Name of Policy:	**Internal Assessment/ Process Improvement**
Policy Number:	3364-108-107
Department:	Pathology/Laboratory – Blood Bank
Approving Officer:	Chief Operating Officer - UTMC Director, Blood Transfusion Service
Responsible Agent:	Blood Transfusion Service Supervisor Administrative Director, Lab
Scope:	Pathology/Laboratory – Blood Bank

THE UNIVERSITY OF TOLEDO 1872

Effective Date: **03/20/2023**
Initial Effective Date: 6/1996

_____ New policy proposal	__X__ Minor/technical revision of existing policy
_____ Major revision of existing policy	_____ Reaffirmation of existing policy

(A) Policy Statement

The Blood Transfusion Service and the hospital Quality and Utilization Management Review department perform periodic audits to monitor quality of service and adherence to policy and procedure and identify opportunities for process improvement.

(B) Purpose of Policy

To assess quality and appropriateness of service in the performance of all transfusion related operations including blood ordering practices, compatibility testing, blood dispensing, handling, administration and effects of blood and component transfusion on patients.

(C) Procedure

Internal Assessments

Assessments of all transfusion related processes are performed as a part of the Quality Program of the Blood Transfusion Service. Internal assessments consist of record review and data collection or direct observation of the activity with documentation of required information. Trends observed are reported to the Lab CQI Coordinator, Quality and Utilization Management Review department and the Lab/Blood Utilization Review Committee for the purpose of evaluating the need for corrective actions, system or procedure change or to initiate process improvement activities. Special focused audits may be devised and performed on the recommendation of the Quality and Utilization Management Review department, the Blood Transfusion Service, the Lab Utilization Review Committee or the Medical Director of the Blood Transfusion Service as a component of process improvement.

Annual internal self-assessments are performed by the BTS supervisor or Lab Clinical Manager or designee, using the current versions of College of American Pathologists Transfusion Medicine Inspection Checklist and/or the American Association of Blood Banks Quality System Assessment Tools based on current AABB Standards. Changes or revisions to processes, procedures, and policies may be identified during self-assessment and review of new CAP Checklists and AABB Standards. Findings are reported to the Clinical Lab Director. Deficiencies are corrected as appropriate.

Proficiency Testing

The UTMC Blood Transfusion Service subscribes to the Comprehensive Transfusion Medicine Survey of the College of American Pathologists. The BTS supervisor assigns proficiency testing on a rotating basis to every technologist performing tests in the Blood Transfusion Service. Testing is performed according to routine procedure. Sharing of specimens or results with other laboratories is prohibited. Each technologist must complete at least one proficiency sample with satisfactory results per year and document the performance on their Annual Competency Checklist.

The BTS supervisor reviews proficiency testing results before returning them for evaluation. The BTS Medical Director or designee and the BTS supervisor review the results of the evaluation upon receipt and confer with the technologist performing the testing if indicated. Unacceptable results are reviewed for possible sources of error. The

supervisor initiates retraining, reagent evaluation or process change, if appropriate. All work sheets, reports, critiques and corrective action documentation are kept on file in the Blood Transfusion Service for a minimum of 5 years.

External Assessments

The Blood Transfusion Service periodically hosts external assessments by the College of American Pathologists (CAP), and Joint Commission for Accreditation of Health Care Organizations (Joint Commission). The BTS Medical Director and BTS supervisor prepare for, and participate in these assessments as requested by Hospital and Lab Administration.

Process Improvement

Personnel at UTMC are trained in the use of problem-solving methods and tools as part of Hospital Orientation. Laboratory QA/PI Committee and the Blood Transfusion Service utilizes the "**PMAAR**" model (**P**lan, **M**easure, **A**nalyze, **A**ct, **R**eview) for process improvement. Ad hoc groups composed of the appropriate staff (BTS, Laboratory CQI Committee, Quality and Utilization Management Review department, Nursing Services or ancillary departments) will address negative trends, adverse events and problems according to the following procedure:

- Investigate, analyze and define the problem or adverse event, or evaluate data gathered through system check audits to identify patterns, trends and the need for additional data collection/audit.
- Define corrective actions and preventive actions to improve the process being evaluated.
- Devise a plan for implementation of corrective action and preventative actions. A Change Control form will be initiated according to policy #3364-108-104.
- Report plan to oversight Committee or Quality and Compliance Director as appropriate.
- Data collected from system checks or focused audits will be used to monitor the effectiveness of the action taken.
- Process improvement will be reinitiated when the corrective and/or preventative actions are determined to be ineffective or insufficient based on results of follow-up audits and routine system checks.

Risk Management department will perform Root Cause analysis for adverse events considered "Sentinel Events," and at the request of the Lab/Blood Utilization Committee, as required.

Approved by:		**Review/Revision Date:**
/s/	03/21/2023	6/96 03/22/2011 1/98 3/01/2013 3/99 3/2/2015 4/00 3/1/2017 1/05 3/1/2019 7/2006 3/1/2021 1/2008 3/20/2023 6/9/2008
Lauren Stanoszek, M.D. Assistant Professor Director, Blood Transfusion Service	Date	
/s/	03/21/2023	
Christine Stesney-Ridenour Chief Operating Officer - UTMC	Date	
Review/Revision Completed By: Danielle Weilnau, MLS(ASCP)^{CM}		**Next Review Date:** 3/1/2025
Policies Superseded by This Policy:		

References:

Reference: AABB Standards for Blood Banks and Transfusion Services, Current edition.