SUNY Downstate Medical Center -University Hospital of Brooklyn Network
Department of Pathology Policy and Procedure

Subject: PROFICIENCY TESTING

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SUNY DOWNSTATE MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
POLICY AND PROCEDURE

☒ CLINICAL LABORATORIES ☒ BAY RIDGE

Subject: PROFICIENCY TESTING

Policy No.: LAB-9

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	No	Yes			

Discontinuation Date: ______________________

PURPOSE: Provide an external audit system to comply with regulatory agency standards and to assure the highest quality of care.

POLICY: Each laboratory will participate in the proficiency testing programs from New York State Department of Health, College of American Pathologists (CAP), and ASHI for each of the disciplines offered by the Clinical Laboratories.

Laboratory personnel will not communicate with external Laboratories about proficiency testing samples before submission to the proficiency testing provider.

Testing for procedures performed within the Laboratory cannot be referred to another Laboratory and proficiency testing specimens will be handled in the same manner as patient specimens.

Results will be documented and reviewed. Documentation of problems and solutions will be reviewed by the Director of Laboratories and reported to the Performance Improvement Committee.

Proficiency Testing challenges that were intended to be graded, but were not, will be reviewed by the Laboratory Director and reported to the Performance Improvement Committee.

Proficiency results that are graded as unacceptable must be evaluated and corrective action must be taken within ten days of receipt. These actions must be discussed at the Department Performance Improvement Committee meeting. For those analytes categorized as educational challenges, any result that lies outside usual quality specifications should be evaluated and determined if acceptable on a case by case basis. Unacceptable results must be investigated in the same manner as graded analytes.

PROCEDURE:

1. All PT challenges reports are immediately Date/Time stamped in the Laboratory Administrative Office, upon arrival.

2. The reports are reviewed by the Laboratory Administrator and copies of reports with unacceptable/unsatisfactory or challenges that were not graded for various reasons are forwarded to the applicable laboratory section supervisor.

3. The Section Supervisors, Directors and Pathology Residents review the failures and document the findings by preparing an Internal Survey Exception Report.

4. All reports are forwarded to the Laboratory Director for review and approval.

5. The Pathology resident, on rotation, presents the findings of Unacceptable/Unsatisfactory or Ungraded PC Challenges to the Department Performance Improvement Committee.

REFERENCE:

Document Control System: LAB-35
CAP Laboratory Accreditation Manual, Appendix I, GEN.1000, GEN.10500, GEN.11226, GEN.11484, GEN.11742, GEN.12258, GEN.13032, CLIA-88