Ambulance Tasmania

Clinical Governance Framework 2012

Ambulance Tasmania
Department of Health and Human Services

Tasmanian Government

Forward

The mission for Ambulance Tasmania (AT) is to provide excellence in ambulance and health transport care. Building a high quality, safe health care system that is responsible for the best patient outcomes possible, is the number one priority for AT. To support all staff in achieving that aim, a contemporary Clinical Governance Framework has been developed.

The focus on Clinical Governance for health providers is an important aspect of patient care. This Clinical Governance Framework brings together clinical practice, clinical measures and effectiveness, review, audit, education and consumer feedback to implement a standardised, evidenced-based approach to interventions.

The Ambulance Tasmania Clinical Governance Framework has not been developed in isolation. This clinical governance framework forms part of the over-arching governance for Ambulance Tasmania, and is on par to the corporate governance, organisational governance and financial governance of AT. The success of any clinical governance model relies on integration of practice, not just within the organisation it serves, but also with those groups that provide collaboration in practice. This is extremely important in healthcare, as we look to provide measures across the continuum of patient care, and ensure all Department of Health and Human Services (DHHS) interactions with the patient result in the best possible outcome. As a result, AT would like to thank the members of DHHS, in particular the Clinical Governance Oversight Committee and the Tasmanian Ambulance Clinical Council, for their input into developing this Framework.

Importantly, the principles within this framework have been modelled to align with the Australian Safety and Quality Framework for Health Care, that describes a vision for safe and high quality care for all Australians, and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and high quality care, ensuring that care is consumer centred, driven by information, and organised for safety.

This Ambulance Tasmania Clinical Governance Framework provides the over-arching principles to guide the organisation through a continuous feedback loop, and supports the individual to take responsibility for their own behaviours and actions. AT encourages everyone to use the Clinical Governance principles to improve their practice, and become familiar with the relevant documents and policies to ensure AT is delivering high quality, safe care to our communities.

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Introduction

Ambulance Tasmania (AT) provides integrated, high quality, pre-hospital emergency and medical care, patient transport, community transport and medical retrieval services to the Tasmanian community. AT achieves this through a system of permanent paramedics, volunteer officers and the support of operational services.

AT has a team of more than 800 staff, whose mission is to provide optimal care integrated across all aspects of health and community transport. The AT structure has been developed to streamline the organisation to provide the best possible care to patients, and consists of the following business divisions:

