1.0 Policy Statement

This policy relates to all areas of the Service operating as Lauralynn Ireland's Children's Hospice concerning clinical, non-clinical, environmental, and corporate incidents and is to be used by all staff. The purpose of this policy is to ensure consistency in the reporting, escalation and investigations of all incidents, adverse events, and serious reportable incidents and to communicate and action the learning from such events to prevent as far as reasonably practicable similar events occurring in the future.

The Incident Reporting Policy has been developed in alignment with the principles set out in the HSE's Incident Management Framework (2020) and Patient Safety (Notifiable Incident and Open Disclosure) Act 2023, which provide an overarching approach, based on best practice, to assist staff to manage all incidents (clinical and non-clinical) in a manner that is cognisant of the needs of those affected and supports the service to learn and improve.

2.0 Purpose

2.1 That persons affected, or their representative, have the confidence to report a near miss, incident, adverse event, or serious reportable incident.

2.2 To provide simple and transparent guidelines for the management, reporting and investigation of an incident, adverse event, or serious reportable incident.

2.3 To ensure that there is clear understanding of what constitutes a near miss, incident, adverse event and serious reportable incident.

2.4 Each employee shall be orientated to the risk management process and reporting system during their general induction and departmental orientations.

2.5 That near misses, incidents, adverse events, and serious reportable incidents are reported accurately within the specified timelines so that the relevant people are informed, and risks minimised. Serious reportable incidents are escalated as required to the HSE (Health Service Executive) Incident Management Framework and any other relevant agency i.e., HIQA (Health Information and Quality Authority) and or the HSA (Health and Safety Authority).

2.6 All information relating to the risk near miss, incident, adverse event, serious reportable incident shall be handled with the appropriate degree of sensitivity and confidentiality.

2.7 The facts of the near miss, incident, adverse event, serious reportable incident are established, and appropriate action taken to satisfactorily remedy any deficiencies and or minimise a recurrence.

2.8 In the event of a clinical incident, a detailed comprehensive entry must be made in the healthcare record, describing the clinical review, management, and outcome of the incident.

2.9 A fair, appropriate and impartial investigation will be conducted where necessary.

2.10 Open disclosure with patients and families will take place where harm has been reported.

2.11 Lesson learned will be communicated to all staff through the shared learning template (Appendix 1) to prevent as far as reasonably practicable similar events occurring in the future.

2.12 Staff may be subject to disciplinary protocols if they breach Service policy.

3.0 Scope

This policy relates to all areas of the Service i.e. corporate, clinical, non-clinical and environmental and all persons, including:

- Service Users
- Staff
- Volunteers
- Contractors
- Third Parties
- Visitors

4.0 Definitions

4.1 *Incident:* An event or circumstance which could have or did lead to unintended and/or unnecessary harm. Incidents can also originate from staff or service user complaints which are associated with harm.

Incidents can be clinical or non-clinical and can involve, but are not limited to:

- Children, adults in residence, families, staff, volunteers, contractors or members of the public
- The attainment of the services objectives
- ICT systems
- Data security
- The environment

4.2 *Near miss:* An incident that was prevented from occurring due to timely intervention or chance and which there are reasonable grounds for believing could have resulted, if it had not been so prevented, in unintended or unanticipated injury or harm to a person.

4.3 *Adverse Event:* An incident which results in harm, which may or may not be the result of an error.

4.4 *Harm*: **a) Harm to a person** – Impairment of structure of function of the body and or any detrimental effect arising from this including disease, injury, suffering, disability and death. Harm may be physical, social or physiological. The degree of harm relates to the severity and duration of harm and the treatment implications that result from an incident.
b) Harm to a thing – Damage to a thing may include damage to facilities or systems, for example environmental, financial, data breach etc.

4.5 *Serious Reportable Event:* Serious Reportable Events (SREs) are a defined subset of incidents which are either serious or that should not occur if the available preventative measures have been effectively implemented by healthcare providers. Serious Reportable Events are mandatorily reportable by the Service to the CEO

4.6 *Incident Report Form* – documentation used to report all incidents, near misses, adverse & serious reportable events (Incident Report Form (office.com))

4.7 *Key Contact Person*: Nominated by the Head of Department to support the open disclosure communication process between the Service and the child or adult in residence and/or their guardian/relative/representative.

4.8 *Serious Incident Management Team (SIMT)*- serves as a highly responsive panel of senior staff who are responsible for overseeing the management of SREs and serious incidents and reporting into the relevant Senior Accountable Officer at regular intervals to update on the progress of reviews.

4.9 *Category 1 Incident:* Clinical and non-clinical incidents rated as Major or Extreme as per the Risk Impact Table.

4.10 *Category 2 Incident:* Clinical and non-clinical incidents rated as Moderate as per the Risk Impact Table.

4.11 *Category 3 Incident*: Clinical and non-clinical incidents rated as Minor or Negligible as per the Risk Impact Table.

