

# **Clinical Risk Management Program for General Practitioners working in small NSW Rural Hospitals**

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*Evaluation Report*

Prepared by  
Quality & Safety Branch  
NSW Health





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## Executive Summary

### Introduction

Since 2002 there has been progressive implementation of the of a Statewide Patient Safety and Clinical Quality Program. Often General Practitioners working in small rural hospitals have limited opportunity to engage in such programs or to participate in reviewing their own and their peers practice and ultimately minimising risks and harm to patients.

### Project Aims

The project's main objective was to develop a Clinical Risk Management model suited to the rural NSW environment. It sought to identify practice improvement opportunities in small rural NSW Hospitals serviced by VMO GP's where currently such systems do not exist.

### Methods

This project piloted Clinical Risk Management in the form of retrospective chart review and a peer review process in 9 Area Health Services (2004), 13 Divisions of General Practice and 26 facilities. A site Project Officer coordinated and managed the program in close liaison with the pilot sites' GP Champions.

The Clinical Risk Management (CRM) model piloted involves six basic principles

1. Medical Record Screening using flags – level 1 review
2. Medical Record Review by GP of select records – level 2 review
3. Referral to Peer Review if certain criteria met – level 3 review
4. Development of recommendations
5. Taking action on the recommendations and
6. Feedback to the treating practitioners, Divisions, facility and Area Health Services

Variations on the paradigm model were adopted among the pilot sites. The variations afforded a richer source of evaluative data. In this regard the program was successful in achieving one of its major aims.

### Evaluation

An evaluation of the project by an independent contractor was conducted to review evidence of the project's impact. The report presents findings from interviews and surveys with stakeholder groups regarding their experiences and expectations of the CRM Program. The evaluation is predominantly summative and assesses the effectiveness, efficiency and cost of implementing a CRM GP program.

### Results

From the participating sites there was a 44.7% active involvement of GP's in the project as either second level reviewers or members of the third level review panel. In the absence of many quality or risk management initiatives at these sites this level of engagement is quite marked. In this respect the program achieved its major goal.

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Approximately 3000 records have been reviewed during the 12 month pilot project.

Data available from 14 facilities which completed the cycle at the time of this evaluation identified that approximately 12% of screened files had gone to level 2 review and 6.4% to level 3 review.

Issues revealed during chart review include: poor documentation, missed diagnosis, delayed transfers and medication errors & incidents.

**153 recommendations** have been made from 14 facilities that have completed the program. These include revisions or introductions of pathways and guidelines such as: phone medication orders, thrombolysis and chest pain management, trauma care, pathology and radiology requests and results, triage, medication prescribing, and mental health. In this regard the program met its second goal.

### **Feedback**

Although much resistance was encountered among GP's and certain Divisions of General Practice about the project initially, the work of the NSW Project Manager, Project Officers and GP Champions allayed many of the fears held and drove the process to successful ends. The roles and personalities of these players became crucial in addressing issues and progressing the project. With the dedicated resources and credible personalities involved, encouraging results have emerged.

Health service managers have noted changes in the culture, knowledge, practice and skills amongst their staff which they attribute in part to the program. There is a quick turnaround in lessons learned from the reviews as the issues and outcomes are fed back into the system more expeditiously. The lessons learnt are also locally identified, which supports their acceptance and uptake by local service providers. Although a few high-risk clinical incidents were identified, the majority of reviews afforded learning opportunities to improve clinical practice and working conditions. Communication between medical and nursing staff has benefited from the program and an openness and willingness to engage in other learning opportunities is emerging.

The rationale of engaging GP's in the first instance and accessing their input was welcomed by those GP's interviewed. They found the methodology was not onerous or resource intensive given rural constraints. The review process has enabled shared learning and has reforged collegial ties among the participants.

During the project's lifetime the Quality & Safety Branch experienced multiple changes in filling the Project Manager's position which impacted on the continuity of support and assistance offered to the pilot sites.

At the time the Pilot was being rolled out, NSW Health services were experiencing considerable change. The Campbelltown-Camden Inquiries were underway, the re-structure of the Area Health Services had been announced and there was implementation of other statewide initiatives like the Incident Information Management

System. These all contributed to sense of unease and system stress. Notwithstanding these changes and uncertainties, the CRM Program proved very successful, which is most noteworthy. The evidence of this is that 100% of respondents supported the aims of the project and its continuance.

### **Recommendations**

It is recommended:

1. That the Directors of Clinical Governance adopt the clinical risk management model for implementation into rural AHSs.
2. The AHS' Clinical Governance Units and Divisions of General Practice through a Project Steering Committee jointly manage that governance of the program.
3. That a base model of the Limited Adverse Occurrence Screen is developed, with local adaptation possible, in consultation with key stakeholders.
4. That initial rollout is co-ordinated by the Department in conjunction with the AHS Clinical Governance Units and Divisions of General Practice. Assistance with planning, implementation and training would be offered by the Quality & Safety Branch.
5. That sufficient resources and support be provided for the program.

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## **Introduction**

This report reviews evidence of the impact of a Clinical Risk Management Program implemented in select NSW rural sites and presents findings from interviews and surveys with stakeholder groups regarding their experiences and expectations of a Clinical Risk Management Program.

### **Introduction to Clinical Risk Management<sup>1</sup>**

Formal quality improvement or risk management programs have long been widely used in industry and service organisations. Early risk management programs were primarily focussed upon controlling litigation and protecting the organisation or individual from claims. Over recent years studies of adverse events in healthcare have brought a growing awareness of the scale of the problem of harm to patients.

Gradually the need to address underlying clinical and system problems became apparent and the concept of risk management in the healthcare sector has developed and broadened over recent years to include strategies aimed at reducing the incidence of harm and improving patient safety and the quality of care.

There is an increasing recognition that management of clinical risk at an organisational level is seen as an important aspect of good clinical governance. A clinical risk management (CRM) framework recognizes that risk might arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk. A structured approach to clinical risk management within a clinical governance framework meets the needs of the patient, clinician and organisation. It provides an opportunity to identify risk and prevent the reoccurrence of similar incidents.

A sound clinical risk management framework is underpinned by a process of systematic review of clinical outcomes against agreed standards and is one of the key components for facilitating the continuous improvement of clinical care. A retrospective process of clinical audit identifies adverse events and analyses the factors and conditions that have affected patient outcomes. It then treats the risks associated with these adverse outcomes. The process itself can also promote the recognition and dissemination of good clinical practice.

Although a clinical risk management framework may be informed by retrospective assessment of clinical incidents and events, its objective is to target preventable adverse events that are yet to occur. It encourages a systems approach in examining contributory factors that might lead to the event.

These clinical risk management strategies mark a shift in the traditional approach of adverse event management that in general focused on individuals. The new focus is on

the conditions under which adverse events might occur, and where analysis of these potential events is seen as an opportunity to improve practice and patient safety.

Industry has led the way in risk management. The AS/NZS 4360:99 Risk Management Standard provides a logical and systematic method of managing risk. The concept of risk has three elements: the perception that something could happen; the likelihood of something happening; and the consequences if it happens. The degree of risk is both the combination of the likelihood of a risk occurring and the consequences if it does occur. Action taken to manage the risk and therefore change the level of risk also addresses the likelihood of the event occurring, or the consequences if it does occur or both. Risk treatment involves identifying the range of options for treating the risk, assessing the options, preparing risk treatment plans and implementing them. The Framework is detailed at Table 3- Appendices.

### **Evidence of the benefits of Clinical Risk Management Programs**

The West Victorian Model of Clinical Risk Management for General Practitioners has conducted clinical risk management since 1994, and is based on 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 . The program is now being rolled out through the Divisions of General Practice in Victoria. 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.

The model involves screening medical records from participating hospitals against seven outcome criteria. Records that meet any of the criteria are reviewed by a General Practitioner (GP) to determine whether an adverse event has occurred, or if the case provides educational opportunities. If so, the case is considered by a Reference Panel of general practice peers, and any recommendations made are fed back to participating hospitals and GPs in the Division, so that changes to practices can be made as appropriate.

The Victorian Department of Human Services has allocated \$4.8 million to establish clinical risk management based on Wimmera model in every Victorian public hospital in 2001 – 2002.

## **Purpose of Evaluation**

The purpose of evaluation is to assist people to make better decisions by providing them with information about the benefits and costs of interventions, in this case the implementation of a Clinical Risk Management Program.

This evaluation draws upon previous evaluation studies and is informed by the experience and expectations of participants and other stakeholders.

The purpose of the evaluation is firstly to provide information to guide the redesign and improvement of the CRM GP program and the model best suited to the rural NSW



environment. Secondly, the evaluation provides information to guide decision-making regarding the implementation of CRM GP state wide.

The evaluation is predominantly summative and assesses the effectiveness, efficiency and cost of implementing a CRM GP program.