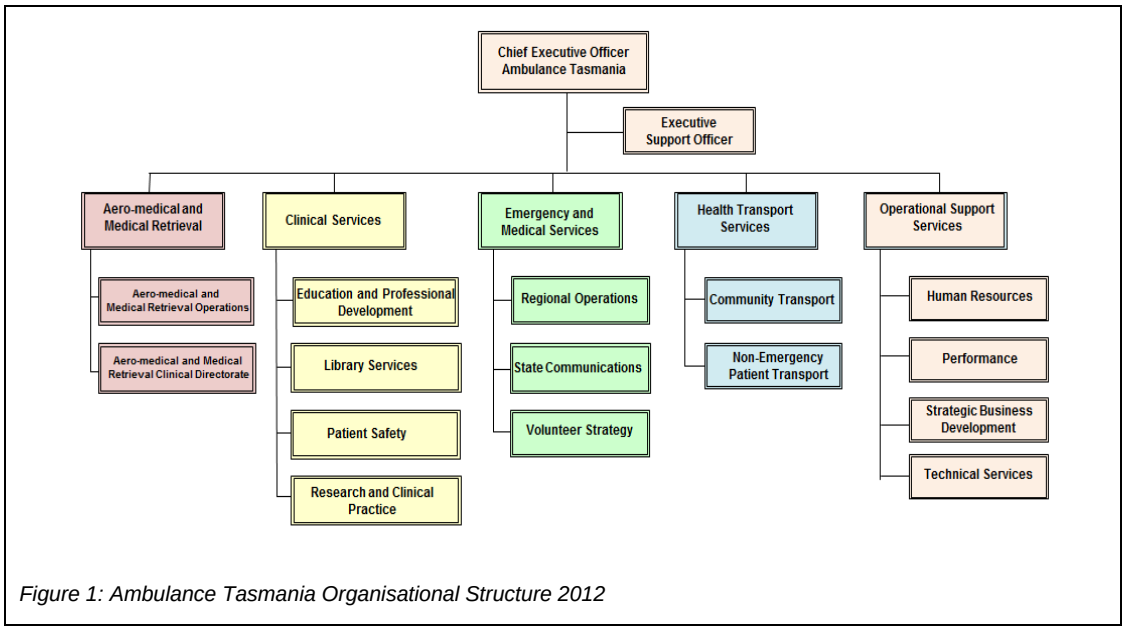

Figure 1: Ambulance Tasmania Organisational Structure 2012

Clinical Governance

Definition

Clinical governance describes the system whereby organisations and clinicians together continually monitor and improve clinical care.

A Clinical Governance Framework is a strategic guide that describes the principles of clinical governance, applicable at the organisational and service delivery levels. In particular, it recognises that the healthcare system operates in a number of contexts:

- The **care delivery context** requires the active engagement of consumers in providing both an understanding of their experience of health care and their support in its improvement
- The **organisational context** requires the development of an organisational monitoring and management process to support local care improvement
- The **departmental (as proxy for society at large) context** requires the active engagement of the department as an active participant in the monitoring of and support of clinical care

Clinical governance is how we hold ourselves accountable for the quality and safety of our clinical activities. AT recognises that without effective governance the quality of our services cannot be assured. A robust Clinical Governance Framework (CGF) provides planning and development, quality

assurance, continual improvement and risk management of services as a part of the everyday routines and practices of the organisation, and for every crew that delivers care[1,2].

This CGF provides a broad outline of the structures and processes, specific to AT. The underlying premise is patient safety, and the focus is on outcomes that can demonstrate where improvements to services are being made.

Guiding principles

The AT Emergency and Medical Services Business Plan describes a three year plan that strives for continuous improvement in all aspects of service delivery. Strategic priorities for AT have been shaped by the DHHS Overarching Departmental Objectives[3]. They are:

a) Supporting individuals, families and communities to have more control over what matters to them

b) Promoting health and well-being and intervening when needed

c) Developing responsive, accessible and sustainable services

d) Creating collaborative partnerships to support the development of healthier communities

e) Shaping our workforce for the future

The doctrine of this Framework, and the values of AT are:

- Respect for clients and staff
- Equity of access
- Integrity
- Collaboration
- Safety and quality
- Efficiency and effectiveness
- Continuous learning and improvement
- Promotion and support of health and wellbeing

Clinical governance is central to this strategy and an integral component of the overall success of service delivery. The DHHS has provided broad principles and approaches within a framework in support of Tasmanian healthcare. These include:

Principle 1:	All involved share a responsibility for the delivery of high quality clinical care
Principle 2:	Organisations have a responsibility for assisting clinicians to improve their care systems
Principle 3:	Clinical governance systems must be based in improving care
Principle 4:	Clinical Governance systems must reflect a proper understanding of clinical practice
Principle 5:	Clinical Governance systems must have a 'whole of system' view
Principle 6:	Care must be consumer centred, driven by information, and organised for safety

Clinicians and clinical teams are directly responsible and accountable for the safety and quality of care they provide. Executives and management are responsible and accountable for ensuring the systems and processes are in place to support clinicians in providing safe, high quality care and in ensuring clinicians participate in governance activities.

Framework

Several key clinical governance outcomes emerged when identifying the needs of AT in servicing the Tasmanian communities. The objectives centred on clinical governance activities, the methods to achieve the objectives and the ways we can measure our success. As a result, the AT CGF has been built on four pillars of performance areas[4].