4.12 *Open Disclosure:* An open, consistent, compassionate and timely approach to communicating with service users and where appropriate, their relevant person following SREs and serious incidents. It includes expressing regret for what has happened, keeping the patient informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the service to try and prevent a recurrence of the incident.

4.13 *Incident Review:* Incident review involves a structured analysis and is conducted using best practice methods, to determine what happened, how it happened, why it happened, and whether there are learning points for the service, wider organisation, or nationally.

4.14 *System Analysis Review:* A methodical review of an incident which involves collection of data from the literature, records (general records in the case of non-clinical incidents and healthcare records in the case of clinical incidents), individual interviews with those involved where the incident occurred and analysis of this data to establish the chronology of events that led up to the incident, identifying the Key Causal Factors that the investigator(s) considered had an effect on the eventual adverse outcome, the Contributory Factors, and recommended control actions to address the Contributory Factors to prevent future harm arising as far as is reasonably practicable.

4.15 *Corrective Action:* Action taken to eliminate the cause of incidents to prevent recurrence.

4.16 *Preventive Action:* Action taken to eliminate the cause of potential incidents to prevent their occurrence.

4.17 *NIMS (National Incident Management System)*: The National Incident Management System, hosted by the Clinical Indemnity Scheme, is a highly secure web-based database which facilitates direct reporting of adverse events by State authorities and healthcare enterprises; it is the single designated system for reporting of all incidents in the public healthcare system. NIMS is only applicable for Section 38 HSE funded agencies, i.e., Disability Care Services (DCS), but not for Section 39 HSE funded agencies, i.e., Children's Palliative Care Services, (CPCS).

4.18 *State Claims Agency (SCA):* The National Treasury Management Agency is a State body which operates with a commercial remit to provide asset and liability management services to Government and is designated as the State Claims Agency when performing the claims and risk management functions delegated to it under the National Treasury Management Agency (Amendment) Act 2000.

5.0 Roles & Responsibilities

5.1 Board of Management

The board of the organisation is ultimately accountable for the safety and quality of care of service users, staff, visitors and others and will support the Executive Management team in the implementation of systems for the effective management of risk

5.2 CEO

Is accountable to the Board and is the Senior Accountable Officer for the Service. The CEO provides assurance to the Board that the following elements are in place:

5.2.1 Governance

Arrangements for clinical governance to provide assurance for the quality of care and safety through the following committees

- QRS – Quality, Risk & Safety Committee
- CEC – Clinical Effective Committee

- Ensure that there is a local policy for incident reporting that clearly defines the system for incident reporting, investigation and management
- Delegates responsibility and provides adequate resources where reasonably practicable to implement and develop effective risk management systems throughout the organisation
- Promotes a positive reporting culture within the Service

5.3 Quality, Risk & Safety Manager

- Effective management and implementation of the incident reporting process
- Is responsible for the management & recording of all incidents, adverse events, serious reportable events onto the national incident reporting system
- Ensure all external organisations are informed of any reportable incidents
- Escalates all serious reportable events to the HSE/HIQA as per the National Safety Incident Policy
- Reviewing, trending and reporting of incidents to the CEO & Quality, Safety and Risk Committee
- Provides support for staff, service users and carers following serious reportable events
- Ensures that arrangements are in place for scene preservation, labelling and safe storage of equipment involved in serious reportable events
- Ensuring that all employees are aware of, and comply with, the local, National and the related Open Disclosure Policy & facilitate training for staff where necessary
- Ensuring that staff involved in an incident are provided with adequate support in the aftermath of the incident and throughout the open disclosure and incident review process

5.3.1 Investigation and Action Planning

- Arrangements to ensure investigations take place within agreed timeframes and use best practice methodologies such as system analysis to identify the root cause
- Arrange for delegated staff to attend training in investigations and analysis techniques
- Arrangements to ensure that action plans developed following investigations are monitored and reported to the CEO

5.3.2 Learning & Follow Up

- Ensure that learning from incidents is disseminated across the organisation. Appendix 1– Shared Learning Notice
- Mechanism in place to ensure appropriate actions are taken where referral to a professional body is indicated – Code of Conduct 3.3 Staff Code of Conduct Policy Sep 2022.pdf & Trust in Care Policy 5.2 Trust in Care Guidelines.pdf

5.4 Clinical Pharmacist/GP

- All medication incidents that are reported from the CPCS are forwarded to the Clinical Pharmacist & in the DCS to the GP as soon as possible i.e., within 48hrs of the medication incident occurring. In the event of a SRE report incident immediately to most senior person on duty i.e. Clinical of Call and or Executive On Call
- The Clinical Pharmacist & or GP review all medication incidents
- Medication Incidents are forwarded to the QRS Dept by the Head of Department with review and recommendations from the Clinical Pharmacist & or GP

5.5 Department Heads

- Promote a positive and open culture of reporting of incidents
- Circulate and ensure full compliance with this policy
- Be familiar with and adhere to the relevant statutes, the guidelines of their professional bodies with the organisation, policies, and protocols in relation to the management of risks

