Guideline

Health Service Directive

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Health Service Directive Patient Safety

Guideline for Patient Safety Notification System

1. Purpose

This Guideline describes Queensland Health's process for managing and responding to potentially state-wide patient safety issues and risks, through the development and distribution of patient safety notifications issued by the Department of Health.

2. Scope

This Guideline applies to Queensland Health employees, agents, volunteers, contractors, consultants and managed service providers working for the Divisions within the Department of Health, Agencies and Business Units and for the Hospital and Health Services (HHSs) (including Visiting Medical Officers).

3. Reporting patient safety issues that have state-wide impacts

3.1 HHSs have commonalities in the use of equipment, processes and interactions in the provision of health care. Therefore, an opportunity exists to prevent incidents of patient harm and risk across the public health system by sharing locally identified issues which have potential state-wide implications.

3.2 HHSs should have local processes for identifying and managing patient safety issues/risks. The local processes should include a specific line management responsibility for considering the potential for the identified issue/risk to also apply to other HHSs.

Examples of potential state-wide patient safety issues that may be identified locally include: medical device or consumable failures or malfunctions and unclear labels or instructions for use on medical devices.

3.3 Potential state-wide patient safety issues/risks must be reported to the Patient Safety and Quality Improvement Service (PSQIS). They may be reported by telephone or email using the contact details below. Where there is uncertainty about whether an issue/risk should be reported, please telephone the PSQIS for advice:

PSQIS contact details for locally identified potential patient safety issues/risks:
Phone: 3328 9430
Email: Patient_Safety_Notifications@health.qld.gov.au

4. Actioning a patient safety notification

4.1 The PSQIS, Clinical Excellence Queensland, Department of Health co-ordinates a patient safety notice system that assesses potential statewide patient safety issues/risks with key stakeholders. Where an issue/risk is identified, the PSQIS will advise HHSs of the identified risk, lessons learned from the analysis or investigation and any recommendations for local action to address potential patient harm.

4.2 The three-tiered patient safety notification system is based on clearly identifiable categories (alert, notice or communique) which indicate the suggested importance for local prioritisation and management:

- Patient safety alerts are colour coded **RED** and are issued regarding patient safety matters requiring mandatory, immediate attention and action
- Patient safety notices are colour coded **AMBER** and issued regarding potential patient safety issues requiring local risk assessment to inform appropriate action.
- Patient safety communiques are colour coded **GREEN** and are issued to disseminate patient safety information to ensure lessons learned from local incident analyses/investigations (and a variety of other sources) are shared across the state.

4.3 Patient safety notifications will be distributed by email from PSQIS to the generic HHS email accounts. HHSs should have local processes for ensuring the timely distribution of all patient safety notifications to relevant staff within the HHS.

4.4 HHSs should have local processes for prioritising and actioning patient safety notifications that include clear roles, responsibilities and timeframes for those responsible to action notifications.

4.5 HHSs should have a process that provides a coordinated response to patient safety notifications across all facilities within a HHS through Chief Executive/Executive Director of Medical Service/Director of Clinical Governance to PSQIS.

4.6 Where requested in the patient safety notification, the HHS should submit a response through its Chief Executive/Executive Director of Medical Services/Director of Clinical Governance to the designated contact address, within the designated timeframe, using the feedback template which will be supplied with the patient safety notification

Supporting and related documents

Authorising Health Service Directive

Patient Safety Health Service Directive QH-HSD-033:2014

Legislation

Therapeutic Goods Act 1989 (Cth)

Competition and Consumer Act 2010 (Cth) (previously *Trade Practices Act 1974*)

Radiation Safety Act 1999 - s.45

Radiation Safety Regulation 2010

Radiation Safety (Radiation Safety Standards) Notice 2010

Work Health and Safety Act 2011

Work Health and Safety Regulation 2011

Plant Code of Practice 2005

Resources

Queensland Health's alerts, advisories and communiques are available at: https://qheps.health.qld.gov.au/psu/alerts

Accreditation references

Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards 2nd Edition; 2017 Clinical Governance Standard

5. Definition of terms used in this Guideline

Term	Definition / explanation / details	Source
Patient safety notification	The term patient safety notification is a generic term used in this Guideline to refer to a range of different types of patient safety notifications that include patient safety alerts, patient safety notices, patient safety communiqués,	
Patient safety alert	Aims to quickly disseminate information to HHSs regarding a safety matter requiring immediate mandatory attention and action. It specifies mandatory action to be undertaken by HHSs, assigns responsibility for action and feedback as well as timeframes in which the action should occur.	
Patient safety notice	Aims to inform HHSs regarding potential quality and safety issues requiring risk assessment at the local level to determine appropriate action with regards to incidents. The patient safety notice will specify that HHSs must undertake a risk assessment. It also recommends action to be taken.	
Patient safety communiqué	A patient safety communique aims to disseminate quality and safety information to HHSs to ensure lessons learned from local, state-wide, national and international sources are shared across Queensland Health in a pro-active manner.	
Patient safety risk	An event or circumstance that has led to or could potentially lead to patient harm.	
Risk	The potential for an event to have an impact on individuals and/or organisations. It is measured in terms of likelihood and consequence.	

Term	Definition / explanation / details	Source
State-wide patient safety issues/risks	A locally identified patient safety issue/risk that may also apply to other HHS and may result in patient harm; for example; equipment failure or product fault potentially resulting in death.	

7. Approval and implementation

Guideline custodian

Executive Director, PSQIS, Clinical Excellence Queensland, Department of Health

Approving officer:

Deputy Director General, Clinical Excellence Queensland, Department of Health

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8. Version control

Version	Date	Prepared by	Comments
1.0	01/08/2013	HSCI	New Guideline
2.0	31/01/2021	PSQIS	Updated email addresses, phone numbers and the name Patient Safety Unit, to Patient Safety and Quality Improvement Service. Minor clerical amendments in line with the Queensland Health Editorial style guide 2019. Amendment to flow of document. Additional guidance on co-ordination of response to patient safety notifications across facilities within a HHS