

Supervision Policy

NSWHP_PD_019

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1. Purpose

The purpose of this Policy is to provide an organisational framework for the supervision of laboratories in NSW Health Pathology (NSWHP). This document is intended to provide consistent interpretation, understanding, practical application and recording of meaningful supervision activities at or above minimum requirements.

To ensure best practice in pathology and optimise patient safety, clinical governance and supervisory structures are embedded within NSWHP's operations. This Policy describes the supervision governance structures and the roles and responsibilities of all staff involved in supervision activities.

This Policy must be read in conjunction with the National Pathology Accreditation Advisory Council (NPAAC) Tier 2 document [Requirements for Medical Pathology Services \(Third Edition 2018\)](#) and NPAAC Tier 3A document [Requirements for Supervision in the Clinical Governance of Medical Pathology Laboratories \(Seventh Edition 2023\)](#).

2. Background

Laboratory supervision is critical to the maintenance of clinical governance standards. Accreditation of laboratories requires demonstrated adherence to NPAAC requirements which describe the minimum requirements for supervision and the responsibilities of supervising pathologists, clinical scientists, and other supervisory staff.

All laboratories are required to adhere to the mandatory NPAAC [Requirements for Supervision in the Clinical Governance of Medical Pathology Laboratories \(Seventh Edition 2023\)](#),

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3. Abbreviations

NSWHP:	NSW Health Pathology
LPD:	Local Pathology Director
SOM	Senior Operations Manager
FTE:	Full Time Equivalent
NATA:	National Association of Testing Authorities, Australia
NPAAC:	National Pathology Accreditation Advisory Council
QAP:	Quality Assurance Program
RCPA:	Royal College of Pathologists of Australasia
RMPS:	Requirements for Medical Pathology Services
QMIS:	Quality Management Information System

4. Definitions

Clinical Governance: Means a systematic and integrated approach to assurance and review of clinical responsibility and accountability that continually improves quality and safety of services provided to patients resulting in optimal patient outcomes. Clinical governance extends across the boundaries of functions and organisations delivering services along the whole patient care path. Interfaces in, or split responsibility for, delivering patient care are considered points of increased risk.

Clinical Scientist: Means a person with the training and competence to perform the functions required, who has at least 5 years relevant medical laboratory experience and who is responsible for supervising a laboratory and possesses one or more of the following qualifications by examination:

- (a) a Fellowship of the Australasian Association of Clinical Biochemists
- (b) a Fellowship of the Australian Institute of Medical Scientists
- (c) A Fellowship of the Australian Society for Microbiology (medical microbiology or clinical microbiology)
- (d) a Fellowship of the Human Genetics Society of Australasia (biochemical genetics, cytogenetics or molecular genetics)
- (e) a Fellowship of the Faculty of Science of the Royal College of Pathologists of Australasia
- (f) a Fellowship of the Australian Society of Cytology. Or

A Doctorate of Philosophy, Australian Qualifications Framework level 10*1 or equivalent doctoral level degree, in a subject relevant to the scope of diagnostic testing of the laboratory they are supervising. Or For ART laboratories, the Clinical Scientist must meet the criteria in the RTAC code of practice for scientific directors. Or

For Bone Marrow Transplant laboratories, the Clinical Scientists must meet the requirements of the Bone Marrow Transplant Scientists Association of Australasia (BMTSAA).

Designated Person: Means a registered medical practitioner with appropriate qualifications, competence and relevant Scope of Practice who has overall Clinical Governance responsibility for a category GX

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laboratory and associated category GY and B laboratories. The Designated Person must be a Pathologist who works full time at a category GX laboratory.

Associate Director of Clinical Operations: Means a member of NSWHP senior staff responsible for clinical governance and supervision at the operational area level.

Chief Pathologist: The most senior Pathologist in NSWHP. Provides oversight to the Clinical Governance Framework and the Local Pathology Directors.

On-site Manager of a Category B laboratory: Means a Scientist with appropriate qualifications and a minimum of two (2) FTE years relevant experience in the testing performed in the laboratory under their supervision. The onsite manager is delegated to oversee the Category B laboratory by the Designated Person at the Category GX laboratory.

