



National
**PATHOLOGY
ACCREDITATION**

Advisory Council

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Professor Chris Baggoley
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Healthcare
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Dear Professor Baggoley

Re: Meeting between ACSQHC and National Pathology Accreditation Advisory Committee (NPAAC) and Quality Use of Pathology Committee (QUPC)

Thank you for meeting with representatives of the Commonwealth Department of Health and Ageing, NPAAC and QUPC, in your offices in Sydney on 20 Sept 2007 and for the opportunity to discuss issues of concern to the pathology sector.

As you are aware, the meeting was intended as a follow-up meeting of earlier contact between our various bodies and the Commission. With the recent publication of the Commission's Consultation paper *An Alternative Model for Safety and Quality Accreditation of Health Care*, it was thought helpful for all parties to clarify key points raised in the Consultation paper, so as to assist the Commission refine its proposed framework and model.

Pathology has been an "early adopter" of basic principles of safety, quality and accreditation. As described in our previous letter (NPAAC to Dr Lawrence of the Commission, 30th March 2007), NPAAC was established in 1979, and a national accreditation program for pathology has operated since 1986. Since that time, the pathology sector in Australian medicine has achieved world's best practice in terms of the quality of national pathology services, and the Australian pathology accreditation system has been adopted or adapted in many other countries around the world.

Separation of Safety from Quality Improvement.

A key feature of the Pathology experience has been the integration of safety and quality improvement. The accreditation standard used by pathology (ISO15189:2003, AS4633-2004) consists of both technical and quality system elements, and both are assessed within the accreditation framework.

We greatly appreciated your clarification and reassurance that the separation of Safety from Quality Improvement, as described in the Commission's Consultation Paper, was intended to reflect a description of the governance model only, and that there was no intention to propose an operational or accreditation separation of these two activities or functions.

We then discussed the concept of Key Control Points, or Key System Measures, within an overall systems approach to medicine. The mapping of the system, its dissection into key processes, the identification of critical failure points, and the proposal that these key steps needed to be measured, monitored and controlled, was one with which pathology is very familiar and would strongly support. For example, within pathology, these key control points would correspond to:

- Patient identification
- Capture of pathology request instructions with high fidelity
- Analytical Quality Control of the actual test processes within pathology
- Transfer of custody of samples and information at the boundaries between pathology and other parts of the healthcare system.

We drew your attention to the "Chain of Information Custody" document (DoHA, 2003), which was a discussion paper produced for the Quality Use of Pathology Committee. This report on communication issues between requesters and providers of pathology has been referred to NPAAC for further consideration.

We also drew your attention to the mature and sophisticated Quality Assurance and Proficiency Testing programs that are used in pathology (for example, www.rcpaqap.com.au) and in which participation is mandated by NPAAC as a requirement for accreditation.

We noted current work on new types of Quality Assurance programs, such as non-analytical quality (KIMMS –Key Incident Monitoring and Management System, which is designed to provide pathology practices with the tools for continuous measurement and monitoring of key incident indicators), Haemovigilance (Haemovigilance Project Working Group of the National Blood Authority), and issues involving ownership and transfer of information between pathology laboratory and other healthcare IT systems such as the electronic Medical Record (eMR, eHR). The Quality Use of Pathology Committee has a key role in exploring and promoting promising new directions for quality improvement initiatives.

National Minimum Safety Standards applying across all settings of care

Service quality needs to be included within this. This includes issues extending beyond test accuracy and precision – for example responsiveness, turnaround times, reporting and records and decision support. For example, a "correct" pathology result may be "safe", but if it is received only after unacceptable delay, then patient harm may result from this delay. Our suggestion is simply to clarify that there are necessary minimum standards contributing towards safety that are themselves not immediately evident as being in a minimum data set.

There is also some uncertainty with the proposal of another overlay of minimum standards framework that would be applicable to all crafts. The criteria for developing standards and process for determining the minimum standards would have to be clearly set out.

Registration of Healthcare Workers

We noted the Commission's desire to ensure that all healthcare workers are registered under the proposed national registration Boards.

While we were supportive of this approach, we noted that the recently completed COAG review (Ramsay Report) had established that, while Pathologists were registered as Medical Practitioners in each State, Laboratory Scientists (etc) were not registered in any State or Territory of Australia, although Registration of Scientists (etc) was standard practice in New Zealand, the United Kingdom and some States of the USA. We have been advised by some of the Scientific and Professional Societies within Pathology that their understanding of the timetable for uniform national registration of healthcare workers would mean that there was unlikely to be any opportunity for registration of medical scientists until such time as all other healthcare workers had been registered nationally; such a timetable might imply a delay of many years.

We suggested that an alternative approach that might achieve the same outcome would be to establish a national set of competency standards combined with credentialing of laboratory scientists (etc). Such a framework might be an appropriate basis for a future registration program should this come to pass. We noted that it was within the scope of NPAAC's activities to develop and mandate such a framework of competency standards.

Pathology as a “non-clinical” discipline

We drew your attention to the grouping in the Consultation Paper of pathology with “non-clinical and technical compliance” activities (section 5) and we noted that the Pathology community strongly considered itself to be a clinical discipline.

It was pleasing to learn that it was the Commission's intention to regard the Pathology accreditation framework as already being strong and mature, and the grouping of pathology in this section was with the intention of proposing that no further action was likely to be required by the Commission.

Nevertheless, we would respectfully suggest the wording of this section be revised to reflect this intention, and to remove the ambiguity that might be read as implying pathology was a non-clinical discipline.

Other areas where we would support the Commission's approach

Time did not permit the discussion of the following points in our meeting of 20th September. We offer the following points as areas where we would support the Commission's approach:

1. Separation of standards-setting from accreditation to ensure there are no perceived conflicts of interest between the standards setter and

accreditation body. The distinction between the standard setting role of NPAAC and NATA/RCPA as the accreditation body is a good example.

2. Surveyor training programs to ensure consistency and competence of assessors/surveyors. This is currently performed by the accrediting agency in Pathology – NATA/RCPA.
3. Unannounced surveys and tracer methodology has been an integral part of the NPAAC-NATA accreditation framework. The strategy of unannounced surveys is supported as being part of the accreditation framework given the expectation that there is compliance with standards at all times. This is being further enhanced through the recently introduced alternative surveillance system.

As advised previously, tracer methodology is already an integral part of the NATA assessment process, which requires bidirectional traceability of patient/test/result/report information linkages.

4. Single national body to set standards and lead and coordinate change (already occurs with pathology; but we would not support *another* body *on top* of this). It is considered that there are also a number of contradictions within the Paper in relation to which body is charged with the responsibility for developing such standards.

Pathology as a potential model for other medical disciplines

We offered you the advice that the Pathology profession might lend itself as a possible model for the Commission to consider as an example of how accreditation has led to sustained and measurable improvements in both Quality and Safety. The Commission might wish to engage in further discussion with key parties within the Pathology sector if it wished to explore this suggestion further, and we would be pleased to assist the Commission in this regard.

Thank you again for the opportunity to provide input to the Commission's health care accreditation review.

Yours sincerely



Professor Leslie Burnett
Chair NPPAC



Dr Michael Harrison
Chair QUPC, Chair of Medical
Testing Accreditation Advisory
Committee.

9 October 2007

cc. Dr Margaret Banks, ACSQHC