

Quality Qorner

The Problem With Programs

I have a dear friend who reviews all my Quality Qorner essays before I submit them to the *LABMEDICINE* editor. Either he's mellowed out on the power of the editing pencil or I'm getting to be a better writer. Instead of pencil marks on every sentence, I'm finding only a few scattered marks here and there. Maybe it's just that he's getting tired of his monthly editing assignment. Hmm...if a free home-cooked dinner is not enough of an inducement, I may have to up the chocolate ante!

After he reviewed last month's column about the new opportunity, the new perspective, and the new strategy, he said he really appreciated the part about the laboratory being operated as a collection of many separate programs—the financial management program, the outreach program, the quality control program, the quality assurance program, the proficiency testing program, the work safety program, and the patient safety program. Here are a few more to add to the list: the continuing education program, the equipment maintenance program, the cost containment program, and the quality improvement program. It's a rare laboratory that doesn't have most, if not all, of these programs.

My friend said this was one problem with the way the Army ran things—too many programs. The problem with programs, he went on to explain (as an accomplished retired Army career physician), is that each program had an owner. Owners perceive their respective programs as their personal turf. Suggestions for changes or improvements are often met with cold disdain and a grumbled "Don't mess with the (my) program!"

In the laboratory environment, it's likely that programs are owned by laboratory committees rather than individuals. There's the supervisors' committee, the continuing education committee, the safety committee, the quality committee, the LIS implementation committee, the "hospital-initiative-of-the-month" committee, and the holiday party committee. The CAP recently released a template for a Laboratory Patient Safety Program and recommended that it come under the auspices of—you guessed it!—a Patient Safety Committee, or the Laboratory Quality Assurance Committee.

As I see it, the "program by committee" mentality is problematic for several important reasons. Committees only meet periodically and some of those meetings get cancelled because of "workload" and other reasons. Good committees actually get their objectives accomplished; bad committees meet only because they have to or are content with only just discussing issues but never making decisions or taking any actions. Some committees are convened for the purpose of making recommendations, which then are forwarded for a different committee to make a decision (or not). The problem with programs, and the committees that run them, is that usually the activities stay within the program, never to become integrated into the work performed by the laboratory staff.

Here's an example. Hardworking laboratory safety committees meet regularly to verify that all required information is contained in the laboratory's safety manual. However, it's 2:30 AM in the sample receiving area when a carrier comes loose inside the centrifuge. The sample receiving clerk needs to decontaminate the

now-defunct centrifuge—but where is the procedure? It's likely to be buried in the Work Safety Manual, a ring binder about 6 inches thick. The decontamination instructions may or may not be easy to find in the manual—would they be under "D" for decontamination or "C" for centrifuge or "S" for spills or buried in "E" for equipment safety? Wouldn't it just be easier if the instructions were in the Sample Receiving Procedures Manual, right where the clerk could look it up in the table contents of their own manual, which is much more likely to be regularly accessed? What's my point, you ask? It's this—instead of the safety committee owning the safety program and the safety manual, perhaps the best way to routinely achieve correct safety practice is to ensure that safety procedures are easily accessible when they're needed the most—in a safety emergency. Perhaps the 6-inch safety binder should be unbundled and respective instructions placed only where they are most likely to be needed. After all, the transfusion service doesn't need a copy of the anatomic pathology formaldehyde monitoring program in its binder. The point is to facilitate the practice of safety in real time, not just to have a book to trot out for inspectors every 2 years.

Here's another, more pressing, example—that of patient safety. Patient safety should not be a program run by a committee. Instead, the proper patient identification, sample labeling, sample handling, results review, and report verification steps should be *built into* the work processes and procedures that all staff follow every day. Patient safety is achieved when mistake proofing and process controls are *built into* the work as prevention—not as a list of "monitors" to be reviewed by a committee in addition to laboratory work.

The activities conducted in all the programs mentioned above should not be "in addition to" the laboratory staff's assigned work; the activities should be *integrated into* laboratory work so that the tasks are accomplished as a matter of routine. Quality management thinking is the best way to make this happen. Every program and committee product mentioned above is part of at least one Quality System Essential (QSE). Laboratory staff should design the work processes and procedures to include the relevant program requirements and proper controls. Then staff members are trained to follow the processes and procedures and to report nonconformances as part of their daily work responsibilities. No programs, no committees as fiefdoms—just the work that needs to get done.

This Month's Quality Quote:

"Prior planning prevents poor performance."

—U.S.Army

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