

## Point-of-Care Testing Governance Outside the Laboratory: Connectivity, Competence and Result Traceability

Wilhelmina Doornekamp<sup>1\*</sup>, Ruairi Glenbawn<sup>2</sup> and Emanuel Kaltenbock-Reiter<sup>3</sup>

<sup>1</sup>Department of Point-of-Care Testing, Drenthe Institute of Laboratory Medicine, Assen, Netherlands. ORCID: [0000-0003-6768-5481](#)

<sup>2</sup>Department of Clinical Biochemistry, Blackstairs Institute of Laboratory Medicine, Enniscorthy, Ireland. ORCID: [0000-0001-2536-7915](#)

<sup>3</sup>Department of Laboratory Quality, Lungau Centre for Clinical Biochemistry, Tamsweg, Austria. ORCID: [0000-0001-2768-5255](#)

\*Correspondence to: Wilhelmina Doornekamp, Department of Point-of-Care Testing, Drenthe Institute of Laboratory Medicine, Assen, Netherlands, E-mail: [w.doornekamp@dilm.nl](mailto:w.doornekamp@dilm.nl)

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### Abstract

*Point-of-care testing (POCT) devices deployed across wards, clinics and community settings outside the central laboratory's direct physical control present a governance challenge distinct from central laboratory testing: device connectivity, operator competence assessment, and result traceability into the patient record must all be maintained across dozens or hundreds of dispersed devices and operators rather than a single controlled environment. We surveyed POCT governance structures across 26 hospitals and reviewed connectivity, competence assessment completion, and result traceability audit data from each. Device connectivity to a central data management system was achieved for 89.4% of devices overall but varied widely by device type and clinical setting, and competence assessment completion rates for glucose meter operators -- the highest-volume POCT device across nearly all sites -- ranged from 58% to 97% across the 26 hospitals despite similar stated policy requirements. We identify the structural governance features associated with higher performance on both measures and propose a practical governance framework for POCT programmes operating at scale outside the central laboratory.*

**Keywords:** Point-of-care testing; POCT governance; Connectivity; Competence assessment; Result traceability

### Introduction

Point-of-care testing devices operate under accreditation and regulatory requirements broadly similar to central laboratory testing, but the operational context is fundamentally different: a POCT programme typically involves large numbers of non-laboratory operators -- ward nurses, community clinicians, primary care staff -- using devices dispersed across many physical locations, none of which are under the laboratory's direct day-to-day physical oversight in the way a central laboratory instrument is.<sup>[1][2]</sup>

Three governance functions are widely recognised as central to safe POCT operation at this scale: device connectivity to a central data management system, enabling result capture and quality control monitoring without relying on the operator's own manual record-keeping; operator competence assessment,

verifying that a non-laboratory operator can use the device correctly; and result traceability into the patient's clinical record, ensuring a POCT result is as reliably available to the clinical team as a central laboratory result would be.<sup>[3]</sup> We surveyed how consistently these three functions are achieved across a sample of 26 hospitals with established POCT programmes.

The distinction between POCT and central laboratory governance is not merely administrative: a central laboratory instrument is operated by a small number of trained laboratory staff within a single physical space subject to continuous quality oversight, whereas a POCT device fleet of the kind surveyed here may involve hundreds of occasional operators, each performing the test as a small part of a much broader clinical role, across dozens of physical locations the laboratory visits only intermittently for quality checks.<sup>[1][3]</sup> This operational reality

means governance mechanisms that work well for a handful of trained laboratory staff in one location do not automatically translate to a POCT programme operating at this scale and dispersion.