Local Pathology Director (LPD): Means a Senior Pathologist within a NSWHP Local Pathology Team organisational structure with delegated responsibility for clinical governance and to ensure that supervision requirements are being adhered to at the sites where they have responsibility. A LPD based at a Category GX laboratory acts as the Designated Person for that Category GX laboratory and the Category GY and B laboratories related to that Category GX laboratory.

Normal Working Hours: Means the hours during which the laboratory is operating and during which supervision needs to be provided on-site. It should be noted that access to pathologists for consultations may need to be provided outside of normal working hours.

Quality Manager: Means a member of staff appointed with delegated authority to ensure that processes required for the Quality Management System (QMS) are established, implemented and maintained.

Risk Assessment: Means a process to enable decision makers to document, grade and manage barriers to meeting operational and strategic objectives and evaluate the adequacy of controls already in place.

Risk Management Plan: The Risk Management Plan describes the risk management response to ensure risks are being managed and controlled at acceptable levels.

Senior Operations Manager (SOM): Member of NSWHP senior staff responsible for operational management of one or more laboratories.

Supervising Pathologist: Means a pathologist with a relevant scope of practice who has been delegated supervision responsibilities by the Designated Person.

5. Policy Statement

All laboratories must adhere to the [Requirements for Supervision in the Clinical Governance of Medical Pathology Laboratories \(Seventh Edition 2023\)](#) published by NPAAC. This Policy builds on the minimum

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regulatory requirements for laboratory supervision and provides a clear standard for how supervisory responsibilities should be discharged and recorded within NSWHP.

This Policy provides NSWHP's interpretation of the NPAAC requirements and how supervision must be addressed within NSWHP. In circumstances where the appropriateness of the supervision activity or the method for determining supervision is unclear, the Associate Director Clinical Governance (Quality), or local Clinical Governance team should be consulted.

The **Clinical Governance framework** ensures that appropriate procedures are in place to ensure that standards are in place for a laboratory or group of laboratories. This Supervision Policy is a key plank in the Clinical Governance Framework

6. Supervision Activities and Accountability

For further clarification of supervision activities please refer to Section 17.

6.1. Supervision Accountability Matrix

A balance of activities covering the items in the matrix below should be attained over time.

Activity	Designated Person, LPD, Supervising Pathologists, Clinical Scientists or Scientists	Quality Manager	Directors of Clinical Operations, Senior Operations Managers	On-site Manager of Cat B Laboratory (Laboratory Manager)
Accommodation review	✓		✓	✓
Action review	✓		✓	✓
Continuing education	✓	✓	✓	✓
Customer liaison	✓		✓	✓
Equipment / methods review	?		?	?
Incident/complaint management	✓	✓	✓	✓
Internal audit	✓	✓		✓
Management meeting	✓	✓	✓	✓
Performance review	✓		✓	✓
QC / QAP review	✓			✓
Risk management plan review	✓	✓	✓	✓
Staff meeting	✓		✓	✓
Training/competency assessment	✓		✓	✓
Troubleshooting	?		?	?
Workforce	✓		✓	✓

Most of these activities require on-site attendance at Category GY or B laboratories by the Supervising Pathologist or delegate (Clinical Scientist) or Quality of Manager within their Scope of Practice. Tele/videoconference is acceptable for educational meetings and management meetings. Visits of the

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Category GY or B Laboratory Manager to the GX laboratory for the above purposes also count as supervision activities.

6.2. NSWHP Exclusion of Supervision Activities

Activities that are not supervision activities for the purpose of NPAAC supervision compliance include:

- a) Finance meetings
- b) Social occasions or events
- c) Staff Specialist clinics or clinical activities
- d) Travel time.

7. NSWHP Documentation of Supervision Activities

The following section provides a framework and a NSWHP organisational standard for meaningful supervision.

7.1. Agenda Items and Minutes

Staff meetings counted towards supervision activities must include agenda items relevant to supervision. Minutes must document the supervisor(s) in attendance. Documentation of agendas and minutes support supervisory visit records. Relevant agenda items include:

- a) Laboratory process issues and corrective actions
- b) Review of incidents and complaints
- c) Review and update of the risk register/risk management plan
- d) Quality control and assurance review
- e) Review of patient safety records
- f) Upcoming supervisory visits, reciprocal visits and review of compliance with required supervisory visit needs
- g) Educational activities.

