Government of **Western Australia**
Department of **Health**

‘Closing the Loop’ on Clinical Incident Management

November 2016

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Outline

- What is ‘Closing the Loop’?
- CIM Policy requirements
- Why evaluate recommendations?
- Developing SMARTA recommendations
- Outcome measures and evaluation methodologies
- Providing evaluation reports and evidence
- Comments and questions

What is ‘Closing the Loop’?

- A program to enhance two components of SAC 1 clinical incident management (CIM)
  - The development and implementation of recommendations in response to serious incidents
  - The evaluation of the effectiveness of those recommendations in improving health care delivery and patient care

‘Closing the Loop’ resources

- http://ww2.health.wa.gov.au/Articles/A_E/Closing-the-Loop-Program

Resources

Policy

- OD 0611/15 Clinical Incident Management Policy 2015 (external site)
- CIMS Toolkit 2016 (PDF 2MB)

Action Plan

- Closing the Loop Program: SAC 1 Implementation and Evaluation of Recommendations Strategies and Action Plan (PDF 550KB)

Poster

- Closing the Loop poster (PDF 931KB)

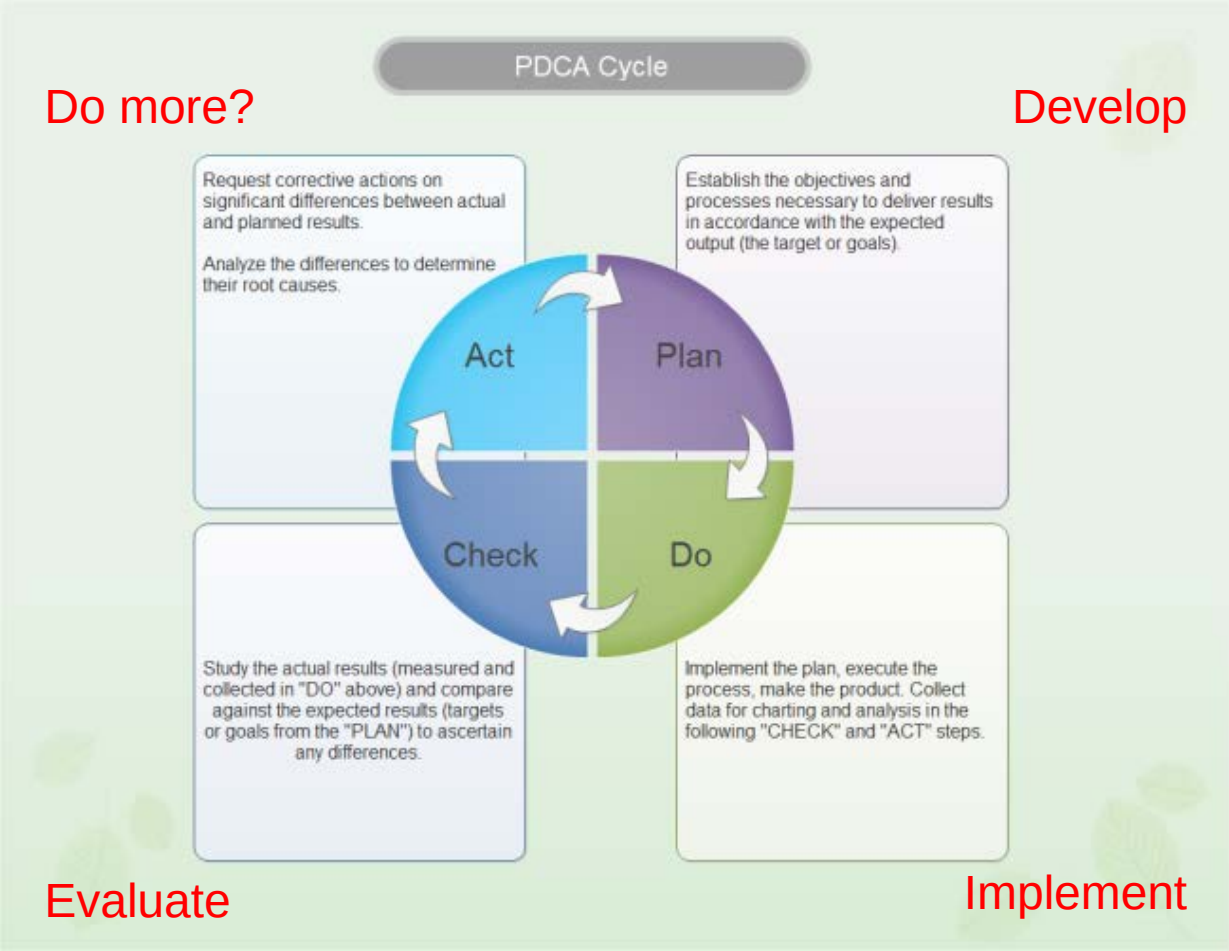
Tools

- Development of recommendations and evidence template: Closing the Loop 'SMARTA Score' Spreadsheet (Excel 103KB)
- Worked example of development of recommendations and evidence spreadsheet (Excel 102KB)

CIM Policy requirements - summary

