How to Manage a Patient Incident

Safety Learning System (SLS) Guide
How to Manage a Patient Incident

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Introduction

SA Health is committed to improving the safety and quality of patient care and achieving the best outcomes possible.

The SA Health incident management system is called the Safety Learning System (SLS). It is more than a tool to record and manage incidents - it provides a means by which valuable lessons can be learnt through investigation and analysis of single and/or groups of incidents, allowing further quality improvements to be undertaken. The SLS patient incident module also facilitates good clinical governance and open disclosure of incidents to patients and carers.

Everyone providing services on behalf of SA Health must report all patient related incidents, including near misses into the Safety Learning System (SLS), and understand their individual responsibility regarding communication with patients who have been affected by an incident, commonly known as open disclosure (SA Health Patient Incident Management and Open Disclosure Policy Directive).

All patient incidents that are reported into SLS must be reviewed by a patient incident manager. Serious, harmful incidents are further notified to senior managers and undergo a more detailed investigation. The findings of review or investigation are used by clinical teams, managers, Safety and Quality and Clinical Governance Committees to develop practice improvements to reduce the recurrence of similar incidents. The data gathered in SLS is also used to monitor trends in incidents and to identify specific areas for improvement at both a state-wide, Local Health Network and ward, unit or service level.

De-identified data is published annually in the South Australian Patient Safety Report and is available on the Safety and Quality section of the SA Health website. The report also contains an overview of some of the quality improvement initiatives that have been implemented.

Information recorded in the Safety Learning System should be factual and objective as the information it contains can be disclosed under certain circumstance, similar to medical records. Please refer to Health Care Act 2008 (SA) section 93 for confidentiality and disclosure of information pertaining to patient incidents.

All SA Health staff have a critical role in identifying, reporting, reviewing and making recommendations for improvement, and in ensuring a strong patient safety and quality culture that is focussed on the patient and improving health services.
Features and functions of the Safety Learning System (SLS)

**System ICONS**

- A red asterisk indicates that the information is **mandatory**

**Text/multi PICK BOXES**

- This is a text box
  - **TYPE** in the required information (128 character limit).

- Free text box
  - **TYPE** in the required information. (No Character Limit)

- ABC symbol
  - **Click on the ABC symbol** (under text boxes) to spell check (No Character Limit).

- Drop down menu
  - Text boxes with a downward facing arrowhead, to the right, indicate that it has a drop down menu.
  - Click the arrow or start typing the word you are searching for and the menu will appear.
  - Single click to highlight your choice and double click to select it to appear in the box.
  - Use the cursor to scroll and reveal the full menu

- If you have incorrectly entered something and wish to change it, highlighting the mistake and clicking on it, then click on the box with a red cross. This will delete the incorrect entry.

**TIME OUT FEATURE**

In order to maintain system security, SLS has a timeout feature after 30 minutes.

Just before this time limit has been reached, a message will appear on the screen advising that the session will end, and offering the option to extend the session.

If the session is not extended, any work that is open will not be saved.
Click to open the calendar.
The calendar will automatically open on today's date. Use the arrows to navigate through the calendar and click on the date you require or type in the date using the dd/mm/yyyy format.
Patient Incident Management: Tool 3 – How to Manage a Patient Incident

How to Manage a Patient Incident

MANAGER’S ACCESS and ‘USER DETAILS’

Patient Incident Managers require login access to SLS to enable them to review reported incidents that occur in areas that they have responsibility for, and to document any investigation and actions arising from the incident, including open disclosure processes in SLS.

Only SA Health personnel who are authorised by the relevant health service or the Department of Health Safety and Quality Unit will be given login access to the incident management section of SLS by their SLS Administrator.

The local SLS Administrators are located in the LHN or health service Safety and Quality teams. These officers must ensure that each patient incident manager understands their responsibilities in relation to the protection of personal information in SLS, and the strict conditions applying to any release of information from SLS. All Patient Incident Managers are reminded of their responsibilities in regards to protection of privacy and confidentiality.

Local SLS Administrators set up each manager's access (also called ‘user details’) so that they receive an automated email about incidents that occur in the area or service that the manager is responsible for.