7.2. Records of Delegation

Delegation of Supervision Form - NSWHP F 072 is to be completed when a Designated Person grants delegation of supervisory responsibility. Completed forms are submitted to the Clinical Governance Team.

7.3. Register of Supervisors

Completed Delegation of Supervision Form - NSWHP F 072 are used to populate a central Register of Supervisors and retained as evidence of delegations granted and accepted.

7.4. Senior Medical Officer Leave

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When a Supervising Pathologist has to take unplanned leave the supervisory responsibility automatically transfers to the deputy named in the Register of Supervisors.

For periods of planned leave the Pathologist with supervisory responsibilities must submit a leave form to the Local Pathology Director for approval. The Local Pathology Director must ensure that the named deputy is available to cover the period of leave. If not, then the Local Pathology Director must ensure alternative cover by an agreeable Pathologist with the relevant scope of practice.

The Local Pathology Director must notify the Clinical Governance Team, Chief Pathologist, Senior Operations Manager and Laboratory Manager of all laboratories affected by the temporary change in supervision arrangements. Delegation of Supervision Form - NSWHP F 072 must be completed if the relieving Pathologist does not yet have supervision delegation recorded.

7.5. Accountability Structures

Details of supervision arrangements, including the names and contact numbers of supervisors, and tools and templates related to supervision activities must be easily accessible within each laboratory.

An extract from the Register of Supervisors detailing current supervision arrangements and deputies must be displayed and be clearly visible to staff in each laboratory.

7.6. Risk Assessment

The Designated Person is responsible for ensuring that a risk assessment is completed and documented. The Designated Person also oversees the assessment and the management of laboratory risk, related to supervision and clinical governance.

Each category GX laboratory is required to have a risk management plan as part of their Quality System detailing risks related to the services they provide, and the services provided by the laboratories they supervise. These plans must document major patient safety risks including adverse incidents to patients generated by failures in request-test-report cycle the strategies proposed to mitigate those risks and the implementation status of each mitigation strategy.

The risk management plan must be monitored regularly and supported by compliance and reporting processes so that any material breach, non-compliance or failure of operations is notified to the Designated Person or Local Pathology Director.

Risks will be continuously monitored and reviewed to ensure:

- a) Changing circumstances do not alter risk priorities
- b) That risk management plans are appropriate and risk control processes are effective
- c) The overall risk management approach remains relevant and
- d) The resources invested in the risk management strategy are commensurate with the level of return for the organisation.

The risk assessment and risk management plan are to be recorded in the electronic statewide risk register for monitoring and reporting purposes.

7.7. Supervision Activity Record – Laboratories Supervised by a G Laboratory

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Supervision activities are required to be documented as supporting evidence that an activity has taken place. This documentation should address the following:

- a) Name and position undertaking supervision activity
- b) Specialty/scope of practice
- c) Date and time spent undertaking supervision
- d) Details of nature and findings of supervision activity
- e) Any corrective and preventative actions requiring follow-up should also be recorded in the Quality System as a non-conformance or opportunity for improvement.

Where the supervisory activity is a meeting (e.g. a Laboratory Manager's meeting, Operations Meeting or a PSQS Meeting) minutes incorporating the above items can be used to substantiate supervisory activity.

Supervisory visits by the Designated Person / Designated Person Delegate need to be recorded in the following document: Supervisory Visit Record – NSWHP F 034. Once complete, the form is to be forwarded to the on-site Laboratory Manager of the supervised laboratory for retention as a quality record.

A guide to completing Designated Person / Designated Person Delegate supervisory activities is contained in the following document: Pre-Designated Person Visit - NSWHP SD 088

All other supervisory visits to Category B laboratories and Category GY disciplines, for which there is no on-site Pathologist supervision, need to be recorded in the Designated Person visit record – NSWHP F 073. Once complete, the form is to be forwarded to the on-site Laboratory Manager of the supervised laboratory for retention as a quality record.

