November 8, 2012 **NEWS RELEASE**

HQCA review results in recommendations for health system improvements in the practice of anatomical pathology

Calgary – The Health Quality Council of Alberta (HQCA) has released its independent review of events that occurred in anatomical pathology in Calgary in 2010 and 2011, and in Edmonton in 2011.

The Calgary events that were reviewed concerned problems in the preparation of 31 tissue specimens at the Calgary Laboratory Services Diagnostic and Scientific Centre (CLS DSC) and Rockyview General Hospital (RGH).

The Edmonton events that were reviewed concerned the misinterpretation of 159 prostate tissue samples by a locum (temporary) pathologist at the Royal Alexandra Hospital (RAH).

The HQCA's review took a systemic view of the events, meaning that all findings and recommendations in its final report are related to system-level improvements associated with the practice of anatomical pathology in Alberta. The HQCA conducted the review at the request of Alberta Health Services (AHS) and based on concerns raised by the Minister of Health regarding assurance of medical quality in anatomical pathology. Following immediate corrective actions taken, AHS wished to determine if any further steps were required to reduce the likelihood of similar events occurring in the future.

"Our report presents findings and recommendations along with required actions that provide clear directions on how to provide a higher standard of assurance of quality in anatomical pathology," said Dr. John Cowell, chief executive officer of the HQCA. "Based on our analysis of the issues we identified in this in-depth review, we believe Albertans will receive improved quality of care should the recommendations from our report be implemented."

"Albertans should have confidence in the work our pathologists do each day. Our processes are comprehensive and thorough," said Dr. Verna Yiu, executive vice president and chief medical officer, Quality and Medical Affairs, Alberta Health Services. "That said, we take this issue very seriously and we have already started work on implementing the recommendations made in this review.

"Any changes that can improve patient safety will be made. That is why we asked for this review – to identify any problems, and fix them."

This review was carried out by an appointed quality assurance committee of the HQCA and in accordance with Section 14 of the *Health Quality Council of Alberta Regulation 130/2006*.

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The HQCA identified the following issues, and has recommendations with required actions for each:

1. Automated tissue processing machines – The automated tissue processing machines at the Calgary Laboratory Services Diagnostic and Scientific Centre (CLS DSC) and Rockyview General Hospital (RGH) anatomical pathology (AP) laboratories are not optimally designed to avoid errors.

Recommendation: Alberta Health Services apply 'human factors' science to further mitigate usability issues associated with the use of AP automated tissue processing machines.

Required actions:

- Undertake a formal human factors evaluation of the automated tissue processors at the CLS DSC and RGH and other automated tissue processors throughout the province, including those of contracted laboratory service providers, and implement the required recommendations. These recommendations should, where possible, incorporate forcing functions, if re-engineering of the tissue processing machines cannot be undertaken.
- Set human factors standards for future purchasing of tissue processing liquids and automated tissue processing machines.
- In the long-term, advocate with the manufacturers for redesign of the automated tissue processing machines and tissue processing liquids (e.g., formalin and alcohol) to improve usability and lessen the probability of human error.

2. Calgary Laboratory Services (CLS) organizational structure – There continues to be lack of clarity related to CLS as a wholly owned subsidiary of AHS and the obligations of both organizations in that relationship. Recent changes in the CLS board structure and in the reporting relationship for the CLS Chief Operating Officer (COO) to AHS have caused more uncertainty for CLS.

Recommendation: Alberta Health Services undertake an organizational review of all aspects of CLS to provide clear reporting and accountability structures within CLS and between AHS and CLS.

Required actions:

- The organizational review include CLS governance; organizational structure; the leadership/executive requirements; reporting relationships, accountabilities, and authority; and the alignment of goals/priorities, funding/budget, communication channels, and human resources with those of AHS.
- Provide educational and mentoring support to individuals (both medical and non-medical) in leadership roles in CLS and in AHS Laboratory Services. This support should be aimed at helping individuals determine if they wish to remain in leadership roles and, if so, to enhance the knowledge, skills, and experience with various aspects of leadership, including setting priorities, responding to crises, and conflict resolution.

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3. Centralization of AP services in CLS – the decision to centralize AP services in CLS remains unresolved.

Recommendation: Alberta Health Services determine if centralization of all AP services in CLS should proceed from the perspective of patient care, the clinicians using the service, and the larger AHS AP laboratory strategy.

Required actions:

- Consider undertaking an operational review to examine service delivery models, type and volume of work, workload, current and future space and ventilation requirements, and equipment utilization for AP tissue processing and interpretation to assist in determining if centralization should proceed. The operational review would include effective staff and clinician engagement and communication strategies.

4. Disclosure of harm – The disclosure process following the events that occurred at the CLS DSC, RGH, and Royal Alexandra Hospital (RAH) was inconsistent and did not appear to follow a specific organizational model.

Recommendation: Alberta Health Services ensure Laboratory Services staff and clinicians follow AHS disclosure policies and procedures.

Required actions:

- Leadership and physicians in AHS Laboratory Services (including CLS) receive disclosure training, and evaluation of future episodes of disclosure is undertaken to ensure consistency with AHS guidelines.

5. Process for recruitment of locum pathologists – A thorough process for the hiring of the locum pathologist to fill a temporary vacant position at the Royal Alexandra Hospital (RAH) was absent.

Recommendation: Alberta Health Services improve the process for the hiring of locum pathologists.

Required actions:

- Develop a comprehensive approach to the granting of privileges, which should include checking the working background of the individual and the amount and type of work completed in a predetermined period.
- Develop and apply a systematic approach to the orientation/induction period of all newly hired pathologists, which would include review by another pathologist of all tissue specimen interpretations for a period sufficient to ensure that all types of tissues and an appropriate number of specimens are reviewed.

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6. College of Physicians & Surgeons of Alberta (CPSA) accreditation – The current accreditation processes for AHS-owned, -operated, or -contracted medical diagnostic laboratories lacks sufficient separation between the organization conducting the accreditation and the laboratory being accredited.

Recommendation: The CPSA, AHS and Alberta Health collaborate to implement an accreditation process for public medical diagnostic laboratories that mitigates the potential for conflict of interest.

Required actions:

- Alberta Health assume responsibility for the signing and funding of the contract for accreditation of public diagnostic medical laboratories with the CPSA.
- The CPSA, as part of the accreditation contract and in addition to the external pathologist consultant, use assessors from other provinces and ensure that no assessor reviews a laboratory twice in succession.

7. Performance/assurance of competence of pathologists – The processes that support the regulation and assessment of the performance of individual pathologists that are conducted by the CPSA and AHS, respectively, need to be more closely integrated to fully support performance management and the assurance of competence of pathologists.

Recommendation: The College of Physicians & Surgeons of Alberta and Alberta Health Services create and implement a coordinated approach to assessing pathologists' competence and performance.

Required actions:

- A provincial working group with representation from the CPSA, AHS leadership, and pathologists be tasked with the creation of a coordinated approach to the performance/assurance of competence of individual pathologists.

The full report is available at www.hqca.ca.

The Health Quality Council of Alberta gathers and analyzes information and collaborates with Alberta Health, Alberta Health Services, health professions, academia and other stakeholders to translate that knowledge into practical improvements to health service quality and patient safety in the health care system.

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