This document provides additional definitions and information about terms used in the Patient Incident Management and Open Disclosure Policy Directive and the accompanying policies and tools.

In the context of the Patient Incident Management and Open Disclosure Policy Directive:

> **actual SAC** means: the Safety Assessment Code rating applied to a patient incident by the patient incident manager after investigation and analysis. Further management of the incident is based on this confirmed rating ([SAC matrix](#)).

> **ad hoc review** means: the survey of a specific practice prompted by the development of a related hypothesis. A potential problem is identified and investigated and if necessary, changes in practice that are designed to improve patient care are implemented. These comprehensive reviews can involve several activities such as literature review, focus groups and constructing a process flow chart. The review process should be led by a person who has the authority and skills to do so, and undertaken by a team of people who have expertise in the process being reviewed, and who are able to make recommendations for improving the processes of care given to this group of patients.

> **adverse event** means a term used by Therapeutic Goods Administration (TGA) for reportable unwanted and sometimes harmful occurrences from using medicines, vaccines or medical devices (collectively known as therapeutic goods).

> **adverse outcome** means: a poorer than expected outcome for the patient from treatment.

> **avoidable complication of care** (or potentially avoidable complication of care) means: a known or unexpected complication of care, or side effect of treatment that may have been prevented by improvements to the processes and systems in which the care was provided.

> **carer(s)** means: families, relatives persons responsible, substitute decision-makers and significant others.

> **clinical workforce** means: the nursing, medical, allied health and scientific staff who provide patient care and students or trainees who provide patient care under supervision.

> **clinician** means: a healthcare provider. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.

> **coronial notification** means: the process of reporting certain categories of death to the SA State Coroner. A death must be reported to the State Coroner where it has occurred:

- unexpectedly, unusually or by a violent, unnatural or unknown cause
- on a flight or voyage to South Australia
- while in custody
- during, as a result or within 24 hours of certain surgical or invasive medical procedures, including the giving of an anaesthetic for the purpose of performing the procedure
- within 24 hours of being discharged from a hospital or having sought emergency treatment at a hospital
- while the deceased was a ‘protected’ person
- while the deceased was under a custody or guardianship order under the [Children’s Protection Act 1999](#)
- while the deceased was a patient in an approved treatment centre under the [Mental Health Act 2009](#)
- while the deceased was a resident of a licensed supported residential facility under the [Supported Residential Facilities Act 1992](#)
- while the deceased was in a hospital or other facility being treated for drug addiction
- during, as a result or within 24 hours of medical treatment to which consent had been given under Part 5 of the [Guardianship and Administration Act 1993](#), or
- when a cause of death was not certified by a doctor.
**degree of harm** means: the severity and duration of any harm, and any treatment implications, that result from an incident.

**desktop review or audit** means: using electronic health records, the Safety Learning System (SLS) and other readily available patient information to review a patient incident or significant event.

**detailed clinical review** means: a thorough examination of the patient's medical record by senior health practitioners who were not involved in the patient's care, to determine the circumstances leading to a death or other incident with serious outcomes. Further information can be obtained through interview of health practitioners and included in the investigation.

**contributing factors** means: the circumstances, actions or influences which are thought to have played a part in the origin or development of an incident, or to increase the risk of an incident. Examples are human factors or system factors. Most incidents have more than one contributing factor (WHO).

**disclosure** means: the act of making something known or revealed or uncovered (WHO). To disclose, in relation to information, means to give, reveal or communicate in any way (Health Care Act 2008).

**error** means: a failure to carry out a planned action as intended, or application of an incorrect plan. An error can be by omission (not doing the right thing) or by commission (doing the wrong thing) (WHO).

**health service** means: all public health organisations, including SA Ambulance Service and other statewide clinical support services, such as SA Pharmacy, that are the responsibility of SA Health and the South Australian Department of Health and Ageing.

**health service manager or supervisor** means: the staff member/person/SA Health employee who is responsible for the activities of a particular location for example ward nursing manager, medical head of unit or local team manager.

**incident (patient incident)** means: 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 that occurs during an episode of health care.

Types of incidents include:

- **Harmful incident**: any event or circumstance which resulted in unintended and/or unnecessary psychological or physical harm to a patient during an episode of health care. In some instances this is calculated as all SAC1 and SAC2 rated incidents, but may also be defined by the classification of the outcome of the incident by the notifier in SLS (Harm / no harm / near miss).

