Healing, learning and improving: A framework for collaborative responses to healthcare incidents in shared care services

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Acknowledgement

We honour the many Goori Tribal Nations on whose territories we work across South East Queensland (SEQ).

We honour the legacy and the vision of those who paved the way and those who continue to guide us.

We also pay homage to the Torres Strait Islander Nation who have walked this journey with us.

We honour our future generations by maintaining the vision with focused determination.

Contents

Definitions

In this framework:

- the terms *Aboriginal and Torres Strait Islander*, *First Nations*, and *Indigenous* are used interchangeably with respect towards the diversity of cultures and identities across SEQ
- *Hospital and Health Service (HHS)* is used as a collective term for Children's Health Queensland (CHQ), Gold Coast HHS, Metro North HHS, Metro South HHS and West Moreton HHS
- *partner organisation* is used as a collective term for the HHSs, Mater Misericordiae Ltd (Mater Health), the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) located in SEQ, the Queensland Ambulance Service (QAS), and the Primary Health Networks (PHNs) located in SEQ
- *IUIH Network Member Organisations* include:

    - Aboriginal and Torres Strait Islander Community Health Service Brisbane (ATSICHS Brisbane)
    - Kalwun Development Corporation (Kalwun)
    - Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS)
    - Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba)
- the term *mainstream* is used to describe an organisation/healthcare worker that provides services to the general population or a service or program that any eligible member of the Australian community may access
- the term *community controlled* refers to an organisation that delivers a model of Indigenous-led and Indigenous-specific health care operated by an Aboriginal and Torres Strait Islander non-government organisation
- the term *healthcare* is used broadly to describe any service or support provided by partner organisations for individuals, families and community (for example, primary care, allied health, family wellbeing, community liaison, specialist care)
- *Healthcare worker* refers to any member of staff in any clinic, program or service in the mainstream or community controlled sectors who has a role in planning, delivering, supporting and evaluating healthcare services for the communities we serve, including: clinical professionals (for example, GPs, nurses, pharmacists); client-facing support professionals (for example, community liaison officers, receptionists, transport officers, family wellbeing workers); and all other members of staff (for example, cleaners, managers)
- the term *healthcare incident* is used synonymously with the term 'clinical incident' but recognises that incidents in shared care services may involve broader healthcare services and supports, including those that address the social determinants of health and wellbeing, in addition to clinical services.

Background

The *South East Queensland First Nations Health Equity Strategy 2021-31* ('Regional Strategy') brings together the region's ATSICCHOs, HHSs, and PHNs, Mater Health and QAS, with the aim of accelerating the pace of health system reform in SEQ to close the health gap between First Nations people and other Queenslanders by 2031. The Regional Strategy was refreshed in June 2024 and is being implemented through a cooperative governance partnership, overseen by the SEQ First Nations Health Equity (FNHE) Governance Committee.

Clinical quality and safety and continuous quality improvement initiatives underpin the entire Regional Strategy; however, the SEQ FNHE Clinical Governance Sub-Committee is responsible for implementing particular priority reforms and actions that are specifically focused on access and ensuring quality health care (see Table 1).

Table 1. **SEQ FNHE Strategy key result areas, priority reforms and actions relevant to the Clinical Governance Sub-Committee**

Key Result Area (KRA)	Priority Reform	Action
KRA 2 – Access	Partnership & shared decision-making	Improve integration of care by investing in service models that strengthen coordination between primary and secondary care.
KRA 4 – Delivering Quality Healthcare		Implement *Healing, learning and improving: A framework for collaborative responses to healthcare incidents in shared care services*

Clinical governance

Clinical governance is a crucial component of corporate governance for all healthcare organisations. It ensures that all healthcare workers are accountable to clients, families and communities for ensuring that healthcare services are culturally responsive, safe, effective, integrated, high quality and continuously improving.[1] For Aboriginal and Torres Strait Islander clients, families and communities, clinical governance must incorporate:

- ***Community governance and accountability*** - accountability to clients, families and communities, with healthcare systems designed to ensure the voices of clients, families and communities are reflected in the way healthcare services are designed, delivered and continuously shaped and improved
- ***Aboriginal and Torres Strait Islander governance and leadership*** - governing boards, leadership and management work collectively to build and sustain organisational cultures and systems which promote integrity, authenticity, openness and reflection, ensuring health care is delivered within an Aboriginal and Torres Strait Islander Frame of Reference
- ***integration and coordination*** - healthcare systems strive to ensure healthcare journeys are culturally responsive, safe and of high quality for clients, families and communities, integrating and coordinating care as people move between providers, across health sectors and across the life course
- ***workforce capacity and competence*** - building, sustaining and valuing a skilled, competent and culturally responsive workforce, motivated by the common purpose of ensuring improved access to and experience of health services, equity in health outcomes and a culturally responsive health system free of institutional and interpersonal racism for Aboriginal and Torres Strait Islander people
- ***monitoring and evaluation*** - accountability for healthcare quality and safety is underpinned by innovative, robust and reliable systems for capturing and utilising health information for the purposes of understanding health needs, planning, building evidence and continually reflecting, revising and improving care.[2]

SEQ FNHE Clinical Governance Sub-Committee

The SEQ FNHE Clinical Governance Sub-Committee reports to the SEQ FNHE Governance Committee and brings together a diversity of knowledge and expertise from across the partner organisations to provide strategic oversight of shared systems underpinning quality and safety of health care for First Nations people in SEQ. The SEQ FNHE Clinical Governance Sub-Committee is responsible for:

- interrogating data across the whole health system to identify patterns of access to and uptake of care, including unwarranted variation in health and health care
- benchmarking and sharing knowledge about healthcare interventions and innovations
- strengthening systems of clinical governance across the interface of primary, secondary and tertiary care
- developing systems and structures to support a shared response to healthcare incidents and adverse events affecting clients as they transition between community, primary care and hospital care
- identifying opportunities, sharing knowledge and advancing implementation of shared models of healthcare delivery between community, primary care and hospital-based services.

Purpose

This framework has been developed to support a shared approach to the identification, reporting, review, and follow-up of healthcare incidents by partner organisations, with a focus on:

- **healing**, by taking a relational approach to understanding and addressing the needs of Indigenous people who are affected by a harmful event or experience, within an Aboriginal and Torres Strait Islander Frame of Reference[3]
- **learning**, through a positive, constructive, open, honest, and supportive process of working out how and why an incident occurred and what can be done to mitigate risk and to prevent future harm

[1] Australian Commission on Safety and Quality in Health Care. (2017). *National Model Clinical Governance Framework*. https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

[2] IUIH Network. (2024). IUIH Network Healthcare Quality and Safety Framework and Toolkit (internal IUIH Network document).

[3] Based on the concept of healing in relation to adverse events set out in *Healing, learning and improving from harm – Te whakaora, te ako me te whakapai ake i te kino* – New Zealand's national adverse events policy.

- **improving**, by using what is learned to improve the quality and safety of care and restore relationships with, and wellbeing for, those who have been harmed.

Definition of a healthcare (clinical) incident

This framework adopts a broad approach to the concept of a healthcare incident. For the purposes of this framework, a healthcare incident is defined in the same way as a 'clinical incident', but use of the term 'healthcare' reflects the broad, holistic nature of shared care services delivered by the partner organisations in SEQ. A healthcare incident is defined as: ***any harm and near miss event or circumstance that occurs, or has the potential to occur, to a client, family member, community member or healthcare worker because of, or related to, the provision of healthcare services.***[4] Healthcare incidents include, but are not limited to:

- near miss
- identification of a risk or hazard in the absence of harm
- harm caused in the course of a client being provided with healthcare services
- harm caused by omission to provide healthcare services which could have benefited a client
- failure to follow clinical and practice policies, guidelines and procedures (in the absence of harm or resulting in harm)
- failure to provide health care to a reasonable standard, with or without harm
- negative outcomes for clients and families that may not be directly associated with the provision of health care but could potentially be avoided by partner organisations exploring the operation of broader related systems and how they could be improved (for example, removal of a child from a family, an unexpected death not associated with health care, restrictions being placed on a client's access to services arising from behaviour that is perceived as challenging).

Harm

This framework recognises that harm in relation to healthcare incidents can take many forms, including physical injury, psychological distress, and impact on social and emotional wellbeing. Health care is a complex adaptive system, and therefore there are many potential contributors to harm that may arise for people accessing healthcare services, including system and organisational factors, technological factors, and human factors and behaviour.[5]

> ***"Healthcare harm is context specific, emergent, and is rarely intentional. Within complex adaptive health systems there is no single way to improve safety, enhance wellbeing, or respond to harm because the behaviour of the 'system' reflects the interconnections and interdependencies between people, organisations, policy, and other elements."***
>
> **The National Collaborative for Restorative Initiatives in Health. (2023). *He Maungarongo ki Nga Iwi: Envisioning a Restorative Health System in Aotearoa New Zealand.***

For Aboriginal and Torres Strait Islander people, harm may also arise from:

- inequity in access to and quality of health care
- experiences of racism, discrimination and bias
- previous traumatic experiences of interactions with the health system and other institutions leading to mistrust and reluctance to share information with healthcare providers
- discomfort with a Western model of health care and feelings of powerlessness, intimidation and uncertainty about the care being provided
- failure to consider and respect men's and women's business
- language and terminology barriers

[4] Australian Commission on Safety and Quality in Healthcare. (2021). *Incident Management Guide November 2021*. https://www.safetyandquality.gov.au/sites/default/files/2021-12/incident_management_guide_november_2021.pdf; Health Quality & Safety Commission New Zealand. (2023). *Healing, learning and improving from harm – Te whakaora, te ako me te whakapai ake i te kino* – New Zealand's national adverse events policy.
[5] World Health Organization. (September, 2023). *Patient safety*.

