



Clinical Audit Process

Purpose

Clinical audits for high-risk / low-frequency clinical events aim to evaluate performance across the system and at the individual provider level. These clinical activities are infrequently performed and represent treatments or conditions that are considered to have increased risk if not performed properly or for the correct patient. Therefore these clinical events require active monitoring from the Office of the Medical Director. The information gathered through this process will be utilized to identify opportunities for improvement and build strategies to assure competency in these critical skills.

This process aims to evaluate:

- Clinical decision making
- Protocol compliance
- Adherence to documentation standards
- Identify potential adverse events

Process

1. A summary of clinical narratives of high-risk / low-frequency clinical activities (as defined by the SCPIC) is compiled every month and submitted electronically to the System Clinical Performance Improvement Committee (SCPIC) members. The report includes the following elements (no patient identifiers):
 - a. Incident number and date
 - b. Clinical event (intervention)
 - c. Name of provider performing the intervention
 - d. Entire patient care record narrative
2. Clinical audits of high-risk clinical events occur on a monthly basis by the Deputy Medical Director or his designee.
3. Clinical narratives will be reviewed to evaluate for clinical decision making (appropriateness), protocol compliance (standard practice), documentation (adherence to current documentation standards), and identified or potential adverse events.
4. A complete patient care record may be reviewed as part of this process when there is insufficient information to evaluate the case.
5. The Deputy Medical Director or his designee may refer any potential clinical concern to the provider's agency/organization clinical performance improvement subcommittee (CPIS) for further review through the clinical event review process.
6. The referred clinical concerns are tracked through established clinical event review process systems.
7. The monthly volume, findings and outcomes are summarized for presentation to the CPIS and SCPIC. The CPIS or SCPIC determines appropriate improvement actions.
8. Improvement actions are documented and recorded by the CPIS and available to the SCPIC.
9. The SCPIC may conduct additional clinical audits as needed to evaluate the effectiveness of implemented improvement actions within 6 months post-implementation.