

## Patient Safety and Clinical Quality Program Implementation Plan

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**Functional Sub group** Clinical/ Patient Services - Governance and Service Delivery  
Clinical/ Patient Services - Incident management

**Summary** This is an implementation plan for the Directors of Clinical Governance to implement the NSW Patient Safety and Clinical Quality Program.

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**Applies to** Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals

**Audience** Directors of Clinical Governance, Chief Executives, Clinical Governance Units

**Distributed to** Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes

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**Compliance with this policy directive is mandatory.**

# Implementation Plan

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# Introduction

# 1

In 2004, the Government invested \$55 million in frontline clinical care through the NSW Patient Safety and Clinical Quality Program. Specific enhancement funds were made available to all Area Health Services (AHS) for the expansion of existing resources and the establishment of new structures and support to clinical staff.

With the recent implementation of the health reforms, clinical governance has been embedded in the new AHS through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) directly reporting to the Chief Executives. The CGU is responsible for the rollout of the NSW Patient Safety and Clinical Quality Program within the AHS.

To further ensure consistency across the health system NSW Clinical Governance Directors have developed eleven core functions to guide the role of CGUs from 2004-2006. A copy of the core functions is available at <http://internal.health.nsw.gov.au/quality>.

The Implementation Plan has been developed by Directors of Clinical governance to ensure uniform implementation of the *NSW Patient Safety and Clinical Quality Program* across Area Health Services in NSW.

These are linked to the standards from the NSW Patient Safety and Clinical Quality Program and the Quality Systems Assessment (QSA) to be conducted by the Clinical Excellence Commission.

Related policies, guidelines and other documents have been included as resources to support implementation of the core functions.

# 2

## Standards

The *NSW Patient Safety and Clinical Quality Program* is based on standards against which a health service's quality system will be assessed. These standards are derived from existing Departmental policies and guidelines that are familiar to health service staff, administrators and clinicians building upon existing frameworks, programs and initiatives currently well established in all Area Health Services.

### **Standard 1**

Health services have systems in place to monitor and review patient safety.

### **Standard 2**

Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

### **Standard 3**

An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

### **Standard 4**

Complaints management systems are in place and complaint information is used to improve patient care.

### **Standard 5**

Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

### **Standard 6**

Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

### **Standard 7**

Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

# Timeline for implementation

# 3

Completed by	Activity	Standard/s <sup>1</sup>	Function <sup>2</sup>
JUN 05	Organisational structure agreed and staff appointed	1	1
	The 2005/06 workplan is signed off by the Chief Executive	1	1
	90% of RCAs on SAC 1 incidents undertaken in appropriate timeframe	3	2
	80% of recommendations from RCAs implemented within stated time frame	3	2
	Designated Senior Complaints Officer appointed	4	4
	System in place to enable reporting of complaints	4	4
JUL 05	Proportion of incidents notified which have recommendations for action entered Numerator: Number of incidents notified with recommendations for action Denominator: Total number of incidents notified	3	3
	Proportion of incidents notified where recommendations have been completed Numerator: Number of incidents with recommendations completed Denominator: Total number of incidents notified	3	3
	Proportion of SAC 1 incidents notified where incident status = new for ≤ 24hrs of incident Numerator: Number of SAC 1 incidents where incident status = new for ≤ 24hrs of incident Denominator: Total number of SAC 1 incidents notified	3	3
	Proportion of SAC 2, 3 & 4 incidents notified where incident status = new for ≤ 5 days of incident occurring Numerator: Number of SAC 2, 3 & 4 incidents where incident status = new for ≤ 5 days of incident occurring Denominator: Total number of SAC 2, 3 & 4 incidents notified	3	3
	Proportion of all actual SAC 2, 3 & 4 incidents where incident status = complete in ≤ 28 days Numerator: Number of actual SAC 2, 3 & 4 incidents where incident status = complete in ≤ 28 days Denominator: Total number of actual SAC 2, 3 & 4 incidents notified	3	3
OCT 05	Structure in place to enable analyse and action of incident management data of SAC 2, 3 & 4 incidents	3	2
	All clinical units discuss incident management data routinely	3	2
DEC 05	RCA teams have completed their investigation and provided a report to Chief Executive on all SAC 1 incidents in appropriate timeframe	3	2
	Points of accountability for actioning management findings from analysis of SAC 2, 3 & 4 incidents have been identified	3	2
	System in place to screen all deaths within 45 days of the event	3	5
	AHS have implemented policies to ensure patient safety including policies addressing; <ul style="list-style-type: none"> <li>• management of incidents</li> <li>• complaints, concerns or concerns about a clinician</li> <li>• introduction of new interventions</li> <li>• implementation of correct patient/procedure/site model policy</li> </ul>	2	8
	Systems are in place to prompt timely review of policies relating to patient safety and clinical practice	2	8
	First annual report of the implementation of credentialing and clinician performance management	6	10
	First quarterly report of the management of complaint or concern about a clinician	6	10
	First quarterly report of the implementation of recommendations arising from RCA and other investigations of serious incidents and complaints	7	10
First quarterly summary report of clinical incidents, quality indicators, recommendations on area wide actions to improve patient safety	5, 7	10	

