Health Service Directive

Effective Date: 13 November 2014
Review Date: 13 November 2017
Supersedes: QH-HSD-032:2013

Patient Safety

Purpose

The purpose of this Directive is to contribute to fulfilling the requirements for monitoring the quality of health services delivered by Hospital and Health Services as identified in the Hospital and Health Boards Act 2011. This Health Service Directive specifies the monitoring, reporting and response requirements of Hospital and Health Services for:

- Clinical Incident Management, including coronial management.
- Variable Life Adjusted Displays (VLADs) and other National Patient Safety Indicators (PSIs) e.g. Hospital Standardised Mortality Ratios.
- Patient Safety Alerts and Notifications.

Scope

This Directive applies to all Hospital and Health Services.

Principles

- Patient safety – collection, monitoring and analysis of clinical incidents and patient outcome data (VLADs) and patient safety notifications supports Hospital and Health Services to reduce preventable patient harm.
- Continuous quality improvement – regular collection and monitoring of patient outcome data supports Hospital and Health Services in identifying areas for improvement.
- System improvement focus – state-wide analysis of clinical incidents and patient outcome data supports Hospital and Health Services in identifying and correcting underlying system issues.

Outcomes

Hospital and Health Services shall achieve the following outcomes:

Clinical Incident Management

- All Severity Assessment Code (SAC) 1 clinical incidents and analysis reports are submitted to the Patient Safety Unit of the department (“the Patient Safety Unit”).
- All responses to coronial recommendations are submitted to the Patient Safety Unit to meet whole-of-government reporting requirements.
VLAD and other National PSIs

- All lower level 2 and 3 VLAD flags and statistically significant National Patient Safety Indicators Review Responses are submitted to the Patient Safety Unit.

Patient Safety Alerts and Notifications

- Where Hospital and Health Services identify a patient safety issue and identify that the issue may impact on the safety of patients in other Hospital and Health Services, this will be reported to the Patient Safety Unit.

Mandatory Requirements

Clinical Incident Management

- Hospital and Health Services shall report all Severity Assessment Code (SAC) 1 clinical incidents to the Patient Safety Unit in PRIME Clinical Incidents (CI) within one (1) business day of becoming aware of the SAC 1 event.
- Hospital and Health Services shall conduct an analysis of all SAC 1 clinical incidents and submit a report to the Patient Safety Unit within 90 calendar days of the clinical incident being reported as a SAC1.
- Each analysis report must contain:
  - A factual description of the event
  - The factors identified as having contributed to the event
  - Recommendations to prevent or reduce the likelihood of a similar event happening again.
- Where a coroner makes a recommendation to a Hospital and Health Service following an inquest, the Hospital and Health Service shall provide a preliminary response to the recommendation to the Patient Safety Unit within 90 days of the inquest findings, and continuing quarterly updates until the implementation of the recommendations is complete.

VLAD and other National PSIs

- Hospital and Health Services shall conduct a review of all lower level 2 and 3 VLAD flags and statistically significant National PSI (e.g. Hospital Standardised Mortality Ratios) and provide a Review Response to the Patient Safety Unit within 30 calendar days.

Patient Safety Alerts and Notifications

- Hospital and Health Services shall report all locally identified patient safety issues with the potential for statewide adverse impact to the Patient Safety Unit.
Related or governing legislation, policy and agreements

- Health Service Directive: Enterprise Architecture
- National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care)
- Coroners Act 2003
- Health Ombudsman Act 2013
- Hospital and Health Boards Act 2011

Supporting documents

- Clinical Incident Management Guideline
- Variable Life Adjusted Display and National Patient Safety Indicator Guideline
- Patient Safety Notification System Guideline

Business area contact

Patient Safety Unit, Health Systems Innovation Branch, Health Service and Clinical Innovation Division, Queensland Health.

Review

This Health Service Directive will be reviewed at least every three years.

Date of last review: 29 May 2014
Supersedes: QH-HSD-032:2013

Approval and Implementation

Directive Custodian

Senior Director Patient Safety Unit, Health Systems Innovation Branch, Health Service and Clinical Innovation Division

Approval by Chief Executive

Director-General, Department of Health
Chief Executive

Approval date: 13 November 2014

Issued under section 47 of the Hospital and Health Boards Act 2011
Version Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Prepared by</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>01/07/2013</td>
<td>Patient Safety Unit</td>
<td>First issue</td>
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<tr>
<td>1.1</td>
<td>17/04/2014</td>
<td>Patient Safety Unit</td>
<td>Removed reference to Data collection and provision of data to the Chief Executive Health Service Directive</td>
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<tr>
<td>1.2</td>
<td>02/07/2014</td>
<td>Patient Safety Unit</td>
<td>Mandatory requirements simplified. Review of related or governing legislation, policy and agreements.</td>
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<tr>
<td>1.3</td>
<td>26/8/2014</td>
<td>Patient Safety Unit</td>
<td>Clarification of the purpose</td>
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<td>1.4</td>
<td>29/10/14</td>
<td>Patient Safety Unit</td>
<td>Refining purpose and review period</td>
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</table>

Definitions of terms used in this directive

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
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<tbody>
<tr>
<td>Clinical incident</td>
<td>Any event or circumstance which has actually or could potentially lead to unintended and/or unnecessary mental or physical harm to a patient.</td>
<td>Clinical Incident Management Guideline</td>
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<tr>
<td>Flag (VLAD)</td>
<td>A point on the VLAD, identifying a predetermined level of variation has been reached. i.e. more (or less) patients have experienced an outcome than expected over a period of time.</td>
<td>VLAD Guideline</td>
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<tr>
<td>Patient Safety Issue</td>
<td>An event or circumstance that has actually or could potentially lead to patient harm.</td>
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<tr>
<td>Hospital Standardised Mortality Ratio</td>
<td>The HSMR compares the observed number of deaths in a hospital with the expected number of deaths based on jurisdictional (state or national) data, using a logistic regression model that adjusts for factors that affect the risk for in-hospital death, such as age, principal diagnoses, comorbidities, length of hospital stay, and route of admission.</td>
<td>The Medical Journal of Australia Volume 194 Number 12 20 June 2011</td>
</tr>
<tr>
<td>Lower level 3 flag (VLAD)</td>
<td>A level 2 and 3 flag indicates a hospital's result is highly statistically significantly different from the State average.</td>
<td>VLAD Guideline</td>
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<tr>
<td>Patient Safety Unit</td>
<td>Refers to the Patient Safety Unit within the Health Service and Clinical Innovation Division of Queensland Health.</td>
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<tr>
<td>SAC</td>
<td>Severity Assessment Code, the measurement of consequences to a patient associated with a clinical incident. The SAC score (1, 2 or 3) is used to determine the appropriate level of analysis, action and escalation for clinical incidents.</td>
<td>Clinical Incident Management Guideline</td>
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<tr>
<td>SAC 1</td>
<td>Death or likely permanent harm which is not reasonably expected as an outcome of healthcare.</td>
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<tr>
<td>Variable Life Adjusted Display (VLAD)</td>
<td>A statistical methodology used to monitor patient outcomes to assist in identifying possible areas of concern or strength for safety and quality of care. It is to be interpreted and viewed with the intention to understand causation and to determine whether corrective action is necessary.</td>
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<tr>
<td>VLAD Review Response</td>
<td>Feedback from a HHS detailing what was considered in the review, review findings and actions.</td>
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