

# BreastScreen

## AUSTRALIA

A joint Australian, State and Territory Government Program

## NAS Protocol Management Checklist

### DETAILS OF SERVICE/SCU

**Name of SERVICE/SCU** Click or tap here to enter text.

**Date Completed** Click or tap to enter a date.

**Completed by (name)** Click or tap here to enter text.

This Checklist was originally developed for internal use by Services and SCUs to track their observance of National Accreditation Standards (NAS) Protocols.

The Guide aligns Protocols with relevant NAS Criteria across respective criteria and allows for the recording of relevant quality improvement (QI) initiatives and other commentary.

From 2021, it is mandatory that the NAS Protocol Management Checklist (PMC) be provided to the Survey Team as part of the confidential Surveyor Pack, exclusively for their use in undertaking the survey.

Provision of this documentation to the National Quality Management Committee as part of the accreditation submission is optional and at the discretion of the Service/SCU.

**This version includes the following modifications kindly provided and shared by BreastScreen Victoria (BSV):**

- **an evidence column has been added to list the supporting documents.**
- **responsibility for each protocol as per the NAS Accountability Framework (NAF) is shown.**
- **responsibility is designated as Service, BCU or Joint (i.e. shared between BCU and the Services)**

NAS Protocol	Current Status	Status Rationale	Other information/ QI activity	Evidence	Responsibility (SCU Unit/Service) & review date
<b>Standard 1: Access and Participation:</b> Appropriate levels of access and participation to BSA are achieved in the target and eligible populations.					
<p><b>Protocol 1.1:</b> The Service and/or SCU implements appropriate policies and protocols to:</p> <ul style="list-style-type: none"> <li>a) Recruit clients for participation;</li> <li>b) Send invitations for screening and rescreening;</li> <li>c) Follow-up clients who do not respond to invitations; and</li> <li>d) Deliver services to clients in the target age group and enable equitable participation of clients in special groups as outlined in Measure 1.2.1.</li> </ul>	Choose an item.				

NAS Protocol	Current Status	Status Rationale	Other information/ QI activity	Evidence	Responsibility (SCU Unit/Service) & review date
<b>Standard 2: Cancer Detection:</b> Breast cancer detection is maximised in the target population and harm is minimised.					
<p><b>Protocol 2.1:</b> Where there is discordance between the two independent screen readers on whether further assessment for the presence of breast cancer is required, the Service and/or SCU implements a protocol to achieve a single recommendation, through either:</p> <ul style="list-style-type: none"> <li>a) a third reader where that reader is a radiologist with a high level of expertise in screen reading, or</li> <li>b) consensus reads by the original two or more readers.</li> </ul>	Choose an item.				
<p><b>Protocol 2.2:</b> The Service and/or SCU ensures the following quality and safety measures:</p> <ul style="list-style-type: none"> <li>a) The ALARA principle (As Low As Reasonably Achievable - a radiation safety principle for minimising radiation exposure) is applied and monitored;</li> <li>b) The mammographic screening examinations consist of the two standard views (they are, cranio-caudal and medio-lateral oblique);</li> <li>c) There is documentation of the reasons for any deviation from the standard two views or more than 4 images for each client; and</li> <li>d) A protocol for adequate examination of clients with internal breast prostheses is in place.</li> </ul>	Choose an item.				
<p><b>Protocol 2.3:</b> The designated radiographer implements a process for providing ongoing assessment and feedback to radiographers in all units about the quality of screening images using criteria such as those used in the PGMI evaluation system outlined in Appendix G.</p>	Choose an item.				
<p><b>Protocol 2.4:</b> The Service and/or SCU demonstrates annually that each radiographer achieves 50% or greater P or G ratings in a PGMI evaluation of 50 randomly selected image sets as outlined in Appendix G.</p>	Choose an item.				