- lack of understanding and respect for cultural identity
- failure to consider the person's physical, social, emotional, cultural and spiritual needs holistically
- failure to include family, kin, community and other support networks (where this is welcomed and consented to by the individual).[6]

Compounded harm

In addition to direct harm from a healthcare incident, there is potential for 'compounded harm' for clients, families, friends, other supporters and healthcare workers, resulting from the response to that harm. People affected by a healthcare incident may be hurt and their relationships may be affected. Responses to healthcare incidents must ensure that wellbeing is restored and trust and relationships are rebuilt. "Compounded harm arises when these human considerations are not attended to, resulting in shame, contempt, betrayal, disempowerment, abandonment or unjustified blame, which can intensity over time."[7]

For Aboriginal and Torres Strait Islander people, the concept of 'shame' has a much broader meaning than the non-Indigenous use of this word. For Indigenous people, the meaning of shame can include deep feelings of embarrassment and discomfort in certain situations, often as a result of attention on the person (both positive and negative), feeling judged, or the environment (for example, being expected to speak about women's or men's business with someone of a different gender or sharing private information with a healthcare worker).[8] For Indigenous people who are involved in a healthcare incident, either as a client, family member, supporter or healthcare worker, shame may be a barrier to raising concerns and participating in the review process. It is crucial that cultural identity and practices are considered and respected to ensure that Aboriginal and Torres Strait Islander clients, families, supporters and healthcare workers feel comfortable and supported to engage with the healthcare incident review process.

Scope

This document is intended to provide a broad, shared framework for the management of healthcare incidents involving Aboriginal and Torres Strait Islander people, where care is shared across partner organisations. It aims to enhance consistency and cohesiveness of approach but with scope for individual services to develop specific protocols that meet local needs, are consistent with applicable legislation and all partner organisations' policies, guidelines and procedures for healthcare incident management, and draw on the principles of this broader framework.

Definition of shared care service

This framework adopts a definition of 'shared care service' which encompasses situations where an Indigenous person is cared for by healthcare workers from at least two partner organisations, in a context where care is delivered jointly within a single service or is coordinated between organisations in a systematic manner. Such situations include:

- Services where there is, or will be, an enduring, ongoing relationship between the partner organisations, with integrated care provided by all partners under one overarching 'label'. An example of this is the *Birthing in our Communities* (BioC) model, which provides comprehensive and culturally informed maternal and infant health and family wellbeing services by practitioners from ATSICCHOs, HHSs and Mater Health.
- Care coordination services for people who are transitioning from one service to another (for example, from hospital to the community), which involve intensive liaison and communication between partner organisations, but care is not provided jointly or concurrently. For example, *Mob Link*, which is a connector service that links Aboriginal and Torres Strait Islander people with care and support services.

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[6] Australian Commission on Safety and Quality in Health Care. (2017). *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health;* Jones, B., et al. (2020). Seldom heard voices: a meta-narrative systematic review of Aboriginal and Torres Strait Islander peoples healthcare experiences. *International Journal for Equity in Health, 19,* doi.org/10.1186/s12939-020-01334-w

[7] Wailing, J., et al. (2022). Humanizing harm: Using a restorative approach to heal and learn from adverse events. *Health Expectations, 25(4),* 1192-1199. https://doi.org/10.1111/hex.13478

[8] Jones, B., et al. (2020). Seldom heard voices: a meta-narrative systematic review of Aboriginal and Torres Strait Islander peoples healthcare experiences. *International Journal for Equity in Health, 19,* doi.org/10.1186/s12939-020-01334-w

- Other services where care is provided by healthcare workers from partner organisations co-located in ATSICCHO clinics or working in partnership with colleagues in the community controlled sector. For example, the *Urban Respiratory Outreach Program* and the *IUIH Network Social Health Service*.

Appendix A contains a schedule of services in SEQ currently identified as operating shared care models within the definition employed by this framework. This schedule will be updated on a six-monthly basis via the SEQ FNHE Clinical Governance Sub-Committee. It is expected that this framework will guide the response to and review of healthcare incidents arising in the services identified in this schedule.

This framework will include consideration of situations where initial review of a healthcare incident that occurs outside the services listed in Appendix A identifies the relevance of a shared care model and needs to evolve to incorporate a cross-organisational approach. This framework will also support joint reviews of healthcare incidents that occur outside the identified shared care services, but where shared care forms part of the client's overall healthcare journey and partner organisations agree that joint review is appropriate in the circumstances. Shared care in these situations may encompass situations "where there is joint responsibility for planned care that is agreed between healthcare providers, the patient and any carers they would like to engage."[9]

Principles

Health care provided in partnership, drawing on the knowledge, skills and resources of a range of organisations and healthcare workers, can extend the reach, impact and sustainability of health outcomes. Addressing complex issues in contemporary healthcare systems can benefit from collaboration and cooperation between organisations, working together with clients and their supporters, towards a shared goal.[10] The partner organisations are committed to the following principles in relation to the joint management of healthcare incidents arising in shared care models of service delivery:

- The management of healthcare incidents must be seamless from the client's perspective and respect their view of what happened, acknowledging that clients may not perceive that multiple organisations are involved in their care.
- Harm in relation to health care encompasses physical, psychosocial, cultural and spiritual harm, which may be identified and reported by any source, including healthcare workers, clients, families or community members.
- Responses to harm must incorporate both Safety-I and Safety-II approaches:
    - reactive, to respond to an event that has already occurred (Safety-I); and
    - proactive, to create open, trusting and transparent relationships that facilitate identification of potential harms and mitigate the risk of future harm (Safety-II).[11]
- Healthcare incidents may be identified at the time of occurrence or sometime after the event and may be identified through a range of sources, including but not limited to:
    - an organisation's internal risk management system (for example, RiskMan)
    - complaints
    - morbidity and mortality meetings
    - clinical governance and patient safety committees
    - media
    - concerns raised via community engagement
    - general yarns with clients and healthcare workers.
- The management of healthcare incidents in shared care services will be culturally responsive, recognising the centrality of culture to Aboriginal and Torres Strait Islander people's identity and working with clients and families to understand what is culturally safe for them.[12]

[9] Royal Australian College of General Practitioners. (February, 2023). *Shared Care Model between GP and non-GP specialists for complex chronic conditions – Position statement.* https://www.racgp.org.au/getmedia/e58af0d0-de01-4228-8064-468584f371be/Shared-Care-Model-between-GP-and-non-GP-specialists-for-complex-chronic-conditions.pdf.aspx

[10] Commission on Excellence and Innovation in Health. (January, 2023). *Building quality partnerships in the healthcare sector*. Government of South Australia.

[11] Hollnagel, E., et al. (2015). *From Safety-I to Safety-II: A White Paper.* The Resilient Health Care Net (University of Southern Denmark, University of Florida, Macquarie University). https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

[12] Indigenous Allied Health Australia. (2019). *Cultural Responsiveness in Action: A IAHA Framework*. Indigenous Allied Health Australia. https://iaha.com.au/wp-content/uploads/2020/08/IAHA_Cultural-Responsiveness_2019_FINAL_V5.pdf

- Processes for responding to and reviewing healthcare incidents will respect Aboriginal and Torres Strait Islander Ways of Seeing, Knowing, Doing, Belonging and Being, including:
    - primacy of Place, Identity and Autonomy as an organising principle
    - primacy of family
    - taking a non-hierarchical, relational approach with positive group dynamics, consensus decision-making, positive conflict management and maintenance of harmonious relations
    - relational, kind, compassionate responses when something unexpected happens
    - valuing the importance of relationships, connections, respect and reciprocity with each other
    - a sense of fellowship and inclusiveness towards all, recognising that identifying and responding to healthcare incidents is everybody's business
    - valuing, respecting and appreciating the capabilities of clients and families and their right to raise concerns about their care
    - recognition of the strengths of clients and their supporters and the interconnectedness of physical, social, emotional, political, psychological and spiritual factors in maintaining this strength.[13]
- Clients have a right to know when something unexpected has occurred in relation to their health care.
- Responses to healthcare incidents will be consistent with restorative just culture[14], incorporating the concepts of:
    - accountability – recognition of the harm caused to all parties, with a forward-looking accountability to come together to be part of a healing, learning and improvement process
    - identifying needs – collaboratively exploring the needs arising from the harms to all parties
    - meaningful apology – respectful dialogue, acknowledgement of responsibility and actions that address the needs of all involved
    - voice – listening with empathy to the client's and their supporters' experiences to find out what matters to them
    - reconciliation and forgiveness – upholding dignity and restoring relationships and wellbeing after harm has occurred.[15]
- Aboriginal and Torres Strait Islander people and healthcare workers in partner organisations will feel safe and supported to report healthcare incidents and make suggestions for improvements without fear of negative personal or community consequences.

Policy context

This framework draws on, and is consistent with, the following legislation, policies, frameworks and guidance in relation to healthcare incident management. This framework does not supersede existing legislative and policy requirements for HHSs, ATSICCHOs and other partner organisations.

