	Department of Health Government of Nunavut	**NURSING POLICY, PROCEDURE AND PROTOCOLS** Community Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety Event - Incident Reporting and Immediate Management		Administration	05-034-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
All Department of Health Staff (Community Health Centre and Iqaluit Health Service Providers)			

1. BACKGROUND:

The Department of Health (Health) is committed to delivering safe and quality care for Nunavummiut. In addition to supporting client and family needs, timely notification, review, and management of harmful incidents are key activities to reducing preventable harm and improving quality of care for Nunavummiut.

Harm and errors in healthcare almost always occur due to complex system interactions involved in delivering care. Incident reporting is a **non-punitive** learning process which provides frontline staff with the ability to identify system and organizational constructs that may lead to undesirable outcomes. All staff play a critical role in identifying and reporting incidents and contributing to a learning culture to understand what happened, how and why it happened, and how it can be prevented from happening again.

2. POLICY:

2.1 It is the responsibility of all staff to report client safety incidents, including near misses, through the MEDITECH Quality and Risk Management (QRM) Module or downtime incident reporting process as soon as safely possible.

2.2 Immediate action will be taken to respond to client, visitor, and staff needs, and to prevent imminent recurrence.

2.3 All incident reports will be reviewed by the appropriate immediate supervisor within one (1) business day. The supervisor, and/or other relevant members of leadership, will:

- 2.3.1 Respond to any actionable items within a maximum of thirty (30) calendar days; and
- 2.3.1 Proactively address any ongoing concerns in collaboration with involved parties until all concerns have been addressed.

2.4 All client safety incidents categorized as severity level 5 and 6, or identified as never events, will receive additional notifications and actions as outlined in *Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis.*

2.5 Following review of an incident, learnings will be shared as appropriate with involved staff, other practice areas, and the organization.

3. PRINCIPLES:

3.1 This policy aligns with the following Inuit Qaujimajatuqarigit Principles:

i. *Tunnaganarniq*, fostering good spirits by being open, welcoming and inclusive;
ii. *Inuuqatigiitsiarniq*, respecting others, relationships and caring for people;
iii. *Piliriqatigiinniq*, working together for a common cause, and more specifically, for the health and safety of clients of the Department of Health;
iv. *Pilimmakasarniq/Pijariuqsarniq,* development of skills through practices, effort, and action.

3.2 Clients, visitors, and staff have the right to a safe environment in which to receive care, visit, and work.

3.3 Health actively supports a workplace environment rooted in just culture. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events. This includes:

3.3.1 Fostering an environment of support and safety for staff;
3.3.2 Ensuring that reports are reviewed in a non-judgmental, consistent, fair, and supportive manner, utilizing a systems-thinking approach; and
3.3.3 Supporting individual and organizational learning by providing the opportunity to discuss safety incidents, review contributing factors, and determine how to reduce the risk of recurrence.

3.4 Incident reporting is a non-punitive learning process that increases safety for clients, visitors, and staff, and informs quality improvement initiatives.

3.5 The Government of Nunavut (GN) has mandated responsibilities under the *Workers Safety and Compensation Commission Act* (WSCC) and the *Safety Act* for Nunavut to protect the health and safety of its clients, visitors, and staff.

4. DEFINITIONS:

Client: A person who receives health services.

Clinician: A person who provides health services for Health either as an employee or a contractor, including physicians. The term 'staff' is inclusive of clinicians in this policy.

Critical Incident: An unintended event or circumstance that occurs when a client's interaction with the health system results in severe harm or death and does not result primarily from the client's underlying medical condition, or from a known risk of treatment.

Harm: An unexpected or normally avoidable outcome that:

i. Negatively affects a client's health or quality of life;
ii. Occurs or occurred during the course of health care treatment; and
iii. Is not directly due to the client's underlying illness.

Harm implies impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, suffering, disability, and death. Harm may be physical, social, or psychological.

Immediate Supervisor: The staff member to whom you report (e.g., Supervisor of Health Centre (SHP), Regional Manager, or Director of Health Programs (Director)).

Incident: An unintended event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events.

