Question on Notice

No. 1003

Asked on 12 September 2023

MS R BATES ASKED MINISTER FOR HEALTH, MENTAL HEALTH AND AMBULANCE SERVICES AND MINISTER FOR WOMEN (HON S FENTIMAN)—

QUESTION

With reference to the work undertaken by the Patient Safety and Quality Improvement Service in relation to clinical incident management—
Will the Minister provide for the 2020 to 2023 (year to date) calendar years, the number of Severity Assessment Code (SAC) 1 analysis reports related to a patient waiting longer than clinically recommended for (a) a specialist outpatient appointment, (b) an elective surgery procedure, (c) a radiology result and (d) a pathology result?

ANSWER

Our frontline health staff work hard every day to care for Queenslanders when they need it most, and are committed to ensuring patient safety.

Queensland Health has developed a patient safety culture where staff are actively encouraged to report clinical incidents. By reporting and analysing the root cause of incidents, Queensland Health can better understand how to avoid repeat instances and improve patient safety.

It is important to acknowledge there is a degree of clinical subjectivity when Hospital and Health Service (HHS) staff are selecting the appropriate classification of a clinical incident, as part of the initial reporting of a SAC1 incident into Queensland Health's clinical incident management reporting system (RiskMan). For example, factors contributing to a patient waiting longer than clinically recommended time frames might be reported under a broad range of classifications includingclinical process, medical imaging, deterioration, clinical communication, and surgical complication. This can create difficulties in identifying an accurate data set for review of a specific incident type.

The analysis of SAC1 incidents may identify a series of interrelated contributory factors, and it may not always be possible to easily determine the extent to which any individual factor contributed to the incident.

I am advised that interpreting the factors that contribute to SAC1 incidents that form part of this Question on Notice would require a comprehensive review of each individual analysis report, potentially also requiring significant clinical specialty oversight to be able to answer this question.

As such, I am advised by the Department, that it is not appropriate to provide the specific information sought as to do so would also require a substantial explanation to be provided, per case, to ensure the information is interpreted and understood correctly

and it would not possible to answer this question without unreasonably diverting the use of Queensland Health resources.