

CLINICAL RISK MANAGEMENT STRATEGY
WEST VIC DIVISION OF GENERAL PRACTICE
MODEL OF
LIMITED ADVERSE EVENT SCREENING

*Improving Patient Safety in Victorian
Small Rural Hospitals*

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**Clinical Risk Management Strategy
West Vic Division of
General Practice
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Acknowledgements

The clinical risk management program for small rural hospitals was piloted in 1994, by the Monash University Centre of Rural Health, under the auspice of West Vic Division of General Practice.

We acknowledge the work and assistance of the Rural Hospitals' Quality Assurance Project Management Committee Members:

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Dr Alan Wolff	Director of Medical Services, Wimmera Health Care Group

We also acknowledge the current program leaders who have participated in the transition from a pilot project to an established and evolving clinical risk management program:

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Foreword

Medical practitioners have a long tradition of critical evaluation, peer review and research into health outcomes. However we have been slow to adopt the use of organisational systems to improve “quality” that have been sweeping across manufacturing and service industries over the past twenty years. Consumers and managers of our hospitals are demanding that medical staff, along with all other members of the organisation, embrace quality improvement. While many within the profession may feel that this is just a “passing fad”, it may be viewed as professional arrogance to ignore what seems to be an effective management system. Quality improvement (assurance) is here to stay. The concepts and systems themselves will evolve through a continual cycle of improvement.

The model of Quality Improvement presented in this manual is contextually relevant to the rural environment and linked by common professional ideals. It has been developed within the framework of the Division of General Practice program. Divisions of General Practice are advocacy, support and networking organisations, funded by the Commonwealth Department of Health and Ageing, to encourage and facilitate general practitioners’ contribution to improving health outcomes in their local area. The Department of Human Services has recognised that Divisions provide the mechanism to engage regional health providers to bring about system changes.

The West Vic Division of General Practice has developed and refined a divisional based model of case screening with true general practitioners’ peer review, as opposed to a punitive response to adverse events. It must be acknowledged that this process has been solidly supported by the Department of Human Services, and is now a component of a state wide quality improvement strategy.

This model has only been possible through an inclusive cooperative development process, creating an environment where professionals can learn from experience and shared knowledge that only a systems approach can yield. This is a true example of where process analysis, through a quality improvement program can lead to various strategies of systematic and ultimately, clinical change.

Dr Robert Grenfell

General Practitioner Consultant
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Table of Contents

ACKNOWLEDGEMENTS	4
FOREWORD.....	5
A GUIDE TO THIS MANUAL	9
EXECUTIVE SUMMARY	11
<i>Flow chart - Clinical risk management.....</i>	<i>12</i>
CLINICAL RISK MANAGEMENT.....	15
<i>Clinical Risk Management and Small Rural Hospitals</i>	<i>15</i>
<i>Background of Occurrence Screening</i>	<i>15</i>
<i>Modification to Occurrence Screening.....</i>	<i>15</i>
<i>Rural Hospital's Quality Assurance Project.....</i>	<i>15</i>
<i>Advantages of limited Adverse Occurrence Screening.....</i>	<i>16</i>
<i>Process of Limited Adverse Event Screening in Small Rural Hospitals.....</i>	<i>16</i>
PRE-PLANNING	17
<i>What are the first steps?</i>	<i>17</i>
INFORMATION MEETING	18
GOVERNANCE.....	19
<i>Flow chart - medical records flow system.....</i>	<i>20</i>
GENERAL PRACTITIONERS	21
<i>Medical reviewer's role</i>	<i>21</i>
<i>Treating General Practitioner's Role</i>	<i>22</i>
HOSPITAL CHIEF EXECUTIVE OFFICERS	23
HEALTH INFORMATION MANAGER.....	24
PROJECT OFFICER.....	26
STATUTORY IMMUNITY COVER	27
SCOPE OF STATUTORY IMMUNITY	27
REQUIREMENTS FOR DIVISIONS PRIOR TO APPLYING FOR STATUTORY IMMUNITY	28
WHAT MUST BE INCLUDED IN A STATUTORY IMMUNITY APPLICATION?	29
REVIEW OF STATUTORY IMMUNITY	29
<i>Statutory immunity – application procedures.....</i>	<i>30</i>
<i>Statutory immunity checklist.....</i>	<i>33</i>
<i>Proforma letter to the Minister For Health.....</i>	<i>34</i>

DATA COLLECTION TOOLS	35
1 ANALYSIS FORM	35
2 REGISTERS TO ASSIST IN IDENTIFYING THE LOCATION OF MEDICAL RECORDS. ..	38
3 REFERENCE PANEL REPORT FORM	39
4 HOSPITAL AND GENERAL PRACTITIONER CODES.....	41
5 DATABASE	41
POSTAL ARRANGEMENTS	43
FLOW OF MEDICAL RECORDS.....	45
REFERENCE PANEL MEETING	49
<i>Sample document – Recommendation Report.....</i>	<i>51</i>
<i>Sample document – Recommendation Report.....</i>	<i>52</i>
<i>Sample document – Recommendation Report.....</i>	<i>53</i>
<i>Sample document – Recommendation Report.....</i>	<i>54</i>
<i>Sample document – Recommendation Report.....</i>	<i>55</i>
<i>Sample document – Recommendation Report.....</i>	<i>56</i>
<i>Sample document – Recommendation Report.....</i>	<i>57</i>
BUDGET.....	58
FURTHER READING	57
DEFINITION OF TERMS.....	58
APPENDICES	61
<i>Sample document – checklist</i>	<i>63</i>
<i>Sample document - Position Description.....</i>	<i>65</i>
<i>Sample document - Analysis Form</i>	<i>67</i>
<i>Sample Document - Definition of screening criteria</i>	<i>69</i>
<i>Sample document – Treating general practitioner comment form</i>	<i>71</i>
<i>Sample document - Confirmation of Postage Card.....</i>	<i>73</i>
<i>Sample document - Health Information Manager Hospital Registration Form.....</i>	<i>75</i>
<i>Sample document - Project Officer Hospital Registration Form</i>	<i>77</i>
<i>Sample document – Register for Treating General Practitioner Form.....</i>	<i>79</i>
<i>Sample document - Reference Panel Register</i>	<i>81</i>
<i>Sample document - General Practitioners Register</i>	<i>83</i>
<i>Sample document - Before, During & After Meetings Flow Chart</i>	<i>85</i>
<i>Sample document - Reference Panel Report Form.....</i>	<i>87</i>

A GUIDE TO THIS MANUAL

This manual is laid out in program implementation sequence, covering four major areas.

1. Pre-program commitment
2. Implementation of program
3. Program systems and roles
4. Sample documentation

Before progressing further into this manual please read the **Forward, Executive Summary** and the **Clinical Risk Management** section.

The following sequence blocks may be used to locate information on any particular stage of the program or as a guide to an overall review of the total program.

PRE-PROGRAM COMMITMENT

Pre Planning Guide

Page 15

Governance

Page 17

Gaining Commitment from General Practitioners

Page 19

Gaining Approval from Hospital Chief Executive Officers

Page 21

**PROGRAM
IMPLEMENTATION**

Project Officer's Role

Page 24

**Organizing Statutory Immunity
Cover**

Page 25

Preparing Data Collection Tools

Page 33

Organising Postal Arrangements

Page 41

**PROJECT SYSTEMS
& ROLES**

Medical Records Flow Sequence

Page 43

Health Information Managers Role

Page 43

Project Officer's Role

Page 44

General Practitioner's Role

Page 45

Reference Panel Role

Page 47

Budget Guidelines

Page 56

Executive Summary

Since commencing in 1994, the Clinical Risk Management Program has aimed to improve the quality and safety of patient care, by providing rural general practitioners in small rural hospitals with a peer review process that monitors adverse patient events. An adverse event is an untoward occurrence, which under optimal conditions, is not a natural consequence of the patient's disease or treatment.

This is a quality improvement program that offers true peer review for rural general practitioners. The doctors reviewing medical records are working in a similar environment to the doctors whose work is being reviewed and are sensitive to the issues faced by doctors working in isolation in a small hospital. It is non-punitive and has general practice acceptance.

The program is confidential and is protected under Statutory Immunity by Section 139 of the Health Services Act 1988.

Small rural hospitals with only one or two doctors often find it difficult to sustain formal medical quality improvement programs. One significant problem for doctors who work closely together, is difficulty in objectively reviewing the medical records of patients treated by their neighbouring professional colleagues. Similarly it would be difficult for a doctor working on their own in a small hospital to objectively review their own work.

This clinical risk management program is based on a selection of cases for review by a process known as Limited Adverse Occurrence Screening developed by Dr Alan Wolff at the Wimmera Health Care Group, Horsham in the early 1990's. This limited form of screening for adverse patient events was found to be highly efficient and effective in detecting up to 50 % of adverse patient events.

By participating in this program, small hospitals gain the benefit of:

- An independent review of some of their medical records
- Access to the details of recommendations in response to adverse events that have occurred at their hospital and others of similar size
- General practitioner involvement with hospital quality improvement programs.

Participating general practitioners are eligible for quality assurance points towards maintaining vocational registration through the Royal Australian College of General Practitioners.

The steps and tools involved in establishing a clinical risk management program are outlined in this manual to assist application by colleagues in new workplaces. Due to the confidential nature of the medical record, a system has been developed that maintains security of the copied medical record by coding data entry and the postage of all photocopied medical records by registered mail. This system is detailed in the manual.

In summary, the medical records of patients discharged at each of the participating hospitals are screened by the health information managers during the discharge coding process, using seven outcome criteria:

1. Patient death
2. Returning to theatre within 7 days
3. Unplanned re-admission within 28 days
4. Transfer to another acute care facility
5. Patient lengths of stay greater than 21 days
6. Unexpected re-admission following discharge from another hospital
7. Any record which has been recommended by a doctor for peer review

The relevant medical records identified by the screening criteria are photocopied and sent to the Division project officer. The project officer then forwards the photocopied medical records to a general practitioner reviewer from a separate geographical area. The doctors are grouped in different geographical areas to provide anonymous “arms - length” review. General practitioners do not review their own medical records. The purpose of the medical review is to identify preventable adverse patient events.

The reviewing general practitioners attend reference panel meetings to discuss the adverse events and identify any issues that require recommendations. The recommendations are sent to all general practitioners within the Division and the chief executive officers of the participating hospitals. For the clinical risk management cycle to be completed at the local level, the doctors discuss the appropriateness of the reference panel recommendations at the quality improvement forum in their local hospital, where recommendations may be modified and implemented at that level. A representative from each hospital provides feedback to the reference panel on action their hospital has taken in response to each case and the recommendations.

For Divisions adopting this program, it is necessary to hold information sessions for hospital chief executive officers, general practitioners and health information managers. General practitioners are approached to review records and to participate in the reference panel meetings. A champion general practitioner needs to be identified and a steering committee for the program formed. The Division needs to appoint a project officer and provide training.

At the time of printing this manual, more than 2,700 medical records have been reviewed in this clinical risk management program.

This has resulted in a cultural change, from an attitude of individual blame to one that acknowledges systemic causes for adverse events. Knowledge and experience have been shared in a non-threatening way and recommendations have led to quality improvement in small rural hospitals. There has been an improvement in the standard of the medical record documentation, including the availability of discharge summaries, death certificates and copies of ante-natal results, enhancing the continuity of patient care.

Small rural hospitals and the West Vic Division of General Practice have been able to put in place interventions with the ultimate aim of improving patient care.

The Program has identified medical and system issues. Through recommendations and general practitioner education, this has led to improved patient care in the hospitals.

There has been acceptance of this program because of the non-competitive anonymous peer review between neighbouring hospitals. The general practitioners have ownership of the program and are therefore committed to the clinical risk management process.

This program has identified trends which individual general practitioners and small rural hospitals would have been unable to recognize on their own. It has provided input into state policy matters, and also provided local quality improvement forums with recommendations and material for further discussion on patient care, educational and system issues.

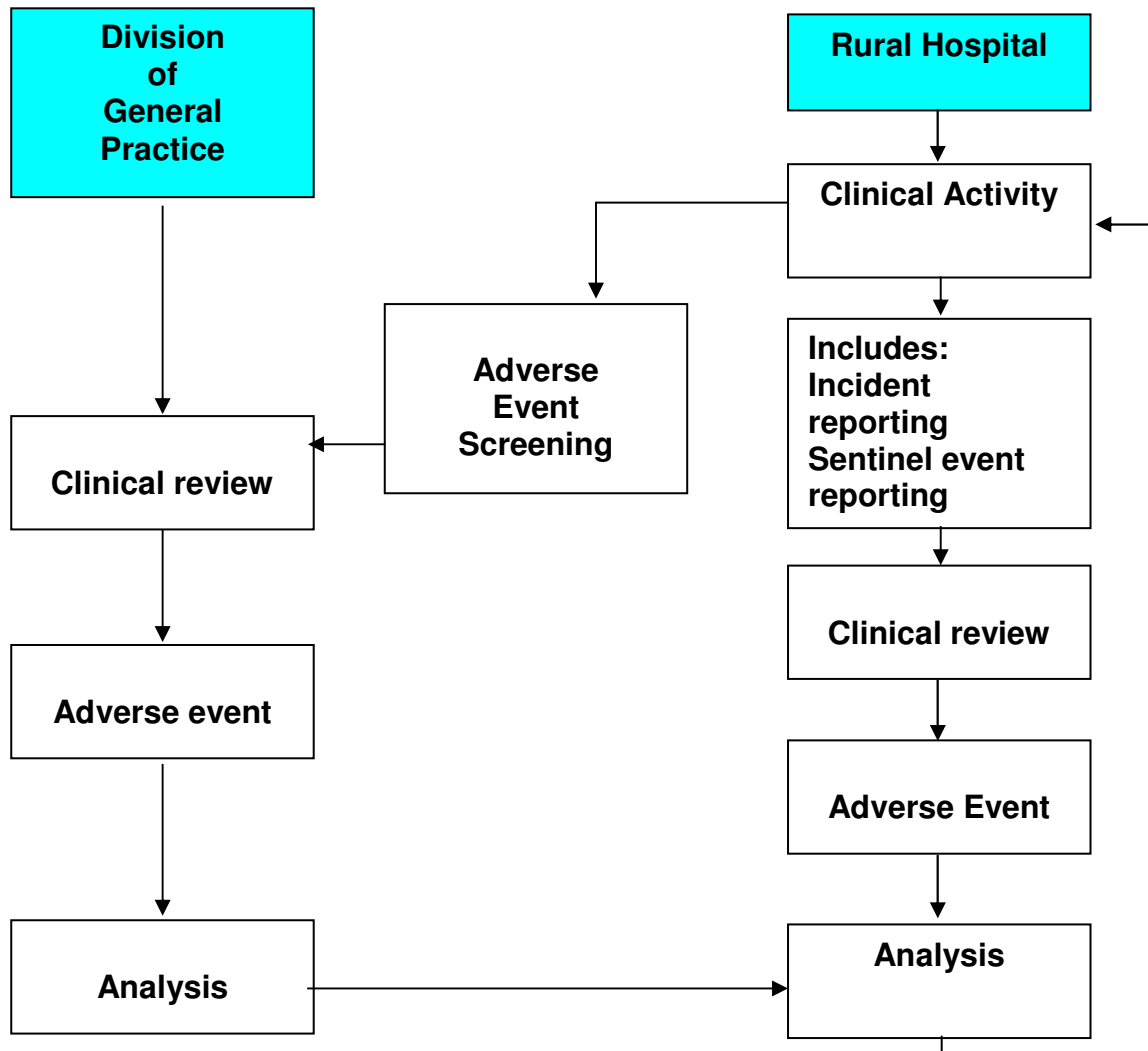
This is a true quality improvement program, as the general practitioners are providing input on how to improve the program and it has continually been reviewed since its inception in 1994. It is expected that there will be increased involvement, as more hospitals participate in the program to comply with the State Government funding requirements.