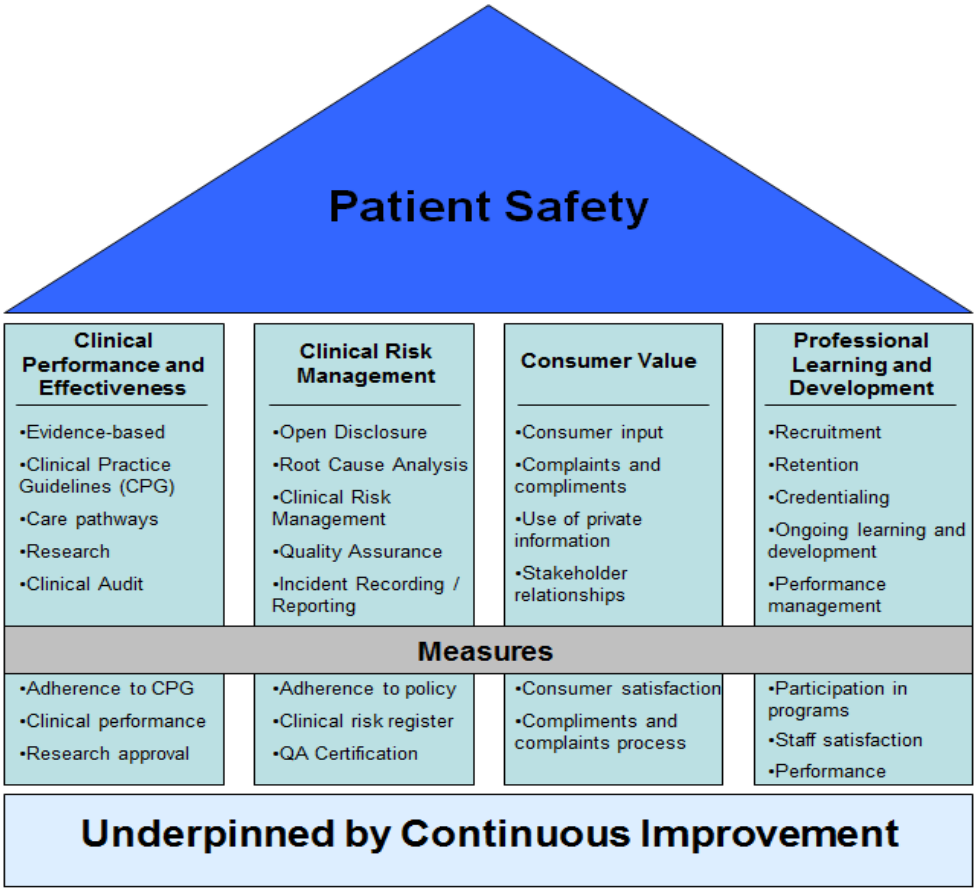

Figure 2: Ambulance Tasmania Clinical Governance Framework Pillars.

The pillars are an adaptation of original work undertaken by the Western Australia Department of Health, the use of which is acknowledged and appreciated[4].

The following table provides a description of each Pillar.

Pillar	Description	Clinical Standards	Clinical Indicators
Clinical Performance and Effectiveness	The first pillar sets the standards to achieve contemporary, evidence-based practice for the best patient outcomes. This pillar establishes the scope of practice and safe intervention as part of a clinical care pathway. Clinical evaluation forms an integral part, so that systematic review of clinical performance against identified benchmarks becomes commonplace, and an expected part of clinical service.	**Evidence-based clinical practice guidelines** • *Policy and process is developed to ensure all clinical interventions are based on current and best practice, supported by the literature and relevant bodies such as the Australian Resuscitation Council.* **Scope of practice** • *Is developed to ensure cost-effective care for the best possible outcomes for patients, while meeting the needs of communities. The scope of practice, including clinical interventions, protocols, equipment and work instructions, is clearly defined for cohorts within the organisation, and is easily accessible to individuals.* **Clinical care pathways** • *The focus of clinical care is to ensure the best outcomes for patients. AT will ensure that all interventions compliment broader health initiatives across the continuum of care, and will participate in opportunities for improved clinical care pathways for patients, such as referral services, direct admissions to acute specialist units, and prevention.* **Evaluating research findings against quality of evidence** • *Policy is developed to ensure research is evaluated utilising a suitable hierarchy of evidence so that best practice can be implemented. This policy will also influence submissions for changes to practice, and will help guide staff in critiquing the literature to promote a culture of critical thinking in practice.* **Clinical audit** • *Is the method of evaluating and improving clinical practice, by analysing the quality of clinical care against the identified standards. Operational staff will be informed of the basis for, and frequency of audits, and results will be available to individuals. Audit will occur regularly, and will include both in-field audit as well as retrospective audit of documentation such as patient care records.*	• Adherence to Clinical Practice Guidelines • Clinical Performance: o Cardiac arrest management o Pain management o Care Packages (Stroke, STEMI) o Response times o Transport not required / Referral to alternate care • In-field audit and case reviews completed • Completion of Patient Care Records • Benchmarking of Clinical Protocols • Research / Grant applications and approvals • Research publications

