



(Use your Letterhead)

This document records review, evaluation and improvement activities of the System Clinical Performance Improvement Committee. Per Texas Health and Safety Code Chapter 773 Subpart A section 773.095, the proceedings and records of this committee are confidential.

Clinical Event Review
MM/DD/YYYY
Incident Number XX-XX-XXXX

Incident Specifics:

This section should include:

1. the incident number (preferably the AFD Dispatch or EMS Inc. No.)
2. date the event(s) occurred,
3. your Agency's name,
4. name of the providers involved in the patient care for this incident
5. name of the lead provider for this incident

Clinical Concerns:

What are the specific clinical performance concerns that prompted this review?

This section should briefly and objectively describe the clinical performance concern(s).

This section should have statements that are clinical performance related. The statements should not include a provider's personal opinion or unsubstantiated facts. Though such information may be obtained, it is the PI Officer's responsibility to filter personal opinion and remain focused on the clinical performance issues. All non-clinical performance issues should be addressed separately. When in doubt, seek guidance from the SCPIC on whether a concern is a clinical performance issue.

Summary of Pertinent Facts and Sequential Information:

This section should provide a summary of the facts that surround the overall event and the details that surround the specific concerns. All information in this section should be objective and first-hand information. Although you may have gathered much more information, the report should focus on including only the pertinent information to help the reader understand how you reached the conclusions you will outline in the next section. You do not need to include verbatim accounts from those from whom you received information. You should consider the following:

1. What were the general actions in sequence that occurred during the care of the patient(s)?
2. What specific actions occurred that may have led up to or contributed to the occurrence of the performance concerns?
3. How did the providers reach the decisions to perform the actions or omitted actions (things not done) that were associated with the clinical concerns?

This section SHOULD NOT include any discussion of causes or actions to be taken.

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Clinical Performance Improvement Opportunities (Causation):

This section outlines the specific clinical performance that could have been improved and specifically states why any less than optimal performance occurred. Broad categories of improvement opportunities might include (this is an abbreviated list):

1. The design of a piece of equipment or device increases the likelihood of error (e.g. two different medications with nearly identical labels, a device that requires recall of complex operating instructions)
2. Work design or environment that increases the likelihood of poor human performance (e.g. excessive fatigue, distractions, information or task overload)
3. Work direction that is incorrect (e.g. a memo sent to providers that encourages poor habits or incorrect actions)
4. Procedures that are unclear in scope, application or limitations. (e.g. a protocol that vaguely defines when not to perform a specific procedure)
5. Training that is ineffective, incomplete or incorrect (e.g. training that uses lecture as a sole means of teaching a skill, instructor who provides personal opinion that conflicts with the desired performance)
6. Communication (verbal, written and other) between providers and other System providers, other healthcare providers, patients, family members or bystanders. (e.g. one provider assumes another provider will be performing a task without confirming this, a provider makes a statement that is interpreted differently by the receiver of the statement)

This section **SHOULD NOT** focus on whether a provider was right or wrong, whether an error occurred or not, or whether a concern can be substantiated or not. Such a focus is not the primary purpose of the review process.

For now, this section should identify the specific performance that was not quite optimal and, based on the review findings, should state the specific performance that should be performed in the future (improvement). The PI Officer should also state the facts that support the review findings and the possible reasons for the less than optimal performance. In the future, this section will be expanded to include causation with an emphasis on root cause (when possible). We will need to develop additional tools and training before we expect PI Officers to effectively complete this section.

Secondary/Additional Findings (if applicable):

Sometimes, the review identifies less concerning actions (or omitted actions) that are not related to the initial concerns. These additional findings should be noted here. Noting these additional performance issues in this section does not imply that each of these requires any specific additional review or any recommendations for improvement. An example might be a case where the initial concern was a failure to apply CPAP to a patient when the indications for this therapy were present. In the course of the review, the PI officer finds that the provider does not know the role of position 1 in the pit crew model. Since the case being reviewed was not a cardiac arrest, this new finding is incidental and did not result in any performance concern or adverse event during this specific incident. So, it is merely a secondary or additional finding. In many cases this section will be blank.

Recommendations for Improvement:

The PI Officer should outline any recommendations or suggestions for improvement. Each recommendation should be directly linked to the specific findings outlined in the Causation section above. A common misconception is that all performance concerns can be improved upon through training. This is often the case but not as often as we used to believe. Since the categories of causation listed above are not always a result of a knowledge gap or a skill deficit, it is very possible that another element of the provider's system needs improvement. In some cases, the provider's less than optimal performance was caused by one of the above factors. So, simply retraining the provider is unlikely to change performance and does not address prevent similar performance concerns with other providers in the future.

Next Steps

This section is only applicable if the PI Officer is aware of specific steps that will need to occur next. An example might be if the reviewer spoke with the OMD about the event review and decided on a meeting between the providers and the OMD, this could be listed as a next step. It is important to note that next steps are not the same as Improvement Recommendations outlined in the section above. They may be the same but do not always have to be.

Signature Line

List the name of the PI officer who reviewed the event and prepared the report. In addition, note the date the report was finalized. This is important for version control since at times we will need to revise a document.