## **Background**

NSW Health is committed to developing a system wide approach to improve the safety and quality of health care provided in NSW. A comprehensive strategy to achieve this is underway in NSW through the Patient Safety and Clinical Quality Program that is currently being implemented across NSW. The Program is designed to provide a comprehensive system-wide response to improving clinical care while providing a particular focus on the patient through health system redesign. A key component of the program is Clinical Risk Management.

The Clinicians Toolkit<sup>2</sup> was produced to assist clinicians to identify and develop skills and strategies that will facilitate identifying problems with systems of care and with an individual clinicians practice. General practitioners (GPs) working in small rural hospitals have limited opportunities to participate in peer review, as each hospital may have only a solo or a few practitioners. The Clinical Risk Management Program for General Practitioners Working in Small NSW Rural Hospitals was introduced so that these doctors are provided with that opportunity.

This Clinical Risk Management Program is based on a version of the Limited Adverse Outcome Screening (LAOS) that was developed by Dr Alan Wolff at the Wimmera Health Care Group, Horsham in the early 1990's. Current incident management processes were incorporated into the program

The basic elements of the CRM pilot consisted of screening medical records against identified flags that are then reviewed for potential adverse events. Those medical records flagged are reviewed by participating rural General Practitioners and if warranted presented to a panel of peers for further review and recommended action. Recommendations from both processes are made available to both the Area Health Service (AHS) and the Divisions of General Practice through the Health Care Quality Committee.

## **Overview of Project, Phases and Implementation**

### **Consultation**

The Alliance of NSW GP Divisions, Rural Doctors Association, Rural Doctors Network and Area Directors of Medical Services gave their support to the program. The concepts were also presented at the NSW GP Alliance Forum held on 23 May 2003 and at an information session held on 6 June 2003 to the Chief Executive Officers of AHSs

and Chairs of the Rural Divisions were invited. The program was developed through consultation and feedback with the above participants.

### **Purpose**

This CRM Program was designed to assist GPs working in small district and rural hospitals and multipurpose service centres in NSW to minimise risks of care to patients.

### **Sponsors**

1. Quality and Safety Branch, NSW Health managed the pilots and Project Manager of the program. The branch also provided some funding.
2. Medical Training and Workforce Development Branch, NSW Health provided the funding for the pilot of the program.

### **Governance**

A steering committee was convened to oversee the pilot study in select sites.

The role of the GP CRM Steering Committee is:

1. To provide high level governance and strategic direction to the introduction of the CRM program for GPs working in small rural hospitals in NSW.
2. To review the implementation of the models of the CRM program that are being conducted in the pilot sites and provide advice as required.
3. To advise on the communication, education and implementation strategies for the program.
4. To provide assistance in overcoming barriers, including access to key stakeholders, for the introduction and implementation of the program. To endorse the evaluation criteria, and the selection of an evaluator.
5. To make any other recommendations that will improve the program.

Membership of the steering committee includes representation from professional, industrial and divisional groups of GPs, consumer groups, AHS, and NSW Health.

### **Management**

A senior project manager, NSW Health Department, was appointed to:

1. develop the CRM Program for rural GPs
2. support the pilots in the chosen AHS's
3. engage and support GPs working in small rural hospitals in NSW



## Participants

Expressions of Interest were sought from Area Health Services and Divisions of General Practice within NSW to participate in the project. It was envisaged that three pilot Areas would be engaged. Due to overwhelming support and interest, further funding was sought to accommodate all the nine Area Health Services (together with their local Division of General Practice) who applied to participate in the pilot.

Northern Rivers AHS & Northern Rivers Division of General Practice <b>Ballina</b> <b>Casino</b>	Southern AHS & South East NSW Divisions of General Practice <b>Boorowa</b> <b>Harden</b> <b>Crookwell</b> <b>Bombala</b> <b>Braidwood</b> <b>Delegate</b>	Greater Murray AHS & Riverina Division of General Practice <b>Junee</b> <b>Cootamundra</b> <b>Tumut</b> <b>Gundagai</b>
Mid West AHS & NSW Central West Division of General Practice <b>Blayney</b> <b>Grenfell</b> <b>Oberon</b>	Hunter AHS & Hunter Division of General Practice <b>Cessnock</b> <b>Kurri Kurri</b>	Macquarie AHS & Dubbo/Plains Division of General Practice <b>Mudgee</b> <b>Wellington</b> <b>Gulgong</b> <b>Coolah</b>
Mid North Coast AHS & Coffs Harbour, Hastings/ Macleay and Hunter Rural Divisions of General Practice <b>Gloucester</b> <b>Wauchope</b> <b>Bellingen</b>	New England AHS & North West, Barwon and New England Divisions of General Practice <b>Moree</b> <b>Warialda</b>	Far West AHS & Outback Division of General Practice <b>Walgett</b> <b>Lightning Ridge</b>

1. *List of Participating Facilities, AHS's and Divisions of General Practice (2004)*

Area Health Service staff were involved in the pilot program were responsible for its operation in that Area and will be expected to play a lead role in the rollout of the program to other Areas, should the program prove to be successful.

A Project Officer employed by the AHS (2004) or Division provided quarterly reports to all rural Divisions, rural (and participating outer metropolitan) Area Health Service CEOs, and NSW Health. These reports included the collated recommendations from all

reference panel meetings. The reports were discussed at Area Quality Council meetings and any recommendations were to be implemented within the context of those discussions. Quarterly activity summaries were also to be provided to NSW Health. Most AHSs have broad sub committee structures including Quality Councils and Clinical Governance or Quality Improvement units that are responsible for the quality and safety programs that are being implemented in that area. These Units provided additional support to the project officer.

The general practitioners were led by a GP Champion who took responsibility for leading the reference panel meetings, which may have involved the reviewing and treating GPs and also and in some instances, representation from the AHS. This GP also provided a report of the issues and recommendations from the reference panel meeting to the Area Quality Council and to the Divisions of GPs for further action.

### **Project Aims**

1. Development of a CRM model suited to the rural NSW environment
2. Facilitate clinical review to identify practice improvement opportunities in small rural NSW Hospitals where currently such systems do not exist.
3. Leverage the system to participate in quality improvement and improve safety and quality of patient care

### **Project Objectives**

At the outset of the project it was anticipated that the following objectives would be achieved with the introduction of this program.

1. Improved processes and outcomes for patients accessing care from rural general practitioners working in local health services.
2. Improved patient safety and reduced risk in providing patient care in small district, rural hospitals and multipurpose service centres through communication and collaboration between rural GPs and their local hospitals.
3. The opportunity for GPs and hospital staff to learn from recommendations made after adverse events in similar size hospitals elsewhere. This enables systems and practices to be modified to prevent similar events occurring in their facility, thereby improving patient safety.
4. The provision of a mechanism for rural practitioners to participate in quality activities and peer review consistent with the objectives of the NSW Safety Improvement Program and Clinician's Toolkit for Improving Patient Care.

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5. Improved retention of rural GPs, particularly in Areas of Need, because of enhanced relationships with local hospitals and an increased sense of support through peer review processes.

## Pilot Models

The pilot sites, after assessing their own capacity and available resources, modified and developed the LAOS model to create their own local adaptations.

Two major variants existed. The first and most common utilised the flag system for identifying prospective adverse events. Participating sites identified which particular flags they would apply to cull records for review. This ranged from using 3 to 7 flags<sup>3</sup> and in some instances included specific clinical presentation types for clinical auditing (e.g. stroke, chest pain). The other methodology used was a review of all medical records within a specific time frame. A multi-disciplinary team conducted the review of the records. This version of review became too onerous for the team and was later scaled down to a random selection of records within a specified timeframe.

The timelines for establishing and rolling-out the project in each site and its participating facilities varied. Expressions of interest were received in November 2003, funding approval was granted to the 9 successful sites in January 2004 and pilot site development commenced in June 2004. The minimum time from pilot site establishment and reviewing the first set of records was 3 months. The maximum time taken from pilot site set-up and first file review was 8 months. This was due to a variety of factors, including resistance from GP's to the idea of the project, determining whether qualified privilege should be sought for participating sites, identifying which facilities could be involved and then engaging them and establishing roles and responsibilities between involved parties. The fact that some sites only completed their first Review Panel at the time of this evaluation has limited the scope of the evaluation.

Initially in the West Vic Program the charts were all de-identified before being sent to the reviewing GP. It was found that valuable information was lost by doing this and prevented the reviewer from being able to reach meaningful conclusions. Although the project's intention was not to de-identify the records for the reviewer and the treating GP, some sites did de-identify the data for GP review. This decision was made locally in response to fears held by treating GP's that they will be 'singled out' otherwise. This increased considerably the workload in photocopying records for de-identification. Over time, and once confidence in the process was gained these sites hoped to eliminate this step.