The reference panel aims to further enhance the recommendations sent to general practitioners and hospitals. This will be done by co-opting disciplines with relevant clinical experience to further research/develop the recommendations from the reference panel.

The Division is currently reviewing the forms and tools, including coding the adverse event information to further enhance analysis of the database entries, and identify trends in rural medicine that have state wide implications.

This manual will assist Divisions and small rural hospitals to participate in the state-wide strategy of clinical risk management funded by the Department of Human Services.

Clinical risk management flow chart



CLINICAL RISK MANAGEMENT

Formal quality improvement programs have achieved widespread use in industry and service organisations. Clinical risk management in public hospitals is perceived as an essential element for involving medical and other hospital staff in improving service delivery, the safety of patient care as well as demonstrating a commitment to quality improvement. The medical profession has a tradition of individual and peer review processes. The principles of clinical risk management are a formal extension of this process.

Clinical Risk Management and Small Rural Hospitals

Whilst it is feasible in larger institutions to have peer review with medical clinicians dedicated to a clinical risk program, small rural hospitals can find it difficult to sustain a formal program. In these hospitals there may only be one or two doctors with minimal medical administrative support.

Background of Occurrence Screening

Occurrence screening was first developed in the United States with a program called Medical Management Analysis. In this program, hospital medical records were screened, by nursing or health information services, during the patient's admission, using 23 general outcome criteria. Records found to be positive for any criteria were sent for medical review. The reviewer assessed the care given and determined if an adverse event had occurred. Such events were then reported to a surveillance committee, which monitored trends in adverse events and determined if any action needed to be taken. Importantly, once action was taken, the screening process continued, allowing the effectiveness of the action in preventing adverse events to be assessed.

Modification to Occurrence Screening

A major disadvantage of the Medical Management Analysis Program in the United States was that the implementation required significant additional resources. To make the program more efficient and cost effective, the following modifications were introduced:

- * The number of screening criteria was reduced from 23 to 7.
- * Screening of the medical record was conducted retrospectively rather than concurrently with the patient's admission.
- * The medical records department as part of the normal discharge coding duties, performed the screening process.

Rural Hospital's Quality Assurance Project

The Rural Hospital's Quality Assurance Project aimed to provide medical quality assurance programs for small hospitals by pooling the peer review activities of several small hospitals.

This project initially linked general practitioners from ten small hospitals into three subgroups and has been extended to a total of nineteen towns from Bacchus Marsh, west to the Victorian border. The program was developed with Monash University Centre for Rural Health providing leadership and academic support; the West Vic Division of General Practice providing local infrastructure, and the regional office of

the Department of Human Services along with the Commonwealth Department of Health and Family Services providing funding.

Advantages of limited Adverse Occurrence Screening Project

This modified or limited form of screening for an adverse patient occurrence was found to be highly efficient, requiring only 0.1% of hospital budget for implementation. It was also effective in detecting up to 50% of adverse events. Over a three year period, Limited Adverse Occurrence Screening showed a reduction of almost 50% in the number of adverse events.

Process of Limited Adverse Event Screening in Small Rural Hospitals

The medical records of patients discharged from each of the participating hospitals are screened by health information managers using seven outcome criteria:

1. Patient death
2. Returning to theatre within 7 days
3. Unplanned re-admission within 28 days
4. Transfer to another acute care facility
5. Patient lengths of stay greater than 21 days
6. Unexpected re-admission following discharge from another hospital
7. Any record which has been recommended by a doctor for peer review.

The relevant medical record admissions that meet the screening criteria are photocopied and sent to the Division project officer. The project officer then forwards the photocopied medical records to a General Practitioner reviewer from a separate geographical area. The doctors are grouped in different geographical areas to provide anonymous "arms - length" review. General practitioners do not review their own medical records. The purpose of the medical review is to identify preventable adverse patient events. The reviewing general practitioners share attendance at reference panel meetings.

The summarised adverse events are discussed by the reference panel to identify any issues that require recommendations. The recommendations are sent to all general practitioners within the Division and the chief executive officers of the participating hospitals. For the clinical risk management cycle to be completed at the local level the doctors discuss the appropriateness of the reference panel recommendations at their main improvement forum in their hospital and modify recommendations to be implemented locally. A representative from each hospital provides feedback to the reference panel on the action their hospital has taken in response to the recommendations for each case.

The case review documentation and Reference Panel deliberations are protected under Statutory Immunity provided by Section 139 of the Victorian Health Services Act 1988. This is currently under review by the Victorian State Government and will not be finalised until the autumn session of Parliament in 2002. We would encourage participants in the program to keep a watching brief on their Statutory Immunity status.

PRE-PLANNING

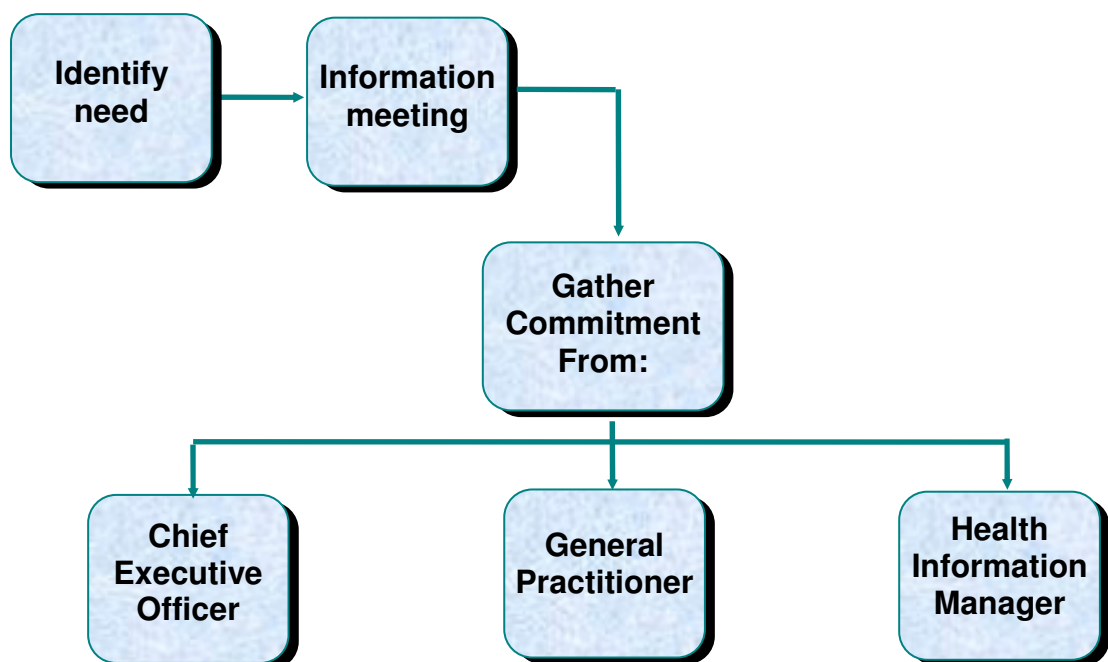
Gather Support

It has been identified that small rural hospitals have different needs compared to medium and larger sized hospitals in establishing a clinical risk management program. The West Vic Division of General Practice's Clinical Risk Management Strategy has been developed specifically for small rural hospitals.

The Clinical Risk Management Strategy for 2001-2002 will target preventable adverse events and encourage a systems approach in examining contributory factors leading to these events. This strategy marks a shift in the traditional approach of adverse event management from one that in general focuses on individuals, to one that focuses on the conditions under which adverse events occur and where the investigation of these events is seen as an opportunity to improve practice and patient safety.¹

In Victoria all hospitals are expected to instigate a clinical risk management program to comply with Victorian Policy and Funding Guidelines for 2001-2002.

What are the first steps?



¹Victorian Department of Human Services Acute Health Division Clinical Risk Management Strategy 2001

INFORMATION MEETING

A meeting is held to provide information to small rural hospitals in the Division detailing how a clinical risk management program could operate. This meeting should identify general practitioners considered to be local opinion leaders. They may be able to assist with the review of medical records, participate on the reference panel and convince other general practitioners of the benefits of participating in the program.

Objectives of the information meeting

- To identify existing hospital based clinical risk management and quality improvement programs in the region.
- To provide information on the processes of the program.
- To gain commitment and support from participants.
- For participants to gather have sufficient understanding of the program to be able to discuss the details with other key persons in their hospital.
- To identify key people to become members of the management committee for the program.
- To answer any questions that the participants may have regarding the program.

Organising the meeting

Details regarding the organisation of meetings can be found in the section on the reference panel meeting.

In addition to the usual meeting procedures:

- Ensure that at least one representative general practitioner, chief executive officer and health information manager from each hospital are able to attend the meeting.
- Start the meeting by identifying the current clinical risk management programs being undertaken at each hospital.
- Describe the Division's Clinical Risk Management Program outlining the advantages for small rural hospitals.
- Identify key people to become members of the management committee for the program and elect these people at the meeting.
- Make available a contact person who is familiar with the program (i.e. either the project officer or the general practitioner chairperson).

Prior to the commencement of the program it is essential to clarify the role and responsibilities of all participants and to ensure they are committed to the program.

GOVERNANCE

The management committee oversees the progress and development of the program. Optimally the management committee comprises of members from the health sector, with diverse interests and responsibilities.

The information meeting should identify key people who have an interest the program as well as expertise in program management.

The management committee should be elected at the information meeting and members need to be selected from participating hospitals and the Division.

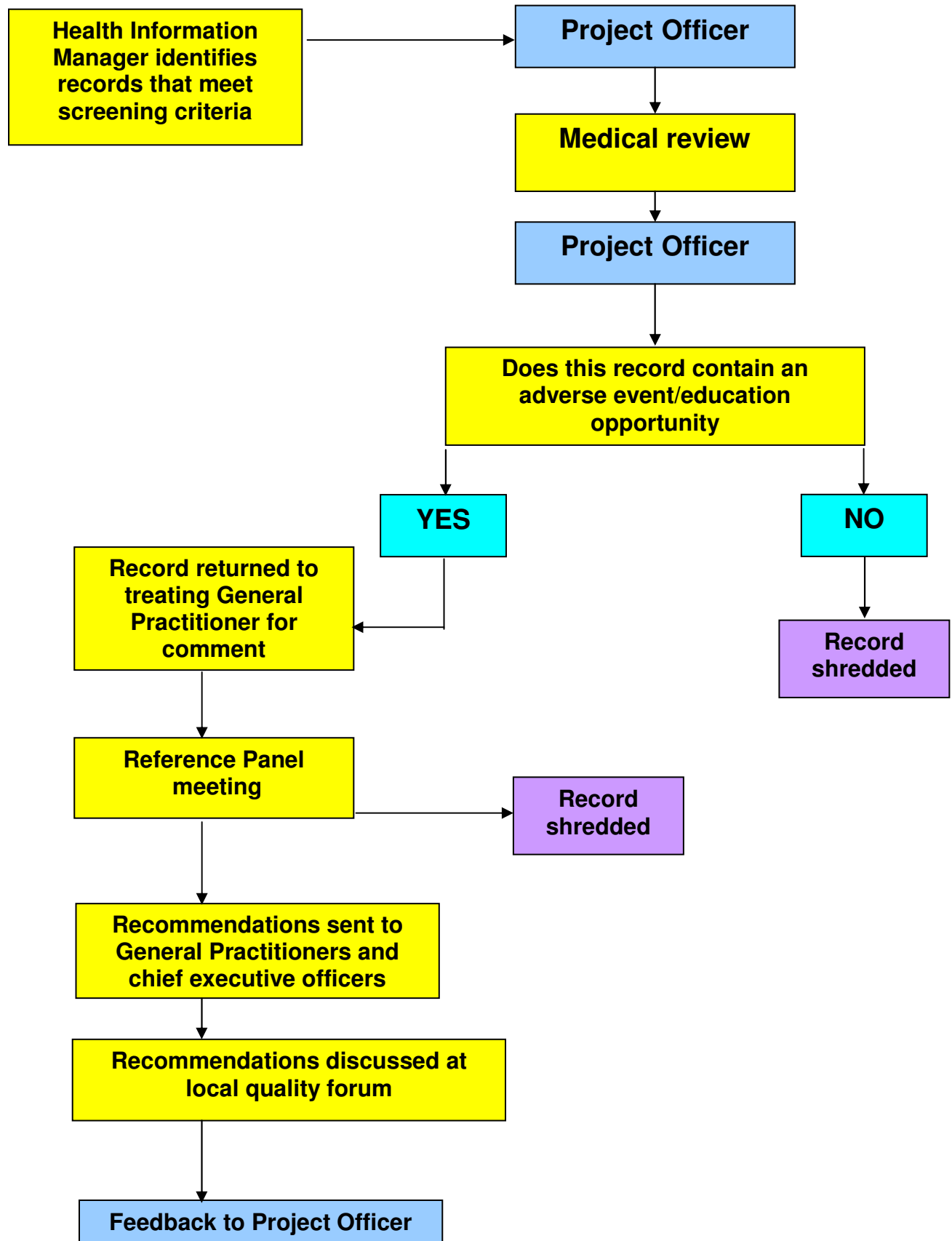
It should consist of a cross section of:

