# 2014 PLAN OF CARE

## Laboratory Department

**Approved by:**

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| *Stella Visaggio, Chief Operating Officer* | *Date* 6/18/14 |
| *Jun Li MD PhD, Laboratory Director* | *Date* 6/18/2014 |
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## I. PURPOSE

### A. AUTHORITY AND RESPONSIBILITY

The Medical Director (Technical Supervisor) is responsible for all test results and procedures performed by the laboratory personnel. The Manager (General Supervisor) of Laboratory Services is accountable for the administration of operations, staff development, finance and performance improvement activity of the service. He/She will support efforts to continually improve the quality of the service's delivery system. Laboratory staff is expected to demonstrate authority, responsibility and accountability for their individual practice in addition to utilizing educational opportunity for professional growth.

### B. GOAL, VISION, MISSION, KEY VALUES

The Laboratory Department adheres to the values of respect, integrity, service, excellence, and stewardship in order to meet it's mission of providing the highest quality of reliable results for our patients.

## II. SCOPE OF SERVICE

### A. SCOPE AND COMPLEXITY OF PATIENT CARE NEEDS

The primary function of the Clinical Laboratory is to assist the physician in the diagnosis of disease and monitoring of patient health by prompt analysis of body fluids, and tissues. These services are provided to inpatients and outpatients, the former on a 24 hour/7 days per week basis. Pathology services are provided for both surgical and non surgical procedures that result in submitted specimens for gross and/or microscopic examination. The Laboratory is comprised of nine departments. These include Hematology, Coagulation, Chemistry, Urinalysis, Serology, Transfusion

Service, Microbiology (limited), Phlebotomy, and Pathology. Testing performed in these departments is regulated by procedures approved by the Medical Director and reviewed on a bi-annual basis. In order to assure that the test results released from the Clinical Laboratory are of the hightest quality, daily control schedules and periodic calibrations are adhered to in accordance with state, federal (CLIA) , and CAP regulations. Proficiency testing is performed for all analytes on a regularly scheduled basis. Testing that is requested in limited volume or not available for testing on current analyzers, is sent to an approved reference laboratory for analysis and result reporting. Slides and stains for Pathology are prepared by St. Clare's Hospital in Denville, and micro testing is performed there as well. A courier system supports transportation of the specimens.

### B. TYPES AND AGES OF PATIENTS SERVED

Patients of all ages, from newborn through geriatrics are served. Phlebotomists are trained in technique and use of equipment appropriate to the age and condition of the patients.

### A. KEY INTERDEPARTMENTAL RELATIONSHIPS

The Laboratory is responsible for providing care/service that is within their professional realm of practice to patients at Hackettstown Regional Medical Center regardless of age, race, religion or financial status. The Laboratory provides internal support services for various departments of the hospital including nursing units, Cancer Center, Wound Care Center, Cardiology, Operating Room, Counseling Center, Corporate and Employee Health. In addition, external customers include Outpatients and area nursing homes (Heath Village, House of the Good Shepherd, Colonial Manor, and Paragon Village).

### B. HOURS OF OPERATION

The Laboratory operates 24 hours/ day 7 days/week. Hours of operation for Outpatient Phlebotomy services are as follows: 6:30am – 8:00pm M-F, Saturday hours are 7:30am – 2:00pm and the department is closed on Sunday. Stats are accommodated as needed.

## III. THE EXTENT TO WHICH THE LEVEL OF CARE OR SERVICE MEETS PATIENTS' CARE NEEDS

### A. PATIENT/CUSTOMER SERVICE AND EXPECTATIONS

- All patients will receive courteous professional care during the phlebotomy process
- Testing will be ordered and performed in an accurate and timely manner

- Results will be available to physicians and patients in an appropriate timeframe.

## B. PERFORMANCE IMPROVEMENT PLAN

The Laboratory Department participates in reporting performance improvement activities at least annually. This data is aggregated by the Manager of the Laboratory Department into a service-wide performance improvement summary report and distributed quarterly to the Chief Operating Officer and Laboratory Medical Director and annually to the Hospital Performance Improvement Council.

HRMC utilizes Lean as its foundational performance improvement methodology to support continuous elimination of waste within processes and systems. The Plan, Do, Check, Act improvement cycle is the methodology used for implementing and evaluating process changes of any magnitude.

