Hospital clinical governance event review guidelines

Who is the guideline for?

All Southern Cross Healthcare (SCH), staff and credentialled practitioners.

What does it contain?

The process for reporting and reviewing clinical cases at Hospital Clinical Governance Committee (HCGC), including who is responsible for initiating the process and who is responsible for making decisions.

Why is this important?

The process of reporting and analysing adverse events, near misses, and other events with potential for harm or no harm is of utmost importance. This provides significant opportunities to identify weaknesses in our medical practices and systems. By doing so, we can put in place necessary precautions to prevent similar situations from arising in the future. The aim is to thoroughly review these events, critically assess our medical approaches and protocols, and consistently enhance patient safety through ongoing improvements.

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Introduction

One of the functions of the HCGC is to evaluate and assess various clinical cases, and events that occur within our facilities. This committee plays a crucial role in examining adverse events, near misses, and other occurrences to identify contributing factors, analyse root causes, and determine potential areas for improvement in patient care and safety. By conducting thorough reviews, the clinical review committee aims to enhance medical practices, protocols, and procedures, ultimately striving to prevent similar events in the future and promote a higher standard of patient well-being.

Most adverse events arise from the inherent risks associated with medical investigations and treatments. These recognised complications or side effects can occur independently of the healthcare provider involved. However, in some cases, harm may result from failures within the healthcare system. Additionally, harm can also arise from issues in the performance of individual healthcare provider(s). Sometimes, harm may stem from a combination of these factors.

What cases should be reviewed at HCGC?

Prior to each meeting, it is essential to conduct a structured triage process for identifying cases. This approach aims to enhance the quality and consistency of reporting complications and ensures that they can be adequately addressed within the allotted meeting time. The primary goal of this process is to prioritise cases that offer the most valuable learning opportunities for the hospital. By doing so, we can optimise the utilisation of meeting time and focus on cases that provide significant insights and potential improvements for patient care and safety.

During the triage process, the following questions may be helpful:

- How severe was the event and its impact on patient safety?
- Are there lessons to be learned to enhance patient care and safety?
- Is the event isolated, or are there recurring patterns?
- Has there been any breach or deviation in policy or procedure?
- Are there system improvements to be gained to prevent future error and harm?
- Does the patient, Whānau and/or carers have any concerns regarding the event?
- Are there concerns on the conduct or performance of an individual healthcare provider?

Some of the reviews are often identified from the following categories:

- Unexpected deaths
- Surgical complications
- Medical errors
- Unplanned return to theatre
- Unplanned re-admission to hospital
- Unplanned transfer of patient to another hospital
- Significant infections
- Failed treatments
- Diagnostic errors
- SAC 1 & 2 or significant near miss events
- 'Always report and review' events.

Additional cases that are relevant or are nominated for discussion may also be reviewed at HCGC including but not limited to:

- Significant trends
- Clusters
- Consent matters

Process for eventful case review

Eventful clinical cases for review at HCGC are prepared and coordinated prior to the meeting so that all required information is available for review. Coordination of the information is the responsibility of the General Manager (GM), or this task may be delegated to the Safety, Quality and Risk Manager or another delegated authority.

Triage events	• Triage team to complete a file/desk top review to identify those cases to take to HCGC.
Review	• Complete a learning review focusing on systems and processes. • Talk to those involved in the event to gather as much information as possible. • Event review may include review of clinical notes, relevant policy, best practice, regulation, product documentation, interviews with subject matter experts as appropriate. • Seek medical practitioner and/or anaesthetist feedback using the letter to Medical practitioner template or by meeting with them. • Include the patient / whanau story or perspective in the review where appropriate. • The type of review should be aligned to the SAC rating of the event. Where there is significant potential for harm, clusters/trends, safety concerns or legal considerations in lower SAC rated events, more extensive review may also be warranted.
Reporting	• Review findings are documented into SafeHub and can be merged into the Clinical case review template' (found in the documents section of SafeHub) to present at HCGC and NCGC. • Ensure contributing factors, learnings and actions are clearly documented.

HCGC meeting	• Medical Practitioners involved with a high-risk eventful case may be requested by the GM to attend the HCGC meeting to contribute. • Eventful cases are presented by the GM, QM, or medical specialist. During discussion the focus is on the factors contributing to the event, what has been learned, and what system or process improvements the hospital can implement to prevention similar occurrence. • Feedback on outcomes and learnings from the meeting are shared with the medical practitioners involved either during the meeting or after by the GM or committee member as appropriate. • If the HCGC is concerned that there may be a medical competence or performance concern, then an appropriate HCGC member (usually from the same specialty) is nominated to consider the case further. Competence concerns are then referred to NCGC.
Documentation	• Event outcomes and actions from the committee are documented in the 'Governance Committee Feedback' section of SafeHub and the clinical case review template updated to include the summary. • Where a case review remains, open this shall be retained on subsequent reports to HCGC and NCGC until closure is recorded in the report. • A copy of the event report, including the committee outcomes, the minutes of the meeting and any additional information is forwarded to NCGC on conclusion of the meeting via 0HHCMCMinutes@schl.co.nz
Sharing learning and improvement	• Where M & M and/or Peer Review Meetings are held in forums outside of SCH the GM will seek information and feedback to enable learning and systems and process improvements to be implemented locally. • The implementation of quality improvement initiatives is monitored to completion and signed off by the GM and HCGC (where appropriate). • System and process improvements of value to the wider network may be shared via National Support Office to the network as open book learnings.

Privacy and Confidentiality

Clinical case reviews limit patient identifiers to NHI number only. Patient names are not used. HCGC minutes and case reviews are confidential in nature and disclose the medical practitioner's identity so should be marked as such. Care should be taken to preserve the confidentiality of the documents by limiting the circulation of these to HCGC members and appropriate National Support Office (and NCGC) personnel. Archived records are stored in Safehub or restricted access electronic folders.

References

- Adverse event management Conducting effective Morbidity and Mortality Meetings for improved patient care (surgeons.org)
- Credentialing and Defining Scope of Practice Guide for Surgeons, Anaesthetists and other health practitioners National Adverse Events Reporting Policy | Health Quality & Safety Commission (hqsc.govt.nz)Southern Cross Hospitals Ltd Governance Committees Charters and Terms of Reference

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