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<b>Standard 2: Cancer Detection:</b> Breast cancer detection is maximised in the target population and harm is minimised.					
<b>Protocol 2.5:</b> Image identification complies with relevant radiation licensing regulations and complies with the RANZCR Standards of Practice for Diagnostic and Interventional Radiology and the Australasian College of Physical Scientists and Engineers in Medicine (ACPSEM) Position Paper 'Recommendations for a Digital Mammography Quality Assurance Program' as updated from time to time.	Choose an item.				
<b>Protocol 2.6:</b> The Service and/or SCU implements a protocol for: a) identifying all interval invasive breast cancers and interval cases of DCIS; b) reviewing and investigating all interval invasive breast cancers and interval cases of DCIS within the Service and/or SCU; and c) identifying and implementing changes to improve practice where necessary.	Choose an item.				
<b>Protocol 2.7:</b> The Service and/or SCU provides audit and timely feedback which advises each individual reader of: a) their individual rate of detection, including small invasive breast cancers in all screens, in initial and subsequent screens see Appendix H); b) any interval invasive breast cancers not detected in images read by the reader (Appendix H); and c) any invasive breast cancers not detected as an abnormality by an individual reader at screen reading.	Choose an item.				
<b>Protocol 2.8:</b> The Service and/or SCU implements a timely review process, and where necessary, implements	Choose an item.				

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<b>Standard 2: Cancer Detection:</b> Breast cancer detection is maximised in the target population and harm is minimised.					
strategies to address the individual reader's performance.					
<b>Protocol 2.9:</b> The Service and/or SCU implements a protocol for the management of clients who report breast symptoms.	Choose an item.				

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<b>Standard 3: Assessment:</b> Assessment and diagnosis of breast cancer are appropriate, safe and effective.					
<p><b>Protocol 3.1:</b> The Service and/or SCU ensures that the multidisciplinary team involved in the assessment of clients recalled from screening has expertise in:</p> <ul style="list-style-type: none"> <li>a) breast examination;</li> <li>b) mammographic image interpretation and work-up;</li> <li>c) ultrasound performance and interpretation;</li> <li>d) percutaneous needle biopsy;</li> <li>e) pathology technique and interpretation;</li> <li>f) surgical planning; and</li> <li>g) supportive care.</li> </ul>	Choose an item.				
<p><b>Protocol 3.2:</b> The Service and/or SCU implements a protocol which ensures that the radiologist and other designated examining medical doctor from the multidisciplinary team, correlate and evaluate the clinical, pathological and imaging findings and decide on further investigations or management.</p>	Choose an item.				
<p><b>Protocol 3.3:</b> The Service and/or SCU ensures that all cases which underwent percutaneous needle biopsy are reviewed by a radiologist and at least one other designated medical doctor of the multidisciplinary team, before giving the results to the woman. Where results of radiology and pathology are inconclusive or inconsistent, the cases are reviewed at a minimum by a radiologist in consultation with a pathologist.</p>	Choose an item.				
<p><b>Protocol 3.4:</b> The Service and/or SCU implements a protocol for reviewing and correlating the clinical, radiological and pathological findings for all lesions detected as a result of screening for which surgery was performed.</p>	Choose an item.				
<p><b>Protocol 3.5:</b> Where there is discordance between assessment and post-surgical results the Service and/or</p>	Choose an item.				

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<b>Standard 3: Assessment:</b> Assessment and diagnosis of breast cancer are appropriate, safe and effective.					
<p>SCU implements a protocol for the follow-up of these clients which may include:</p> <ul style="list-style-type: none"> <li>a) notification of the surgeon;</li> <li>b) notification of the general practitioner;</li> <li>c) notification of the woman for review &amp; assessment at the Service; or</li> <li>d) any combination of these.</li> </ul>					
<p><b>Protocol 3.6:</b> The Service and/or SCU has systems in place to ensure that screening unit staff work closely with a specific assessment unit to ensure an integrated service.</p>	Choose an item.				
<p><b>Protocol 3.7:</b> The Service and/or SCU implements protocols for the evaluation of all clients recalled to assessment which incorporates, as required:</p> <ul style="list-style-type: none"> <li>a) clinical examination;</li> <li>b) mammography/ultrasound; and</li> <li>c) percutaneous needle biopsy.</li> </ul>	Choose an item.				
<p><b>Protocol 3.8</b> The Service and/or SCU that plans to implement remote radiology must establish and implement a protocol for delivering those remote radiology services to assessment clinics that includes and complies with all of the Remote Radiology Guidelines and utilises appropriate technology/telehealth facilities that meet the minimum technical requirements and quality control procedures in Appendix G in the NAS Commentary.</p>	Choose an item.				