Methods

Governance structure, device connectivity rate, operator competence assessment completion rate, and result traceability audit findings were collected via structured survey and follow-up data request from 26 hospitals with an established, accredited POCT programme. Connectivity was defined as automatic electronic transmission of results and quality control data to a central data management system without manual operator transcription; competence assessment completion was measured for glucose meter operators specifically, as the highest-volume POCT device type present at all 26 sites.<sup>[4]</sup>

Result traceability -- whether a POCT result reliably reaches the patient's electronic clinical record in a form a treating clinician can readily find, as opposed to existing only on a device display or a paper log -- was assessed through a standardised audit sample of 50 recent POCT results per hospital, checked against the corresponding patient's electronic record for presence, correct patient matching, and time-to-availability after the result was generated at the device.<sup>[4][5]</sup>

Results

Overall device connectivity across all POCT device types and all 26 hospitals was 89.4%, but this aggregate obscured substantial variation by device type: blood gas analysers and glucose meters achieved connectivity above 95% at most sites, while newer or lower-volume device categories, including several point-of-care coagulation and cardiac marker devices, showed connectivity as low as 61% at some sites, generally reflecting devices deployed before the site's central data management system supported that device model.

Glucose meter operator competence assessment completion -- measured as the percentage of active operators with a current, in-date competence assessment on file -- ranged from 58% to 97% across the 26 hospitals, despite all 26 reporting a nominally similar policy requiring annual competence assessment for every active operator.<sup>[5]</sup> The hospitals achieving completion above 90% shared two structural features not present at most lower-performing sites: a dedicated POCT coordinator role with protected time specifically for competence assessment administration, and an automated reminder system flagging operators approaching their assessment expiry date rather than relying on manual tracking.<sup>[6][7]</sup>

Result traceability audit findings were more uniformly strong than either connectivity or competence completion: 24 of the 26 hospitals achieved traceability above 95% in the 50-result audit sample, with the two lower-performing sites both attributing their gap to a specific device category -- bedside urinalysis and point-of-care pregnancy testing -- that remained paper-based at the time of survey, rather than to any broader traceability

weakness across their programme as a whole.<sup>[5]</sup>

| Governance Metric     | Range Across Sites | High-Performer Feature            |
|-----------------------|--------------------|-----------------------------------|
| Device connectivity   | 61%-99%            | Integration at device go-live     |
| Competence completion | 58%-97%            | Dedicated coordinator role        |
| Result traceability   | 83%-99%            | Electronic capture, no paper step |

Table 1: Range of Governance Performance Across the 26 Surveyed Hospitals and the Structural Feature Most Associated With High Performance.

Discussion

The variation in both connectivity and competence completion correlates more closely with structural programme features -- a protected coordinator role, automated tracking systems -- than with hospital size or resource level in a general sense, suggesting that governance performance at this scale is substantially a function of how the programme is structured rather than simply how well-resourced the hospital is overall.<sup>[8]</sup> A hospital investing in POCT expansion without a corresponding investment in a dedicated coordination role and automated tracking infrastructure risks the pattern seen at the lower-performing sites in this survey, regardless of overall institutional resourcing.

The lower connectivity rate for newer device categories reflects a predictable lag between clinical adoption of a new POCT device type and the central data management system's capability to support it, and programmes introducing a new device category should treat connectivity integration as a go-live prerequisite rather than a subsequent upgrade, given how much lower the connectivity rate remained for these device categories even at otherwise well-governed sites.<sup>[9][10]</sup>

Why a Dedicated POCT Coordinator Role Matters So Much

The structural feature most consistently associated with higher performance across all three governance metrics surveyed in this study was the presence of a dedicated POCT coordinator role with protected administrative time, and understanding why this single structural feature mattered so much helps explain the broader governance pattern observed.

A POCT programme spanning dozens of locations and device types generates a continuous stream of administrative tasks -- tracking competence assessment expiry dates, following up connectivity gaps as devices are replaced or relocated, coordinating quality control review across sites -- that, without a role whose explicit job is to perform this coordination, tends to fall to ward or clinic staff for whom POCT administration is a minor addition to a primary clinical role, and is consequently deprioritised whenever competing clinical demands arise.<sup>[6][7]</sup>

Sites without a dedicated coordinator role in this survey typically distributed POCT administrative responsibility across

ward nursing leadership on an informal, as-available basis, and the resulting inconsistency in attention translated directly into the wider range of competence completion rates observed at these sites compared with sites having a dedicated role.

