FNQH Pathology Reporting Errors Protocol [INTERNAL] V1.0

INTERNAL

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About This Document

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REPORTING ERRORS

Standard Operating Procedure (Protocol)

INTERNAL

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About This Document

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26/06/22	V0.1	Sarah Sharpe	Initial Draft
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03/07/22	V0.3	Sarah Sharpe	Review and accepted edits
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Contents

1. Introduction, Purpose Scope & Users

This document is intended to document the Standard Operating Procedures (protocol) at FNQH Pathology for reporting errors and details the processes, steps, and detailed instructions so that the relevant (authorised) team member can carry out the task correctly every time.

2. DEFINITIONS

Supplementary Reports: These include instances where further information or refinement of diagnosis or further ancillary test results are expected at the time of issuing of the original report and the fact that such information will be available in future is mentioned in the body of the original report on the case. Thus any person reading the original report knows to expect another report (“supplementary report”) to exist or expect it to be created in time.

Amended Reports: These include instances where “significant” information in the original report is deemed to be incorrect (in error) and which is identified at a date later than issuing of the original report. Such incorrect information may relate to patient demographics, specimen details or significant alteration of diagnosis or important prognostic parameters.

In respect of Supplementary Reports:

1. The subsequent report issued should be titled SUPPLEMENTARY REPORT.

2. Such title be added to the original report at the top of the 1st page of the report.

3. The original report be altered in no way.

3. The additional information be added to an appropriate location of the report with other relevant details such as date, time, and reason for addition.

2. The report should be authorized as per the usual protocols.

In respect of Amended Reports:

1. The subsequent report be titled AMENDED REPORT

2. Such title be added to the template of the original report at the top of the 1st page of the report with any other relevant details such as date and time of addition and reason for the amendment or the addition as is deemed prudent;

3. The additional information be added in detail in an appropriate location of the report so as to ensure that all aspects of the additional information be readily apparent to the recipients (for example bolded or italicized)

4. The original report be altered in no way with the additional and/or altered information or assessment be an addition without altering the previous report;

5. Any known additional clinicians or locations involved in the management of the patient since the original report was transmitted be added to the distribution list of the amended report as is deemed prudent;

6. In addition the relevant amended information should be verbally transmitted to the clinician primarily involved in the current management of the patient or to multiple clinicians where a definite primary clinician cannot be identified to make the clinicians aware of the existence of the amended report.

3. REFERENCES

https://www.rcpa.edu.au/getattachment/51f90738-97a2-415c-a21c-f264f15362c6/Supplementary-Amended-Reports-Anatomical-Pathology.aspx

4. NOTES

When a report is issued in Anatomical Pathology the clinicians may access the information in one of three ways:

1. Electronically

2. Printed paper copy

3. Orally from the Pathologist

In case of a supplementary report further information is expected to be relayed at a later date and this would be taken in to consideration when management decisions are made for the patient. In case of amended reports there is an unexpected correction of the error in the information contained in the original reports – this correction requires to be communicated by all of the three ways mentioned above. It is possible that in the meantime management decisions may have been made on the basis of “erroneous information contained in the original report” hence for medicolegal purposes the content of the original report should not be altered in any way except by way of addition that details the additional information or the error correction clearly.

5. Managing Records kept on the basis of this document

All records supporting this policy shall be kept in the FNQH Pathology document management system

in the location, or system based, indicated in the procedure document. Any additional or deleted records shall be kept account of in the FNQH Pathology logging system so that any future enquiry will be able to clearly identify when the changes occurred, who made them, what these changes were and how they were were approved.

6. Validity and Document Management

This document is valid from the date of its approval and will be reviewed on an annual basis. The current working copy will be identified as such, and any superseded documents will be archived and maintained for a period of five years.

New versions will be identified with a versioning number. Full integers will denote a major document version, and a decimal number will indicate minor amendments or edits.