	SAC 1 incidents	SAC 2 / 3 incidents
Take immediate action when a clinical incident occurs to ensure the patient receives appropriate care; notify the incident into Datix CIMS	Yes	Yes
Notify the incident to the PSSU within 7 working days of the event	Yes	No
Investigate the incident to identify contributory factors and develop recommendations in response	Complete within 28 working days of notification	Complete within 60 working days of notification
Provide a copy of the investigation and recommendations to PSSU	Yes	No
Implement recommendations and evaluate their effectiveness within 6 months of investigation completion	Yes	Yes
Provide a copy of the evaluation of the recommendations and evidence to PSSU	Yes	No

Why evaluate recommendations?



Developing recommendations

- Recommendations developed in response to clinical incidents should directly address the contributory factors.
- Four key considerations:
  1. Aims - What are the goals?
  2. Actions – What actions are required to achieve these goals?
  3. Outcome measures – What can be measured that will indicate whether the action led to improvement?
  4. Evaluation methodology – How will I collect and assess information about the outcome measures?

SMARTA recommendations

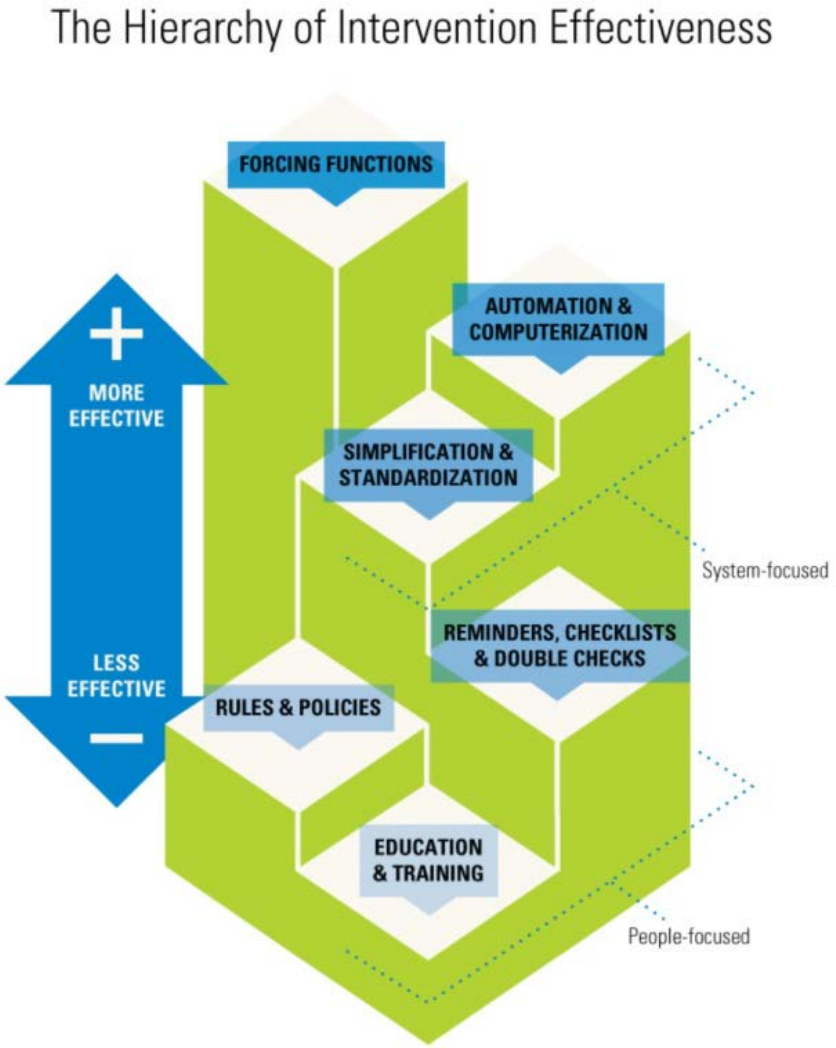
- Adopting the SMART principles for goal setting increases the likelihood of successful implementation
  - Specific
  - Measureable
  - Accountable
  - Realistic
  - Time-related