Although there was variance in the scale and type of limited adverse event screening methodologies adopted by each of the sites, what is most important is that there was GP involvement in risk management and quality initiatives in the facilities.

## Evaluation Model

The program has been evaluated throughout the project including the structures, processes and outcomes to determine the level of achievement of the proposed objectives. A range of methods was used for each of the strategies, including:

- Focus groups,
- informal structured interviews with key stakeholders and participants,
- analysis of key data indicators collected from status reports and questionnaires.

This evaluation report primarily reports on:

- the measure of engagement of GP's and health service staff with the CRM process,
- the effectiveness of the processes and tools that were adopted and modified by each site,
- the project's impact on the quality and safety of patient care at the pilot sites, and
- recommendations for proposed statewide rollout.

22 respondents provided feedback for this review. 14 Health Service Managers and 9 GP's who were involved in the project from the pilot sites. For the purposes of this evaluation the response rate is moderately reliable for statistical confidence. The error rate is reduced further since the feedback appears to reflect little variance in the qualitative data provided.

Due to delays in commencing the program some sites were still collecting data at the time of this evaluation, therefore results reported here are incomplete. However, the data provided to date indicates comparable results which may be extrapolated with some confidence.

## Evaluation Results - What we learned

The main goal of this project was to develop a CRM model suited to small rural hospitals which have VMO GP coverage in NSW. Its purpose was to facilitate clinical review to identify practice improvement opportunities where currently such systems do not exist. It also sought to lever the system to participate in quality improvement and improve safety and quality of patient care.



The project data from 20<sup>4</sup> rural health services indicated that over 2583 records were reviewed over a 9 month period against several criteria for possible adverse events or learning opportunities.

Approximately 55 VMO GP's out of a possible 123 practitioners from the participating facilities were engaged in the project (47.7%) as reviewers. A Further 12 GP's expressed interest in becoming reviewers for the program after its inception.

Of the 9 participating sites, only six sites recorded data to report on the three levels of review.

Pilot Site By AHS	Separations	Records Reviewed	Records Flagged with positive criteria	Records reviewed by Panel	Recommendations
Northern Rivers	2439	244	17	12	14
Mid West	487	100	20	12	4
Mid North Coast	1297	669	121	61	116
Southern	-	-	-	-	-
Hunter	5126	562	15	7	14
New England		13	7	8 <sup>5</sup>	-
Far West <sup>6</sup>	294	294	77	4	-
Greater Murray	2578	342	7	-	-
Macquarie	-	359	21	8	5

## 2. Pilot site records data

A variety of flags were used to between the pilot sites to determine which records might reveal an adverse event or possible learning opportunity. Some sites used more flags and therefore yielded more records for review. A list of the flags utilised is found in the Appendices at Table 2.

All participating sites found that the quality of medical record documentation was poor and impacted on the review process. In the absence of medical entries, analysis of the care given was limited. Although this was of concern, it in turn generated educational and improvement strategies to address this deficiency at the facilities. As a result of the CRM project all sites indicated an improvement in the quality of medical record documentation.

Other issues revealed during chart review included: missed diagnosis, delayed transfers and medication management.

**153 recommendations** were made to improve the safety and quality of health care services provided within the five participating sites (14 facilities) who completed the review cycle.

These include revisions or introductions of pathways and guidelines:

phone medication orders,

thrombolysis and chest pain management,

trauma care,

pathology and radiology requests and results,

triage,

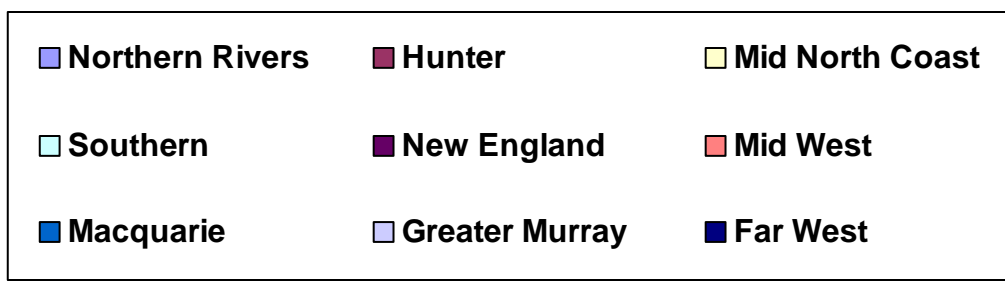
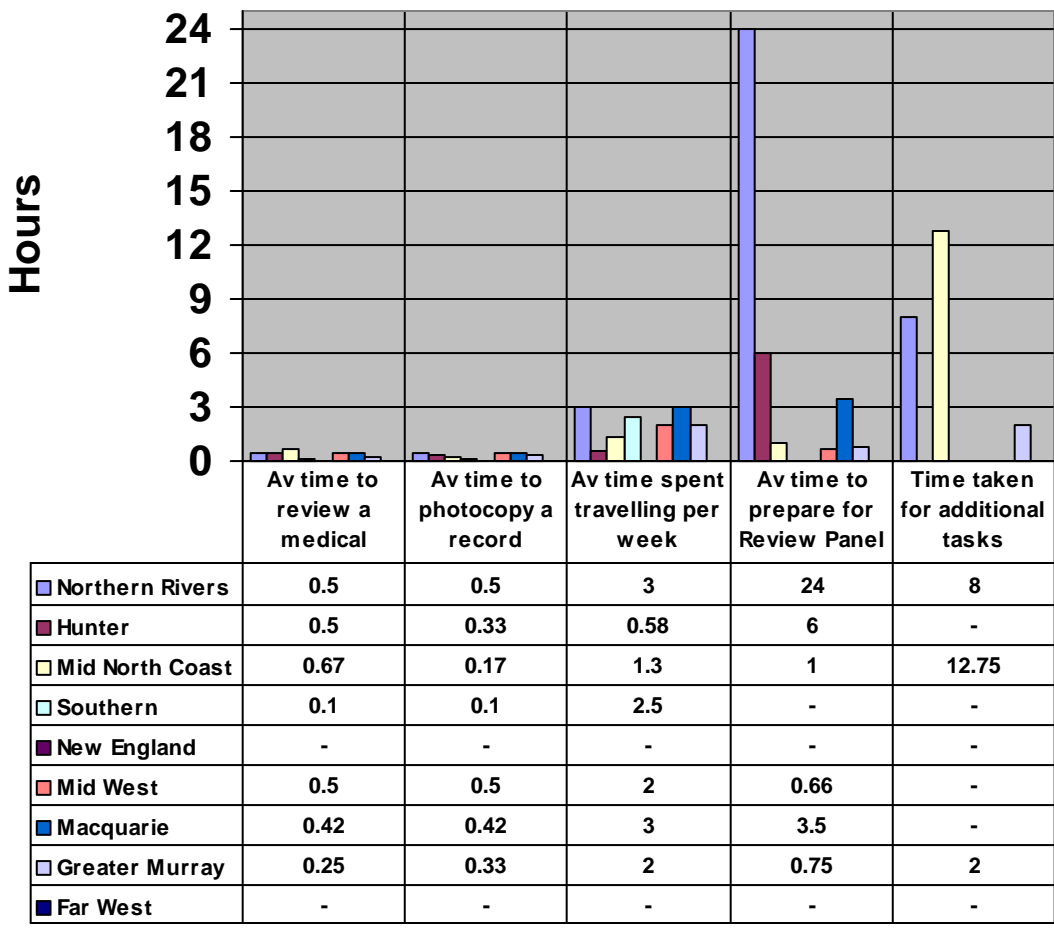
medication prescribing, and

mental health.

