

National QA Programme in Histopathology Workshop 25<sup>th</sup> October– Key Discussion Items and Outcomes

Topic	#	Question/Comment	Answer/Discussion	Comments/Actions								
<b>MORNING SESSION – IT/Coding issues/Guideline implementation</b>												
<b>IT solution- Data extraction</b>	1	<b>Is there a danger using St Vincent’s Hospital as a benchmark as more IT support for them?</b>	<p>Need to emphasise St Vincent’s was used as a pilot site for IT implementation and not benchmarking. Piloting at St Vincent’s facilitated validation of the central NQAIS system. Additional pilot sites have been chosen for each of the main lab IT systems i.e.</p> <table border="0"> <tr> <td>Letterkenny General</td> <td>Copath (Sunpath)</td> </tr> <tr> <td>Galway University Hospital</td> <td>Apex( iSoft)</td> </tr> <tr> <td>St James’s</td> <td>Telepath (iSoft)</td> </tr> <tr> <td>Mater Private</td> <td>Winpath (Clinysis)</td> </tr> </table> <p>IT Implementation is in progress at these sites. Please see Brian Dunne’s ICT presentation from the workshop for further details of IT implementation phases.</p>	Letterkenny General	Copath (Sunpath)	Galway University Hospital	Apex( iSoft)	St James’s	Telepath (iSoft)	Mater Private	Winpath (Clinysis)	<p>It is important at this stage to validate extraction software. Cognos is used by many labs as part of this validation to do this but excel also works as a basic version of this. It is hoped that this piloting will make rollout quicker elsewhere</p>
Letterkenny General	Copath (Sunpath)											
Galway University Hospital	Apex( iSoft)											
St James’s	Telepath (iSoft)											
Mater Private	Winpath (Clinysis)											
<b>Primary Organ Site</b>	2	<b>Discussion about proposed primary organ site Q codes. Issue: Need to identify primary organ/site for every case for the QA programme but cases frequently comprised of a number of specimens from a number of different organ/sites</b>	<p>Challenge: How to identify primary organ/site for each case.</p> <p>The working group recognise wider consultation was required regarding this issue. The plan now is to await the roll out of IT system to all laboratories so as to find a solution that satisfies the majority. In the meantime if individual laboratory do chose to introduce and use these Q codes the IT system is set up to facilitate this and it will enable them to analyse their data by primary organ/site.</p>	<p>Each laboratory to discuss with their laboratory over coming months potential solutions to this problem and to feedback suggestions to faculty via email (<a href="mailto:judygannon@rcpi.ie">judygannon@rcpi.ie</a>)</p> <p>Reference group to also explore this issue.</p> <p>To discuss and agree upon potential solutions at next workshop in Q2 2012.</p>								

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<b>Discrepancy in coding document (Proposal for the generation of specific codes for National QA Programme in Histopathology – Version 6.0)</b>	<b>3</b>	<p><b>Skin ellipses and shave excisions are under P04 in section 3.1 of the coding document but FAQ no 1 says skin lesions are P01 and not P04.</b></p> <p><b>(Coding document: Proposal for the generation of specific codes for National QA Programme in Histopathology – Version 6.0)</b></p>	<p>Where do you want to categorise skin specimens with respect to TAT?</p> <p>Using proposed primary organ/site Q codes would allow separation of inflammatory skin biopsies from non-melanoma skin cancer using same P code for all.</p>	<p>No consensus reached on the day</p> <p>Requires further consideration: Reference group to review with Working group.</p> <p>Update guidelines and coding document accordingly.</p>
<b>SNOMED</b>	<b>4</b>	<p><b>Concern regarding integration of QA programme and National Laboratory Procurement project (LIMS). Need to standardise codes and reflect international codes. If we are to change to SNOMED codes in the future will the IT system be able to recognise historical codes?</b></p>	<p>LIMs project are very aware of QA programme and its requirements. The QA programme endorses and has been waiting for the procurement of a national SNOMED license. In the absence of this it has had to create standard national codes for the extraction of data as different labs are using different versions of SNOMED codes and some are not using SNOMED codes at all.</p> <p>The procurement of individual SNOMED licenses was looked at in the beginning of the programme but was too costly and the procurement of a National license would be more cost effective.</p> <p>There will be the IT capability (through mapping tables) to switch to using SNOMED codes in the future.</p>	<p>Working group liaise with National LIMS procurement group.</p>
<b>MDT</b>	<b>5</b>	<p><b>If a case is sent out to another institute for MDT, how should it be coded?</b></p>	<p>If the pathologist from the referring hospital actively participates in the MDT either by direct attendance or video conference code as Q017. If they do not participate in the MDT code the case as Q001 case referred externally for review.</p>	