- Ensure that all incidents are reported accurately within specified timelines and appropriately managed
- Ensure that staff working in the department are appropriately trained and supported to report incidents and where appropriate conduct investigations in a rigorous and impartial manner
- Support staff who have been involved in incidents with internal or external support if considered appropriate
- Ensure staff are advised to attend Occupational Health or an Emergency Department/Medical Practitioner as appropriate after an incident
- Treat staff fairly and equitably during any investigation
- Provide feedback to staff on the outcome of incidents
- Identify and inform the QRS Department of incidents reporting training requirements
- Implement recommendations /changes in practice resulting from an investigation
- Ensure that Serious Reportable Incidents are reported immediately to the most senior accountable officer on duty for escalation to the Senior Incident Management Team

5.6 Occupational Health Department

Provide informal and formal support services to staff involved in adverse incidents and /or serious reportable events as required. Assess individual requirements on a case-by-case basis.

5.7 Quality, Risk & Safety (QRS) Department

Manage all hazards/adverse events concerning safety health and welfare at work of all persons onsite, in particular staff, visitors and contractors. Notify the Health & Safety Authority and other relevant bodies such as HIQA, HSE and or An Garda Síochána of the following:

- The death of any employed or self-employed persons, which was caused by an accident during the course of their work on the premises
- Any injury sustained in the course of their employment which prevents any member of staff from performing the normal duties of their work for more than three working calendar days, not including the date of the accident

5.8 Infection Control Department

- Participate in the management of all incidents relating to infection prevention control (IPC)
- Notify the QRS Department / Senior Management of any SRE or serious incident relating to IPC
- Notify the relevant incidents to the Department of Public Health as appropriate

5.9 All Employees

- Must be familiar with incident reporting and investigation systems and fully co-operate with this policy.
- Report and investigate all incidents accurately and within specified timelines as outlined in Incident Management Pathway – Appendix 2, 15.2 A & B
- Any staff involved in an occurrence or who witnesses an occurrence is responsible for reporting the incident and initiating an incident reporting form as soon as possible and within 48
- Any staff to which an event is reported may take the responsibility to initiate the incident report form
- Discuss possible solutions to prevent further incidents with the Department Head
- Cooperate fully with any investigation
- Cooperate & participate with the implementation of recommendations / changes in practice resulting from an investigation
- Comply with their professional codes of conduct as they relate to incident management

5.10 Health and Safety Committee: Is responsible to review any non-clinical incidents and to provide recommendations for implementation.

5.11 Quality, Safety and Risk Committee*:* is responsible for:

- Obtaining assurance that the process for incident reporting and management are being adhered to
- Oversee the implementation of recommendations and actions from incident reviews/investigations
- Reviewing quarterly reports from the Quality, Safety and Risk Manager in regard to the number of incidents reported, trends, recommendations and learnings
- Agreeing a comprehensive incident/near miss reporting system for both clinical and non-clinical incidents
- Promoting an open, responsible and accountable culture within the organisation

6.0 Principles

6.1 The following core principles shall underpin the Service's incident reporting system:

- Person-Centered: The needs of persons affected (service users and or staff) are considered of primary importance and required supports are put in place from the outset and throughout any review/investigation
- Fair and Just: That all persons affected are treated in a manner which is fair and just. Where issues of individual accountability is identified that the service responds to these in a manner which is proportionate, and safety focused
- Openness and transparency: That all persons affected by an incident are aware of the incident and the steps taken to learn from it. Staff members have an obligation under the National Standards for Safer Better Healthcare 2012 and Patient Safety (Notifiable Incident and Open Disclosure) Act 2023 to fully and openly inform and support the children or adults as soon as possible after an adverse event affecting them has occurred, or becomes known, and shall continue to provide information and support as needed.
- Responsive: That all actions taken following the identification of an incident are taken in a timely and proportionate manner
- Improvement focused: That incidents occurring are viewed by the service as an opportunity to improve
- Learning: That the incident management system is focused on learning both locally and within the wider service

7.0 Incident Identification and Immediate Actions Required

7.1 Incidents and or near misses may be identified by any member of staff, volunteer or member of the public through:

- Direct observation or involvement, and/or
- Quality and safety mechanisms (e.g., audits, external assessments)

7.2 Where an incident or near miss has occurred:

- The first response must be to any person harmed to ensure that the impact of the incident is minimised and any remedial actions are taken
- An assessment must take place to ensure that any immediate action required to prevent the risk of recurrence is identified and actioned
- The needs of persons affected i.e., service users, families, and staff, should be identified and supported
- The open disclosure process must be initiated promptly
- For incidents involving service users, the event should be factually documented in the service users clinical/care record along with details of the information and care provided to the service user.
- For any persons involved in an incident where medical intervention, assessment or follow up is advised but refused, this should be recorded in the incident reporting record
- Named key contact person as liaison to the service user/family and staff are to be appointed

7.3 Incidents where the impact is Negligible, Minor or Moderate, (Category 2-3, refer to sections 8.2 & 8.4) shall trigger the informal open disclosure procedure, which is where the parents/next of kin (NOK) shall be informed of the incident and be initiated within 24-48 hours after the incident occurs or becomes known to the service.