Pillar	Description	Clinical Standards	Clinical Indicators
Clinical Risk Management	The next pillar concentrates on minimising risk and improving overall clinical safety. The Department of Health and Human Services' (DHHS) has provided an electronic incident reporting system that forms the basis for recording and reporting information. Potential risks are identified and limited occurrence and adverse incidents are examined for causative factors and for trends. Investigations are centred on quality improvement and focus on systems evaluation as a critical component. Preventative lessons are shared across the relevant healthcare organisations.	**Established policies and procedures** **Open Disclosure** • *The open discussion of incidents that resulted in harm to a patient while receiving health care. Policies and education are implemented to develop a culture of open disclosure and active participation by individuals, in a safe environment that encourages learning.* **Root Cause Analysis** • *A class of problem solving methods aimed at identifying the root causes of the event, and incorporates activities such as learning from local incidents or patterns of incidents, and reporting on analysis and findings.* **Sentinel Events / Limited Occurrence Screening (LOS)** • *Policies are developed for the identification, reporting and investigating sentinel events and monitoring LOS. Sentinel events are relatively infrequent events that result in unnecessary outcomes for patients. LOS identifies high-risk interventions utilised by operational staff that occur infrequently in practice.* **Clinical Review and Clinical Variance** • *Definitions are applied to clinical occurrences to identify variances, and the severity of variance. Patient cases are reviewed by clinical experts against the clinical standards. Where variances have occurred, these are graded to trigger investigation and reporting, to assist changes to practice. The severity of variance is defined from Level 1 (most severe) to Level 4 (least severe), and is complimented by the AT clinical variance ratings (Appendix A).* **Clinical Risk Management** • *A methodology to prevent adverse events and improve patient safety by implementing policies, procedures and structures to embed identification, management and correction or reduction of clinical risk into the everyday activities of AT, and includes maintaining a risk register and monitoring medico-legal cases.*	• Clinical Risk Register • Limited Occurrence Screening: o Attend and no transport then re-attend the same patient within 24 hours o Unexpected death while in AT care o Defibrillated patients o Intubation facilitated by sedation (IFS) o Decompression of suspected Tension Pneumothorax o Ergometrine Administration o Sedated / restrained mental health / aggressive patient o Synchronised cardioversion • Sentinel Events (requiring Root Cause Analysis): o An initially undetected oesophageal intubation o Hospital admission unrelated to the original presenting condition and as a clear consequence of the actions or inactions by AT o Death of a patient as a clear consequence of the actions or inactions by AT • Adherence to established investigation timeframes • Adverse events outcomes • Number of potential and actual medico-legal events

Pillar	Description	Clinical Standards	Clinical Indicators
Clinical Risk Management cont.		**Quality Assurance Registration** • *AT will align with the DHHS Quality Assurance standards, and implement the appropriate National Health Standards.* **Electronic Incident Reporting System** • *AT will continue to utilise the DHHS Electronic Incident Reporting Software for recording and reporting all required events.*	• Number of clinical variances, and outcomes QA certification
Consumer Value	This pillar promotes strong links with the Tasmanian community. It ensures consumer groups remain a compelling voice in maintaining and improving performance, and influencing the future direction of the organisation. This pillar places the consumer of our services at the forefront of our business, to be considered in all aspects of clinical decision making.	**Consumer participation** • *Is the involvement of consumers in AT's planning, policy development and decision making to help ensure that AT are providing accessible and equitable health care to our communities.* **Compliments and Complaints Register** • *AT will continue to utilise the relevant DHHS Electronic Incident Recording Software for recording and reporting complaints and compliments. Established policy will maintain standards to ensure complaints are managed effectively within prescribed timeframes, and will ensure feedback is provided to staff for all compliments and complaints received.* **Use of information – confidentiality, privacy, storage and access** • *Development of policies and procedures to ensure all personal information collected is managed appropriately, and that AT meets all legislative requirements in regards to privacy, confidentiality, storage of information and access to records.* **Stakeholder relationships and representation** • *AT will continue to foster collaborative relationships with stakeholder and community groups, through representation on internal and external committees, councils and working groups, and through informal discussions.*	• Consumer satisfaction surveys • Number of complaints and compliments • Adherence to policy for management of complaints • Management of Right To Information (RTI) requests