Completed by	Activity	Standard/s <sup>1</sup>	Function <sup>2</sup>
<b>2006</b>			
MAR 06	Second round of quarterly internal reports	5, 7	10
MAY 06	Senior clinicians are engaged in performance management	6	9
JUN 06	Each public health organisation identifies and systematically improves (five) 5 major care processes per year	2, 6	6
	Third quarterly internal reports	5, 7	10
SEP 06	Fourth quarterly internal reports	5, 7	10
DEC 06	Communication programs established in each AHS	6	7
	AHSs have developed a methodology for clinician performance management	6	9
	Fifth quarterly internal reports	5, 7	10

## Footnotes

<sup>1</sup> NSW Patient Safety and Clinical Quality Program, 2004

<sup>2</sup> NSW Clinical Governance Directions Statement, 2004

# Clinical governance functions

# 4

## Function 1. Structural establishment

**Description:** Establish a specific Area wide Clinical Governance Unit, led by a full time senior clinician with direct reporting to the Chief Executive. The Unit should incorporate or, at a minimum, develop formal links with existing quality and safety structures and resources to ensure an efficient and coordinated approach to clinical governance.

**Relates to Standard 1.** Health services have systems in place to monitor and review patient safety.

### Performance measures

Measure	Benchmark	Timeframe
1.1 Organisational structure agreed and staff appointed to roles	100%	30 Jun 05
1.2 The 2005/06 Workplan is signed off by the Chief Executive	100%	30 Jun 05

### Policies, guidelines and other documents

- PD2005\_585 A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999
- NSW Clinical Governance Directions Statement (V5), NSW Health, 2005
- PD2005\_404 (Circular 2004/82) NSW Incident Information Management System (IIMS) Policy, 2004
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
1.1 Committee structure	<ul style="list-style-type: none"> <li>• Patient safety and quality improvement embedded across all aspects of the service</li> <li>• Committee structures in place to effectively support patient safety and quality improvement</li> </ul>
1.2 Clinical governance unit	<ul style="list-style-type: none"> <li>• CGU established to manage patient safety and clinical quality risks</li> </ul>
1.3 Establishing clinical indicators and performance information	<ul style="list-style-type: none"> <li>• Selected clinical indicators, performance measures and established Area targets demonstrates patient safety and improving performance</li> </ul>
1.4 Monitoring and reporting performance information	<ul style="list-style-type: none"> <li>• Performance information on quality and patient safety is monitored, analysed and reported</li> <li>• Area benchmarks its performance and makes improvements in patient safety and clinical quality as a consequence of benchmarking practices</li> </ul>
1.5 Using performance information to improve patient care	<ul style="list-style-type: none"> <li>• Evidence that performance information has been used to guide planning and resource allocation, patient safety risks and system issues requiring improvement</li> <li>• Area has strategy to reduce clinical and patient safety risks</li> </ul>
1.6 Public reporting	<ul style="list-style-type: none"> <li>• Performance information regarding patient safety is readily accessible to public</li> </ul>
1.7 Patient safety performance	<ul style="list-style-type: none"> <li>• Services are meeting their performance targets for patient safety and performance is improving over time</li> </ul>