A guide to completing these supervisory visits is included Person Delegate supervisory activities is contained in the following document: Supervising Pathologist Visit - NSWHP SD 089

Supervisory activity also needs to be logged into the Supervision Compliance Record template NSWHP SD 036 or QMIS (where available) by the on-site Laboratory Manager.

7.8. Summary of Supervision Activity

A centralised Summary of Supervision Activity is held by Clinical Governance to record the current status of each laboratory's compliance with this policy. The QMIS and copies of NSW Health Pathology Supervision Compliance Record NSWHP SD 036 held by each laboratory is used to feed data into the Summary of Supervision Activity on a monthly basis. Details of supervision in any month must be available for Clinical Governance to access by the 7th day of the following month to guarantee inclusion in performance reports.

All records of supervision activities must be readily accessible for inspection and auditing purposes at all times.

7.9. Supervision Record Management

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Documentation relating to supervision must be regularly updated and maintained within each laboratory. It is the responsibility of the Laboratory Manager or on-site supervisor to ensure that accountability structures, risk management plans and record of supervision visits are easily accessible, and staff are aware of all supervision arrangements.

8. Operational Supervisory Requirements

The following operational requirements must be demonstrated to be in place:

- Supervision responsibilities for each area of testing in a Category GX, GY and B laboratory are mapped to a Designated Person via a Pathologist with relevant qualifications, current scope of practice and competency
- Staff with supervision responsibilities be allocated sufficient time to discharge these duties
- Local Pathology Directors and supervisors have implemented systems to monitor and measure quality including QC and QA, the issuing of reports, and patient safety data
- Systems for the communication of issues that require escalation to the Local Pathology Director and/or the Designated Person due to potential adverse clinical impact have been implemented and work effectively
- Systems for the communication and escalation of enquiries or complaints from clinicians or patients that have potential adverse clinical consequences to the Local Pathology Director and/or the Designated Person
- Systems to record the evidence of the effectiveness of clinical governance e.g. nature and timeliness of response to escalated issues.

For further information and clarification of supervision activities please refer to the [Requirements for Supervision in the Clinical Governance of Medical Pathology Laboratories \(Seventh Edition 2023\)](http://www1.health.gov.au/internet/main/Publishing.nsf/Content/health-npaac-docs-supervision.htm)<http://www1.health.gov.au/internet/main/Publishing.nsf/Content/health-npaac-docs-supervision.htm>.

8.1. Supervising Pathologist

Responsibility for supervising a discipline at a GX laboratory may be delegated by the Designated Person, to one or more Pathologists who in aggregate can ensure full time on-site supervision of all testing performed by the laboratory. Supervising Pathologists must only provide supervision within their scope of practice. Supervising Pathologists may further delegate supervision of specific testing to Clinical Scientists and Scientists with the relevant scope of practice.

8.2. Delegation of Supervision Responsibilities

If the supervision of pathology services is not provided by an on-site pathologist at a GY or B laboratory it must be delegated by the Designated Person in consultation with the Local Pathology Director (where relevant) to a Pathologist with relevant scope of practice from another Category B, GY or GX laboratory with access to the supervised laboratory's Information and Quality Systems.

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8.3. On-Site Laboratory Manager of Category B Laboratory

All Category B laboratories must have an on-site manager who is a scientist with appropriate qualifications and a minimum of 2 FTE years relevant experience in the testing performed in the laboratory they are supervising.

The delegated on-site manager must be present at the laboratory during normal working hours. The Register of Supervisors will contain details of a suitable alternate Scientist or Technical Officer who has been delegated to relieve during absences of the on-site manager (see NPAAC Requirements for suitability).

9. Minimum Supervision Activity Time Requirements

Supervision is limited to scope of practice and supervision hours are therefore generally pathology specialty specific ie discipline specific.

