Queensland Government
Queensland Health

Queensland Health
Patient Safety and Quality Executive Committee

Communiqué – July 13 2009

The Queensland Health Patient Safety and Quality Executive Committee (PSQEC) met on July 13 2009. Key discussions and outcomes included:

Consumer Complaints Management Policy and Implementation Standards

The Queensland Health Consumer Complaints Management Policy and Implementation Standard have been reviewed and rewritten in accordance with feedback received from Queensland Health staff and consumers.

The revised Consumer Complaint Management Policy and Implementation Standard are detailed in the Consumer Complaint Management Handbook – which is a state-wide publication for all Queensland Health staff who are involved in the consumer complaints process.

The Consumer Complaint Management Policy is applicable to all Health Service Districts (HSDs) and is designed to be able to be implemented in the smallest HSD.

The Policy and Implementation Standard will be made available online at the Queensland Health web page and QHEPS.

The PSQEC approved these Guidelines.

For more information contact: David Park, Manager Healthcare Experience Improvement Team. Email: David_Park@health.qld.gov.au

Statewide Maternity & Neonatal Clinical Guidelines

The Statewide Maternity and Neonatal Clinical Network (SMNCN) resolved to develop best practice, evidence based clinical guidelines to:

- improve standardisation of service delivery across the State
- support smaller and or non metropolitan facilities
- reduce duplication of effort.

They include:

- Primary postpartum haemorrhage,
- Prevention of neonatal early onset Group B streptococcal disease,
- Management of neonatal respiratory distress incorporating the administration of continuous airway pressure (CPAP) and
- Examination of the newborn baby.

Public and Private Maternity and Neonatal Units have been advised of, and are anticipating, the publication of the attached guidelines. Three (3) of these guidelines are required for participation in the CPIP scheme.

The Guidelines are designed to support / assist all clinicians who are undertaking the process in all facilities. They are not expected to provide the only resource clinicians would apply.

The Guidelines will be available on the web.

The PSQEC endorsed these Guidelines

For more information please contact Joan Kennedy on 3131 6979 or joan_kennedy@health.qld.gov.au

Coronial Management Report

The Coronial Management Annual Report 2007/08 reports on all cases received by the Patient Safety Centre as completed coronial inquest findings from July 2007 to June 2008.

The report presents aggregated data on demographic and clinical characteristics, contributing factors to the deaths, recommendations made by the Coroner, and information on implementation rates.

A total of 20 coronial inquest cases were identified and examined for the above data. This is limited to those received by the Patient Safety Centre.

Frequent contributing factors included staff and patient factors, followed by communication issues. Improvements to information and/or documentation and policies and/or procedures were the most frequently identified themes in the recommendations.

Of the 44 recommendations made for these 20 cases, Queensland Health had implemented two-thirds in full with the remaining in the process of being implemented as of February 2009.

Next years report will include non-inquest findings.

For more information contact Jessica Martin on email Jessica_M_Martin@health.qld.gov.au

The next meeting is scheduled for 10 August 2009

For further information, please contact:

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