International

- *Healing, learning and improving from harm – Te whakaora, te ako me te whakapai ake i te kino* (Health Quality & Safety Commission New Zealand)

National (Australian Commission on Safety and Quality in Health Care)

- *National Safety and Quality Health Service* (NSQHS) and *National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards* – Clinical Governance Standard
- *National Safety and Quality Mental Health Standards for Community Managed Organisations* – Practice Governance Standard
- *National Model Clinical Governance Framework*
- *National Safety and Quality Health Service Standards – User Guide for Aboriginal and Torres Strait Islander Health*
- *Incident management guide*

[13] IUIH. (2020). *The IUIH Cultural Integrity Investment Framework & The Ways Statement: Bringing Aboriginal Terms of Reference to consciousness and rebalancing our organisational stance and operations.*
[14] Dekker, S. (2018). *Restorative just culture checklist. https://www.safetydifferently.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist-1.pdf*
[15] Cook, K.J., & Powell, C. (2003). Unfinished business: Aboriginal reconciliation and restorative justice in Australia. *Contemporary Justice Review: Issues in Criminal, Social, and Restorative Justice, 6(3),* 279-291. https://doi.org/10.1080/1028258032000115912

- *Australian Open Disclosure Framework*

Queensland

- *Hospital and Health Boards Act 2011*
- *Hospital and Health Boards Regulation 2023*
- *Patient safety health service directive (QH-HSD-032:2014)*
- *Clinical incident management guideline (QH-HSDGDL-032-2)*
- *Best practice guide to clinical incident management* (Queensland Health)
- *Sad news, sorry business* (Queensland Health)

SEQ

IUIH Network

- IUIH Network Guideline – *Healing, learning and improving: responding to healthcare incidents*
- IUIH Network Healthcare Quality and Safety Framework and Toolkit

Children's Health Queensland

- Clinical incident management procedure (CHQ-PROC_00200)
- RCA processes at Children's Health Queensland procedure (CHQ-PROC_64417)
- Notification of critical incidents to the Chief Psychiatrist under section 305(2)(i) of the Mental Health Act (CHQ-PROC-50026)

Mater Health

- Clinical incident management – State-wide procedure

Metro South HHS

- Metro South Clinical incident management procedure

Metro North HHS

- Consumer feedback (compliments, complaints & suggestions) (003851)

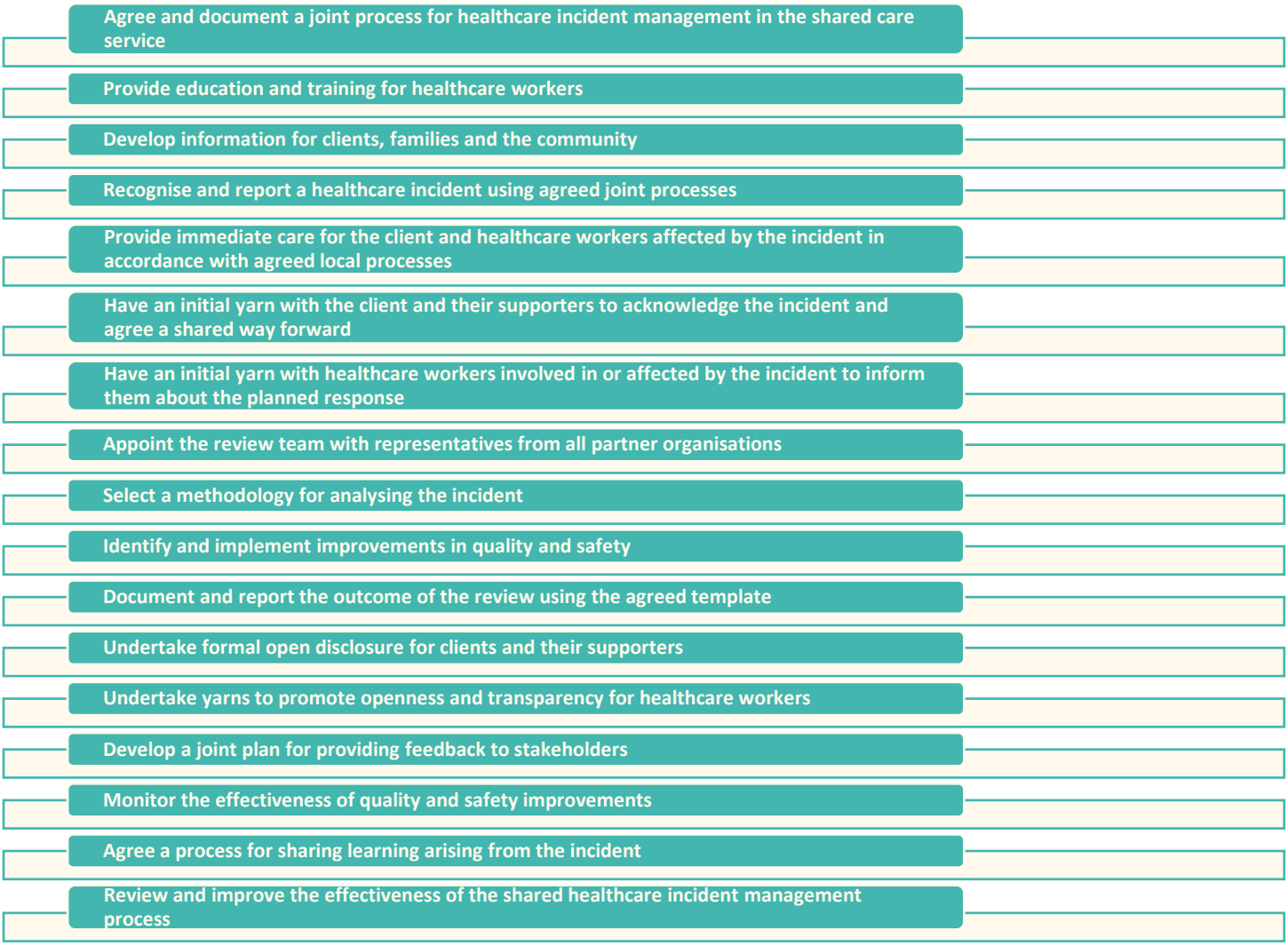
West Moreton HHS

- Clinical Incident Management Procedure (WMHHS2012030)
- Clinical Incident Triage Procedure (WMHHS2012085)
- Consumer Feedback Procedure (WMHHS2014112)
- A Just Culture Policy (WMHHS2015191)

Overview

Figure 1 provides an overview of the shared processes for responding to and reviewing healthcare incidents involving Aboriginal and Torres Strait Islander people in SEQ.

Figure 1. Outline of a shared process for healthcare incident management.



Shared processes for healthcare incident management

1. Embedding joint processes for healthcare incident management in shared care models

Aim

Planning of new shared care services and reviews of existing services will include consideration of how the partner organisations will share accountability for the management of healthcare incidents that occur in services that are jointly delivered or at the interface of services.

Criteria

1.1 A process for managing healthcare incidents will form part of initial agreements when shared care services involving joint delivery of care and/or systematised care coordination across partner organisations are established. Where shared care services are already in existence, processes for managing healthcare incidents will be included when agreements are reviewed and updated.

1.2 Where a shared care model is identified but does not involve a formal agreement or contract to jointly deliver care, Memoranda of Understanding (MOUs) may be used to document a shared process for managing healthcare incidents that occur at the interface between organisations and sharing information to support the response to, and review of, healthcare incidents.

1.3 Agreements (both formal and informal) regarding shared processes for managing healthcare incidents will include reference to applicable information sharing protocols across partner organisations and will outline processes to safeguard confidentiality and privacy and ensure data security.

1.4 Shared processes for the management of healthcare incidents will reflect the individual and collective requirements and obligations of all partner organisations, including legislative and organisation-specific obligations.

1.5 Where partner organisations conduct separate internal reviews of healthcare incidents, and the need for a joint review is identified, there will be agreement regarding timeframes and processes for such reviews.

2. Healthcare worker training and awareness

Aim

All healthcare workers involved in the planning, implementation, delivery and evaluation of a shared care service will be aware of and comply with the service's joint process for managing healthcare incidents.

Criteria

2.1 Healthcare workers will receive education that allows them to effectively carry out their individual and collective obligations in a shared healthcare incident management process, which will include:

- encouraging and embedding a restorative just culture of safety, comfort and support when responding to and reviewing healthcare incidents
- potential impacts of healthcare incidents on healthcare workers
- familiarity with the processes for healthcare incident management in the shared care model and the relevant partner organisations
- briefing on their likely and/or potential roles in healthcare incident management
- understanding that healthcare incident management involves reviewing systems rather than individuals
- training in the use of particular methodologies for the review of healthcare incidents (where relevant to the individual's role)
- cultural responsiveness for Aboriginal and Torres Strait Islander clients, families and colleagues with respect to healthcare incident management.

2.2 Opportunities for joint training and education on healthcare incident management for healthcare workers in identified shared care services are encouraged. This may include:

- partner organisations providing access to their in-house training programs and educational resources for healthcare workers from other organisations
- development of bespoke training programs and educational resources for particular shared care services.

2.3 Processes for managing healthcare incidents will clearly identify healthcare workers who have mandatory reporting responsibilities in relation to adverse events.

2.4 This framework will be supported by an implementation, education and training plan.

3. Information for clients

Aim

Clients of shared care services will be informed in a range of accessible ways about how to raise concerns and the process for managing healthcare incidents to ensure they are supported to work in partnership with providers to understand and learn from harm.

Criteria

3.1 Information about the service that is provided to clients will include information about:

- how to raise concerns
- the process for managing complaints and healthcare incidents, including notifying clients about this framework and how it can be accessed
- how clients and their supporters may be involved in the process of managing complaints and healthcare incidents, emphasising the prioritisation of client choice and preferences regarding involvement in the process
- how the outcome of a review will be communicated to the client and their supporters
- how the findings of reviews are used to inform service improvements.

3.2 The service will have a system in place for informing the local community about the service's process for managing complaints and healthcare incidents.

3.3 Information for clients and the community will be provided in a range of accessible ways that are appropriate to the shared care context and may include:

- information provided on referral to the service or program
- posters displayed in waiting areas or clinic rooms where shared care services are delivered
- on webpages or social media about the shared care service
- via local consumer groups
- yarns with clients and their supporters.

3.4 There will be a process in place to ensure that consent is sought to share the personal information of clients affected by healthcare incidents. The process for seeking consent will include:

- a clear explanation regarding the rationale for, and risks and benefits of sharing the client's personal information
- the organisation/s with which the client's personal information will be shared
- protocols in place for data protection and to ensure confidentiality and privacy and are upheld.

4. Recognising and reporting healthcare incidents

Aim

Clients and healthcare workers in shared care services will be supported to recognise and report concerns and healthcare incidents without negative personal consequences.

