

## Four Myths That Impede Quality and How To Dispel Them

It was indeed an honor to be asked to present a keynote speech at the awards luncheon of the ASCP Leadership Exchange program in Baltimore in March. After accepting this invitation, however, I began to get anxious. You see, a keynote presentation is meant to be short, inspirational, motivational, and sometimes humorous. It's completely different from the teleconferences and workshops I've prepared and presented for the ASCP for more than 2 decades. I had to speak my piece in about 35 minutes. For someone used to 2, 4, and 8-hour time slots, this was going to be tricky. Could I deliver?

All programs that teach how to improve public speaking skills emphasize that one should be true to one's self and speak about what's in his/her heart and what one knows best. Well, professionally, that leaves only one thing for me—quality management and its impact on patient safety. So, here's the essence of my keynote presentation for the ASCP's first Leadership Exchange.

### Myth #1: The customer is the patient.

We've all been trained to think that the customer is the patient. In any workflow, however, the customer is the person or process that receives the output of the preceding process. For example, it's not the patient who receives samples for testing from the sample accessioning process; the customers of this process are the testing technologists and technicians. Similarly, it's not the patient who receives laboratory test results from the result reporting process; the customers of this process are the physicians and nurses who receive and take action on the results to diagnose, treat, and care for patients—who are, in turn, the caregivers' customers.

Why is this important? It's important to know which process is receiving the output of *your* efforts because that process is *your* customer. That process has needs that must be met for it to function correctly the first time. You should know the output that process needs from you, so that your process can be designed in a manner to meet those needs. When each process meets the needs of the next process, the likelihood of the whole workflow being successful will dramatically increase. Ultimately, this leads to the patient—and better patient safety.

### Myth #2: Our SOPs meet inspection.

Far too many times, I've heard a laboratory supervisor lament that there's an inspection in a few months and now he/she has to rewrite all the procedures. The sad truth is that laboratory procedures written in the old "NCCLS format" may please the inspectors, but they absolutely do not represent the way work is performed in the laboratory. The "old format" outlined information about a single analyte (eg, bilirubin, cholesterol, protime, etc) but provided no instruction for how to set up and run a batch of patient samples on an automated analyzer; or how to work up a microbiology culture; or how to issue a blood component; or how to execute laboratory computer system functions.

The customers of the SOPs are the *staff*, not the inspectors. Therefore, laboratory documents should provide descriptions of the sequence of laboratory activities (ie, process flowcharts) and also instructions for how to perform those activities (ie, procedures). If

your laboratory does not proactively document, understand, and communicate its processes and procedures to staff, then you are likely to have to document them retroactively as part of time-consuming and expensive error and sentinel event investigations.

### Myth #3: We need to get ready for an inspection.

Whenever I hear a laboratory director or supervisor say that their laboratory is "getting ready for an inspection," I wonder what they've been doing with regard to quality management and cleanliness since the last inspection. Does everything simply stop after the inspection? No more SOP writing, straightening of clutter, organizing of training, competence assessment, and equipment records? What does the laboratory *do* in the interim until they start a few months before the inspection to see if they are meeting inspection requirements?

To me, this is backward thinking. The laboratory should incorporate meeting the requirements into all its actual work processes and procedures so that all staff members are working in an environment where meeting the requirements is the way the work is done all the time—not as a scramble in preparation for an inspection. Managing quality *is* the laboratory's work, not simply a sideline addition to work. Laboratories that understand this basic paradigm shift will be well prepared for the new unannounced inspection environment.

### Myth #4: We're already doing quality—you know, QC/QA.

In this new millennium, anyone who still treats the acronyms QC and QA as interchangeable or who thinks they represent the same activity has not been paying attention to the ever-widening body of quality knowledge being applied to the health care environment. Quality control is simply method control; all the quality control ever performed in a laboratory has not prevented a single sample mislabeling error or a misdiagnosis. Quality assurance is process measurement; all the high/low and positive/negative quality controls ever performed has not eliminated unacceptable samples or reduced the result turnaround time to the emergency department. Quality management in the medical laboratory encompasses QC and QA, as well as many other important elements of the laboratory's management infrastructure.

If a laboratory truly understands and then implements a quality management system, these 4 and other quality myths will be dispelled, and your laboratory will truly be on the road to patient safety.

#### *This Month's Quality Quote:*

*"If quality is not inspected in but is built in, if quality is integral to the product or service, then quality is a function of management."*

—Rafael Aguayo (who wrote about Dr. W. Edwards Deming)



Lucia M. Berte  
MA, MT(ASCP)SBB, DLM;  
CQA(ASQ)CQMgr

Send comments/questions to  
lmberte@worldnet.att.net.