Internal Quality Assurance Framework

Anatomical Pathology

The Royal College of Pathologists of Australasia received funding from the Department of Health, under the Quality Use of Pathology Program (QUPP) to develop a comprehensive framework for internal quality assurance, focused on the morphological disciplines of Histopathology, Cytopathology, Haematology and Forensic Pathology. The overall governance of this project was provided by the College, and was supported by a Steering Committee that included representatives of the morphological disciplines. The Board of Education and Assessment and the Board of Directors further decided to develop separate discipline specific Frameworks for the other disciplines of pathology.

The Anatomical Pathology IQA Framework contains activities that will aim to help monitor performance, drive improvement and support collaborative on-going professional practice. The IQA Framework activities focus on peer-review and clinical audit and require documented evidence of a pathologist's involvement in these internal quality activities. The Framework is practice based and the Anatomical Pathology Advisory Committee provided guidance with the development of the Chemical Pathology Framework activities.

The new requirement for Anatomical Pathology Fellows to participate in a minimum of 10 hours per annum of peer review activities (Section 1 of the IQA Framework) under Category C of the RCPA CPD Program was introduced from 01 January 2016.

For any queries about the Framework or the project, contact the DCEO, Dr Bronwen Ross at bronwenr@rcpa.edu.au

Framework Features

The Internal Quality Assurance framework divides activities into 3 specific cycles:

1. *Pre-analytic* phase of the test cycle is specimen delivery and accessioning, gross examination/cut-up and laboratory technical processing.

2. *Analytic* phase of the test cycle in the current context relates to the pathologist diagnostic component.

3. *Post-analytic* phase of the test cycle begins with report authorisation through to report delivery, and may include adjunct activities such as billing.

The Framework records these activities under 2 sections:

Section 1: Diagnostic Measures (the analytic phase) relates to peer review activities, participation in 10 hours per annum required.

Section 2: Technical Laboratory Measures (pre-analytic) & Service Performance (post analytic/ overview) relate to clinical audit activities, participation in 10 hours per annum recommended.

Please refer to the tables on the following pages for information on examples of suitable activities and further document requirements.

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Internal Quality Assurance Activities

ANATOMICAL PATHOLOGY

Section 1: DIAGNOSTIC MEASURES - (engaging in peer review activities)

Requirement: Minimum 10 hours per annum Diagnostic Measures

Activity	Quality activity monitor related	Suggested document requirements
Case Reviews Using clinical audit techniques	• Internal random case review - Defined % of cases	Document the review type - Who performed the review - What was reviewed - What cases were reviewed - Time it took Structure discordance as - None (agreement) - Minor/ typo error - Minor discordance/ no effect on patient care - Major discordance /potential impact on patient care
	• Internal target case review - Specific case types	
	• Internal correlations i) Frozen section – paraffin ii) Non gynae cytology – histology Or other types of correlations performed	
	• Inter institutional correlations - 2nd opinions (incoming and outgoing)	
	• Intradepartmental correlations - Formal 2nd opinions - Informal 2nd opinions	
	• Multi Disciplinary Team (MDT) case presentations** - Any discordant opinions	Document discordance - None (agreement) - Minor /non clinical - Minor / clinical - Major / clinical
	• Audit of corrected/ amended reports	
	• Compliance with / utilization of structured report templates - Other (where available)	
Formal peer review	• Validated 360 degree peer review completed	Date, time and duration and brief description of activity.

** The MDT meetings are the responsibility of the individual laboratory, and are expected to be documented and records maintained with the above criteria mentioned. Record any disagreement which may arise between the original diagnostic report and the MDT review. Issue an addendum post MDT if required and follow–up according to your individual laboratory policy for such incidents. Each laboratory must have documented processes for handling diagnostic discordances when detected.

For example: Correlation results:

Agreement – represents frozen section/ histopathology/ cytology where all present agree with the report.

Deferral rate - represents the cases where frozen section diagnosis was deferred until final diagnosis was reached on paraffin sections.

Minor disagreement/discordance - represent where there is a small change in diagnosis but there is minimal or no clinical impact.

Major disagreement/ discordance - represent a significant difference between original diagnosis and the final diagnosis where potentially there is a significant impact on a patient's treatment or outcome.

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Section 2: TECHNICAL MEASURES - laboratory based non-conformances (audit activities)

Requirement: Minimum 10 hours per annum combined Technical Measures/Service Performance

Activity	Examples of quality monitors related to lab based non-conformances	Suggested document Requirements
Non-conformance reporting A laboratory non-conformance is an incident that has the potential to cause an error or harm. Documentation of these is a requirement. Laboratories should have existing policies, procedures and processes in place if such an incident occurs. The examples stated in this table should be reported.	• Specimen receipt issues* - Incorrect identifiers - Labelling errors - Lost specimens • Specimen handling issues - Cut-up • Laboratory technique issues - Embedding - Cutting - Staining - Special stains - Frozen section TAT	- Incidence +/- % of non-conformances
Section 2: SERVICE PERFORMANCE - suggested examples below of types of service activities that may Be monitored and specific data collected		
Audit of Service Performance The goal is to monitor and improve internal laboratory performance using auditable measures and collect acceptable data to develop benchmarks for the future.	• Turn Around Times** - Whole workload or - Selected case type • Report format review - Typographical/ transcript errors - SNOMED coding • Billing Errors	Documentation of TAT - Overall - Different phases of reporting process - By different case types % Errors concluding check

* Laboratories must have policies for handling detected non-conformances

** For Histology consider criteria from either current ACHS or RCPA recommendations

Establishing an Anatomical Pathology IQA Framework that will be used to routinely review processes in the discipline should facilitate improved laboratory practices. It provides a mechanism for peer review, introduces a mechanism for laboratories to benchmark their processes to measure improvements, reduce the risk of aberrant/uninformative/false reports being issued in a clinical environment, thereby improving the quality of patient management and/or outcomes.

The Anatomical Pathology IQA Framework is a stand-alone program and activities performed from the Framework will be linked to the RCPA CPDP and will likely be an important part of any Revalidation Framework the College may need to adopt in the future.

The completion of activities under Section 1 forms part of the RCPA audit substantiation for the RCPA CPD Program effective 01 January 2016.