Criteria

4.1 Shared care services will ensure there are culturally safe and inclusive communication pathways and feedback mechanisms that reflect genuine partnership with clients and support Aboriginal and Torres Strait Islander people to tell the story of their healthcare journey, through which healthcare incidents may

be identified. Stories told by clients, their supporters, community members and healthcare workers will be listened to and accepted however and whenever they are told.

4.2 Shared care services will ensure that processes for recognising and reporting healthcare incidents are responsive and adapt to the needs of clients and their supporters, as far as is possible within applicable legislative and policy frameworks. This may include:

- waiting for a client to be ready to tell their story even if this is not at the time the incident occurred
- pausing the response process to allow the client and their supporters time to reflect and access support
- agreeing a 'check in' schedule with the client and their supporters if they do not feel ready to tell their story but may wish to do so in future.

4.3 All healthcare workers will be responsible for reporting incidents and raising concerns, regardless of how they became aware of an incident or concern.

4.4 Local protocols for managing healthcare incidents will identify the role/s within the shared care service that are responsible for receiving initial reports of an incident ('the responsible person').

4.5 The responsible person will work with the person who identified the incident to ensure that the incident is reported via the appropriate systems. This may include:

- identifying a lead organisation through which incident reporting will occur
- specifying that all partner organisations will report incidents through their internal processes
- identifying a bespoke process for reporting healthcare incidents that occur within the shared care service.

4.6 Where there is a need for mandatory reporting, local protocols should clearly identify the point at which partner organisations will be invited to participate in the healthcare incident management process.

4.7 Appendix B contains a tool to facilitate the recognition and reporting of healthcare incidents in shared care services.

5. Immediate care for the client, their support network and healthcare workers and risk minimisation

Aim

Clients and healthcare workers affected by incidents will receive timely, compassionate and culturally responsive care and any immediate risks will be mitigated.

Criteria

5.1 Local protocols for managing healthcare incidents will include a mechanism for identifying which partner organisation will be responsible for providing initial care for the client and their support network and implementing risk minimisation strategies. The partner organisation that is responsible for initial care and risk minimisation may depend on:

- the location where the incident occurred
- where the incident was reported and who reported the incident
- where the client was located at the time the incident was identified
- the client's and their supporters' preferences.

5.2 The client's and their supporters' views will be respected when identifying the most appropriate healthcare worker to provide initial care and support, recognising that this may not be the usual responsible person in the shared care service.

5.3 Healthcare workers who provide initial care and support for clients who have been harmed will be supported by service, program and cultural leaders from within the shared care service or appropriate external services.

5.4 When an incident is first identified, initial care and support for the client should include exploring whether they may be part of a shared care arrangement and identifying relevant partner organisations that the client and their support network may wish to be involved in providing immediate care and support.

5.5 When an incident is identified that is, or is likely to be, classified as a 'negative outcome for a client not directly associated with health care', such as a child removal or a client becoming homeless, broad consideration will be given to the immediate care and support provided to the client and their supporters to ensure that the client's healthcare and wellbeing needs are addressed holistically, including:

- prompt referral to support services, such as legal, housing and financial assistance services
- ensuring the client and their supporters are connected to the IUIH Network System of Care if they wish to be, for example by referring to Mob Link (1800 254 354)
- ensuring the client can continue to access culturally responsive healthcare services, even if this is via an alternative clinic, program, service or organisation
- ensuring the client has a culturally safe single point of contact, such as a Family Support Worker, Community Liaison Officer or Indigenous Health Worker, to walk alongside them and coordinate access to relevant services.

5.6 Healthcare workers involved in incidents will be offered immediate support, which may include:

- psychological first aid
- after-action review
- referral to employee assistance programs.

5.7 Clients and their supporters will be offered culturally responsive ongoing care and support throughout the process of responding to and reviewing the incident and following the conclusion of the review, in accordance with their preferences. This care and support may include:

- providing the client and their supporters with continuity of a single contact person throughout the process and following its conclusion, respecting the client and their supporters' preferences regarding the individual and organisation best placed to provide this support
- adapting support to meet the evolving needs of clients and their supporters as the review progresses
- involving cultural support networks
- consideration of whether a broader community response is required to facilitate healing.

6. Initial yarns with the client and their supporters

Aim

Clients have a right to know when something unexpected has occurred in relation to their health care and will be informed of incidents affecting them, including those where no harm was experienced, in a supportive and compassionate manner.

Criteria

6.1 There will be an initial, informal yarn with the client and their supporters and relevant healthcare workers to:

- acknowledge the incident
- apologise
- answer questions
- let the client and their supporters know the next steps in the review process
- invite the client and their supporters' ongoing participation in the review process and agree the nature and extent of this involvement
- inform the client and their supporters about the formal open disclosure process that may take place following the review process, depending on their choice and preferences
- agree a shared way forward.

6.2 All clients and families will have different preferences regarding how they wish to be involved in responses to incidents. Clients' wishes will be prioritised when planning responses to healthcare incidents and may include:

- wishing to raise a concern (anonymously or otherwise) but not wanting to be involved in the process of reviewing the incident or receive any feedback
- preferring to not be directly involved in the process of responding to an incident but happy to receive feedback on the outcome and learnings
- preferring to be represented by a family member, friend, carer or other supporter through the process
- wishing to be fully involved in all aspects of the process.

6.3. There may be circumstances where an initial yarn with the client and their family may not be appropriate. Such circumstances may include, but are not limited to:

- where information gathering suggests that informing the client of the incident may lead to harm or exacerbate existing harm
- where the client indicates they do not wish to be informed about or involved in the response to the incident
- where the client does not have decision-making capacity with respect to the process for responding to the incident and raising the incident with the client's substitute decision-maker, family, carers or other supporters may result in harm.

6.4 When deciding who will be responsible for having initial yarns with the client and their supporters and the process to be followed, cultural safety will be prioritised, including viewing the process through an Aboriginal and Torres Strait Islander Frame of Reference and considering the following issues:

- the client's and their supporters' preferences
- existing relationships of trust with particular healthcare workers
- language differences
- differences in principles and beliefs regarding health and other matters
- men's and women's business
- involving family and community
- previous experiences of racism, discrimination and bias when accessing health care
- trauma associated with colonisation, marginalisation, government policy and historical events
- where yarns will take place to ensure the client and their supporters are in an accessible, supportive, comfortable and safe environment.

6.5 The outcome of the initial yarns should be shared with all partner organisations, if representatives from all organisations were not involved. The tool at Appendix B may be used to facilitate sharing of this information.

7. Initial yarns with healthcare workers

Aim

Healthcare workers involved in or affected by an incident will be informed of the incident and the planned response at the earliest opportunity and receive culturally responsive care and support through the review process.

Criteria

7.1 As a general rule, the responsible person will have an initial yarn with healthcare workers involved in or affected by an incident. However, it may be appropriate for this responsibility to be delegated to another healthcare worker, considering:

- the preferences of healthcare workers involved in or affected by the incident
- the location of incident (for example, the region of SEQ, the clinic setting)
- the nature of the healthcare service where the incident occurred

- the relationships between the affected healthcare workers and those potentially responsible for the initial yarns (for example, it may be preferable for the initial yarn to be had with someone not directly involved in the relevant shared care service or outside the healthcare worker's line management structure).

7.2 Healthcare workers involved in an incident will be offered culturally responsive ongoing care and support throughout the process of reviewing the incident and following the conclusion of the review. This care and support may include:

- receiving feedback on the progress and outcome of the review, if appropriate and welcomed
- ongoing opportunities to access psychological support
- referral to employee assistance programs
- adjustments to work duties where appropriate
- involving cultural support networks
- consideration of whether a broader workforce response is required to facilitate healing.

8. Appoint the review team

Aim

The review team will include representatives from all partner organisations involved in the client's shared care arrangement, including representation from the Aboriginal and Torres Strait Islander community.

Criteria

8.1 The views of the client and their support network will be considered when convening the review team.

8.2 The review team will be co-led by representatives from all partner organisations involved in the shared care arrangement and will include Aboriginal and Torres Strait Islander representation, where this is the preference of the client and their supporters.

8.3 Cultural knowledge and embedding of Aboriginal and Torres Strait Islander Ways and Terms of Reference will be acknowledged as areas of expertise crucial to the review team, in the same way as other relevant expertise, such as clinical specialisms and knowledge of healthcare quality and safety principles and practices.

8.4 Appointment of the review team will take into account the client's perspective, in particular acknowledging the client's journey and that they may not be aware of organisational boundaries in their care. The review team should represent the client's entire cross-sectoral care pathway.

8.5 The client and their supporters will be offered the opportunity to yarn with the review team at the commencement of the review process and at agreed intervals throughout the process to give their perspective, tell their stories and contribute to the review.

8.6 The composition of the review team will be consistent with the required response to the incident and reflective of a collaborative response involving all relevant partner organisations. For example, a review team may involve:

- one representative from each partner organisation involved in the client's shared care arrangement, where only a brief review is required
- a panel of representatives drawn from all relevant partner organisations
- representatives from outside the partner organisations, where it is determined that the input of independent advisors is required
- representatives from clinical governance and/or patient quality and safety teams from relevant partner organisations
- Elders and community leaders, where appropriate.

9. Select a method for reviewing the incident

Aim

Healthcare incidents will be reviewed using the methodology appropriate to the context, acknowledging there may be legislative and other obligations that will influence selection of methodology.

Criteria

9.1 Where a partner organisation is required by legislation or other obligation to use a particular methodology for reviewing a healthcare incident, other partner organisations involved in the shared care model will agree to use the mandated methodology for joint analysis of the incident.

9.2 Where no legislative or other restrictions apply, partner organisations will agree on an appropriate methodology for analysing the healthcare incident, taking into account:

- the severity of the incident
- probability of recurrence
- complexity of factors that may have influenced the incident
- the client's preferences
- cultural safety for clients and staff
- the expertise of the review team.

9.3 Appendix C contains a non-exhaustive list of methodologies that may be used to analyse healthcare incidents being reviewed under this framework.