**Standard 4: Timeliness:** Screening and assessment services are provided to clients in a timely and efficient manner.

**(There are no Protocols associated with this Standard)**



NAS Protocol	Current Status	Status Rationale	Other information/ QI activity	Evidence	Responsibility (SCU Unit/Service) & review date
<b>Standard 5: Data Management and Information Systems:</b> Data and information management systems and processes ensure the safe and effective use of data for strategic, clinical management and service improvement purposes.					
<p><b>Protocol 5.1:</b> The Service and/or SCU conforms with requirements of the BreastScreen Australia Data Dictionary, with regard to:</p> <ul style="list-style-type: none"> <li>a) collection of all required data items; and</li> <li>b) the definitions and methods used by the Service and/or SCU in the calculation of performance measures.</li> </ul>	Choose an item.				
<p><b>Protocol 5.2:</b> The Service and/or SCU undertakes ongoing quality control procedures for data throughout the screening and assessment process, including:</p> <ul style="list-style-type: none"> <li>a) review of the completeness and legibility of paper clinical records;</li> <li>b) review of the consistency between paper and computer records where required; and</li> <li>c) verification of the accuracy of the output of system generated reports.</li> </ul>	Choose an item.				
<p><b>Protocol 5.3:</b> All relevant staff are instructed in procedures to ensure quality of data at all levels of the screening and assessment pathway.</p>	Choose an item.				
<p><b>Protocol 5.4:</b> The Service and/or SCU ensures effective policies, procedures and protocols to achieve a high level of data security, accuracy, integrity and organisation and systems management.</p>	Choose an item.				
<p><b>Protocol 5.5:</b> The Service and/or SCU ensures the integrity and reliability of the file tracking system used.</p>	Choose an item.				

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<b>Standard 5: Data Management and Information Systems:</b> Data and information management systems and processes ensure the safe and effective use of data for strategic, clinical management and service improvement purposes.					
<b>Protocol 5.6:</b> Each client has one unique identifier within any State and Territory program.	Choose an item.				
<b>Protocol 5.7:</b> All client records held by all units in the Service and/or SCU are dated and identifiable to the relevant health professional for that part of the screening and/or assessment pathway.	Choose an item.				
<b>Protocol 5.8:</b> The Service and/or SCU complies with relevant State/Territory legislation for the retention and storage of client records.	Choose an item.				
<b>Protocol 5.9:</b> The Service and/or SCU has disaster recovery systems that address the risk of network failure and data loss from Picture Archiving Communication System (PACS) and business information management systems.	Choose an item.				
<b>Protocol 5.10:</b> The Service and/or SCU has policies, procedures and guidelines for the development and maintenance of high quality Information, Communication and Technology systems.	Choose an item.				

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<b>Standard 6: Client Focus.</b> High quality information is provided to inform clients, and clients feel appropriately engaged and supported.					
<p><b>Protocol 6.1:</b> Evidence based written information, which has been approved by the SCU and is consistent with state and national policies, is available to all clients as appropriate, throughout the screening and assessment pathway, and includes:</p> <ul style="list-style-type: none"> <li>a) purpose of screening;</li> <li>b) likelihood of recall;</li> <li>c) possibilities of false positive and false negative results;</li> <li>d) uncertainties and risks;</li> <li>e) rescreening;</li> <li>f) the investigations which may be required;</li> <li>g) the benefits, limitations and risks of the investigations; and</li> <li>h) the possible outcomes of assessment.</li> </ul>	Choose an item.				
<p><b>Protocol 6.2:</b> Clients are provided with information on waiting times at each step of the screening and assessment pathway.</p>	Choose an item.				
<p><b>Protocol 6.3:</b> All non-benign assessment results are given to the woman by a medical doctor of an assessment team, unless the woman specifically asks for them not to be. Women diagnosed with breast cancer or recommended for diagnostic open biopsy are additionally:</p> <ul style="list-style-type: none"> <li>a) told their results by a medical doctor and with a member of staff responsible for providing counselling present, unless the woman specifically asks them not to be, in accordance with the recommendations in the 'Clinical practice guidelines for the psychosocial care of</li> </ul>	Choose an item.				

