

The BTS supervisor reviews proficiency testing results before returning them for evaluation. The BTS Medical Director 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 or reagent evaluation 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

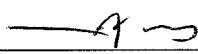
The Blood Transfusion Service periodically hosts external assessments by the American Association of Blood Banks (AABB), the College of American Pathologists (CAP), and Joint Commission for Accreditation of Health Care Organizations (JCAHO). The BTS Medical Director and BTS supervisor prepare for, and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

Process Improvement

Personnel at UMC 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 (Plan, Measure, Analyze, Act, Review) 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 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.
- Make suggestions for solving the defined problem; improving the process being evaluated.
- Select a solution and devise a plan for implementation to include corrective and preventative action. 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 Blood Utilization Committee, as required.

<p>Approved by:</p> <div style="text-align: center;">  </div> <hr/> <p>Robert L. Booth, Jr., M.D. Associate Professor Director, Clinical Pathology/Hematopathology</p> <p>Review/Revision Completed By: Michelle Bartkowiak, MT(ASCP)SBB</p>	<p>Review/Revision Date:</p> <p>6/96 1/98 3/99 4/00 1/05 7/2006 1/2008 6/9/2008</p> <hr/> <p>Next Review Date: 6/1/2011</p>
<p>Policies Superseded by This Policy:</p>	

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

References:

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