7.4 All incidents identified as having a Major of Extreme impact (Category 1, refer to sections 8.2 & 8.3) shall trigger the formal open disclosure procedure and be initiated within 24-48 hours after the incident occurs or becomes known to the service. This shall be conducted in line with the HSE's Open Disclosure policy.

7.5 An open disclosure meeting shall take place ideally in a face-to-face meeting with the service user and/or their relevant person. Open disclosure shall be led by the most senior health care professional involved in the care of the service user. If it is not practical for the service user or their relevant person to attend the meeting the service user or their relevant person can be contacted by telephone.

7.6 The service shall adequately prepare for an open disclosure meeting by giving due consideration to:

- The nature of the incident and the level of open disclosure required
- Establishing the facts available to the service at the time of the open disclosure meeting
- The need to consult with relevant stakeholders prior to the open disclosure meeting
- Who the open disclosure should be made to (i.e., the service user and/or their relevant person)
- Who should make the open disclosure i.e., establishing the open disclosure team
- Determining if an apology is required and the wording of such an apology
- The provision of support to the service user and/or relevant person to assist them in preparing for an attending the open disclosure meeting e.g. advocacy support, appointment of a designated person, providing information on how the meeting will be conducted
- Whether the statutory protections available under the Civil Liability Act Open Disclosure are being sought

8.0 Initial Notification and Reporting

8.1 Once the immediate containment actions have been implemented staff shall:

- Immediately consult with the relevant Line Manger to address the incident or potential incident and determine if the impact of the incident results in major or extreme harm and notify the Quality, Safety and Risk Manager immediately or at the latest within the first 24 hours of the incident occurring
- Complete the on-line Incident Report form on Sharepoint immediately or at the latest within the first 24hrs. (Incident Report Form (office.com)
- Consider any internal and external reporting requirements
  - (i) Where the incident is a statutory notifiable event the Director of Nursing (DoN) and Quality, Risk and Safety Manager (QRSM) shall be notified immediately. If the incident occurs out of hours the Clinical Nurse Manager on Call shall be notified who will inform the Executive Manager on Call. The DoN/QRSM, shall ensure the appropriate forms are completed and sent to the relevant statutory body within the required timescales. Where required, an internal investigation shall be initiated.
- Gather all relevant information in relation to the incident or near miss and secure all related evidence
- Where an adult or child is involved, the staff member shall document the clinical facts in the child or adult's individual care plan

8.2 The relevant line manager shall be nominated as owner of the Incident and receive a copy of the on-line form. The incident reporting database shall be updated by the Quality, Safety and Risk Officer to reflect the new incident.

8.4 Incident forms shall be referred to the appropriate committee e.g., Local QRS or the Health and Safety Committee for review.

9.0 Categorisation and Initial Assessment:

9.1 The purpose of categorising and assessing incidents is to assist with determining the level of review required. The level and approach to review must also be proportionate to the impact of the incident and the opportunity provided by the incident to identify learning that can be used to minimise the risk of a similar incident occurring in the future.

The line manager in whose service the incident occurred will identify the level of harm relating to the outcome of the incident. The level of harm experienced informs the categorisation of the incident. (r3efer to 8.4)

9.2 Incidents are categorised as follows:

1. Category 1 Major/Extreme – Clinical and non-clinical Incidents rated as major or extreme as per the HSE's Risk Impact Table. (HSE's Risk Impact Table Appendix 3)
2. Category 2 Moderate – Clinical and non-clinical incidents rated as moderate as per the HSE's Risk Impact Table.
3. Category 3 Minor/Negligible – Clinical and non-clinical incidents rated as Minor or Negligible as per the HSE's Risk Impact Table

9.3 Where the incident has been identified as a **Category 1 incident**, the QRSM and DoN/Assistant Director of Nursing (ADoN) shall be informed immediately or no later than 24hours after the incident occurred. The QRSM (out of hours the Executive on Call) shall inform the CEO, who shall notify the Board of Directors.

9.4 A preliminary assessment shall be carried out on **Category 1** and **Category 2** incidents due to the level of harm incurred. The assessment shall support a formal decision being made in relation to the type of review required. Details of the assessment and decision-making process must be recorded using Part A of the Preliminary Assessment Form in Appendix 4.

9.4.1 For Category 2 incidents, the line manager in whose service the incident occurred must complete Part A of this form i.e., the Case Report and subsequently complete Part B in consultation with the QRS Manager.

9.4.2 Category 1 incidents must be referred to the **Serious Incident Management Team (SIMT)** for decision making in relation to their management. Ideally decisions relating to the Category 1 incident review should be made within 72 hours of occurrence of the incident and at the latest must be made within one working week. Decision should be recorded using Part B of the Preliminary Assessment Form in the Appendix 4

9.5 The SIMT has two key responsibilities:

- To meet on a scheduled basis to monitor and gain assurance in relation to the on-going management of all **Category 1** incidents within the service and;
- To convene on an unscheduled basis and within 5 working days of a Category 1 incident being notified to the CEO/Designate to gain assurance in relation to any immediate actions required and to conduct a preliminary assessment to inform the requirement for further review.