9.4 Irrespective of the method selected for reviewing the healthcare incident, all reviews will include specific consideration of whether or not racism, discrimination and/or bias contributed to the harm experienced by the client. In this context:

- ***Racism*** refers to "the process by which systems and policies, actions and attitudes create inequitable opportunities and outcomes for people based on race. Racism is more than just prejudice in thought or action. It occurs when this prejudice – whether individual or institutional – is accompanied by the power to discriminate against, oppress or limit the rights of others."[16] For Aboriginal and Torres Strait Islander people, the process of colonisation, and the beliefs that underpin it, continue to contribute to racism.
- ***Discrimination*** refers to the unjust and differential treatment of clients due to their Indigenous status and/or other personal characteristics at the individual level and the institutional level that has the effect of restricting opportunities. Discrimination is usually the behavioural manifestation of prejudice and may involve unfair, negative, hostile or injurious treatment.[17]
- ***Bias*** refers to attitudes towards, or perceptions about Aboriginal and Torres Strait Islander people that can lead to unfair outcomes and harm, particularly when it appears in organisations such as the healthcare system.[18]

9.5 Regardless of the method selected for review of the healthcare incident, the client and their supporters will be offered the opportunity to be involved in the review process in accordance with their preferences.

10. Identify and implement improvements in quality and safety

Aim

Improvements in quality and safety will be informed by, and meet the needs of, clients, their support network and healthcare workers involved in the incident.

Criteria

10.1 Clients who have experienced harm and their families will be supported to work in partnership with review teams to suggest improvements that will meet their needs, if they wish.

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[16] Australian Human Rights Commission. (2024). *What is racism?* https://humanrights.gov.au/our-work/race-discrimination/what-racism

[17] American Psychological Association. (2018). *APA Dictionary of Psychology*. https://dictionary.apa.org/

[18] Shirodkar, S. (2019). Bias against Indigenous Australians: Implicit association test results for Australia. *Journal of Australian Indigenous Issues, 22(3-4)*, https://search.informit.org/doi/10.3316/informit.150032703197478

10.2 Recommendations for improvements will be made in conjunction with relevant healthcare workers, including those involved in the incident and those directly responsible for implementing improvements.

10.3 Consideration will be given to whether improvements need to be implemented more broadly than just the shared care service where the healthcare incident occurred. This may occur via local clinical governance/patient safety committees and/or the SEQ FNHE Clinical Governance Sub-Committee.

11. Document and report the outcome of the healthcare incident review

Aim

The outcome of the healthcare incident review will be documented in a final report that outlines who was involved, the process of review, findings, and recommendations.

Criteria

11.1 Wherever possible, one report outlining joint findings and recommendations of all partner organisations will be produced, with the content and format agreed between organisations and the client.

11.2 Local processes for managing healthcare incidents will identify relevant senior members of staff in each partner organisation who will be responsible for endorsing joint reports.

11.3 Where it is neither possible nor preferable to produce one joint report, partner organisations will share their individual reports with each other, if the client consents and there are no legal restrictions to information sharing.[19]

11.4 Regardless of whether one joint report is produced, shared care services should develop and implement a mechanism for recording healthcare incidents that arise in their services, such as a deidentified service-specific register, and noting:

- how the incident was identified, using the categorisation system in the template at Appendix B; and
- the nature of the incident, using the categorisation system at Appendix D.

11.5 Deidentified service-specific healthcare incident registers may be shared with the SEQ FNHE Clinical Governance Sub-Committee to facilitate cross-sectoral, regional monitoring of incidents and inform quality improvement activities.

11.6 The client, their support network and relevant healthcare workers will have the opportunity to contribute throughout the review process, if they wish, and their contributions will be reflected in the final report. Draft reports should be shared with the client and their supporters before being finalised to ensure their views are accurately represented.

11.7 Clients, their families and other supporters will be asked about their preferences regarding how they wish to be referred to in reports and their preferences and cultural practices will be respected.

11.8 Reports will be written in an appropriate style to ensure they are accessible for clients and their support network. Checks for understanding will be undertaken when the draft report is shared with the client and their support network and amendments made as necessary to the final report.

[19] It is acknowledged that there may be rare situations where there are legal or other restrictions on the sharing of incident review reports and that in these situations, partner organisations will follow their organisational legal advice.

12. Formal open disclosure for clients and their supporters

Aim

Clients and their supporters will have the opportunity to openly and transparently consider and yarn about the outcome of an incident review with relevant healthcare workers and the review team in a respectful, empathetic, compassionate, and culturally responsive manner.

Criteria

12.1 Healthcare workers responsible for formal open disclosure will receive appropriate training via their employing organisation, which should include training in culturally responsive management of incidents. Opportunities for joint training and education are encouraged where appropriate.

12.2 When deciding who will be responsible for implementing formal open disclosure and the process to be followed, cultural safety will be prioritised, including viewing the process through an Aboriginal and Torres Strait Islander Frame of Reference and considering the following issues:

- preferences for communication previously expressed through initial yarns and the review processes
- language differences
- differences in principles and beliefs regarding health and other matters
- men's and women's business
- involving family and community
- previous experiences of racism and discrimination when accessing health care
- trauma associated with colonisation, marginalisation, government policy and historical events
- where yarns will take place to ensure the client, their supporters and healthcare workers are in an accessible, supportive, comfortable and safe environment.

12.3 Staff involved in the open disclosure process will receive culturally responsive support.

12.4 The client and their supporters' views should be considered when deciding who will be responsible for open disclosure.

12.5 The open disclosure yarn will be documented, including:

- topics discussed
- consensus reached
- any outstanding issues
- agreement regarding follow-up and next steps.

12.6 The documentation will be shared with all involved in the open disclosure yarn and everyone will have the opportunity to review and agree its content before it is finalised.

12.7 If open disclosure is not conducted jointly by representatives of all partner organisations (for example, this may be the client's preference), the documentation of the yarn should be shared with all partner organisations to ensure that everyone involved in the review of the healthcare incident is aware of what has been said to, and shared by, the client and their supporters. The client's and their supporters' consent should be sought to share the open disclosure documentation.

13. Openness and transparency for healthcare workers

Aim

Healthcare workers will have the opportunity to openly and transparently consider and yarn about the outcome of an incident review in a respectful, empathetic, compassionate and culturally responsive manner.

Criteria

13.1 Healthcare workers involved in, or affected by, an incident will have the opportunity to yarn about the incident and their experiences of being involved in the review and response process.

13.2 It is recognised that mechanisms to promote psychological safety, trust, care and support for healthcare workers will need to be adapted to suit the requirements of each situation and service. In general, opportunities for healthcare workers to yarn about their experiences of being involved in, or affected by incidents in shared care services should include:

- choice regarding the nature and extent of each healthcare worker's involvement in the process, for example offering the choice of individual or group yarns
- facilitation by representatives of each partner organisation who have received appropriate training
- clear expectations regarding confidentiality and ensuring psychological safety
- empathic and compassionate acknowledgement of the incident and the impact on healthcare workers
- saying sorry for harm experienced by healthcare workers
- opportunities for healthcare workers to tell their stories about what happened, including their experiences of being involved in the review of and response to the incident
- an explanation of the review process and its outcome, including any recommendations for improvements
- agreement regarding follow-up and next steps, including identifying the need for ongoing psychological support where required.[20]

13.3 The supportive yarn for healthcare workers will be documented and the documentation will be shared with all involved in the yarn and everyone will have the opportunity to review and agree its content before it is finalised.

14. Provide feedback to relevant stakeholders

Aim

There will be a shared process for providing feedback to all relevant stakeholders, highlighting learning and improvements following review of a healthcare incident.

Criteria

14.1 Those affected by the healthcare incident, including clients, their support networks and healthcare workers, will be consulted regarding how feedback will be shared with relevant stakeholders.

14.2 Depending on the nature of the healthcare incident, consideration may be given to providing feedback to the community, such as through local consumer groups. Feedback to community will be provided in consultation with the client, their support network, Elders and community leaders.

14.3 A joint plan for providing feedback to relevant stakeholders will be agreed by all partner organisations involved in the shared care arrangement, which will include:

- stakeholders who will receive feedback
- the form that feedback will take for each stakeholder, acknowledging this may be different to meet the needs of different stakeholders
- timeframe for provision of feedback
- representatives from partner organisations who will be involved in the provision of feedback
- consideration of how the client and their supporters wish to be involved in providing feedback
- forums for feedback to be disseminated
- any legislative or policy obligations that may impact on the nature of information that can be shared and method of sharing
- the information to be shared, taking account of any privacy and confidentiality requirements.

[20] Adapted from Health Service Executive Quality and Patient Safety Directorate (Ireland). (2013). *Supporting staff following an adverse event: The 'ASSIST ME' model.* https://www.lenus.ie/handle/10147/305964

15. Monitor and assess the effectiveness of actions taken to improve quality and safety

Aim

Actions taken to improve quality and safety will be monitored to determine their effectiveness and to ensure they meet the needs of clients and healthcare workers.

Criteria

15.1 Recommendations for improvements will have clear, measurable objectives that are capable of evaluation.

15.2 The views of healthcare workers involved in implementation of recommendations will be taken into account when evaluating effectiveness of improvements in quality and safety.

15.3 Where clients and their supporters have chosen to be involved in the review of the healthcare incident, their views, as well as the views of clients receiving services after improvements have been implemented, will be taken into account when evaluating effectiveness of improvements in quality and safety.

15.4 Partner organisations will agree how shared recommendations will be monitored and evaluated.

16. Share learning

Aim

Partner organisations will create opportunities to share learning and improvements from all levels of harm across organisational boundaries to minimise the risk of repeated harm.

Criteria

16.1 Partner organisations will agree the appropriate time for sharing learning from a healthcare incident. This may be:

- at the conclusion of the review
- following evaluation of the effectiveness of actions to improve quality and safety
- on a rolling basis with regular updates on key issues arising from the review.