The Designated Person will define the minimum contribution of hours required from each testing discipline to make up the aggregate hours of on-site supervision at each Category B laboratory and remotely supervised Category GY discipline. This definition will be based on the assessment of risk, taking into account: -

- the complexity of the tests performed in each discipline
- the number of tests performed in each discipline
- the qualifications and experience of scientific and technical staff in that discipline

The total amount on-site supervision in any given 12-month period shall not be less than 16 hours for a Category B laboratory. The outcome of the risk assessment may indicate that more than 16 hours of on-site supervision is required to adequately manage the risks identified in each discipline.

The minimum discipline contribution for on-site hours are provided to Clinical Governance and retained as minimum quotas in the Summary of Supervision Activity for the purposes of performance reporting.

The minimum supervision time required where:

- Testing is not provided under the full time in aggregate supervision of on-site pathologists and
- Access to the Laboratory Information System and central monitoring of the Quality System and quality control at the laboratory by the supervisors can and does occur, is:

Position	Minimum time in any given 12 months	Modality	Applies to
Designated Person or their Pathologist delegate (Supervising Pathologist)	At least one visit to discharge responsibilities	On-site supervision	Cat B

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Designated Person or their delegate (Supervising pathologist or Scientist)	At least one visit to discharge responsibilities	On-site supervision	Cat B POC
Supervising Pathologists, Clinical Scientists or Scientists	As defined by Designated Person and not less than 16 hours	On-site supervision	Cat B
	As defined by Designated Person	On-site supervision	Remotely supervised Cat GY disciplines
On-site supervisor (Laboratory Manager) Reciprocal visit by On-site supervisor to another laboratory in the same pathology network.	16 hours	Supervised training or professional development at another GX, GY or B laboratory	Cat B
Quality Manager or their delegate	At least one visit to discharge responsibilities	On-site supervision	Cat B
Senior Operations Manager with or without Local Pathology Director	Minimum 12 meetings (at least 1 meeting per month)	On-site, teleconference or videoconference with formal agenda relevant to the management of the Cat. B Laboratory	Cat B

Note: In addition to minimum time requirements for supervision, all supervisory duties related to the testing performed at the laboratory must be discharged.

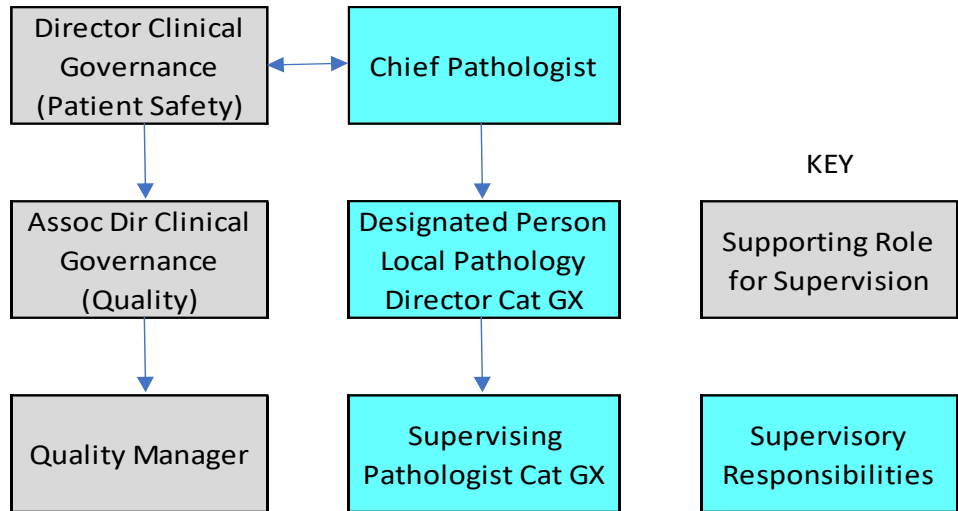
Please refer to Section 17 Supervision Activities and Tasks Table A.