SIMTs must be chaired by the CEO/Designate. At a minimum, the core membership of the SIMT should include nominated members of the executive management team, commonly the CEO (Chair), Director of Nursing, Head of Operations, Head of Marketing & Communications and the QRS Manager.

9.6 In order to assist decision making at the SIMT on notification of the incident the CEO shall assign an appropriate person e.g., QRSM to gather the information required for the completion of the preliminary

assessment. This shall then be presented to the SIMT meeting to assist in framing the discussion relating to the need for further review of the incident.

9.7 Where the SIMT have agreed that the Category 1 or 2 incidents requires a detailed systems analysis review, it shall be undertaken by the department manager in conjunction with the QRSM, to determine the key causal factors and contributing factors to the incident. Part C of the Preliminary Assessment Form in Appendix 4 will be used to document the decision. Staff who were involved in the incident shall be informed that a system analysis review is being conducted.

9.8 The Systems Analysis Review shall be timely, thorough, and credible.
The following 6 steps of the systems analysis review shall be applied
Step 1 – Organise the review and gather the data/information
Step 2 – Determine the incident chronology
Step 3 – Identify the key causal factors (KCFs) and incidental findings (IFs)
Step 4 – Identify the contributory factors (CFs)
Step 5 – Make recommendations
Step 6 – Prepare a report and submit it to the person requesting the review

9.9 Whilst all incidents must be subject to review, the level of review should be guided by the following categorisation:

Level 1 Review – Comprehensive Review (Category 1 incidents)
Level 2 Review – Concise Review (Category 2 and some Category 1 incidents)
Level 3 Review – Aggregate Review (Category 3 incidents)

Within each level a number of approaches to review are included. These are set out in Table 1 below;

Table 1.

Level of Review	Approaches to Review	Methodology underpinning approach
Comprehensive	1. Review Team (SIMT). It requires commissioning by CEO/Delegate	Systems Analysis
Concise	1. Facilitated multidisciplinary team approach 2. Desktop approach (incidents that occurred in the past) 3. Incident specific review tool e.g. Risk assessment	Systems Analysis or After-Action Review (AAR) Systems Analysis Systems Analysis
Aggregate	1. Scheduled MDT incident review meeting	Systems Analysis

Regardless of the approach adopted the focus is on finding out:
- What happened?
- How it happened?
- Why it happened?
- What the service can learn from the incident and the changes the service could make to reduce the risk of future harm arising from similar causes?

9.10 Where the incident is identified to have a severity rating of Moderate or Low, (Category 2 or 3) the Department Manager shall be notified. The Department Manager shall review the incident and determine in consultation with the QRSM where required if an incident review is required.

9.11 Where the incident or near miss has resulted in injury, to a child or adult they shall be referred to the relevant health care professional e.g., Physiotherapist, Occupational Therapist, GP etc. for review.

9.12 Where a low-level response has been identified the staff involved in the incident, with support from a manager or colleague will:

- Meet with the service user and or their relevant person
- Acknowledge what happened and the impact on the service user (if any)
- Provide an explanation, a meaningful apology and reassurance in relation to ongoing care and support.

This conversation may involve one meeting with the service user and/or their relevant person or if they have been discharged can be contacted by telephone or a similar method of communication. The information provided, apology and agreed actions must be documented in the service users care plan

9.13 Corrective and preventive actions where identified are assigned to reduce the risk, address responsibility, agree timelines for implementation and strategies for measuring the effectiveness of the actions. Actions may be assigned to more than one person for each of the stages. A plan shall be agreed in line with the child or adult's on-going care, to include identification of any on-going support required as a result of the incident or near miss. It is the responsibility of the line manager to ensure details are recorded of any investigations completed and related actions taken, either corrective or preventive, to help ensure incidents are addressed appropriately, promptly, and effectively.

9.14 Once the corrective and preventive actions have been completed the line manager shall forward the incident report to the department manager. It is the responsibility of the department manager to review the incident, irrespective of the risk rating, and ensure all aspects of the incident have been addressed and that they are satisfied that the actions have been implemented. Once all actions have been completed it is the responsibility of the QRSM to close out the incident.

9.15 Clinical incidents shall be reviewed at the LQRS (Local Quality, Risk & Safety) Group and non-clinical incidents at the Health & Safety Committee, to approve follow up and closure. The incident reporting database shall be updated to reflect the status of the incident.

9.16 The QRSM shall undertake trending and analysis of all incidents and near misses on a monthly basis. This information shall be presented in a report for review by the Quality, Safety and Risk Committee.

