

QUALITY ASSESSMENT PLAN
NORTHWEST PRIMARY CARE MONTHLY EVALUATION

ANALYTIC

Month Reviewed: _____	Date: _____
Reviewer: _____	
Method of Review: _____	
Other Participants: _____	

Lab Specific Documentation			
Items for Review	(v) if NO deficiency noted	Suggestions for Correction	Initial when done
L-J and data Tables printed and reviewed since previous evaluation		<input type="checkbox"/> Axcel <input type="checkbox"/> ACCESS2 <input type="checkbox"/> XP300 <input type="checkbox"/> Afinion	
Review of QC Records <ul style="list-style-type: none"> • Monthly QC reports are present as required • QC reports are acceptable • QC is being properly performed for analyzers and POC testing • Outliers reviewed and documented • Corrective action taken when appropriate and logs completed as appropriate 		<input type="checkbox"/> Axcel <input type="checkbox"/> ACCESS2 <input type="checkbox"/> XP300 <input type="checkbox"/> Afinion	
Temperature/Humidity Logs printed and reviewed		<input type="checkbox"/> Temp <input type="checkbox"/> Humidity <input type="checkbox"/> Freezer <input type="checkbox"/> Refrig	
Review of all instrument maintenance and problem logs for completeness and correctness		<input type="checkbox"/> Axcel <input type="checkbox"/> ACCESS2 <input type="checkbox"/> XP300 <input type="checkbox"/> Afinion	
Calibrations up to date?			
Calibration Verifications up to date?		Cal-Ver Results: <input type="checkbox"/> Axcel <input type="checkbox"/> ACCESS2 <input type="checkbox"/> XP300 <input type="checkbox"/> Afinion <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable <input type="checkbox"/> NA Next Cal-Ver?	

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Items for Review	(v) if NO deficiency noted	Suggestions for Correction	Initial when done
Review of QA Plan for <ul style="list-style-type: none"> • Any new documents added this month • Lab director signature on reviewed QA patient test audit forms • Lab director signature on yearly calendar items required in QA Plan 			
Review POC Logs-QC		<input type="checkbox"/> INR <input type="checkbox"/> UA-120 <input type="checkbox"/> Flu <input type="checkbox"/> Strep <input type="checkbox"/> BVBLue	
Notifications to facility from license or proficiency testing agencies		<input type="checkbox"/> CLIA: <input type="checkbox"/> PT: <input type="checkbox"/> NA	
Perform monthly meeting, review communications, complaints, incident reviews, remedial actions			
Corrective action from prior review completed and documented?			
Other New/Relevant Items			

Attach additional sheets if more room for comments required

Staff Member: _____ Lab Director: _____ Date: _____

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Calendar for Review		Year			
Month	Item	Initials	Date	Notes	
November	Complete items on Monthly Checklist to include compilation/review of QC reports, LJ graphs, QC Logs, and maintenance checklists (Responsible parties: Laboratory staff, laboratory Director and/or technical consultant)				
	Proficiency Testing, if applicable			<input type="checkbox"/> See separate form	
	Completion/review of corrective action for incidents or errors during the month				
	Call with consultant/meeting with lab director to review QC/QA				
	Other				
	Critical Values and Turnaround Times Review – Review of Critical value log. Evaluation of 5 patient orders with review of order time to results entry, evaluation of 5 reference lab requisitions with review of time sent to time receipt of results. Date Range Reviewed _____				
	Critical value log is documented and reviewed by supervisor to include patient name, result, date and time of notification, person notified				
	Routine results are available to physician within 24 hours of processing				
	STAT results are available to physician within 2 hours of processing if warranted				
	Turnaround times for specimens sent to reference lab are within reference lab stated time frames				

Lab Director: _____ Date: _____

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Critical Value and Outside Lab Turnaround Time Review

MONTH: _____ YEAR: _____

Critical Values Notification Review

Date of Test	Patient Name	Patient #	Test or Analyte	Result	Time of Result	Person Notified	Time Notified	Comments

Outgoing Lab Turnaround Time Review

Date of Test	Patient Name	Patient #	Test/Analyte	Date Returned	Within Expected?	Comments

Lab Director: _____ Date: _____