

PERTH CLINIC CLINICAL REVIEW COMMITTEE

ANNUAL REPORT TO THE PUBLIC FOR 2021

ON

QUALITY IMPROVEMENT ACTIVITIES UNDERTAKEN OR OVERSEEN

BY

CLINICAL REVIEW COMMITTEE – PERTH CLINIC

The *Health Services (Quality Improvement) Act 1994* provides for the approval and protection of quality improvement committees reviewing, assessing and monitoring the quality of health services and for related purposes. Section 9 of the *Health Services (Quality Improvement) Regulations 1995* each committee is to make a report available to the public at least once in each period of 12 months.

The following fulfils the requirements of the committee under section 9 of the *Health Services (Quality Improvement) Regulations 1995*.

A copy of the committee's Terms of Reference is attached.

Report on issues, projects and/or activities undertaken by the Committee for which Qualified Privilege was required

Description

A detailed review was undertaken in relation to:

- *Use of patient category observations and assessment of at risk patients.*
- *Documentation in the patient health record to ensure that records reflect the specific context and needs of each individual patient.*
- *Inclusion of family members/supporters in the patient's episode of care.*
- *Multidisciplinary treatment processes and treatment referrals.*
- *Processes for patient discharge planning and post discharge follow up.*

Action Taken

Throughout the review a number of actions were taken including

- *Review of relevant national standards and guidelines.*
- *Review of documented policies and procedures.*
- *Review of health records, including risk assessments, care plans and outcome measures.*
- *Review of adverse event, risk and complaints data.*
- *Review of quality improvement activities.*
- *Assessment of staff knowledge.*

Outcomes

The systems were found to be effective and consistent with national standards. Specific outcomes of the review included:

- 1. Confirmation that the systems for managing patient care are effective.*
- 2. Confirmation via audits that health records documentation is appropriate and consistent with relevant standards.*
- 3. Review and update of processes for patient observations and risk assessment.*
- 4. Review of multidisciplinary treatment processes and documentation.*
- 5. Staff knowledge and competence with procedures was confirmed.*