

Johns Hopkins Medical Institution
 Department of Pathology
 General Procedure Manual
Quality Management

Procedure	Quality Management – Quality Assessment and Monitoring
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Prepared by	Date Adopted	Supersedes Procedure #
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Review Date	Revision Date	Signature
7/8/07		<i>Brooks Jackson MD</i>

OBJECTIVE:

The goal of the Quality Management Program is to establish a structure that helps provide high quality laboratory services. This includes development of a system that provides for the continuous monitoring and evaluation of patient care activities within the Department of Pathology. Laboratory performance is evaluated in pursuit of these goals.

The department monitors pre-analytical, analytical and post analytical processes. A quality control system maximizes the quality of laboratory testing to produce the accurate and timely results needed in support of quality patient care. Functions periodically reviewed include policies, procedures, staffing, and personnel qualifications. Each is evaluated to include hospital and departmental goals. Because of the rapidly changing environment, goals and standards must be continuously reassessed.

POLICY:

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.

The Department of Pathology focuses on quality defined in each of the following sections: Lab Structure and Function, **Quality Assessment programs**, and Proficiency Testing.

I. Quality Assessment Program and Monitoring

- A. The Pathology Department participates in a variety of departmental and interdepartmental quality assurance and performance improvement programs and

initiatives. Collaboration with other departments is pursued in order to improve outcomes. Each clinical department of the hospital is responsible for scheduling and holding departmental meetings in order to review Quality Improvement initiatives, patient safety activities, documentation quality and other clinical matters of the department. Key committees within Pathology include the Executive, Clinical Advisory, Laboratory Advisory, Performance Improvement, Pathology Administrative Team, Compliance, Credentials, Education Advisory, Pathology Data Systems Steering, Human Resources and Outreach Testing Committees.

- B. Committee involvement in hospital-wide quality committees, as specified in the hospital Medical Staff Bylaws, demonstrates integration of laboratory and hospital quality management programs. Selected members of the department 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 departmental and interdepartmental quality activities are described below.

1. The Laboratory Advisory Committee (LAC) meets monthly. The Deputy Director for Clinical Affairs chairs the LAC and the members are comprised of physicians, nursing administration, pharmacist, laboratory directors and administrators. The committee assists in the education of physicians and other staff on the appropriate use of laboratory services and provides recommendations to the Medical Board and Hospital Administration regarding improvement of pathology and laboratory services and their utilization.
2. The hospital Clinical Quality Improvement Committee meets monthly. Members are comprised of department physician advisors who review identified performance measurements, policies and other quality, utilization or risk management issues. The Pathology Department physician advisor is a member of the committee and reports pertinent information to the department.
3. The Surgical and Invasive Procedure Review Committee (SIPRC) meets quarterly. Members are comprised of physician and administrative representatives of Anatomic Pathology, nursing administration, clinical departments or divisions and quality improvement who evaluate cases that meet specific criteria for review. A list of cases reviewed and findings are presented semiannually to appropriate Chiefs of Service and to the Vice President for Medical Affairs.
4. The Transfusion Practices Committee meets quarterly. Members are comprised of Director, Associate Director and Laboratory Manager of the Transfusion Division of the Department of Pathology, physician and nurse

representatives of clinical departments. Members review the practices related to 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.

5. The Pathology Performance Improvement (PI) Committee meets monthly. The Physician Advisor and CQI Manager co-chair the committee and the members are comprised of the Administrator for Operations, Laboratory Directors, Faculty, Assistant Administrators, Lab Managers and QA technologists. The committee facilitates the department PI plan, 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 PI initiatives are reported monthly to the Laboratory Director in Chief and annually to the hospital Quality Improvement Council.
 6. The Chief of Service Department of Pathology / 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.
 7. Performance Improvement 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.
 8. The Pathology Office of Continuous Quality Improvement Programs (CQI) is responsible for ongoing monitoring of quality improvement and regulatory compliance of all areas that provide laboratory testing for patient care. CQI staff provides oversight and guidance for performance improvement activities and reports of occurrence.
- C. Each laboratory division maintains a quality assurance monitoring program to monitor quality and appropriateness of department services. Opportunities to improve patient service are systematically pursued.
1. Laboratory Director
 - a) Approves the quality assurance program developed by the Assistant Administrator, Laboratory Supervisors, Quality Assurance Technologists and Lead Technologists.
 - b) Approves quality monitors on an annual basis in conjunction with the Supervisors, Quality Assurance Technologist or Lead Technologist. Quality monitors may be developed as needed if a performance issue is discovered or reported.

- c) Reports to hospital committees as required or necessary.
2. Assistant Administrator / Manager
 - a) Ensures the development of an appropriate quality assurance program.
 - b) Assists in the selection of Process Improvement (PI) monitors.
 - c) Determines how quality and safety information is communicated.
 - d) Communicates performance improvement activities to laboratory staff.
 - e) Encourages staff to report quality and safety concerns
 3. Supervisor, Quality Assurance Technologist or Technical Specialist
 - a) In conjunction with the Assistant Administrator, defines the PI monitors for the year.
 - b) Prepares and reviews the quality assurance monitoring reports and/or annual quality summaries.
 - c) Collects data, reports department measures to the Pathology Performance Improvement Committee. Prepares any other summaries required by the department.
 - d) Participates in interdepartmental performance improvement activities, as needed.
 4. Lead Medical Technologist
 - a) Prepares reports as directed by the supervisor or the director.
 - b) Assists in the preparation of the quality assurance monitoring reports.
 5. Bench Medical Technologist
 - a) Follows quality laboratory practices
 - b) Collects raw data

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.