- General practitioners
- Directors of medical services
- Chief executive officers
- Health information managers
- Project Officer / Division staff
- Local clinical risk management expert – if available

Role of the program management committee

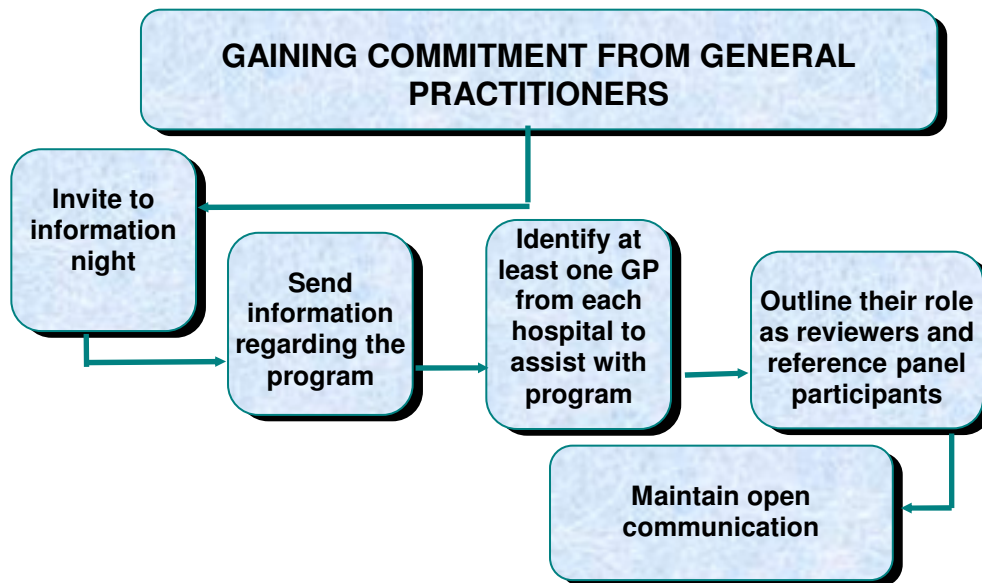
- To understand and contribute to the development of the clinical risk management program.
- To maintain an overview of the program and its progress towards the objectives.
- To attend regular meetings of the Clinical Risk Management Program and act on information and reports presented.
- Ensure that there is sufficient expertise in clinical risk management represented on the management committee.

Flow chart - medical records flow system



GENERAL PRACTITIONERS

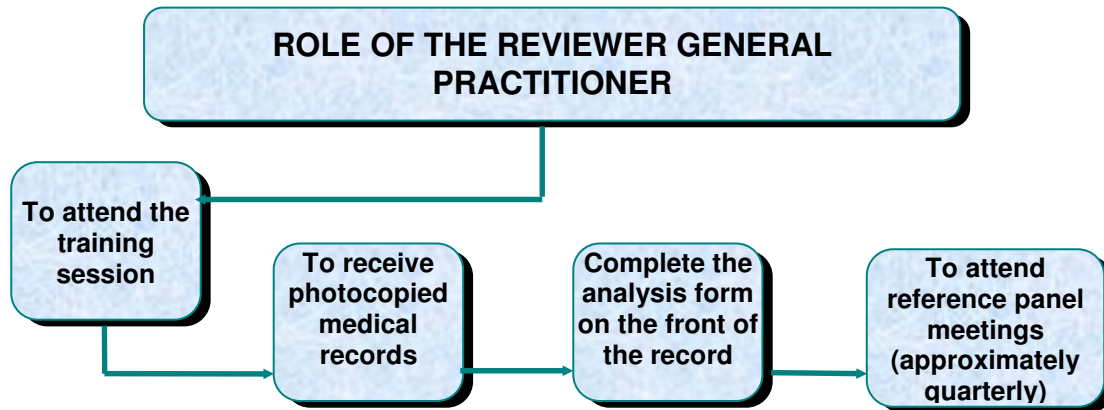
- Identify general practitioners willing to participate in the program.
- General practitioners need to formally acknowledge participation in the program to allow their records to be screened
- All general practitioners should be encouraged to participate as reviewers and there should be at least one reviewer per hospital.
- General practitioners participating in the program may be eligible for quality assurance points towards maintaining vocational registration through the Royal Australian College of General Practitioners.



Medical reviewer's role

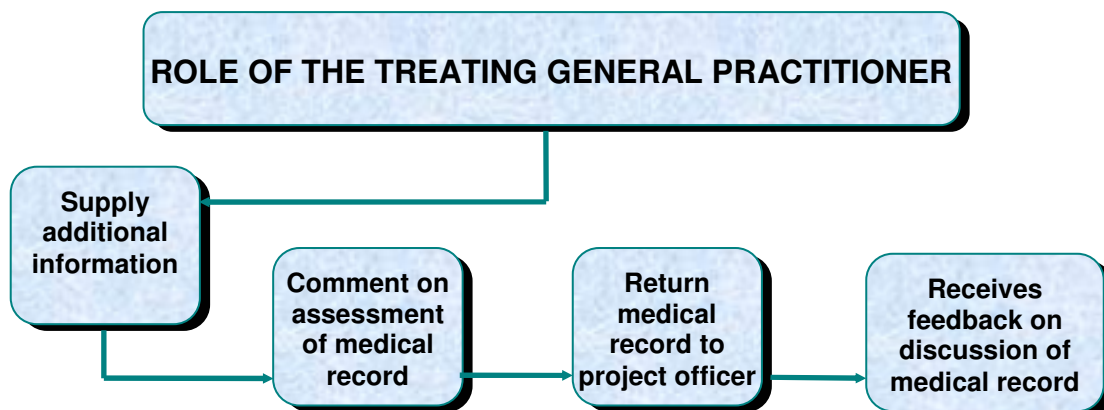
Once a general practitioner has agreed to be a reviewer their role is as follows:

- Attend a training session
- Have practice administration staff collect and sign for the medical records at the local post office.
- Review each medical record sent to them (approximately 20-30 medical records per year).
- Complete the Adverse Event Analysis form and record the time spent on each review.
- Place the reviewed medical record into the registered Post Pak provided and return to the Project Officer.
- Attend reference panel meetings when possible
- Review the recommendations sent out and discuss them with colleagues.
- Present local issues to their hospital quality improvement committees or other appropriate forums.

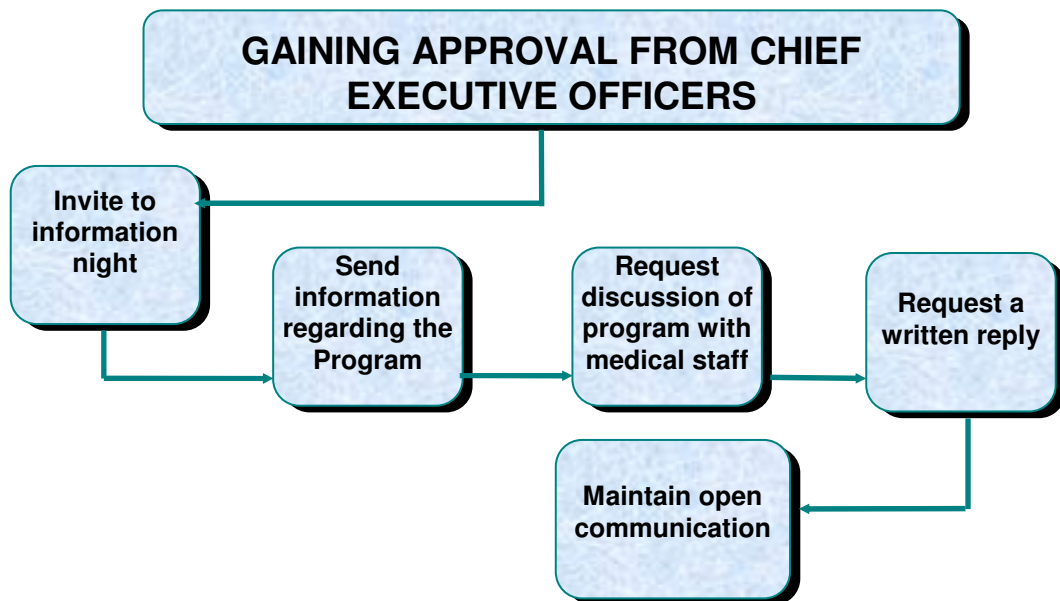


Treating General Practitioner's Role

- A reviewed medical record returned to the project officer with a score of 4 or more is considered to be an adverse event. This medical record is then sent to the original treating general practitioner for follow up comment. A copy of the form sent to the general practitioner is contained in the Appendices.
- The treating general practitioner has the opportunity to supply additional information to assist in the discussion of the adverse event and can also comment on the assessment of the medical record made by the medical reviewer.
- The medical record and completed forms with comments are then returned to the project officer.
- The postage requirements for the medical record are the same as for the medical record sent to the reviewing general practitioner.
- The treating general practitioner is sent a follow up letter by the Project Officer informing the general practitioner about the progress of the record through to the reference panel meeting.



HOSPITAL CHIEF EXECUTIVE OFFICERS

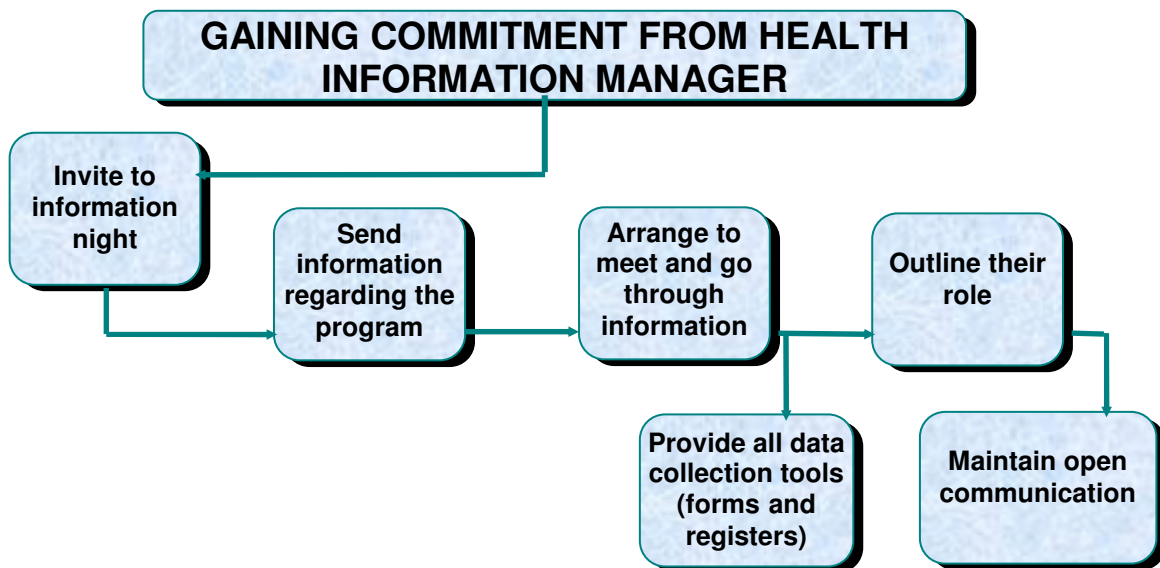


Role of the Chief Executive Officer

- Attend information meeting.
- Give consent for the hospital's medical records to be photocopied and sent for review.
- Give a commitment ensuring adequate health information manager time is available for the screening. Photocopying of medical records is time consuming and can therefore be completed by clerical staff with available funding from the Division.
- Ensure that medical staff are aware that the program is being conducted and that the hospital medical records are being sent for peer review.
- Chief executive officers ensure that reports from the reference panel meetings are summarised and presented by the visiting medical officers to the hospital quality improvement committee.
- Chief executive officers will receive recommendations directly from the program. They are to ensure that these recommendations are discussed at the appropriate forum and not act on them until discussion has occurred.

Note: The Project Officer should receive written approval from the Chief Executive Officers giving their consent for their medical records to be screened and sent for review.

HEALTH INFORMATION MANAGER



Checklist - data collection tools required by the Health Information Manager

- Hospital codes
- General practitioner codes
- Analysis forms
- Definition of criteria
- Hospital register
- Registered reply paid addressed post packs
- Confirmation of postage cards
- Blue photocopy paper

Note: A draft sample of all data collection tools is in the appendix.

Role of the Health Information Manager

- The Health Information Manager must commit time to screening and organising the photocopying of selected medical records. Clerical staff can complete the photocopying. Funding is available for this clerical support.
- During the routine discharge coding process medical records of all patients are screened for an adverse event.
- If any medical record meets one or more of the Limited Adverse Event screening criteria, the relevant admission(s) are photocopied. The top section of the analysis form is completed and attached to the front of the photocopied record.
- The original patient medical record is filed.
- The photocopied medical records are logged into a register.
- The photocopied medical records are sent to the project officer by registered mail in the Post Paks provided by the Division.
- The medical records are logged off the register once the Health Information Manager receives confirmation from the Project Officer that the medical record has been shredded.
- The Project Officer will forward a quarterly payment of \$4.50/record to participating hospitals to assist with administration costs.

PROJECT OFFICER

Role of the Project Officer

The Project Officer has responsibility for implementation of the program under the direction of the management committee. The Project Officer is required to ensure the program runs efficiently and effectively with limited supervision.

The Project Officer is responsible for:

- Co-ordinating and facilitating communication between the management committee, chief executive officers, health information managers and general practitioners.
- Assisting with recruitment of general practitioners who will review medical records and attend the reference panel meetings.
- Facilitating the organisation of training sessions for reviewing general practitioners.
- Organising reference panel meetings, including the distribution of the recommendations to visiting medical officers of hospitals involved in the program.
- Regularly reporting on the progress of the program to the management committee through monthly reports.
- Overseeing the handling of medical records ensuring a high standard of quality and confidentiality through the development of appropriate data collection tools such as registers and codes. Appropriate mailing systems should ensure that the movement of medical records is tightly managed. Records must be kept in a locked cabinet and facility.
- Monitoring and evaluation of the program.
- Overseeing the documentation and reimbursement of expenses, such as payment for review of medical records time, meeting costs, office costs and management tools.
- *Note: For draft copies of the job description see the Appendices.*

It is the Project Officer's responsibility to ensure that:

- Regular contact is maintained with all participants.
- A contact person is identified (this is usually the project officer).
- Meetings are at a time suitable for all participants.
- The program has statutory immunity cover before any medical records are photocopied and sent out for review (refer to statutory immunity section).
- All general practitioners are aware that their medical records are being sent for peer review.

