OLIVE VIEW-UCLA MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
POLICY & PROCEDURE

NUMBER: 2079
VERSION: 5

SUBJECT/TITLE: ADM 36.0A: VERIFICATION OF RELIABILITY OF TEST RESULTS IN THE ABSENCE OF STANDARD PROFICIENCY TESTING

POLICY: Each section supervisor will establish a protocol for determining the accuracy and reliability of analytical results on patient samples for each test performed for which no external proficiency testing program is offered.

PURPOSE: To establish a protocol for verifying the accuracy and reliability of analytical results of tests for which external proficiency testing is not available.

DEPARTMENTS: PATHOLOGY

DEFINITIONS:

PROCEDURE:

1. It is the responsibility of the section supervisor to establish a protocol for determining the accuracy and reliability of analytical results on patient samples for each test performed in his or her section for which no external proficiency testing program is offered.
2. This may be accomplished through:
    - Sending specimens at least twice a year to an approved referral laboratory for comparison of results; number of specimens to be sent out will be determined in consultation with the laboratory director.
    - Blind testing of specimens with known results
    - Parallel testing of specimens with another laboratory and comparing findings
    - Retesting of a random sample of microscopic tests by the technical supervisor of the laboratory throughout the year to cover all testing staff
    - Or other equivalent systems approved by the laboratory director.
3. This testing must be conducted at least semiannually.
4. The section supervisor must establish criteria for acceptability that are acceptable to the laboratory director.
5. The section supervisor must review the results of this testing. If results fall outside acceptable ranges, remedial action must be taken and documented in the same manner as for external proficiency testing.
6. The section supervisor is responsible for reporting the results of this alternative performance assessment to the Laboratory Quality Control Coordinator semiannually. Documentation of investigation, conclusions, and remedial action for any unacceptable or out-of-range results will be

reviewed with the laboratory director and filed with the proficiency testing reports.

Date:	Revisions made:	By:	Rev:
9/10/2012	Placed in PPM System	S. Spike	36.0
8/13/2018	TLC.11485 – New Director Procedure Approval	F. Lowder	36.0 v2
8/22/2018	Reassigned document owner	F. Lowder	36.0 v3
10/3/2018	Change "reference" laboratory to "referral" lab	F. Lowder	36.0 v4
4/13/2020	DRA.11485 – New Director Procedure Approval	J. Agaton	36.0 v5

"No changes in procedure content, new version was created to satisfy **CAP requirement DRA.11485** - New Director Procedure Approval"	
References: CLIA '88, Appendix C: Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services, 493.1709.; CLIA '88: Federal Register/Vol. 57, No. 40/Feb. 28, 1992, 4931709; College of American Pathologists: Accreditation Checklist (Laboratory General, rev. 06/17/10), GEN. 20377, GEN 20425	
Approved by: Holli Mason (Laboratory Director)	Date: 04/15/2020
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