- **Cluster incident**: a type of adverse incident where there is a group or series of more than one harmful incidents that are the result of a systemic error or issue, and that involves a systems failure or multiple systems failure that does or has the potential to place other patients directly at risk (South Australian Government Gazette, 21 May 2015). An example is an incorrect medication formulation, or treatment protocol.

- **Near miss**: a patient incident that did not cause harm, but had the potential to do so. An arrested or interrupted sequence where the incident was intercepted before causing harm. The incident cannot be a near miss if the consumer/patient was harmed or injured.

- **No harm**: the incident occurred and the patient was exposed but no harm resulted, for example one dose of an incorrect medication was administered with no effect.

- **Adverse incident**: any of the following classes of patient incident, including Sentinel events, as defined by the South Australian Government Gazette:
  - the death of a patient unrelated to the natural course of the person's illness and differing from the immediate expected outcome of the patient's health care management.
  - **Sentinel events** (refer to definition below).
  - the abduction of an infant/child from a hospital facility.
  - an intrauterine death that may be related to a system failure in health care delivery.
  - the stillbirth of an infant that may be related to a system failure in health care delivery.
  - the suspected:
    - homicide or suicide
    - attempted homicide or suicide
  - committed by a person who has received care or treatment from a health services entity where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the entity.
the suspected suicide or the suspected attempted suicide of a person in custody applying the definition of ‘custody’ in the Coroner’s Act 2003 (SA)

• an incident where a patient:
  - suffers a major permanent loss of function (sensory, motor, physiologic or intellectual) unrelated to the natural course of the patient’s illness and differing from the expected outcome of the patient’s health care management.
  - suffers significant disfigurement as a result of the incident
  - is, or was, at significant risk due to being absent against medical advice
  - who, whilst detained, has:
    > without leave, left the place at which he or she has been detained, or
    > having been absent with leave from the place at which he or she has been detained, failed to return at the conclusion of the period of leave
  and has been at significant risk during the period of absence or unauthorised absence

• an incident or occurrence that has system-wide safety implications, namely one that involves a systems failure or multiple systems failure that does, or has the potential to compromise the safety of a patient(s) (see also cluster incident)
  and otherwise an incident or occurrence that is not consistent with the routine health care of a patient or client, or the routine operation of the health services entity providing health care, and that does or has the potential to result in harm to a person receiving health care.

  > incident characteristics means: the selected attributes of an incident such as care setting, treatment status, specialties involved and date of an incident
  > incident investigation means: a detailed systematic inquiry conducted to ascertain the underlying causes and facts of a patient incident. It usually involves reviewing evidence, and interviewing people who have a firsthand knowledge of the incident. Other subject expertise can be included through requesting reviewer(s)
  > incident management means: all the activities involved in the reporting, notification or documentation of an incident or near miss, including the review, investigation and analysis of the individual incident, and the analysis of groups of incidents, or data arising, for the purpose of improvement of the safety and quality of the health service and the care provided
  > incident review means the initial review, done by the manager, of the notifier’s report of an incident submitted into SLS
  > incident classification means: the category of incident determined by its clinical features such as relating to a pressure injury or the provision of a treatment or procedure
  > legal professional privilege means: communications brought into existence for the purpose of obtaining legal advice or for actual or contemplated legal proceedings against the Department for Health and Ageing, an agency or the Minister. If the communication is for the purpose of actual or anticipated Court proceedings, or for the purpose of providing legal advice, the communication will normally be protected by Legal Professional Privilege
  > medical record (or health record) review means: a review of the medical record to gain a thorough understanding of a patient incident. This is achieved through extensive research, collection and organisation of a medical record, chronology of medical treatment and an explanation of the issues of the incident. Information gained is subject to disclosure unless undertaken as a Part 7 Review
  > open disclosure means: a process of providing an open, consistent approach to communicating with consumers/patients and their carer/support persons following a patient incident
  > open disclosure facilitator means: an Open Disclosure Facilitator is an SA Health staff member who has completed the prescribed face to face Open Disclosure training
  > organisational outcomes means: the impact upon an organization which is wholly or partially attributable to an incident. Organisational outcomes indicate the consequences directly to the organization such as an increased use of resources to care for the patient, media attention or legal ramifications (WHO)
  > patient means: a person currently receiving health services from an SA Health service or a service funded by SA Health. For the purpose of this document patients, consumers and clients and residents (of residential care facilities operated by SA Health) are equivalent terms
  > patient characteristics means: a description of the characteristics or features of the patient that provide context to the incident, including patient demographics, the original reason for seeking care and the primary diagnosis
  > patient incident manager means the senior staff member of a clinical area or service who is designated as the recipient
of email notification about all incidents occurring in that area and who is responsible for the conduct of all activities to do with the management of the incident. In order to do fulfil this role the staff member is;

- verified as an appropriate person by the SLS administrator
- provided with log-in access to the management section of SLS by the SLS Administrator, and setup with access to appropriate locations,
- provided with the SLS guide How to manage a patient incident, that includes practical information and information about legal aspects of incident management
- completed the SA Health eLearning course Patient incidents and open disclosure.