For example, if you are the CSC of a ward, you will be notified by email about incidents in your ward (this may include patient incidents, worker incidents and security incidents). If you are a Director, you will receive notification about all incidents occurring in the areas or services for which you have responsibility, for example all renal services across the LHN. Some Directors receive limited emails, for example only those rated SAC 1 or 2.

If you think that your SLS access (‘user details’) is incorrect please discuss with the local SLS Administrator.

GETTING STARTED

First open the South Australian Health Incident / Event Notification Form.

On the top right of the page there is a ‘Login to Safety Learning System’ link. Click on it.

It will request your username (which will be your ‘HAD login’), and your password.

Your password

> If this is your first time logging in, your local SLS administrator will have provided you with a temporary password that you will need to change.
> Your password will expire every 3 months.
> When changing your password it cannot exactly match any of your last 6 passwords.
> If you attempt to login incorrectly up to 3 times, you will be locked out of the system and will need to contact your local SLS administrator to regain access.

Click on the top bar to login.

Please note that there is also a link to the SA Health Safety Learning System website that house information and guides.
Overview of the Managers section of Safety Learning System (SLS)

Once you have logged in, the Incidents main menu will appear on your screen. This menu has a variety of Options relating to:

- designing reports/data and saving these data queries
- searching for individual patient incident reports, or setting up a search for groups of incidents.

There is training available in report/data generation and searching from LHN SLS Administrators and the Department of Health and Ageing Safety and Quality Unit. SLS Support team can consider requests for training (see For more information, and contacts).

Under the heading Status, you will see the total number of records within the locations that you are responsible for. Note that this total may include patient incidents, security incidents and worker incidents.

After an incident is reported it is automatically labelled ‘In holding area, awaiting review’. These are incidents that have been reported and are waiting for review by a manager.

As the review and investigation of an incident proceeds it should be moved through to ‘Being reviewed’ then lastly to ‘Finally approved’. Managers are required to assign the correct ‘Approval Status’ as the investigation proceeds.

The requirements for rejecting incidents are described on page 15.

Overdue records are displayed according to their incident status. Timelines for overdue review of incidents are described on page 15.

The yellow exclamation symbol indicates that you have overdue incident reports.

Click on the number of records in the holding area. Another panel will open showing a list of all incidents that you may need to review and approve. The total number of records will be displayed on the top left of the page.
To select a record to review, click on any of that incident's details that are displayed. The first page that appears will be the ‘incident details’. It will contain all the information entered into the incident / event notification form by the notifier.

**VERIFY the CONTACTS**

To select a record to review, click on any of that incident's details that are displayed. The first page that appears will be the `incident details`. It will contain all the information entered into the incident / event notification form by the notifier.

The first task for the manager is to review all information that was entered by the notifier.

> If any information in the incident detail panel is not completed, please take the time to complete.

> The manager should ensure that the information entered is relevant to the event, brief and factual.

SLS will keep a record of any changes made.

Managers may need to follow up with the notifier for further information about the incident and can find the notifier details at the bottom of the incident information.

Under the incident details provided by the notifier click on ‘unapproved’ below the current approval status and then review the contacts details.

If you believe the notifier's details to be correct, click on ‘check for matching contacts’.

> If you see the correct contact you can ‘choose’ it. This has now approved this contact, click on ‘save’ and you may return back to the incident.

> If there isn’t a match, click ‘cancel’. This will bring you back to the contact details for you to create a new contact.

To create a new contact, complete all the fields you can and change the approval status to ‘approved’ and then click on ‘save’.

If the contact is incorrect, you will need to click ‘unlink contact’. This has now removed the contact from this incident.