### Comparison with Previously Published POCT Governance Surveys

This survey's findings are broadly consistent with, and extend, previously published work on POCT governance and management challenges, while adding a specifically comparative element across 26 hospitals that most prior single-site or small-sample reports have not provided.

Nichols' foundational description of connectivity, competency and quality as the three pillars of POCT programme management anticipated the structure of this survey's findings closely, and this study's contribution is largely to provide multi-site quantitative evidence of how widely performance on these three pillars varies even among hospitals with nominally similar accreditation-driven policy requirements.<sup>[5]</sup>

Meier and Jones' taxonomy of POCT error sources and amplifiers similarly anticipated that competence gaps and connectivity failures would amplify error risk, and this survey's finding that competence completion ranged as low as 58% at some sites provides a concrete quantitative illustration of how large that amplification risk can be even at hospitals that consider their POCT programme to be functioning adequately.<sup>[8]</sup>

### Implications for Patient Safety

The governance gaps identified in this survey carry direct patient safety implications beyond the administrative and quality-management framing used throughout most of this report.

An operator without a current competence assessment is not necessarily performing the test incorrectly, but the absence of verification removes the primary mechanism by which an incorrectly performed test would be identified before it produces a result acted upon in patient care, meaning the competence completion gap observed at lower-performing sites represents an unmeasured, rather than necessarily absent, elevated risk of operator-related testing error.<sup>[9][10]</sup>

A connectivity gap for a given device category similarly removes the central data management system's ability to flag a quality control failure or an out-of-range result pattern at that device, meaning the lower-connectivity device categories identified in this survey -- coagulation and cardiac marker devices in particular -- carry a correspondingly reduced capacity for centralised quality monitoring until connectivity integration is achieved.

### Economic Considerations for Implementing a Dedicated Coordinator Role

Hospitals considering whether to invest in a dedicated POCT coordinator role, in response to this survey's findings, will reasonably want to weigh the cost of that role against its demonstrated benefit.

A single dedicated coordinator, even part-time, appeared sufficient to achieve the governance improvement observed at high-performing sites in this survey regardless of overall hospital size, suggesting the role's cost scales more with the complexity and diversity of a POCT programme than with raw hospital bed count, making it a comparatively predictable, bounded investment relative to the open-ended risk exposure of an ungoverned POCT programme at scale.<sup>[6]</sup>

The cost of a single significant adverse event traceable to an inadequately competence-assessed operator or an undetected quality control failure at a non-connected device -- whether measured in direct clinical harm, regulatory consequence, or institutional reputational cost -- would in most cases exceed the ongoing cost of a dedicated coordinator role many times over, providing a straightforward economic case for the investment independent of the broader quality rationale.

### Study Limitations

This survey's cross-sectional design and reliance on self-reported structural features alongside independently audited performance metrics carry limitations worth noting explicitly.

The association between a dedicated coordinator role and higher governance performance, while consistent across the surveyed sites, is observational rather than experimental, and this study cannot exclude the possibility that hospitals with the institutional culture or leadership engagement to establish a dedicated coordinator role also share other unmeasured characteristics that independently contribute to stronger POCT governance performance.<sup>[8]</sup>

The 26 participating hospitals were not randomly selected from all hospitals operating POCT programmes but were drawn from institutions with sufficiently established programmes to have the data infrastructure needed to respond to this survey's data request, meaning hospitals with even less mature POCT governance than the lowest-performing sites surveyed here may exist but are not represented in this sample.

### Future Directions

A prospective, interventional study introducing a dedicated POCT coordinator role at a sample of currently lower-performing hospitals, and measuring the resulting change in connectivity, competence completion, and result traceability over a defined follow-up period, would provide stronger causal evidence for this survey's central structural finding than the observational cross-sectional design used here can offer.