16.2 Where a partner organisation wishes to share learning outside their organisation, for example, at training and education sessions, conferences or other external events, the agreement of other partners to the shared care service will be sought and will include consideration of privacy and confidentiality requirements and any organisational ethics governance processes.

17. Review and improve the effectiveness of the shared healthcare incident management process

Aim

Shared processes for healthcare incident management will be regularly reviewed by partner organisations to ensure they adhere to this framework and any improvements are identified and implemented.

Criteria

17.1 The final step in each healthcare incident review will be to evaluate the operation of the shared healthcare incident management process and identify any necessary improvements. A checklist to facilitate this review is at Appendix E.

17.2 Review of the shared healthcare incident management process will include the voices of clients, their supporters and healthcare workers in continuous improvement of the process.

17.3 When agreements between provider organisations are established and renewed, such agreements will include provisions to ensure that local joint processes for managing healthcare incidents are reviewed and updated as necessary.

17.4 Deidentified checklists documenting reviews of the shared healthcare incident management process may be shared with the SEQ FNHE Clinical Governance Sub-Committee to facilitate continuous improvement of the process.

17.5 The SEQ FNHE Clinical Governance Sub-Committee will review this framework annually, taking into account feedback provided by partner organisations, to ensure it remains fit-for-purpose.

Version control

Version control summary	Date	Author	Status
V 1.0	14/11/2024	SEQ First Nations Health Equity Clinical Incident Management Working Group	Draft for implementation in shared care services in SEQ

Appendix A – Schedule of Shared Care Services for Indigenous People in SEQ (updated November 2024)

Fully integrated shared care services

Service	Description	Shared care partner organisations	Length of operation
Birthing in our Community (BiOC)	BiOC delivers a unique model of maternity care that provides comprehensive and culturally informed maternal and infant health services for Aboriginal and Torres Strait Islander families, in a culturally appropriate community-based space.	IUIH, ATSICHS Brisbane, MATSICHS, Yulu-Burri-Ba, Mater Health, Metro South HHS, Metro North HHS, My Midwives	Since 2013

Systematised care coordination services

Service	Description	Shared care partner organisations	Length of operation
Adult post-operative rehabilitation	A multidisciplinary team providing a culturally capable alternative to hospital rehabilitation in: • post-operative orthopaedic surgery rehabilitation in the post-acute and hospital discharge phase • post-operative surgery rehabilitation for other surgical interventions.	IUIH, Metro North HHS	Since 2022
Hospital in the Home (HiTH)	This partnership aims to provide a culturally appropriate referral pathway for Aboriginal and Torres Strait Islander people, who are over-represented in hospital admission, hospital readmission and discharge against medical advice statistics but under-represented in existing HiTH programs.	MATSICHS, Metro North HHS	Since 2022
IUIH Cataract Surgery Pathway	This pathway has been specifically designed to embody IUIH's values of providing holistic primary care services with a continuum into tertiary care for Aboriginal and Torres Strait Islander people in SEQ.	IUIH, Metro South HHS, Mater Health, Infinite Vision	Since 2015

Service	Description	Shared care partner organisations	Length of operation
	The pathway begins when clients access IUIH's in-house optometrists for diagnosis and referral and is completed when the client returns to this point for post-operative care. Throughout the entire loop, IUIH staff provide wrap-around support and alleviate socio-economic barriers to care, such as transport and health literacy. The pathway involves a culturally safe process of explaining clinical information in a yarn-based format, assisting with hospital paperwork, attending hospital surgical days to liaise with surgical and hospital staff, and telehealth consultations following surgery until return to face-to-face care in the clinic.		
IUIH Regional Palliative Care Service	The IUIH Regional Palliative Care Service includes: • use of the Mob Link 1800 telephone service to connect Indigenous people in SEQ with information and advice about palliative care • supporting linkage and connection into palliative care services within the IUIH Network and other healthcare organisations • training and workforce support • establishing, strengthening and expanding linkages and partnerships with specialised palliative care services, including bed-based providers and palliative care specialist advice and care • peer support and supervision for IUIH Network generalist palliative care providers • development and collation of client and community resources.	IUIH and IUIH Network Member Organisations, Metro North HHS, Metro South HHS, Gold Coast HHS, West Moreton HHS, Mater Health, community and bed-based palliative care services (including hospices)	Since 2024
Mob Link	Mob Link provides Aboriginal and Torres Strait Islander people with advice, same-day clinical care, short-term intensive transition care and support and	IUIH, IUIH Network Member Organisations, Queensland Health, Queensland Ambulance Service, Queensland Police Service	Since 2021

Service	Description	Shared care partner organisations	Length of operation
	connection to a variety of health and social services, via a 1800 telephone number, operating 7am-7pm, 7 days per week.		
Open Doors Surgical Pathway	Aims to develop a culturally safe, seamless pathway between IUIH and CHQ models of care for Aboriginal and Torres Strait Islander children and young people to access specialist ENT and eye clinics.	IUIH, CHQ	Since 2021
Cardiac and pulmonary rehabilitation	Multidisciplinary teams providing specialised cardiac and pulmonary rehabilitation for Indigenous people not currently accessing treatment or who commence rehabilitation in a hospital and could transition to IUIH. This model of care provides an initial assessment, an 8-week rehabilitation program and ongoing support from the IUIH Work It Out program.	IUIH, Metro North HHS, Metro South HHS, West Moreton HHS, Gold Coast HHS	Since 2023
Direct referral agreement between Metro South HHS (Bayside Acute Care Service) and Yulu-Burri-Ba	An agreement is in place to support direct referrals from Yulu-Burri-Ba staff to the Bayside Acute Care Service for clients experiencing acute mental health concerns.	YBB, Metro South HHS	Since 2023
Staying Deadly Mental Health Hubs	The Staying Deadly Mental Health Hubs incorporate a lived experience-led assertive outreach team as part of an integrated multidisciplinary mental health and alcohol and other drugs team to support Indigenous people aged 15 years and over with moderate to severe mental health needs, who are at risk of entering the acute care system if their symptoms are unmanaged or who are stepping down from an inpatient episode of care to ensure they are well supported in the community and their risk of relapse is minimised. The Staying Deadly Hubs are embedded within the IUIH System of Care that provide a suite of wrap around services addressing	IUIH, ATSICHS Brisbane, West Moreton HHS, Metro North HHS, Metro South HHS	Since 2023

Service	Description	Shared care partner organisations	Length of operation
	the social determinants of health. There are currently two Staying Deadly Mental Health Hubs located in the Ipswich Region and Inner City (Brisbane).		
Cancer services	This initiative will coordinate cancer screening and diagnostic services for First Nations women in a culturally safe environment. Bringing together HHS mobile breast cancer screening infrastructure and cervical cancer screening provided through IUIH Network clinics, supplemented and supported by visiting HHS gynaecological services into IUIH Network clinics, the model will integrate cancer screening and diagnostic services into IUIH's System of Care in four locations across SEQ (South Brisbane, Gold Coast, Moreton Bay and West Moreton).	IUIH and IUIH Network Member Organisations, Metro North HHS, Metro South HHS, Gold Coast HHS and West Moreton HHS	Since 2023
Child health	ATSICHS Brisbane and CHQ have a shared care model for child health where a child health nurse from CHQ attends ATSICHS Brisbane clinics at Woolloongabba and Logan Central weekly to undertake health checks and consultations for children aged 0-4 years. An ATSICHS Brisbane GP or registered nurse then sees the child to complete the health check and carry out immunisations if required.	ATSICHS Brisbane, CHQ	Since 2020
Child and Youth Mental Health Shared Care	A CHQ Child and Youth Mental Health Service consultant provides face-to-face visits in two locations (Goodna and Woolloongabba), with a combination of telehealth and virtual case discussions with GPs and other providers available to the whole IUIH Network at other times. This has worked well in beginning to meet the needs of children and young people with complex mental health needs.	IUIH and IUIH Network Member Organisations, CHQ	Since 2023

Service	Description	Shared care partner organisations	Length of operation
Deadly Feet	A specialist outreach service for Aboriginal and Torres Strait Islander people, providing culturally responsive care closer to home for people diagnosed with, or at risk of, foot conditions related to diabetes and/or peripheral vascular disease.	IUIH, MATSICHS, Metro North HHS	Since 2023
HOPE – Health Outreach Program for Health Equity	This service aims to improve heart health for Aboriginal and Torres Strait Islander people by providing specialist cardiology outpatient services at IUIH clinics. Clients who attend HOPE clinics have access to specialist cardiac investigations, such as ECG, holter and echo services, and see a specialist cardiology physician.	MATSICH, Metro North HHS	Since 2023
IUIH Regional Allied Health Service	IUIH provides a suite of allied health services including audiology, diabetes education, dietetics, exercise physiology, occupational therapy, optometry, podiatry, physiotherapy, pharmacy, and speech pathology. Fully integrated into clinics, IUIH and its member organisations can access specialist allied health services to support core teams to deliver coordinated and timely health care.	IUIH and IUIH Network Member Organisations	Since 2011
IUIH Regional Oral Health Service	Provides community-based preventative and procedural dental services to Aboriginal and Torres Strait Islander people through the IUIH Network's clinics. Embedded in the IUIH System of Care, the IUIH Network dental services also expose clients to a range of medical, allied health and social support services provided via IUIH's no-wrong-door and 'one-stop-shop' approach to service delivery.	IUIH and IUIH Network Member Organisations, Queensland Health, Gold Coast HHS	Since 2011
IUIH Regional Social Health Service	IUIH's Social Health Service includes: • crisis intervention, support and opportunistic engagement • referrals and warm handover to internal and external services as required	IUIH and IUIH Network Member Organisations	Since 2009

