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This document can be made available in alternative formats such as audio tape, computer disc, Braille or in black and white on relevant request from a person with a disability.
1. Introduction

WA Health places a high priority on the delivery of safe and quality healthcare to all patients. A key mechanism for improving patient safety is the system wide dissemination of patient safety alerts and sharing lessons learned from clinical incidents, to prevent future recurrence of healthcare errors.

Given WA Health’s strong focus on patient safety, the Office of Safety and Quality in Healthcare (OSQH), has developed the WA Health Patient Safety Alert System to ensure state-wide communication of clinical risk information, and rapid action to improve patient safety.

The OSQH has developed the WA Health Patient Safety Alert System to provide hospitals/health services with brief reports and recommendations for action on identified clinical risks and safety improvement issues arising from clinical incident investigations and quality improvement activities.

The WA Health Patient Safety Alert System will provide a systematic approach to the dissemination and management of important patient safety information to improve the delivery of health care in WA hospitals/health services.

1.1 Purpose of the WA Health Patient Safety Alert System

The purpose of the WA Health Patient Safety Alert System is to prevent the occurrence of clinical incidents by systematically disseminating patient safety information and recommendations for action across the WA Health system, thereby “closing the loop”.

“Closing the loop” is the completion of the process where recommendations arising from the investigation into clinical incidents are disseminated at multiple levels of the health system resulting in change to policy/procedures/guidelines/clinical practice to prevent the recurrence of healthcare related errors and ultimately increase patient safety.¹

Through the WA Health Patient Safety Alert System, closing the loop will occur in two ways:

1. Ensuring that important patient safety information is fed back in to the health system at various levels

2. Ensuring that action is taken and changes to clinical practice are implemented to improve patient safety and prevent recurrence of clinical incidents.

1.2 Scope
This policy applies to patient safety information disseminated by OSQH, to relevant stakeholders across the WA health system, from identified clinical risks that have state-wide implications for patient safety.

This policy does not apply to:
- Public health alerts regarding environmental health issues, food safety, or consumer products or public health events related to communicable diseases such as SARS or pandemic influenza
- WorkCover WA alerts and notices.

1.3 Objectives
In developing and distributing patient safety alerts and notifications, the OSQH aims to:
- Effectively share recommendations arising from the management of clinical incidents
- Recommend achievable and practical actions to be implemented in response to patient safety issues
- Share national and international evidence and practice guidelines to improve patient safety
- Effectively contribute to the improvement of safety and quality in healthcare.

1.4 Identification of clinical risk
OSQH identifies clinical risks through a number of sources that include:
- Clinical Incident Management System using AIMS
- WA Sentinel Event Program
- Health Networks
- WA Medication Safety Group (WAMSG)
- Safety Alerts, product recalls and notices issued by national organisations such as the Therapeutic Goods Administration (TGA) and international organisations such as the United States Joint Commission On Accreditation of Healthcare Organisations
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Other hospitals/health services and inter-state jurisdictions.

Once a clinical risk has been identified, the OSQH with input from relevant expert advisory groups, will undertake an assessment of the patient safety issue to determine the level of response and action required by hospitals/health services.

Clinical risks identified at a local level by WA hospitals/health services may be escalated to the OSQH for consideration of the development of a state-wide alert.
2. WA Health Patient Safety Alert System – notification options

The WA Health Patient Safety Alert System includes three different options for the dissemination of patient safety information to be used depending on the priority of the response required by WA hospitals/health services. The three levels of notifications use the colours of a traffic light to indicate the level of urgency of the information provided.

1. Patient Safety Alerts (red)
2. Safer Practice Notice (amber)
3. Patient Safety Information (green)

2.1 Patient Safety Alert

Patient Safety Alerts aim to effectively and rapidly disseminate information to hospitals/health services about patient safety matters that require immediate action to prevent the occurrence of clinical incidents.

Mandatory action to be taken will be outlined in patient safety alerts including the timeframes within which such action should occur. The information and recommended actions provided in the alert will take precedence over any pre-existing policy or procedural guidelines. Following receipt of a Patient Safety Alert hospitals/health services must ensure that action is taken as directed in the alert and that local policy/procedures/guidelines are amended as required to comply with the alert directives.

As part of the Patient Safety Alert, Area Health Services will be requested to provide feedback on the action taken in response to the alert.

The colour coding of the Patient Safety Alert is RED.

2.2 Safer Practice Notice

Safer Practice Notices advise hospitals/health services of potential patient safety issues. A risk assessment is required at a local level to determine the response required and the relevance of the information.

The colour coding of the Safer Practice Notice is AMBER.
2.3 Patient Safety Information

The dissemination of Patient Safety Information ensures that lessons learned from a variety of sources are actively shared system-wide. Patient Safety Information may include the following:

- updates regarding patient safety initiatives at a State and National level
- outcomes of patient safety research
- tools and resources for patient safety reform and improvement
- international patient safety improvement programs etc.

