CPSM STANDARDS POLICIES
For Winnipeg Regional Health Authority

The Central Standards Committee (CSC) of The College of Physicians and Surgeons of Manitoba (CPSM) is a legislated standing committee of the CPSM and reports directly to the Council. The committee is responsible for the maintenance and supervision of the quality of medical practice by members of the CPSM. The committee is mandated by *The Medical Act*. Its activities, which are for the purpose of medical education or improvement in medical or hospital care or practice, have been afforded the protection of *The Evidence Act*. All rural hospital standards committees and area standards committees are subcommittees of the CSC.

RESPONSIBILITIES OF CPSM

The College shall appoint members to the CSC and its subcommittees and fill vacancies on these committees when they arise. The College shall be responsible to appoint persons and to fill vacancies on the Winnipeg Regional Health Authority (WRHA) Committees appointed under Section 26 (now Section 24) of *The Hospitals Act*. As a result of this process, the various Standards Committees will have protection under *The Evidence Act*.

RESPONSIBILITIES OF WRHA

The WRHA shall:

1. request the Minister of Health to establish each WRHA Standards Committee to be established pursuant to Section 9 (2) (a) of *The Evidence Act*.
2. submit a list of recommended names of members to sit on the WRHA Standards Committees to the CPSM. CPSM will be responsible for final approval of the membership of these committees.
3. notify the College of its preference for persons to fill vacancies as they arise.

RESPONSIBILITY OF THE CHAIR, WRHA STANDARDS COMMITTEE

The Chair of the WRHA Standards Committee will be a physician who is a member of the CPSM. The Chair of the WRHA Standards Committee shall:

1. Submit a semi-annual report to the CSC. The report shall include a summary of each audit of clinical practice that has been completed during the reporting period, including the audit tool used, audit results, recommendations and actions taken by the committee and by management.
2. Report sentinel events to the CSC in a timely fashion.
3. Submit copies of clinical audits that may be requested by the CSC.

STANDARDS

A Standard may be defined as a desired and achievable level of performance against which actual performance can be compared[1], or as a generally accepted level of performance. Whenever possible, the standard should be determined by systematic examination of the scientific literature and best practice.

SENTINEL EVENT

A sentinel event is defined as one that results in the unanticipated death of a patient or a major permanent loss of function not related to the natural course of a patient's illness. The term "critical clinical occurrence" (CCO) may be used to describe sentinel events, but includes "near misses", which could have, but did not, result in death or impairment.

Sentinel events also include:

1. suicide of a patient in a setting where the patient is receiving 24-hour care or supervision, and the suicide is not related to the patient's illness and is an unanticipated event; (am. 12/04)
2. an incorrect procedure, e.g. surgery on the wrong patient or wrong part;
3. repeated occurrence of an error, e.g. incorrect drug administration.

CLINICAL AUDIT

A clinical audit is defined as a review that is performed for the purpose of education of health care providers or improvement in community or hospital care or practice. Clinical audits offer a means to assess and comment upon care, treatment and overall management of patients and their illnesses. Regulation 453/88 states that the policies, procedures and records of clinical audits performed by Standards Committees must be in accordance with the requirements of the CSC.

Potential topics of clinical audits include, but are not limited to:

1. death reviews;
2. review of the management of specific diseases;
3. review of adverse patient occurrences, including:
   - unplanned return to the operating room on this admission. Planned return to operating room **must** be documented prior to first surgery if the case is to be excluded from the review.
   - unplanned admission following a surgical procedure
   - pathology reports that do not match the pre-operative diagnosis. This is the follow up of routine tissue review which is **required** as part of standards activities.
   - hospital acquired nosocomial infection
   - unexpected transfer from general care to special care unit (where applicable).

[1] Canadian Council on Health Services Accreditation

- unplanned transfer to another acute care facility
- randomly selected code blues
- random cases classified as emergent using Canadian Triage Acuity Scale.
- wrong side or wrong part surgery
- medication errors leading to death or significant morbidity

Clinical Audit Process

1. Determine the focus of the audit

The purpose of a clinical audit is to determine whether patient care is consistent with best practice. A process should be selected for audit on the basis of clinical risk to patients. Low-volume, high-risk conditions or procedures are important to audit. High volume conditions should also be audited to determine whether clinical practice meets current standards.
Any Standards Committee may initiate a clinical audit. The Chair of the Standards Committee is responsible for ensuring that the analysis and report are completed in a timely fashion and are communicated appropriately.

2. Design the audit tool

a. Before beginning a clinical audit, the literature should be reviewed to determine current best practice. A quantitative audit tool should be developed based on best practice and should include all variables relevant to the delivery of care.
b. The scope of the audit should be determined, with consideration of available resources, ability to complete audit in a timely manner, and include all settings where the care is being delivered.

3. Audit and analyze the data

Data may be obtained retrospectively from patient charts, or prospectively using survey tools. The Evidence Act protects all data collected for the purpose of standards audits. Data containing identifiers must be maintained securely. Statistical analysis of the data may be conducted by the Standards Committees or by assigned staff.

4. Develop recommendations

The Chair of the Standards Committee should develop a summary and recommendations. Recommendations may be systemic or specific and may lead to follow-up audits after practice changes.