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<b>Standard 6: Client Focus.</b> High quality information is provided to inform clients, and clients feel appropriately engaged and supported.					
<p>adults with cancer. A summary guide for health professionals (NHMRC/NCCI 2005)'; and</p> <p>b) encouraged to discuss treatment options with their preferred medical doctor such as a family doctor or treating surgeon.</p> <p>Benign assessment results may be delivered by a suitably trained and experienced medical practitioner, breast care nurse or nurse counsellor, on the conditions that:</p> <ul style="list-style-type: none"> <li>the multi-disciplinary team recommendation is for routine re-screening;</li> </ul> <p>the woman is offered the opportunity for further discussion with a medical officer.</p>					
<p><b>Protocol 6.4:</b> The Service and/or SCU implements a protocol, consistent with relevant State and Territory policies for a woman to have access to her own records, including copies of images.</p>	Choose an item.				
<p><b>Protocol 6.5:</b> The Service and/or SCU implements a strategy to encourage participation of key stakeholders, including consumers, in its structure, processes and activities.</p>	Choose an item.				
<p><b>Protocol 6.6:</b> The Service and/or SCU actively seeks feedback from clients about the acceptability and appropriateness of screening and assessment.</p>	Choose an item.				
<p><b>Protocol 6.7:</b> Clients are offered the opportunity to ask questions in private before giving consent for any procedure. Health professionals are available to answer clinical questions.</p>	Choose an item.				

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<b>Standard 6: Client Focus.</b> High quality information is provided to inform clients, and clients feel appropriately engaged and supported.					
<b>Protocol 6.8:</b> The consent process provides a record that information has been given and understood to the woman's satisfaction. This process clearly indicates that the woman may decline or request discontinuation of a procedure at any time.	Choose an item.				
<p><b>Protocol 6.9:</b> In accordance with Commonwealth and state and territory legislation, consent is obtained from all clients for:</p> <ul style="list-style-type: none"> <li>a) the screening mammogram;</li> <li>b) investigations at the assessment visit;</li> <li>c) her general practitioner, or other doctor to whom she is referred, to be notified of her results;</li> <li>d) the Service and/or SCU requests information about procedures and treatment from doctors to whom she is referred;</li> <li>e) data which identify the woman being transferred for clinical, research and monitoring purposes or released in any form; and</li> <li>f) an invitation to be sent to her for rescreening.</li> </ul>	Choose an item.				
<b>Protocol 6.10:</b> Clients with confirmed breast cancer are given the option of referral to a treatment clinic specialising in the treatment of screen detected breast cancer or returning to their nominated general practitioners for referral to an appropriate surgeon.	Choose an item.				
<b>Protocol 6.11:</b> The Service and/or SCU implements a protocol for the referral of all clients with a diagnosis of breast cancer for subsequent management. The Service and/or SCU ensures that all referrals to treating medical doctors include complete and accurate information to	Choose an item.				

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<b>Standard 6: Client Focus.</b> High quality information is provided to inform clients, and clients feel appropriately engaged and supported.					
enable appropriate management, and include a request for appropriate follow-up information.					
<b>Protocol 6.12:</b> The Service and/or SCU ensures that all clients with a diagnosis of breast cancer, which has been diagnosed within the program, are advised in writing of their status in relation to the Program in future years.	Choose an item.				

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<b>Standard 7: Governance and Management:</b> Effective structures and processes are in place, evaluated and continuously improved, to ensure high quality governance and management of the Service and/or State Coordination Unit.					
<b>Protocol 7.1:</b> The Service and/or SCU implements appropriate position descriptions which describe staff roles and responsibilities.	Choose an item.				
<b>Protocol 7.2:</b> All staff meet the relevant expertise, experience and training standards outlined in Appendix C.	Choose an item.				
<b>Protocol 7.3:</b> All staff are trained to ensure an understanding of the policies, protocols and procedures of the Service and/or SCU.	Choose an item.				
<b>Protocol 7.4:</b> All staff participates in regular clinical breast specific professional development activities.	Choose an item.				
<b>Protocol 7.5:</b> The designated pathologist and deputy/ies: a) participate in the Royal College of Pathologists of Australasia Anatomical Quality Assurance Programs Breast Diagnostic Module; and b) Implement the recommendations for quality assurance and uniform reporting of breast FNA cytology and core biopsy in 'The pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, 2008', as amended from time to time as outlined in Appendix I and J.	Choose an item.				
<b>Protocol 7.6:</b> The Service and/or SCU ensures that all screening and assessment units operate in a space, which is clearly identifiable as a BSA service: a) and that screening and assessment of screen-detected abnormalities are exclusively performed at a given time; and	Choose an item.				

