OFFICE ADMINISTRATION PROCEDURES

SCOPE AND PURPOSE

This document describes the procedure for all office administration. This procedure is operable throughout the Cervical Cytology EQA Scheme.

RESPONSIBILITY

The Interpretive Assessment organiser is responsible for the preparation, implementation and maintenance of this procedure. The medical lead is responsible for the authorisation of this procedure.

APPLICABILITY

All Cervical Cytology EQA Scheme Personnel

RELATED DOCUMENTS

- GNSF001 Laboratory registration
- GNSL001 Code notification letter
- IASL019 Complaints letter

The undersigned have read and understood the following procedure

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1 LABORATORY REGISTRATION

Annually, the organiser sends a registration form to all participating laboratories. [GNSF001] This provides the scheme with confirmation of each laboratory’s participation in the scheme and accurate contact details. All laboratory lead consultants are required to nominate a fellow consultant who will receive a copy of the lead consultant’s results in the event of two substandard performances out of three circulations. The nominated colleague must be a participant in the EQA scheme for cervical cytology. All laboratories will nominate a member of staff from the laboratory who will assist the organiser in administering the EQA Interpretive Assessment. He/she is referred to as the laboratory coordinator (LC).

2 CHANGES IN A PARTICIPANT’S STATUS

2.1 Trainee screeners/trainee pathologists
The first time that a participant sits the IA after qualifying as a cytoscreener / BMS and reporting cervical cytology independently, the scheme organiser issues he/she with a unique code number which will be the number that the participant is identified by in this and future assessments. The participant is informed of their code by letter. [GNSL001] It is the individual’s responsibility to keep the code number safe and to check all response sheets are coded correctly.

2.2 Promotion
Screeners promoted to checkers keep the same code as previously issued. A checker that becomes an advanced practitioner is issued with a new code number.

2.3 Changing laboratory/retirement.
It is the responsibility of laboratory lead consultant in each laboratory to inform the organiser when participants move laboratories or retire. Before each EQA round, the organiser confirms the list of participants’ names with the LC.

3 PARTICIPATION CERTIFICATES

- Annually, laboratories are issued with a certificate confirming participation in the components of the scheme for the current year.
- When final results are issued individual participants’ certificates of participation will be issued by the organiser in order for the individual to maintain a record of this CPD activity.

4 SCHEME REPORTS

- The annual NSD report is due at the end of May each year and it is the responsibility of the organiser and medical lead to provide a report following the NSD template.
- A midyear report for NSD is submitted each October.
- An annual report for NQAAP is submitted each October.
5 PRESENTATION TO PARTICIPANTS

The organiser and medical lead will present final results/questionnaire responses and any scheme changes at the November meeting of the Scottish Association for Clinical Cytology.

6 AUDIT- QUALITY IMPROVEMENT

The organiser and medical lead undertake regular audit and review of the scheme. Service review and development are requirements of the service level agreement with NSD and are outlined in the annual report to NSD.

7 REVIEW AND UPDATE OF SOP’s AND MANUAL

The organiser and medical lead will update/amend sop’s and the guidance manual as required with formal revision of these every three years. Any changes are discussed and approved by the Laboratory QA group.

8 STORAGE & BACKUP

All work is backed up on the H drive on Tayside IT system at the close of the working day. Computers used for the administration of the scheme comply with NHS security policy and access is password protected.

9 COMPLAINTS

All comments, incidents or complaints from individuals or laboratories regarding the administration or marking of the scheme must be addressed in writing either to the organiser or the medical lead. The medical lead and organiser will consider the complaint and an acknowledgement and initial written response will be issued within fourteen days. The Laboratory QA group will consider each complaint formally at its next meeting and a final response will be given thereafter. A record of all complaints together with the subsequent actions will be maintained by the medical lead. [IASF019]

10 RESPONSIBILITY AND ACCOUNTABILITY

Individual roles and responsibilities and the accountability structure are outlined in the Guidance Manual. A service level agreement will be drawn up by NSD between NSD and the scheme providers, specifying the requirements of the service and duration of the agreement. Once the medical lead and organiser are satisfied that they are able to deliver the service as specified, this should be signed off by the Chief Executive of the hosting Health Board.
11 DOCUMENTATION AUDIT

AMENDMENT TABLE

<table>
<thead>
<tr>
<th>No</th>
<th>Date</th>
<th>Page</th>
<th>Amendment</th>
<th>Authorised By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The amendment must be authorised by the document authoriser, scheme organiser or medical lead
- The amendment must be underlined and an asterisk (*) written in the margin alongside the change - use 'Track Changes - Highlight Changes' option if changing electronic version.
- Ten or less minor amendments can be made before the procedure is revised
- Major changes must result in the immediate review of the procedure