STATUTORY IMMUNITY COVER

The following information was provided to the West Vic Division of General Practice by the Department of Human Services, Victoria.

Section 139 of the Health Services Act 1988 enables quality assurance bodies of registered funded agencies, health service establishments, psychiatric services or professional associations to obtain statutory immunity to promote full and open discussions of quality issues. Section 139 was designed to ensure that information generated specifically for the purposes of 'gazetted' quality assurance bodies which could identify expressly or by implication, any individual (including quality assurance committee members, health practitioners and patients) is not capable of disclosure to any person or body outside the quality assurance body and is not admissible in court proceedings.

Sub-section 139(1) of the act provides the Minister for Health with the power to declare a specified committee, council or other body ('committee') as 'an approved quality assurance body' for statutory immunity purposes.

In accordance with **sub-section 139(2)** of the Act, the Minister must not approve a committee unless he or she is satisfied that:

- a. it is established under the by-laws or constitution of the agency.
- b. its functions include the assessment and evaluation of the quality of health services provided by the agency, including the review of clinical practices or clinical competence of persons providing those services.
- c. the carrying out of its functions and powers would be facilitated by the provision of certain immunities in respect of proceedings; and
- d. it is in the public interest that persons be prohibited from disclosing information given to it in the course of the carrying out of its functions.

The underlying aim is to provide a protected environment where health care professionals can freely review treatment of individual patients and ways in which this can be improved. The ultimate objective of the statutory immunity protection is to enhance clinical care standards.

Scope of statutory immunity

A number of questions have arisen about the scope of statutory immunity provided for under section 139 of the Health Services Act. It is definitely not the case that all documentation generated by a gazetted quality improvement committee is protected from disclosure in all circumstances.

The following points should be noted about s.139:

- The immunity applies only to gazetted quality assurance bodies and does not actually take effect until the notice is published in the Government Gazette.
- Section 139 does not cover case notes used to provide care for the patient or any reports or documents prepared as part of the patient's ongoing care.

- Section 139(3) and (4) do not apply to information or documents that do not identify, expressly or by implication, a particular individual or individuals (such as aggregate data).
- The ‘immunity’ conferred by s.139(3) and (4) only covers current and former *members, officers and employees of a gazetted quality assurance body*. It does not cover the Division itself or Division staff who are not members, officers or employees of a gazetted quality assurance committee.

Requirements for Divisions prior to applying for Statutory Immunity for the Reference Panel Committee

Section 139 (2) (a) of the Health Services Act requires the quality assurance body to be established under the constitution of a professional association. Accordingly the constitution of the Division managing the clinical risk project should provide for the establishment of the committee. Divisions supporting this project will need to call a special general meeting to include a clause as outlined in **Attachment A**. The clause should clearly state the functions of the quality assurance body (i.e. reference panel) include the assessment and evaluation of the quality of health services provided by GP members of the Division (i.e. the process of Clinical Risk Management), including the review of clinical practices and/or clinical competence of persons providing those services (i.e. the participants of the Reference Panel).

If the committee wishes to establish sub-committees, Divisions will need to note that the statutory immunity granted to a gazetted quality assurance committee will only extend to cover a true sub-committee. The Department of Human Services takes the view that a true sub-committee is one which is comprised of members drawn solely from the parent body and which includes, in its principle functions, the matters specified in section 139 (2) (b). If the association intends sub-committees of the committee to be created, the Department requires the constitution of a professional association to include clauses establishing sub-committees. **Attachment A** provides an example of clauses suitable for this purpose.

As noted these sample clauses in **Attachment A** will assist you in drafting suitable clauses for the purposes of section 139. However, Divisions are encouraged to seek their own legal advice with respect to any amendments to their rules and with respect to the scope and limitations of section 139 more generally. Divisions are also encouraged to submit a draft of any proposed changes to the Department for review before they proceed to change their rules.

ATTACHMENT A

Section 139 (2) (a) and (b)

The Board may establish as many quality assurance committees for the Division as, in the opinion of the Board, are necessary or desirable.

The functions of each quality assurance committee established by the Board shall be the functions specified by the Board for that committee and must include:

- (a) The assessment and evaluation of the quality of health services provided by the members of the Division; and

- (b) The review of clinical practices or clinical competence of persons providing those services.

In establishing a quality improvement committee, the Board must specify the:

- (a) Name of the committee.
- (b) Initial Chairperson and initial members of the committee.
- (c) Rules of membership of the committee.
- (d) A quorum for the committee.
- (e) Procedures to be followed by the committee.

(NB. It also may be appropriate to include provisions relating to quorums, vacancies etc.)

Sub-committees

A quality improvement committee established by the Board may form sub-committees. A sub-committee shall consist solely of the members or officers of the quality assurance committee for the time being.

In establishing a sub-committee, the quality improvement committee must specify the members and functions of that sub-committee.

What must be included in a statutory immunity application?

Included as **Attachment B** is the application process for obtaining statutory immunity. These procedures should be carefully observed to ensure that statutory immunity applications are processed as quickly as possible.

For this reason a check list (**Attachment C**) is also provided with the aim of ensuring that very few applications should be returned to hospitals because of inadequate documentation. Please note that this checklist must be completed in full and attached as a cover-sheet to the statutory immunity application.

Review of Statutory Immunity

The Department is currently reviewing section 139 as part of a wider review of existing Victorian legislation designed to support quality improvement in the health care sector.

A discussion paper canvassing the ways in which a coherent statutory framework can facilitate quality improvement will be released and all stakeholders will have an opportunity to comment and provide feedback on the specified reform options.

ATTACHMENT B

Statutory immunity – application procedures

THE APPLICATION PROCESS:

Agencies (i.e. Divisions of General Practice) seeking to apply for statutory immunity under section 139 of the Health Services Act (1988), must submit an application consisting of all of the following documents:

- a **completed statutory immunity checklist** attached as a coversheet to the application
- a **covering letter**, addressed to the relevant contact point in the Department of Human Services (refer to advice below), indicating that statutory immunity is being sought for a specified committee or committees, whichever the case may be;
- a **letter to the Minister for Health** (refer to proforma letter) - seeking declaration of the specified committee or committees;
- a copy of the agency's **by-laws or constitution** which provide for the establishment of the specified committee;
- the **terms of reference** for each committee for which statutory immunity is sought, including its membership and reporting structure;
- a copy of the agency's **quality plan**; and
- supporting documentation demonstrating that it is in the **public interest** to provide statutory immunity for each committee specified in the application.

Applications should be submitted via the following contact points in the Department of Human Services:

- *For all rural public hospitals/Divisions of General Practice*, applications should be addressed to the appropriate Regional Office of the Department of Human Services. The application will then be referred onto Head Office for an initial assessment.

When an application has been received it will be reviewed to ensure that the checklist has been completed and all required documents have been provided. If all is in order a letter acknowledging receipt of the application will be sent to the agency. If the checklist is not completed in full the entire statutory immunity application will be sent back to the agency for amendment and resubmission.

Once an application is complete it will then be assessed by Acute Health to determine whether it meets the criteria outlined in section 139. This may include obtaining advice from the Department's Legal Services Branch.

After it has considered the request the Department will then seek a decision under section 139 from the Minister. (Under section 139 it is the Minister who determines whether a committee should be an approved quality assurance body).

Where a request has been submitted to the Minister by the Department, agencies should note that the Minister may request further information before making a decision.

If the Minister approves an application by declaring the specified committee 'an approved quality assurance body' for the purposes of section 139, a copy of this declaration will be published in the *Victorian Government Gazette*. The agency will also be notified in writing by the Minister for Health. The Department will also provide the agency with a copy of the published gazette notice. The statutory immunity protection afforded by this declaration will take effect from the date of publication of the gazette notice.

Please Note: To minimise delays it is recommended that agencies clarify any queries with the Department prior to submitting their application. Further information regarding the application process may be obtained from Anna Hancox, Performance Unit, Quality & Care Continuity Branch on (03) 9616 7258.

SOME IMPORTANT INFORMATION:

COMMITTEE FUNCTIONS ~ SECTION 139 (2):

The intent of section 139 of the Act is to provide statutory immunity protection for quality assurance bodies with a **clinical** focus that will facilitate improvements to health services and health care outcomes. It was designed to provide statutory immunity in quite specific circumstances where a committee's emphasis will be upon the review of clinical practice or clinical competence. It is the responsibility of the agency to demonstrate how it considers that the functions of each of the specified committees in respect of which statutory immunity is sought, meet the requirements of **section 139 (2)**.

PUBLIC INTEREST:

Under section 139 (2)(d), the Minister must not approve a committee, council or other body unless he or she is satisfied that;

'it is in the public interest that persons be prohibited from disclosing information given to it in the course of the carrying out of its functions'.

The following criteria will provide guidance to agencies in establishing a public interest argument for the approval of a quality improvement committee as required under s. 139(2):

- the committee will be undertaking systemic quality improvement work in compliance with a detailed quality improvement plan;
- the committee will play a central and clearly defined role as part of a systemic approach to quality improvement on the part of the sponsoring organisation(s);
- the committee's work is likely to result in demonstrable improvements to health services and improvements in health care outcomes, and this work will not be done or is unlikely to be done without the benefit of statutory immunity;
- there is a clear strategy in place for communicating and implementing the committee's findings and recommendations for improvements within the relevant organisation and for reporting in general terms on the activities and findings of approved quality improvement committees by the organisation;
- there are suitable mechanisms in place to review the effectiveness of the quality improvement committee; and
- overall the benefits to be gained from approving the committee outweigh any disadvantages that may be caused to individuals or the public as a result of the granting of approval.

Whilst each case must be assessed on its merits, it is recommended that applications address the above criteria for each committee for which statutory immunity is sought and also provide sufficient supporting information to demonstrate that these criteria are met in relation to each committee.

For example, it is recommended that an application provide a detailed explanation of the organisation's systemic quality assurance strategy and how the activities of the committee seeking statutory immunity fits within, and contributes to, the achievement of the objects of this strategy.

This should include a discussion of how the activities of the committee are expected to improve the identification and management of risks and systemic failures in the provision of health care and explain how this would be facilitated by the granting of statutory immunity to the particular committee.

The above criteria are a guide only and additional material or other arguments supporting the application for statutory immunity are welcome.

RE-APPLYING FOR STATUTORY IMMUNITY:

Should the name and/or terms of reference of 'an approved quality improvement body' change from that specified in the approved application the relevant agency will be required to reapply for statutory immunity.

ATTACHMENT C

Statutory immunity checklist

This checklist must be **COMPLETED IN FULL** and included as a cover sheet to all statutory immunity applications

NAME OF HEALTH SERVICE/HOSPITAL/DIVISION:

.....

COMMITTEE(S) FOR WHICH STATUTORY IMMUNITY IS SOUGHT:

1.
2.
3.
4.
5.

All boxes must be ticked before a statutory immunity application will be processed

COVERING LETTER ADDRESSED TO THE RELEVANT CONTACT POINT IN THE DEPARTMENT OF HUMAN SERVICES

COPY OF AGENCY BY-LAWS OR CONSTITUTION ATTACHED

COPY OF AGENCY QUALITY PLAN ATTACHED

COPY OF TERMS OF REFERENCE FOR EACH COMMITTEE FOR WHICH STATUTORY IMMUNITY IS SOUGHT

LETTER TO MINISTER FOR HEALTH ATTACHED AND SIGNED BY THE CHIEF EXECUTIVE OFFICER OF THE AGENCY

PROVIDED A PUBLIC INTEREST ARGUMENT FOR EACH COMMITTEE FOR WHICH STATUTORY IMMUNITY IS SOUGHT

Proforma letter to the Minister For Health

(Letter must be typed on Division letterhead)

Hon John Thwaites MP
Minister For Health
Level 22
555 Collins Street
MELBOURNE VIC 3001

Dear Minister Thwaites

RE:[Insert name of quality assurance committee(s)]

I wish to inform you of the establishment of a quality assurance committee(s), to be known as the [*insert name of the quality assurance committee(s)*] on [*insert date the committee(s) was established*]

I seek your declaration under section 139 of the Health Services Act 1988 of [*insert name of quality assurance committee(s)*] as an approved quality assurance body for the purposes of Part 7 of the Act.

To assist you in making your decision please note that accompanying this letter is evidence supporting our application for statutory immunity. This evidence demonstrates that:

- the committee(s) is/are established under the by-laws/constitution of the [*insert name of the agency*]
- the functions of the committee(s) include the assessment and evaluation of the quality of health service provided by the [*insert name of the agency*]
- the carrying out of the functions and powers of the committee(s) would be facilitated by the provision of those immunities provided by section 139 of the Health Services Act 1988.
- there is a strong enough public interest argument for each committee for which statutory immunity is sought.

Yours sincerely

[*to be signed by the CEO or Chair of the Division*]

Data Collection Tools

For the program to run efficiently data collection tools must be developed. Examples that are being used in the small rural hospital clinical risk management program are outlined in this section.

Note: These are a guide and may need to be modified to meet the local circumstances of your program.

1. Analysis Form

Note: A sample of the analysis form used in the small rural hospital clinical risk management program is in the Appendices.

Format

Guidelines:

Design a form, which is clearly laid out and easy to use.

Design the form so that codes are used to ensure anonymity of the hospital, treating and reviewing general practitioner and patient (use codes and unit record numbers).

Health Information Manager's section of analysis form

Guidelines:

Suggested items for this section include:

Hospital code and the treating general practitioners code. The patient's unit record number, their date of birth, admission date, discharge date, admission ward, discharge code and the health information manager initials.

Add a list of the criteria; give each criterion a number to be entered in the database.

Project Officer Adverse Event No: _____

**CONFIDENTIAL SMALL RURAL HOSPITAL CLINICAL RISK MANAGEMENT PROGRAM
ADVERSE EVENT ANALYSIS FORM**

A. HEALTH INFORMATION MANAGER

Hospital Code: _____	Doctor Code: _____	Sex: _____
Patient UR number: _____	Date of Birth: _____	
Admission Date: _____	Diagnosis Code: _____	
Discharge Date: _____		

Adverse Criteria (Tick all criteria met during this admission)

- () 1. Patient death
- () 2. Returning to theatre within 7 days
- () 3. Unplanned re-admission within 28 days
- () 4. Transfer to another acute care facility
- () 5. Patient length of stay greater than 21 days
- () 6. Unexpected readmission following discharge from another hospital.
- () 7. Any record which has been recommended by a GP for peer review

(Please specify) _____

Suggested definitions of each criterion are included in the Appendices.