SMARTA recommendations

- ‘A’ is for Action Strength

Stronger Actions	Intermediate Actions	Weaker Actions
• Architectural/ physical plant changes • New devices with usability testing before purchasing • Engineering control, interlock, forcing functions • Simplify processes and remove unnecessary steps • Standardize on equipment or process or care maps • Tangible involvement and action by leadership in support of patient safety	• Redundancy/ back-up systems • Increase in staffing/ decrease in workload • Software enhancements/ modifications • Eliminate/ reduce distractions • Checklist/ cognitive aid • Eliminate look- and sound-alikes • Enhanced documentation/ communication	• Double checks • Warnings and labels • New procedure/ memorandum/ policy • Training • Additional study/ analysis

from Veterans Affairs National Center for Patient Safety *Root Cause Analysis Tools (2015)*



From www.healthcarequarterly.com/content/22845

Outcome measures

- Action/process outcome measures
  - Measure implementation/ completion of recommendations
- Root cause outcome measures
  - Measure the effectiveness recommendations have on contributory factors and root causes
- Adverse event outcome measures
  - Measure whether recommendations have prevented an incident from reoccurring

Evaluation methodologies

- Will depend on the type of recommendation and the outcome measure chosen
  - Audits
    - Compare actual practice to expected/best practice
    - May require baseline data for comparison
    - Can give quantifiable results
  - Surveys
    - More likely to provide descriptive data

Providing evaluation reports and evidence

- The PSSU has developed a spreadsheet to assist with the development, implementation and evaluation of recommendations
- Use of the spreadsheet is not mandatory but the summary information is required
- Evaluation summaries and evidence to support the work undertaken can be uploaded to the Datix incident record as documentation