The colour coding of Patient Safety Information is **GREEN**.

Figure 1 outlines the three different notification types of the WA Health Patient Safety Alert System.
Figure 1: WA Patient Safety Alert System

Identification of clinical risk/patient safety issues and treatment pathway

Immediate Action

Patient Safety Alert

Hospital/health service to:
- Take immediate action as appropriate for action
- Implement recommendations
- Review and amend local policy/procedures/guidelines
- Provide feedback on action taken in response to the alert

Risk assessment and determine action

Hospital/health service to:
- Undertake risk assessment to determine response
- Implement recommendations/take action as required
- Review and update policy/procedures/guidelines as required

Safer Practice Notice

Patient Safety Alert Information

Consider action

Hospital/health service to:
- Consider patient safety information
- Identify any action required to improve patient safety

Implementation, monitoring and review of patient safety alert
3. Dissemination and responsibility for action

3.1 Office of Safety and Quality in Healthcare (OSQH)
The OSQH will undertake the development and production of Patient Safety Alerts, Safer Practice Notices and Patient Safety Information based on clinical risks identified from a number of sources (see section 1.4).

Following the identification of a clinical risk, the OSQH will undertake to review and assess the risk to determine the level of notification that is required to be issued by the WA Health Patient Safety Alert System. As part of the review, OSQH will examine the following (as required):
- Clinical Incident Management Data – AIMS
- WA Sentinel Event Program and mortality review data
- National / international information (i.e. best practice guidelines etc.)
- Literature review
- Input from clinical experts / Health Networks / Chief Nursing and Midwifery Officer / Chief Psychiatrist
- Colleges (i.e. Royal College of Surgeons etc.)

OSQH will disseminate all notifications from the WA Health Patient Safety Alert System via email and add notifications and updates to the OSQH website.

Patient safety alerts and information generated from the WA Health Patient Safety Alert System will also be sent to private hospitals/health services and the Australian Commission on Safety and Quality in Health Care where issues are identified that have State and National implications.

3.2 Chief Medical Officer
The Chief Medical Officer will approve the release of all Patient Safety Alerts. This authority may be delegated to the Executive Director, Performance Activity and Quality Division (PAQD) or the Director OSQH as required. OSQH will direct requests for input of the Health Networks in the production of Patient Safety Alerts, Safer Practice Notices and Patient Safety Information to the Chief Medical Officer for approval.

3.3 Hospitals/health services
Patient Safety Alerts require immediate action and will be disseminated to Area Health Service Chief Executive Officers (cc Executive Directors and Directors of Safety and Quality) in order that the information is circulated to the correct people within the organisation to implement the required recommendations.
Area Health Services should establish a process for distribution and action to be taken in response to the receipt of a Patient Safety Alert.

Dissemination of Patient Safety Alerts at the Area Health Service level should include:

- Director of Medical Services / Director Clinical Services
- Director of Nursing
- Head of Department (clinical specialty relevant to the alert)
- Risk Manager / Clinical Governance Unit.
### Table 1: Dissemination and responsibility for action

<table>
<thead>
<tr>
<th>Alert type</th>
<th>Purpose of the alert</th>
<th>Response required</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Alert</td>
<td>Specify immediate and mandatory action to be taken.</td>
<td>Requires immediate action to address high risk safety problems. Action to occur in time frame outlined in the safety alert.</td>
<td>Issued from the Chief Medical Officer (or Executive Director PAQD or Director OSQH as delegate). Disseminated to:</td>
</tr>
<tr>
<td></td>
<td>Local policy/procedures/guidelines must be updated in response to alert information and mandated action is required to be completed within specified timeframes.</td>
<td>Action to provide feedback regarding the action taken following receipt of the alert.</td>
<td>• Area Chief Executives (cc Directors of Safety and Quality) • Private sector CEOs • Chief Psychiatrist • Clinical Nurse Manager • Chief Health Professions Officer • OSQH website – alerts register</td>
</tr>
<tr>
<td>Safer Practice Notice</td>
<td>Advise hospitals/health services of patient safety issues with recommendations for action.</td>
<td>Local risk assessment required to determine appropriate response and actions to be taken to improve patient safety.</td>
<td>Issued from the Director OSQH. Disseminated to:</td>
</tr>
<tr>
<td></td>
<td>Requires hospitals to consider the information and lessons learnt regarding relevance for their hospitals/health services.</td>
<td>Requires hospitals to identify and implement any actions required to improve patient safety and delivery of healthcare.</td>
<td>• Directors of Safety and Quality • Clinical Governance Network • Health Networks • Medical Directors’ Forum • Private sector Risk Managers • OSQH website – alerts register</td>
</tr>
<tr>
<td>Patient Safety Information</td>
<td>Dissemination of patient safety information (i.e. sharing lessons learned) across the WA health system.</td>
<td>Hospitals/health services to implement any actions required to improve patient safety and delivery of healthcare.</td>
<td>Issued from Director OSQH (or Managers OSQH as delegate). Disseminated to:</td>
</tr>
<tr>
<td></td>
<td>Hospitals/health services to consider the information and lessons learnt regarding relevance for their hospitals/health services.</td>
<td>Hospitals/health services to identify and implement any actions required to improve patient safety and delivery of healthcare.</td>
<td>• Directors of Safety and Quality • Clinical Governance Network • Health Networks • Medical Directors’ Forum • OSQH website – alerts register</td>
</tr>
</tbody>
</table>
4. Evaluation of the WA Health Patient Safety Alert System