Service	Description	Shared care partner organisations	Length of operation
	• team care and family centred care planning • advocacy services and social support to access housing, crisis accommodation, domestic and family violence services and Centrelink • social health care coordination • transition care planning for people in prison, including pre-release planning and post-release community-based support and connection to healthcare • therapeutic modalities ranging from brief intervention to specialised care • alcohol and other drugs counselling and support • paediatric psychological assessments and provision of paediatric medical and allied health services • intensive case management • assertive outreach services • psychiatry, psychology and counselling services.		
Mob ED	Healthcare workers employed by IUIH are based within CHQ to collaborate with CHQ staff and develop integrated paediatric service delivery models across primary and tertiary healthcare sectors. This role is directly supported by Mob Link, to connect care for Aboriginal and Torres Strait Islander people transitioning either to or from tertiary care to community controlled health care.	IUIH, CHQ	Since 2021
Paediatric specialist and allied health services	IUIH provides a range of specialist medical and allied health paediatric services throughout SEQ, which includes paediatricians, paediatric nurse coordinators, speech pathologists and occupational therapists. One avenue of service is through the Multidisciplinary Team (MDT) Assessment Clinic. The MDT provides a multidisciplinary mode of	IUIH and IUIH Network Member Organisations, CHQ	Since 2011

Service	Description	Shared care partner organisations	Length of operation
	assessment, diagnosis and care planning for children presenting with development concerns.		
Pain management program	Interdisciplinary community-based pain services, providing comprehensive assessments, evidence-based treatments and education for Aboriginal and Torres Strait Islander people living in the North Brisbane region. The partnership approach between MNHHS Specialist and Allied Health providers, and IUIH/MATSICHS Allied, Social and Primary health providers, delivered in a community-based setting, offers a collaborative model of comprehensive care to holistically address the needs of Aboriginal and Torres Strait Islander people with persistent pain.	IUIH, MATSICHS and Metro North HHS	Since 2023
Urban Respiratory Outreach Program (UROC)	UROC provides specialist respiratory outreach clinics to Aboriginal and Torres Strait Islander adults in a culturally safe and respectful environment. A clinical team comprising a respiratory specialist, respiratory scientist and administrative officer attend MATSICHS clinics to provide a specialist respiratory service clinic. Clients are connected to IUIH rehabilitation and exercise programs for ongoing management through an integrated pulmonary rehabilitation pathway.	IUIH, MATSICHS, Metro North HHS	Since 2022
Women's Business gynaecology pathway	The Women's Business pathway provides specialist gynaecology clinics delivered by gynaecology consultants from Metro North HHS in MATSICHS clinics and associated dedicated surgical lists.	IUIH, MATSICHS, Metro North HHS	Since 2023

Appendix B – Tool to facilitate identification and reporting of healthcare incidents in shared care services

Guidelines for use

- The overarching purpose of this tool is to provide guidance for healthcare workers in shared care services when an incident is identified.
- This tool is not intended to provide a template for comprehensive documentation of incidents arising in shared care services or to replace organisation-specific documentation, but rather to guide the process, especially in relation to steps where cross-organisational work in this area may be unfamiliar for healthcare workers.
- This tool is intended to provide a template that can be customised to meet the needs of individual services.

Service Name:				
Partner organisations:				
Contacts for healthcare incidents in each partner organisation:	*Organisation*	*Name*	*Role*	*Email/phone*

1. Identification of the healthcare incident
For completion by the person who identified the incident

Name of person who identified the incident (optional):	
Role (optional):	
Employing organisation:	
Date:	
Location:	
How was the incident identified?	☐ Directly observed by the reporter ☐ Reported by a healthcare worker not directly involved in the incident ☐ Clinical governance/patient safety committee ☐ Morbidity and mortality meeting ☐ Reported by client ☐ Reported by a client's family member or supporter ☐ Reported by community member ☐ Media ☐ Correspondence from a politician (e.g., Minister or MP) ☐ Ahpra ☐ Office of the Health Ombudsman (OHO) ☐ Reported by an external healthcare organisation ☐ Complaint from client/family member/supporter ☐ Review of healthcare record ☐ Other (please specify): _____

2. Initial response
For completion by the person who identified the incident

2.1 Briefly summarise what happened.

2.2 Describe immediate actions taken to support the client and their supporters (e.g., care provided, first aid, removal of faulty equipment, ambulance called).

2.3 Describe the immediate actions taken to support healthcare workers involved in the incident.

3. Notification to responsible person
For completion by the person who identified the incident

3.1 Notify the responsible person in your organisation or their delegate (see above).

Name of responsible person (see above):	
Date/time notified:	

4. Initial rating of incident severity

For completion by the responsible person in the organisation where the incident was identified

4.1 If there is sufficient information available, provide an initial rating of severity for this incident.

☐	**SAC 1 - Serious harm or death (which is not reasonably expected as an outcome of health care)** • major permanent loss of physical function • significant disfigurement • major psychological injury • reportable events.[1]
☐	**SAC 2 - Moderate harm (which is not reasonably expected as an outcome of health care)** • significant reduction in bodily functioning or psychological injury • lost time in work and/or social functioning • restricted duties • cultural or spiritual harm that impacts on access to health care services.
☐	**SAC 3 - Minimal harm (which is not reasonably expected as an outcome of health care)** • temporary need for increased level of care, including review or evaluation (for physical and/or psychological injury) • additional or repeated clinical investigations required • referral to another healthcare worker/service • cultural or spiritual harm • client/supporter distress • client/supporter raises concerns about their care.
☐	**SAC 4 - No harm or near miss** • something unexpected has occurred in relation to the client's health care that has not caused harm • an unsafe situation is identified that could have resulted in harm to the client and/or their supporters but did not.

5. Initial classification of the nature/type of incident

For completion by the responsible person in the organisation where the incident was identified

5.1 If there is sufficient information available, please indicate the nature/type of incident using the classification system at Appendix E.

	Category	Sub-classification
☐	**Client access**	Choose an item.
☐	**Communication between healthcare providers and client**	Choose an item.
☐	**Communication of information between healthcare settings**	Choose an item.
☐	**Referral**	Choose an item.
☐	**Assessment and diagnosis**	Choose an item.
☐	**Investigations**	Choose an item.
☐	**Vaccines**	Choose an item.
☐	**Medications**	Choose an item.
☐	**Treatment, therapy or other care (not medication or vaccine related)**	Choose an item.
☐	**Equipment and environment**	Choose an item.
☐	**Negative outcomes for clients not directly associated with health care**	Choose an item.
☐	**Racism, discrimination and bias**	Choose an item.

6. Notification to partner organisation/s

For completion by the responsible person in the organisation where the incident was identified

6.1 Notify the responsible person/people in the relevant partner organisations.

Partner organisations	Responsible person/s	Person/s notified	Date/time notified

7. External notifications

For completion by the responsible person in the organisation where the incident was identified

7.1 Consider whether early notification of other people or entities is required, such as:

☐	Not applicable
☐	Coroner (all deaths related to health care)
☐	Organisation's insurer
☐	Healthcare workers' indemnity provider
☐	Ahpra
☐	Office of the Health Ombudsman
☐	Office of the Information Commissioner (Queensland and/or Australian)
☐	Media / press release
☐	Other: _____

8. Initial yarns with the client and family

For completion by the person responsible for initial yarns with the client and family in the organisation where the incident was identified

Date:			
Attendees:	*Name*	*Role/Relationship*	
Topics:	☐	Incident acknowledged and an apology provided.	
	☐	Opportunity provided for the client and their supporters to tell their story, yarn about their experience and explain how the incident has affected them (if they wish to do so).	
	☐	Yarn about follow-up care, including reassurance about the client's access to ongoing care, emotional, cultural, and psychological support and specific actions to be taken to rectify the incident and support healing and restoration of relationships.	
	☐	Client and their supporters advised about the healthcare incident review process, formal open disclosure and next steps.	
	☐	Client and their supporters wishes determined regarding how they wish to be involved in the response to the incident.	
	☐	Outcome of initial yarns shared with all partner organisations (if the client and their supporters consent).	
	☐	Other: _____	
Meeting notes:			

9. Initial yarns with healthcare workers

For completion by the person responsible for initial yarns with healthcare workers in the organisation where the incident was identified

Date:			
Attendees:	*Name*	*Role/Relationship*	
Topics:	☐	Incident acknowledged and an apology provided.	
	☐	Opportunity provided for healthcare workers to tell their stories, yarn about their experiences and explain how the incident has affected them (if they wish to do so).	
	☐	Yarn about follow-up care and support that can be provided.	
	☐	Healthcare workers advised about the healthcare incident review process, formal open disclosure and next steps.	
	☐	Healthcare workers' wishes determined regarding how they wish to be involved in the response to the incident.	
	☐	Outcome of initial yarns shared with all partner organisations (if healthcare workers consent).	
	☐	Other: _____	
Meeting notes:			

10. Review
For completion by the review lead for the organisation where the incident was identified

10.1 Will this incident be jointly reviewed by all partner organisations?

☐	Yes (go to 9.2)
☐	No Provide reasons: _____ _____ _____

10.2 Specify the review team.

Organisation	Name	Role

10.3 Agree the method for reviewing the incident.

Method	Rationale

11. Reporting
For completion by the review lead for the organisation where the incident was identified

11.1 Will a joint or individual organisation reports be produced?

☐	Joint report
☐	Individual organisation reports
☐	Both joint and individual reports
Provide reasons for this choice:	

12. Formal open disclosure for clients and their supporters
For completion by the review lead for the organisation where the incident was identified

12.1 Summarise the process for formal open disclosure

Actions:	☐	Open disclosure facilitator identified. Name: _____ Role: _____
	☐	Yarn arranged in line with client and supporters' preferences. Date: _____
	☐	Documentation of the open disclosure yarn shared with all participants.
	☐	Documentation finalised and incorporates feedback from all participants.
	☐	If all partner organisations were not involved in the formal open disclosure process, finalised documentation shared with all partner organisations (if consented to by the client and their supporters).
	☐	Other: _____
Meeting notes:		

13. Openness and transparency for healthcare workers
For completion by the review lead for the organisation where the incident was identified

13.1 Summarise the process for promoting psychological safety, trust, care and support for healthcare workers

Actions:	☐	Facilitator identified. Name: _____ Role: _____
	☐	Yarn arranged in line with healthcare workers' preferences. Date: _____
	☐	Documentation of the yarn shared with all participants.
	☐	Documentation finalised and incorporates feedback from all participants.
	☐	Ongoing psychological support arranged for relevant healthcare workers.
	☐	Other: _____
Meeting notes:		

14. Feedback to relevant stakeholders
For completion by the review lead for the organisation where the incident was identified

14.1 Agree how feedback will be provided to relevant stakeholders

Stakeholder	Method of feedback	Responsible person/s and organisation/s	Date feedback provided
Workforce			
Community			
Partner organisations			
Others (add rows as necessary)			

15. Sharing learning
For completion by the review lead for the organisation where the incident was identified

15.1 Agree a plan for sharing learning arising from review of this incident.

Forum	Method	Responsible person/s and organisation/s	Timescale (e.g., anticipated date, rolling updates)
Local training/education events			
Conference			
Others (add rows as necessary)			

16. Review the shared healthcare incident management process
For completion by the review lead for the organisation where the incident was identified

16.1 Use the 'Checklist for reviewing a shared process for healthcare incident management' at Appendix E of *Healing, learning and improving: A framework for collaborative responses to healthcare incidents in shared care services* to review the effectiveness of the shared process and identify any learning and improvements.

