Document Type: Policy	**Ref No:** HRS/HPSD/CG/1/2019	**Version Number:** 1
Document Title: Clinical Governance	**Effective Date:** 08/10/2019	**Revision Date:** 08/10/2024
Ownership: Health Regulation Sector		
Applicability: This Policy applies to all DHA licensed Health Facilities and Healthcare professionals in the Emirate of Dubai.		

1. Purpose:

1.1. To set the framework for Clinical Governance for all Health Facilities under the jurisdiction of Dubai Health Authority.

1.2. To ensure health facilities implement Clinical Governance.

1.3. To enhance the quality and safety of care provided in all DHA licensed Health Facilities.

2. Scope:

2.1.All DHA licensed Health Facilities.

3. Definitions and Abbreviations:

Adverse events: includes any unanticipated, undesirable or potentially dangerous occurrence within the health facility.

Clinical Audit: is a systematic examination to review and determine whether actual activities and results comply with standards of care.

Clinical Governance: is the system by which the health facilities, managers and clinicians share responsibility and are held accountable for patient care, through minimizing of risks and continuous monitoring and improvement of clinical and nonclinical services.

Conflict of Interest: shall refer to the conflict between an external entity's private interests and its official responsibility toward the health facility being grandfathered.

Grandfathering: An external competent entity which oversees and supports a health facility to meet the requirements for clinical governance.

Injury: Minor negative impact and time off work up to 7 days as a result of the treatment provided to the patient e.g. minor fall, development of rash/irritation of skin,

Minor injury: No negative minor impact and time off work as a result of the treatment provided to the patient e.g. strains, sprains, aches, minor cuts and bruises and minor whiplash (including forms of TMJ and WAD).

Major injury: Significant negative impact as a result of the treatment provided to the patient e.g. broken or loss of limb or function or has led to an irreversible condition.

Mortality: Death as a result of treatment or care provided to the patient.

Risk management: Coordinated activities that aim to identify, control and minimise threats within the health facility which will enhance the efficiency and effectiveness of services provided to the patient.

Serious injury: Negative impact and time off work 7 or more days as a result of the treatment provided to the patient e.g. fracture, infection and requires more than two patient follow appointments.

Sentinel Event: shall refer to the unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient illness or underlying condition.

CG: Shall refer to Clinical Governance.

CME: Shall refer to Continued Medical Education.

HF: Shall refer to Health Facilities.

HP: Shall refer to Healthcare Professionals.

TMJ: Temporomandibular Joint

WAD: Whiplash-Associated Disorders

4. Policy Statement:

4.1. Clinical Governance

4.1.1. All Health Facilities (HF) will put in place a Clinical Governance (CG) system to assure the continuous improvement of quality and patient safety.

a. The CG system shall include a designated CG Lead who is responsible to oversee and report on CG.

b. Resources for the CG lead shall be made available to assure identification and improvement of quality and patient safety.

4.1.2. Type of CG will be subject to the Health Facility Self-Assessment Score (**Appendix 1**).

4.1.3. Health Facilities with less than twenty (20) Clinical and Allied Health staff may opt to adopt a Grandfathering approach for Clinical Governance.

a. A Memorandum of Understanding shall be in place between the health facility and the external grandfathering health entity.

b. The grandfathering entity must have sufficient and competent healthcare professionals to assist in Clinical Governance.

c. Both parties shall put in place measures to avoid conflicts of interest.

4.2. Clinical Audit

4.2.1. All HF shall engage in clinical audit (**Appendix 1**).

4.2.2. The HF shall have in place a Clinical Audit plan which to improve the quality of patient care and outcomes through a systematic review of care against explicit criteria and implementation of change.

a. Clinical Audit should be undertaken annually or quarterly dependant on the urgency for improvement and risk to patients.

b. The results of clinical audit shall be implemented in a systematic manner, and further monitoring shall be conducted to assure improvement.

4.3. Evidence Based Practice

4.3.1. All HF shall ensure services/treatments provided in the HF are aligned to Evidence Based Practice (EBP) and delivery of high quality and safe care (**Appendix 1**).

4.3.2. The HF shall measure the effectiveness of the services provided, by assessing the extent by which the services/treatments achieve the desired outcomes set by the HF against the EBP.

4.3.3. The HF shall encourage a culture of evaluation and performance improvement in line with EBP.

4.4. Training and Education

4.4.1. All HF shall ensure staff are supported with training and education programs to provide effective, safe and high quality services.

4.4.2. The HF shall ensure a comprehensive staff education program is in place to address clinical and non-clinical issues.

4.4.3. The HF shall ensure its HP are trained and educated to provide safe and high quality care and receive ongoing support for their development.

4.4.4. The HF shall have in place a process to assess and monitor all HP performance.

4.4.5. The HF shall align their HP training requirements to satisfy the CME requirement mandated in the Professionals Qualification Requirements (PQR).

4.5. Staffing and Staff Management

4.5.1. The HF shall have in place comprehensive approaches and plans for recruiting and allocating competent healthcare professionals.

4.5.2. The HF shall ensure all HP have the appropriate qualifications and experience to provide safe, high-quality care and ongoing professional development to maintain their skills.

4.5.3. The HF shall have a process in place to ensure that clinical staff knowledge and skills are consistent with patient needs.

4.5.4. Staffing levels shall not compromise patient safety and provision of high quality of care.

4.6. Clinical Governance Committee

4.6.1. All HF with risk rating scale of thirty one (31) or above shall establish a CG committee with written terms of reference. The committee shall be accountable to implement CG, and the continuous improvement of patient services and clinical outcomes (**Appendix 1**).

a. The committee shall meet on a monthly basis and regularly monitor, oversee and document all areas related to CG in the HF as per DHA Policy.

b. Committee members shall undergo ongoing education and training to improve and implement appropriate measures for CG.