Further research characterising the specific connectivity integration barriers for newer, lower-volume POCT device categories such as point-of-care coagulation and cardiac marker testing would help central data management system vendors and hospital informatics teams prioritise the integration work most likely to close the connectivity gap identified for these device categories in this survey.

### **Governance Recommendations for Programmes Operating at Scale**

Drawing together this survey's findings, we propose a practical governance framework for POCT programmes operating across many sites and device types, organised around the three functions assessed throughout this study.

For connectivity: treat integration with the central data management system as a mandatory go-live prerequisite for any new POCT device category, rather than a subsequent upgrade project, given how persistently lower connectivity rates for newer device categories were observed at otherwise well-governed sites in this survey.<sup>[4][9]</sup>

For competence assessment: establish a dedicated coordinator role with protected administrative time, paired with an automated reminder system flagging approaching assessment expiry dates, since this combination was the structural feature most consistently associated with high completion rates across the surveyed hospitals.

For result traceability: prioritise electronic capture over paper-based workflows for every POCT device category, including lower-volume categories such as bedside urinalysis and point-of-care pregnancy testing, which this survey's two lower-performing sites identified as their specific remaining paper-based gap.

### **Applicability to Community and Primary Care POCT Settings**

This survey's 26 participating hospitals were all acute-care institutions, and the applicability of its findings to community pharmacy, primary care, and residential-care POCT settings -- increasingly significant venues for POCT deployment -- warrants separate consideration.

These community settings generally lack the institutional infrastructure, such as an established laboratory department capable of hosting a dedicated POCT coordinator role, that enabled the governance improvements observed at high-performing hospitals in this survey, suggesting that an equivalent coordination function in community settings may need to be provided externally, for example by a regional laboratory network or primary care organisation, rather than internally by the community site itself.<sup>[2][3]</sup>

Connectivity integration is, if anything, a more significant challenge in community settings than in the acute-care hospitals surveyed here, since community sites frequently use devices connected, if at all, to a different data management ecosystem

than the hospital or laboratory network ultimately responsible for clinical oversight of the results generated, an interoperability challenge beyond the scope of what this survey's acute-care-focused findings can directly address.

### **Role of Accreditation Bodies in Driving Structural Change**

Accreditation standards for POCT programmes generally specify the outcomes to be achieved -- documented competence, traceable results -- without specifying the particular organisational structure, such as a dedicated coordinator role, through which a programme should achieve them, and this survey's findings suggest accreditation bodies could usefully revisit that approach.

Explicitly recognising a dedicated POCT coordinator role, or an equivalent structural mechanism, as an expected feature of a well-governed POCT programme at scale -- rather than leaving the organisational means of achieving competence and traceability outcomes entirely to individual institutional discretion -- would align accreditation expectations more closely with this survey's empirical finding about which structural features actually predict strong governance performance.<sup>[7][10]</sup>

### **Interaction Between the Three Governance Functions**

Although connectivity, competence assessment, and result traceability were measured and discussed throughout this report as three separate governance functions, this survey's site-level data suggests the three functions interact rather than operating entirely independently of one another.

Sites with low connectivity for a given device category frequently also showed lower result traceability for that same category, since a non-connected device typically depended on manual transcription into the patient record, the same manual-step dependency identified as the specific weakness at this survey's two lowest-traceability sites, suggesting that connectivity integration and traceability improvement are, in practice, often addressed by the same underlying intervention rather than requiring entirely separate remediation efforts.<sup>[4][5]</sup>

Competence assessment completion showed a weaker but still discernible relationship with the other two functions: sites with a dedicated coordinator role driving high competence completion also tended to report, informally, greater attention to connectivity gaps as they arose, consistent with a single well-resourced coordination function tending to improve governance performance across all three dimensions simultaneously rather than each dimension depending on an entirely separate structural intervention.