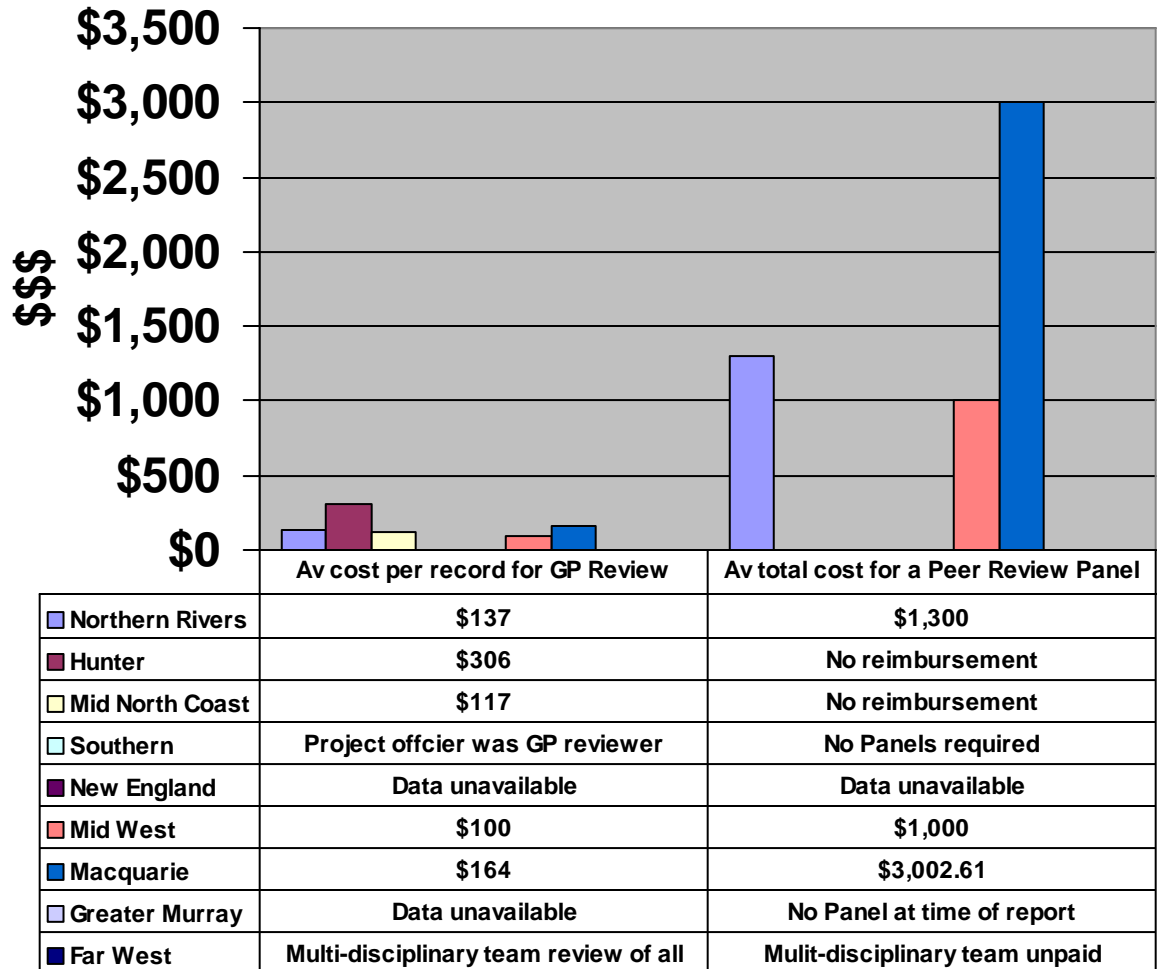
Since the different pilot sites adopted varying processes, there is no baseline for evaluating certain aspects of these processes. Some sites utilised the clinical expertise of the Project Officer to conduct a thorough review of the flagged files, culling the number of records forwarded to the GP reviewer and also the review time. This impacted on the number of second level reviews and the timeframes involved. Other factors that make comparative analysis difficult is the fact that some sites have included travel costs for their reviewers attending Panels in their budget summations and others have not. Some sites utilised their Medical Staff Councils as the forum for presenting the third level file reviews and others convened Peer Review Panels particular to the project. Depending on the local agreements made, some Panellists were reimbursed and others were not. Other sites had yet to convene a Panel so costings were unavailable. As a result, costings on reviewer involvement whether that be the number of GP second level reviews conducted at each site or the number Peer Panels held, offer no meaningful comparative analysis.

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### Project Officer workload times

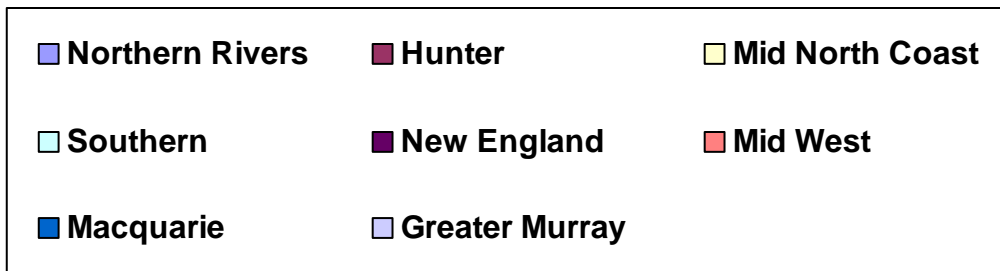
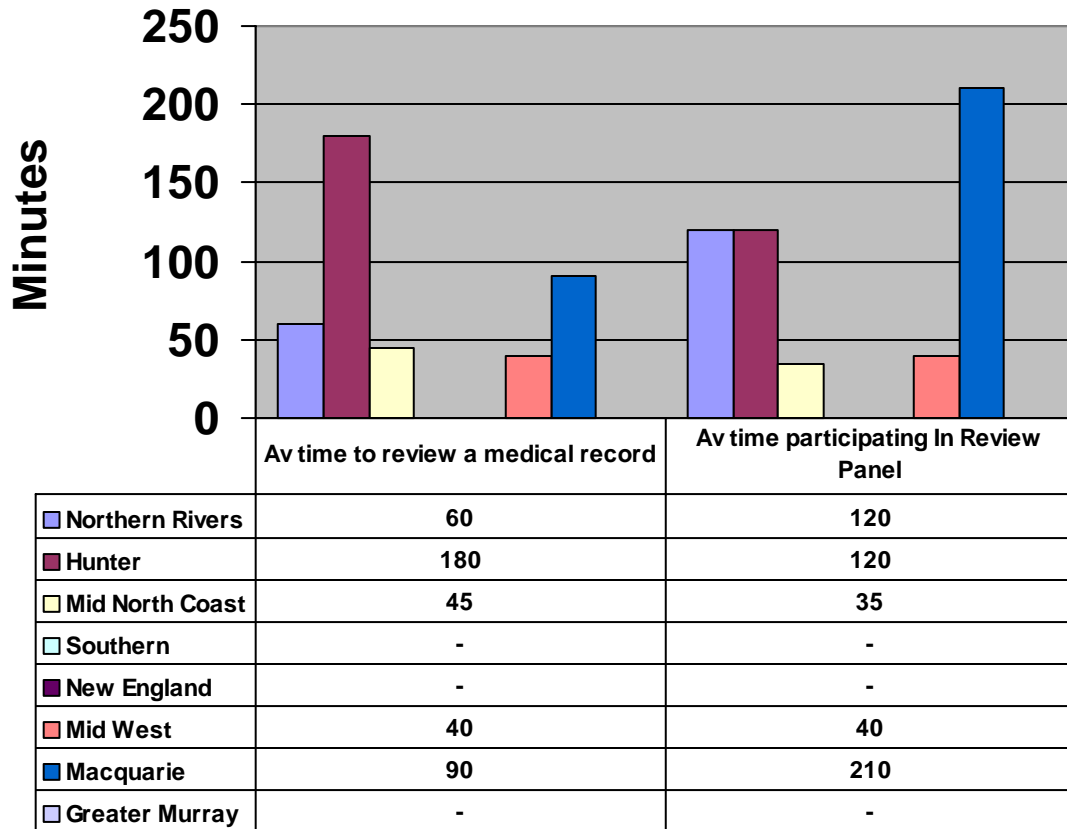


## GP Reviewer costs



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### GP Reviewers time



## Stakeholder Experiences and Expectations

**Project Officers** from each of the participating sites completed questionnaires and attended a Focus Group meeting on the 16th June 2005 as part of the project evaluation.

Feedback from the Focus Group and questionnaires identified the following elements as evidence of the success of the program. The project demonstrated better practice to the GP's and was used as a learning opportunity. It also demonstrated to the GP's that AHS's, the Department of Health and health service facilities were interested in them and their work. It also allowed GP's a voice and the means to be involved in the process of change and improvement in their local facilities. It was noted that recommendations from Panels generated improvements directly and indirectly at the local facility. Furthermore there was evidence to suggest the program stimulated quality improvement thinking and supported and developed a Safety & Risk Culture within facilities.

### **Barriers**

The Project Officer Focus Group also identified those elements which were a barrier or a problem in the roll-out of the program. Of greatest concern was the lack of trust for the process by GP's. A current theme identified by the Project Officers in their attempts to engage the GP's cooperation and support was the resistance encountered due to a fear that the program was **"another tool to performance manage GP's and keep them in check"**. This attitude was strongly reflected in the responses received from the interviewed GP's and Health Service managers engaged in the program as well. It was the primary reason why many sites were delayed in commencing the program. As a result of the program however, these suspicions and views were allayed. Major delays were experienced in some sites due to their exploration of qualified privilege and discussing the issue of indemnity. This issues was addressed when it was explained to participants that the hospitals indemnity coverage also included their activities.

Other areas of concern included a perceived lack of clear direction regarding the goals, processes, and support that were to be offered from the Department of Health. This situation arose due to the demands and resource issues the Quality & Safety Branch experienced during the life of the project. An unforeseen yet serendipitous result was that in the absence of such advice from the Department, variation arose amongst the pilot sites. The resulting variety of models and processes developed at each site afforded the invaluable opportunity for analysis and the generation of alternate options for a statewide rollout.