## Function 2. Incident management system

**Description:** Management of clinical incidents in the NSW Health system.

**Relates to Standard 3.** An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

### Performance measures

Measure	Benchmark	Timeframe
2.1 For SAC 1 incidents, the RCA team has signed off the report within 55 days of the incident date	100%	Aug 05
2.2 Proportion of RCA recommendations implemented within stated time frame	80%	Jun 05
2.3 A structure is in place for analysis and action of SAC 2, 3 and 4 incidents Designated staff has been nominated to action findings.	100% 100%	Oct 05 Dec 05
2.4 Clinical units include discussion of incident management (i.e. patient safety/incident management) as a standing item on meeting agendas	100%	Oct 05

### Policies, guidelines and other documents

- PD2005\_337 (Circular 2003/88) Reportable Incident Briefs to the NSW Department of Health, 2003
- PD2005\_404 (Circular 2004/82) NSW Incident Information Management System (IIMS) Policy
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
3.1 Notifying and assessing incidents	<ul style="list-style-type: none"> <li>• Environment and culture which supports incident reporting</li> <li>• Systems in place to notify and record incidents</li> <li>• Incidents examined to assess an individuals contribution to incident</li> <li>• All incidents assigned a SAC rating, investigated within prescribed timeframes and reported as required</li> </ul>
3.2 Investigating incidents	<ul style="list-style-type: none"> <li>• High risk incidents are investigated to determine reason for occurrence and prevent future recurrence</li> <li>• Investigations undertaken in timely manner by multidisciplinary team in accordance with NSW Department of Health guidelines</li> <li>• Recommendations from investigation teams aim to reduce the likelihood of recurrence, are practical and relate to the issue</li> </ul>
3.3 Implementing recommendations	<ul style="list-style-type: none"> <li>• Recommendations arising from investigations are implemented</li> <li>• Recommendations improve patient safety</li> <li>• Incident data is trended to determine whether system wide improvement is required</li> <li>• Outcomes and changes arising from investigations fed back to RCA teams and incident notifiers</li> </ul>
3.4 Incidents involving death of a patient	<ul style="list-style-type: none"> <li>• System in place to monitor deaths and determine if practice changes are needed</li> </ul>

### Function 3. Performance measures for the Incident Information Management System (IIMS)

**Description:** There is staff designated for the implementation of the IIMS across all facilities within this financial year.

**Relates to Standard 3.** An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

#### Performance measures

Measure		Timeline
3.1	Proportion of incidents notified which have recommendations for action entered Numerator: Number of incidents notified with recommendations for action Denominator: Total number of incidents notified	Jul 05
3.2	Proportion of incidents notified where recommendations have been completed Numerator: Number of incidents with recommendations completed Denominator: Total number of incidents notified	Jul 05
3.3	Proportion of SAC 1 incidents notified where incident status = new for $\leq 24$ hrs of incident Numerator: Number of SAC 1 incidents where incident status = new for $\leq 24$ hrs of incident Denominator: Total number of SAC 1 incidents notified	Jul 05
3.4	Proportion of SAC 2, 3 & 4 incidents notified where incident status = new for $\leq 5$ days of incident occurring Numerator: Number of SAC 2, 3 & 4 incidents where incident status = new for $\leq 5$ days of incident occurring Denominator: Total number of SAC 2, 3 & 4 incidents notified	Jul 05
3.5	Proportion of all actual SAC 2, 3 & 4 incidents where incident status = complete in $\leq 28$ days Numerator: Number of actual SAC 2, 3 & 4 incidents where incident status = complete in $\leq 28$ days Denominator: Total number of actual SAC 2, 3 & 4 incidents notified	Jul 05

#### Policies, guidelines and other documents

- PD2005\_404 (Circular 2004/82) NSW Incident Information Management System (IIMS) Policy

## Function 4. Complaints

### Description

1. **Single Point of Contact:** Provide a single, publicly recognisable point of contact for the receipt and management of serious complaints from members of the public and staff.
2. **Designated Senior Complaints Officer:** A Senior Complaints Officer will be available 24 hrs per day, 7 days per week to ensure appropriate action is being taken to resolve serious complaints.