If you need to create a new contact, click on ‘create a new person affected’.
Is the subject of the incident a patient, or is it actually a worker incident? If it is a worker incident, a request should be made to the local SLS Administrator to change it to a Worker incident. There are some incidents where a number of people are affected and advice should be sought from the local Safety and Quality team for correct entry of these. Examples include incidents where:

> more than one person affected at one time, for example a gas leak affecting all the people in the immediate vicinity
> more than one person affected by the one incident/event, such as when a patient incident also involved harm to an employee contractor or student for example a fall when the employee attempted to catch the falling person
> In this case, there is a requirement to report the worker injury into the **Worker incident module** of SLS, as well as the patient report into the patient incident module.
> by the one system error, for example incorrect medication protocol or readings by a medical device or test over a period of time affecting more than 5 patients and with potential to affect more (these are called cluster incidents).

The location of the incident is where the incident occurred.

If the incident did not occur in your area of the health service, or the patient is not from your area of the health service, you need to alert the relevant manager so that they can undertake the review and investigation. Use the tab ‘Send an e-mail’ to do this.

If you don’t know who the relevant manager is, please contact the local SLS Administrator for assistance.

If you or your staff have identified an incident that occurred at another service, report the incident, then contact the local SLS Administrator. This includes:

> incidents that occurred in another SA Health service during or before a transfer from one health service to another.
> patient incidents that involved a series of events that occurred across more than one health service (a cross-boundary incident).
> incidents that occurred in a service external to SA Health for example private hospitals; nursing homes; independent midwives.

The authority for transfer of a patient incident from one health service to another and acceptance of that transfer resides with local Safety and Quality teams. In this case, the health service that becomes aware of the patient incident must:

> as soon as possible, notify the health service where the patient incident occurred
> report the patient incident into the Safety Learning System Incident module.

In a more complex scenario, the patient incident may involve a series of events that occurred across more than one health service (a cross-boundary incident). In this case, the management is the same as single health service patient incidents with the following additions:

> to ensure that an investigation or review team includes members from both/all health services, the health service reporting the incident into SLS should ensure that the appropriate staff from the other health service(s) involved are added as reviewers, and any final report should cover all components of the investigation
> the responsibility for overseeing the management lies with the Manager of Safety, Quality and Risk of the health services, and
> any recommendations should clearly state to which health care service they apply, and each health service is responsible for the implementation of the recommendations at their site.
Patient incident investigation and analysis

Most patient incidents result from a complex system of interaction between health-care professionals, treatment procedures and medical equipment.

Investigation of a patient incident provides facts and information, and leads to understanding about when and how the health care led to the poor outcome for the patient.

The patient incident manager uses the information provided by the notifier to decide:

> what further information, and what type of investigation is required?
> what level of open disclosure is required?
> who else should be involved in investigation of the incident, as a reviewer or a staff member with a more senior role?
> what other requirements there may be for additional notification or escalation to senior management?

The investigation or review of SAC 3 and 4 patient incidents can be managed by the relevant patient incident manager. As well as the review of the information provided by the notifier, these investigations should include, at a minimum:

> discussion with staff
> discussion with patient involved (this can be part of the open disclosure process)
> review of careplan and medical record, and any physical evidence
> review of any relevant procedure(s), protocol(s)
> contribution by any relevant Reviewer(s)

and should lead to identification of contributing factors, and implementing actions to reduce risk of recurrence.
Team review

Interdisciplinary team review is recommended for harmful incidents and repeat incidents such as repeat falls. This team activity promotes shared team learning, and engagement with the patient.

A team review can be a brief team meeting (huddle) led by the patient incident manager, within 48 hours of an incident if practicable. The patient and carer should be supported to participate if possible. At this meeting, the team reviews the incident, reviews the care plan and shares their expertise.

After the team review:
> changes to the care plan are documented in medical record and communicated to the clinical team at handover and other usual processes
> the outcomes of a team review are documented in the SLS managers’ section
> local changes are implemented
> the patient incident manager refers recommendations to the committee(s) that have responsibility for action across the health service.

Other types of incident investigation
These are used for SAC 1 or SAC 2 incidents. These are conducted with advice from Safety and Quality or Risk Managers, and include review by Part 7 committees, Root Cause analysis.

Analysis of incidents determines which category(s) of contributing factors led to an incident occurring, and suggests what action(s) can be taken to reduce risk of recurrence. This list guides identification of possible contributing factors.