Patient Safety Alerts will require Area Health Services to provide a response to the Director OSQH regarding the action taken following the receipt of the alert (within a specified time frame) to ensure the effective implementation of action to prevent the occurrence of clinical incidents.

Feedback regarding action taken by Area Health Services following the release of Safer Practice Notices and Patient Safety Information will be sought on a six-monthly basis, unless otherwise specified on the alert, via the WA Sentinel Event Program feedback process for the reporting on the status of implementation of recommendations. Note Area Health Services may assess that no action is required in some hospitals/health services in response to the release of Safer Practice Notices and Patient Safety Information.
5. Relevant WA Health Policy

The WA Health Patient Safety Alert System should be utilised in conjunction with the following Department of Health policies\(^2\):

- Sentinel Event Policy (2008)
- Clinical Incident Management Using the Advanced Incident Management System (2006)
- Clinical Risk Management Guidelines for the Western Australian Health System (2005)

\(^2\) The referenced policies may be updated at regular intervals. For the latest version of these policies please visit the Office of Safety and Quality in Healthcare’s website at: http://www.safetyandquality.health.wa.gov.au
6. References


## Appendix 1: Patient Safety Alert Template

**PATIENT SAFETY ALERT**

**NUMBER:**

**DATE:**

Patient Safety Alerts aim to effectively and rapidly disseminate information to hospital/health services about patient safety matters that require immediate action to prevent the occurrence of clinical incidents.

### Subject / Issue:

<table>
<thead>
<tr>
<th>Issued by:</th>
<th>Background:</th>
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<tbody>
<tr>
<td>• Chief Medical Officer</td>
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### Distributed to:

<table>
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<th>Distributed to:</th>
<th>Action for hospitals/health services:</th>
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<tr>
<td>• Area Chief Executives (cc Directors of Safety and Quality)</td>
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<tr>
<td>• Private sector Chief Executive Officers (cc Risk Managers)</td>
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<tr>
<td>• Chief Psychiatrist</td>
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<tr>
<td>• Chief Nursing and Midwifery Officer</td>
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<tr>
<td>• OSQH website – alerts register</td>
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</tr>
</tbody>
</table>

### Action required by:

### For response by:

### Deadline for completion of action:

Please advise of action taken in response to this alert.

### Dissemination recommended to:

### References:
### SAFER PRACTICE NOTICE

**NUMBER:**

**DATE:**

**Safer Patient Notices** advise hospitals/health services of potential patient safety issues. A **risk assessment is required at a local level** to determine the response required and the relevance of the information.

<table>
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<th>Subject/Issue:</th>
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<tbody>
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<td><strong>Issued by:</strong></td>
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<tr>
<td>- Director of Safety and Quality in Healthcare</td>
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<td>- Health Networks</td>
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<th>Deadline for completion of action:</th>
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Please advise of action taken in response to this notice.

<table>
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<th>Dissemination recommended to:</th>
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<table>
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<tr>
<th>References:</th>
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Office of Safety and Quality in Healthcare | WA Department of Health

- 08 9222 4080 | 08 9222 4014 | safetyandquality@health.wa.gov.au | www.safetyandquality.health.wa.gov.au
Dissemination of patient safety information (i.e. sharing lessons learned) across the WA health system

Subject/Issue:

**Issued by:**
- Director of Safety and Quality in Healthcare

**Background:**

**Distributed to:**
- Directors of Safety and Quality
- Clinical Governance Network
- Health Networks
- Medical Director’s Forum
- OSQH website – alerts register

**Action for hospitals/health services:**

**Action required by:**

**For response by:**

**Deadline for completion of action:**

Please advise of action taken in response to this information.

**Dissemination recommended to:**

**References:**

Office of Safety and Quality in Healthcare | WA Department of Health

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WA Patient Safety Alert Policy 2011

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