Incident Report: A written report describing the factual elements of an incident. Incident reports provide valuable data that are used to identify local, regional, and territorial trends. Incident reports inform policy

and health system changes to improve client and staff safety. These reports are confidential and are not a part of the client's medical record nor the clinician's file.

Just Culture: An organizational approach which balances the need for staff to act safely with the responsibility of a responsive, safe system. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events.

Levels of Harm: See ***Appendix A: Patient Safety Incident Levels of Harm***.

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event.

Systems Thinking: An approach which focuses on the conditions under which people work (i.e., the system), rather than on the individual. Systems thinking in healthcare emphasizes that client safety incidents typically occur due to system failures.

5. PROCEDURE:

The following procedure applies to all incidents involving client care (severity level 1-6). See section 5.10 for other incident types. The order of procedural activities is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

See ***Appendix B: Policy Guides*** for quick reference guides separated by stakeholder group.

5.1 Immediate Response and Risk Management

5.1.1 Staff shall take immediate action to protect the health and safety of clients, visitors, and staff. This may involve:

i. Ensuring that the physical environment and situation are safe for clients and staff;

ii. Responding to the immediate needs of the client and family.

5.1.2 If imminent harm may reoccur, or if the incident imminently impacts the safety of others, staff shall take measures to reduce the risk of recurrence and other potential threats;

5.1.3 The immediate supervisor shall provide support to staff involved in the incident. Consider:

5.1.4 Providing a quiet, private place for communication and documentation to occur;

5.1.5 Arranging coverage of duties to provide involved staff with respite;

5.1.6 Arranging a debrief with mental health staff, or using Homewood services, for all facility staff directly or indirectly involved in the incident no later than 72 hours after the event:

i. Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142

5.1.7 Facilitating debriefing use ***Appendix C: Guiding Questions for Debriefing After Critical Incidents.***

5.2 Preservation of Evidence

5.2.1 Staff or the immediate supervisor shall remove, label, and secure any items involved in the incident or that may have contributed to the incident (e.g., biomedical equipment, packaging, medication, supplies) in a restricted location (e.g., supervisor's office), if possible. Items shall be secured until further instruction is provided.

5.2.2 If death has occurred, do not remove any items touching the client (e.g., dressings, lines) until instructed by the coroner to do so.

5.3 **Notification of Immediate Supervisor**

5.3.1 The most responsible health practitioner and supervisor shall be notified as soon as safely possible.

5.3.2 Depending on the level of harm, verbal notification is required in addition to automatic notifications. Submission of an incident report via the MEDITECH QRM Module will prompt automatic email notifications to the required stakeholders (see Table 1).

5.3.3 The date and time of all verbal notifications must be entered in the MEDITECH QRM Module.

Practice Point: Verbal or email notification is not a replacement for submitting an incident report in a timely manner. The incident report is what initiates the screening process for further incident analysis and is essential to maintaining the integrity of the process.

Table 1: Verbal and Automatic Notification Requirements

	Near Miss, No Harm, Mild Harm, Moderate Harm	**Severe Harm, Death, Never Events**
Verbal Stakeholder Notification Requirements	• Most responsible health practitioner • Immediate supervisor (to be notified by the staff member who witnessed or discovered the incident or their delegate)	• Most responsible health practitioner • Immediate supervisor (to be notified by the staff member who witnessed or discovered the incident or their delegate) • Director of Health Programs (to be notified by the immediate supervisor or their delegate) • Executive Director (to be notified by the Director or their delegate) • Assistant Deputy Minister, Operations (to be notified by the Executive Director or their delegate) • Others, as required (e.g., RCMP, Coroner, Mental Health Services, Department of Family Services (to be notified by the staff member who witnessed or discovered the incident, the immediate supervisor, or their delegate)
Automatic Stakeholder Notifications (sent upon submission of MEDITECH QRM Module Incident Report)	• Supervisor • Director of Health Programs	• Supervisor • Director of Health Programs • Executive Director of Health Programs • Assistant Deputy Ministry – Operations • Chief of Staff • Chief Nursing Officer • Manager, Continuous Quality Improvement Unit and/or Iqaluit Health Services (IHS) Quality Assurance and Risk Management Coordinator

The immediate supervisor is responsible for notifying Health IT (HealthIT@gov.nu.ca) when supervisory coverage changes to ensure appropriate access levels with the MEDITECH QRM Module and inclusion in the Manager's dictionary for referrals.

