Safety Learning System

Frequently Asked Questions
Reporting patient incidents

Government of South Australia
SA Health

Introduction

We all want a health system that is designed and delivered in a way that ensures that patients are kept safe from preventable harm. SA Health is committed to continuous quality improvement and an environment in which there is:

- recognition that patient incidents usually have many contributing factors that are mostly related to the systems of care, rather than an individual
- active reporting and management of patient incidents by the whole clinical team, leading to timely action to eliminate or reduce risk
- a clear focus on quality improvement in an open, just and transparent culture that includes support for staff affected by the incident.

What are patient incidents?

An incident is any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a consumer/patient that occurs during an episode of health care.

- A harmful incident means any event or circumstance which resulted in unintended and/or unnecessary psychological or physical harm to a patient during an episode of health care.
- No harm means the incident occurred and the patient was exposed, but no harm resulted.
- A near miss is a patient incident that did not cause harm, but had the potential to do so.

Avoidable complications of care are considered to be incidents. Investigation can uncover ways to reduce risk of their recurrence.

Examples of near misses are:

- when the check of the patients identity shows that they were about to be given medications prescribed for the patient in the next bed
- staff discover patient with materials preparing to harm themselves
- the patient was about to eat the meal when the family member realised that it contained something that the patient has an allergy to
- a theatre nurse identified that the sterile pack was damaged, just before the pack was opened.

What are the immediate actions after an incident?

- Ensure that any person affected by the incident is safe and all necessary steps are taken to support and treat the person/s and prevent further injury.
- Inform a line manager; and preserve evidence in the area if required.
- Document information about care provided before and after the incident in the medical record.

Who reports the patient incident into the Safety Learning System(SLS)?

All SA Health workers, students and contractors can access SLS to submit a report about a patient incident. The person who is reporting a patient incident is termed the notifier.

- Those who observe or become aware that a patient incident or near miss has taken place, or who have the most information about the incident must make the initial report into the SLS.
- This task cannot be allocated to non-clinical staff or other staff.
- Students should include their supervisors name in ‘Other people involved’.

When should the patient incident report be made?

All patient incidents must be reported into the patient incident module of the Safety Learning System (SLS), via the online web form, within 24 hours or as soon as practicable. A late report is preferable to no report.

What are the responsibilities of all SA Health staff, students and contractors?

- Report all identified patient incidents into the SLS. Encourage colleagues to report and/or notify incidents and near misses that have been identified.
- Participate in the investigation of incidents as required.
- Participate in the implementation of recommendations arising from the investigation of incidents.
- Commence and/or participate in the open disclosure process as appropriate.
- Support consumers/patients and carers to bring patient incidents to staff's attention, and to engage with the process of incident investigation.
- Participate in relevant patient incident management and open disclosure training.

What is the role of the Safety Learning System in quality improvement?

The patient incident management module of the SLS is used to document the circumstances of the incident, its subsequent investigation, analysis, and open disclosure processes in an accurate and timely manner.

After the report into SLS is submitted by the notifier, SLS will automatically send an email to the designated patient incident manager(s) for the area.

How is an incident that affects more than one patient reported?

In most instances, the patient incident module is used for incidents that affect a single patient. There are some events where a number of patients were affected, or where there were near misses.

An example commonly raised is where an area is unexpectedly understaffed either in numbers of staff or skill/experience levels. This might occur, for example if there was an emergency situation that required staff to attend, leaving their other patients untended or with fewer staff to continue providing care.

In this situation:

- the first action required is for the senior team member is to notify the Shift Coordinator or equivalent, to request additional back-up if staff are concerned that patient safety is imminently at risk
- there are potentially a number of types of incident that may affect the untended patients and may require reporting into the SLS. The table has some examples, and how they can be classified.

Examples include:	**If these occur they should be reported as usual in the SLS. Suggested classification:**
Delays in receiving medication	Level 1 - Medication incidents: Level 2 - Administration of medication Level 3 - options include 'Delayed dose' or 'Omitted dose'
Delays in usual monitoring or care	Level 1 - Implementation of care incidents: Level 2 – Possible delay or failure to monitor Level 3 - options include 'Delay/difficulty in obtaining clinical assistance' and 'Failure to follow-up' and 'Failure to monitor'.
Delay or failure to have a test performed, possibly because senior/ more experienced staff unavailable to assist	Level 1 - Treatment, procedure Level 2 – Connected with the management of Operations /procedures Level 3 - 'Delay / difficulty in obtaining clinical assistance'

- the staffing levels can be described as contributing factors leading to the incident(s) or near miss(es) in the 'What happened?' section
- any staff affected or harmed should enter a worker incident into the SLS.

