

# STREAMLINED INCIDENT REVIEW AND CLOSURE PROCESS AT HUMBER RIVER HEALTH

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## DESCRIPTION

The Quality and Risk Management (QRM) system in Meditech tracks incident reports across all programs within Humber River Health (HRH). In August 2023, a monthly reporting process was developed after identifying a need to highlight outstanding reports, prompting timely review, and action by clinical and non-clinical teams. With the streamlined approach, once program teams complete their review, a final verification is done to ensure accuracy and completeness before closure. This structured approach enhances accountability, strengthens communication between programs, and ensures issues are addressed promptly to drive organization-wide improvements. Ultimately, it prevents delays in investigations, ensures proper follow-up on incidents, and supports patient safety across the organization.

## OBJECTIVE

To strengthen organization-wide patient safety by facilitating prompt closure and follow-up of incidents.

## ACTIONS TAKEN

Once it was identified that there was a need for streamlining and reporting of outstanding incidents, the following steps were taken:

- The existing processes for incident review and closures were assessed.
- The Quality and Patient Safety (QPS) and Risk Departments collaborated to develop a process of reviewing, identifying, and reporting outstanding QRMs for appropriate follow-up and closure.
- Once finalized, the QRM reports were implemented and shared with all programs on a monthly basis.
- The reports highlight outstanding incidents requiring review and action, and engage leadership and frontline teams in timely reviews.
- Ongoing compliance of incident reviews and actions are monitored by the Risk Department, and ongoing follow up is completed to support staff in timely closures of QRMs.

## Process of QRM Review, Reporting, and Closures

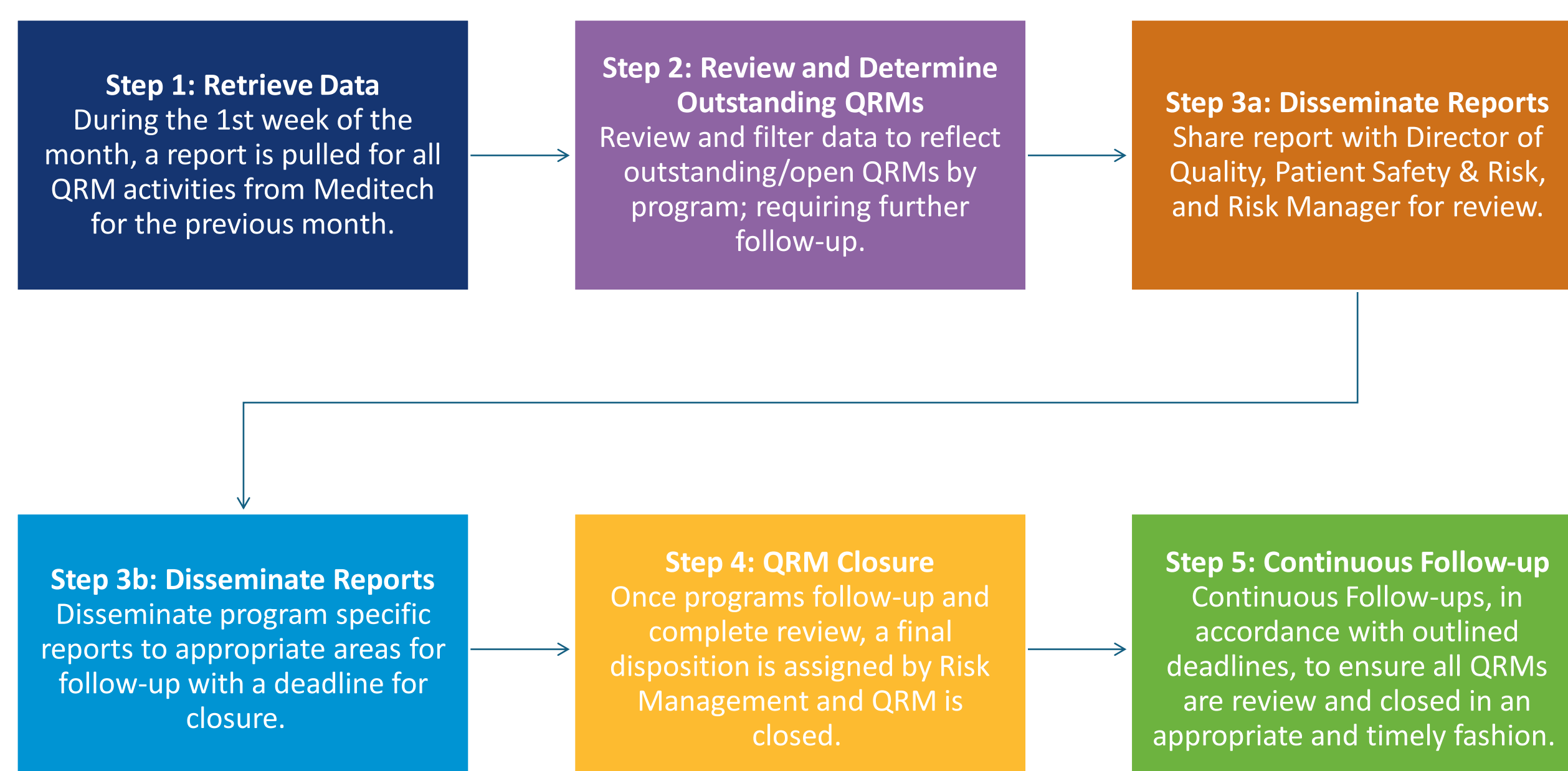


Figure 1. The streamlined process of QRM closures supports adequate review and timely follow-up of reported incidents.