> **patient outcome** means: the impact upon a patient which is wholly or partially attributable to an incident. Patient outcomes can be classified according to the type of harm, the degree of harm, and any social and/or economic impact (WHO)

> **Part 7 committee** means: a committee that is formed in accord with the requirements of, and under the protection of, Part 7 of the Health Care Act 2008

> **peer review** means: a type of review where clinicians seek to improve treatment of patients, and to maintain their practice by focussing on recent events and outcomes (individual or collected) of the patients under the care of the group. This method may include:

- discussion of patient incidents
- quantitative indicators of the clinical unit's performance
- identification of systemic deficits
- follow up of previously identified matters
- making recommendations for improving the processes of care given to this group of patients.

> **prescribed act** means:

- an act that is offence under the law of the State that appears to have been committed by a member of the staff of the health services entity; or
- an act that is attributed to a member of the staff of the health services entity, or any other person involved in the adverse patient incident, being medically unfit; or
- an act that constitutes the abuse of a patient; or
- an act that appears to be a deliberately unsafe act (other than an act that might be reasonably undertaken in the provision of a health service).

> **quality** means: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (ACSQHC)

> **retrospective chart review (also medical record review)** means: the periodic monitoring of medical records to detect deviations in an appropriate standard of care, provide objective information about the consequences of that deviation and to assist in understanding its causation. The retrospective chart review identifies a possible ‘issue’ of clinical management that has (or may in a future recurrence) lead to an adverse event. Information gained is subject to disclosure

> **risk** means: the probability that an incident will occur (WHO)

> **root cause analysis (RCA)** means: a method of investigating incidents. It is a systematic iterative process whereby the factors that contribute to an incident are identified by reconstructing the sequence of events and repeatedly asking “why” until the underlying root causes (contributing factors or hazards) have been elucidated (WHO). Conducting a Root Cause Analysis

> **sentinel event** means a subset of incidents listed as adverse incidents in the SA Government Gazette.

**Sentinel events** are:

- procedures involving the wrong patient or body part resulting in death or major permanent loss of function
- suicide of a patient in an inpatient unit
- retained instruments or other material after surgery requiring re-operation or a further surgical procedure
• intravascular gas embolism resulting in death or neurological damage
• haemolytic blood transfusion reaction resulting from ABO blood type incompatibility
• medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
• maternal death associated with pregnancy or birth. Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from a cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
• discharge of an infant to the wrong family.

> **safety** means: the reduction of risk of unnecessary harm associated with health care to an acceptable minimum (ACSQHC). An acceptable minimum refers to the collective notions of safety given current knowledge, resources available and the context in which care was delivered, weighed against the risk of non-treatment or other treatment. (WHO)

> **Safety Assessment Code (SAC)** means: 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. An incident rated at SAC 1 has had a very harmful consequence for the patient. All sentinel events and most gazetted adverse incidents are SAC1, whereas most near misses will be SAC4 because there has been no harm to the patient

> **Safety Learning System (SLS)** means: The electronic system and database used in SA Health for reporting information about all phases of patient incident management. The SLS system includes other sections for reports of work health safety incidents, security incidents, and modules for consumer feedback, and Notifications such as coronial and medical malpractice notifications

> **staff member** means: includes worker, contractors, students and others

> **system failure** means: fault, breakdown or dysfunction within an organization's operational methods, processes or infrastructure (WHO)

> **team review** means: a brief (5-10 minutes), informal team meeting that has features of both a ‘huddle’ and a ‘debrief’ (in TeamSTEPPS® terminology). Ideally it occurs as soon as possible after the incident (ideally that day or the next). The inter-professional team reviews the incident, with the patient and carer if possible. A revised care plan is developed and documented to address the patient's risk and prevent further incidents. This is communicated through medical records and handover processes. The outcome of the team review is documented in the management section of SLS.