Question on Notice

No. 1075

Asked on 13 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 (PSQIS), in relation to clinical incident management—
Will the Minister provide for the 2020 to 2023 (year to date) calendar years (reported separately by Hospital and Health Service) (a) the number of Severity Assessment Code 1 (SAC1) analysis reports submitted to (PSQIS) and (b) the percentage of analysis reports received by PSQIS within 90 calendar days of the clinical incident being reported as a SAC1?

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.

While the Patient Safety Health Service Directive requires the analysis to be completed within 90 days, this may not always achievable due to the volume of clinical information requiring review and assessment, the availability of suitably qualified clinical staff undertake the review and the receipt of external documents, such as coronial autopsies.

I am advised that compliance with completing an incident analysis for SAC1 incidents within 90 days is monitored through the quarterly Hospital and Health Service (HHS) performance management meetings. Compliance rates are flagged for attention where the HHS falls below 70%. This target has been set in acknowledgement of the time required to conduct an analysis. However, demonstrating compliance with meeting this target may be problematic where HHSs have low numbers of SAC1 incidents.

In addition, where HHSs have very low numbers of SAC1 incidents, there is a potential risk to patient privacy, as they may be able to be identified. As such, I am advised by the Department, that it is not appropriate to provide the specific information sought. Doing so would also require a substantial explanation to be provided, per case, to ensure the information is interpreted and understood correctly, representing an unreasonable diversion of resources.

Further, sentinel events may be a more appropriate measure to determine patient safety outcomes across a health system. Sentinel events are reported through the Federal Government, in line with nationally consistent processes and according to nationally consistent definitions.

The Report on Government Services for 2020-21 identified 82 sentinel events across Australia, including 30 in Victoria, 19 in New South Wales and 12 in Queensland.

In line with national and international standards, each reported sentinel event is reviewed with a focus on learning and improving safety.