Evaluation summary page

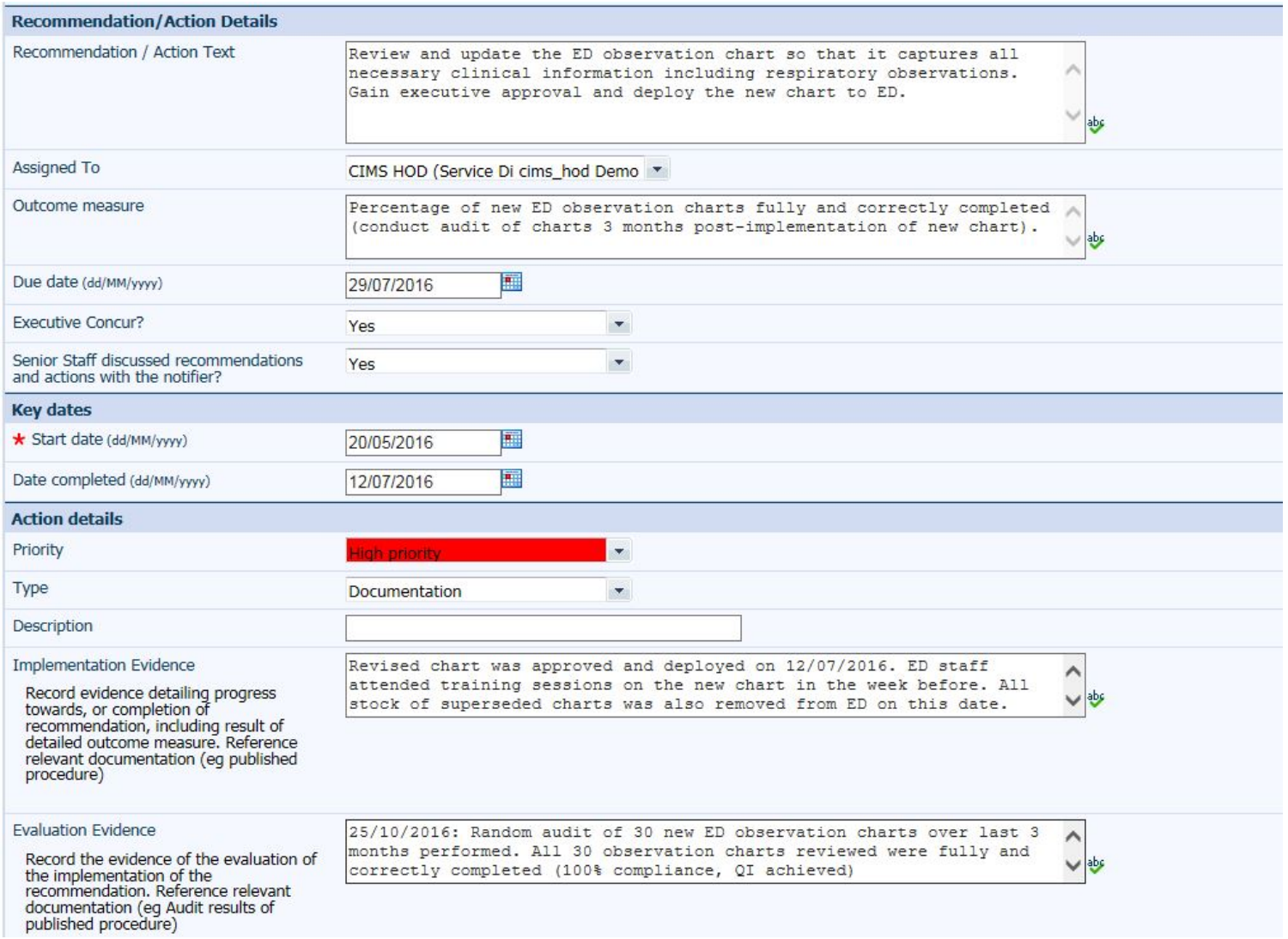
Datix CIM Number: CIMS999999
Hospital/Service: A hospital
Date investigation report submitted to PSSU: 01/05/2016
Date evaluation report due: 01/11/2016

		Recommendation/Action		Implementation	Evaluation			
Contributing/Causative factor as per investigation report	Aim	Recommendation/Action details	Action type	Evidence of implementation (If implementation not complete state why not and provide latest results)	Evaluation Date	Evidence of evaluation of effectiveness of recommendations/actions	Has QI been achieved? Fully/Partially/Not achieved If not fully achieved, state why not	Sign off that achievements completed State date
The observation chart currently in use in ED does not capture all necessary information regarding respiratory observations	Improve the observation chart so that it captures all necessary clinical information	Update the observation chart so that it captures all necessary clinical information including respiratory observations and gain executive approval	Enhanced documentation, communication	Revised chart was approved and deployed on 12/07/2016. All outdated charts were removed from ED on this date.	25/10/2016	Random audit of 30 ED observation charts over 3 months performed. All 30 obs charts reviewed were fully and correctly completed (100% compliance)	Yes	29/10/2016
Insufficient clinical documentation led to ineffective handover from ED to ward staff and a luck of appreciation of the acuity of the patient	Ensure all observation charts in the ED are correctly and fully completed 100% of the time	Provide training to all ED staff regarding the standards for clinical documentation and clinical handover	Training	Training was delivered to ED staff between 13-29/5/2016. 48 of 50 staff attended (96%). Two staff were on leave over this time.	25/10/2016	Survey of 20 handovers completed. 16 handovers were identified as fully meeting required standard (80% compliance). 3 of the 4 non-compliant handovers were to the surgical ward	Partial - while improvement has been made the issues with handover from ED to the surgical ward require further review to identify why this may be occurring	29/10/2016

Providing evaluation reports and evidence - Datix CIMS

- Complete individual recommendations when they are implemented and enter a summary of the implementation evidence
- When the subsequent evaluation has been completed a summary can also be entered in each recommendation record
- More detailed evidence can be attached to the incident record as documentation