Pillar	Description	Clinical Standards	Clinical Indicators
Professional Learning and Development	The final pillar supports recruiting and retaining the best staff, ensuring they are adequately prepared to safely perform their duties through comprehensive induction and ongoing professional learning and development programs. It encompasses the credentialing of clinicians, including remedial programs and performance management of staff identified at risk.	**Recruiting best staff and retention of current staff** • *Workforce development provides for health personnel with appropriate skills and diversity. Processes are in place to support the appropriate selection and recruitment of the best staff.* **Induction programs for all staff** • *All staff participate in an appropriate introduction to the organisation, are well informed of their role and are exposed to the policies, processes, work instructions, clinical guidelines and equipment within their scope of expertise and practice.* **Credentialing of clinicians** • *AT must be confident its staff have adequate skills and experience in order to undertake the responsibilities of their position. This includes an assessment upon appointment and regular assessment throughout their employment. Accurate and up-to-date training records are maintained and reviewed.* **Access to professional learning and development programs** • *All employees are provided with adequate information, resources, training and professional development to support the organisation's clinical governance activities.* **Performance management framework** • *Policies are implemented to identify staff at risk, and provide a transparent supportive process to assist the clinician to achieve the required standards.*	• Participation in induction and learning and development programs: o Initial education o Ongoing education o Learning packages o Accredited courses o Specific programs such as driver standards, mental health, manual handling, occupational health and safety, workplace behaviours, equal opportunity legislation and Specialist roles o Return to Practice after extended absence o Remedial programs • Staff satisfaction • Recruitment and retention targets • Accurate up-to-date records

Critical Success Factors

Culture

The success of this CGF is reliant upon a culture that supports the underlying focus on patient care. The most important aspect of progressing a robust CGF is ensuring the people understand the value of good governance, and are willing participants in the everyday activities. This is not a top-down management strategy, and not just a focus on clinicians. All staff within AT play an important role in excellence in patient care, and therefore every person has a responsibility within the Framework, and a right to know how the individual and the organisation are performing.

To further enhance a supportive culture that embraces clinical governance, and actively contributes to the fundamentals for improving patient outcomes, AT promotes cooperation and inclusion through the following guiding principles:

- ✓ A supportive, learning culture that seeks continuous improvement and risk minimisation.
- ✓ A commitment to patient safety in all aspects of the organisation, where all staff share the belief that the core of AT business is the patient.
- ✓ A strong focus on systems reviews, and asking "how" did things go wrong, not "who is to blame".
- ✓ A supportive, open and inclusive culture where sharing of ideas and practices are commonplace and valued, and where staff feel secure when highlighting errors.
- ✓ A clear allocation of duties and responsibilities, and access to learning and development to create greater understanding and opportunity.
- ✓ Robust policies and procedures that define the clinical governance practices, and are easily accessible to staff.
- ✓ Actively using evidenced-based research to influence decisions, practices and education within the organisation.
- ✓ A regular, honest communication program discussing the CGF, the achievements in meeting standards, and the lessons learnt from audit and reviews.
- ✓ Involvement of patients, communities and stakeholders in the planning and development of AT.