## Differences by Clinical Setting Within Hospitals

Beyond the hospital-level variation already discussed, this survey's data also showed meaningful variation in governance performance between different clinical settings within the same hospital, a dimension worth examining separately from the overall site-level findings reported above.

Emergency department and intensive care POCT operations, where testing volume is high and a relatively small, stable group of clinical staff perform the majority of tests, generally achieved higher competence completion rates than general ward settings, where testing volume per individual operator is lower and staff turnover or rotation is typically higher, spreading the competence assessment burden across a larger and more transient operator pool.<sup>[6]</sup>

This within-hospital variation suggests that a single hospital-wide governance framework may need to apply differentiated competence assessment and reminder strategies by clinical setting rather than a uniform approach, since the operational pattern driving lower completion in general ward settings -- a large, high-turnover operator pool with lower individual testing frequency -- differs structurally from the pattern in emergency department or intensive care settings and may not respond equally well to the same intervention.

## Vendor and Device Design Considerations

Several of the connectivity and traceability gaps identified in this survey trace back, at least in part, to specific device design and vendor integration choices rather than purely to hospital-side governance failures, a dimension worth acknowledging alongside the structural governance recommendations made throughout this report.

Devices designed from the outset with a standard, open connectivity interface conforming to established point-of-care connectivity standards integrated into central data management systems considerably more readily, in sites' informal commentary accompanying this survey's data, than devices using a proprietary or non-standard interface requiring bespoke integration work by each purchasing hospital's informatics team.<sup>[4]</sup>

Hospitals procuring new POCT devices could reasonably weight demonstrated conformance to open connectivity standards as an explicit procurement criterion, alongside analytical performance and cost, given this survey's finding that connectivity integration delay was a persistent problem even at hospitals otherwise demonstrating strong POCT governance, suggesting the remaining barrier in many cases sits with device-side integration readiness rather than hospital-side governance capacity.

## Practical Checklist for POCT Programme Leaders

Drawing together the recommendations made throughout this report, we propose the following practical checklist for POCT programme leaders assessing or establishing governance structures at scale.

Establish a dedicated POCT coordinator role with protected administrative time before expanding device diversity or clinical site count significantly; pair this role with an automated reminder system for competence assessment expiry; require connectivity integration as a go-live prerequisite for any new device category; weight open connectivity standard conformance in device procurement decisions; and periodically audit a sample of results for traceability into the clinical record, following the methodology used in this survey, rather than assuming traceability is adequate in the absence of a specific audit.<sup>[7][10]</sup>

For clinical settings with high operator turnover, such as general wards relative to emergency department or intensive care settings, consider a differentiated, higher-frequency competence reminder and tracking approach reflecting the larger and more transient operator pool typically found in these settings, rather than applying a uniform hospital-wide competence assessment cadence regardless of setting-specific operator turnover patterns.

## Regulatory and Accreditation Audit Implications

Accreditation assessors reviewing a POCT programme's compliance typically sample a limited number of records for competence assessment and traceability review rather than conducting a comprehensive audit of every operator and every result, and this survey's wide range of site-level performance on both measures has direct implications for how representative such a limited sample is likely to be.

A hospital with the kind of substantial within-programme variation by device category or clinical setting documented in this survey could plausibly pass a small, favourably-sampled accreditation audit despite having a materially lower underlying overall completion or traceability rate, suggesting accreditation audit sampling methodology might usefully be revised to deliberately include a stratified sample across device categories and clinical settings rather than a single pooled random sample, to better capture the kind of variation this survey identified as common.<sup>[8]</sup>

## Patient and Clinician Communication Implications

Governance gaps in POCT programmes are typically framed, as throughout most of this report, as a laboratory quality and accreditation concern, but they also carry direct implications for how clinicians and patients should understand the reliability of a given POCT result.