Project Officer's sections of analysis form

Guidelines:

Every adverse event analysis form should be given a unique identifying number; this number is used to link the information in the database and on subsequent forms.

Project Officer Adverse Event No: _____

Devise a section including date sent for review, reviewing general practitioner and the time taken to review the medical record.

B. PROJECT OFFICER

Reviewing General Practitioner Code _____
Date Medical Record sent for review _____ Time taken to review record _____

Reviewer general practitioner's completed section of the analysis form

Guidelines:

Incorporate a section for the relevant clinical details of the case.

Establish a rating for the adverse event.

Have a yes/no section asking if the history contains an adverse event. If the answer is no the reviewer moves to the section 'Were they able to reach a decision', the amount of time taken and then signs and dates the form.

C. REVIEWING GENERAL PRACTITIONER:

An **adverse event** is an untoward patient event which, under optimal conditions, is not a natural consequence of the patient's disease or treatment.

Please evaluate the medical care given by rating the evidence that an adverse event was caused by medical management (enter number in box)

1. Little or no evidence of an adverse event caused by management
2. Slight evidence
3. Not quite likely (Less than 50/50 odds, but a close call)
4. More likely than not (Greater than 50/50 odds, but a close call)
5. Strong evidence
6. Virtually certain evidence
7. Uncertain due to lack of information, but worth further discussion.

Score
<input type="text"/>

A score of 4 or higher is considered an Adverse Event and is referred to the Reference Panel for Quality Improvement action.

Does this record contain such an Adverse Event? YES()NO()

1. Please give relevant clinical details regarding the case:

If the answer is yes the reviewer completes the information below.

- *Where the adverse event occurred*
- *The severity of the adverse event,*
- *Rating of preventability.*

2. Tick location of Adverse event:

() Inside hospital () Outside hospital () Another facility

3. Select a code for the severity of the Adverse Event (enter number in box) :

- 0.= **Minor severity**, no disability (definition: no significant resultant discomfort; no cosmetic or functional impairment; and no increased length of stay as a result of the adverse event).
- 1.= **Minor temporary**, (definition: minimal to moderate clinical effect requiring no or minimal clinical intervention, or no increased length of stay or re-hospitalisation for the same or related problem)
- 2.= **Minor permanent**, (definition: minimal to moderate clinical effect with permanent residual, and without significant functional or cosmetic impairment)
- 3.= **Major temporary**, (definition: moderate to severe clinical effect with no significant functional or cosmetic residual effect) This usually results in increased length of stay or re-hospitalisation and requires moderate to major clinical intervention.
- 4.= **Major permanent**, (definition: moderate to severe clinical effect with significant functional or cosmetic residual).
- 5.= **Potential major or major continuing**, (definition: when doubt exists as to the outcome but the probability is that a major impairment or repeated hospitalisation will be necessary).
- 6.= **Death.**

Score

4. Rate on a 6 point scale your confidence in the evidence for preventability:

- 1.= little or no evidence for preventability
- 2.= Slight or modest evidence for preventability
- 3 = Preventability not quite likely ; less than 50 - 50 but close call
- 4.= Preventability more likely than not; more than 50 - 50 but close call
- 5.= Strong evidence for preventability
- 6.= Virtually certain evidence for preventability

Score

Allow space for comments on further action recommended.

Include a section on the adequacy of the medical record data and any limitations that the reviewer may have had with the medical record.

Provide a section for the time taken to review the medical record, the reviewer's signature and the date.

5. What further action would you recommend?:

6. Were you able to reach a decision on the information contained in the patient's medical record?:

() YES () NO

If no was it due to:

() Lack of information () Legibility of notes () No discharge summary () Other _____

7. Time

Time taken to review record _____ Minutes

Reviewers signature _____ Date _____

(To ensure confidentiality, name of reviewer is not required)

2. Registers to assist in identifying the location of medical records.

For the pilot project several manual registers were developed to assist in the tracking of medical records throughout the process. The registers were of a similar format with variations relating to audience. Samples of registers used in the small rural hospital clinical risk management program are in the Appendices.

For the ongoing program a data base on Microsoft Access was developed. This data base has 2 functions: The first is an administration function that contains details of hospitals, general practitioners, codes and payments. The second is to track the medical record through the system, recording reviewers and treating GP comments and producing reports for the reference panel, participating GPs and hospitals.

Participating hospitals will also need to keep a register. This register is maintained by the Health Information Manager and can be a manual or electronic record.

- O **Health Information Manager hospital register:** This register is used by the Health Information Manager to log in medical records that have been sent to the Project Officer and then sent for medical review. Once the Health Information Manager has been notified that the medical record has been shredded it is then logged off the register.

The program database contains a number of registers. The same data can be collected on a paper based system if preferred. These registers are maintained by the Project Officer.

- O **Hospital register:** Each hospital is allocated a unique code and register, where the records are entered upon receipt by the Project Officer.
- O **Reference panel register:** This register records the medical records the reference panel has identified for further discussion.
- O **Treating general practitioner register:** This records the medical records that have been returned to the treating general practitioner for comment.

1. Format

Guidelines:

All registers need to be clearly set out and easy to use.

The registers can be formatted on a spread sheet or word processing program.

The program data base also has a tracking system for the progress of the medical record.

2. Information contained in the registers

Guidelines:

Unique identifying number of the medical records sent for review (all registers).

Criterion number - the number of the criterion under which the medical record was screened positive. This can be one or more of the criteria listed (for all registers except the general practitioner register).

Patient unit record number - the hospital unit record number on the patient medical record (all registers).

Discharge date – as a particular medical record may be screened positive for more than one admission (all registers).

Date sent for medical review (all registers).

Date shredded (Health Information Officer & Project Officer register).

Reviewing general practitioner - general practitioner that the medical record was sent to (project officer register).

Date reviewed by the reference panel - the date that the reference panel meets and discuss the medical records. (reference panel register).

Time Taken - the amount of time spent by the reviewer going through the medical record and completing the analysis form. (general practitioner register).

Total time taken. (general practitioner register).

3. Reference panel report form

This form is placed on the front of each medical record that has been identified for further discussion by the reference panel. The Project Officer prepares a summary of the reference panel report before the meeting. During the reference panel meeting the chairperson completes the issues and recommendations section on the form as each item is discussed.

Note: A sample of the reference panel report form is in the Appendices.

Components of the form

Guidelines:

Record the unique identifying form number to identify the medical record that has been reviewed.

The screening criteria met by this medical record.

Prior to the meeting a summary of the clinical details can be performed by the Project Officer. This can be gathered from the information contained on the Adverse Event Analysis Form in the data base. There needs to be a space available to add information from discussion of the medical record.

Further action recommended: *this is the reviewer's comments obtained from the analysis form*

Treating general practitioner's comments: *add comments made by treating general practitioner after the initial medical review.*

Issues *that have been raised from discussion of each case.*

ISSUES Please list

1. _____

2. _____

3. _____

Recommendations can be broken down into three areas:

Medical i.e. medical management of the patient.

System/hospital i.e. hospital policy/procedures and management

Clinical risk management i.e. training and education.

RECOMMENDATIONS

(1) MEDICAL ie. principally related to medical management of the patient
Please list

(2) SYSTEM / HOSPITAL ISSUES ie. principally related to hospital policy/procedures & management
Please list

(3) CLINICAL RISK MANAGEMENT ISSUES ie. principally related to training & education
Please list

This section notes the types of issues raised and allows for any further notes to be made regarding the case.

Issues identified

Other identified issues

4. Hospital and general practitioner codes

Objective

- To maintain confidentiality and anonymity for the general practitioners and hospitals involved in the program.
- To have a standardised code when entering data on the data base.

Ensure that the form has no identifiable information regarding the patient, general practitioner or hospital.

Steps

A. Prepare the hospital and doctor codes

Guidelines:

These are specific to this program only. For the purpose of this program, hospital codes are made up of four digit numbers and the general practitioner's codes were made up of three digit numbers. The general practitioner codes were identified from the hospital codes by putting D in front of the general practitioners code. Select the codes for each hospital randomly and record them on the computer. Also keep a hard copy.

B. Distribute the codes

Guidelines:

Each health information manager should only be given their hospital's code and the codes for the individual general practitioners who have admitting rights to their hospital. Ensure that the codes are kept confidential.

5. Database

Objective

- It is an administrative tool that tracks the progress of the record and the clinical risk management process.
- Collects data on the adverse event for analysis.
- Provides statistical reports when required.

Steps

A. Use the available program in the manual package.

B. Setting up the program

Guidelines:

Ensure that the person keying in the data has training in using such programs.

Summary

It is essential that the data collection tools:

- Indicate that the information collected is confidential.
- Have a coding system that ensures the hospital and doctors involved are unidentifiable.
- Have codes that do not have any other significance outside the program.
- Use random allocation of codes.
- Codes are distributed on a “need to know” basis.
- Include the unit record number and discharge date of each record when entering information on a register, as one medical record may contain multiple admissions for review.

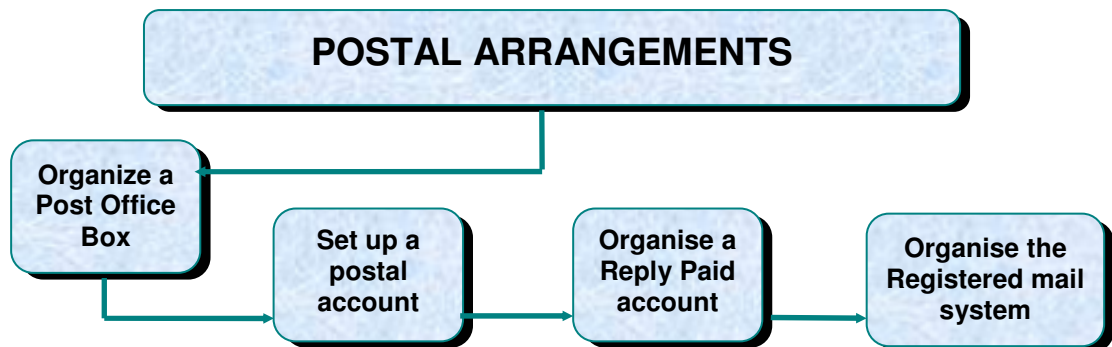
POSTAL ARRANGEMENTS

To ensure a confidential and efficient process for mailing the medical records it is necessary to have an account at the post office. A reply paid account is also required for the return postage materials sent from the Health Information Managers and general practitioners involved in the reviews. In this way all postage costs related to the program are paid by the Division.

Objective of the postal arrangements

- To ensure that the program runs smoothly and efficiently.
- To alleviate any postal cost to the hospitals and general practitioners involved in the program.
- To ensure that all photocopied medical records are sent by registered mail, to maintain confidentiality.
- Ensure that an adequate tracking system is in place to identify where the photocopied medical records are at any given time.

Steps



1. Organize a postal box

Guidelines:

Through the post office arrange for a post office box for program correspondence.

2. Set up an account at the post office

Guidelines:

Through the post office arrange to have all postal costs debited to a monthly account.

3. Organise a reply paid account

Guidelines:

Arrange through the post office for a reply paid address so that all postage charges, for the photocopied medical records sent via the reply paid address, will be billed to the program.

4. Purchase pre-paid registered mail labels and Post Pak tough B6 bags

The Post Paks and labels are supplied to the Health Information Managers to ensure that the photocopied medical records are sent

via registered mail in secure bags. Also send to the Health Information Managers blank registered mail lodgment forms or they can obtain them from the post office. The forms are to be kept as a record of when the registered mail was sent.

5. Confirmation of postage card

Design a 'confirmation of postage' card that can be posted at the same time as the photocopied medical records are sent to the Division. An example of this card can be found in the Appendices. This card alerts the Project Officer that the General Practitioner/Health Information Manager has posted the records.

6. Organise the registered mail system

Guidelines:

When sending the medical records to a reviewing or treating general practitioner, prepare a return addressed Post Pak marked "Confidential" with a registered label, a registered mail lodgment form and a confirmation of postage card attached.

Ensure that the general practitioner knows to keep the lodgment form as a record of postage. This way all the general practitioner has to do, once the review is completed, is to place the copy of the medical record and the completed medical review form in the envelope and have them posted.

FLOW OF MEDICAL RECORDS

To ensure the smooth flow of medical records a streamlined tracking system of the photocopied medical records needs to be established. It is essential that all precautions are taken to prevent the loss of the photocopied medical records (registered mail must be used) and that the Project Officer is able to accurately track the whereabouts of the medical record at all times.

Note: *Ensure that all postal arrangements have been organised*
*This is covered under **Postal Arrangements**.*

Note: *Ensure that all materials required are well prepared*
*This is covered under **Data Collection Tools***

Steps involved in the flow of the medical records

Health Information Manager's Role

HIM 1. Patients' medical records are screened by the Health Information Managers during the discharge coding process.

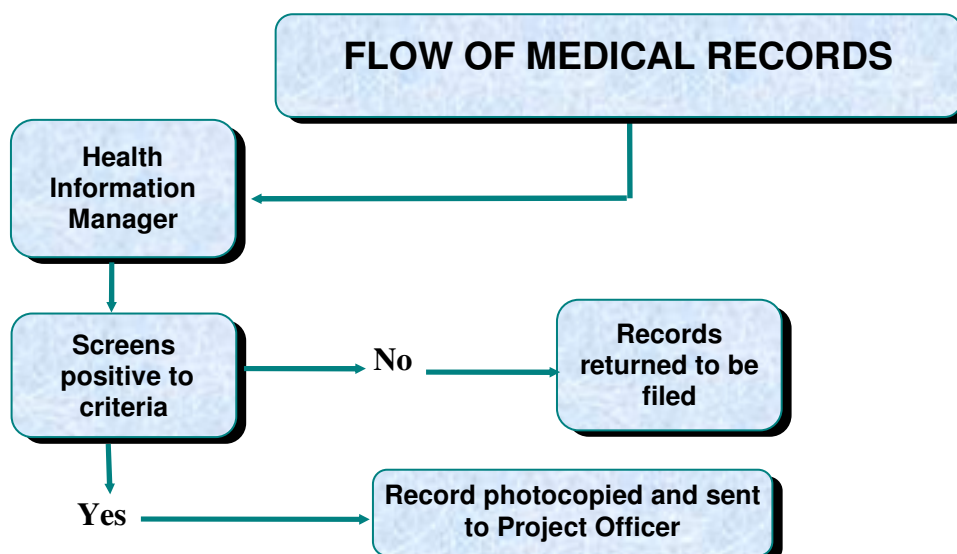
HIM 2. If the medical record meets one or more of the limited Adverse Event screening criteria on the analysis form, that record is photocopied and the top section of the analysis form is completed. If the medical record screens positive to *criterion 3: re-admission within 28 days*, both admissions should be photocopied.