Supervision Governance Structure

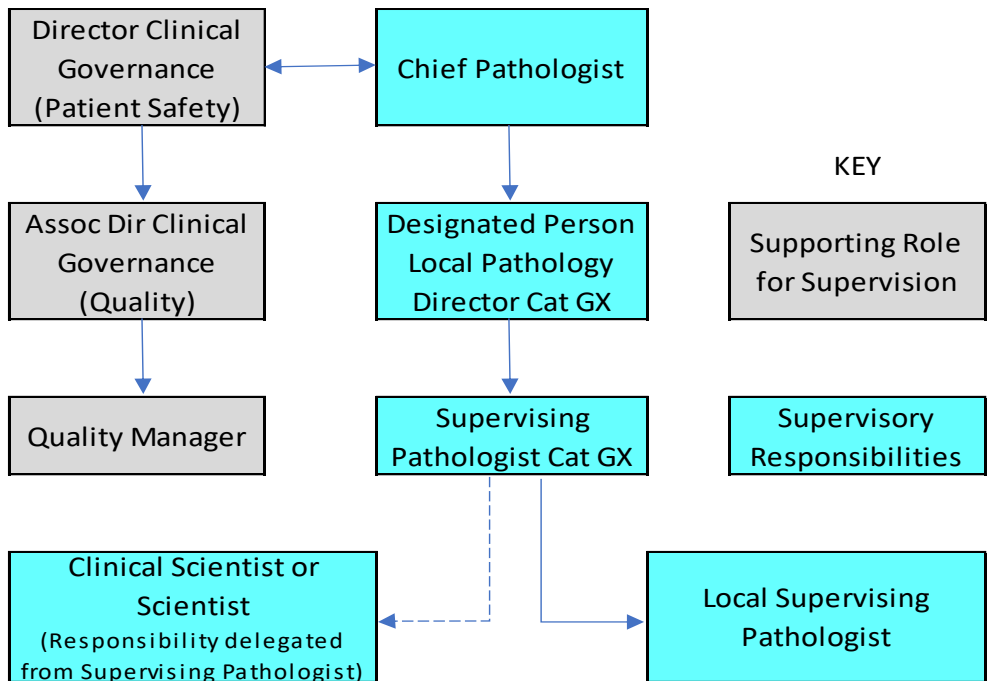
9.1. Supervision Governance Structure at GX Laboratory

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9.2. Supervision Governance Structure at GY and B Laboratories



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10. Roles and Responsibilities

10.1. Director Clinical Governance (Patient Safety) and Associate Director Clinical Governance (Quality)

- a) Provides advice, guidance and support for the management of quality assurance/improvement activities and patient safety initiatives.
- b) Accountable for the standard of meaningful supervision that must be practiced
- c) Sets the vision and standard for meaningful supervision
- d) Provides advice and guidance for interpretation of NPAAC requirements
- e) Monitors consistency of interpretation and delivery of meaningful supervision throughout the organisation
- f) Provides tools and an organisational framework for supervision
- g) Identifies anomalies in compliance and advises on options for corrective action
- h) Reports to the Chief Executive and relevant NSWHP executive committees on the status of compliance with supervision requirements.

10.2. Chief Pathologist

- a) Ensures NPAAC and NSWHP requirements for laboratory supervision are implemented and maintained
- b) Ensures appropriate identification and management of major risks to patient safety across Clinical Operations
- c) Champions and communicates supervision requirements and roles and responsibilities of staff
- d) Ensures appropriate resourcing and operational capabilities for supervision requirements to be met
- e) Monitors compliance to the requirements and addresses shortcomings or deviations to ensure Standards are met
- f) Escalates supervision risks and issues requiring attention.

10.3. Designated Person

As defined in the NPAAC [Requirements for Medical Pathology Services \(Third Edition 2018\)](#) document the Designated Person must have the authority and competence to ensure and take active responsibility for:

- a) Clinical Governance
- b) Policy setting and implementation
- c) Identification and management of risk (noting Appendix A of RMPS)
- d) Ensuring that required arrangements are in place for operating effectively within their region and for escalating risks and issues that require attention