**Relates to Standard 4.** Complaints management systems are in place and complaint information is used to improve patient care.

### Performance measures

Measure	Benchmark	Timeframe
4.1 Appointment and implementation of designated Area Senior Complaints Officer to deal directly with serious complaints	100%	Jun 05
4.2 A system in place to enable reporting of and management of complaints	100%	Jun 05

### Policies, guidelines and other documents

- GL2005\_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1998
- PD2005\_586 Guideline on the management of a complaint or concern about a clinician, 2001
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
4.1 Complaint monitoring and review	<ul style="list-style-type: none"> <li>• Systems are in place to record, monitor and review complaints</li> <li>• Complaints are dealt with in a timely manner and feedback on the outcome of investigations is provided to complainants</li> </ul>
4.2 Systems improvement	<ul style="list-style-type: none"> <li>• Where necessary, complaint investigations recommend changes in practice to prevent recurrence and such recommendations are implemented</li> <li>• Complaint data monitored and analysed to detect trends and determine whether system-wide improvement is needed</li> <li>• Processes are in place to address the systems issues identified by complaints</li> <li>• Information on complaints is reported to NSW Department of Health and other relevant authorities</li> </ul>
4.3 Management of complaints or concerns about individuals	<ul style="list-style-type: none"> <li>• Complaints or concerns against individuals are dealt with according to Departmental policy and within relevant timeframes</li> </ul>

## Function 5. Death reviews

**Description:** Ensure that all deaths in health services are reviewed and that untimely deaths are referred appropriately to the Coroner, the Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA), the Special Committee for Investigating Deaths Associated with Surgery (SCIDAWS), the Maternal and Perinatal (M&P) Committee and other appropriate committees.

**Relates to Standard 3.** An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

### Performance measures

Measure	Benchmark	Timeframe
5.1 System in place to screen all deaths within 45 days of the event	100%	Dec 05

### Policies, guidelines and other documents

- PD2005\_404 (Circular 2004/82) NSW Incident Information Management System (IIMS) Policy
- PD2005\_604 Incident Management Policy, 2005
- Relevant Quality System Assessments (QSA) components:

Component	Criteria
3.4 Incidents involving death of a patient	<ul style="list-style-type: none"> <li>• System in place to monitor deaths and determine if practice changes are needed</li> </ul>

## Function 6. Continuous Quality Improvement (CQI) support

**Description:** Provide ongoing support to clinicians and managers for the implementation of quality policies and procedures in accordance with A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999.

**Relates to Standard 2.** Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

**Relates to Standard 6.** Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

### Performance measures

Measure	Benchmark	Timeframe
6.1 Each public health organisations identifies and systematically improves five (5) major care processes per year.	100%	Jun 06

Explanatory note: Selection of processes for improvement should be promoted from incident trends identified from within IIMS. Clinical Practice Improvement (CPI) methodology is recommended for practice improvement.

### Policies, guidelines and other documents

- GL2005\_062 The Clinician's Toolkit for Improving Patient Care, NSW Health, 2001
- Easy Guide to Clinical Practice Improvement – a guide for healthcare professionals, 2002
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
5.1 Record review processes	<ul style="list-style-type: none"> <li>• Health services have developed an appropriate system of chart review.</li> </ul>
5.2 Systems improvement	<ul style="list-style-type: none"> <li>• Recommendations arising from chart review investigations bring about changes in practice</li> <li>• The results of reviews and investigations are reported to management/Area executive</li> <li>• Feedback is provided to staff on the results of chart review</li> </ul>
6.1 Peer review processes	<ul style="list-style-type: none"> <li>• Health services have developed an appropriate system of peer review</li> </ul>
6.2 Systems/performance improvement	<ul style="list-style-type: none"> <li>• Matters identified via peer review that require more in depth review are investigated accordingly</li> </ul>

## Function 7. Communication training

**Description:** Improve the processes of communication between clinicians and patients/families including the provision of communication training to all clinical staff in conjunction with the Clinical Excellence Commission (CEC).