10.0 Notifiable Events

10.1 Certain incidents are notifiable to HIQA within a certain timeline. For full details of notifiable events please see Appendix 5

10.2 The QRSM in conjunction with the DoN/ADoN and or Consultant/GP is responsible for determining if the incident needs to be externally reported and ensuring that all such incidents are reported as required:

- Nursing and Midwifery Board of Ireland where there is a concern regarding a Registered Nurses and their adherence to their Code of Practice
- Coroner's Office where the child or adult is deceased
- Garda Siochana where there is a danger to staff, children or adults, or a criminal offence

- Health and Safety Authority where the incident is dangerous, or an employee has been injured as a result and is off sick for 3 days or more
- Health Products Regulatory Authority (HPRA) where the incident is related to adverse drug reactions
- Organisational Insurers where a claim is identified
- Health Information and Quality Authority (HIQA)
- Health Protection Surveillance Centre (HPSC)

11.0 Incident Reporting Database

11.1 All incidents shall be inputted onto the Organisations incident reporting database on SharePoint

11.2 The service is also required to report all incidents relating to the disability services through NIMS which is managed by the SCA.

11.3 The database shall be updated by the QRS Dept. on a regular basis to reflect the status of the incident.

12.0 Staff Education

12.1 All staff shall receive education regarding the incident reporting process, particularly:

- Identification of an incident or near miss
- Completion of an Incident Report Form (Incident Report Form (office.com)

12.2 Line managers shall receive internal training on risk rating incidents and conducting incident reviews

12.4 The Service shall facilitate all staff to receive mandatory training on open disclosure.

13.0 Staff Support

13.1 Line managers in conjunction with the QRSM shall:

- Support staff involved in a serious incident/serious reportable events/ near miss, in terms of their compliance with this policy and follow-up required
- Treat staff fairly and equitably during a review/investigation arising from an incident
- Provide feedback in a timely and honest manner to staff on the outcome of an investigation
- Help identify the actions required to prevent reoccurrence of the event and implement the actions relevant to their department
- Promote a positive and open culture of reporting

14.0 Records

14.1 All incident reports in the Service shall be retained for at least seven years after the incident to which it relates or the child or adult(s), to whom they relate cease(s) to be child or adult in the service, whichever is longer. Records include: Incident reports, analysis of incidents/systems analysis reviews, child or adult clinical records and or minutes of meetings related to the incident management process.

15.0 Evaluation

15.1 Ongoing compliance to this policy will be monitored by the QRS Dept and results will be presented to the Quality, Safety and Risk Committee.

16.0 Appendices:

16.1 Appendix 1: (A) Incident Reporting Pathway (B) Serious Reporting Pathway

16.2 Appendix 2: HSE Risk Assessment Tool - Impact Table, Likelihood Table, Risk Scoring Matrix, Risk Rating

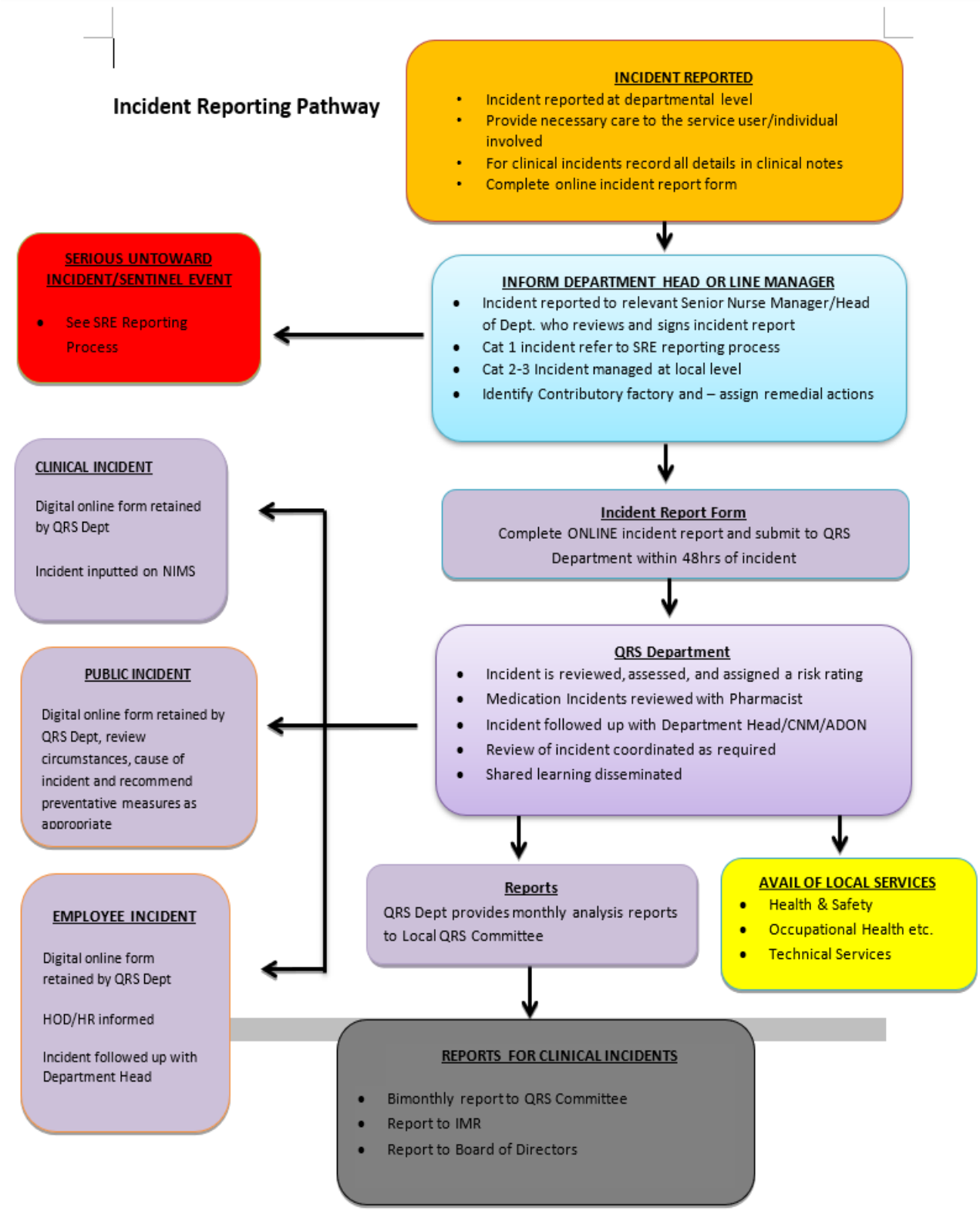
16.3 Appendix 3: Preliminary Assessment Form

