Clinical Governance in NPAAC Standards

Beverley Rowbotham, Chair

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Pathology returns to healthcare

Definitions

- **Govern**: to conduct the policy, actions, and affairs of (a state, organization, or people) with authority.

- **Corporate governance**: The framework of rules and practices by which a board of directors ensures accountability, fairness, and transparency in a company's relationship with its all stakeholders (financiers, shareholders, customers, management, employees, government, and the community)

- **Clinical governance**: A framework whereby (NHS)organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

  Three key attributes: recognisably high standards of care, transparent responsibility and accountability for those standards, and a constant dynamic of improvement

  Scally and Donaldson, UK Department of Health 1998

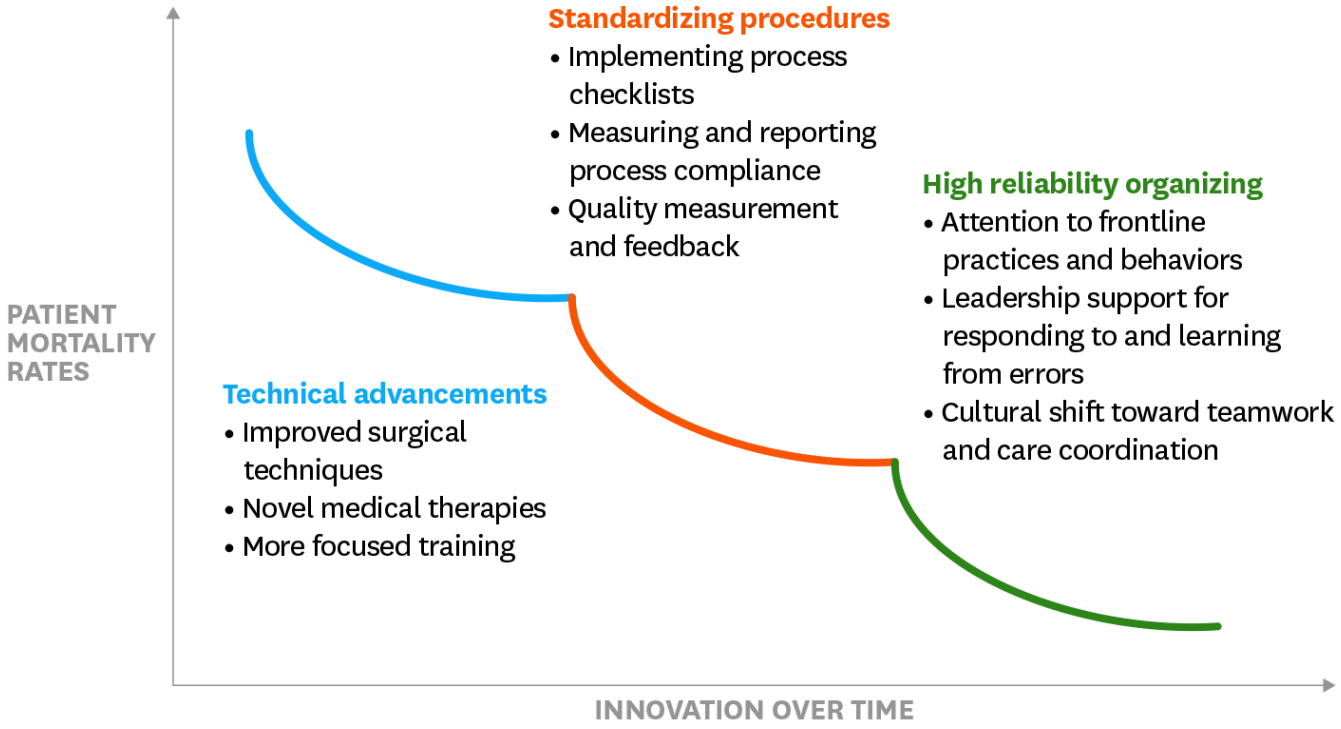
  Now used Australia NZ Canada Europe

" …the vehicle through which patient centred, integrated health service delivery and continuous improvement occur. It is a melding of administrative and clinical elements, providing a framework within the organisation for clinical accountability. It speaks to how clinical services should be led and organised. It clearly defines the roles and responsibilities of clinical leaders and their accountabilities and defines the various structures and their roles." Carlow 2010 Healthcare Quarterly

Rescue/ Resilience culture

3 Waves of Innovation in Patient Safety

Technical and procedural improvements have made surgery safer, but future innovation will focus on reliably organizing the work of patient care.



SOURCE AMIR GHAFERI ET AL.

Leeds Teaching pathology IT crash blamed on “human error”

IT failure sees operations postponed amid backlog of 10,000 blood tests

Leeds still working to recover from pathology IT crash

Pathology IT crash in Leeds drags on

Leeds pathology IT crash into third week without resolution

Human error and ageing infrastructure is being blamed for a protracted IT pathology crash at one of Europe’s largest teaching trusts pathology IT crash.

Leeds Teaching Hospital NHS Trust has published an independent review of a major pathology outage at September last year. The crash caused the postponement of 143 non-urgent procedures, disrupted regional blood services, and knocked out part of the electronic microbiology systems for more than two months.

The review, commissioned by the trust, found the “cause of the failure was a mixture of hardware/technical failure and human error”.

It described the pathology IT system as “old, difficult to maintain and is probably in need of replacement”.

RCPAQAP
The Royal College of Pathologists of Australasia
Quality Assurance Programs

A KIMMS survey on high risk results handover

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Notification Time

Only 119 of the 333 results had the time taken to notify the referrer recorded. As this is likely to be the major KPI for notification of HR results, this is a poor outcome. It is unknown whether this information is not kept or is too difficult to extract from laboratory's LIS.

Discussion

As expected, most HR results are from inpatients and emergency departments, however a significant number come from non-hospital situations (43%). A third of respondents still find communication of HR results a problem, and a third do not see this issue as a "a clinical transfer". There is no common practice of when a pathologist should be called into an escalation procedure, and in many cases they are not involved. More than a quarter of laboratories rely on staff to recognize a HR result i.e. with no input from the LIS system.

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SA Pathology clarifies prostate tests

South Australian pathology is contacting local doctors to clarify some recent results from prostate cancer screening after two different test kits were used.