5.4 **Disclosure**

5.4.1 Staff and the immediate supervisor shall review the *Policy 05-035-00 Client Safety Event Disclosure Policy* prior to initiating disclosure.

5.4.2 The immediate supervisor shall ensure that disclosure is provided as soon as possible. Immediate disclosure to the client/family must include:

i. Information about the event (e.g., objective facts, known consequences to the client of the incident),

i. Information regarding next steps (e.g., urgent teleconference, incident analysis),

ii. The contact information of the immediate supervisor.

5.4.3 Disclosure may be ongoing if further information is discovered through the analysis of the safety incident.

5.5 **Documentation in Client Medical Record**

5.5.1 Staff shall document the facts and times of what occurred, including follow-up clinical actions, in the client's medical record as soon as safely possible and no later than the end of the shift. Documentation shall be objective, factual, concise, specific, and accurate.

5.5.2 Documentation may include: details of the event, clinical assessments, statements made by the client and/or caregiver(s), notification details, disclosure details, details of treatment provided, details of the client's response to treatment.

i. All discussions with the client and/or caregivers related to the incident shall be documented in the client's medical record.

5.5.3 Documentation may **not** include: subjective insights, opinions, assumptions, blame, accusatory language. Documentation in the client's medical record shall not reference the incident report.

5.5.4 If required, staff may augment the client's medical record with a retrospective summary. These must be entered as soon as possible and marked as a late entry.

5.5.5 Complete additional reports and forms as required (see Section 5.10 *Other Incidents)*.

5.6 **Reporting a Client Safety Incident**

5.6.1 All staff have a responsibility to report incidents and near misses for the purposes of learning and improving safety. Incident reports shall be factual and objective (see Table 2).

5.6.2 The staff member who witnessed or discovered the incident shall complete an incident report using the MEDITECH Quality and Risk Management (QRM) Module;

i. Contact healthcqi@gov.nu.ca or IHSquality@gov.nu.ca to learn how to submit an incident report;

ii. For incidents resulting in no harm, mild harm, or moderate harm, and for near misses, documentation shall be completed within 24 hours of occurrence.

iii. For incidents resulting in unexpected and/or unintended severe harm or death, and/or classified as a never event, documentation shall be completed within 12 hours of occurrence.

5.6.3 For staff who do not have access to the MEDITECH QRM Module, reporting responsibilities are assigned to the most responsible health practitioner or to the immediate supervisor of the individual who witnessed or discovered the incident.

5.6.4 If the MEDITECH QRM Module is not available before the end of the shift, the staff member who witnessed or discovered the incident shall complete a *Downtime Form* and provide to the immediate supervisor before the end of the shift.

i. The *Downtime Form* shall only be used when the *MEDITECH QRM Module* is not available or as a communication tool between the staff identifying the incident and the staff entering the report.

5.6.5 The *Downtime Form* must be transcribed into MEDITECH by the immediate supervisor or their delegate as soon as MEDITECH becomes available.

5.6.6 There are multiple ways to access the *Downtime Form*:

i. Microsoft Teams: GN-HEA-CNO-Nunavut Nurses Education > Health Continuous Quality Improvement Channel

ii. By email request: HealthCQI@gov.nu.ca or IHSQuality@gov.nu.ca

iii. Printed copies may be available in areas where staff are known to not have MEDITECH accounts

5.6.7 If more than one client is involved in or impacted by an incident, a report shall be completed for each client.

5.6.8 If non-patient factors (e.g., employee injury, damage to property) are involved, additional incident report(s) must be completed (see Section 5.10).

