Thunder Bay Regional Health Sciences Centre

UPDATE: QM-80

Quality of Care Reviews

QM-80 provides an overview of the Quality of Care Review process, starting from when management and QRM receive an incident report regarding a patient safety event.

What's new?

- **Policy Statement Change:**
  Our focus on "Patient Safety" has changed to "Just Culture", and we have added learners to the employees included.
- **New Definitions:**
  Clinical Debrief (aka "Hot Debrief"): Following a critical incident, a meeting to summarize the case, determine what went well and opportunities for improvement, and to highlight where actions are required, including whether further debriefing is required by the team.
  Critical Incident: An unintended event, resulting in death or serious disability, injury or harm, and does not result from patient's underlying medical condition or from a known risk inherent in providing treatment.
  Incident Triage Team (ITT): A group of leadership who will meet within 48-72 hours of a critical incident to determine if a Quality of Care (QOC) Review is required, and if so, what type of review.
  QOC Reviews: We further define these as: Departmental Reviews led by Department Leadership; Morbidity & Mortality (M&M) Reviews led by Professional Staff; or Critical Incident and Process Reviews for systemic issues facilitated by Quality and Risk Management.
- **Procedural Updates:**
  Procedure 5.1: Updated to include reference to ITT.
  Procedure 5.2 & 5.3: Clarification provided regarding when Quality of Care Information Protection Act (QCIPA)-protected reviews are undertaken.
  Procedure 6.2: Insertion of Clinical Debriefing process. Upon the discovery of harm (any level), the healthcare team should meet as soon as possible to discuss. This may just be a conversation with the Department Manager, or for more serious events/critical incidents, a clinical debriefing (aka "hot debrief") should occur. Members of this debrief team may include involved Staff, Professional Staff, Managers or MRP, or after hours, Unit Lead supported by Administrative Coordinator as needed.

Thunder Bay Regional Health Sciences Centre

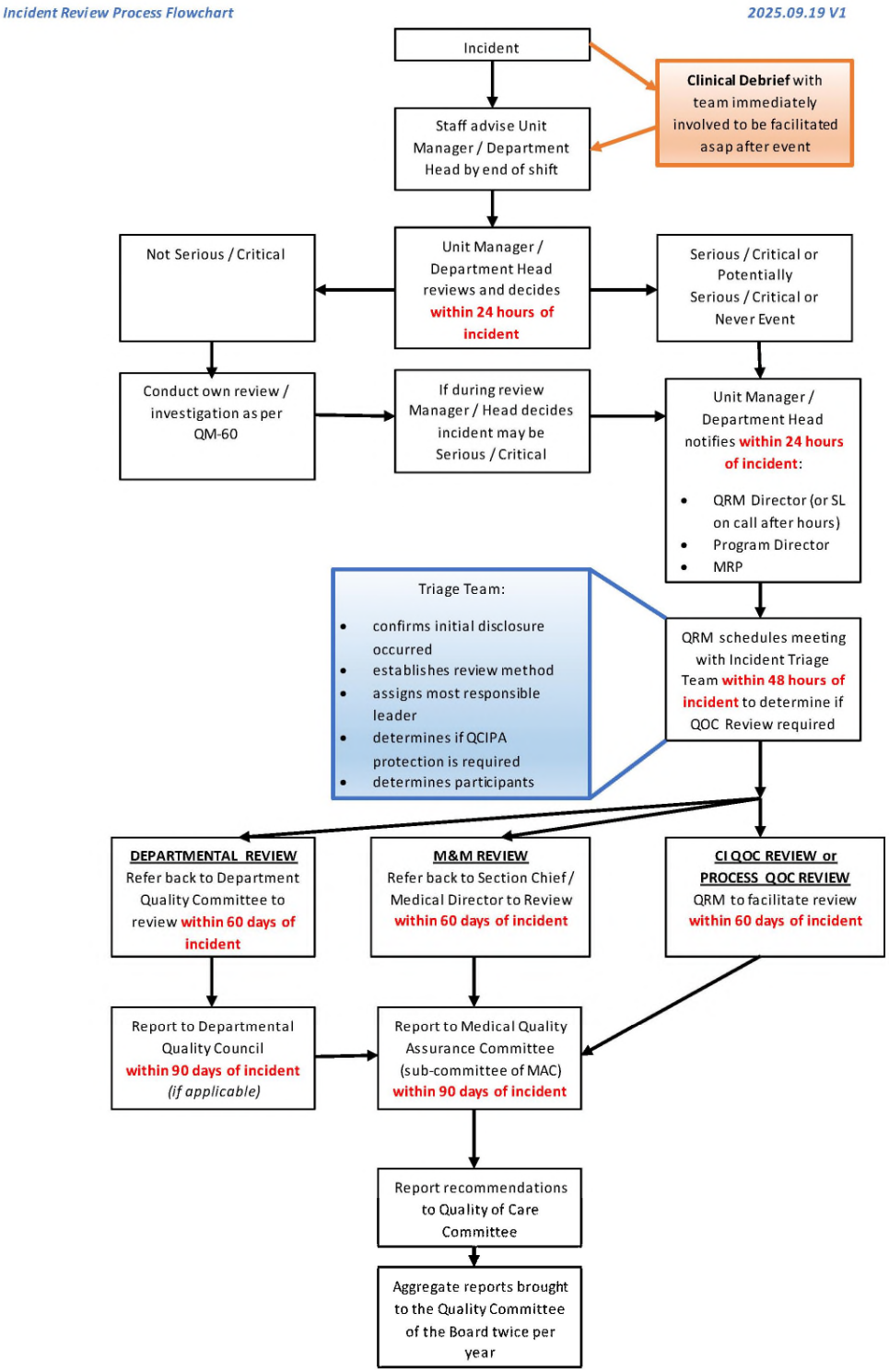
Procedure 6.3: Updated requirements of incident review report, classification of the incident, and when to contact the QRM Director.
Procedure 6.4: Insertion of process for consultation with ITT and determining necessity of QOC Review.
Procedure 6.8: Clarification added to whom the organization can disclose information pertaining to reviews. Although all discussions during the review remain confidential, the Quality of Care Committee may disclose information pertaining to reviews in accordance with the *QCIPA 2016.*
Procedure 7: References updated; information on debriefing included.
Appendix A: Incident Review Process Flowchart.
Appendix B: Clinical Debriefing Guide **(S.T.O.P.)**.

