Policy Directive

Patient Safety: Clinical Care and Patient Safety Monitoring & Review

Document No:	SLHD_PD2013_028
Functional Sub-Group:	Corporate Governance Clinical Governance
Summary:	Clinical services should have in place monitoring and review processes for evaluating patient / client care inputs / interventions. This should include where appropriate the following: monitoring and review; clinical pathway variances; clinical indicators; death reviews; incidents monitoring; morbidity and mortality and peer review.
Consultation	Clinical Governance Units
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Note: Sydney Local Health District* (SLHD) was established on 1 July 2011 following amendments to the Health Services Act 1997 which included renaming the former Sydney Local Health Network (SLHN). The former SLHN was established 1 January 2011, with the dissolution of the former Sydney South West Area Health Service (SSWAHS).

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1. Introduction

Reflecting on clinical care practices and outcomes is a key element of patient safety and risk management. It is a thoughtful intentional process by which individuals, teams and organisations think about the care they provide. It includes an analysis of care in terms of care inputs/interventions and making a judgement about the effectiveness and outcomes of these inputs/interventions. It is also about taking steps based on the evaluation to reduce future risk and improve care.

(i) The Risks Addressed by this Policy

Care inputs / interventions are reviewed to identify and mitigate potential risks, highlighting areas for improvement in patient management.

(ii) The Aims / Expected Outcome of this Policy

All care inputs / interventions are evaluated to identify risk and areas for improvement. There is evidence of changes to practice based on the evaluation.

2. Policy Statement

All Clinical Services must have in place monitoring and review processes for evaluating; patient / client care and interventions. This should include where appropriate the following:

Monitoring / Review

- Clinical Pathway Variances
- Clinical Indicators
- Death Reviews
- Incident Monitoring
- Morbidity / Mortality (M&M) Committees
- Peer Review

Audits

- Ad hoc Clinical Audits
- Retrospective Chart Audits

3. Principles / Guidelines

3.1 Monitoring / Review Processes

3.1.1 Clinical Pathway Variance

The use of clinical pathways is discretionary rather than mandatory. The decision on whether it is appropriate to use a clinical pathway is made by the treating clinician (team). However once the decision is made to utilise a clinical pathway for a particular patient then the following must occur:

Variance from the clinical pathway must be documented and reviewed in terms of outcome for the patient. Examples of variance may include:

- Changes in the patient condition or complications e.g. DVT, Pulmonary Embolus, slow mobilization, excessive pain, etc
- Patient and family factors e.g. non-compliance with instructions, refusal of treatment, unable to collect patient at specified discharge time, etc.
- Clinical decision based on clinical judgment: the decision must be documented.
- Internal delay e.g. unable to get test appointment, referral response delay, etc
- External systems delay e.g. no nursing home bed available, no available community support system, etc.

Causes of variance from clinical pathways and the resulting patient outcomes must be analysed as a means of identifying areas for improvement. Examples of outcomes may include:

- Extended length of stay
- Shortened length of stay
- Length of stay unaffected
- Complications in clinical presentation
- Post discharge complication

3.1.2 Clinical Indicators

Clinical Indicators are tools *and* flags, which allow for collection and analysis of data which can alert clinicians to possible problems and opportunities for improvement. However, only people who understand the processes and outcomes being measured can undertake the analysis. The benefits do not lie in the collection of data but rather in how the data is used to bring about improvements to clinical care.

Each clinical service must review their identified clinical indicators, identify appropriate clinicians to use the indicators and be able to report against identified benchmarks and improvements based on analysis of these indicators.

3.1.3 Death Reviews

All deaths within each facility are screened. This screening process involves an initial screen, which identifies the presence of clinical issues and the antecedents, which may be present 24 hours prior to the death. Cases identified during the initial screen are further reviewed by a designated staff member e.g. CNC / Clinical Director / Director Medical Services or Death Review Committee.

Actions following the initial screen may include:

- Notification on IIMS as SAC 1 which will invoke the RCA process or SAC 2 which will involve an in-depth investigation.
- Recommendations implemented as a result of the review by the designated staff member(s).
- Referral of the case to the specialty Morbidity & Mortality Committee or Quality Committee for review and consideration. .

- No further action required.

In addition any unexpected deaths, if appropriate, must be referred to:

- The NSW Coroner,
- The NSW Health Special Committee for Investigating Deaths under Anaesthesia (SCIDUA),
- The Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
- The NSW Ministry of Health's Maternal and Perinatal (M&P) Committee.

3.1.4 Incident Monitoring

Each clinical service must have in place a process to enable notified incidents to be discussed and for the opportunistic identification of other incidents of concern, within the clinical area. Staff should be involved in these processed and their input should be sought regarding solutions which may prevent similar incidents.

