Name of Policy:	**Proficiency Testing**
Policy Number:	3364-136-CBGL-02
Department:	Pulmonary Services
Approving Officer:	Senior Hospital Administrator
Responsible Agent:	Director, Pulmonary Services
Scope:	The University of Toledo Medical Center Pulmonary Services Department

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: March 1, 2023

Initial Effective Date: April, 2003

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

(A) Policy Statement

The blood gas lab will establish guidelines for participating in proficiency testing (PT) as part of the Quality Control program.

(B) Purpose of Policy

Per the College of American Pathologists (CAP) program, the blood gas laboratory will enroll and participate in an approved program of inter-laboratory comparison testing of unknown samples three times a year. All proficiency testing samples will be integrated within the routine laboratory workload and will be analyzed by staff members who routinely test patient samples using the same primary method systems as for patient samples.

(C) Procedure

1. Storage Instructions:
   a. Refer to any special handling instructions enclosed with the survey samples.

2. Analysis Procedure:
   a. Prior to use, refer to any special handling instructions enclosed with the survey samples.
   b. Carefully snap open the ampule and analyze immediately.
   c. Each analyzer has its own set of specimens for analysis and all samples will only be analyzed in the Blood Gas Lab on a rotating basis.
   d. Body Fluid Proficiency will need to be drawn up in a syringe.

3. Reporting Results:
   a. Report results following the instructions provided with the survey kit. Result form must be returned via internet on or before the date specified in the kit.
   b. All results will be kept confidential until CAP receives and reviews them.
   c. Active review of the survey results (inter-laboratory comparison) will be documented by the Laboratory Medical Director (or designee) or the Blood Gas Lab Coordinator (or responsible party in the Pulmonary Services department).
   d. For any unsatisfactory analyte or testing event, the lab must take all necessary steps to analyze and correct the problem. This includes both failure of an analyte or an unsatisfactory result. A thorough review and analysis of instrument function and quality control records will be conducted by the Blood Gas Lab Coordinator or designee. Once the problem has been determined the "Proficiency Testing Corrective Action Form" is to be completed, signed then submitted to both the Pulmonary Services Director and Laboratory Medical Director. The response form needs to be returned to CAP. This procedure will be conducted within the

deadline specified by the CAP. This review and analysis will be kept with the failed/late results in the CAP notebook.

e. In the event there has been a lapse in timely reporting of proficiency testing material to the CAP, or unsatisfactory results from a PT, the following procedure will be followed:
   - a full report that includes all relevant information explain the failure will be sent to the Laboratory Medical Director.

f. All records must be maintained for two (2) years.

g. In the event that results are late, notify the Director of Pulmonary Services and Laboratory Medical Director and follow the guidelines set forth by CAP.

Approved by:		**Review/Revision Date:**
		12/15/2004 11/17/2005
/s/	3/28/2023	12/06/2006
Michael Taylor MSEd, RRT Director, Pulmonary Services	Date	04/18/2007 02/25/2008 02/12/2009 04/28/2010
/s/	3/28/2023	02/23/2011
Lauren Stanoszek, MD Medical Director	Date	04/11/2012 03/03/2014 03/01/2023
/s/	3/31/23	
Russell Smith B.S. Pharm D, MBA, BPS Senior Hospital Administrator	Date	
Review/Revision Completed By: *Director, Pulmonary Services*		**Next Review Date:** March 2025
Policies Superseded by This Policy:		

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.