Where can I get more information?

Contact your Quality and Patient Safety (QPS) colleagues/department.

Find guidance and other documents on our website – *https://www.hse.ie/eng/about/qavd/incident-management/*

HSE Employee assistance and counselling services – *https://www.hse.ie/eng/staff/workplacehthwellbng/stfsuprts/eacounsell/*

Contact Details

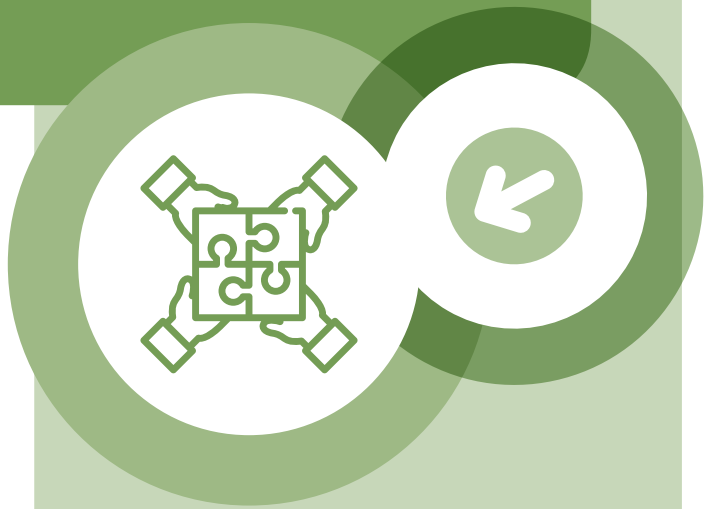
Name of Liaison Person:

Email:

Phone:

Incident Review

Staff Information Leaflet



Why do we review incidents?

Outcomes for those accessing services are generally good but despite our best efforts things sometimes do not go according to plan. When this happens, we need to find out what happened, how and why it happened so that we can make changes to minimise the risk of it happening again.

As the causes of incidents are rarely the fault of any individual staff member, incident reviews seek to understand the system of care and service delivery and by doing so identify factors that may have contributed to the incident occurring.

It is by understanding where system weaknesses exist that we can identify where improvements to safety can be made. The adoption of a systems approach to review is also critical in promoting a just and fair culture.

The aim of any incident review is to learn and improve safety in the system. To do this we need to review the incident to understand any systems weaknesses and the changes required to improve safety. As part of the process the Review Team will seek to engage with relevant staff either on an individual basis or as a group. This engagement allows the Review Team to consider the perspectives of staff in understanding what happened and why and what suggestions staff may have to reduce the risk of recurrence.

One of the reasons that things go wrong in health and social care services is that the system is complex, those we engage with are vulnerable and we are all human.

Using systems analysis to review safety incidents recognises that there are usually lots of factors that come together and contribute to an adverse outcome.

Changing and improving systems is more likely to make care safer than blaming the people that operate those systems.

What is expected of you?

Participation: to engage and co-operate with reviews conducted in line with the HSE Incident Management Framework.

What can you expect?

Respect: We will be open and honest with you and treat you with care and compassion.

A named contact: We will nominate a liaison person who you can contact to discuss the review process, your involvement in it, the supports available and answer any questions you may have. The liaison person will keep you informed throughout the process.

Fairness: The review will be conducted in line with fair procedures and natural justice.

Outcome: You will be made aware of the outcome of the review and any recommendations that are made.