> Patient assessment
  - eg Delay or failure to note test results, or another clinicians assessment
> Staff factors
  - eg The staff in the area had not completed wound dressing training, and used incorrect dressing on wound
> Patient factors
  - eg Patient has cognitive impairment and was pulling off wound dressing
> Equipment
  - eg The medical device was faulty
> Work environment
  - eg The air conditioning in theatre failed
> Information
  - eg Test results were delayed
> Communication
  - eg Inadequate or incomplete handover / transfer of information between healthcare team
  - eg The pressure injury was not mentioned in handover to SAAS before a 3 hour transfer to a country hospital
> Policies and procedures
  - eg The procedure for calling for Code Black and security assistance had changed, but staff at a community service had not been informed
> Coordination of care
  - eg The patient was delayed in prep for theatre because radiology was unaware time that theatre booked
Many hospital acquired complications or side effects of treatment are preventable or avoidable, and have serious impacts on patients and health services. These are described as complications of care.

There are benefits to investigating avoidable complications of care or unexpectedly poor outcomes from treatment or care, in predicting and preventing this from happening to other patients.

Therefore, these are considered to be patient incidents, and must be reported, openly disclosed and managed in accord with SA Health Patient incident management and open disclosure policy.

An investigation of these types of incidents might ask:

> Was the patient’s response to treatment or diagnostic procedure unexpected?
> What could be done in future to predict and/or prevent that complication/poor outcome next time, or for other patients?
> Was there a delay, error or failure in a system that contributed to either (or both) of its occurrence or severity?
> What were the contributory factors?

### Management of a patient incident using SLS functions

Information arising from the review, investigation and analysis phases should be documented in this managers’ section of SLS, where there are functions that are designed to assist with this.

Click on the Management Tab on the top left of the page. If you are taking responsibility for the management of this incident, assign yourself as the incident manager by entering your name or finding your name on the drop down list.

After reading the notifiers’ entries, the incident manager changes the incident status from ‘holding area, waiting review’ to ‘being reviewed’, at the bottom of the page. It is important the manager changes the approval status from ‘In the holding area, awaiting review’ to ‘being reviewed’ within 2 working days, otherwise the incident is considered to be overdue.

The timeframes for completion of the review, investigation, management and documentation of the incident in the SLS are:

> 30 days for SAC 3 and 4
> 70 days for SAC 1 and 2 (required for additional investigations).
There are a number of activities that can form part of an investigation. Investigations can include:

- further discussion with notifier and team
- seeking input from Reviewer(s)
- analysis of contributing factors
- review of linked incident records.

Record the type of investigation that was conducted for this incident – manager review, team review or the less common structured review processes such as Root Cause Analysis (RCA) or Part 7 committee review.

The Progress notes section can be used by the manager or any of the reviewers to record notes about the ongoing review and investigation of the incident, including analysis of contributing factor(s). Record what is now known about the patient outcome or consequence, for example a fracture resulting from a fall.

SLS maintains a read-only record of previous entries into the Progress note section, which includes the date and name of the person who made the entry. An entry cannot be changed after it has been saved.
If a manager requests, through SLS, that a staff member from another area review an incident, that reviewer will automatically have access to the designated incident, even if their area of responsibility is outside of the location.

Reviewers can include managers from Work Health and Safety, Mental Health, Security Services, Biomedical Engineering, Safety and Quality, Risk Managers, SA Pharmacy, SA Pathology, SA Medical Imaging, SA Ambulance or Drug and Alcohol Services SA or other manager(s) with particular content expertise relevant to the incident.

Any manager who is sent a link to a patient incident report requesting their input as a reviewer, is required to enter their feedback in the reviewers comments box. A reviewer does not assign the actual SAC rating, nor are they permitted to reject an incident.

Please note you can only select staff / managers who already have login access for the SLS system to be a reviewer.

NOTE: A shortcut to finding a relevant Reviewer is to start typing either their name, job title or service acronym (eg BME).

Additional questions will appear if the incident has been classified as a fall or restraint/seclusion.

For a fall incident, these questions ask for a summary of the care provided to the fallen patient/consumer, and a summary of the post fall team review.
For incidents of use of restraint or seclusion, these questions ask for further information.

