Health Service Directive

Directive: QH-HSD-033:2014
Effective Date: 31/01/2021
Review Date: 31/01/2024
Supersedes: Version 2.0

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 – the collection, monitoring and analysis of clinical incidents and patient outcome data as well as the development of patient safety notifications supports Hospital and Health Services reduce preventable patient harm.
- Continuous quality improvement – the collection and monitoring of patient outcome data supports Hospital and Health Services identify areas for improvement.
- System improvement focus – state-wide analysis of clinical incidents and patient outcome data supports Hospital and Health Services to identify and address underlying system issues.

Outcomes

Hospital and Health Services will achieve the following outcomes:

Clinical incident management

- All severity assessment code (SAC) 1 clinical incidents and analysis reports are submitted to the Patient Safety and Quality Improvement Service (PSQIS), Clinical Excellence Queensland (CEQ), Department of Health.
- All responses to coronial recommendations are submitted to the PSQIS, to meet whole-of-government reporting requirements.

VLAD and other national patient safety indicators

- All VLAD lower level 3 flags and statistically significant national patient safety indicator review responses will be submitted to the PSQIS.

Patient safety notifications

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

Mandatory requirements

Clinical Incident Management

- Hospital and Health Services will report all SAC1 clinical incidents to the PSQIS through Queensland Health's RiskMan information system within one (1) business day of becoming aware of the SAC1 event.
- Hospital and Health Services will conduct an analysis of all SAC1 clinical incidents and submit a report to the PSQIS 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 will provide an initial response to the recommendation to the PSQIS within 90 days of the inquest findings, and provide six monthly updates until the implementation of the recommendations is complete.

Variable Life Adjusted Display and other National Patient Safety Indicators

- Hospital and Health Services will conduct a review of all lower level 3 VLAD flags and statistically significant national patient safety indicators (for example, hospital standardised mortality ratios) and provide a review response to the PSQIS within 30 calendar days.

Patient Safety Alerts and Notifications

- Hospital and Health Services will report to the PSQIS, all locally identified patient safety issues or risks with the potential for statewide adverse impacts.

Related and governing legislation, policy and agreements

- Enterprise Architecture Health Service Directive
- National Safety and Quality Health Service Standards Second Edition 2017. (Australian Commission on Safety and Quality in Health Care)
- *Coroners Act* 2003
- *Health Ombudsman Act* 2013
- *Hospital and Health Boards Act* 2011
- *Hospital and Health Boards Regulation* 2012.

Supporting documents

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

Business area contact

- The Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, Department of Health Website: http://qheps.health.qld.gov.au/psu/
- Telephone: 3328 9430

Review

This Directive will be reviewed prior to: 31/01/2024

Date of last review: 16/12/2020

Supersedes: Version 2.0

Approval and implementation

Directive custodian

Executive Director, PSQIS, CEQ, Department of Health

Approved by

Director-General, Queensland Health

Approval date: 20/01/2021

Issued under Section 47 of the *Hospital and Health Boards Act 2011*

Version control

Version	Date	Prepared by	Comments
1.0	01/07/2013	PSQIS	First issued.
2.0	17/04/2014	PSQIS	Second version issued
3.0	05/05/2020	PSQIS	Removal of the requirement to submit lower level 2 VLAD to the Patient Safety and Quality Improvement Service. Modified requirement of coronial reporting from quarterly to six monthly. Updated email addresses, phone numbers and the name Patient Safety Unit, to the Patient Safety and Quality Improvement Service. Minor clerical amendments in line with the Queensland Health Editorial style guide 2019.

Definitions of terms used in this Directive

Term	Definition / explanation / details	Source
Clinical Incident	Any event or circumstance which has actually or could potentially lead to unintended and/or unnecessary mental or physical harm to a patient.	Clinical Incident Management Guideline
Flag	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.	VLAD Guideline
Patient safety issue	An event or circumstance that has led to patient harm or could potentially lead to patient harm.	
Hospital standardised mortality ratio	The hospital standardised mortality ratio 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, co-morbidities, length of hospital stay and route of admission.	The Medical Journal of Australia Volume 194 Number 12 20 June 2011
Lower level 3 flag	A level 3 flag indicates a hospital's result is highly statistically significantly different from the State average.	VLAD Guideline

Patient Safety and Quality Improvement Service	The Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, Department of Health	
Severity assessment code 1 (SAC1)	Death or likely permanent harm which is not reasonably expected as an outcome of healthcare.	Clinical Incident Management Guideline
Variable Life Adjusted Display also referred to as VLAD	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.	VLAD Guideline
VLAD review response	Feedback from a Hospital and Health Service detailing what was considered in the review, review findings and actions.	VLAD Guideline