A clinician receiving a POCT result from a device category known, through internal governance reporting, to have lower connectivity and therefore reduced centralised quality monitoring coverage might reasonably apply a higher threshold for corroborating an unexpected or clinically discordant result.

with an alternative testing method, an informal risk-adjustment practice that becomes possible only if governance performance data of the kind collected in this survey is made visible to clinical users rather than remaining solely within laboratory quality reporting.<sup>[3]</sup>

Making a hospital's own device-category-specific connectivity and competence completion data visible to ordering clinicians, for example through a brief note in local POCT policy documentation, would extend the benefit of this kind of governance transparency beyond the laboratory quality function to the point of clinical decision-making itself.

### **Why This Survey Focused on Glucose Meters for Competence Measurement**

Competence assessment completion was measured specifically for glucose meter operators in this survey, and the rationale for this choice, rather than measuring across all device categories uniformly, is worth making explicit.

Glucose meters were present at all 26 participating hospitals and represented, by a substantial margin, the highest-volume POCT device category and the largest operator pool at every site, making glucose meter competence completion both the most broadly comparable single metric across all 26 hospitals and the metric with the greatest absolute patient safety significance given the sheer volume of glucose testing performed relative to lower-volume device categories.<sup>[9]</sup>

Competence completion data for lower-volume device categories was less consistently available across all 26 hospitals, reflecting the less mature governance tracking typically applied to lower-volume devices even at hospitals with strong glucose-meter-specific governance, a pattern consistent with this report's broader finding that governance maturity varies considerably by device category within the same institution.

### **Scalability of This Governance Framework to Larger Programmes**

The governance framework proposed in this report was derived from a survey of 26 hospitals of varying size, and its scalability to considerably larger POCT programmes, such as those operated by large multi-site hospital networks or national health systems, warrants brief separate comment.

The core structural recommendation -- a dedicated coordinator role paired with automated tracking -- is likely to require scaling into a small coordination team rather than a single individual as programme size grows substantially beyond the scale of most sites surveyed here, but the underlying principle, that dedicated, protected coordination capacity rather than informal distributed responsibility drives strong governance performance, is unlikely to change simply because the absolute scale of the programme increases.<sup>[2][6]</sup>

### **Relationship to Overall Hospital Quality Culture**

Although this survey's central finding is that specific structural features, rather than overall institutional resourcing, predict strong POCT governance performance, this should not be read as suggesting broader hospital quality culture is irrelevant to POCT governance outcomes.

Several of the hospitals achieving strong performance across all three governance metrics in this survey also reported, in accompanying free-text survey responses, a broader institutional emphasis on structured quality roles across multiple clinical support functions beyond POCT specifically, suggesting that an institution's general willingness to invest in dedicated coordination roles for quality-sensitive functions may be a precondition that makes the specific POCT coordinator investment more likely to occur in the first place, even though the coordinator role itself, once established, was the more directly predictive structural feature measured in this survey.<sup>[8][10]</sup>

### **Interdisciplinary Coordination Between Laboratory and Clinical Divisions**

Because POCT devices are physically operated by clinical staff rather than laboratory staff, effective governance depends on sustained coordination between the laboratory, which typically holds ultimate accreditation responsibility for POCT quality, and the clinical divisions where devices are actually deployed and used.

The dedicated POCT coordinator role identified throughout this report as the key structural predictor of strong governance performance functions, in practice, substantially as an interdisciplinary liaison position, translating laboratory accreditation requirements into practical workflows clinical staff can follow, and translating clinical operational constraints back to the laboratory in a way that shapes how governance requirements are implemented without placing undue burden on ward or clinic workflow.<sup>[1][7]</sup>

### **Equity Considerations in POCT Governance Resourcing**

Resourcing a dedicated POCT coordinator role, as recommended throughout this report, is more readily achievable for larger or better-resourced hospitals than for smaller institutions, raising an equity consideration this survey's findings should not be read as dismissing.

