From Incidents to Improvements



Something has gone wrong

• Refer to your local policies and procedures





• It is important to report all incidents and near misses as soon as possible

• The goal is to improve safety, not to assign blame



Ongoing system and service improvements

Improving the experience and outcomes for consumers, family, carers, staff and communities



What happens then?

• Leaders and quality team review and support ongoing process



Incident check-in



- Leaders will check-in with staff and offer support
- Identify who has been impacted $\textcircled{0} \rightarrow \textcircled{2} \rightarrow \textcircled{3} \rightarrow \textcircled{9}$
- Consider open disclosure process

Developed in partnership with:









Eastern Health









Learnings

- Develop a collaborative plan to implement learnings and recommendations
- Ongoing evaluation to ensure continuous improvement



Poster design & illustration by Monique Gabrielle Illustration

Close the loop

 Provide feedback to those involved in the incident; including consumer, family, carers, staff and stakeholders

Incident review

- Review panel may include independent panel members and other services
- Findings and recommendations for system improvements are made

Information gathering

 Conversations with people and services involved • Incident timeline developed



Northern Health









