How to Report a Patient Incident

Safety Learning System (SLS) Guide
How to Report 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 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 affected following 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 entered into SLS is personal and therefore confidential. There are strict rules for release (disclosure) of any information.

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)

Open the SAFETY LEARNING SYSTEM (SLS) PROGRAM

Double click on the SLS icon on the computer desktop

OR

Click on:
- the Start button
- All programs
- Corporate programs
- SAH Applications
- Safety Learning System

System ICONS

A red asterisk indicates that the information is mandatory

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. Once the spell check completed, click symbol again to turn this function off.

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 by single clicking on it, then click on this box with a red cross. This will delete the incorrect entry.

SLS has a timeout 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.
How to report a patient incident using the SA Health Incident / Event Notification form

The incident / event notification form is displayed when you first open the SLS.

SLS is subject to disclosure.

The date the incident occurred must be entered, by either using the calendar icon or typing the date directly into the cell using a dd/mm/yyyy format.

Staff are reminded to report all incidents, even if it was not identified for over 24 hours.

The time will need to be entered using the hh:mm format.

For a patient incident, the location (in SLS termed the ‘location exact’) of the incident is where the incident occurred.

If you are unsure about the location exact you can ask your manager or team member

If you know the location exact type it in, and SLS will automatically backfill the rest of the fields above.

Check that the autofilling is correct – some location exacts have similar names.

Please note that the incident may have occurred in another service, and the location may therefore be that other service. For these incidents, seek advice from your manager or local SLS Administrator.
The subject of the incident must be selected from the drop down box. For all patient incidents - select ‘incident affecting patient’.

The person affected is the patient involved in the incident. The ‘Add Another’ button allows you to add an additional person affected if the incident involved more than one person. This does not include witnesses or workers, who can be added later in the form.

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:

- people all 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).
How to Report a Patient Incident

Information entered into the ‘What happened’ and the ‘What was the outcome of the incident / event’ fields should be brief, factual and de-identified.

These fields are subject to disclosure (this means that information recorded here can be made public if requested), and therefore these should not include names, medical record numbers or opinions, and must be relevant to the incident.

Please note that it is also mandatory to record if the incident has already been disclosed to (discussed with) the patient / consumer or not (refer to Open Disclosure principles and practices).

The notifier is the person reporting the incident. While it is only mandatory to provide professional group, providing additional contact details will allow the incident manager to contact the notifier if needed. Note that this section is prohibited from disclosure, that is, the information is protected under the Health Care Act and can only be released under strict conditions.

If you wish to receive an email to confirm that you have submitted the report of the incident, please provide your SA Health email address.

The incident is classified according to 3 levels of classification. Classify the incident itself objectively based on the actual details on the incident.
First Select Level 1 from this list of incident types:

- access, appointment, admission, transfer, discharge
- clinical assessment
- challenging behaviour
- communication and teamwork
- implementation of care
- medical device/equipment
- maternal
- medication
- neonate
- patient falls and other injuries
- patient information
- pressure injury/ulcer
- restraint/seclusion
- staffing, facilities, environment
- treatment, procedure

The Appendix includes a brief description of the types of incidents that are recorded under each of these.

Then select the most appropriate from level 2, then level 3 drop down boxes. It is very important that by the end of the classification process that the level 3 category closely matches the incident. If it doesn’t you may need to go back to Level 1 and try another classification. This will assist in the correct notifications being sent by SLS to the relevant manager, and for the review, analysis and reporting of data.

The manager or SLS administrator may change the classification after review and investigation if incorrect. For example a pressure injury may be incorrectly classified as medical device / equipment incident if caused by pressure from the device.

Using the SA Health Safety Assessment Code (SAC) matrix (click on the link in SLS), assign a SAC rating that is based on:

- the consequence (the harm or outcome as known at the time the report is made) and
- the probability, or likelihood of similar incidents occurring.

When the consequence and likelihood are selected from the drop down boxes, the SAC score will be automatically calculated by SLS.

Select the Result that best indicates the actual harm caused to the patient:

- Harm caused to an individual or the organisation
- No Harm caused to an individual or the organisation
- Near Miss
If another person was involved, the Additional Information section can be used to provide those extra details, this may include witness to the event. Multiple people can be added by clicking the ‘Add Another’ button.

Students reporting an incident must identify their student supervisor in this section.

Once the form is complete, click submit.

> A message stating the incident number (SAHI-xxxx), and that it has been saved will appear. Note this information if you would like to follow up with the relevant manager as to the outcome or progress of the incident.

> An acknowledgement email is automatically generated by the SLS system and sent to the relevant manager/senior staff (managers) to inform them that an incident has been reported in their area of responsibility.

If you have any questions about reporting an incident or how to use SLS please contact your local SLS Administrator.