Structure of AT committees

With the establishment of the CGF it is important to structure resources responsible for the execution of the relevant policies, procedures and reporting. AT has established the following committees as part of the CGF:

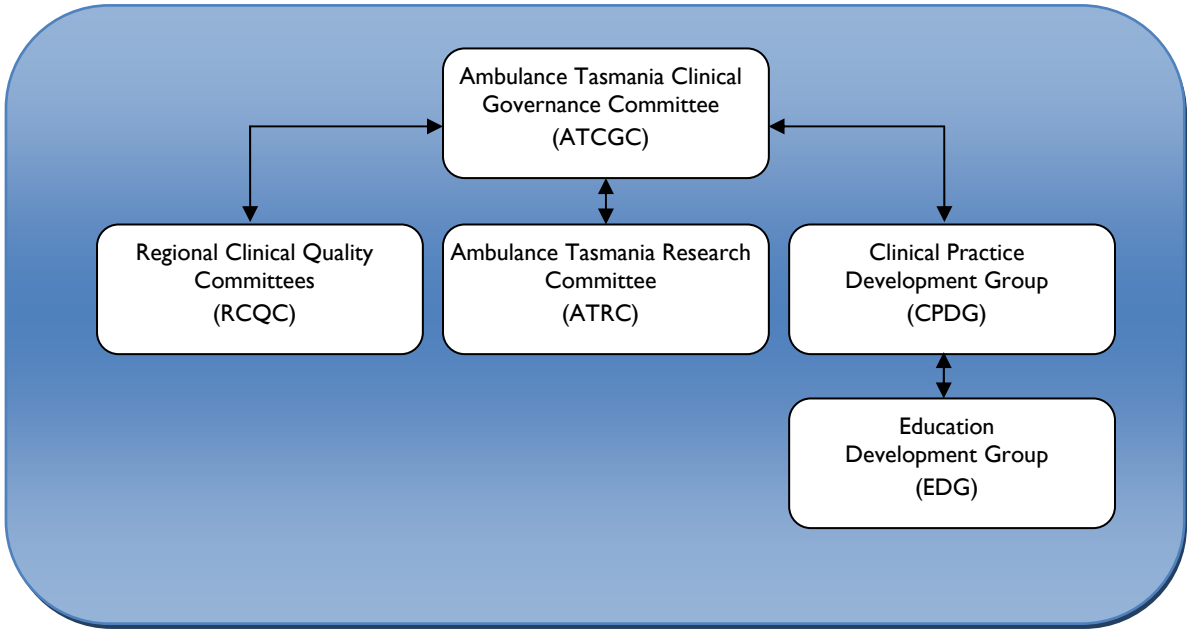

Figure 3: Ambulance Tasmania Clinical Governance Framework Committee Structure

The Committees are responsible for taking forward the work of the strategy, through:

- Developing measures, policy and process to support the CGF, and supporting the continuous improvement loop
- Monitoring progress against relevant parts of the Framework
- Reporting to identified groups and the organisation on progress
- Contributing comprehensive information in their identified area to assist with influencing best practice
- Collaborating and communicating with other sub-committees and committees to promote a learning culture
- Working together with partner organisations where applicable
- Maintaining confidentiality, respect and professionalism in all activities

It is important that the clinical governance process is managed through expert committees that have clear lines of authority and reporting using quality management processes and project management disciplines. The programme's outcomes, through the implementation of change in practice, allows for 'closing the loop', that can be signed off by ATCGC and ultimately by the Board, to provide reassurance.

It is critical that each committee, just like each person within the organisation, has clear direction on their responsibilities and required activities within the CGF. The table below identifies the broad responsibilities of each committee.

Name	General Duties
AT Clinical Governance Committee (ATCGC)	• Clinical oversight and advice from expert panel for clinical standards, clinical practice and protocols, interventions and equipment and clinical review, audit and risk management for AT • Focus on continuous quality improvement and evidence based practice • Level 1 and Level 2 severity variances reviews • Open Disclosure • Root Cause Analysis • Collate state-wide clinical indicator data and Limited Occurrence Screening (LOS)
Regional Clinical Quality Committees (RCQC)	• Collate, interpret and report regional clinical audit data • Discuss clinical variance and ensure reports progressed as appropriate and records completed • Investigate and manage regional Level 3 and Level 4 variances • Assist with clinical investigations as required
Clinical Practice Development Group (CPDG)	• Development of CPGs, Volunteer Protocols, Clinical Work Instructions, Clinical pathways, equipment and relevant justification materials
Education Development Group (EDG)	• Development, design and approval of continuing education programs for: o Continuing Professional Development (CPD), Continuing Vocational Education (CVE), remedial programs, learning packages, Learning Management System (LMS) content, Return to Practice after extended absence (RTP), student Intensive care education programs, Non-Emergency Patient Transport (NEPT) continuing education programs, Communications centre staff ongoing education programs, introduction of new equipment, Occupational Health and Safety updates, Organisational development programs • Development, design and approval of induction and initial education programs for: o Graduate induction and internship, new recruits including NEPT, Communications centre, Volunteers, Paramedics, Operations managers, support staff (where applicable) • Equivalency of Qualification (EOQ) and recruitment policy and procedure
AT Research Committee (ATRC)	• Identify areas for research • Grants / Funding applications • Approve research requests both internal and external • Seek collaboration opportunities