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<b>Standard 7: Governance and Management:</b> Effective structures and processes are in place, evaluated and continuously improved, to ensure high quality governance and management of the Service and/or State Coordination Unit.					
b) with dedicated staff and resources.					
<b>Protocol 7.7:</b> The Service and/or SCU continually review, assess and implement a detailed quality improvement plan.	Choose an item.				
<b>Protocol 7.8:</b> For any research projects using screening and/or assessment data, the Service and/or SCU has evidence of Institutional Ethics Committee approval where appropriate and that they have advised the SCU, and relevant state or territory health department. Where data are to be published, the SCU and state or territory health department is advised and an independent final review is undertaken.	Choose an item.				
<b>Protocol 7.9:</b> The Service and/or SCU has a management or advisory structure which has representation from all key stakeholder groups.	Choose an item.				
<b>Protocol 7.10:</b> Where the Service and/or SCU and are separate, there is a written contract detailing their respective responsibilities and accountabilities, including compliance with the National Accreditation Standards	Choose an item.				
<b>Protocol 7.11:</b> The Service and/or SCU implements financial management systems that maximise efficiency and accountability.	Choose an item.				
<b>Protocol 7.12:</b> The Service and/or SCU implements, monitors and continually evaluates infection control processes that meet relevant state, territory and national standards.	Choose an item.				
<b>Protocol 7.13:</b> The Service and/or SCU implements, and continually evaluates, an incident management process	Choose an item.				



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<b>Standard 7: Governance and Management:</b> Effective structures and processes are in place, evaluated and continuously improved, to ensure high quality governance and management of the Service and/or State Coordination Unit.					
that includes the identification, reporting, investigation, analysis, action, feedback and open disclosure of incidents that occur in the Service and/or SCU.					
<b>Protocol 7.14:</b> The Service and/or SCU has an up-to-date Policy, Protocols and Procedures Manual that is maintained and updated regularly, and underpins all aspects of service delivery.	Choose an item.				
<b>Protocol 7.15:</b> The Service and/or SCU ensures that all of the policies, protocols and procedures outlined in the Policy, Protocols and Procedures Manual are implemented, continuously reviewed and improved.	Choose an item.				
<b>Protocol 7.16:</b> The Service and/or SCU implements an audit schedule to monitor compliance with all policies, protocols and procedures, and where necessary, develops strategies for improving compliance.	Choose an item.				
<b>Protocol 7.17:</b> The Service and/or SCU has access to appropriate equipment to maximise breast cancer diagnoses.	Choose an item.				
<b>Protocol 7.18:</b> X-ray systems, premises and users meet radiation protection regulations.	Choose an item.				
<b>Protocol 7.19:</b> Breast imaging systems, including ancillary items, meet:  a) manufacturer's specifications; b) imaging system performance and standards for quality control as specified in Appendices D, E, and F; and c) standards relating to storing, retrieving, displaying and transmitting images, in accordance with the	Choose an item.				

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<b>Standard 7: Governance and Management:</b> Effective structures and processes are in place, evaluated and continuously improved, to ensure high quality governance and management of the Service and/or State Coordination Unit.					
RANZCR 'Standards of Practice for Diagnostic and Interventional Radiology'.					
<b>Protocol 7.20:</b> Preventative maintenance and repair of imaging equipment meets manufacturer's recommendations or other appropriate standards.	Choose an item.				
<b>Protocol 7.21:</b> The Service and/or SCU uses pathology laboratories which maintain Royal College of Pathologists of Australasia National Association of Testing Authorities accreditation.	Choose an item.				
<p><b>Protocol 7.22:</b> For new technologies being introduced at the Service and/or SCU:</p> <ul style="list-style-type: none"> <li>a) introduction is in accordance with State and Territory and/or national policies;</li> <li>b) where relevant, evaluation of the technology is undertaken;</li> <li>c) a protocol for the safe and effective introduction exists;</li> <li>e) quality assurance protocols are in place and monitored regularly;</li> <li>f) relevant staff receive appropriate training in the use of such technologies prior to commencing their use; and</li> <li>g) appropriate information is provided to the client about the new technology when it is to be used at assessment or screening.</li> </ul>	Choose an item.				