Other examples of incidents affecting more than one patient include:

- If an air conditioner breaks down and a number of patients are affected by the heat. These incidents can be classified as Level 1 – Staffing facilities, environment, Level 2 Environmental matters and Level 3 unsafe environment (personal safety, light, temperature, noise, air). In this case instead of a single patient name the name can be entered as 'Multiple Multiple', unless each patient affected requires open disclosure.
- Under the classification Level 1 – Staffing facilities, environment, there is a Level 2 option 'adverse events that affect staffing levels'. This is used for external events such as severe weather events where staff may be delayed or prevented from getting to work, and a patient is affected.

There are some single system errors that can affect a number of patients. These are called **cluster incidents**. Examples of a cluster incident include where the one test or treatment protocol that is used for a number of patients is found to have a problem. Suspected cluster incidents require immediate discussion with senior managers and the Safety and Quality team, as well as an SLS incident report. Further information is available in the SA Health Lookback review Policy Directive. What if the incident was a worker incident? There are some incidents where both a patient and a worker were affected, and each requires a separate report.

What if the incident was a worker incident?

In the event that a worker incident has been incorrectly reported as a patient incident it will need to be correctly identified and moved.

- In the Management Tab add the local WHS SLS Administrator or WHS Professional as a Reviewer.
- Use the Email tab to send an email to those added as a reviewer with an explanation that the incident should have been a worker incident and requesting that they take the appropriate action.
- Lists of local patient SLS administrators and WHS SLS administrators can be found on the SLS webpage.

Can the incident report be modified by a manager?

The free text fields in which the incident is described 'What happened?' cannot be amended. New entries can be made and these will be 'date and time stamped', and indicate who made the additional entry.

Generally managers use the Managers section for their entries. The manager is expected to review the SAC rating, usually at the conclusion of the investigation, and assign an 'actual SAC', that is a final SAC rating. Managers can also change the classification type, for example if the wrong medication was given during a delivery, change from 'maternal' incident to a 'medication' incident.

Can a report be rejected?

Yes. The reason for the rejection of the incident must be recorded in the relevant field in the SLS.

The most common reason is if two staff members report the one incident, thus creating a duplicate incident. If this occurs, the local Safety and Quality Team (the SLS Administrator) will link the 2 duplicate reports together, keep the incident report that has the most information, and change the duplicate to 'rejected' status. The content of the rejected incident report is retained by SLS. Changing to rejected status means that the incident report isn't included in any count of incidents.

Can a report be deleted?

In general, no. Duplicates are managed as described above. There are very rare circumstances in which applications to delete incidents will be granted by the Department for Health and Ageing Safety and Quality Unit, who will then arrange for the incident report to be deleted.

What is patient incident management?

Patient incident management means all the activities involved in the reporting, notification or documentation of an incident or near miss. This includes the review, investigation and analysis of individual incidents, and the analysis of groups of incidents, or data arising.

Incident management is a key quality improvement activity and has three main parts. These are:

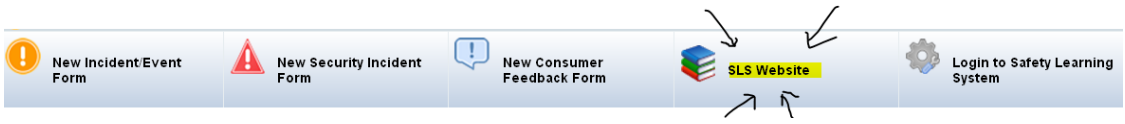
What	Who is responsible	Results
1.Incident reporting	All staff, students and contractors providing care to the patient must report patient incidents, and may be involved in > the investigation of incidents > open disclosure.	> information about the incident, and the immediate actions taken to reduce risk
2.Incident review, investigation and analysis of: > single incidents > groups of like incidents	Patient incident managers(*) are responsible for review and investigation of all incident and planning actions to reduce risk. Incident reviewers who have expertise relevant to the incident, for example biomedical engineers for medical device failure	> information about the contributing factors including any system issues that contributed or caused the incidents > local action to prevent recurrence to that patient and others in the area
3.Analysis of SLS data from groups of incidents	Managers, committees and safety and quality teams	> information for planning actions to minimise risk or to prevent recurrence in areas or across the health service.

** Examples of Patient Incident Managers are the team leader, the senior nurse or midwife on the ward, the supervisor or other health professional lead for the unit. These senior staff are given access by the LHN SLS Administrators to review all the incidents that occur in their area of responsibility.*

Patient Incident Managers should be familiar with the SLS Guide How to manage a patient incident, and know when and how to seek advice and assistance from S&Q teams in each health service. Serious, harmful incidents are further notified to senior managers and may undergo additional investigation.

Help is available

> Managers, and Safety and Quality teams.
> The SA Health Safety Learning System webpages via a link within SLS



These webpages have SLS Guides and topic guides. These describe the features and functions of SLS and include tips and examples.

> Tool 1 SLS guide - How to report a patient incident
> Analysing the contributing factors of an incident
> SA Health Patient Incident Management and Open Disclosure Policy Directive

For more information

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