Table 2: Guide for Writing Incident Report 'Description of Event'

	Required	DO NOT Include:
Description of Event	• Relevant dates/times • Brief, factual description of event or circumstance • Outcome of event/circumstance • Assessment of client • Client's response	• Subjective insights or opinions • Assumptions • Speculation • Vague language • Accusatory language or blame

5.7 Immediate Management (For Immediate Supervisors and/or Directors)

5.7.1 Once notified of a safety incident, the immediate supervisor and Director are responsible for ensuring that appropriate incident management has occurred. This includes ensuring completion of procedural activities listed from 5.1 through 5.6.

5.7.2 If more than one area of care is involved, incident management shall be a collaborative effort between supervisors.

5.7.3 Additional responsibilities of the immediate supervisor and/or Director include:

i. Reviewing the facts of the incident and gathering relevant information to obtain a preliminary understanding of what occurred, including speaking with staff involved;

ii. Entering a referral to the appropriate supervisor(s) (e.g., SHP);

iii. Taking local action to prevent recurrence of a similar event;

iv. Documenting additional actions taken on the incident report;

v. Ensuring the level of harm entered in the MEDITECH QRM Module is accurate and adjusting if necessary;
    a. Contact HealthCQI or the Iqaluit Health Service (IHS) Quality Assurance and Risk Management Coordinator if assistance is required to determine and/or adjust the correct level of harm.

5.7.4 If an incident has resulted in unexpected and/or unintended severe harm or death, and/or is classified as a never event, further review is required.

5.7.5 See *Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis* for information, including preparation for an Urgent Teleconference.

5.8 **Sharing Learnings**

5.8.1 The immediate supervisor and/or Director is responsible for:

i. Sharing learnings with the client/family. Refer to the *Policy 05-033-00 Client Safety Event Disclosure*

ii. Providing feedback to staff whom reported the incident, including actions taken to prevent reoccurrence;

iii. Sharing learnings and actions taken with other areas/staff where a similar event could occur or with those whom are impacted by actions taken.

5.9 **Closing Incidents**

5.9.1 Depending on the level of harm, various stakeholders are responsible for closing incident reports through the MEDITECH QRM Module (see Table 3).

5.9.2 An incident report cannot be closed by the staff member who enters it; it must be referred to their immediate supervisor to be closed (e.g., if a SHP enters a report, it must be closed by their Director, even when it is a no harm incident).

5.9.3 Documentation by the immediate supervisor and/or Director must include: additional steps taken to provide support to client/family/staff, findings related to what happened and how it happened, actions taken to prevent recurrence;

5.9.4 Documentation must not include: speculation, blame, assumptions or opinions of the quality of care provided by healthcare practitioners.

Table 3: Documentation Requirements

	Near Miss, No Harm, Mild Harm, Moderate Harm	Severe Harm, Death, Never Events
Timeframe to Close (from the time incident report is submitted)	30 days	90 days
Closed By	Immediate supervisor of reporting staff	Director, Executive Director, HealthCQI or IHS Quality Assurance and Risk Management Coordinator

5.10 **Other Incidents**

Incident Type	Requirements
Employee Injury/ Workplace Violence	Complete Non-Patient Incident Report in the MEDITECH QRM Module; contact OH&S for more information
Incident Involving a Visitor	Complete Non-Patient Incident Report in the MEDITECH QRM Module

Breach of Client Privacy	Complete ATIPP Privacy Breach Report (available from the ATIPP Coordinator or HealthCQI@gov.nu.ca) and submit to the ATIPP Coordinator
Theft or Loss of Personal or Facility Property	Complete Non-Patient Incident Report in the MEDITECH QRM Module
Other	Complete additional forms, as required. Examples include: - Workers' Safety and Compensation Commission (WSCC) form - Report of Adverse Events Following Immunization Form - Maintenance Work Order - Biomedical Work Order

6. APPENDICES

APPENDIX A: PATIENT SAFETY INCIDENT LEVELS OF HARM
APPENDIX B: POLICY GUIDES
APPENDIX C: GUIDING QUESTIONS FOR DEBRIEFING AFTER CRITICAL INCIDENTS

