Manager and QA Specialist of the Transfusion Division of the Department of Pathology, medical director and manager of HATS division, Department of Pathology Physician Advisor, Pathology Data System (PDS) Lab Director, Assistant Director of Quality Management and physician and nurse representatives of clinical departments. Members review the practices related to the administration of blood and blood components, review and approve sources of blood and blood components and serve as a forum for discussion of transfusion practices.

Duties and responsibilities:

- Review the practices relating to administration of blood and blood components within the hospital
- Review the overall institutional utilization of blood products by type of component
- Advise clinical departmental Quality Improvement Committees and other s on blood and blood component utilization. This shall include review of departmental transfusion monitoring activities
- Provide oversight of processes that ensure prompt review, and documentation as indicated for actual or suspected untoward events, including reported transfusion reactions, post-transfusion infections, or events associated with actual or potential patient harm as identified by the Risk Management Department or other bodies concerned with patient safety issues.
- Review and approve sources of blood and blood components
- Review and evaluate new blood components or services for possible additions to the Blood Bank inventory and Hemapheresis and Transfusion Support (HATS) division
- Serve as a forum for discussion of transfusion practices and blood donation activities.
- Develop and update every two years, and as needed, the Johns Hopkins Transfusion Guidelines

The Pathology Performance Improvement Committee (PIC) a committee within the Department of Pathology meets monthly (at least 10 times per year). As defined in the Medical Staff Bylaws, each clinical department of the Hospital shall schedule and hold meetings in order to review quality improvement initiatives, patient safety activities, documentation quality and other clinical matters of the department. The Physician Advisor and Assistant Director of Quality Management co-chair the committee and the members are comprised of the finance Director or designee, Administrator for Operations, Laboratory Directors, Faculty, Lab Managers, QA Specialists/Technologists and other individuals upon request. The committee facilitates the department QI plans, decides which processes and outcomes should be monitored, reviews results of data collection, assesses the effectiveness of actions and makes recommendations for improvement. Progress reports and summaries of QI initiatives are reported monthly to the Laboratory Director in Chief and Deputy Director and annually to the hospital QIC.

The committee is responsible for:

- Planning the program to assess and improve the quality of patient care functions of the Department
- Facilitate the plan and design of functions in the Department to identify areas of potential improvement through the use of performance measures
- Decide which processes and outcomes should be monitored. Emphasis is placed on those aspects of care, which are high risk, high volume and/or problem prone and where the opportunity exists to improve care
- Review the results of data collection. Other sources of data may include but are not limited to reports of occurrence, physician complaints, autopsy reports, medical records, amended pathology reports, proficiency reports, and other support service
- Document actions taken to facilitate resolutions of identified problems and improve quality of patient care
- Redesign and assess effectiveness of actions taken and document improvement in care and/or services
- Identify and prioritize issues that need more focused data and analysis
- Coordinate the communication of quality related information to pertinent individuals throughout the Department
- Maintain confidentiality of all quality of care and risk management information. This information is protected from discovery under Maryland Annotated Code
- Review findings from the following committees or departments and make recommendations as relevant:
 - Infection Control
 - Quality Council
 - Laboratory Advisory
 - Transfusion Practices
 - Regulatory Compliance Committee
 - Risk Management
 - Safety
 - Patient Relations
 - Service Performance Improvement Committee
 - Clinical Performance Improvement Committee
 - Surgical and invasive Procedure Review Committee
 - Subcommittees/working groups of the departmental PIC

Quality Assurance Work Group, a subcommittee of PIC, meets monthly. The meeting is chaired by the Department of Pathology's Office of Continuous Quality Improvement (CQI) and attended by the Physician Advisor, and laboratory QA personnel for each division. Significant patient safety events, other patient safety matters and process improvement activities are discussed. Any items needing further investigation are brought to the monthly PIC.

The Pathology Data Systems (PDS) Steering Committee, a Pathology Quality Team within the Department of Pathology that meets every other week. The committee is chaired by the Pathology Systems Manager and comprised of the Director and Manager of the PDS/Informatics Division, the Department Administrator, Finance Director, Managers of major laboratory Divisions, and other individuals upon request. The Committee reports to the Director of the Department of Pathology through the Pathology Operating Group (POG), and to the Administrator of the Department directly and through the Pathology Administrative Team (PAT).