- Standards Committee may take educational action and notify the College of the action and outcome.

- Recommendations for system change should be reported to the College and to management, **without** identification of any patient or health care provider.

5. Communicate report to appropriate committee or person

The reports of all audits conducted under the auspices of the Standards process must be available to the College on request. When an audit indicates that patient safety is at risk, concerns should be communicated to CPSM or appropriate administration for action.

THE DEATH REVIEW PROCESS

A death review, as with all other activities of standards committees, is an educational event to improve clinical practice parameters, develop or redefine policies or maintain the quality of medical practice. It offers the physician a means to assess and comment upon the care, treatment, and management of the patient precedent and subsequent to death. While retrospective, the educational rewards, and improvements in the subsequent care of other individuals, make this method of peer review a valuable exercise.

General Requirements

- Standards committees should perform death reviews on a regular basis. It is suggested that death reviews be completed within a 3-month period of time.
- Selected deaths meeting predetermined criteria specific to the Program will be reviewed. A screening process may be initiated, such as is shown in the first two questions of the attached example. Selected cases would have a more detailed review. These cases would include those events in which a review would have educational benefit and contribute to improved practice.
- Deaths occurring in a long-term care setting, or after terminal illness, may only require randomly selected cases to be reviewed on a regular basis.

Reporting And Recording

- Communicate the results in summary form (e.g. ages of patients, number of deaths during that reporting period, causes of death, any trends noted, autopsy performance).

- Communicate the recommendations designed to improve or correct matters found in the review.

- Ensure that any educational or continuing medical education recommendations are acted upon and an opportunity exists for participation by all appropriate staff.

- Refer matters that involve other regulated health professions to the appropriate regulatory body (e.g. College of Registered Nurses of Manitoba, Manitoba Pharmaceutical Association, Manitoba Dental Association) for follow-up.

Criteria included in Review

- The attached **sample** death review form was developed to assist this process. While it is not a requirement that this form or the entire criteria list be implemented into the review process, it may be used as a template.

- The two highlighted questions should be completed on all deaths. Generally, these preliminary responses provide enough information to base a decision on whether further review is necessary.

- A "no" response on the criteria form may indicate a need for a more in-depth review and follow up by way of discussion/correspondence with the most responsible parties.

- The criteria on this form are by no means an all-encompassing list of what could be reviewed on all charts. It is meant to provoke thought and provide guidance to the reviewing process.

- This format and criteria may also be used for the performance of reviews other than death reviews.

Privileged according to *The Evidence Act*

SAMPLE DEATH REVIEW CRITERIA FORM	
Health Record No.:	Principal Diagnosis:
Reviewed By:	Cause of Death:
Date:	Date of Death:

If you answer yes to either of the first two questions, complete entire review.	**N/A**	**Yes**	**No**
Was death caused by a complication of the primary diagnosis?			
Was death related to a re-admission within 7 days? (from this hospital or any other)			
Do the principal diagnosis and cause of death correlate? (If no, further review)			
Was the death anticipated? (If no, explain, consider further review)			
Was this a Medical Examiner case? (see reverse side)			
Does the death summary provide a clear, concise outline of patient management? (If no, further review)			
Was an autopsy performed?			
If no, in this reviewer's opinion, should an autopsy have been requested?			
If yes, was the cause of death confirmed by the autopsy?			
Does the progress note clearly indicate this patient/family's request for CPR or evidence of advanced medical directive?			
Are the historical data complete? (other medical problems noted)			
Is the primary diagnosis indicated?			
Do the progress notes document family involvement in the care and treatment decisions of the patient?			
Do the progress notes document the changes in patient condition?			
Was the therapeutic regime changed according to the patient's condition?			
Do the progress notes document changes in the therapeutic regime, as appropriate to the patient's changing condition?			
Do progress notes indicate the physician's understanding of the severity of the case?			
Were consultations ordered when necessary?			
Were the consultations obtained in a timely fashion?			
Were appropriate laboratory tests ordered?			
Were these tests performed in a timely fashion?			
Was the patient clinically monitored as frequently as necessary?			
Were clinical and lab studies re-evaluated as necessary?			
Were drug doses within acceptable limits?			

Were medication orders written in accordance with standards? ▪ Was the writing consistently legible? ▪ Was each prescription signed, dated and timed? ▪ In children, were drug doses written in mg/kg or mg/m^2 as well as in total?			
Was the attending physician, or an appropriate alternate, available when required?			
Did the physician call and/or attend to the patient in a timely fashion when requested?			

Comments:

CLASSIFICATION of Death: D_____ M_____ C_____ (see Death Review Classification Key)		
RECOMMENDATION: 1. No action.	**Yes**	**No**
2. Further review required. Chart referred to_____.		
3. Educational action. Indicate _____.		

DEATH REVIEW CLASSIFICATION KEY		
Death	**Management**	**Charting**
DX Not enough information to assess D1 Inevitable D2 Unexpected/Unavoidable D3 Unexpected/Avoidable	M1 Adequate M2 Minor Deficiency M3 Major Deficiency	C1 Adequate C2 Minor Deficiency C3 Major Deficiency