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 05-033-00 Managing Nursing Practice and Professional Conduct
Policy 05-035-00 Client Safety Event Disclosure Policy
Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis
Workers Safety and Compensation Commission Act (WSCC) and the Safety Act for Nunavut

8. REFERENCES:

Alberta Health Services (n.d.) Immediate management checklist. Retrieved from https://www.patientsafetyinstitute.ca
Alberta Health Services (n.d.) Ongoing management checklist. Retrieved from https://www.patientsafetyinstitute.ca
St. Joseph's Healthcare Hamilton (2020, January). Safety Incident Reporting and Management – Patient and Visitor

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Appendix A: Patient Safety Incident Levels of Harm

Level of Harm	Patient Safety Incidents
1 – Near Miss	An incident that has potential for harm and is intercepted or corrected prior to reaching the patient.
2 – No Harm	Patient outcome is not symptomatic or no symptoms are detected and no treatment is required.
3 – Mild Harm	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review, or minor treatment) is required.
4 – Moderate Harm	Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure, additional therapeutic treatment, short term hospitalization for assessment and/or minor treatment in either ED or hospital unit), an increased length of stay, or causing minor permanent or long-term harm or loss of function.
5 – Severe Harm	Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention (e.g., prolonged hospitalization or admission to a high acuity setting such as an ICU), or shortening life expectancy or causing major permanent or long-term harm or loss of function.
6 – Death	On balance of probabilities, death was caused or brought forward in the short term by the incident.

SUPPORT TOOL ONLY – NOT PART OF CLIENT MEDICAL RECORD

The order below is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

Client Safety Event – Incident Reporting and Immediate Management

POLICY GUIDE A: FOR CARE PROVIDERS

Purpose: to provide an overview of actions to take in the immediate response to a safety incident

Intended Audience: the individual(s) who discover and/or respond to the incident (typically, the care provider)

IMMEDIATE RESPONSE

- **Ensure the physical environment and situation is safe** for clients and care providers
- **Provide support** to client(s)/ family involved (i.e., respond to physical and emotional needs)
- **Reduce the risk** of incident recurrence; remove potential threats to client, family, and staff
  - ASK YOURSELF - Is anyone else at risk of harm? Does this incident impact care or safety? What can we do to decrease the risk/harm and prevent recurrence?

PRESERVE EVIDENCE

- **Remove, label, and secure** equipment, packaging, medication and other hazards that may have contributed to the incident; store items in a restricted location
  - If death has occurred, do not remove any items touching the client until instructed by the Coroner to do so

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Immediate Supervisor ASAP

- Notify the most responsible health practitioner
- Notify immediate Supervisor
- Notify Coroner (if required)
- Notify RCMP (if required)

DISCLOSE

- In collaboration with the immediate supervisor, **initiate the disclosure process** as per the *Client Safety Event Disclosure Policy* (if required), and document details in the client's medical record:
  - Meeting date, time, place
  - With whom, by whom (roles and functions of all present)
  - Agreed upon treatment options

DOCUMENT

- **Document the FACTS and TIMES** of what occurred, including follow-up actions, in the client's medical record:
  - Details of what occurred
  - Notifications
  - Clinical assessments
  - Treatment provided and response

REPORT!

- **Complete an Incident Report** using the MEDITECH Quality and Risk Management (QRM) Module or Downtime Form as soon as safely possible. Include factual, objective information that is concise and specific.

POLICY GUIDE B: FOR IMMEDIATE SUPERVISORS

Purpose: to provide an overview of actions to take in the immediate and ongoing response to a safety incident

Intended Audience: the immediate Supervisor of the individual(s) who discovered and/or responded to the incident

ASSESS RESPONSE

- **Review and ensure** that all steps in Policy Guide A have been completed
  - Ensure that the immediate needs of clients/family/staff have been addressed
    - E.g., arrange a team debrief, facilitate peer support, arrange coverage duties
  - Ensure that items involved in the incident are removed and secured
  - Complete disclosure with the most responsible health practitioner, if required
  - Verify that documentation, including incident reporting, is complete and accurate
- ASK YOURSELF – Are there any further immediate actions required to decrease or mitigate risk/harm to the client and to others? Have we done everything that we can do to manage/mitigate the risk or harm and prevent recurrence?