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- e) Implementation and maintenance of the quality management system
- f) Compliance with NPAAC and jurisdictional requirements
- g) Operational practices and staffing including training
- h) Determining the range of tests provided, their methods and procedures while considering that the numbers processed are sufficient to maintain competence
- i) Determining the suitability of referral laboratories
- j) Regular review of the quality management systems, proficiency testing data, reports and all aspects of performance
- k) Provision of medical and scientific consultation
- l) Procedures used and the tests performed being within the scope of the education, training, continuing professional development and experience of individual staff members
- m) Determining work suitable to be performed outside normal working hours and that such work is performed by staff who are qualified, trained and competent to work in the absence of an on-site supervisor
- n) Provision of a clearly defined process for contacting a supervisor who is not currently onsite
- o) Ensuring the ongoing availability and integrity of materials and for providing storage for pathology records in the event of amalgamation or merger of a Medical Pathology Service.
- p) Delivers meaningful supervisory visits for local laboratory staff as outlined in activities listed in the Designated Person visit record – NSWHP F 073, or, where agreed, delegates these visits to the Local Pathology Director

10.4. Local Pathology Director

- a) Operates as the Designated Person if credentialed and resides in a Category GX laboratory as per NPAAC requirements
- b) Ensures local supervisory arrangements are documented, in place and are effective
- c) Delegates supervisory responsibilities in consultation with the Designated Person (where this is a different person) to Pathologists and Clinical Scientists with a relevant scope of practice, ensuring clear documentation of arrangements in an accountability structure that is easily accessible in each laboratory
- d) Ensures interpretation of NPAAC supervision requirements aligns with this Policy
- e) Monitors documentation of supervisory status for Laboratories
- f) Approves Leave for Supervising Pathologists and ensures that backup arrangements are in place and communicated to laboratory
- g) Escalates supervision risks and issues requiring attention

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- h) Makes risk-based decisions about the provision and supervision of tests based on the complexity of the tests performed, the number of tests performed, the qualifications and experience of scientific staff and the level of Pathologist supervision.
- i) Where agreed, acts as a delegate of the Designated Person to perform meaningful supervisory visits for local laboratory staff as outlined in activities listed in the Designated Person visit record – NSWHP F 073

10.5. Supervising Pathologist or Clinical Scientist

- a) Undertakes discipline specific supervisory visits and activities evidenced by supervisory visit records
- b) Discharges the supervision responsibilities as set out in the NPAAC requirements and Supervision Requirements
- c) Documents and maintain records of supervisory visit details and shares information with the on-site laboratory manager (on-site supervisor) for recording keeping of activities into a central register
- d) Delivers meaningful supervisory visits for local laboratory staff as outlined in activities listed in the NSW Health Pathology Supervisory Visit Record NSWHP_F_034.
- e) Provides notification of leave as set out in the relevant Award or Policy to Local Pathology Director with documented backup arrangements for supervisory responsibilities that will be covered by another pathologist with the required scope of practice
- f) Fulfils requirements of all annual site visits and supervision activities as per scope of practice and allocated site responsibility determined by the Designated Person
- g) Escalates supervision risks and issues requiring attention
- h) Refer to the Section 6.1 Supervision Accountability Matrix.

10.6. On-Site Manager of Category B Laboratory (Laboratory Manager)

- a) Prepares and plans reciprocal visits and supervisory visits in conjunction with the Supervising Pathologist and/or Clinical Scientist
- b) Monitors compliance with supervisory requirements against NPAAC standards and NSWHP Policy
- c) Maintains centralised documentation of the laboratory's supervision activities
- d) Responsible for real-time records management of supervision activities in conjunction with Supervising Pathologists, Clinical Scientists and others
- e) Escalates supervision risks and issues requiring attention
- f) Refer to Section 6.1 Supervision Accountability Matrix.

10.7. Senior Operations Manager

- a) Ensures records management practices are in place, easily accessible and up-to-date

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- b) Escalates supervision risks and issues requiring attention
- c) Refer to Section 6.1 Supervision Accountability Matrix.

10.8. Quality Manager

- a) Ensures that Quality System processes are established, implemented and maintained
- b) Provides advice, guidance and support for the management of quality assurance/improvement activities and patient safety initiatives
- c) Refer to Section 6.1 Supervision Accountability Matrix.