It was also believed that the training provided was inadequate to equip the Project Officers and GP's to do their job from the start, especially since the program was new and faced the normal teething problems associated with new endeavours. Furthermore, the role delineation of the Project Officer was not specified and led to misunderstanding between key stakeholders and accountabilities, causing delays. This situation was

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compounded by a poor understanding of the project, the process and expectations of the AHS by the AHS. Once the parties did come on board the users found certain tools provided by the department to assist in the review process did not incorporate rural needs and had to be modified, which caused further delays.

Other concerns identified included the following:

- Many of the GP Panel's did not know how to conduct a Peer review, nor did the panellists know how to write recommendations. Many of them did not have an adequate understanding of local policy, procedure or knowledge of governance requirements to frame and draft recommendations that facilitated best fit with current practices;
- There was a lack of technology (access to computers) or understanding of technology (computer literacy and database management) available in smaller facilities to expedite review process;
- The roles of the AHS and the existing quality & safety governance structures were undefined and unclear which led to a perception of little or no support and a sense that expectations were not being met;
- The de-identification of files and other administrative functions associated with the reviews was very time consuming.
- GP's uncomfortable with someone "reviewing and questioning their care" especially if it is believed their private practices are in competition.

**Opinions of health service staff** from a sample of facilities amongst the participating sites, which included Health Service Managers, quality and safety officers and Directors of Clinical Services, were canvassed using semi-structured interviews. Of the 16 respondents interviewed, all supported the project and its aims. In most cases there was no, or very little quality or risk management mechanisms in place for GP's to report incidents or engage in improvement processes. In the absence of such this project filled the need and was greatly welcomed.

In four of the participating sites approached for this evaluation, feedback had not been presented back to the facility managers on the outcomes of the Review Panels conducted and the recommendations arising from them. This was the result of a few factors, but primarily due to the delay in holding the panels and the reporting channels identified by the pilot sites that did not include the local facilities, only the Divisions and the Area quality committees.

Most facility managers saw the programs greatest success was that it got GP's to think about what they're doing and got them talking about quality improvement. The review process was an opportunity to learn. The fact it actually engaged GPs where there was an absence of involvement before in any quality initiatives is a significant breakthrough.

**"Was a groundbreaking project for small district hospitals"**

All respondents shared the view that the program was an -

**"Unbelievable opportunity to formally review records and practice, based on manageable and identifiable criteria to improve the quality and safety of health care".**

The program provided the added benefit of standardising procedures between neighbouring small hospitals. This has led to the development of networking opportunities with other pilot sites now within the new restructured Area Health Services.

Respondents noted that with the success of their first reviews and with "runs on the board" it allowed the project to run on its own merits rather than being driven by personalities. The evidence of the project's success has now paved the way for the uptake and acceptance of other quality initiatives amongst staff e.g. advanced care directives, palliative care etc.

**"My expectations of the program were not only met, but surpassed."**

The collaboration has strengthened the partnerships between the Divisions and the Area Health Services and the GP's and health services. The flow on effect in the effective and efficient management of primary care and the public hospital system is anticipated.

Of particular note is the situation faced by small rural hospitals, in that they exist in a low volume environment for episodes of care. The project gave clinicians the opportunity to review and deepen their knowledge and understanding of less frequent presentations. The lessons learnt have fed through the whole clinical team as an experience of shared learning in the management of these less frequent presentations.

The shift in culture amongst GP's and staff engaged in the program has been evidenced in the manner in which clinicians will now approach each other on the wards to ask questions about care and management and are open to querying and evaluating themselves. It is believed this has cemented the growing quality and safety culture. Many respondents spoke about staff being more aware of quality & safety issues as they provide services rather than on second reflection after the event or post review.

**"Staff now talk about 'level of risk'"**



## Post implementation survey of GP's views

An opinion held by the interviewed GP's involved in the program cited that generally GP's believe such programs to be a "Government intrusion". It was noted that as GP's primarily have control over their practices and use that control to achieve favourable patient outcomes, distrust was generated in the belief that that control was being taken from them. The selling point to overcome this attitude was to not to focus on the individual doctors' management but the care provided as a whole within a systems context. If any comment was made about individual care and management it was provided in a de-identified, 'face-saving' and no-blame framework.

Those involved in the reviews found the methodology as not being onerous or resource intensive, given rural constraints. The design of the program allowed the issues and outcomes identified to be fed back into the system more expeditiously. The programs quick turnaround in completing the quality cycle engendered confidence in the program. Furthermore the lessons learnt were locally identified, and this supported their acceptance and uptake by local service providers.

**"The culture is changing as a result of the program. There is a greater willingness & openness amongst GP's to discuss performance objectively and receive constructive advice and look at improvements, both systemically and professionally"**

It was also believed that the CRM model, using its case flags was found to be more objective than other self-reporting mechanisms and processes the respondents had previously engaged in. The use of an outside reviewing GP also helped overcome any local biases which may have influenced the rigour and analysis of the reviews conducted. It was noted that –

**" Objective issues are dealt with away from local politics, and local politics can be challenged on quality and safety grounds"**

Another benefit the program offered that all respondents appreciated and highlighted was the opportunity to socialise and overcome the issue of isolation experienced by many rural GP's. By maintaining such links between themselves the program facilitated professional development as well as social and psychological support in demanding practices, which directly and indirectly impact on the quality and safety of the care they provide.

**"It revives collegial fellowship"**

## Successful strategies

Overall feedback from respondents identified the project's success was a result of a number of factors.

Of considerable note was the collaborative partnership between the Area Health Services and the Divisions of General Practice. It was stated regularly that without this collaboration, success and buy-in from all parties would have been jeopardised. The roll of the GP Champion was instrumental in cementing this partnership as they gave the program credibility amongst VMO GPs and garnered their trust and willingness to participate.

The Project Officer was also a major contributor to the program's success. This was universally identified by all respondents. By having a dedicated position the project officer was afforded the time, responsibility and resource to establish networks and spearhead the project. Without the Project Officer's dedicated role, many health service managers believed the program would have faltered in the face of other competing demands and resources. It is feared that the larger health facilities within an AHS will siphon off resources and direct focus away from the smaller sites unless the officer responsible for managing the program and the allocated funds to support it are quarantined.

The program was also delivered and managed within a "no blame" framework. This ethos focussed on improvement rather than shaming and reassured participants of its credit and worthiness.

Those facilities who extended an invitation to all health workers to become involved in a local and autonomous quality improvement initiative found there was ownership of the learnings and changes in practice. This was supported by a thorough education and training roll-out to all stakeholders regarding the project's aims, goals and philosophy.

Facilitating factors and conditions that assisted with the project's reception and implementation was due to the prior education and training provided by the statewide roll-out of the Safety Improvement Program (SIP). This initiative paved the way for uptake and acceptance amongst health staff and those GP's familiar with it, especially its "no blame" message and focus on systems and improvement.

## Stakeholder Recommendations

In reviewing the feedback received from the key stakeholders, certain elements for a successful statewide rollout and continuance of the program were identified. Discussion with respondents saw these elements as crucial and not to be viewed by decision makers as a 'wish-list'. The following recommendations are listed in order of importance as rated by key-stakeholders:

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1. Success of the program is dependent on all stakeholders being engaged and on board with the process, having a thorough understanding of their roles and actively supporting its aims and objectives. This should include necessarily the Clinical Governance Unit's, The Divisions of General Practice, Directors of Clinical Services, Facility and Quality Managers, VMO GP's and facility staff. Governance of the program needs to be the joint responsibility of the AHS and the local Divisions of General Practice.
2. A GP Champion from the Division of General Practice should facilitate and communicate with the VMO GP's to gain their support and buy-in for the project.
3. The project Officer driving the process should be a dedicated role.
4. It would be ideal, where the invitation was received favourably to have the Project Officer and HSM present at the Peer Review Panel, even if this was only for drafting recommendations.
5. Due to the size and distance between sites within an AHS, groups of CRM facilities should be clustered based on geographical proximity.
6. Sufficient administrative support should be provided to GP's to ensure efficient and expedited processes.
7. Appropriate remuneration and incentives should be provided to GP's involved in the project, such as CME points, monetary payment for reviews, travel and Panel work, and exploring recognition of CRM practices with Medical Indemnity Insurers.

## **Budget considerations**

The program funded nine pilot sites (2004) to a maximum of \$59,000 per site. Funds totalling approximately \$531,000 was identified. The Quality & Safety Branch contributed by providing a state manager to coordinate the Program.