If known, it is important to indicate if the incident involved a consumer who is currently being treated by an SA Health mental health service. There are options to indicate recency of contact by a mental health service or an emergency department.

The manager is asked to confirm that the incident has been disclosed to the patient / consumer and carer. This means that a discussion has taken place, in accord with open disclosure principles, that includes:

- an expression of regret, which should include the words ‘I am sorry’ or ‘we are sorry that this has happened’
- a factual explanation of what happened
- an opportunity for the patient, their family and carers to relate their experience
- a discussion of the potential consequences of the incident
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.
The incident manager is asked if Open Disclosure has taken place yet, and if so was it level 1 or level 2.

An additional question asks if a Trained OD Facilitator was present at the OD meeting with the patient/family for a Level 1 open disclosure (SAC 1 and 2 incidents). This is a requirement for SAC 1 and 2 incidents, as these staff have additional training in how to conduct these discussions.

The help text notes that the record of the Open Disclosure process (meeting) can be uploaded into the Documents tab. Tool 14 is the recommended template for OD meeting summaries.

After completing the investigation the manager records a brief summary and the actions taken to reduce the risk of recurrence of the incident, and other quality improvement.

SLS maintains a read-only record of previous entries into the summary section, which includes the date and name of the person who made the entry. An entry cannot be changed after it has been saved.

If the notifier has identified themself, it is good practice to provide feedback to reinforce that the incident has been investigated, and that action has been taken to improve practices and safety.

Other team members require information especially if there have been changes to the patient/consumer’s care plan (in medical record and at handover), or changes to local procedures or practices.

Some incidents are complex because they require more than one investigation, for example from the one event there can be a patient incident and a complaint received. The patient incident manager may be aware of other notifications or processes that are occurring. These should be recorded here and can be updated as required.
After the investigation, the Patient Incident Manager must assign an appropriate SAC rating. SLS has a link to the SAC Matrix. Ideally this is done after completion of investigation unless the incident is clearly SAC 1 or 2, in which case you will need to notify the appropriate senior manager(s) in your LHN governance structure within 24 hours.

Patient incidents that meet the definition of a sentinel event must always be reported as SAC 1 incidents. (The Matrix also includes the current sentinel event definitions).

Options for approval status are:

- **Being reviewed**: This means that the incident is undergoing the review and investigation process and awaiting input, comment or feedback from a reviewer(s), if applicable. Final actions arising are still being formulated. Whilst under review, it is possible to add information, save and return at a later time to complete.

- **Finally approved**: By selecting ‘Finally approved’ you are confirming that you have completed the investigation and actions arising from this incident.

- **Rejected**: If the incident record is rejected, the manager is required to complete the ‘reason for rejection’ section. There must be an appropriate reason for rejection, for example two similar reports made for the one incident.
  
  - If your reason for rejection is unclear, please follow up with your SLS administrator for advice and information. A local SLS Administrator from the Safety and Quality or Clinical Governance Unit is required to review any rejected incidents to confirm reason.
  
  - Rejected SAC 1 patient incidents must be discussed with the Department of Health Safety and Quality Unit (HealthSentinelEvents@sa.gov.au).
An overdue incident can be:

> if the approval status is not changed from ‘In holding area, awaiting review’ to ‘being reviewed’ within 2 working days.

> if the approval status is not changed from ‘being reviewed’ to ‘finally approved’ within 30 days.

Ensure that any entries or updates are retained by clicking Save at the bottom of the form.

There are features of SLS that assist with documentation, tracking and report generation. These tabs are all located on the top left hand side of the manager's screen.

The Documents tab allows the incident manager or reviewer(s) to attach any evidence or supporting documentation to the incident report.
The Actions tab allows the manager to create a new action and assign or monitor existing actions. An action is the same as a recommendation that is a result of the review and investigation of the incident. These recommendations (actions) can be assigned, in consultation with other staff. When creating a new action a new page will appear, identifying the action details and status.

![Actions Tab](image)

The Linked Records tab allows the manager to link related incident records together. Links can be made between 2 or more incidents in the same module, for example two patient incidents.

