SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	SAER Recommendations Compliance Monitoring
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/320
DATE OF PUBLICATION	July 2022
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standard: Standard 1 – Clinical Governance Standard RCA Recommendations PD2020-047 Incident Management
REVIEW DATE	July 2025
FORMER REFERENCE(S)	PD160 - Root Cause Analysis Recommendations Compliance Monitoring Procedure
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Patient Safety Manager
POSITION RESPONSIBLE FOR THE DOCUMENT	Lynette Woodhart SESLHD Patient Safety Manager Lyn.Woodhart@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Clinical Governance
KEY TERMS	RCA Recommendations, Incident Management
SUMMARY	This procedure outlines the monitoring and reporting process to ensure the completion of recommendations generated from Root Cause Analysis Reports.

SAER Recommendations Compliance Monitoring

SESLHDPR/320

1. POLICY STATEMENT

South Eastern Sydney Local Health District ensures that all recommendations arising from Serious Adverse Event Reviews (SAER) are implemented within the recommended timeframe as mandated by the NSW Ministry of Health Policy Directive PD2020_047 - Incident Management Policy.

2. BACKGROUND

The procedure outlines the SESLHD reporting and compliance requirements for the implementation of SAER recommendations from root cause or contributing factors (not systems improvement recommendations) and the process for managing recommendations that are at risk of not being implemented within agreed timeframes.

3. RESPONSIBILITIES

3.1 The Deputy Director Clinical Governance and Medical Services:

Is responsible for providing summary reports of completed and uncompleted RCA recommendations to the SESLHD Clinical and Quality Council. Completion information and evidence will be recorded in the Content Manager system.

3.2 General Manager:

Approves the evidence and completion of the SAER recommendation prior to submission to the Clinical Governance Unit.

3.3 The Clinical Practice Improvement Unit (CPIU) Manager (or equivalent)

Is responsible for monitoring and reporting on implementation of SAER recommendations within their services to the facility General Manager, facility Patient Safety and Clinical Quality Committee and SESLHD Deputy Director of Clinical Governance and Medical Services. The CPIU Manager will provide recommendation completion evidence to the District Clinical Governance Unit for record keeping in Content Manager.

3.4 Staff responsible for implementation of RCA recommendations:

Must complete the RCA recommendation within the agreed time frame and provide evidence of completion to the CPIU Manager or relevant CPIU staff member. If the recommendation is not completed within the timeframe the staff responsible for the implementation of the RCA recommendation must show due cause.

4. PROCEDURE

4.1 Reporting Process:

A SAER compliance summary is generated from Content manager and the report is to be provided for tabling at the SESLHD Clinical and Quality Council within the CGU report.

4.2 Extensions to RCA recommendation completion dates:

The CPIU Manager or relevant CPIU staff member is responsible for conducting regular progress checks of all recommendations. An extension of one month to implement the recommendation may be given by the relevant CPIU staff member, provided that the delay will not result in a significantly increased risk to patient safety.

4.3 Recommendations at risk of non-completion by due date:

An action plan must be negotiated with those responsible to ensure timely completion wherever recommendations are at risk of non–completion by the due date (other than the above allowed extensions). Those responsible for implementation are to provide an internal briefing to the General Manager which, once approved, will be forwarded to the Director of Clinical Governance and Medical Services. The brief (Appendix 1) is to include:

- barriers / reasons which will or have impacted on implementation by the agreed date
- strategies in place to ensure implementation
- revised completion date.

4.4 Recommendations unable to be implemented

When recommendations cannot be implemented, those responsible for implementation are to provide an internal briefing to the General Manager which, once approved, will be forwarded to the Director Clinical Governance and Medical Services.

It is recommended that the “intention” of the recommendation is considered and approval sort for an alternate recommendation which will address the patient safety issue identified by the SAER team.

The brief is to include:

- barriers / reasons why the recommendation cannot be implemented
- strategies in place that will mitigate risk or alternate recommendations to address the identified patient safety issue
- the date by which the alternate recommendation will be implemented
- in the event that no alternate recommendation or mitigation strategy can be put in place, the patient safety issue must be included on the risk register.

4.5 Endorsement of revised recommendations

All revised recommendations are to be **endorsed by the Chief Executive** via internal briefing from the Director Clinical Governance and Medical Services. The revised recommendation will be reported to NSW Ministry of Health by the District Clinical Governance Unit. Compliance is then monitored as usual by CPIU.

5. DOCUMENTATION

Example of Internal briefing – Appendix 1

6. AUDIT

Monthly reports to Clinical and Quality Council

7. REFERENCES

NSW Ministry of Health Policy Directive PD2020_047 - Incident Management Policy

8. REVISION AND APPROVAL HISTORY

9.

Date	Revision No.	Author and Approval
August 2008	0	Bronwyn Cowan. Approved by DCG: Dr. Wendy Cox
January 2014	1	Kim Brookes Approved by DCG: Professor George Rubin
March 2018	2	Lyn Woodhart Approved by DCG: Kim Brookes
May 2018	2	Processed by Executive Services prior to publishing
June 2021	3	Minor review by Lyn Woodhart. Changes to RCA/SAER terminology.
September 2021	3	Approved by Dr John Shephard. Approved by Executive Sponsor.
June 2022	4	Minor review following agreement for GM to approve completed SAER recommendation at CQC (May 2022)
July 2022	4	Approved by Dr John Shephard. Approved by Executive Sponsor. Processed and published by SESLHD Policy.

Appendix 1 – Example of briefing note for reporting recommendations at risk

Briefing Ref: T18/XXXX

INTERNAL BRIEFING
Self-Initiated Briefing

Purpose:
To provide advice to the Chief Executive concerning

Background and Key Issues:
- Provide context for the issue. Implications should be considered.
- Impact on patients, finances, staff, and any relevant policy position
- Any impact on patients should be explained in detail.
- Required resources and source of funds
- Consider risks - assessment and mitigation strategies
- Consider potential external interest
- Essential facts to support recommendation and advantages / disadvantages of proposed recommendation outlined
- Reference prior documents and list as Tabs

Risk
This brief {identifies / does not identify} unmitigated risks *(do not delete this line)*
Enterprise Risk Management System [ERMS] risk number XXXXX and current risk rating XXXX *(delete this line if not applicable)*

Recommendation:
That the above information be noted.
That the attached letter be signed if approved.

Author: **Phone:** **Date:**
Title:

Consultation: (List officers consulted)

Approval: 1. Director (Tier 2)

Submit electronically to SESLHD-Mail@health.nsw.gov.au

2. Manager Executive Services
3. Chief Executive

Executive Services, for noting, dispatch and file

4. Return to Author