HIM 3. The hospital copy of the medical record is filed.

HIM 4. The photocopied medical record is then logged into the register.

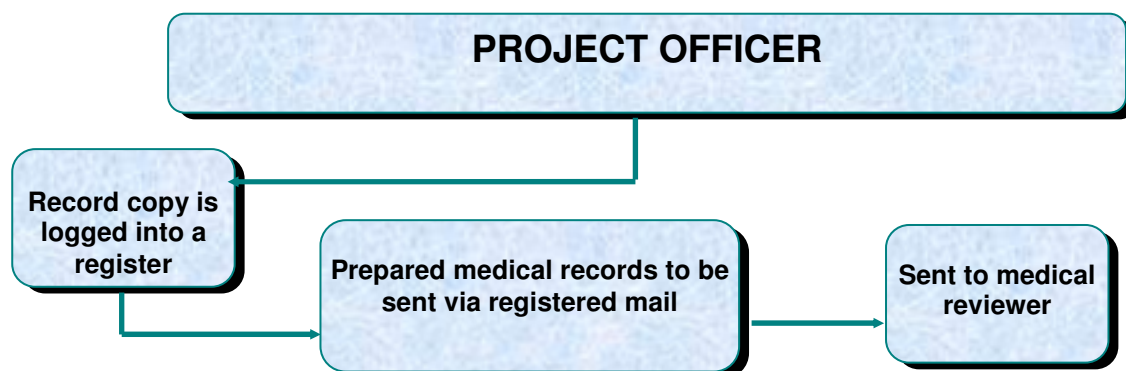
HIM 5. The photocopied medical records are prepared for sending to the Project Officer.

HIM 6. The photocopied medical records are then sent via registered mail to the Project Officer. The registered mail lodgement form is kept as a record.



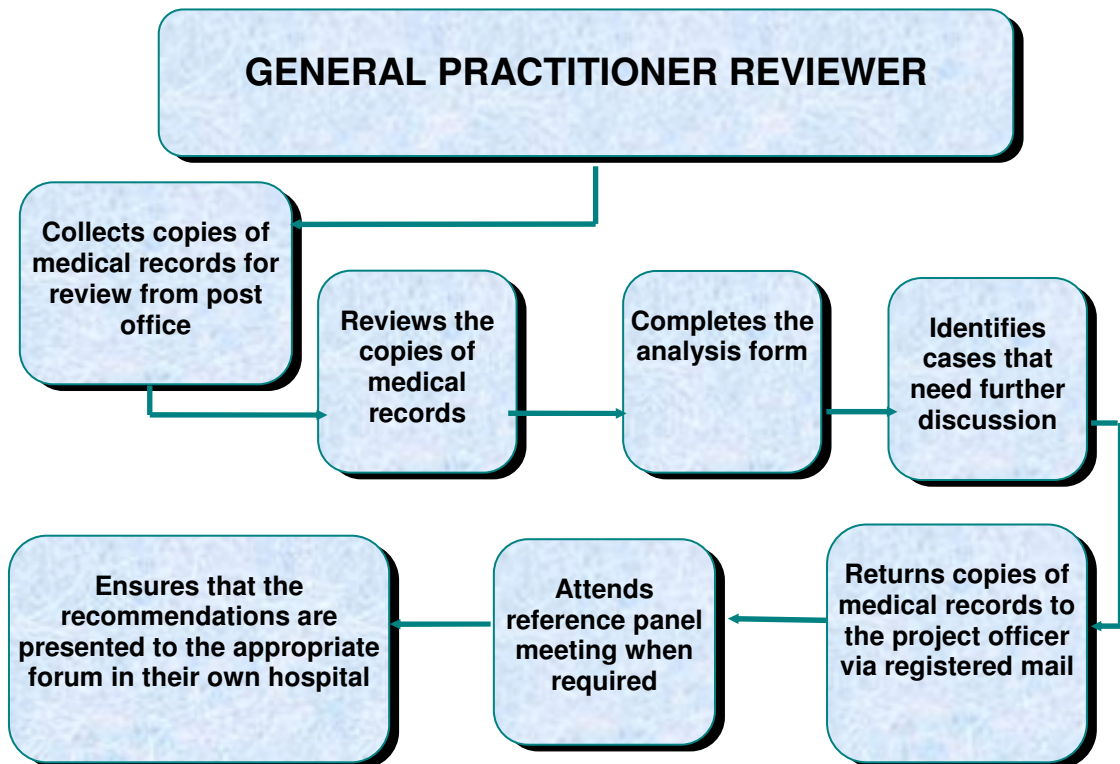
Project Officer's role

- PO 7. The Project Officer collects the mail and signs for it at the post office.
- PO 8. Information regarding the photocopied medical records is logged onto the data base or a manual register.
- PO 9. Hospitals are grouped geographically and the number of groups depend on the number of hospitals. Each hospital has general practitioners who conduct the review of medical records.
- PO 10. Reviewing general practitioners in each group review the hospital photocopied medical records of a different group (this ensures that a general practitioner does not review his own medical records).
- PO 11. The name of the reviewing general practitioner is added to the data base including the date that the record was sent for medical review.
- PO 12. The photocopied medical records are then placed into a large Post Pak that is addressed to the reviewing general practitioner. The Post Pak is to be marked **“Confidential”** with a **registered mail label** and a **delivery confirmation advice receipt** attached.
- PO 13. Another Post Pak is prepared with a **reply paid address label** to be returned to the Project Officer. It is to be marked **“Confidential”** with a **registered mail sticker** and a **registered mail lodgement form** (stapled to it). This ensures that the photocopied medical records are returned by registered mail.
- PO 14. A **confirmation of postage** card is prepared and is sent with the envelope. The card is to be posted at the same time as the medical records are returned to the Project Officer. This will inform the Project Officer that the photocopied medical records are in the mail. If they are not received within a few days the post office is contacted.
- PO 15. All registered mail is logged in the **registered mail form** which contains the registered number and the destination. This form is stamped by the post office with the date and is kept by the Project Officer as a record.
- PO 16. The registered mail is then taken to the post office and posted.



General Practitioner Reviewer's role

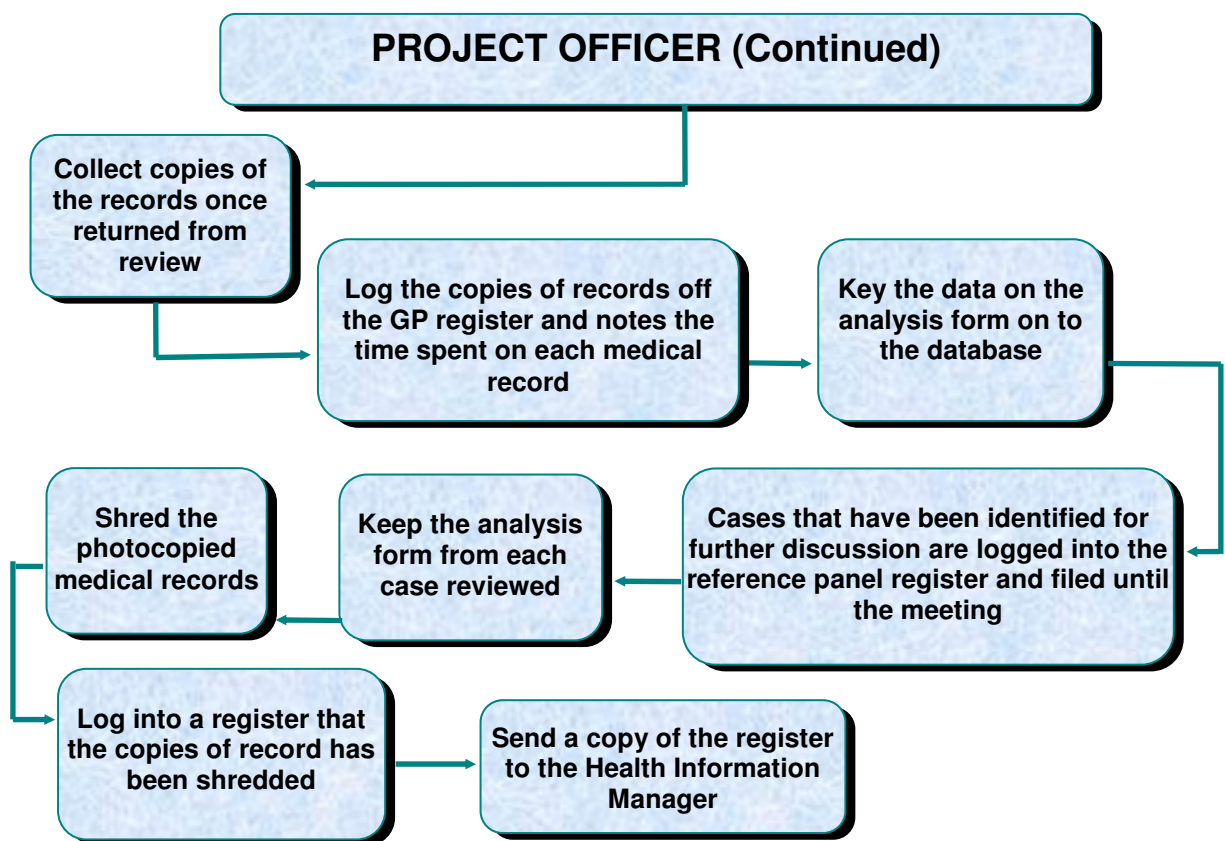
- GP 18. The general practitioner or his/her administration assistant collect and sign for the photocopied medical records at their local post office.
- GP 19. The post office returns the delivery confirmation advice receipt to the Project Officer.
- GP 20. The general practitioner reviews each photocopied medical record.
- GP 21. The general practitioner completes the analysis forms and records the time spent on each review.
- GP 22. The photocopied medical records and completed analysis form are then placed in the Post Pak provided and returned via registered mail to the project officer within 1 month of receiving the medical records.
- GP 23. The registered mail lodgement form is filed as their record and the confirmation of postage card is posted to the Project Officer.



Project Officer's role (continued)

- PO 24. The Project Officer collects and signs for the registered mail.
- PO 25. The information on the analysis form is entered in the database.
- PO 26. The analysis form is removed and the medical record is logged out of the general practitioner's register.

- PO 27. For records returned with a medical review score below four: enter on the database and file the analysis form. The photocopied medical records are shredded. Details of the shredding are logged into the data base and a report is sent to the Health Information Managers so that they can log the shredded medical record off their register. A photocopying payment is also sent to the hospital with the report.
- PO 28. For medical records returned with a medical review score of four or above: the photocopied medical record is returned to the original treating general practitioner for his comments on the assessment of the record. The same postage procedure as for the reviewing general practitioner is used. These medical records are logged into the data base for the treating general practitioner. Often, once this information has been provided, there is no need for recommendations
- PO 29. When the treating general practitioner sends the medical record back to the Project Officer, it is logged into the data base for review by the reference panel. These photocopied medical records are presented at a subsequent reference panel meeting for discussion. After the meeting the Project Officer shreds the photocopied medical record and notes this on the data base.



Health Information Manager's role (continued)

- HIM 30. On receipt of the register the Health Information Manager notes on their register that the medical record has been shredded.

REFERENCE PANEL MEETING

The purpose of the reference panel meetings is to draw general practitioners together to discuss medical records that have been previously identified as containing an adverse event by the medical review. In keeping with the anonymous, non-threatening nature of this program this assessment will be discussed anonymously and used as a learning experience for all reviewing general practitioners. The meetings allow the general practitioners reviewing records to confidentially discuss the adverse events under the protection of statutory immunity. The reference panel meeting gives general practitioners the opportunity to discuss the medical records with their peers, raise issues of concern about medical practices and develop recommendations to help improve patient care.

Organising the reference panel meeting

Details of the organisation of meetings can be found in the Appendices.

In addition to the usual organisational procedures:

- Select a chairperson for the meeting. The chairperson will assist the project officer compile the final report.
- Prior to the meeting go through the medical records that are to be discussed by the reference panel. There are two methods of preparation:
 - 1) All records with an adverse event are discussed at the meeting.
 - 2) Chairperson (or elected general practitioner) vets the records before the meeting. This general practitioner should have an understanding of peer review. Often, once a treating general practitioner has recorded his comments on an adverse event, it is not necessary for the record to progress to the reference panel.
- The general practitioners attending the meeting are given a summary of the records to be discussed without any data that can identify a hospital, doctor or patient. This allows open communication without the participants being aware of the identity of the general practitioner involved in the case being discussed.

Reference panel meeting

- The chairperson opens the meeting by explaining the meeting has statutory immunity under s.139 of the Health Services Act 1988
- The medical records that scored four or more at medical review are then discussed. The chairperson has the medical record to refer to and the reviewing general practitioners have the summary that was sent to them prior to the meeting.
- **Guidelines:**
- *General practitioners will present record summaries they have reviewed, outlining the issues for discussion. If the reviewer is not at the meeting the chairperson discusses the issues identified.*
- As each medical record is discussed the chairperson completes the reference panel report form attached to the front of the medical record.

Guidelines:

The reference panel report form has been devised to assist in developing the recommendations following the meeting (Appendices).

After the meeting:

- Ensure that all information (copies of analysis forms, copies of the medical records discussed) have been collected for shredding once the meeting is finished.
- In conjunction with the chairperson, the Project Officer prepares a report on the meeting for all participants.
- **Guidelines:**
- *This report is sent only to participants of the meeting. It is a confidential report, covered by statutory immunity.*
- In conjunction with the chairperson, the Project Officer prepares a report on the recommendations arising from the meeting.

Guidelines:

This report is sent to all visiting medical officers of the hospitals involved in the program. These general practitioners then present local issues to their quality improvement committee or other appropriate forum. The report has a short de-identified clinical summary outlining the issues in the medical record and identifying the recommendations in three areas: hospital, medical or quality improvement issues.

- Chief executive officers of participating hospitals are also sent a copy of the recommendations. The Chief Executive Officer is to ensure that the recommendations are discussed at the next hospital quality assurance meeting or another appropriate forum.
- The recommendation report can be:
- Sent out in its entirety following each reference panel meeting; or
- A set number of recommendations (for example - three) can be sent out on a regular basis (for example - every 3 months).