## Quality and Risk Management Report Template

Incident Number	Patient Specific Identification Number	Population Category	Incident Type	Incident Location	Event Date
xxx	xxx	xxx	xxx	xxx	xxx
xxx	xxx	xxx	xxx	xxx	xxx
xxx	xxx	xxx	xxx	xxx	xxx
xxx	xxx	xxx	xxx	xxx	xxx

Figure 2. This table depicts the information included in the QRM monthly report shared across the organization by program. This allows for appropriate individuals to adequately review and locate outstanding QRMs requiring review and closure.

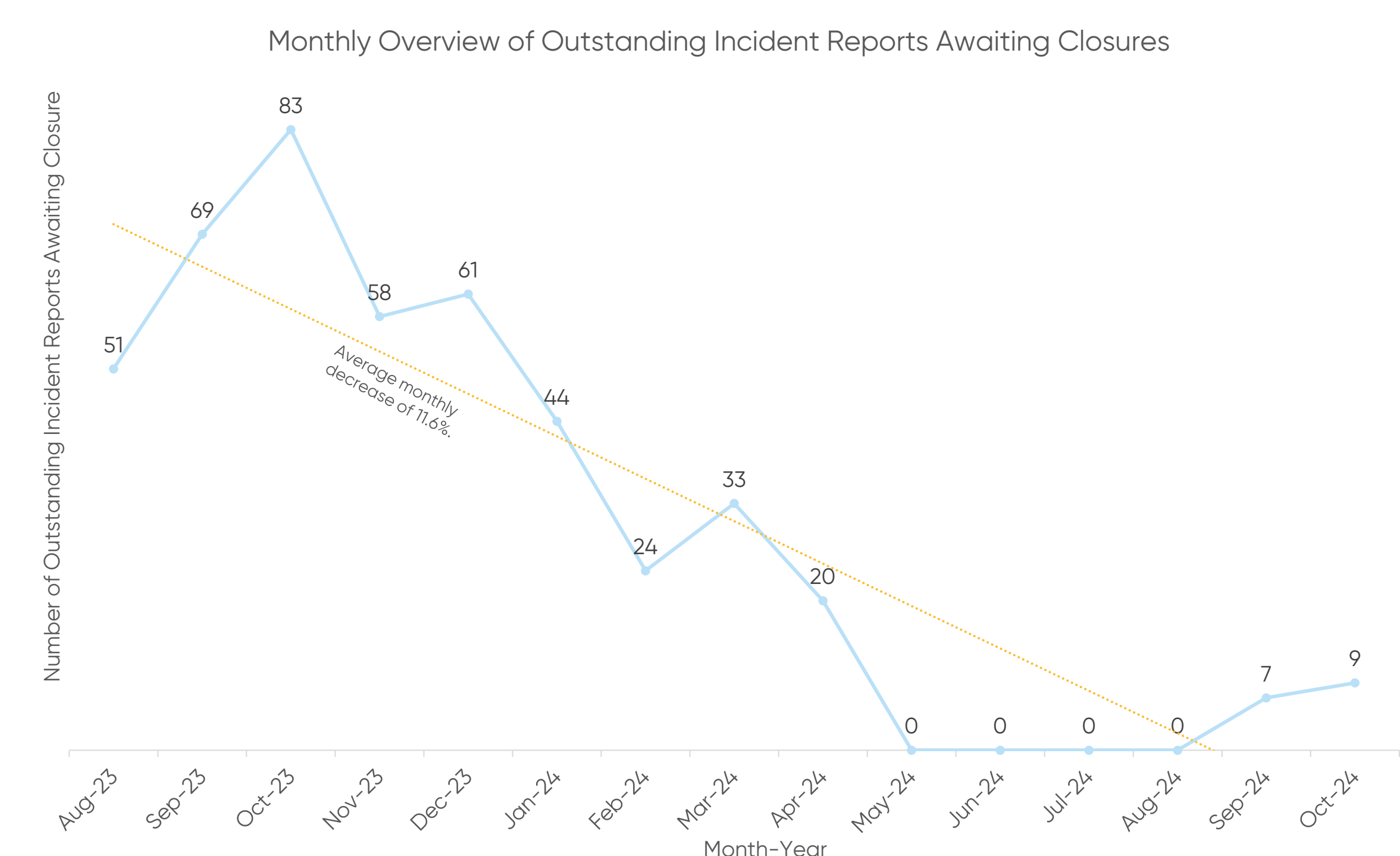


Figure 3. There was an average decrease of 11.6% of outstanding incident reports awaiting closures since the development of the monthly report and closure process.

## SUMMARY OF RESULTS

The monthly reporting process enhanced program engagement, improved the timeliness of reviews, and reduced the number of outstanding reports awaiting closure. Programs demonstrated greater accountability, while the QPS and Risk teams observed more consistent communication and documentation. Overall, the process strengthened HRH's capacity to address risks proactively, drive quality improvements focused on patient safety, and continue to foster a culture of safety.

## LESSONS LEARNED

Clear communication, monthly reminders, and strong leadership support improved timeliness and accountability, making the QRM review and closure process both more effective and sustainable.