The committee is responsible for:

- Advising the Department's executive and administrative leadership on matters relating to the Department's and to Johns Hopkins Medicine's "laboratory information system" (LIS) patient-care, administrative, and billing functions.
- Reviewing current operational problems with LIS services for the Institutions and for Johns Hopkins Medicine, it advises on a broad range of LIS-related policies and procedures, it assists with strategic and short-term planning for LIS services, and it reviews and makes recommendations regarding internal and external requests for new or additional LIS services.

Interdisciplinary Phlebotomy Committee, a Pathology Quality Team within the Department of Pathology that meets periodically. The meeting is chaired by the Physician Advisor and the Core Lab Manager. Membership is comprised of representatives from Pathology, Hospital QI, Nursing, Vascular Access Team (VAT), House staff and Outpatient Services. The committee develops service expectations, reviews patient safety events, advises on safe/efficient/timely phlebotomy practices and addresses challenges on an inpatient and outpatient level.

Progress reports and summaries of Phlebotomy improvement initiatives are reported monthly to the Laboratory Director in Chief and to the Laboratory Advisory Committee (LAC).

The Department of Pathology's Office of Continuous Quality Improvement (CQI), under the direction of the Assistant Director of Quality Management, is responsible for:

- Ongoing monitoring of quality improvement and regulatory compliance
- Interface and coordinate with regulatory agencies
- Maintenance of an updates regulatory compliance database
- Review Patient safety Net (PSN) and other reports of occurrence
- Coordinate safety investigations and corrective action plans
- Provide oversight and guidance for Quality Improvement and Safety activities

Quality Improvement (QI) Teams are formed when problems or opportunities for new or improved services or processes are identified. Representatives of the department participate on these whenever appropriate. The department can initiate a team if any opportunity is identified.

SECTION III

Division Quality Plans

The Department of Pathology maintains a strong commitment to quality and patient safety. Employees are encouraged to discuss quality and safety concerns with their supervisor and or quality assurance specialist. Each division quality plan is designed with this in mind. It is the responsibility of management and all laboratory personnel to do the right thing, all the time, for the patient.

Each laboratory division maintains a discipline specific quality improvement plan to monitor and trend the quality and appropriateness of services. Division quality plans should outline a process for identifying current and foreseeable customer needs using the 5 Key quality system components, planning (organization), teamwork (personnel), monitoring (assessment), improvement (PI) and review (organization). Quality plans generate a process for effective, team-based decision making, sustaining ongoing monitoring of operational process and customer satisfaction, identifying process problems, implementing appropriate process improvement and practicing ongoing quality reviews. The focus is improved patient safety and increased quality outcomes. This is accomplished through ongoing programs designed to assess, measure, improve and monitor improvement of care provided by the Department of Pathology in conjunction with clinical users, and others in the Health Care Organization. The goal of these plans is to ensure processes that systematically measure areas needing improvement, and develop programs appropriate to enhance performance in optimum utilization of health care resources, and patient health outcomes.

Plan Elements:

Quality System Essentials

Each division and or lab area follows the outline of the Quality System Essentials (QSE) for their specific quality plan. The QSEs are defined in the Quality Management System and in a general Quality Plan template/aide designed for lab area use.

Key Quality Indicators

The Laboratory Director in Chief, the Clinical & Financial Administrator for Pathology and the Assistant Director for Quality Improvement, together with safety, service and quality improvement leaders across the institution align the key indicators with the Quality Improvement Plan for the hospital. The Key quality indicators are selected on an annual basis and are consistent with the patient centered goals of the Johns Hopkins Health System (Safe Care, Evidence-based/Effective Care, Efficient/Timely Care and Patient Centered Care), CAP and other accreditation agencies patient safety goals.