It is essential that the reference panel meetings:

- **Start with the statutory immunity statement** (*Refer to section on statutory immunity*).
- Ensure confidentiality of the patients, hospitals and general practitioners is maintained throughout the meeting.
- The report detailing the recommendations is sent to the visiting medical officers of the hospitals involved in the program. They are asked to discuss the issues outlined with their local peers and present the local issues to the appropriate forum in the hospital.
- A representative from the hospital forum is required to provide feedback on local discussion of the recommendations. This feedback is provided to the Project Officer.

Sample document: Recommendation Report

Confidential Small Rural Hospital Clinical Risk Management Program Reference Panel Report

***Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act***

Unplanned re-admission within 28 days

Transfer to another acute care facility

SUMMARY

70 year old male admitted with (L) sided stroke and hypertension. Diagnosis confirmed by CT scan and patient sent home four days later on anti hypertensive medication. Readmitted five days later with further stroke. Investigated further with repeat CT scan and carotid doppler ultrasound and started on anticoagulants. Transferred two days later to large metropolitan hospital when stroke became denser.

Issues

- Unclear as to what the discharge medication was.
- Inadequate documentation

RECOMMENDATIONS

Hospital

1. That documentation of discharge medication to be put in the discharge summary or medical record.
2. That hospitals have an medical history sheet used on admission that provides a prompt to collect all relevant patient details. When patients are transferred to another hospital the standard transfer letter should include a request for a discharge summary which can later be included in the referring hospitals' medical records. Along with the recommendation to include death certificate copies in the medical records, this recommendation will improve the completeness of the medical record.

Sample document: Recommendation Report

Confidential Small Rural Hospital Clinical Risk Management Program Reference Panel Report

*Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act*

Patient Death

SUMMARY

Patient admitted with metastatic carcinoma for palliative care. Given overdose (five times usual dosage oral Morphine) on two occasions. Morphine ordered "5-10mg orally 4 hourly prn". Patient given 10 mls of morphine 5mg/ml - 50mg. This probably accelerated death. Last medical officer to see patient noted that patient died after large haemoptysis – this was not recorded in nursing report.

ISSUES

- Dosage administered in ml instead of prescribed mg leading to a significant overdose.
- Morphine ordered PRN (as required): Is this an inappropriate way to order analgesics in this situation?

RECOMMENDATION

Medical

1. When prescribing mixtures the dosage is to be prescribed as a dose (mg) as well as volume (ml).

Hospital

2. Hospital pharmacy committee is to review the correct way of ordering syrups. We recommend that the medication chart allow for the prescribing of both the strength of the mixture and the number of ml to be administered.

Sample document: Recommendation Report

Confidential Small Rural Hospital Clinical Risk Management Program Reference Panel Report

*Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act*

Patient Death

SUMMARY

Elderly 82 year old patient with a past history of renal failure and ischaemic heart disease, was admitted with congestive cardiac failure and found to have significant hyperkaleamia. The patient died the morning following admission. This patient admitted with "acute dyspnoea", was not reviewed for 11 hrs by a doctor following admission. There was no evidence in the medical record that an ECG had been performed or was there any documentation of an attempt to treat hyperkaleamia. This patient had multiple significant problems.

ISSUES

- Inadequate hand over, patient was not reviewed for several hours after admission.

RECOMMENDATION

Hospital

1. To ensure patients are promptly reviewed, each hospital needs to review its hand over guidelines for after hour emergency admissions.
2. Hospitals need to consider admitting patients formally under the doctor who will continue to look after them.
3. All medical admission forms need to contain a section which lists the medication that the patient is on prior to admission.

Sample document: Recommendation Report

Confidential
Small Rural Hospital Clinical Risk Management Program
Reference Panel Report

***Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act***

Patient Death

SUMMARY

79 year old man with a past history of chronic obstructive airways disease, and carotid and peripheral arterial disease. Admitted "pale and unwell". Diagnosed as congestive cardiac failure and having had anterior myocardial infarction. Oxygen saturation was 52% on air, 90% on oxygen. Respirations ceased 6 & 1/2 hours post admission. Cardiac enzymes and ECG didn't support diagnosis of myocardial infarct. The reviewer queried whether the death was due to respiratory failure ie. CO₂ retention, caused by over treatment with oxygen.

ISSUES

- Cause of death not determined.
- Seriously ill patient not monitored frequently.
- Oxygen therapy may have lead to respiratory depression.

RECOMMENDATIONS

Medical

1. Investigate role of oxygen in patient with severe respiratory problems. *

Hospital

2. To review the issues of indications, availability and logistics of post mortem examinations.
 -] As a result of this comment the West Vic Division of General Practice sought advice from a local respiratory physician who provided medical literature which was sent with the report to all participating visiting medical officers.

Sample document: Recommendation Report

Confidential
Small Rural Hospital Clinical Risk Management Program
Reference Panel Report

***Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act***

Unplanned re-admission within 28 days

Summary

29 yr old (Para 2) woman had Keilland's delivery. Had postpartum haemorrhage of 600+ mls (no Haemoglobin measurement taken or iron tablets prescribed to our knowledge). Discharged on day two and readmitted two days later with Haemoglobin of 60g/l for transfusion. Not documented where haemorrhage occurred.

ISSUES

- Difficulty in assessment / diagnosis of post partum haemorrhage.
- Lack of information.
- Appropriateness of early discharge after midcavity forceps delivery and post partum haemorrhage.

RECOMMENDATIONS

Medical issue

1. Medical staff should review within their group the management of post partum haemorrhage.
2. That haemoglobin should be checked two days after a post partum haemorrhage.

Hospital issue

3. The appropriateness of early discharge of patients with a history of a difficult or complicated birth.

Sample document: Recommendation Report

Confidential Small Rural Hospital Clinical Risk Management Program Reference Panel Report

Covered By West Vic Division of General Practice's Reference Panel Statutory Immunity Cover Section 139 of the Health Services Act

Transfer to another acute care facility

SUMMARY

56 year old woman had laparoscopic cholecystectomy and developed respiratory distress next day. ?aspiration, ?left ventricular failure. Found to be hypokalemic.

ISSUES

- No information regarding her pre-operative state - no evidence of pre-anaesthetic assessment /drugs etc.
- The medical record does not record the patient's pre-operative state, but transfer letter mentions she does get "short of breath".
- No discharge letter from destination hospital included in the medical records.
- Unexplained low potassium.

RECOMMENDATIONS

Medical

1. Documentation on the pre-operation assessment with appropriate investigations carried out and documented in the medical records.

Hospital/System Issues

2. A form could be provided in the medical records for documentation of pre-operation assessment, which is available to assist the anaesthetist and general practitioner/visiting medical officer. *(Examples of such forms were sent with the report)*
3. Copy of the discharge summary from hospital of destination to go back to the referring hospital. Note this has been previously recommended. *(Sample blank transfer letter sent with the report)*

Sample document: Recommendation Report

Confidential Small Rural Hospital Clinical Risk Management Program Reference Panel Report

***Covered By West Vic Division of General Practice's
Reference Panel Statutory Immunity Cover
Section 139 of the Health Services Act***

Transfer to another acute care facility

Unplanned re-admission within 28 days

Patient Death

SUMMARY

84 year old man with extensive premorbid history including congestive cardiac failure, hypertension, recent onset of renal failure and a six week history of diarrhoea. Transferred from rural hospital to base hospital for colonoscopy to investigate diarrhoea. Then re-admitted to rural hospital. Febrile on admission, poor urine output, drowsy. Treated with intravenous Keflin, Lasix and fluids with no response. Noted to have died of septicemia, chest infection, acute renal failure and pulmonary oedema. Patient likely to have been dehydrated on admission following colonoscopy. Not seen by a doctor for almost 21 hours. Intravenous therapy not began until then. This may have precipitated acute renal failure.

ISSUES

- Full investigations were needed – full blood examination, chest X-ray, urea, electrolytes and creatinine estimation.
- Delay in intravenous therapy.
- Danger of colonoscopy procedure and preparation of elderly patients.

RECOMMENDATIONS

Medical

1. Preparation and anaesthetic are not a minor procedure in the elderly and ill.
2. In general doctors need to satisfy themselves beyond doubt that the patient does not need to be visited on admission.
3. Full investigations such as full blood examination, chest x-ray, urea, electrolytes and creatinine estimation to be carried out before the procedure.

BUDGET

Attached is the budget prepared by the West Vic Division of General Practice for the 2001 – 2002 financial year.

The West Vic Division's Clinical Risk Management Program currently provides services for 11 rural hospitals with a total WIES of approximately 13,000. At the time of publication there were twenty general practitioners participating as reviewers. The other factor taken into consideration in preparing this budget were the geographical size of the region (62,500 square kilometres) and the implications this has for travel. It is also worth considering the West Vic Division's clinical risk management program has been running since 1994 and is a well established and accepted program with high levels of participation.

In preparing a budget for establishing a clinical risk management program Divisions should consider their annual costs and then add an additional ten percent for the first 12 months of operation to assist with the additional travel, promotion and educational requirements during the establishment phase.

Items

Project officer (0.5 EFT)	\$	32,000.00
Administration support (0.2 EFT)	\$	7,750.00
Medical reviewer payments /program support	\$	13,000.00
Travel	\$	3,000.00
Postage	\$	5,000.00
Program management / supervision	\$	14,000.00
Hospital administration support*	\$	6,000.00
Office accommodation / phone / incidentals / equipment	\$	6,250.00
total	\$	87,000.00
GST	\$	8,700.00
	\$	95,700.00

**Hospital administration support calculated at \$4.50 per record multiplied by 10% of the total WIES for the region.*

FURTHER READING

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Dooling, C. and Wolff, A. (1992). Limited adverse occurrence screening: a program with significant benefits for the medical record department. *Australian Medical Records Journal* 3(22): 98-101.

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O'Neil, A.C., Petersen, L.A. and Cook, E.F. (1991). Physician reporting compared with medical record review to identify adverse medical events. *Annals of Internal Medicine* 119: 370-376.

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Wilson, R.M., Runciman, W.B. and Gibberd, R.W. (1995). The Quality in Australian Health Care Study. *Medical Journal of Australia* 163: 458-471.

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Wolff, A. (1995). Limited adverse occurrence screening: an effective and efficient method of medical quality control. *Journal of Quality in Clinical Practice* 15: 221-233.

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DEFINITION OF TERMS

Adverse Event	An untoward incident or circumstance which, under optimal conditions, is not a natural consequence of the patient's disease or treatment.
Blame	Hold at fault (implies culpability).
Clinical Risk Management	An approach aimed at improving patient care, through the active minimisation of risk, by the detection, monitoring, prevention and early management of clinical incidents.
Error	The failure to complete an action as intended, or the incorrect use of an incorrect plan to achieve an outcome.
Harm	Death, disease, injury, suffering and / or disability experienced by a person.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Health Care	Services provided to individuals or communities to promote, maintain, monitor or restore health.
Monitor	To check, supervise, critically observe, measure or record the progress of an activity, action or system on a regular basis in order to identify change.
Outcome (Health Care)	Something that follows as a result or consequence of health care processes.
Quality Improvement Program	Strategy that monitors, evaluates and implements actions to improve health care processes and achieve desired outcomes.
Risk	The chance of something happening that will impact on objectives, measured in terms of consequence or likelihood. Risk threatens the provision of quality patient care and efficient use of clinical resources.
System failure	A fault, breakdown or dysfunction within operational methods, processes or infrastructure.

**Adapted from 'Improving Patient Safety in Victorian Hospitals (2000)' and 'Guidelines for managing risk in the health care sector (HB 228: 2001).*

APPENDICES

Sample document – checklist

Have you completed the following tasks?	<input checked="" type="checkbox"/> When completed		
	YES	No	N/A
◆ Identify hospitals			
◆ Identify interested general practitioners			
◆ Employ a project officer			
Identify key people to be a part of the steering group			
◆ A person with prior expertise in a similar activity			
◆ Visiting medical officer of a participating hospital			
◆ Chief executive officer of a participating hospital			
◆ Health information manager of a participating hospital			
◆ Project officer			
◆ Hold an information meeting			
Recruitment of general practitioners			
◆ Select a general practitioner who is a local opinion leader to assist with the review of the photocopied medical records and to be on the reference panel			
◆ Training session			
Gain commitment from			
◆ Chief executive officers			
◆ General practitioners			
◆ Statutory immunity cover			
◆ Ensure that health information managers are aware of their role			
Prepare data collection tools			
◆ Analysis form			
◆ Registers for the photocopied medical records			
◆ Hospital and doctors codes			
◆ Data base			
Set up postal arrangements:			
◆ Organise a post office box			
◆ Set up an account at the post office			
◆ Organise a reply paid account			
◆ Purchase pre-paid registered mail labels			
◆ Obtain delivery confirmation advice receipts			
◆ Obtain registered mail lodgement forms			
◆ Print confirmation of postage card			

Sample document: Position Description

General

1. Hours: The position is ___ hours per week (___EFT)
2. Location:
3. Salary:

Specific Tasks

The Clinical Risk Management Project Officer, in line with the policies set by the Board of Directors, will:

1. Work closely with the Senior Project Manager / Executive Officer, General Practitioner Consultant and small rural hospitals to implement and conduct a clinical risk management program.
2. Develop in conjunction with the Senior Project Manager / Executive Officer, an implementation plan.
3. Maintain database records in a timely manner and ensure that confidentiality is paramount when handling medical records.
4. Identifying potential improvements to current processes.
5. Prepare reports as required by the Department of Human Services funding agreement.
6. Prepare meeting agendas, minutes, recommendations and other program administrative tasks as required.
7. Prepare Royal Australian College of General Practitioners Quality Assurance and Continuing Professional Development Point applications and reports as relevant.
8. Identify and support general practitioners to undertake training to become reviewers as part of the clinical risk management program and ensure general practitioners and hospitals' satisfaction with the program is maintained.
9. Participate in clinical risk management networking and program support opportunities provided.
10. Provide additional support to the Reference Panel, Board and Senior Project Manager / Executive Officer in planning tasks as required.
11. Undertake other duties as required.

Key Selection Criteria

Essential

1. Experienced Division 1 registered nurse or health information manager
2. A demonstrated interest in clinical risk management and quality improvement.
3. Highly developed interpersonal, negotiation, written and verbal communication skills.
4. An understanding of the issues faced by rural general practice and / or experience working with general practitioners.
5. An ability to behave in a self-reliant manner and set high realistic goals.
6. Demonstrated ability to undertake investigations, planning and research activities including the analysis, development and implementation.
7. A current driver's licence.

Desirable

1. Experience in using databases (particularly Access), an awareness of the issues and concepts in database design.
2. Ability to work as a member of a team, often working independently and to operate under pressure and to meet deadlines.
3. Knowledge of health services in the area.

