Name of Policy: **Proficiency Test Protocol** **Policy Number**: 3364-107-307 **Approving Officer**: Medical Director, Clinical Pathology **Responsible Agent**: Director, Clinical Pathology Administrative Director, Lab **Scope**: Pathology Laboratory University of Toledo Medical Center	UTOLEDO HEALTH **Effective date:** 01/04/2025 **Original effective date**: 08/11/1993
Key words: Proficiency testing, workflow, staff rotation, unsatisfactory responses, corrective action.	

☐	New policy proposal	☐	Minor/technical revision of existing policy
☐	Major revision of existing policy	☒	Reaffirmation of existing policy

(A) Policy statement

The Laboratory has a system for integrating proficiency test samples into workflow and for documentation of corrective actions for unsatisfactory proficiency test responses.

(B) Purpose of policy

Assure consistent and proper functioning/verification of all clinical laboratory diagnostic procedures and analyses based on results obtained in assaying commercial unknown samples.

(C) Procedure

1. Proficiency test surveys will be logged in upon receipt and stored properly to preserve specimen integrity.

2. Testing of proficiency samples will be rotated among all regular staff working in the department on all shifts. Testing will be performed in the same manner as specimen testing, that is, no duplicate testing of specimens unless patient specimens are routinely tested in duplicate. Testing may be repeated by other personnel for competency assessment only after results have been reported to CAP. Proficiency testing is not to be sent to an outside lab, or results compared with an outside lab when testing is normally performed at UTMC. Proficiency testing specimens are not accepted from any other institution or laboratory for analysis at UTMC.

3. Compilation, review and sending results will be accomplished by the designated tech in each lab area.

4. Proficiency test results will be reviewed by the Clinical Laboratory Director.

5. Successful test grades will be forwarded to the respective laboratory department, where they are to be reviewed and signed by the laboratory department section chief and shared with the technologists.

6. Some results may be acceptable but show bias or trends to the right or to the left of the mean. QC results generated at the time the PT was performed should be reviewed for bias and/or trends. Previous results of PT should be reviewed also. Corrective action should be taken if deemed necessary.

7. The Clinical Laboratory Director will discuss unsatisfactory proficiency test grades with the laboratory's section chief to determine cause and corrective action. This information is also shared with all technologists in that laboratory department.

Corrective Action

a. If original sample is available, the analyte should be retested. Instrument function and quality control records should be reviewed.

b. Once the problem has been determined the "Survey Exception Report Response Form" is to be completed and signed.

c. The Response form should be returned to CAP by FAX following instructions on the form.

d. The above procedure should be conducted within the deadline specified by CAP for Survey Exception Response.

Approved by: /s/ _____ Name: Amira Gohara, M.D. Title: Medical Director, Clinical Pathology 1/10/2025 _____ Date *Review/Revision Completed by:* *Joshua Otiso, Administrative Director, Lab*	**Policies Superseded by This Policy:** • *Q-07* Initial effective date: 08/11/1993 Review/Revision Date: 01/04/2025 Next review date: 01/04/2027