Links can be made between 2 or more incidents of different types, for example a patient incident and a worker incident, or a patient incident and a security incident.

It is also possible to link a patient incident to a consumer feedback report in the consumer feedback module.

The Send an E-mail tab within SLS can be used:

> to notify the local SLS Administrator or Safety and Quality manager of a new SAC1 or 2 incident
> if you need to obtain more information regarding the incident
> to notify the correct manager if this incident does not belong to your location.
All e-mails are saved by SLS so it is a reliable way to record outgoing correspondence about a patient incident. Please note:

- Sending an e-mail contains a link to the record (however, this does not automatically grant access to the incident).
- If you e-mail a manager who already has login access to SLS, you will be able to find their name in the ‘all users’ drop down box, otherwise you can manually type in their health e-mail address in the additional recipients box. When they reply to your email, you can attach the reply in the documents section.

The staff initially notified tab provides a record of which managers were notified by automatic SLS email about the incident when it was first reported.
<table>
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<tr>
<th>GLOSSARY</th>
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<tr>
<td><strong>Actual SAC</strong></td>
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<tr>
<td><strong>Harm</strong></td>
</tr>
<tr>
<td>&gt; An incident that results in harm to a patient. For example, the wrong unit of blood was infused and the patient died from a haemolytic reaction)</td>
</tr>
<tr>
<td>&gt; impairment of structure or function of the body and/or any deleterious effect arising from there, including disease, injury, suffering, disability and death, and may be physical, social or psychological.</td>
</tr>
<tr>
<td><strong>Near miss</strong></td>
</tr>
<tr>
<td>&gt; An incident which did not reach the patient, for example, a unit of blood being connected to the wrong patient’s intravenous line, but the error was detected before the infusion started.</td>
</tr>
<tr>
<td><strong>No harm</strong></td>
</tr>
<tr>
<td>&gt; An incident in which an event reached a patient but no discernible harm resulted, for example, if the unit of blood was infused, but was not incompatible)</td>
</tr>
<tr>
<td><strong>Incident (patient incident)</strong></td>
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<tr>
<td><strong>Local SLS Administrator</strong></td>
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<td><strong>Open disclosure</strong></td>
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<tr>
<td><strong>Safety Assessment Code (SAC)</strong></td>
</tr>
<tr>
<td>The score is determined by the use of the SAC Matrix. The score guides the level of incident investigation or review that is undertaken.</td>
</tr>
<tr>
<td>Any incident rated a SAC 1 or SAC 2 is deemed to be a harmful incident. A harmful incident is any event or circumstance which resulted in unintended and/or unnecessary psychological or physical harm to a patient.</td>
</tr>
<tr>
<td><strong>Sentinel events</strong></td>
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<tr>
<td><strong>SLS Support team</strong></td>
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</table>
Further information and useful contacts

**Web-based INFORMATION**


- SLS guides and SLS topic guides about specific incident types, for example pressure injuries
- the SAC matrix
- classification diagrams
- contributing factors classification.

These webpages can also be accessed by clicking ‘SLS Website’ at the top of the Notification Form.

**Local SLS ADMINISTRATOR**

The local SLS Administrator is the first contact point for queries regarding access to, and advice about SLS.

The contact list for Local SLS Administrators can be found on the SA Health SLS web page ([www.sahealth.sa.gov.au/SafetyLearningSystem](http://www.sahealth.sa.gov.au/SafetyLearningSystem)).

It can also located by clicking ‘SLS Website’ at the top of the Notification Form.
APPENDIX  Description of Level 1 patient incident classifications

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<th>Description of Level 1 patient incident classifications</th>
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<td><strong>Access, appointment, admission, transfer, discharge</strong></td>
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<td><strong>Clinical assessment</strong></td>
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<td><strong>Neonate</strong></td>
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<td><strong>Patient falls and other injuries</strong></td>
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<td><strong>Patient information</strong></td>
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<td><strong>Staffing, facilities, environment</strong></td>
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<td><strong>Treatment, procedure</strong></td>
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