Among the nine pilot sites, 26 facilities with 9 Project officers were covered by these funds. When considering a statewide roll-out there will be over 76 facilities within the new Area Health Services eligible for implementing the CRM program. The funded positions had management of 2-5 facilities. The project officers were generally 0.5 FTE positions, and feedback indicates they worked beyond this. There may be savings in administrative costs if the Project Officers were established within the AHS Clinical Governance Units. Geographical distance between sites may necessitate 'in the field' project officers responsible for clusters of rural facilities.

## Discussion

There is considerable feedback and evidence to support the recommendation for a statewide rollout of the CRM program. The opportunities for improved clinical care, shared learning and team building within the usually isolated rural hospitals is evident. The comparative cost is worthwhile.

Although much was achieved among the pilot sites, many issues requiring support and assistance still exist if they are to continue in their current arrangement. As noted, the project was conducted within 9 pilot sites based on the 2004 AHS structures. With the amalgamation, pilot sites from old AHS's are now included within the new structures. As it is believed that oversight of the program would appropriately be situated within the Clinical Governance Units, what may prove difficult to manage centrally is the coordination of the various models adopted by the different sites. Standardising the CRM program within the AHS may require an overhaul of the existing processes within the local sites. Such change management would require skilful handling considering the sensitive history of the program and the tentative relationships that still exist between the AHSs and Divisions of General Practice.

Linking the program to the NSW Safety Improvement Program was an initial objective of the project. The CRM Program is to be seen as part of the over all NSW Patient Safety and Clinical Quality Program. It is therefore possible that adverse events may be identified in both programs and may be addressed in both programs, as was the case in the pilot. What is suggested is a generic base model that can be adopted statewide and modified to meet with local need and practice. Base reporting lines and tools can ensure consistent data analysis and centralised management. Table 1 contains a generic model developed by the Project Officers and other respondents. In considering statewide implementation it was suggested that a number of core flags could be developed in conjunction with the CGU's. Obviously the more flags used in an audit the greater will be the yield in results. This in turn will create a greater workload. If the same few flags are used exclusively then other learning opportunities may be missed. Yet if the quality cycle is completed as a result of the reviews then lessons learned and areas of risk should be mitigated. Other than monitoring success of the recommendations, continuing with reviewing the same flags over and over would prevent the redress of other areas of concern. One suggestion posed was using a three year cycle of rotating the flags ensuring greater risk management coverage over time with only high risk areas and deaths forming core flags.

Project Officers with clinical expertise seemed better equipped to manage the first level file review and do an initial cull of the flagged records that were not appropriate for GP review. However, those without clinical experience still proved very successful. They utilised the clinical skills of the key stakeholders on hand and focussed their attention on developing the partnerships between the VMO GP's and health service staff and engaging them in the program.

The collaborative nature of this program was crucial to its success. Without the endorsement of the Divisions and the credibility of the GP Champions, resistance and

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resentment from the VMO GP's would have continued. What is feared by many of the respondents is that if management of the program resided solely in the CGU's as the funder, then the support, voice and active involvement of the Divisions would be lost. Another fear was that the officers responsible for managing the CRM program would be drawn from the CGU and hold other responsibilities. Either these responsibilities would compete with the program's operation or that funds and resources would be diverted from the program. Respondents wished to have the budget for the program quarantined to prevent this.

Reports were required to be provided to the Divisions, AHS and NSW Health so that the issues and recommendations could be disseminated across the State. The types of reports that were required differed depending on their purpose.

The reports to the Divisions and AHS were to be de-identified and include the issues and recommendations identified by the panel so that they can be discussed in multidisciplinary meetings to bring about improvement. The reports provided to NSW Health were to monitor the progress of the project. In evaluating this program, feedback was sought from Health Service Managers. In some instances they were actively involved in the program. As such, the results, suggestions and recommendations arising from the reviewers and Panels were canvassed with them. In many instances the recommendations related to local practice and did not require area quality approval or action. The speedy notification resulted in expedited remedial action. Those sites that only fed the Panel reports to the area quality forums and Divisions did not have evidence that improvements or learning opportunities were fed back to the local facility. Any statewide rollout should have appropriate feedback loops and may consider the requirement to notify the local facility of Panel outcomes.

Feedback from many respondents, which included GP's, identified a great desire to see the review process evolve into a multi-disciplinary event rather than a solely GP peer review. The opportunities for team learning and team building were seen as advantageous. Those sites that had a pre-existing working relationship between the VMO GP's and HSM's that was trusting and collaborative did not find this option threatening. Those sites where the GP's distrusted health service management only came on board when the model was purely peer review. The recommended framework developed by the project officers in Table 1 incorporates this option.

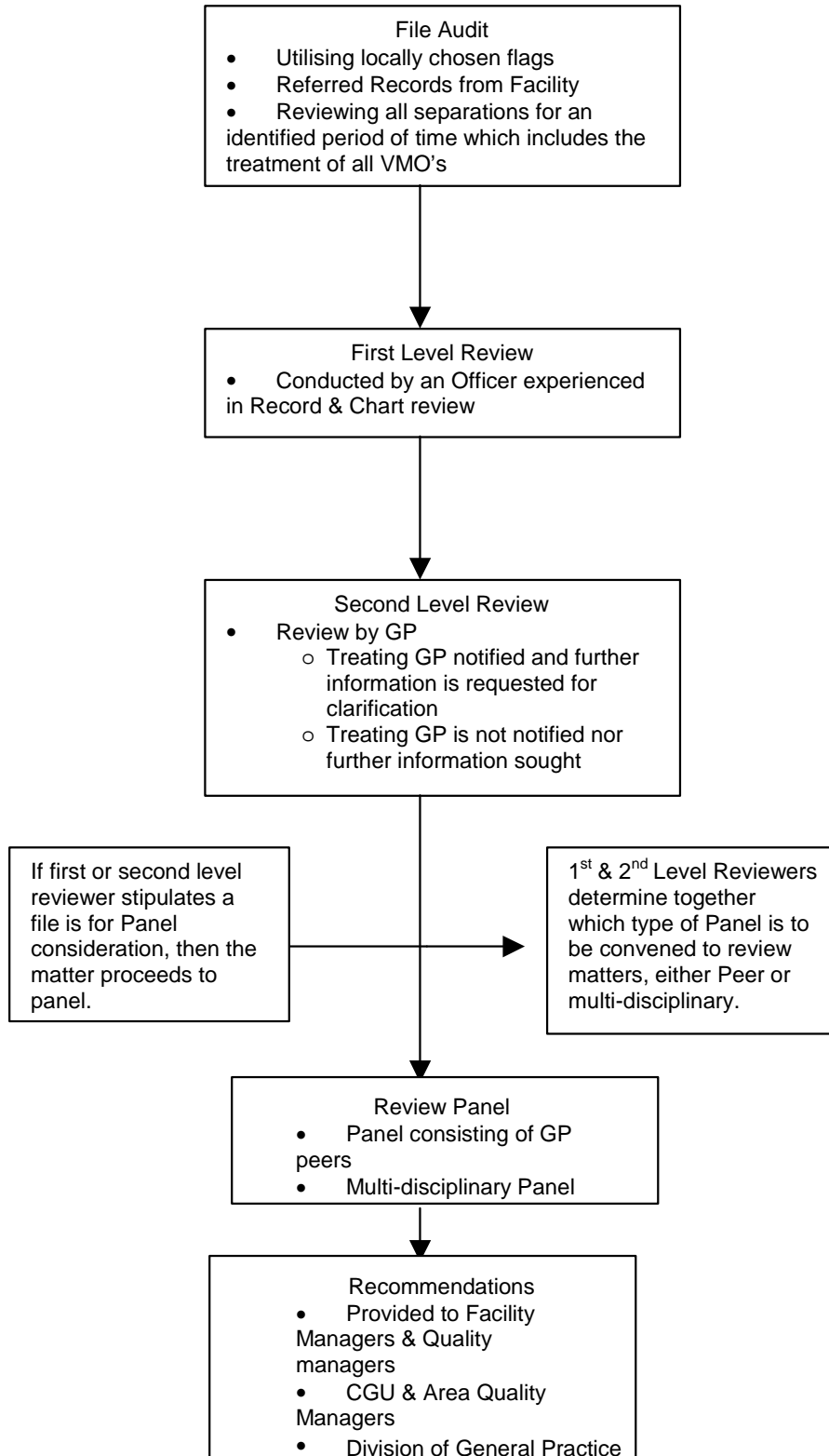
The program was also based around those GPs who were willing to participate and therefore were open to undertake review and to be reviewed. However some GPs elected to be reviewed but not to be reviewers. In any future program development it is important that treating GPs are provided with feedback from the issues and recommendations that come from the review process.

## Recommendations

It is recommended:

1. That the Directors of Clinical Governance adopt the clinical risk management model for implementation into rural AHSs.
2. That governance of the program is jointly managed by the AHS' Clinical Governance Units and Divisions of General Practice through a Project Steering Committee.
3. That a base model of the Limited Adverse Occurrence Screen is developed with local adaptation possible in consultation with key stakeholders.
4. That initial rollout is co-ordinated by the Department in conjunction with the AHS Clinical Governance Units and Divisions of General Practice. Assistance with planning, implementation and training would be offered by the Quality & Safety Branch.
5. That sufficient resources and support be provided for the program.