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	6	<b>Discussion around retiring of Q018 code for MDT codes.</b>	<p>The number of MDT cases with disagreement is typically very small and there is significant workload involved in recording the agreement codes. Therefore to reduce this coding workload the agreement code (Q018) is now being deprecated.</p> <p>All cases sent for MDT review will still need to be coded with Q017 as this is required to calculate the total number of cases reviewed at MDT. However, the QA report will now assume that there was agreement in these cases reviewed at MDT review unless Q019 has also been added to the case.</p> <p>Some participants felt it would be more appropriate to have retired Q017 as Q018 is the more specific code for agreement. To rectify this, the description of the Q017 code in the coding document will be amended to reflect that this code now means that a case was sent for MDT review and, when Q19 has not also been added to the case, there was agreement between the diagnosis in the pathology report and the consensus reached at the MDT review.</p>	Need to amend the description of the Q017 code in the coding document accordingly.
<b>External Quality Assessment Scheme</b>	7	<b>Would it be possible to code in-house cases stained for EQAs?</b>	<p>These EQAs are not currently captured by NQAIS. Comment- there is currently an increasing amount of “unofficial” EQAs being conducted between laboratories. There is a need to consider scope/procedure around these EQAs in more detail. Also need to review whether new Q codes should be created to identify individual cases subject to EQA and the outcome of each case i.e. pass/fail.</p>	Further consultation required Reference group to review with working group.

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Lab based non conformances	8	<p><b>Duplication of non conformance entry as currently have to enter into document control system such as Q pulse and now LIS system as well.</b></p> <p><b>It is important to log pre-analytical non conformances locally but is this information required nationally? Would summary numbers of these non-conformances be sufficient rather than raw data?</b></p>	<p>The IT system has been set up based on the raw data rather than the summary data approach. This approach was taken due to the added long term benefit, the flexibility of reporting and analysis and the fact that less audit would be required at hospital level.</p>	<p>Further consultation and discussion will be required.</p> <p>Reference group to review with Working group.</p> <p>Revisit at workshop in Q2 2012.</p>
	9	<p><b>Comment: During a recent accreditation visit by INAB, INAB inspectors were very impressed by the National QA programme and fact that it was patient centred.</b></p>	<p>Glad to hear that and will feed this information back to the INAB cellular pathology working group.</p>	<p>Will liaise with Faculty representative on INAB Cellular Pathology working group.</p>
Reports communicated directly to clinician	10	<p><b>If a clinician rings the pathologist for a report result is that a direct report and should it be coded as such?</b></p>	<p>Yes, code as Q023.</p>	<p>It is reasonable to record any successful direct communication to a clinician as it reflects good practice</p>
	11	<p><b>Should communication regarding frozen sections be counted as direct reports?</b></p>	<p>Although these are communicated directly to the clinician the activity is part of the frozen section diagnosis and should be coded as such. It is irrelevant if the frozen section is sent for a diagnosis or margin assessment.</p>	
	12	<p><b>Comment from the floor- A document outlining a list of critical diagnoses that should be communicated directly would be helpful.</b></p>	<p>Comment- It is not feasible to have a one size fits all approach to reports communicated as different practices in different hospitals. Has to be at discretion at local policy.</p>	<p>Current international evidence<sup>i</sup> recommends that “each institution should create its own policy regarding urgent diagnoses and significant, unexpected diagnoses in anatomic pathology”</p>

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	13	<b>How to close the loop to confirm unexpected findings. Is texting an appropriate means for communicating unexpected findings as long as long as patient's not identified?</b>	The form of communication used to report unexpected findings, and the confirmation of successful delivery of this communication, must be based on local policy and at the discretion and professional judgment of the individual reporting pathologist.	
<b>Intradepartmental Consultation</b>	14	<b>Is it necessary to code agreement or disagreement following intradepartmental consultation?</b>	There is no requirement by the QA programme to attach agreement or disagreement to intradepartmental review. Additional optional codes were made available for agreement (Q028) and disagreement (Q029). As these are optional code not mandatory to use them just need Q006 code (Case subject to Intradepartmental Consultation).	
	15	<b>Comment: It may be a representative slide that is shown to a colleague rather than the whole sample In which case there may be a medicolegal concern that it is recorded.</b>	Onus is always on reporting pathologist to decide which slides are selected for review. May be governed by local policy.	
<b>Inter institutional consultation</b>	16	<b>Should you record inter institutional cases by submitting hospital or receiving hospital?</b>	Case should be counted by both submitting and receiving hospital and are captured by cases referred externally for review (Q001) and cases received internally for review (Q002) .	
	17	<b>Comment from the floor- some hospitals are very good at sending back results that have been referred externally for review others not so great.</b>	Request from the floor that reports be sent back on all referred material in a reasonable timeframe	