11. Legal and Policy Framework

The requirements for supervision are mandated by the National Pathology Accreditation Advisory Council (NPAAC) in the:

- a) [Requirements for Medical Pathology Services \(Third Edition 2018\)](#)
- b) [Requirements for Supervision in the Clinical Governance of Medical Pathology Laboratories \(Fifth Edition 2018\)](#)

Related Legislation

- a) [NPAAC Requirements](#)
- b) [Health Insurance Act 1973](#)
- c) [Health Insurance Regulations 1975](#)

Related Policy Document Suite and Supporting Documents

- a) [NSW Health Risk Management – Enterprise-Wide Risk Management PD2022_023](#)
- b) [NSW Health Pathology Critical Incident Procedure NSWHP PR_021](#)
- c) [NSW Health Pathology Risk Management Procedure NSWHP PR_026](#)
- d) [NSW Health Pathology Supervisory Visit Record NSWHP F_034](#)
- e) [Delegation of Supervision Form - NSWHP F_072](#)
- f) [Designated Person Visit Record - NSWHP F_073](#)
- g) [NSW Health Pathology Supervision Compliance Record NSWHP SD_036](#)
- h) [Pre Designated Person Visit – NSWHP SD_088](#)
- i) [Supervising Pathologist Visit - NSWHP SD_089](#)

12. Review

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Approver: Chief Pathologist, Version Number: V2.0, Publication Date: 12/08/2024
This document is subject to change and a printed copy may not be up to date.
The current version is only available online in the [NSW Health Pathology Policy Library](#)

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This policy will be reviewed by 1 July 2026.

13.Risk

Risk Statement	Supervision of pathology services supports the delivery of quality pathology services, enables management of risks to patient safety and improves patient health outcomes.
Risk Category	Clinical Care and Patient Safety

14.Further Information

For further information, please contact:

Policy Contact Officer	Position: Associate Director Clinical Governance (Quality)
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15.Version History

The approval and amendment history for this document must be listed in the following table.

Version No	Effective Date	Approved By	Approval Date	Policy Author	Risk Rating	Sections Modified
1.0	01/08/19	Chair, Clinical Gov, Quality & Risk Committee	31/07/19	Executive Officer, Clinical Operations	High	New Policy.
2.0	12/08/24	Chief Pathologist	26/07/24	Ass Director Clinical Governance (Quality)	High	3, 4, 6.1, 7, 8, 9, 10, 11, 17

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16. Supervision Activities and Tasks

Table A

Activity	Task
Accommodation review	Documented inspection of the laboratory. May involve issues such as maintenance and repair.
Action review	View the record of the previous supervisory visit for outstanding issues and follow-up. View Corrective Action log and records, assist with resolution, monitor sign-off.
Continuing education	Case study, QAP morphology, journal review, current topics, etc. ensure continuing education register is updated with topic and attendance record.
Customer liaison	Follow through on clinical issues, incidents, complaints and queries. Liaise with hospital management in relation to service requirements and performance, collaboration, and new or changed services.
Equipment / methods review	Documented equipment / method review. May involve equipment issues such as maintenance, replacement, and method discussion such as clinical utility.
Incident/complaint management	Review of ims+ incidents, investigation of incidents, follow-up on implementation of recommendations to ensure problem has been corrected by the action.
Internal audit	Targeted audits to determine compliance with the Quality System and Accreditation.
Management meeting	Meetings with minutes detailing supervisor in attendance and discipline the activity will be counted towards, file notes detailing outcome of discussions with staff, completion of supervision record.
Performance review	Documented performance review record for Supervising Pathologists, Clinical Scientists and on-site supervisor (on-site Laboratory Manager) and discussion of issues arising from the performance review of their staff
QC / QAP review	A record of what was reviewed, any actions required and follow-up of those actions. Tick off discipline(s) reviewed. This includes review of results and corrective actions when discordant results are obtained. Includes inter-laboratory sample exchanges.
Risk management plan review	Review and update of risk management plan detailing risk levels and mitigation strategies in line with the NSWHP Enterprise Risk Management Procedure.
Staff meeting	Meeting minutes detailing supervisor in attendance and discipline the activity will be counted towards, completion of supervision record.
Training/competency assessment	Review training records. Perform competency-based assessments.
Troubleshooting	Investigation and rectification of method / analyser problems and management of potential impacts to patient care
Workforce	Discuss training needs, review call-back and overtime issues. Attendance at workforce related meetings.