Date:			
People involved:	*Organisation*	*Name*	*Role*
Learning/improvements:			
Mechanisms for feedback (e.g., local clinical governance committees, SEQ FNHE Clinical Governance Sub-Committee):			

Appendix C – Examples of methodologies for the analysis of healthcare incidents arising in shared care services

Methodology	Description
System Engineering Initiative for Patient Safety (SEIPS)	SEIPS considers how a work system (external environment, organisation, internal environment, tools and technology, tasks and persons) can influence processes which in turn shape outcomes. SEIPS can be used as a method for informing system design as well as learning and improving following a healthcare incident.[22]
London Protocol	Identifies problems in the care delivery process and any contributory factors present at the time of the healthcare incident by chronological mapping of the event.[23]
Cause and Effect Diagram (Fishbone Diagram / Ishikawa Diagram)	Provides a pictorial display of possible causes of a problem or problems. The problem or outcome is displayed at the head or mouth of the fish and possible contributing causes are represented as smaller 'bones' under various categories.
Failure Modes and Effects Analysis (FMEA)	A proactive approach to analysis of a process in which harm may occur, which investigates steps in the process, failure modes (what could go wrong), failure causes (why would the failure occur), and failure effects (what would be the consequences of each failure).[24]
Human Error and Patient Safety (HEAPS)	A proactive approach used to identify patient factors, task factors, practitioner factors, team factors, workplace factors and organisational factors that may lead to harm or have contributed to a healthcare incident (can only be used under licence from the developer and following training in its use).[25]
Healthcare Record Review	May be used where problems with communication and documentation may have contributed to an adverse event or used proactively to ensure that healthcare records are complete and accurate and adhere to relevant standards.
Five Whys	Involves repeatedly asking 'why' and allows for layers of an incident to be explored and the root cause identified. Five Whys may be used independently or as part of an RCA.[26]
Root Cause Analysis (RCA)	A comprehensive and systematic methodology to identify failures in healthcare systems and processes that may not be immediately apparent and may have contributed to an adverse event.

[22] NHS England. (August 2022). *SEIPS quick reference guide and work system explorer.* https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf

[23]Clinical Excellence Commission. (2020). Serious Adverse Event Review: System analysis of clinical incidents – London Protocol (2nd edition) toolkit. NSW Government.
https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/606746/London-Protocol-Toolkit.pdf

[24]Clinical Excellence Commission. (undated). *Failure Modes and Effects Analysis.* NSW Government. https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/failure-modes-and-effects-analysis

[25]Department of Health. (2011). Clinical incident management toolkit. Government of Western Australia.
https://www.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Trauma/PDF/cims_toolkit.pdf

[26]Department of Health. (2011). Clinical incident management toolkit. Government of Western Australia.
https://www.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Trauma/PDF/cims_toolkit.pdf

Appendix D – Classification system for nature and type of healthcare incidents in shared care services[27]

Client access
Delay in accessing, or unable to access, healthcare provider
Non-attendance for planned healthcare
Other error in client access
Communication between healthcare providers and client
Errors in timeliness of communication between healthcare provider and client
Errors in professionalism of communication between healthcare provider and client
Breach of client confidentiality and/or privacy
Issues with the process of seeking and obtaining informed consent
Other errors in communication between healthcare provider and client
Communication of information between healthcare settings
Errors in communication of information between hospital and ATSICCHO
Errors in communication of information between non-hospital providers and ATSICCHO
Errors in communication between different settings/service area within or between ATSICCHOs
Errors in communication between mainstream health providers (hospital or non-hospital)
Other error in communication between healthcare settings
Referral
Delayed referral / errors in timeliness of referral
Inappropriate referral
Delay or errors in follow up after referral
Other errors in referral process
Assessment and diagnosis
Emergency/acute care: errors in assessment and/or prioritisation of care
Wrong or delayed diagnosis
Errors in follow up of investigation results (pathology, radiology, other)
Errors in identification of vulnerable client
Errors in identification of client at risk of deterioration
Other assessment and/or diagnostic error
Investigations (radiology, pathology, other)
Wrong test ordered
Test not ordered when required/appropriate
Error in the process of transmission of test results
Error in interpretation of test results
Delay in follow up of test results with a client
Other errors in investigations
Vaccines
Wrong vaccine administered

[27] Hernan, A., et al. (2021). Nature and type of patient-reported safety incidents in primary care: cross-sectional survey of patients from Australia and England. *BMJ Open, 11(e043551), doi:10.1136/bmjopen-2020-042551*

Vaccine contraindicated by client's medical or vaccine history
Vaccine administration process error
Other errors in vaccination
Medications
Medication unavailable
Medication delayed
Incorrect medication prescribed and/or administered
Incorrect medication dose prescribed and/or administered
Medication contraindicated by medical or medication history
Error in monitoring of medication
Other errors in medication
Treatment, therapy or other care (not medication or vaccine related)
Failure to provide appropriate treatment, therapy or other care
Delay in provision of appropriate treatment, therapy or other care
Wrong or otherwise inappropriate treatment, therapy or other care provided
Error in monitoring and/or follow up of treatment, therapy or other care provided
Other errors of treatment, therapy or other care
Equipment and environment
Required equipment unavailable
Required or appropriate equipment available but not used/provided
Errors in use of equipment
Faulty equipment
Environmental hazard
Other errors with equipment or environment
Negative outcomes for clients not directly associated with health care
Notification to Child Safety – unborn child
Notification to Child Safety - other
Removal of child from a family
Unexpected deterioration in a client's condition
Unexpected death
Unstable housing or homelessness impacts access to health care
Financial circumstances impact on access to health care
Client disengages from employment and/or education
Contact with the criminal justice system impacts on access to health care
Client's access to a healthcare service, clinic or program is restricted due to behaviours perceived as challenging
Other negative outcomes not directly associated with health care
Racism, discrimination and bias
Racism, discrimination and/or bias contributed to the harm experienced by the client

Appendix E – Checklist for reviewing a shared process for healthcare incident management

Criteria	What went well?	How could the process be improved?
Client's experience Consider: • Was the process seamless from the client's perspective? For example, did the client only need to tell their story once rather than multiple times and did they have a single point of contact through the process? • Was the process culturally safe? • Did the client and their supporters receive immediate and appropriate care and support following the incident? • Were the client and their supporters satisfied with the outcome? • Did the client and their supporters feel comfortable reporting concerns (if applicable)? • Did the client and their supporters receive adequate information about the healthcare incident management process? • Did the client and their supporters have an opportunity to provide feedback on the review report? Was this reflected in the final report? • Were the views of the client and their supporters sought as part of evaluating the effectiveness of the shared process for reviewing the healthcare incident?		
Healthcare workers' experiences Consider: • Was the process culturally safe? • Did healthcare workers receive immediate and appropriate care and support following the incident? • Were the healthcare workers involved in the process satisfied with the outcome? • Did healthcare workers feel comfortable reporting concerns? • Had all healthcare workers involved in the process accessed appropriate training and education? • Did healthcare workers involved in the incident have an opportunity to provide feedback on the incident report? Was this reflected in the final report? • Were the views of healthcare workers involved in the delivery of relevant services sought when planning improvements in quality and safety? • Were the views of healthcare workers sought as part of evaluating the effectiveness of the shared process for reviewing the incident?		

Criteria	What went well?	How could the process be improved?
Review procedure Consider: • Did agreements (formal and informal) between the partner organisations support the joint process of healthcare incident management? • Was the incident identified and reported in accordance with local protocols? • Was a joint template/tool used to document the review of the incident? • Was the client's consent obtained to share personal information? • Were risks identified at the time the incident was reported appropriately minimised? Were any further related incidents reported? • Was the outcome of the open disclosure process shared with all partner organisations? • Was an appropriate methodology used to analyse the incident? Did the methodology meet the needs and obligations of all partner organisations? • Did the review team include representatives from all partner organisations? • Were there any issues in relation to information sharing between partner organisations? • Was open disclosure undertaken by the appropriate organisation/person? • Was the outcome of open disclosure shared with all partner organisations?		
Monitoring and assessing improvements in quality and safety Consider: • Were identified improvements in quality and safety implemented in a timely manner? • Is there a plan for monitoring the effectiveness of improvements in quality and safety? • What evidence is there of changes in practice? • Have relevant policies, guidelines and procedures been amended to reflect identified improvements.		
Learning and feedback Consider: • Was feedback provided to relevant stakeholders? • Was learning from the incident relevant to other services/organisations? • Was learning shared with relevant internal and external stakeholders? • Have there been broader changes in practice as a result of shared learning?		