Datix recommendation record



Recommendation/Action Details

Recommendation / Action Text	Review and update the ED observation chart so that it captures all necessary clinical information including respiratory observations. Gain executive approval and deploy the new chart to ED.
Assigned To	CIMS HOD (Service Di cims_hod Demo
Outcome measure	Percentage of new ED observation charts fully and correctly completed (conduct audit of charts 3 months post-implementation of new chart).
Due date (dd/MM/yyyy)	29/07/2016
Executive Concur?	Yes
Senior Staff discussed recommendations and actions with the notifier?	Yes

Key dates

★ Start date (dd/MM/yyyy)	20/05/2016
Date completed (dd/MM/yyyy)	12/07/2016

Action details

Priority	High priority
Type	Documentation
Description	
Implementation Evidence Record evidence detailing progress towards, or completion of recommendation, including result of detailed outcome measure. Reference relevant documentation (eg published procedure)	Revised chart was approved and deployed on 12/07/2016. ED staff attended training sessions on the new chart in the week before. All stock of superseded charts was also removed from ED on this date.
Evaluation Evidence Record the evidence of the evaluation of the implementation of the recommendation. Reference relevant documentation (eg Audit results of published procedure)	25/10/2016: Random audit of 30 new ED observation charts over last 3 months performed. All 30 observation charts reviewed were fully and correctly completed (100% compliance, QI achieved)

Action Chains – Datix CIMS

- Complete action chain 3 when all recommendations arising from the investigation have been implemented
- Complete action chain 4 when all recommendations arising from the investigation have been evaluated
- Follow local processes for completing action chains and notifying PSSU when evaluation has been completed

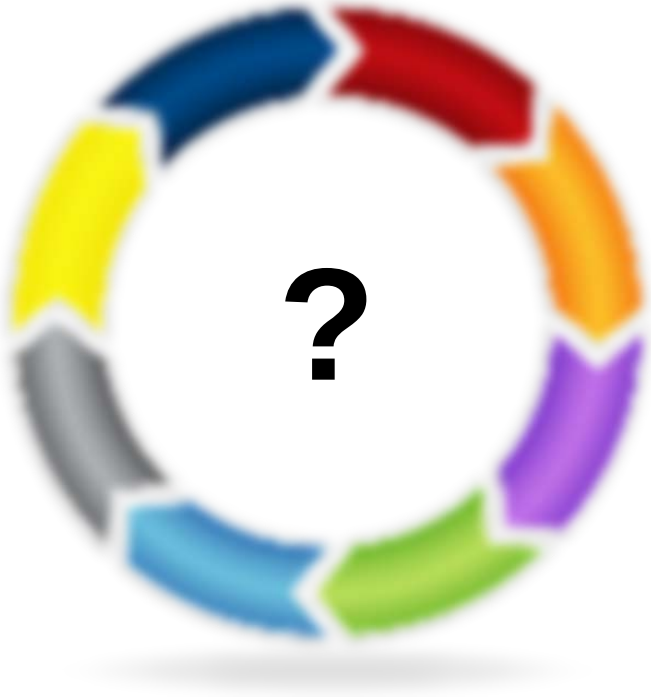
Datix action chains

Action chains

SAC1 Clinical Incident Investigation

Step	Type	Description	Assigned To	Start date	Due date	Date completed	Active
1	Notify	Notify the Patient Safety Surveillance Unit (PSSU) within 7 working days.	Program Officer Susan Woolley	25/09/2015	07/10/2015	25/09/2015	Y
2	Investigate & Submit	Complete the SAC1 Clinical Incident Investigation using Root Cause Analysis or similar investigative methodology & submit completed Investigation Report to PSSU (due within 28 working days). Close event.	Senior Policy Office Tim Van Bronswijk	25/09/2015	05/11/2015	12/11/2015	Y
3	Implement	Review SAC1 Clinical Incident Recommendations to ensure completion within 6 months.	Senior Policy Office Tim Van Bronswijk	12/11/2015	12/05/2016	14/06/2016	Y
4	Evaluate	Review evaluation of SAC1 Clinical Incident Recommendations within 6 months.	Senior Policy Office Tim Van Bronswijk	12/11/2015	12/05/2016	14/06/2016	Y

Comments and questions



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