Table 1: Proposed CRM Process with suggested variations



## Table 2: List of Flags Used for LAOS

1. Unplanned readmission within 28 days of discharge
2. Unplanned return to the operating theatre during the same admission
3. Unplanned admission or transfer to a high dependency or intensive care unit
4. Unexpected death
5. Emergency caesarean section
6. Post partum haemorrhage > 600 ml
7. Transfer of a neonate > 37 weeks to a NICU
8. Unplanned transfer of a patient to a higher level facility
9. Specific referral from a clinician

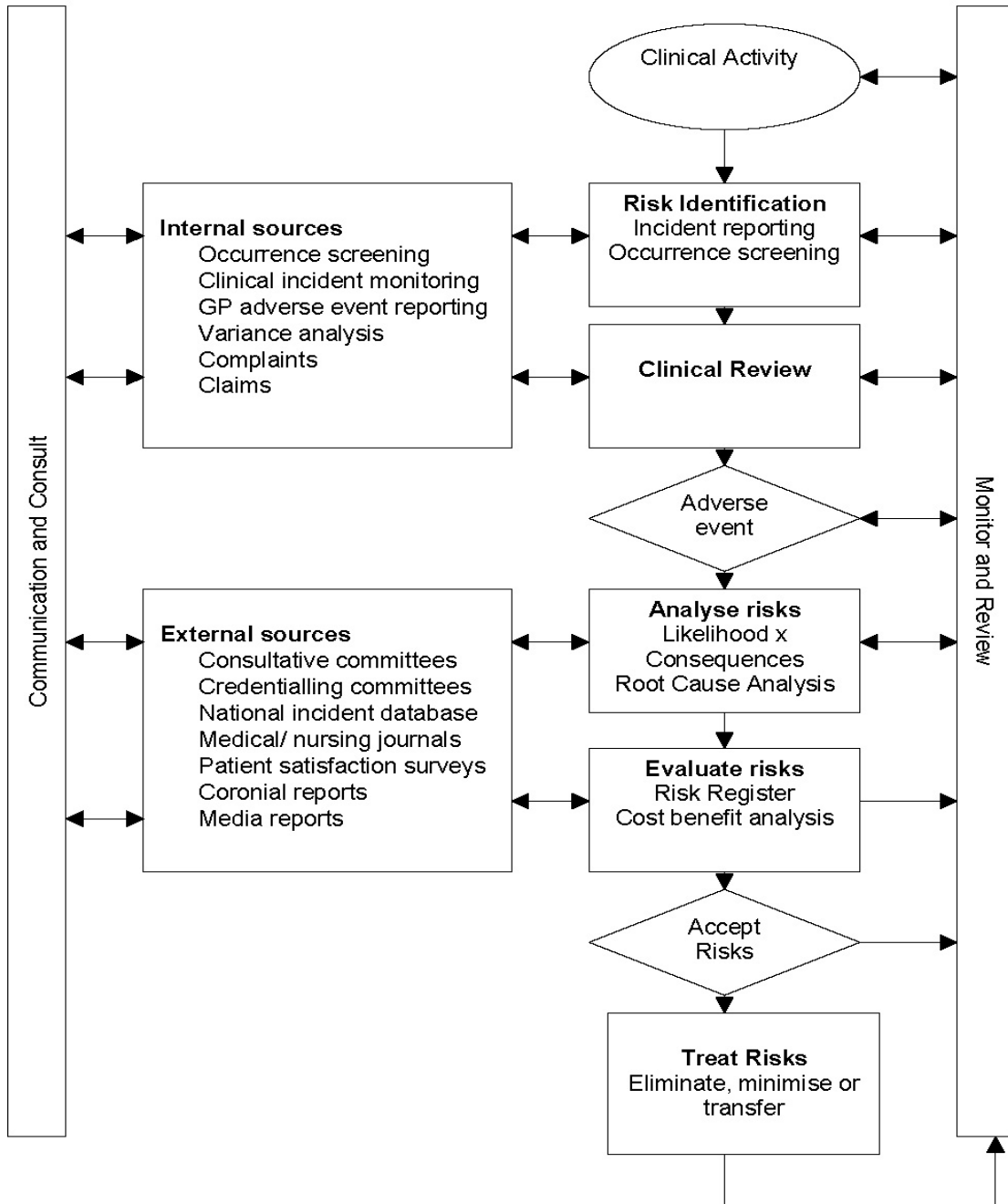
Patients discharged with a diagnosis of:

1. Stroke
2. Chest pain
3. Respiratory disease – pneumonia
4. Cancer

Table 3: Guidelines for managing risk in healthcare

Guidelines for managing risk in healthcare

(AS/NZS HB 228:2001)



#### Table 4: Abstract from The Medical Journal of Australia

##### **Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program<sup>7</sup>**

**Objectives:** To determine whether continuous detection of adverse patient occurrences followed by analysis and medical intervention can alter the rate of adverse occurrences.

**Design and participants:** 15 912 patients discharged from one hospital were reviewed in two stages. Medical records staff screened medical records retrospectively for one or more of eight general patient outcome criteria. Those that screened positive for the criteria were reviewed by one of four doctors. If an adverse occurrence was confirmed, further analysis and recommendations for action to prevent its recurrence were made at meetings of the four doctors, and forwarded to a committee of visiting medical officers who decided on the appropriate course of action.

**Setting:** A rural base hospital in Horsham, Victoria, between July 1991 and June 1994.

**Main outcome measures:** The rate and severity of adverse patient occurrences in each year.

**Results:** 1465 records were screened positive for one or more criteria, and an adverse patient occurrence was confirmed in 155. 88 cases were determined to be minor or not preventable and further action (mostly by changes to hospital policies) was recommended for the remaining 67. Over the three years, the number of adverse occurrences fell from 69 (1.35% of all patient discharges in the first year) to 33 (0.58% of all patient discharges in the third year) ( $P < 0.0001$ ) and there was no significant change in severity.

**Conclusions:** The rate of adverse patient occurrences can be significantly reduced by their continuous detection using retrospective screening in conjunction with review, analysis and action to prevent recurrences.

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## Table 5: CRM Review Templates

### Clinical Risk Management for GPs Working in Small Rural Hospitals.

#### Initial Project Officer Review

Hospital ID:

Medical Record No.

Date chart reviewed:

Flag identified:

Nature of event:

Severity rating    1   2   3   4

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#### External GP review

Date of review:

Time spent reviewing chart:  mins.

Is there an educational opportunity? yes / no

Did the patient sustain an unintended injury/event? yes / no

Was there any undesirable outcome noted? yes / no

Nature of event:

Peer review recommended: yes / no

Summary attached: yes / no

## Clinical Risk Management for GP's working in small rural hospitals

### Treating GP's report

Hospital identification:

Medical record No:

Flag identified:

Patient notes & external GP summary to : treating GP yes / no  
: local Champion GP: yes / no

Date sent for review:

Date returned:

Summary by treating GP supplied: yes / no

Peer review recommended: yes / no

Photocopied chart returned with reviewing Champion's summary: yes / no

Summary.

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## Clinical Risk Management for GP's working in Small Rural Hospitals.

### Reference Group.

Hospital ID:

Medical record No.

Date of review:

Venue for peer review:

Time:

Chairperson ( champion GP):

GPs representatives:

Flag identified:

Nature of event:

Severity rating:

Patient notes and GP summaries with local Champion: yes / no

Recommendations made: yes / no

Agreed by all: yes / no

Report and recommendations supplied yes / no

Time in mins

Notes and summaries returned: yes / no

## Table 6. Interview Protocol - Semi structured interview for GPs

Pilot Site: \_\_\_\_\_ AHS/Division \_\_\_\_\_

Interview Date & Time: \_\_\_\_\_

Involvement: \_\_\_\_\_

### Introduction.

As you are aware I'm conducting an evaluation of the Clinical Risk Management Program which has been piloted – which you took part in the pilot. Your experiences and reflections on your participation are an important part of the evaluation. However no individual remarks will be presented in the final report in a way that it would allow you to be identified.

### Background

First I'd like to learn about your participation in the CRM GP pilot project.

What was the level of your personal involvement in the CRM GP project?

*Prompt - ? as GP reviewer and/or Peer Review Panel.*

### Motivation

Why did you decide to participate in the project?

*Prompt - any personal apprehension in participating (aware of your colleagues attitude to CRM)*

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Do your perceived benefits match actual benefits of participating in the CRM GP pilot project)

Perceived	Actual

Have you been involved in clinical audit before?

If yes how does this compare with CRM utilising limited adverse event screen via retrospective medical record review?