## C.CRITERIA USED FOR PRIORITIZING PERFORMANCE IMPROVEMENT OPPORTUNITIES

The Laboratory will assess and improve upon the key functions, processes, treatments, or activities that are believed to be the most important to the quality of patient care, prioritizing those that are

a. High Risk
b. High Volume
c. Problem Prone
d. Cost Impact

Focused areas will include but are not limited to:

a. Specimen collection and processing
b. Safety and Universal Precautions
c. Customer relations.

## D. DEPARTMENT SPECIFIC PERFORMANCE IMPROVEMENT ACTIVITIES

The following indicators are routinely monitored:

ED Turn Around Time
Blood Culture Contamination Rate
Errors (Incorrect: Order, Patient, Date/Time, Physician, Demographics, Registration)
Timeliness (stroke)
Recalls
Employee incidents.

The department will select performance measures for the aspects of care that have been chosen for review. These performance measures or indicators will be objective, measureable, and based on current knowledge and clinical experience. These measures can be related to process or outcome of care. And should include pre analytic, analytic, and post analytic phases. The information they provide will be used in assessing the quality of care and in directing

attention towards opportunity for improvement. Department members will be responsible for selecting indicators for those important aspects of care to be evaluated.

**The following process is our focus for improvement this year: Formation of a formal Transfusion Committee in an effort to improve Blood Management. This involves:**

- **Select members and a chairman**
- **Establishing a charter**
- **Meet monthly to get established**
- **Review and develop transfusion guidelines based on evidence based practice**
- **Review transfusion appropriateness**
- **Develop blood avoidance strategies.**

### E. PATIENT SATISFACTION

Patient satisfaction surveys are administered by "Healthstream". A telephone call is made to a sample number of patients within one to six weeks of date of service to gain insight in patient/customer expectations of care received. Information from these surveys may be incorporated into process improvement activities.

### F. ANNUAL PLAN OF CARE EVALUATION

The department-specific Plan of Care is evaluated at least annually for:

1. Effective implementation of performance improvement activities
2. Monitoring of problem resolutions
3. Collaboration in performance improvement activities
4. Establishment of priority processes for review

## VI. AVAILABILITY OF NECESSARY STAFF

### A. STAFF GUIDELINES

#### 1. Skill Level of Personnel Involved in Patient Care

The Laboratory is staffed by Medical Technologists, Medical Laboratory Technicians, Lab Assistants, Pathology Assistants, and a Pathologist. .

#### 2. Staff Development

Staff will maintain clinical competence by attending continuing education program self-development opportunities and completion of annual mandatory requirements.

#### 3. Staff Evaluation

Initial 90 day, annual, and as needed.

## B. STAFFING PLAN

During the week, two Lab assistants will provide phlebotomy services to area nursing homes while 3 lab assistants draw the inpatient morning rounds. One lab assistant opens the draw site for Outpatients. Four lab assistants continue the day drawing all patients, processing specimens, and performing clerical duties as needed. Weekend staff is reduced by one person. In the evening shifts there are two lab assistants and one on the night shift..

During the week, there are 4 or 5 technologists staffing the departments of the laboratory. On the weekend, there are 3 technologists working on the day shift. The evening shifts are always covered by two technologists, and one technologist always covers the night shift.

Pathology is covered by one Pathologist and one Pathology Assistant Monday through Friday during the day.

In the event of short staffing, the department Manager will use part time, per diem, reassignment, or overtime to provide adequate staffing.

## C. STAFF - COMMUNICATION

Staff meetings will be scheduled bi monthly during the day and evening. E mail communicatin is preferred and all staff members are expected to review email at least weekly. Written communications are posted for all staff to read. Bulletin boards are used to post important memos and communications that each staff member is required to read. Important communication is entered in the communication books in specimen processing, the West Wing Draw Site, and in Blood Bank. Each staff member is responsible to use all these tools to keep informed about all pertinent information.

## D. SHARED GOVERNANCE

Laboratory staff members are representatives on the Interdisciplinary Shared Governance Councils. Information is shared at departmental staff meetings and via written memo to those unable to attend staff meetings prior to monthly Shared Governance meetings.