### Performance measures

Measure		Benchmark	Timeframe
7.1	Communication programs have been established in each AHS	100%	Dec 06

## Function 8. Policy development

**Description:** Develop Area specific policies associated with patient safety, ethical practice and management, complaints handling, referral of deaths to the coroner and procedures that apply to management of complaints or concerns about clinical staff including appointment, credentialing and performance review of senior clinical staff.

Support clinical operations to ensure local and statewide policies relevant to patient safety are implemented across the Area.

**Relates to Standard 2.** Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

### Performance measures

Measure	Benchmark	Timeframe
8.1 AHS have implemented policies to ensure patient safety including policies addressing; <ul style="list-style-type: none"> <li>• management of incidents and complaints</li> <li>• complaints or concerns about a clinician</li> <li>• introduction of new interventions</li> <li>• implementation of correct patient/procedure/site model policy</li> </ul>	100%	Dec 05
8.2 Systems are in place to prompt timely review of policies relating to patient safety and clinical practice	100%	Dec 05

### Policies, guidelines and other documents

- PD2005\_404 (Circular 2004/88) NSW Incident Information Management System (IIMS) Policy
- PD2005\_380 (Circular 2004/56) Correct Patient, Correct Site, Correct Procedure Model Policy
- PD2005\_333 (Circular 2003/84) Model Policy for the Safe Introduction of New Interventions
- PD2005\_337 (Circular 2003/88) Reportable Incident Briefs to the NSW Department of Health
- GL2005\_062 The Clinician's Toolkit for Improving Patient Care, NSW Health, 2001
- PD2005\_586 Guideline on the management of complaints or concerns about a clinician, 2001
- GL2005\_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1988
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
2.1 Policies and procedures developed	<ul style="list-style-type: none"> <li>• Health services have developed patient safety policies and protocols. Core set must include:               <ul style="list-style-type: none"> <li>– incident management</li> <li>– complaint management</li> <li>– complaints or concerns about clinicians</li> <li>– new interventions</li> <li>– correct patient/site/procedure</li> </ul> </li> </ul>
2.2 Policies implemented	<ul style="list-style-type: none"> <li>• Systems are in place to quickly and efficiently disseminate new policies to health facilities in the Area, including NSW Department of Health directives and safety alerts</li> <li>• Policy and procedures on patient safety have been implemented across the Area.</li> <li>• Patient safety policies and protocols are regularly reviewed and updated.</li> </ul>
2.3 Detailed policy review for new interventions	<ul style="list-style-type: none"> <li>• The Area policy on new interventions is consistent with NSW Department of Health guidelines.</li> <li>• Risk assessments are undertaken before new procedures are introduced.</li> <li>• An implementation plan is prepared for each new procedure introduced by the Area</li> </ul>
2.4 Detailed policy review for – Correct Patient, Procedure, Site policy	<ul style="list-style-type: none"> <li>• Health Services have developed an implementation plan for NSW Department of Health Model Policy on Correct Patient/Site/Procedure</li> <li>• All procedural teams within the Area adhere to the five keys steps identified in the model policy</li> <li>• Health Services test compliance with the model policy</li> </ul>

## Function 9. Clinician performance management

**Description:** Develop an appropriate performance review framework with clinical staff, provide advice and support to clinical operational staff engaged in clinician performance review and report on progress.

**Relates to Standard 2.** Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

**Relates to Standard 4.** Complaints management systems are in place and complaint information is used to improve patient care.