Process Reminders

- Reporting for all incidents will follow the processes outlined in policy QM-60 *Incident Learning System (ILS): Reporting, Investigation and Trending of Incidents and Near Misses.*
- QOC Reviews are completed following an incident (or near miss with potential for patient harm) to identify opportunities for improving quality and patient safety. The purpose of a review is to identify and address systemic issues, not to focus on individual performance.
- Anyone within the organization can request a QOC Review by notifying the Director of QRM. The decision of whether a review will be covered under QCIPA is determined by the ITT, with final decision by the Quality of Care Committee or the Chair as designate. Applicable leaders should report all reviews, QCIPA or non-QCIPA protected, to QRM.
- All reviews should include:
    - the responsible Manager(s);
    - the Chief of Service (if applicable);
    - involved staff, professional staff and learners;
    - other representatives as appropriate.

If you have any questions, please contact:
TBRHSC.QualityandRiskManagement@tbh.net

Appendix A: Incident Review Process Flowchart



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Appendix B: Clinical Debriefing Guide (S.T.O.P.)

HOT DEBRIEFING GUIDE

This guide provides a standardized approach to post-event clinical debriefing.
These conversations are to be facilitated as soon as possible after an event with a target duration of 10 to 15 minutes.
These conversations are not to assess or evaluate personal performance and they do not replace other processes associated with critical events such as PSLS reporting, accessing employee assistance programs, or formal critical incident stress debriefings.

"Thank you for taking the time to gather and discuss this event.
Can I ask someone to assist with note-taking?
We believe this team is capable, has done their best, and is seeking to improve.
We have not gathered to assess or evaluate personal performance.
For this debriefing, we will use the STOP format."

S	T	O	P
Summarize The Case	Things That Went Well	Opportunities To Improve	Points Of Action

"Before we end this debriefing if anyone has any last remarks please share them.
As appropriate and with respect and confidentiality, these findings will be shared with our leadership team.
We will follow up on these items.
Thank you again for joining us. Please continue to take care of yourselves and each other.
Thank you for the work that you do."

Created by CICSL and members of BC Simulation Network and BC Emergency Medicine Network.
Available for download at:

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HOT DEBRIEFING GUIDE

Recent literature supports performance-focused post event clinical debriefings facilitated by healthcare professionals familiar with established debriefing processes. Like other aspects in health care, bringing hot debriefing to clinical settings invites careful implementation considerations.

Considerations for Introduction :

- Consider introducing this guide in advance of initial debriefings.
- Orientate your debriefers and your teams.
- Appreciate the impact of local culture and psychological safety.

Considerations for During:

- Affirm that participation is voluntary and not compulsory.
- Embrace a growth mindset, and a commitment to improvement.
- Learn from success and minimize hindsight bias.

Considerations for After:

- Assign findings to individuals for meaningful clinical improvement.
- Provide debriefers with ways to improve their facilitation skills.
- Provide local resources for those who may benefit from further psychological support.

With acknowledgement and thanks to:
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Walker C.et al. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med (2020) 7(4):259-266.
Coggins et al. Interdisciplinary clinical debriefing in the emergency department: an observational study of learning topics and outcomes. BMC Emergency Medicine (2020) 20:79.
Coggins et al. Twelve tips for facilitating and implementing clinical debriefing programmes. Medical Teacher (2020) Published online.
Heart and Stroke Foundation of Canada 2020 Guidelines. Circulation. Vo. 142 (16): S599-600.

For feedback contact CICSL@viha.ca