The SA Health SLS webpages about Patient Incidents
Further information and useful contacts

**WEB-BASED INFORMATION**

(www.sahealth.sa.gov.au/SafetyLearningSystem) include:

- 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).

It can also located by clicking ‘SLS Website’ at the top of the Notification Form.
## GLOSSARY

<table>
<thead>
<tr>
<th><strong>Disclosure</strong></th>
<th>To disclose, in relation to information, means to give, reveal or communicate in any way (Part 7 of the Health Care Act 2008).</th>
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</table>
| **Harm (harmful incident)** | An incident that resulted in harm to the patient.  
  > an incident that results in harm to a patient (WHO). For example, the wrong medication was given and the patient developed a severe adverse reaction to the drug.  
  > impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death, and may be physical, social or psychological. |
| **Near miss** | An event or set of circumstances where there was the potential for an incident to occur.  
  > an incident which did not reach the patient (WHO) For example, incorrect medication was dispensed, but the error was detected before the medication administered. |
| **No harm** | An incident that occurred but did not cause harm.  
  > An incident in which an event reached a patient but no discernible harm resulted (WHO). For example, incorrect medication was administered, but patient was unharmed. |
| **Incident (patient incident)** | Any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a person or consumer/patient during an episode of health care. |
| **Local SLS Administrator** | SLS Administrators are key members of the Safety and Quality teams in each Local Health Network or statewide service, with expertise in use of SLS and its functions for reporting, management and generating data for clinical governance. SLS Administrators work in collaboration with the Safety and Quality managers, Risk managers and other senior staff in ongoing maintenance, enhancement, monitoring and effective use of SLS to improve safety and quality of health care for patients. |
| **Open disclosure** | A process of providing an open, consistent approach to communicating with consumers/patients and their carer/support persons following a patient incident. |
| **SAC 1 and 2** | 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. |
| **Safety Assessment Code (SAC)** | A numerical score applied to a patient incident, which is based on the consequence of the incident and its likelihood of a recurrence. The score is determined by the use of the SAC Matrix. The score guides the level of incident investigation or review that is undertaken. |
| **SLS Support team** | Staff of the Department of Health and Ageing Safety and Quality Unit, with responsibility for the Safety Learning System. |
Description of Level 1 patient incident classifications

**Access, appointment, admission, transfer, discharge**
> incidents that have arisen from problems with all of these including referral, follow-up, transport, delays and system failures involving a patient.

**Clinical assessment**
> incidents related to delay or problems with diagnosis, laboratory or test results, images and other elements of assessment.

**Challenging behaviour**
> Incidents related to patient absconding or self-harm, challenging behaviour toward staff and/or other patients, and disregard for hospital by-laws, such as property and smoking, maternal mental health.

**Communication and teamwork**
> incidents related to communication between staff, including making contact and handover, with teamwork and with the transfer of information.
> incidents with poor communication with the patient, including care-planning, Open Disclosure and non use of interpreters.

**Implementation of care**
> Incidents relating to daily care such as delay or failure to monitor, or to act on symptoms such as pain or test results, or to discontinue treatment. Management of fluids and nutrition, infection prevention, oxygen, and post-op complications. Also maternal unplanned admission to mental health unit.

**Medical device/equipment**
> incidents relating to the mal-functioning, non-functioning or use of devices or equipment.

**Maternal**
> Incidents relating to pregnancy, birth and puerperium, such as haemorrhage, maternal morbidity or perineal trauma.

**Medication**
> incidents relating to the administration, ordering/ prescribing, supply/dispensing, storage, adverse reactions, monitoring and advice regarding medicines.

**Neonate**
> Incidents relating to care during birth (such as fracture or skin laceration) and to neonatal care (such as delay or failure to diagnose or act on complications, aspiration.

**Patient falls and other injuries**
> incidents where patients fall, and a range of other injuries such as collisions, needlestick injuries to patients, where patients are lifting or being lifted and other injuries.

**Patient information**
> incidents where there is lost, delayed, ignored or inadequate information, including test results about the patient that affects their care. Includes breaches of patient confidentiality or security of patient information; consent forms; advance care directives and 7step resuscitation plans.

**Pressure injury/ulcer**
> incidents where there is development of a new pressure injury, or worsening of existing, or a pressure injury is identified after admission, or after transfer between services.

**Restraint/seclusion**
> Incidents where physical, chemical or mechanical restraint, or seclusion is applied to any patient.

**Staffing, facilities, environment**
> incidents with failure or problems with IT system, infrastructure, the health service environment or facilities, staffing levels, equipment or supplies.

**Treatment, procedure**
> Incidents related to treatments or procedures such as anaesthesia, transfusion or surgery, applied to various body parts, such as unintended injury, failed procedures or unplanned return to theatre.