Department of Pathology key quality indicator selection is discussed at the QA workgroup meeting. The Department selects indicators that measure the performance of processes in the path of workflow. Quality indicators are observations, statistics, or other data that typify and measure the performance of a process. The quality indicators are selected to facilitate and implement strategies to align with the Hospital strategic goals of clinical, service, fiscal and infrastructure. The selected indicators are applied to

issues relevant to improvement of pathology and laboratory services. Once the indicators are chosen they are presented at PIC for final review. (See Appendix B for indicators)

The CAP patient safety goals incorporated into each quality plan are:

- Improve patient and sample identification
- Improve the verification and communication of life threatening or life altering information regarding:
 - Malignancies
 - HIV and other infections
 - Cytogenetic abnormalities
 - Critical results
- Improve the identification, communication and correction of errors
- Improve coordination of the laboratory patient safety role within healthcare organizations

RELATED DOCUMENTS:

Quality Management System
Medical Bylaws ARTICLE XXII MEDICAL BOARD

REFERENCES:

GP26-A2 Application of a Quality System Model for Laboratory Services; Approved Guideline (2003), 2nd Edition. NCCLS

Valenstein, P. (Editor) *Quality Management in Clinical Laboratories: Promoting Patient Safety Through Risk Reduction and Continuous Improvement*. Northfield, Illinois: College of American Pathologists; 2005.

APPENDIX A

As set forth by CLIA the Laboratory Director in Chief and each Laboratory Director designee must –

- Ensure quality services in all aspects of test performance
- Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the pre-analytic, analytic and post-analytic phases of testing;
- Ensure that the physical plant and environmental conditions of the laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical and biological hazards;
- Ensure that the test methodologies selected have the capability of providing the quality of results required for patient care; verification procedures used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method; and laboratory personnel performing the test methods as required for accurate and reliable results
- Ensure that the laboratory is enrolled in HHS approved proficiency testing program for the testing performed and that the proficiency testing samples are tested as required under subpart H of the Federal Register; the results are returned within the timeframes established by the PT program. All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratory's performance and to identify any problems that require corrective action; and an approved corrective action plan is followed when any proficiency testing results are found to be unacceptable or unsatisfactory
- Ensure that the quality control; quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur
- Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system
- Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratory's established performance specifications are identified, and that patient test results are reported only when the system is functioning properly
- Ensure that reports of test results include pertinent information required for interpretations
- Ensure that consultation is available to the laboratory's clients on matters relating to the quality of the test results reported and their interpretation concerning specific patient conditions
- Employ a sufficient number of laboratory personnel with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests and report test results in accordance with the personnel responsibilities described by CLIA
- Ensure that prior to testing patient's specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results

APPENDIX A (continued)

- Ensure that policies and procedures are established for monitoring individuals who conduct pre-analytical, analytical, and post-analytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills
- Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process
- Specify in writing, the responsibilities and duties of each consultant and each person engaged in the performance of the pre-analytic, analytic and post-analytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or results reporting, and whether consultant or director review is required prior to reporting patient results.

APPENDIX B

FY10 Safety Dashboard Measures for JHH Department of Pathology Clinical Divisions

FY10 Measure and Definition	Baseline Metric (e.g. previous year number, rate, or percentage)	Achievement Target in FY10 (number, rate, percentage)	Goal: Improvement or Maintenance
SAFE/OUTCOMES Patient ID Defects <u>Definition:</u> #mislabeled/unlabeled Specimens (phlebotomy collected)	4/year	< 4/year	Improvement
SAFE/OUTCOMES Hand Hygiene <u>Definition:</u> % Pathology staff and faculty compliance (direct patient care responsibilities)	>90%	>90%	Maintenance
EVIDENCE-BASED/PROCESS Assessment/reduction of HAC (“never event”) <u>Definition:</u> #Acute Hemolytic Blood Transfusions	0	0	Maintenance
EFFICIENT/TIMELY Breast Biopsy TAT <u>Definition:</u> % of routine cases reported within 24 hours	TAT = <90%	TAT = >90%	Improvement
EFFICIENT/TIMELY Improve availability of APTT for Heparin Protocol Patients; Pathology phlebotomy drawn specimens <u>Definition:</u> Collection time to results available; TAT 120 min.	TAT 120 min	TAT < 120 min >90% compliance	Improvement
PATIENT CENTERED CARE In Patient all areas, Outreach Phlebotomy Patient Satisfaction, Overall <u>Definition:</u> 550 building, Nel-2, GSS, WM; quarterly survey	65 th percentile (IP) 45 th percentile (OP)	70 th percentile (IP) 50 th percentile (OP)	Improvement