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Information Governance	18	<b>Comment from the floor- Although assured that data on NQAIS is not subject to legal discovery, when Q codes are entered onto the LIS system that record is now on the LIS system which is essentially an extension of patient notes.</b>	Comment is correct and local policy will dictate release of individual case data present in the LIS. However the fact that consultants are participating in the QA programme would be viewed as evidence of good practice by the Faculty of Pathology.	
Cytology/Histo correlation and follow up	19	<b>It is only possible to code this factor retrospectively. Thus there is a complete dependence on the interest of reporting pathologist to code this which may lead to outcome reporting bias.</b>	Fulfilling this criteria is especially difficult for labs when cases come from a number of different hospitals to follow up with these cases. Potentially useful for generating focused audit (i.e. thyroid) assuming that sub-specialist histopathologists are willing to input the codes.	This criteria may potentially be most appropriately fulfilled as an organ specific retrospective review conducted on an periodic basis. Needs further consultation and definition with a revision to current guidelines. Cytopathologist reference group to review.
	20	<b>Guidelines state that “Discordance or Disagreement – represents a difference between the original cytological diagnosis and the final Histological diagnosis where an impact on the patient’s treatment or prognosis may or may not exist”- potentially unclear</b>	Interpretative bias comes in when you’re looking at discordance Further guidance required on what constitutes agreement and disagreement needed.	Further consultation required. Reference group to review

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<b>AFTERNOON SESSION – Guideline implementation</b>				
<b>TAT</b>	<b>21</b>	<b>How is Turnaround Time calculated by the IT system?</b>	Turnaround time is measured from when the laboratory receives the specimen to the time the final report is authorized on the LIS. It is calculated based on working days and does not include weekends or bank holidays. NQAIS has an in-built formula to make this calculation automatically.	
	<b>23</b>	<b>Urgent biopsy turnaround time result is phoned through to clinician. A written report is often not issued till later</b>	To clarify this is not a parameter that is required to be measured by the QA programme. This should be addressed locally in each department with a local policy for urgent report typing.	
<b>Benchmarks</b>	<b>24</b>	<b>How will Q marks be set? Comment - Need to be careful about target setting - Clinical relevance is the most important aspect in benchmarking. International benchmarks may not translate directly to the Irish context.</b>	Plan to create our own benchmark (Q Mark) from national data. A lot of discussion, review of preliminary national data and feedback required prior to setting of these benchmarks.	Benchmarks (Q Marks) will not be set until data has matured and stabilised.
<b>Frozen section</b>	<b>25</b>	<b>Potential for one Frozen section case with multiple specimens to have both concordance and discordance.</b>	For example one case had Q007 (Frozen section correlation - Concordance) and Q009 (Frozen section correlation - Major discordance).  NQAIS just counts the number of Q codes in this section so this case was counted twice - under the concordance KQI and under the discordance KQI.  Currently multiple FS in one case only get counted once for workload purposes.	Further discussion required – to be referred to Reference group
<b>Addendum report</b>	<b>26</b>	<b>What code do you use if a report is authorised and then you discover a spelling error?</b>	Classify as corrected rather than supplementary or amended and code it as Q022.	

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Focused real time review	27	<b>Discrepancy meetings (Round table reviews) taking place in some hospitals following disagreements found during focused real time review.</b>	<p>Clarification that these round table discussions are local policy at some hospitals only. They are not a requirement of the QA programme but an example of good practice.</p> <p>The focused review of previous negative cases is carried out in real time manner such that if a significant discrepancy that would affect patient care is found the clinician is notified as soon as possible.</p>	
	28	<b>Should a first cancer diagnosis double reporting be coded as intradepartmental consultation or a focused real time review? For example all breast core biopsies that are double read</b>	Double reporting should be coded by a focused real time review rather than intradepartmental review.	
Autopsy	29	<b>Discussion around fact that need to go to coroner for permission to use data. Also, coroner work is separate to HSE work so question should it be captured on this HSE database?</b>	Coroner work is covered under pathologist's indemnity, is part of hospital workload and is also under remit of the Faculty of pathology.	Issue to be decided at next steering group meeting.
General	31	<b>Comment: There is a need for further ownership of QA programme at consultant level.</b>	Acknowledge that there is some variability in consultant Pathologist involvement in the programme.	Faculty of Pathology will continue to promote the programme and encourage all Pathologists to be actively involved in it.
	32	<b>NQAIS initial KQI reports</b>	<p>As reports get rolled out to labs- each lab to review report with regards to:</p> <ul style="list-style-type: none"> <li>-Content</li> <li>-Layout</li> <li>-User friendliness</li> </ul>	<p>Email suggestions to Judy Gannon- <a href="mailto:judygannon@rcpi.ie">judygannon@rcpi.ie</a></p> <p>Discuss at next workshop</p>

Please could you feedback these discussion items at your laboratory and email any comments you may have regarding them to [judygannon@rcpi.ie](mailto:judygannon@rcpi.ie)

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<sup>i</sup> Consensus Statement on Effective Communication of Urgent Diagnoses and Significant, Unexpected Diagnoses in Surgical Pathology and Cytopathology From the College of American Pathologists and Association of Directors of Anatomic and Surgical Pathology Arch Pathol Lab Med. 2011 Oct 13. [Epub ahead of print]. Nakhleh RE, Meyer JL, Allen TC, Deyoung BR, Fitzgibbons PL, Funkhouser WK, Mody DR, Lynn A, Fatheree LA, Smith AT, Lal A, Silverman JF. Available online at: <http://www.archivesofpathology.org/doi/abs/10.5858/arpa.2011-0400-SA>