Smaller hospitals, and the community and primary care settings discussed earlier in this report, may need to access an equivalent coordination function through a shared regional or network-level role rather than an institution-specific appointment, an arrangement several health systems have adopted for other specialised quality functions and that could plausibly be extended to POCT coordination for smaller sites unable to justify a dedicated full-time role on their own testing volume alone.<sup>[2]</sup>

## Summary of Practical Implementation Priorities

For a POCT programme leader with limited capacity to act on every recommendation made throughout this report simultaneously, we suggest sequencing implementation with the dedicated coordinator role first, since this single structural change was the feature most consistently associated with improved performance across all three governance metrics surveyed, followed by automated competence-expiry tracking, connectivity integration prioritisation for new device categories, and finally a structured, stratified traceability audit of the kind used in this survey's own methodology.<sup>[4][9]</sup>

## Reflections on Measurement as a Precondition for Governance Improvement

A recurring theme across the structural findings of this survey is that governance performance was measurable, at every surveyed hospital, only because this study specifically requested the underlying data; several participating sites noted in follow-up correspondence that they had not previously quantified their own competence completion or traceability rate at the level of precision this survey's data request required.

This observation suggests a further, more basic governance recommendation underlying all of the more specific structural recommendations made throughout this report: a POCT programme should routinely measure its own connectivity, competence completion, and traceability performance as a matter of regular internal practice, independent of any external survey or accreditation audit cycle, since a programme that does not routinely measure these metrics cannot know whether its governance performance resembles this survey's high-performing or low-performing sites until an external assessment, by definition retrospective, reveals the gap.<sup>[8][10]</sup>

## Applicability of This Framework to Non-Glucose High-Volume Devices

While this survey used glucose meter operator competence as its specific comparative metric across all 26 hospitals, the governance framework proposed throughout this report is not intended to apply to glucose testing alone, and its applicability to other high-volume POCT device categories deserves brief explicit comment.

Blood gas analysis, the other device category achieving near-universal connectivity above 95% at most sites in this survey, shares with glucose testing the characteristic of being performed frequently enough by a relatively stable operator pool, typically concentrated in emergency department, intensive care, and operating theatre settings, that competence tracking and connectivity integration have generally received sustained institutional attention over a period of years, a maturity pattern the newer device categories identified elsewhere in this report as lower-performing have not yet had time to develop.<sup>[1][3]</sup>

This maturation pattern suggests that today's lower-performing newer device categories may, given sufficient

time and sustained institutional attention, eventually reach governance performance comparable to glucose and blood gas testing, but this survey's findings argue against simply waiting for that natural maturation to occur, since the structural interventions identified here -- a dedicated coordinator role, automated tracking, go-live connectivity integration -- offer a faster and more deliberate path to the same outcome than passive maturation over years of use.

## Why This Study Surveyed Hospitals Rather Than Individual Devices

This survey's unit of analysis was the hospital-level POCT programme rather than individual devices or operators, a methodological choice reflecting the governance framing of this report's central question: whether programme-level structural features, rather than device-specific technical characteristics alone, predict governance performance.

A device-level or operator-level analysis would have been better suited to characterising the technical reliability of individual POCT device models, a different and already well-studied question in the POCT literature, whereas this survey's hospital-level approach was specifically designed to surface the programme-level organisational variation -- the presence or absence of a dedicated coordinator role, for instance -- that a device-level analysis would not be positioned to detect.<sup>[5][9]</sup>

## Conclusion

Device connectivity (89.4% overall) and operator competence assessment completion (58-97% across sites) both varied substantially across 26 hospitals despite broadly similar stated policies, and the variation correlated with specific structural governance features -- a dedicated coordinator role and automated tracking -- rather than overall institutional resourcing. POCT programmes expanding in scale or device diversity should prioritise these structural features and treat connectivity integration as a prerequisite for new device adoption rather than a subsequent upgrade.

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