Opportunistic identification of incidents may be facilitated by asking (Clinicians Toolkit 2001) http://www0.health.nsw.gov.au/pubs/2001/pdf/clintoolkit.pdf if there have been any of the following

- Drug errors
- Falls
- Unexpected admission to ICU
- Wound infections
- Unreported results
- Reports not acted upon in a timely manner
- Delayed or premature discharges/transfer
- Gaps in care

The facts of the incident should be presented and the approach to discussion should be educational. This may be assisted by further questioning e.g.:

- What did we do or forget to do which contributed to the incident?
- What needs to be done to prevent this happening again?
- Who is responsible for follow-up action?
- Who needs to know about this incident?

Incidents identified are managed as per Ministry of Health's policy directive: PD2007_061: Incident Management

3.1.5 Morbidity and Mortality Committees

Each clinical service must establish a multidisciplinary committee which meets on a regular basis to review deaths and adverse outcomes if there have been any of the following in within the clinical specialty. The focus of the committee is both inquisitive and educative.

The inquisitive function includes the review and critical analysis of the circumstances surrounding the outcomes of care, which include all deaths, serious morbidity and significant aspects of clinical practice.

The educative function includes discussions around current practice and options for improved practice and patient outcomes.

The committee will also make recommendations based on its deliberations to improve care and initiate action to ensure these recommendations are implemented, monitored and evaluated for their effectiveness.

The committee as per: http://www0.health.nsw.gov.au/pubs/2001/pdf/clintoolkit.pdf

- Have approved Terms of Reference, annually.
- Record minutes including actions planned and taken.
- Provide reports electronically to the relevant Facility using the M&M report template found under the forms section on the SLHD intranet.
- Have a process for providing feedback to the relevant clinicians(s).
- Meet a minimum of once a month.

3.1.6 Peer Review

Peer review is a reflective process accepted as part of quality improvement processes and which contributes to professional development. It is a means by which clinicians seek to improve their clinical management of patients and maintain currency of their practice by focusing on recent outcomes of care.

While it may be a process conducted between two individuals, it may also be a multidisciplinary group process. The main goals of peer review are to identify strengths of the individual *or* group, and provide a supportive environment within which to determine possible areas for improvement.

Principles of peer review include the following:

- The person or group participant/s must agree and be a willing participant in the process.
- What is being reviewed is determined by the individual or group.
- The process should be grounded in critical thinking and reflection.
- Outcomes of the review are known only to the participants and confidential.
- The final outcome of the process should be decisions made by the participants about actions to be taken to ensure improvements in clinical practice.
- Records should be keep regarding meetings noting the limitations around confidentially

3.2 Audits

3.2.1 Ad Hoc Clinical Audits within the review process.

An ad hoc audit is a survey of a specific clinical practice that is not undertaken on a regular or ongoing basis and prompted by the identification of a problem. These audits focus on a specific period in

contrast to other audits which may be part of a continuous improvement program.

To ensure the nature, extent and causes of the problem associated with the clinical practice is fully investigated these audits may involve more than one review process. They may include:

- Reviewing medical records
- Undertaking a literature review
- Conducting surveys and/or questionnaires
- Developing a cause and effect diagram
- Constructing a process flow chart
- Collecting data about the process under review

This review process will enable conclusion to be drawn about clinical practice and for the identification of strategies and actions for practice improvement (Clinicians Toolkit 2001).

3.2.2. Retrospective Chart Audits

Retrospective chart audits are a continuous review process of patient medical records. It involves review against selected criteria. Chart audits must take place according to the facility audit policy.

3.3 Performance Measures

Performance measures provide evidence of improvement in clinical care as a result of the various review and improvement processes. Examples may include:

- Demonstrated reduction in gaps between best practice and clinical performance
- Increased benchmarking between services
- Clinical Practice Improvement Projects
- Regular appraisal of clinical care interventions
- Policy review against best practice

4. Definitions

Clinical Pathway

A clinical pathway is a model for clinical management of patients with a particular disease or requiring a particular procedure. Inherent in the pathway is a process for documenting and analysing variances.

Clinical Pathway Variance

A variance is:

- Any event that occurs and is not specified in the clinical pathway
- Any event, which does not occur within the correct timeframe and is specified in the clinical pathway.

Clinical Indicator

Australian Council of Health Care Standards (ACHS) defines clinical indicators as a measure of the clinical management and outcome of care. It is an objective measure of either the process or outcome of patient care in quantitative terms.

Death Review Committee

A committee formed to review deaths occurring within a facility or service.

Peer Review

Peer review is a professional development process whereby an individual clinician or group's performance is reviewed and evaluated by peers.

Morbidity and Mortality Meetings
A meeting held on a regular basis to review deaths and adverse outcomes in patients of a specific clinical group or specialty.

5. References and Links

The Clinicians Toolkit 1st Edition NSW Health 2001

NSW Ministry of Health: PD2007_061: Incident Management