4.7. Risk Management and Reporting

4.7.1. All HF with risk rating scale of thirty one (31) or above shall ensure a mechanism for Risk Management and Reporting to the management team is in place.

4.7.2. The reports should reflect on clinical and non-clinical risks and preventing clinical incidents, adverse and sentinel events.

a. Adverse and sentinel events initial report shall be sent within ten (10) days. The final report shall be sent within forty five (45) days.

4.7.3. The HF shall embed a system for risk management which aims to support and enable staff to report incidents when things go wrong in a timely and transparent manner.

4.7.4. Risk identification and treatment approaches must be revised as needed to ensure early identification of risks in clinical services.

a. Risks shall be analysed in order to improve safety and a proactive review must be undertaken annually.

4.7.5. Risk reports shall be raised to the HF board of Directors or Governance for evaluation and decision.

4.8. Service User and Caregiver Involvement and Experience

4.8.1. All HF with risk rating scale of forty one (41) or above shall engage in service user and caregiver involvement and experience (**Appendix 1**).

4.8.2. The HF shall ensure it creates an open, honest and transparent environment for patients and their caregivers.

a. Patients should be encouraged to ask and receive information they need to participate in

decisions related to their health.

b. The HF shall ensure patients are encouraged to voice their opinion, provide feedback or make a medical complaint.

c. There should be a patient group established for regular feedback of services provided.

4.9. Morbidity and Mortality Reviews

4.9.1. All HF with a risk rate scale of fifty one (51) or above shall undertake and document monthly morbidity and mortality reviews (**Appendix 1**).

4.9.2. The HF shall have in place an effective procedure for recording and reporting morbidity and mortality cases.

4.9.3. All mortality cases must be reviewed by the HF management team and signed off by the Medical Director and reported to DHA within ten (10) days of the date of occurrence of the event.

a. All mortality reports shall comply with the requirements set out by DHA.

5. References:

5.1. ACT Government Health (2015). ACT Health Quality and Clinical Governance Framework. Available at: http://health.act.gov.au/research-data-and-publications/policy-and-plans (accessed 18/06/2019).

5.2. Darling Downs Hospital and Health Service (2014). Clinical Governance Framework. *Darling Downs Hospital and Health Service*. Available at: https://www.qld.gov.au/ (accessed 18/06/2019).

5.3. Dubai Health Authority (2012). Hospital Regulation. Available at https://www.dha.gov.ae/Documents/Regulations/Hospital%20Regulation.pdf (accessed 19/06/2019).

5.4. Health Direct Australia (2016). Clinical Governance Framework. Available at: https://media.healthdirect.org.au/publications/Clinical-Governance-Framework_2013-v3.pdf (accessed 24/06/2019).

5.5. The Australian Council on Healthcare Standards (2010). Accreditation, Standards and Guidelines – Support and Corporate Functions. *5th Edition*. Sydney.

5.6. Victoria State Government (2017). Delivering high-quality healthcare: Victorian clinical governance framework. Victoria State Government. Available at: https://www2.health.vic.gov.au/ (accessed 24/06/2019).

5.7. The Royal College of Nursing (2019). Clinical Governance. Available at: https://www.rcn.org.uk/clinical-topics/clinical-governance (accessed 24/06/2019).

Appendix 1 – Clinical Governance Self-Assessment

A. Steps to complete Clinical Governance Self-Assessment

- Identify the likelihood level for each impact category and multiply both to obtain the subtotal score
- Add all subtotal score to obtain total score then implement the Clinical Governance actions by the risk rating scale on next page, an example is provided below

Likelihood of occurrence	Impact				
	Minor injury **1**	**Injury** **2**	**Serious injury** **3**	**Major injury** **4**	**Mortality** **5**
1 = Very unlikely (has not occurred within the year)	N/A	N/A	N/A	1x4	1x5
2 = Likely (occurred once during the year)	N/A	N/A	N/A	N/A	N/A
3 = Feasible (occurred more than once during the year)	N/A	N/A	3x3	N/A	N/A
4 = Likely (has occurred more than once and will occur again)	N/A	4x2	N/A	N/A	N/A
5 =Very Likely (occurs frequently during the year)	5x1	N/A	N/A	N/A	N/A
Subtotal score	5	8	9	4	5
Total score	31				

Note: Self-Assessment should be conducted annually and include all outpatient or inpatient departments/units or be conducted independently to determine risk score for each department and/or tallied up for the health facility.

B. Actions to be implemented following Clinical Governance Self-Assessment

Risk Rating Scale	Minimal 15	Low 16 or above	Medium 31 or above	High 41 or above	Extreme 51 or above
Clinical Governance Control Measures to be Implemented by the Health Facility Management Team	-Clinical Audit -Evidence Based Practice -Training and Education	-Clinical Audit -Evidence Based Practice -Training and Education -Staffing and Staff Management	-Clinical Audit -Evidence Based Practice -Training and Education -Staffing and Staff Management -Clinical Governance Committee -Risk Management and Reporting	-Clinical Audit -Evidence Based Practice -Training and Education -Staffing and Staff Management -Clinical Governance Committee -Risk Management and Reporting -Service user and carer involvement and experience	-Clinical Audit -Evidence Based Practice -Training and Education -Staffing and Staff Management -Clinical Governance Committee -Risk Management and Reporting -Service user and carer involvement and experience -Morbidity and Mortality Reviews