Applications

Applications close _____

Please address your applications to: _____

Applicants should address the selection criteria and provide the names and current contact details for three referees.

Sample document: Analysis Form Part (a)

Project Officer Adverse Event No: _____

**CONFIDENTIAL Small Rural Hospital Clinical Risk Management Program
ADVERSE EVENT ANALYSIS FORM**
This form is for review by the Reference Panel

A. HEALTH INFORMATION MANAGER:

Hospital Code _____	Doctor Code _____
Patient U.R. Number: _____	Date of birth: _____ Sex: _____
Admission Date: _____	Diagnosis code: _____
Discharge Date: _____	HIM initials: _____

Adverse Event Criteria (Tick all criteria identified during this admission)

- 1. Patient death
- 2. Returning to theatre within 7 days
- 3. Unplanned re-admission within 28 days
- 4. Transfer to another acute care facility
- 5. Patient length of stay greater than 21 days
- 6. Unexpected readmission following discharge from another hospital.
- 7. Any record which has been recommended by a GP for peer review
(Please specify) _____

B. PROJECT OFFICER:

Reviewing General Practitioner Code: _____

Date medical record sent for review: _____ Time taken to review record: _____

C. REVIEWING GENERAL PRACTITIONER:

An **Adverse Event** is an untoward patient event which, under optimal conditions, is not a natural consequence of the patient's disease or treatment.

Please evaluate the medical care given by rating the evidence that an adverse event was caused by medical management (enter number in box)

1. Little or no evidence of an adverse event caused by management
2. Slight evidence
3. Not quite likely (Less than 50/50 odds, but a close call)
4. More likely than not (Greater than 50/50 odds, but a close call)
5. Strong evidence
6. Virtually certain evidence
7. Uncertain due to lack of information, but worth further discussion.

Score
<input type="text"/>

A score of 4 or higher is considered an Adverse Event and is referred to the Reference Panel for Quality Improvement action.

Does this record contain such an Adverse Event ? **YES**() **NO**()

If YES please complete the remainder of this form.

1. Relevant clinical details regarding the case:

Sample document: Analysis Form Part (b)

2. Tick location of Adverse Event:

Inside hospital Outside hospital Another facility

3. Select a code for the severity of the Adverse Event (enter number in box)

0. **Minor severity:** No disability, no significant resultant discomfort, no cosmetic or functional impairment, and no increased length of stay as a result of the Adverse Event.
1. **Minor temporary:** Minimal to moderate clinical effect requiring no or minimal clinical intervention, or no increased length of stay or re-hospitalisation for the same or related problem.
2. **Minor permanent:** Minimal to moderate clinical effect with permanent residual, and without significant functional or cosmetic impairment.
3. **Major temporary:** Moderate to severe clinical effect with no significant functional or cosmetic residual effect.
4. **Major permanent:** Moderate to severe clinical effect with significant functional or cosmetic residual effect.
5. **Potential major or major continuing:** When doubt exists as to the outcome but the probability is that a major impairment or repeated hospitalisation will be necessary.
6. **Death.**

Score
<input type="text"/>

4. Rate on a 6 point scale your confidence in the evidence for preventability:

1. Little or no evidence for preventability
2. Slight or modest evidence for preventability
3. Preventability not quite likely; less than 50 - 50 but close call
4. Preventability more likely than not; more than 50 - 50 but close call
5. Strong evidence for preventability
6. Virtually certain evidence for preventability

Score
<input type="text"/>

5. What further action would you recommend?

6. Were you able to reach a decision on the information contained in the patient's medical record?

YES NO

If No was it due to:

- Lack of information No Discharge Summary Illegible notes
 Other _____

7. Time

Time taken to review medical record (Minutes) _____

Reviewer's signature _____ Date _____

(To ensure confidentiality, name of reviewer not required)

Sample Document: Definition of Adverse Event screening criteria

CONFIDENTIAL

Small Rural Hospital Clinical Risk Management Program

Definition of the Criteria of Adverse Event Analysis Form:

(One or more criteria may be ticked)

1. **Patient death** - The discharge summary states that the patient has died.
2. **Return to theatre within 7 days** - If it was necessary for further operation for complication(s) related to a previous operation/procedure in the operating room.
3. **Unplanned re-admission within 28 days** - Refers to a readmission of the patient within 28 days of being discharged from hospital. With this criterion the reviewer is looking to see whether an adverse event occurred in relation to the previous admission, resulting in readmission to hospital. When Health Information Managers are completing the analysis form for this criterion, the code of the treating general practitioner during the first admission should be recorded. The admission and discharge dates recorded on the analysis form should also be those from the first admission.
4. **Transfer to another acute care facility** - When the discharge summary states that the patient was transferred to another acute care facility for more specialised treatment.
5. **Patient length of stay greater than 21 days** - If from the time of admission to the time of discharge, the patient stay was greater than 21 days.
6. **Unexpected re-admission following discharge from another hospital** - Refers to the unexpected admission of a patient to hospital following discharge of this patient from another hospital.
7. **Any record which has been recommended by a General Practitioner for Peer Review** - If a General Practitioner requests that a particular admission in a patient's medical record be sent for Peer Review. Please note the reason for the General Practitioner's request.

Sample document: Treating general practitioner comment form

Form containing summary of the reviewed record for completion by treating general practitioner with comments for additional information and on the review of the case.

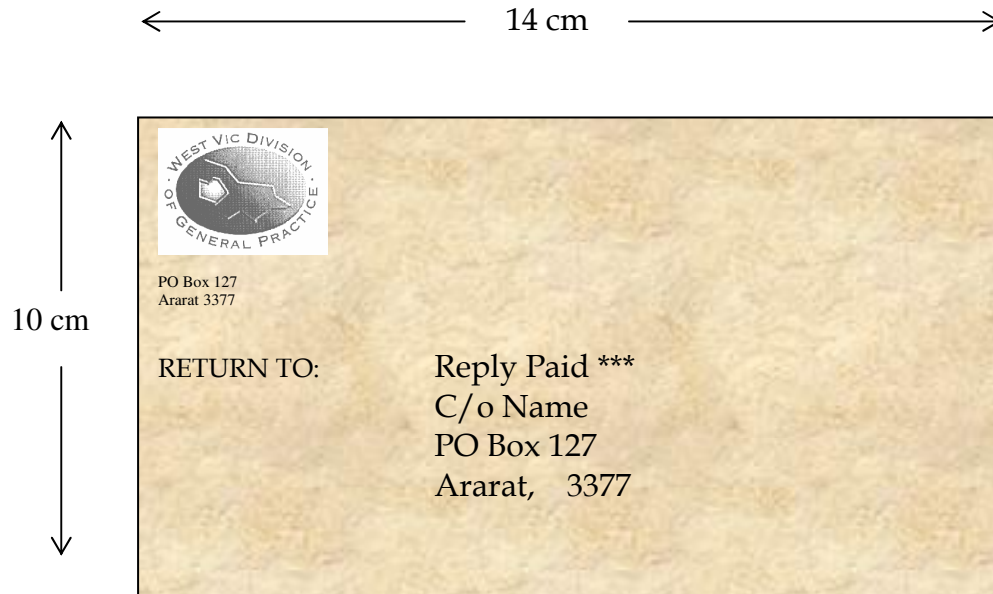
Unique Identifying No:

<p><i>Information provided by the reviewer as per analysis form</i></p> <p><i>Medical screening:</i></p> <p><i>Further action recommended:</i></p>

This case has been identified by the reviewer as requiring further discussion. Please provide additional information that will assist with the discussion of this case.

Would you like to make a comment on the review of this medical record?

Sample document: Confirmation of Postage Card



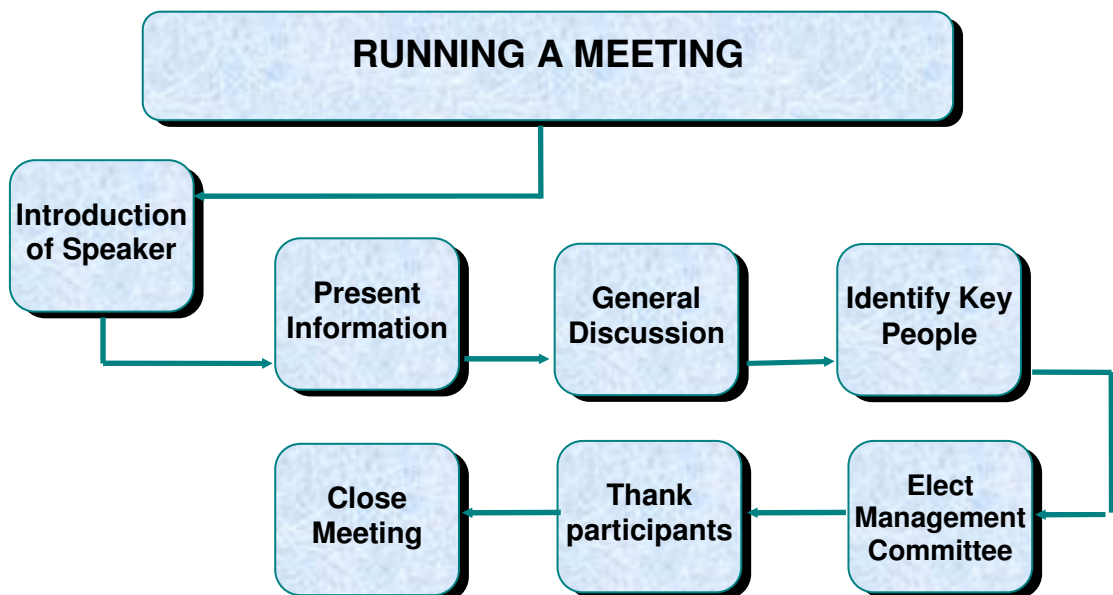
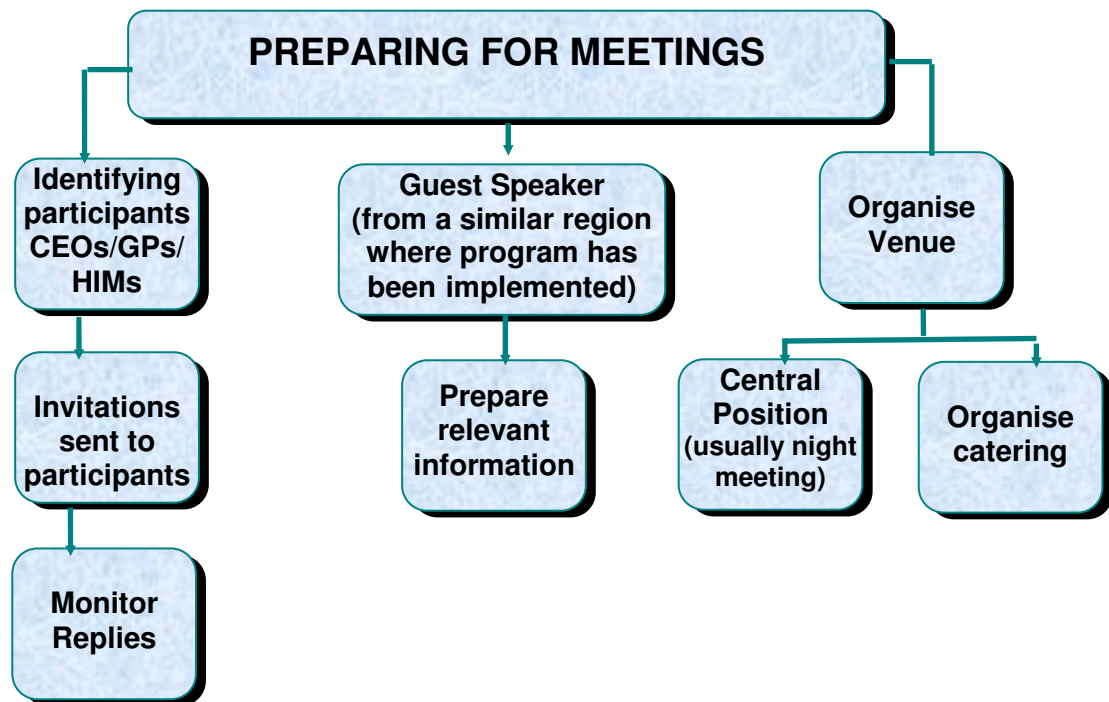
CONFIRMATION OF POSTAGE

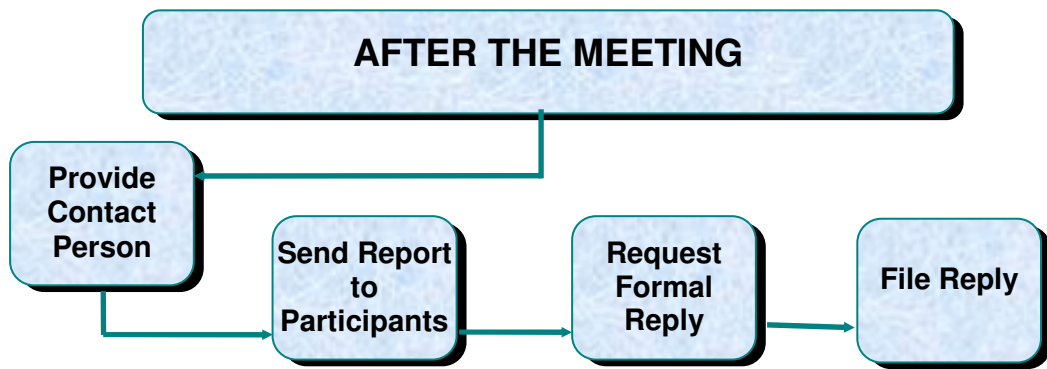
The documents have / have not been reviewed
and are now in the mail. If you have not
received them within 7 days please contact me.

Name _____

Date _____

Sample document: Before, During & After Meetings Flow Chart





Sample document - Reference Panel Report Form

(This form is used to record the Reference Panel Comments and Recommendations)

FORM NUMBER

Small Rural Hospital Clinical Risk Management
Program

REFERENCE PANEL REPORT

Criteria:

Summary:

Further Action Recommended:

Treating GP comments:

Treating GP comments on the review:

Issues

Recommendations

- (1) **MEDICAL** i.e. principally related to medical management of the patient.
Please List

- (2) **SYSTEM / HOSPITAL ISSUES** i.e. principally related to hospital policy, procedures & management.
Please List

- (3) **CLINICAL RISK MANAGEMENT ISSUES** ie principally related to training & education.
Please List

Other Identified Issues