16.4 Appendix 4: The Principles of Open Disclosure

16.5 Appendix 5: HIQA Notifiable Event

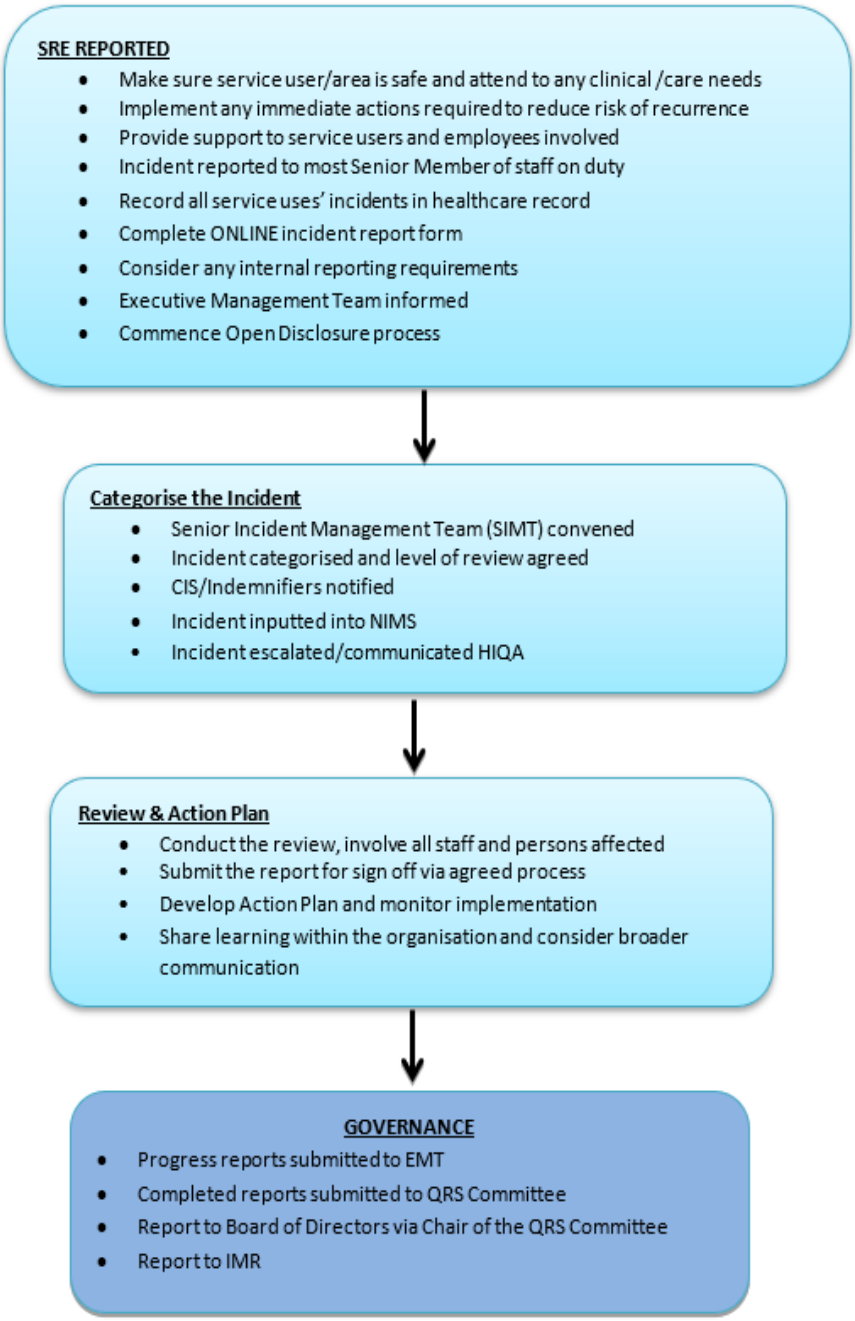
16.6 Appendix 6: Shared Leaning Notice

Appendix 1: (A) Incident Reporting Pathway



Appendix 1: (B) Serious Reporting Pathway

Serious Reportable Events Reporting Process



Appendix 2: HSE Risk Assessment Tool – Impact Table

Impact Rating	1	2	3	4	5
Categories	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Harm to a person (Service User, Patient, Staff & Public)	No harm. No need for treatment. No impairment of ability to manage normal daily routines. No impaired psychosocial functioning. No time off work	Adverse event/incident leading to **minor harm** needing minimal additional intervention. (e.g. first aid, extra observation or minor treatment) Requiring first aid/extended hospital stay for treatment of ≤ 72 hours. Recovery of ability to manage daily routines within 72 hours. Impaired psychosocial functioning (> 72 hours ≤ 1 month) ≤ 72 hours absence from work.	Adverse event/incident leading to **moderate harm** (significant, but not permanent harm) requiring a moderate increase in treatment. (e.g. an unplanned return to surgery, an unplanned re-admission, cancelling of treatment leading to prolonged symptoms/disease, or transfer to another treatment area (such as short stay in intensive care with good recovery) Extended hospital stay for treatment of (> 72 hours to ≤ 8 days) Recovery of ability to manage daily routine within a month and without significant complication or significant permanent disability. Impaired psychosocial functioning (> 1 month ≤ 6 months) > 72 hours absence from work to ≤ 6 months. Agency reportable e.g. Gardaí (violent and aggressive acts), Tusla, HIQA, MHC and HSA.	Adverse event/incident leading to **severe harm** such as permanent lessening of bodily, sensory, motor, physiologic or intellectual functions resulting in long-term incapacity or disability (e.g. loss of limb, blindness, brain damage/HIE, shortening of life expectancy) Extended length of stay in hospital (> 8 days) Significant complication/significant permanent disability impacting ability to manage normal daily routine in the same manner as before. Impaired psychosocial functioning (> 6 months) Absence > 6 months Agency reportable e.g. Gardaí (violent and aggressive acts), Tusla, HIQA, MHC and HSA.	Adverse event/incident leading to death or permanent total disability. (e.g. unanticipated death that did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient occurring while receiving care) Permanent psychosocial functioning incapacity. Agency reportable e.g. Gardaí (violent and aggressive acts), Tusla, HIQA, MHC and HSA.