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Director of Health Programs ASAP

- Notify the most responsible health practitioner
- Notify Director of Health Program (if required)
- Notify Coroner (if required)
- Notify RCMP (if required)

GATHER INFORMATION

- **Review the facts** of the incident and gather relevant information to obtain a preliminary understanding of what occurred
  - Client medical record
  - Incident report
  - Policies, procedures
  - Review environment
  - Examine objects/hazards
  - Speak with involved staff to understand what happened and how it happened

REVIEW

- If the incident requires an Urgent Teleconference, as determined by the CNO/COS, use the information gathered in the previous step to **develop a timeline of events**
- If the incident requires further review, participate as required

CLOSE THE LOOP

- **Close the loop** with staff who reported the incident
  - Thank staff for reporting and provide information regarding next steps
  - Ask if staff have any recommendations for improvement

DOCUMENT

- Review the level of harm entered in the MEDITECH QRM Module and adjust, if necessary
- Supplement documentation with additional actions, including ongoing disclosure discussions
- Close incident reports (severity level 0-4) through the MEDITECH QRM Module **within 30 days**

DISCLOSE

- Continue the disclosure process as per the **Client Safety Event Disclosure Policy**; ensure that the client/family is provided with information regarding next steps

The order below is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

Client Safety Event – Incident Reporting and Immediate Management; Client Safety Event – Screening for and Conducting Incident Analysis

POLICY GUIDE C: FOR DIRECTORS

Purpose: to provide an overview of actions to take in the ongoing response to a safety incident

Intended Audience: the Director of the individual(s) who discovered and/or responded to the incident

ASSESS RESPONSE

- **Review and ensure** that all steps in Policy Guides A and B have been completed
  - Ensure that the immediate needs of clients/family/staff have been addressed
    - E.g., arrange a team debrief, facilitate peer support, arrange coverage duties
  - Ensure that items involved in the incident are removed and secured
  - Complete disclosure with the most responsible health practitioner, if required
  - Verify that documentation, including incident reporting, is complete and accurate
- ASK YOURSELF – Are there any further immediate actions required to decrease or mitigate risk/harm to the client and to others? Have we done everything that we can do to manage/mitigate the risk or harm and prevent recurrence?

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Executive Director ASAP

- Notify Executive Director (if required)
- Notify internal (e.g., Pharmacy, Occupational Health and Safety)
- Notify external stakeholders, as required (e.g., mandated legislated reporting)

REVIEW

- If the incident requires an Urgent Teleconference, as determined by the CNO/COS, prepare by **reviewing the timeline and relevant documentation** (e.g., incident report)
- If the incident requires further review, participate as required

FOLLOW-UP

- **Follow-up** with owners of actions/ recommendations to monitor progress

SHARE

- In collaboration with the Quality Team, **share learnings** with involved staff members, and others, as appropriate

DOCUMENT

- Review the level of harm entered in the MEDITECH QRM module and adjust, if necessary
- Supplement documentation with any additional actions, including ongoing disclosure discussions
- Close incident reports (severity level 5-6, Never Event) through the MEDITECH QRM Module **within 90 days**

DISCLOSE

- Continue the disclosure process as per the **Client Safety Event Disclosure Policy**; ensure that the client/family is provided with information regarding next steps
- Share learnings with the client/family, as appropriate

APPENDIX C: Guiding Questions for Debriefing After Critical Incidents

When used after an unexpected death, resuscitation or other traumatic event, debriefing provides a safe forum for staff to **discuss and process** a recent traumatic event. Debriefing can be a formal or informal process to provide emotional and psychological support immediately following a traumatic event. This allows the team to identify opportunities for improvement in a non-threatening environment focused on **learning and improvement**.

Gather staff in a quiet space and consider the following guiding questions:

- **What went well?**
- **What did we learn?**
- **What would we do differently next time?**
- **What changes could be recommended to improve processes or performances?**

Upon completion of debriefing, identify additional supports for staff, including how to access them:
- Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142