Clinical Quality Requirements

To gain value from a CGF, information must be transparent, and the culture of the organisation must support staff to conduct investigations, reviews, analysis of data and provision of results without fear from reprisal or public blame. Targets must provide useful and meaningful measures, and the reports must demonstrate how the organisation is performing against these determinants. Most importantly, the reports must provide a description of resultant improvements.

AT currently reports on a range of clinical indicators and compliance measures. This CGF has been designed to enhance the existing suite of reports, and ensure the information is used constructively to improve practice. Regular review, monitoring, investigation and evaluation of the governance measures have been allocated to each of the relevant Clinical Governance Sub-committees, with the requirement to report either monthly or quarterly on findings and outcomes.

Individuals and groups/committees are responsible for the collating, monitoring and review of data and information to provide the evidence to support the CGF and the continuous feedback loop. The following table provides an overview of the clinical quality requirements.

Type	Description	Responsibility

Limited Occurrence Screening (LOS)	• Interventions that are used less frequently and/or have a higher risk associated with use
	• Includes:
	  • Attend and no transport then re-attend the same patient within 24 hours
	  • Unexpected death while in AT care
	  • Defibrillated patients
	  • Intubation facilitated by sedation (IFS)
	  • Decompression of suspected Tension Pneumothorax
	  • Ergometrine administration
	  • Sedated / restrained mental health / aggressive patient.
	  • Synchronised cardioversion
	• PCR's retrospectively audited by CSO, clinical rationale and adherence to clinical guideline confirmed. RCQC review of all audits, provide plan for Level 3 and 4 variances, refer Level 1 and 2 to ATCGC. Data and review results reported to ATCGC.
		✓ PCR Audit – CSO
		✓ Audit summary and presentation by CSOs to RCQC
		✓ Management of Level 3 and 4 clinical variance – RCQC
		✓ Monitor of state-wide audit results – ATCGC

Sentinel Events (Root Cause Analysis)	• Incidents that are considered significant risk or error:
	  • An initially undetected oesophageal intubation
	  • Hospital admission unrelated to the original presenting condition and as a clear consequence of the actions or inactions by AT
	  • Death of a patient as a clear consequence of the actions or inactions by AT
		✓ Event is reported via DHHS Incident Recording system
		✓ Root Cause Analysis - ATCGC

Clinical Review (Level 1 and 2) (see Appendix A)	**Level 1** Major variance from clinical protocols, and/or major poor practice of clinical skills, and/or major errors of clinical judgement that **result** in: • Permanent adverse patient harm • Death of patient unrelated to the natural course of the presenting illness/injury differing from the expected outcome of patient management • Permanent increased level of care as a result of specific variance OR • Repeated clinical variance at Level 2 by individual	✓ Information entered into DHHS Incident Recording system ✓ CEO notified ✓ ATCGC notified for investigation

	Level 2 Significant variance from clinical protocols, and/or significant poor practice of clinical skills, and/or significant errors of clinical judgement that **result** in: • Major adverse patient harm • Major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness • Major illness/injury differing from the expected outcome of patient management • Significant increased level of care as a result of specific variance OR • Repeated clinical variance at Level 3 by individual	
Clinical Review (Level 3 and 4) (see Appendix A)	**Level 3** Variance from clinical protocols, and/or poor practice of clinical skills, and/or errors of clinical judgement that **result** in: • Minor and non-permanent adverse patient harm • Minor illness/injury differing from the expected outcome of patient management • Minor increased level of care as a result of specific variance OR • Repeat of Variance Level 4 by individual **Level 4** Minor variance from clinical protocols, and/or minor poor practice of clinical skills, and/or minor errors of clinical judgement that **do not result** in: • Adverse patient harm • Illness/injury differing from the expected outcome of patient management • Increased level of care as a result of specific variance	✓ Information entered into DHHS Incident Recording system ✓ RCQC to investigate and manage ✓ Report and outcomes referred to ATCGC

