Practical tips for CQI in cellular pathology

Dr Cate Wight

Histopathologist Dr Cate Wight offers some practical tips for quality improvement, learnt from her experience of what has worked well and not so well.

Not every idea here will work in every laboratory – the context and history of how a lab has got to the stage it is at will heavily influence your efforts at continuous quality improvement (CQI).

Try to discern the culture – particularly the level of uncertainty avoidance or risk aversion – as this will determine how much and how quickly change can be adopted and implemented. Depending on the current culture of the team, department and organisation, you may need to initially work on developing an effective workplace culture and to foster the cultural conditions that support quality improvement efforts , such as openness.

With that said, here are some practical tips for making CQI in cellular pathology.

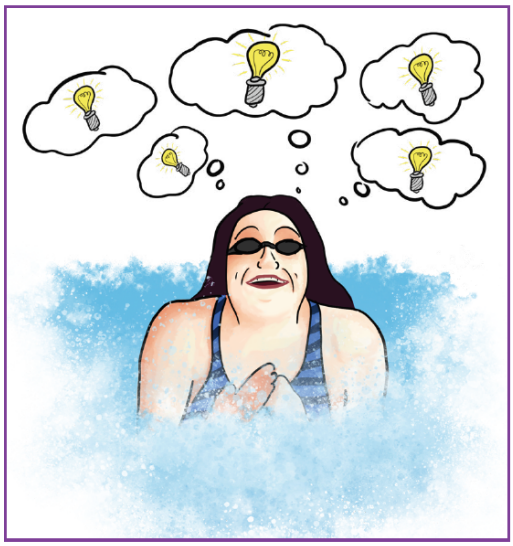
Make sure you have some headspace to think. I've had some of my best ideas while swimming!

Be dissatisfied with the status quo. Get into the mindset of CQI.

Ask questions. Is each task necessary? Is it the best way of doing it? Does it add to the quality of patient management? Is the right person doing the task?

Aim for small incremental change and plan steps. Don't try to do everything at once, even if you're under a lot of pressure to turn things around. I've tried that and it's not good for you or those around you.

Listen to everyone's ideas – communicate within and beyond the laboratory. Consider having huddles for different groups in the laboratory. If multisite, negotiate optimal transport times and let users know the sample pick up times. Ask users what you could do better to help them care for patients. Demand accurate clinical details and demographics, including who has sent the sample, from where and the time of collection (for biopsies to allow rapid processing). For example, by engaging with clinical staff, we reduced the amount of time that a member of staff spent sorting out essential demographics and sample labelling discrepancies from 165 hours to 70 hours a year.



Ensuring you have headspace to think is important when developing new ideas. Illustration by Harry Pearson.

Use support staff to their greatest effect. Have scientists only doing what can't be done by a support grade staff and have medically qualified staff only doing what can't be done by support grade staff and scientists.

Expand advanced practitioners in dissection, reporting and non-gynaecological cytology. Advanced practitioner dissectors release consultants from cut up duties and enable them to spend more time reporting.

Ensure accurate information is available. Component turnaround time data are essential to know where the bottlenecks are and allow you to focus your improvement efforts appropriately.

Look for duplication of steps and rationalise. For example, the duplicated step of stamping the date and time on the request card in specimen reception when it is already on the bar-coded labels.

Minimise reworking. For example, focus on the quality of sections, as having to request full face sections when reporting is costlier in time and money than spending slightly longer getting it right on the first occasion. It is also potentially a patient safety issue due to loss of tissue, while it also increases the levels of frustration experienced by consultants when reporting.

Have a clean and tidy workplace. Ensure all necessary equipment is in the optimal position. Consider using tape to mark out the position of equipment. Use signed equipment checklists. For example, have a checklist of the equipment required in cut up and have the support grade staff member ensure everything is present before calling the dissector.

Use colour coding and other visual management techniques, such as coloured trays for slides in consultant offices with IN, OUT and PENDING, so it is clear which cases can be removed for

filing and multidisciplinary team (MDT) meeting preparation.

Use technology. For example, tracking systems and bar coding to ensure 'chain of custody' of the specimen from arrival in the laboratory. Have scanners in consultant offices to scan in the specimen number from the slide – this is quicker than typing and eliminates the risk of transcription error.

Avoid excessive checking and rechecking. Beware of confirmation bias if you recheck. For example, I have seen a system that in certain subspecialties equated to double consultant reporting of resections before authorisation. This resulted in increased reporting load on consultants and increased turnaround times without good evidence of its superior quality to individual reporting and MDT meeting review.

Consider if something is really necessary. Ask yourself if a test or additional tests such as immunohistochemistry are really necessary? Could it confuse further? Is it what the clinician needs to manage the patient?

Ask users to take patients off the cancer pathway at the earliest opportunity, to enable appropriate prioritisation if used. For example, endoscopy patients need to be taken off the pathway at the time of a normal endoscopy and not after the normal biopsy is reported as an urgent case.

Are paper copy reports required? If still required, is it a good use of secretarial time to check the specimen card against the paper report? What is the evidence?

Work to clinical priority and date order. But think about reporting smaller cases first, which is more efficient overall.

Share good ideas. Don't just develop them alone, unless only applicable to the individual. Negotiate with colleagues and share ideas with the team, department or organisation, so a common standardised solution is developed instead of using effort to create multiple individual solutions. By doing this it is possible to use the effort that would have been expended in developing multiple solutions to further improve the shared solution.

Consider reporting clinics, with consultants 'pulling' work rather than it being pre-allocated or having support staff deliver and collect work from consultants' offices.

Finally, **reflect and learn** from what didn't go well, as well as what did.

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Reflections on the College's CQI mentoring scheme

We hear from Dr Emma Wiley and Dr Frances Davies about their experiences of the scheme as mentee and mentor, respectively.

Dr Emma Wiley

Part one: my experience of being a CQI mentee

Why I participated in the scheme

I was undertaking a year-long Healthcare Infection Society (HIS) fellowship at University College London Hospitals (UCLH). I had already designed a stewardship research project, begun an *Escherichia coli* (*E. coli*) quality improvement (QI) project and was keen to increase my experience of designing and delivering an audit from scratch. UCLH is unusual in that we still use short-course cephalosporins and quinolones on our formulary and in our day-to-day microbiology advice to teams. We decided to audit the prescribing of the 4C antibiotics (cephalosporins, ciprofloxacin, clindamycin and co-amoxiclav) following a positive *Clostridium difficile* (*C. difficile*) result and resulting outcomes, using the Department of Health and Social Care's *How to Deal with the Problem* guidelines as an audit standard.

I already had a fellowship supervisor, who provided global strategic advice and was working in collaboration with our clinical lead for *C. difficile* and our infection control team. However, without the help of a project-specific mentor to nudge things along I was concerned the project might move less quickly. When I saw the email advertising the scheme, I was keen to apply. I wanted to work with someone with expertise in audit and awareness of its pitfalls, in order to ensure high quality methodology and avoid all the classic landmines. The opportunity to be nagged at regular planned intervals was also a plus!