Wake Forest Baptist Medical Center	Anatomic Pathology Quality Assurance Data Procurement Procedure	**Dept:**	**Anatomic Pathology**
		Effective Date:	**3/24/2018**
		Revised Date:	**4/3/2018**
		Contact:	**Lab Compliance QA, Safety and POCT**
Name & Title: Gregory Pomper, MD. Medical Director, Clinical Laboratories.		**Date:**	4/9/18
Signature:			

1) **General Procedure Statement:** The anatomic pathology section adheres to the Department of Laboratory Medicine and Pathology Quality Assurance/Quality Improvement/Quality Management Plan and maintains a planned, systematic, and ongoing departmental quality assurance/quality improvement plan.

    a. **Scope:** The Anatomic Pathology section is to be operated in full compliance with the requirements of the state and federal government and by the higher voluntary standards of the Clinical Laboratory Improvement Amendments (CLIA), College of American Pathology (CAP), and Joint Commission (TJC). All Laboratory employees, faculty and staff are responsible for complying with this policy.

    b. **Responsible Department/Party/Parties:**
        i. Procedure owner: Department of Laboratory Medicine and Pathology.
        ii. Procedure: Department of Laboratory Medicine and Pathology
        iii. Supervision: Department of Laboratory Medicine and Pathology
        iv. Implementation: Department of Laboratory Medicine and Pathology

2) **Definitions:**

3) **Procedure:**

Anatomic Quality assurance performance monitors are obtained as follows:

a) Total accessions for the month:

    a. The "Specimen Count by Specimen Class" report available in the Laboratory information system is used to obtain this information.

    b. Under "Accession Date" indicate the beginning and end date for the report.

b) Amended Reports

    a. The "NCB Amended Report with Date Range" report available in the Laboratory information system is used to obtain this information.

b. Under "Amend Date" indicate the beginning and end date for the report.

c. The data is aggregated by "Amendment Reason" as included in the report.

c) Turnaround Time (TAT) – Accession to pathologist sign out

a. The "Turnaround (%)/Pathologist" and "Turnaround (Days)/Pathologist" reports available in the laboratory information system are used to obtain this information.

b. Under "Accession Date" indicate the beginning and end date for the report.

c. The results are displayed for the entire department and compared with established thresholds.

d. Additionally, results for individual pathologists is tabulated and compared with established thresholds.

d) Total Consults (Intradepartmental Reviews – Green sheets)

a. Intradepartmental reviews are documented on the "Intradepartmental Case Consultation Form" (green sheets)

b. The billing office captures this information into the Laboratory Information system.

c. The "SNOMED II Search" and/or "NCB Green Sheets (Consultations)" reports available in the laboratory information system are used to obtain this information.

d. Under "Accession Date" indicate the beginning and end date for the report.

e. The data is aggregated by type of case (Surgical, Cytology, Bone Marrow, Autopsy, Lexington Medical Center)

e) Total Send Outs

a. The "Send Outs" report available in the Laboratory information system is used to obtain this information.

b. Indicate the beginning and end date for the report.

c. The data is aggregated by send out requesting reason.

f) Cases presented at Interdepartmental conferences

a. Cases reviewed and presented at interdepartmental conferences are documented on the "QA conference and Individual Case Review" log form.

b. Any discrepancy and/or deficiency identified at this time is documented on the same log.

c. The data is aggregated by interdepartmental conference (Breast, Surgical Oncology Thoracic, Endocrine, Heart, Cytology, Hepatobiliary, Colorectal, Hematopathology).

g) Intraoperative diagnosis versus Final Diagnosis

a. The "Intraoperative vs Final by Frozen Section Pathologist" report available in the Laboratory information system us used to obtain this information.

b. Under "Accession Date" indicate the beginning and end date for the report.

c. The resulting report lists side by side the intraoperative diagnosis and the final diagnosis. Cases in which a discrepancy is identified are reviewed by a surgical pathologist and/or the director of surgical pathologist, sometime including the review of frozen section and permanent sections from selected cases.

d. Cases are categorized as "agree", "mayor disagreement" or "minor disagreement" based on the specific clinical scenario.

e. The results are displayed for the entire department and compared with established thresholds.

f. Additionally, results for individual pathologists is tabulated and compared with established thresholds.

h) Transcription productivity

a. Workloads reports available in the Laboratory information system is used to obtain this information.

b. The data is aggregated by position.

i) Second Read New Malignancies Audit

a. Intradepartmental second read of new malignancies are documented on the "New Positive Malignancy Confirmation Form" (pink sheets). In addition, pathologists are encouraged to document the second read on the final pathology report.

b. The forms are submitted on a daily basis to the Compliance office.

c. On a weekly basis, a report of all breast and breast consult cases signed out the previous week, will be pulled from CoPath using the "SNOMEDII" report. Based on our experience with breast cancer reviews, breast cancer cases alone will not yield a sufficient audit sample. Therefore additional anatomic sites will be added to ensure the adequacy of the sample size.

    i. A list of additional unique anatomic sites (lung, kidney, prostate, etc.) will be chosen and pulled using the same report method and added to the breast cases until an appropriate sampling of new malignancies for that month is achieved.

d. The resulting report is reviewed by compliance and malignant cases are identified. For each case, medical records are reviewed to verify this is a new malignancy.

e. For new malignant cases, the existence of a "pink sheet", consult and/or documentation of the second read on the final pathology report is documented on the New Malignancy Double Read Audit Form.

f. The results of the audit are tabulated and submitted to the Medical Director of Surgical Pathology for review. The Medical Director of Surgical Pathology will be responsible for follow up with any pathologist who fails to follow proper procedure for documentation.

g. The established thresholds for review are set at 90% adherence to policy.

4) Review/Revision/Implementation:

a. Review Cycle:
b. Office of Record:

5) Related Policies:

6) References, National Professional Organizations, etc.:

7) Attachments:

8) Revision Dates:

4/3/2018, Updated to include weekly frequency for second read sample CoPath report pulls, included additional anatomic sites used to ensure adequate sample size, defined report name used to retrieve sample reports from CoPath.