In-field Audit (IFA)	• The aim of the in-field audit is to measure and report real time performance of operational staff on an ongoing basis. Subsequent analysis of the results will for the identification of areas of both high and lesser than desired performance, and will support greater validation of retrospective auditing, through triangulation of sources. • IFA also allows for immediate feedback to participants, to promote ongoing professional development and experiential learning.	✓ CSO ✓ Results collated and reported to RCQC
Retrospective PCR Audit	• Patient Care Records (PCRs) are the only written record of the care provided by Operational staff. They must be a true and accurate reflection of the events of the case, and provide evidence of adherence to policy, practice guidelines, interventions and clinical decision making. Audits should occur regularly for all operational staff, and the information collated and reported as part of identification of practice in action. • Feedback must be provided to staff for all audits completed.	✓ CSO ✓ Results collated and reported to RCQC
Compliments and Complaints Review (clinical)	• The interaction with staff and community is an important aspect and must be recorded, reported and managed. • Feedback must be provided to relevant staff (where applicable) and to the instigator of the compliment / complaint (where applicable).	✓ Information entered into DHHS Incident Recording system ✓ RCQC to investigate and manage ✓ Report and outcomes referred to ATCGC
Clinical Review of Call-taking and Dispatch	• Clinical audit of call-taking and dispatch procedures must be part of the clinical data collection. The planned audit activities are aimed at ensuring compliance to agreed call-taking and dispatch procedures to analyse audit results and trends to identify and implement opportunities for improvements to the system. • Targeted audits of cohorts of cases are also conducted in response to requests, as part of the Clinical Governance activities.	✓ RCQC to investigate and manage ✓ Report and outcomes referred to ATCGC

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Appendix A – Ambulance Tasmania Variance Matrix

Clinical Event	Serious Variance Level 1 (Level 1)	Major Variance Level 2 (Level 2)	Moderate Variance Level 3 (Level 3)	Minor Variance Level 4 (Level 4)
Description	Major variance from clinical protocols, and/or major poor practice of clinical skills, and/or major errors of clinical judgement that **result** in: • **Permanent adverse patient harm** • **Death of patient unrelated to the natural course of the presenting illness/injury differing from the expected outcome of patient management** • **Permanent increased level of care as a result of specific variance** OR • Repeated clinical variance at Level 2 or 3 by individual	Significant variance from clinical protocols, and/or poor practice of clinical skills, and/or errors of clinical judgement that **result** in: • **Major adverse patient harm** • **Major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness** • **Major illness/injury differing from the expected outcome of patient management** • **Significant increased level of care as a result of specific variance** OR • Repeated clinical variance at Level 3 or 4 by individual	Variance from clinical protocols, and/or poor practice of clinical skills, and/or errors of clinical judgement that **result** in: • **Minor and non-permanent adverse patient harm** • **Minor illness/injury differing from the expected outcome of patient management** • **Minor increased level of care as a result of specific variance** OR • Repeat of Variance Level 4 by individual	Minor variance from clinical protocols, and/or minor poor practice of clinical skills, and/or minor errors of clinical judgement that **do not result** in: • **Adverse patient harm** • **Illness/injury differing from the expected outcome of patient management** • **Increased level of care as a result of specific variance**
Action	• Information entered into DHHS Incident Recording system • CEO notified • ATCGC notified for investigation	• Information entered into DHHS Incident Recording system • CEO notified • ATCGC notified for investigation	• Information entered into DHHS Incident Recording system • RCQC to investigate and manage • Report and outcomes referred to ATCGC	• Information entered into DHHS Incident Recording system • RCQC to investigate and manage • Report and outcomes referred to ATCGC