OFFICE OF THE HEALTH OMBUDSMAN

Proactive activity—snapshot report

Evaluation focus: Health service entity's management and reporting of clinical incidents (August 2024).

Wider learnings and recommendations for service improvements

The proactive activity highlights the opportunity for health services to:

1. Review recommendations from clinical incident analyses to:
   a. identify common themes arising; and
   b. evaluate progress towards implementation of recommendations.
2. Review the organisation's action plans to ensure they are dated, adequately identify the ongoing/completed actions and person/s responsible.
3. Review the organisation's Safety and Quality Plan to ensure it is aligned to the themes, recommendations and findings from incident analyses.
4. Ensure there are clear processes in place to facilitate the timely provision of Root Cause Analysis reports to the Health Ombudsman.

Background

A Root Cause Analysis (RCA) is a quality improvement process to assess and respond to reportable events that occur while health services are provided.

Section 108 of the *Hospital and Health Boards Act 2011* requires that a commissioning authority must, as soon as practicable after receiving an RCA report under section 101, give the Health Ombudsman a copy of the report and details of the name and address of the entity responsible for providing the relevant health service.

In response to adverse media coverage relating to the provision of services at a health service entity in Queensland, the Health Ombudsman opened a proactive activity to evaluate the entity's management and reporting of incident reviews and associated recommendations. Under section 25(c) of the *Health Ombusman Act 2013*, the Health Ombudsman has a function 'to identify and report on systemic issues in the way health services are provides, including issues affecting the quality of services'.

Issues evaluated

The proactive activity was conducted to identify potential systemic health service concerns arising from severity assessment code 1 (SAC1) clinical incidents[i].

Forty-two clinical incidents were reviewed, identifying the following systemic concerns:

- Deterioration detection (Q-ADDS[ii]) – the recording of observations, calculation of the Q-ADDS score and escalation of care.
- Sepsis – the management within Emergency Department (ED) and at transitions of care.
- Triage within ED.
- Incident reporting and management, including RCA and human error and patient safety (HEAPS[iii]) processes.

Key findings

During the evaluation, information was requested from the health service entity on a voluntary basis. The entity provided information about how they are addressing the concerns identified and provided supporting evidence on the progress in implementing improvements.

From the evidence, it was identified that:

- Systems for Q-ADDS, sepsis, ED triage and incident reporting and management are in place and are regularly audited. However, it was not evident that audit reports were reviewed with corrective actions developed and implemented.
- Action plans, whilst present, were not dated and did not identify the ongoing/completed actions and person/s responsible.
- Due to the poor quality or lack of evidence supplied, it could not be determined if there is a culture of continuous improvement within the health service entity.

In response to further information sought, the entity identified a recent change in leadership and submitted an updated Safety and Quality Plan that addresses the identified concerns and is aligned to the themes, recommendations and findings from the SAC1 incident analyses.

The Health Ombudsman encourages the health service entity and all health service providers to promote continual improvement in the provision of safe and quality healthcare.

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[i] SAC 1 clinical incidents are clinical incidents that have or could have (near miss) caused serious harm or death that is attributable to health care provision (or lack thereof) rather than the patient's underlying condition or illness

[ii] Q-ADDS is an observation chart designed to present the most important vital signs for detecting deterioration in patients.

[iii] human error and patient safety (HEAPS) method is the most commonly used form of clinical incident analysis, taking into consideration how interactions between organisations, tasks, and the individual worker, impact on human behaviour and affect systems performance https://clinicalexcellence.qld.gov.au/sites/default/files/docs/resourses/clinicalincidentguide.pdf