Why report an incident?
The National Safety and Quality Health Service Standards and the SA Health Incident Management Policy Directive recommend reporting incidents, so that action can be taken to improve care for that consumer and for others who may be at similar risk.

- Reporting incidents provides evidence for accrediting surveyors that the organisation is compliant with requirements of national standards.
- Health services should aim for minimisation of both numbers of incidents and harm resulting from incidents.
- Good data will help services to monitor patterns and plan improvements.

Definition of an 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 and/or to a complaint, loss or damage (SA Health Incident Management Policy).

A ‘near miss’ is when an incident was likely but averted through the action of staff or by the consumer themselves, or other. The incident cannot be a near miss if the consumer was harmed or injured.

Does this incident need to be reported?
All incidents related to care or during care should be reported to Safety Learning System (SLS) as soon as practicable (within 24 hours).

Notifiers are the staff making the initial record of an incident into the SLS.

Notifiers and managers have joint responsibility for accurate reporting, review, investigation and quality improvement. The incident should also be clearly documented in the consumer’s medical record.

What are the changes to Labour and Delivery?
In 2015, the one SLS ‘Labour and Delivery’ classification was reviewed, in consultation with SA expert groups.

- Two classifications for ‘Neonate’ and ‘Maternal’ incidents have been created.
- New additions regarding maternal mental health into other classifications – Challenging behaviour, and Implementation of care.

What are the changes to classification of maternal incidents?
- Severe Acute Maternal Morbidity (SAMM) indicators. These 18 indicators are used nationally to ensure that important data about serious maternal morbidity is reported and reviewed.
- New definition of the Sentinel Event - Maternal Death associated with pregnancy, birth and the puerperium. Further defined as: Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but from accidental or incidental causes (WHO).

For more information: SLS Topic guide Maternal and Neonatal care includes definitions.
<table>
<thead>
<tr>
<th>Level 1 (L1)</th>
<th>Level 2 (L2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal (SAMM 1 to 16)</td>
<td>Anaesthetic problem connected with labour or delivery</td>
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<td>Maternal death (Sentinel Event)</td>
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<td>Obstetric haemorrhage</td>
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<td>Acute maternal trauma</td>
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<td>Acute maternal medical morbidity</td>
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<td>Perineal status after vaginal birth</td>
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<td></td>
<td>Other acute maternal morbidity</td>
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<tr>
<td>Neonatal</td>
<td>Incident relating to birth</td>
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<td></td>
<td>Incident relating to neonatal care</td>
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<tr>
<td>Challenging Behaviour</td>
<td>Maternal mental health (SAMM-MMH - 17)</td>
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<tr>
<td></td>
<td>• L3 Maternal suicide</td>
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<tr>
<td></td>
<td>• L3 Maternal attempted suicide</td>
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<tr>
<td></td>
<td>• L3 Maternal self harm</td>
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<tr>
<td>Implementation of Care</td>
<td>MH Care assessment, review, admission, transfer</td>
</tr>
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<td></td>
<td>Maternal unplanned acute admission to a mental health unit (SAMM-18)</td>
</tr>
</tbody>
</table>

**Do Post-Partum Haemorrhages (PPH’s) still need to be reported?**

There has been a change in the reporting of these incidents since the introduction of the SAMM and new definition of sentinel event. PPH’s between 1000-2499mls will only need to be reported if there is also one or more of the following:

- greater than or equal to 2500ml blood loss
- Hb drops 5g/dL compared with any measurement in the last 7 days
- transfusion of more than 5 units of red blood cells in 24 hours

Those PPH’s between 1000-2499mls are captured via coding of medical records on discharge.

**For more information:** SLS Topic guide Maternal and Neonatal care includes definitions.

**What is the reason for separating the recording of labour & delivery into maternal and neonatal incidents? Is the focus audit or medico-legal?**

The intent is to enable focus on the safety and quality of care provided for women, and for neonates, in recognition of their differing needs and possible incidents relating to their care at this time. In some cases, depending on the nature of the incident; a medical-legal notification will also need to be made.

**There are many diagnoses already being recorded into various databases i.e. clinical coding and DRG’s. Why do we need to report these events?**

The reporting of these incidents allows for the timely review and for flagging possible issues with systems of care.

**How are incidents that do not fit the Maternal or Neonate classifications reported in SLS?**

Incidents should be classified by their type, not the location in which they occur, for example:

- incidents involving medication errors in a birthing unit should be recorded under the ‘Medication’ classification in SLS
- incidents involving a fall in a nursery should be recorded under patient ‘Falls and other injuries’ in SLS
- an incident with a medical device failure should be recorded under Medical Devices in SLS.
Once the new classifications are included in SLS can there be additional input or feedback?

Yes, there is always opportunity for review. All requests can be emailed to SafetyLearningSystem@sa.gov.au for consideration.

The Maternal and Neonate classification will be monitored, and reviewed 12 months after implementation.

What is the Manager’s role in review, investigation and managing incidents?

The Clinical manager of the area has responsibilities for managing follow-up after incidents, including review of the incident and team review, if applicable. Managers have login access to SLS that enables them to review incidents.

The managers’ page in SLS has features that are designed to assist with this.

> The manager is required to review the notifier’s report of the incident within 24-48 hours. Once this is done the managers changes the incident status from ‘holding area, waiting review’ to ‘being reviewed’
> If an incident is one of the nationally defined Sentinel events, it is always SAC1 and there are additional reporting requirements. Refer to your local Safety and Quality manager or Clinical Governance.
> Decide if a team review will be done
  o These are recommended for all SAC1 and SAC2 incidents, but other SAC 3 and 4 may benefit from team review.
  o What is a team review? A team review is somewhere between a ‘huddle’ and a ‘debrief’ (in TeamSTEPPS® terminology). That is, it is brief (5-10 minutes), fairly informal, and occurs when the team is most easily able to gather, and as soon as possible after the incident (ideally that day or the next). The inter-professional team reviews the incident with the consumer and carer if possible. Then a revised care plan is documented to address the patient’s risk and prevent further incidents. This is communicated through medical records and handover processes
> Record the outcome of any review or team investigation, or a team review into the manager’s page of SLS.

<table>
<thead>
<tr>
<th>What are the benefits of incident review?</th>
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<tbody>
<tr>
<td>Benefits to consumer</td>
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<tr>
<td>Benefits to team</td>
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<tr>
<td>Benefits to manager</td>
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For more information

Official Use Only I1-A1
SA Health
Safety and Quality Unit
11 Hindmarsh Square
Email: safetylearningsystem@sa.gov.au
Telephone: 08 8226 6539
www.sahealth.sa.gov.au/safetylearningsystem

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