LAC GENERAL HOSPITAL
PATHOLOGY and CLINICAL LABORATORY

On-site Consultation Report and Recommendations
December 1 - 7 2006

This is only a sample excerpt from the report. The original report includes recommendations towards 23 Elements of Performance (EP) and is 60 pages long.

INTRODUCTION

Pathology and Clinical Laboratory at LAC General Hospital is JCAHO accredited. Multiple Recommendations for Improvement were cited during the scheduled inspection in November 2005 and a Conditional Accreditation was awarded.

Lab Accreditation Consultants was engaged to assist in implementation of corrective actions to these citations and write Evidence of Standards Compliance responses. Towards the end of this consultation, the then Laboratory Director retired and a new Laboratory Director came on board. At this point, the hospital administration decided to extend the consultation to full on-site review that includes assessment of level of compliance and to establish a Quality System that is viable in the long term and to coach and train the LD in maintaining total compliance.

PROCESS

I myself performed the on-site assessment. I used JCAHO 2006 camlab as the assessment checklist. As the Laboratory Director is fairly new, the section supervisors, POCT Coordinator and LIS Coordinator were involved in almost all the discussions. This also facilitated to communicate the same information uniformly to all the members of the laboratory leadership team and helped the LD to become familiarize with the current operations. The Medical Director was included in the discussions when ever his schedule allowed. I met with him in a separate session to discuss some leadership responsibilities.

Compliance of policies, processes, procedures is compared against the requirements as described under each Element of Performance of each Standard. The assessment process included a thorough review of Laboratory Quality System encompassing the following:

- Review of existing policies, process descriptions, procedure manuals and supporting documents demonstrating compliance in all the departments and systems:

    - Laboratory Organization
    - Leadership
    - Hiring Practices
    - New Employee Orientation and Training
    - Staff Competency

  - Proficiency Testing
  - Specimen Collection
  - Patient Test Manageemnt
  - Results Reporting
  - Quality Control
  - Error Prevention and Correction
  - Safety and Emergency Management
  - Laboratory Information Systems
  - National Patient Safety Goals (NPSG),
  - Environmental Control
  - Periodic Process Improvement Plan
  - Customer Satisfaction, and Coordination and Integration with other Hospital Services
- Review of QC and Preventive Maintenance documentation included completeness and timeliness of corrective actions
- For staff competency, the target was assessment in every task and/or function the employee assigned to.
- Level of participation of the Medical Director in the laboratory QA
- Support by the hospital administration

The recommendations are described under each Element of Performance. First the applicable Section and the Standard are listed followed by the respective EP and the recommendation(s).

LEADERSHIP

LD 2.90: *the laboratory Director is responsible for determining the qualifications and competence of laboratory staff*

> ***EP 5:*** *The director requires that the staff demonstrate the ability to perform all duties before actually testing patient specimens.*

LAC Observation

There is no policy document that describes a new employee orientation and training. Human Resource Management department provides a hospital level New Employee Orientation for 3 days at the beginning of the employment. This orientation includes administrative issues such as patient rights, leave policy, corporate ethics and general security, but a laboratory specific checklist has not been in use. A given new employee is directed to read the manuals but this is not ascertained. Guidance by the bench technologists is perfunctory at best.

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Discussion with the section supervisors revealed that due to the existing staffing levels, they work at the bench (doing testing) at least 70% of heir time which does not allow structured supervision of their section. Knowledge and skill of the new employee and his/her familiarity of the instrumentation of this laboratory is assumed and problems are solved when they occur.

LAC Recommendations

1. To establish a comprehensive New Employee Orientation and Training checklist. Every function and every task assigned to a given employee must be included in the checklist. If the new employee is a generalist, tasks from all the departments must be included.

2. General issues such as Cultural Diversity, Proficiency Testing, Safety, and Emergency Management must be part of this checklist.

3. On the basis of this laboratory organization, only section supervisors must be the trainers.

4. Once this checklist is established, the section supervisors must be trained to use the checklist.

5. At least 2 months must be allotted to accomplish this orientation and training. Rushing through the process will only results in retraining and waste of time.

6. Unless an employee attests his/her confidence in performing the task and this is approved by the trainer, the employee must not be allowed to work independently.

7. If staffing does not allow a comprehensive training before the employee participates in shift rotation, he/she must be allowed to perform only the tasks he/she has been successfully trained.

8. All new employee orientation and training must be approved by the Medical Director or Designee.

NOTES

- Under the current staffing plan, it is difficult for the section supervisors to become principal trainers. Laboratory Staffing Plan and related recommendations are discussed under "Organization" section of this report.

- LAC has provided a sample Orientation and Training checklist for Hematology section. This document provides a reasonable outline that can be customized to other sections. A copy of this checklist is included in the Appendix section of this report.

- I also gave an in-service to the laboratory leadership team in building up a comprehensive checklist.

HUMAN RESOURCES (HR)

HR 3.10: Staff competence to perform job responsibilities is assessed, demonstrated, and maintained.

EP 13 – 20: Refer to 2006 camlab

LAC Observations

I did not find no written laboratory staff competency policy and process description or supporting document system. When an individual is hired, the Human Resource department provides a 2-day orientation including many hospital level issues such as patient rights, disciplinary process and organizational ethics. After this, a general tour of the laboratory is given, appropriate keys handed over and the employee's laboratory routine begins. Familiarity with the instrumentation is assumed and bench level guidance is at random.

Section supervisors acknowledge their awareness of the requirement and the lack of a structured plan. However, under the current staffing plan, they work at the bench 70% of their time and have no time to streamline the process. They are knowledgeable about the process and enthusiastic to implement.

Reviewing the staffing level and work distribution patterns revealed several facts that are not conducive to quality laboratory testing. *The details and the recommendations are discussed under LEADERSHIP section EP - LD 2.80.*

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LAC Recommendations

A comprehensive Staff Competency Assessment Plan should be implemented ASAP. The paln must describe competency assessment on the basis of universally recommended assessment methods:

- Direct Observation of test performance including patient preparation, specimen collection, handling, transportation, testing and reporting the results
- Record Review including QC, Proficiency Testing, preventive Maintenance and Calibration Checks
- Accuracy of test performance
- Problem-solving skills
- Other measures specifically suitable in this laboratory

Employee competency must be established upon employment, at 6-month post employment (or twice in the first year) and yearly thereafter.

In addition to the laboratory staff, this assessment must extend to all authorized POCT and the contract personnel.

For Provider Performed Microscopy, the competency of the provider including the physicians must be assesses.

Competency must be assessed in the pre-analytical, Analytical and Post analytical phases of testing. Age-specific competency factors must be incorporated in to the assessment methods where applicable.

For all Direct Observation, it is highly recommended to utilize a checklist.

Supervisors' competency assessment must include their supervisory responsibilities.

All competency assessment documents must be filed in the employee's competency folder. The confidentiality of this folder must be strictly maintained and access limited.

A comprehensive in-service was provided to the laboratory leadership team discussing the most efficient and least time consuming ways to build a comprehensive competency binder for each laboratory employee.

LAC has also provided a policy document for Competency Assessment.