**Relates to Standard 6.** Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

### Performance measures

Measure		Benchmark	Timeframe
9.1	AHSs have identified a methodology for clinician performance management	100%	Dec 05
9.2	Senior clinicians are engaged in performance management	100%	May 06

### Policies, guidelines and other documents

- PD 2005\_498 Performance review of visiting practitioners
- PD 2005\_586 Guideline on the management of complaints or concerns about a clinician, NSW Health, 2001
- Relevant Quality System Assessments (QSA) Components:

Component	Criteria
4.3 Management of complaints or concerns about individuals	<ul style="list-style-type: none"> <li>• Complaints or concerns against individuals are dealt with according to NSW Department of Health policy and within relevant timeframes.</li> </ul>
6.2 Performance improvement	<ul style="list-style-type: none"> <li>• More in depth review of clinician performance is undertaken where clinician performance issues are identified within incident management or practice review activities.</li> </ul>

## Function 10. Internal reporting

**Description:** Regularly report to the Chief Executive and Area governance structures on the Area-wide effectiveness of:

- 10.1 implementation of performance management, appointment and credentialing policies and procedures for clinicians,
- 10.2 management of complaints or concerns about individual clinicians in accordance with Departmental policies and standards,
- 10.3 management of serious incidents and complaints including their investigation, analysis and recommendations,
- 10.4 implementation, by responsible managers and clinicians, of the recommendations arising from RCA and other processes used in handling serious incidents and/or complaints, and
- 10.5 provide a regular summary report of clinical incidents, quality indicators and recommendations on Area-wide actions necessary to improve patient quality.

**Relates to Standard 5.** Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

**Relates to Standard 7.** Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

### Performance measures

Measure	Benchmark	Timeframe
10.1 Review of the status of implementation of performance management, appointment & credentialing policies & procedures for clinicians	Review completed	Dec 05, then annually
10.2 Management of complaint or concerns about individual clinicians	100% completed	Quarterly, report Commencing Dec 05
10.3 Implementation of recommendations arising from RCA & other processes used in handling serious incidents &/or complaints	100% completed	Quarterly, report commencing Dec 05
10.4 Summary report of clinical incidents, quality indicators, recommendations on Area-wide actions necessary to improve patient safety	100% completed	Quarterly, report Commencing Dec 05

### Policies, guidelines and other documents

- PD2005\_496 Appointment of visiting practitioners
- PD2005\_500 Appointment of staff specialists
- PD2005\_497 Delineation of clinical privileges for visiting practitioners and staff specialists
- PD2005\_498 Performance review of visiting practitioners
- PD2005\_404 (Circular 2004/82) NSW Incident Information Management System (IIMS) Policy
- PD2005\_337 (Circular2003/88) Reportable Incident Briefs to the NSW Department of Health
- PD2005\_586 Guideline on the management of complaints or concerns about a clinician, 2001
- PD2005\_585 A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999
- GL2005\_061 Better Practice Guidelines for Frontline Complaints Handling, 1998.

## Function 11. External reporting

**Description:** Provide reports to the Clinical Excellence Commission and the Department as agreed by the NSW Department of Health.

**Relates to Standard 5.** Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

**Relates to Standard 7.** Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

# 5

# Appendix

## **Summary of policies, guidelines and other documents**

GL2005\_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1998.

PD2005\_585 A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999.

PD2005\_586 Guideline on the management of complaints or concerns about a clinician, 2001.

GL2005\_062 The Clinician's Toolkit for Improving Patient Care, NSW Health 2002.

PD2005\_337 (Circular 2003/88) Reportable Incident Briefs to the NSW Department of Health, 2003.

PD 2005\_333 (Circular 2003/84) Model Policy for the Safe Introduction of New Interventions, 2003.

PD2005\_404 (Circular 2004/82) NSW Health Incident Information Management System Policy, 2004.

PD 2005\_380 (Circular 2004/56) Correct Patient, Correct Site, Correct Procedure Model Policy, 2004.

PD2005\_500 Appointment of staff specialists, 2005.

PD2005\_496 Appointment of visiting practitioners, 2005.

PD2005\_497 Delineation of clinical privileges for visiting practitioners and staff specialists, 2005.

PD2005\_498 Performance review of visiting practitioners, 2005.

Relevant Quality System Assessments (QSA) Components.

Easy Guide to Clinical Practice Improvement – a guide for healthcare professionals, 2002.