Quality and Safety program

Can you describe how GPs perceive the importance of Clinical Quality and Patient Safety Programs?

Value of CRM GP

What do you think is the value of the current approach to CRM – does it address concern for Quality & Safety?

How would you rate the following tools developed through the project?

	Not Useful	Moderately	Very Useful
Flags			
Review template			
Panel checklist/template			

Comments:

Were there any practice change / improvement opportunities identified or implemented.

Can you describe any experience of shared learning / Peer support through the CRM project.

What has been the impact of CRM on the functioning of the clinical team i.e. nurses allied health and health service management.

What feedback (if any) have you received from treating GP's involved regarding:

1. Their satisfaction with the process

Unsatisfied	Moderately satisfied	Very Satisfied

Comments:

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2. Usefulness and timeliness of feedback from the review panel.

Not Useful	Moderately	Very Useful

Not timely	Timely

Comments:

3. Positive professional development opportunities or experiences as a result of the program

4. Their agreement with recommendations from the Review Panel  
What was the level of agreement?

Weak	Medium	Strong

Comments:

5. Did it prompt them to change practice?

Change & Uptake

Have you noticed any changes in:

A) Knowledge

B) Attitudes

C) Skills

D) Behaviour

E) Culture

F) Policy

G) Practice

... that you would attribute to CRM?

What have been the major causes of these changes?

What has facilitated these changes?

What have been the obstacles to change?

What strategies were/can be devised/employed or considered to deal with these obstacles/resistances?

Conclusion

Is there anything else about your experience with the CRM GP project you would like to add?

Concluding thanks

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**Table 7. Semi structured interview for HSM's from participating hospitals**

Pilot Site: \_\_\_\_\_ AHS \_\_\_\_\_

Interview Date & Time: \_\_\_\_\_

Following are the issues to be covered in survey of Health Service Managers / Executive Officer DON in participating facilities.

1. Can you briefly summarise your understanding of the CRM program?

2. Perceived benefits V actual benefits

Perceived	Actual

3. What is your knowledge of and involvement in the NSW Clinical Quality and Patient Safety Program including Safety Improvement Program – (incident monitoring, RIBS, SACs and RCA)

4. What do you consider to be the value of the current approach to CRM?

5. Are you aware of any practice change / improvement opportunities identified and or implemented as a result of the CRM project?

6. What is your experience of shared learning / team support as a result of the program?

7. Are there processes or mechanisms in place for GPs to report incidents/adverse events?

a. Are they utilised?

b. In your opinion have you noticed any change with the implementation of the CRM program?

8. What has been the level of engagement in quality and safety activities from the GPs prior to and since the implementation of the CRM program?

9. What has been the Impact, if any of CRM on the functioning of the clinical team i.e. GPs nurses, allied health and health service management.

10. Have you noticed a change in

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a. Knowledge

b. Attitudes

c. Skills

d. Behaviour

e. Culture

f. Policy

g. practice?

11. What have been the major causes of these changes?

12. What has facilitated these changes?

13. What have been the obstacles to change?

14. What strategies were/can be devised/employed or considered to deal with these obstacles/resistances?

15. Other comments?

## Table 8: Project Officer Evaluation Questionnaire

### 1.0 Introduction

This questionnaire is for the purpose of description and evaluation of structure and processes of CRM GP model in each participating site. As the CRM GP project officer you are probably in the best position to complete this questionnaire. Due to the constraints and nature of how the pilot was run in your sites certain data may not be available. These limitations are understood, so please answer as fully as possible.

The data will be de-identified in the final evaluation report.

### 2.0 Background Information

2.1 Area Health Service (as per 2004) \_\_\_\_\_

### 2.2 Division/s of GP

- 1)
- 2)
- 3)
- 4)

### 2.3 Participating facilities

- 1)
- 2)
- 3)
- 4)
- 5)

### 3.0 Selection process for participating facilities and GPs.

Please provide a description of the selection process for facilities and GPs to participate. For example were GPs and facilities approached individually or a general invitation circulated. Who approached the GPs. Was this a personal approach or a written request to participate?

### 4.0 Model of Clinical Risk Management implemented.

Please describe the process implemented in the pilot project. eg did you use flags or random selection of medical records or 100% medical record review or a combination of a number of approaches. How were the different levels of review undertaken eg 1st level by project officer or GP etc. it may be helpful to attach a flow chart of the process.

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## 5.0 Evaluation of detail

### 5.1 Uptake of system

Please outline the projects timeline from: EOI – acceptance into programme – infrastructure set-up - training – becoming operational.

### 5.2 No. of GPs utilising system

- 1) Number of VMO GPs at participating facilities.
- 2) Number of GPs who participated as GP reviewers.
- 3) Number of GPs who participated on at least 1 Peer Review Panel.
- 4) Number of GPs who participated in both i.e. GP reviewer and Peer Review Panel.
- 5) No of GPs expressing interest to join program after its commencement

### 5.3 No. of facilities utilising system

- 1) No. of facilities within an AHS which were eligible to participate (No. of GP only facilities) in the project.

## 6.0 Case data

- 1) No. Flagged records reviewed
- 2) % of separations over same period of time
- 3) Number of flagged records reviewed by project officer with positive criteria referred to GP reviewer
- 4) No/% of reviews where treating GP provided a response back to the reviewer.
- 5) No of reviews where the treating GP response clarified the matter as “no issue”
- 6) Number of records referred to GP reviewer forwarded to review panel.
- 7) Number of records referred from GP review with “no issue” for follow up.
- 8) Number of records referred from GP review with issue identified for follow up.
- 9) Number of recommendations made
- 10) Number of recommendations implemented
- 11) Methodology for implementation eg CPI, support project, directive?
- 12) Are there any outcome measures of the effectiveness of these changes? Whether that is empirical or anecdotal.
- 13) Number of SAC 1,2,3 & 4s incidents identified when records were reviewed.
- 14) Please provide a copy of the data collection form adopted by the Pilot site.

## 7. Adequacy/access to resources.

### 7.1 PO travel, review and administrative time

- 1) What was the time in minutes to review a medical record.

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

- 2) What was the time in minutes to photocopy a medical record?

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

- 3) What was the time in minutes spent travelling in one week.

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

4) What was the time in minutes spent preparing reports/papers for Peer Review Panels.  
Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

5) Any additional tasks and the times in relation to the CRM project.

#### 7.2 GP reviewer time & cost

1) What was the time in minutes to review a medical record.

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

2) What was the time in minutes participating in Peer Review Panel.

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

3) What is the cost per record for a GP review.

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

4) Peer review panel time & cost

How many Peer review panels were conducted during the pilot project? \_\_\_\_\_

5) What is the total cost (payment to all participating GPs) of a Peer Review panel?

Minimum\_\_\_\_\_ Maximum\_\_\_\_\_ Average\_\_\_\_\_

#### 7.3 Any additional cost not already identified

7.4 Timeframes involved in identifying adverse events.

7.5 Turn around time for GP review to completion of Peer Review Panel report.

#### 8.0 General

I invite you to consider the following questions. We will discuss them specifically at the Focus Group Meeting on the 16th June, however you might also like to pen your thoughts here.

1) What was the site's biggest success/gain?

2) What was it about the program that was most difficult to manage?

3) What was it about the program that was most helpful?

4) What would you do differently?

5) What skills did you have that proved most helpful?

6) What skills did you lack or require further development of in managing the program?

7) Please comment and make suggestions on the following:

a. Training

b. Support

c. Resources

#### 9.0 Other comments



# Endnotes

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- <sup>11</sup> Reproduced with permission :‘Clinical Risk Management’ ACT Health, Publishing, Plans & Strategies. <http://www.health.act.gov.au/c/health?a=da&did=10020572&pid=1074745387>
- <sup>2</sup> The aim of this booklet is to provide clinicians with information about the tools available to review and improve the quality of their practice and how to report the findings of any review.  
[http://www.health.nsw.gov.au/pubs/2001/pdf/clinicians\\_toolkit.pdf](http://www.health.nsw.gov.au/pubs/2001/pdf/clinicians_toolkit.pdf)
- <sup>3</sup> The flag system proposed to the pilot sites for adoption was developed from the QaRNS system developed at NSAHS. A list of the QARNs flags is found at Table 2
- <sup>4</sup> At the time of this report, no data was available from the six facilities of South East NSW Division of General Practice. The number quoted would be higher if these numbers were available.
- <sup>5</sup> Additional files for review came from self-reporting processes.
- <sup>6</sup> A multi-disciplinary team reviewed all files. One panel reviewed both second and third levels. Four matters were referred externally to Quality Manager as issues concerned external service providers.
- <sup>7</sup> Wolff, A. M., Bourke, J. Campbell, I. A., & Leembruggen, D.W. 2002 Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program. *The Medical Journal of Australia* 18 February 2002 176 4: 192-193.