RTI 3373 Release Notes

Patient Safety and Quality Improvement Service

RTI #3373 - Data relating to clinical incidents reported in PRIME CI where the incident relates to deaths which are not reasonably expected as an outcome of healthcare

Purpose of report

The purpose of this report is to provide statewide data regarding clinical incidents reported in PRIME CI where the incident relates to "death which is **not reasonably expected** as an outcome of healthcare at Queensland Hospitals". It is important to note that the data provided does not precisely align with what is requested in the Right to Information (RTI) request as the RTI seeks '**unexpected** deaths at Queensland Hospitals'.

Important notes in considering the data

- The data presented is unedited information directly reported by frontline clinicians
- The data presented includes deaths which were not reasonably expected as an outcome of healthcare **prior to an analysis being undertaken**
- The data includes deaths that may be a result of an underlying condition
- The data includes deaths that were not preventable i.e. there was no further or alternate action health professionals could have taken that would have prevented the death

Data source

- The data presented in this report is extracted from PRIME CI and is self-reported by HHS staff;
- PRIME CI is the Clinical Incident component of the PRIME information system. It is designed to enable reporting, investigation and management of clinical incidents reported by HHS staff;
- The data was current in PRIME CI as of 27/10/2016 and is subject to change.

Data extracted

- Time period: 01/01/2014 – 31/07/2016
- A total of 288 unique incidents are provided within the "Data" tab of the spreadsheet
- For the 288 unique incidents, the following applies:
    - Public hospital incidents reported (excluding the Mater Hospitals) only
    - SAC rating = SAC 1
    - Patient outcome = Death
    - Person affected type = Inpatient: home ward; Emergency Presentation; Inpatient: outlying ward; Outpatient

- Patient location reported at time of incident in the Description of Event field as in the hospital and grounds or under the direct care of Queensland Health staff (e.g. inter hospital transfer)
- Analysis (i.e. review of incident report) received by the Patient Safety and Quality Improvement (note: no incident was excluded i.e. all incident review reports have been completed and received)

Interpretation notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of clinical incidents, comparing the number of clinical incidents between HHSs, or using the number of clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of a clinical incident does not describe ‘negligence’ or ‘fault’ on behalf of our staff or systems.
- Not all clinical incidents are preventable.
- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.

Severity Assessment Code (SAC) Definitions

SAC 1 - Death or likely permanent harm which is not reasonably expected as an outcome of healthcare