Service User Experience	Unsatisfactory experience not directly related to the provision of care services or supports (e.g. inadequate provision of information)	Unsatisfactory service user experience readily resolvable. (e.g. less than optimal treatment/ inadequate information; not being talked to and treated as an equal; or not being treated with honesty, dignity and respect)	Unsatisfactory level of service user experience resulting in short term resolvable consequences (< 1 week) (e.g. related to less than optimal treatment)	Mismanagement of service user experience resulting in long term consequences. (e.g. related to poor or incorrect treatment)	Totally unsatisfactory service user outcome or extremely poor care provision resulting in long term consequences.
Business/Service disruption/Security (unauthorised and/or inappropriate access to systems/assets including data)	No material disruption to dependent work. Interruption in a service which does not materially impact on the delivery of service user care or the ability to continue to provide service.	Short-term temporary suspension of work. Minor public impact. (e.g. delays in waiting time) Local management assistance required. Short term disruption to service with minor impact on service user care. Backlog cleared in a week. Backlog requires extended work, overtime or additional resources to clear. Unplanned loss of IT facilities ≤ 4 hours.	Medium-term temporary suspension of work. Additional resources/budget required Regional management assistance required (HG CEO or CHO CO). Manageable impact. Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service. Unplanned loss of IT facilities between > 4 ≤ 8 hours.	Prolonged suspension of work. Additional resources, budget. National/management assistance required. (National Director) Performance criteria compromised. Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being involved. Unplanned loss of IT facilities between > 1 day ≤ 1 week.	Indeterminate prolonged suspension of work. Significant additional resources, budget/ management assistance required. CEO, Department of Health and Minister of Health intervention required. Non-performance. Other providers appointed. Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect. Unplanned loss of IT facilities > 1 week.
Loss of trust/ confidence or morale (Public/Staff), including reputational risk	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No review/investigation necessary.	Local/national media coverage – Short term. Some public concern. Minor effect on staff morale/public attitudes. Internal review necessary.	Numerous local/national media outlets – adverse publicity. Significant effect on staff morale and public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/adverse publicity, <3 days. News stories & features in national papers. Local media – long term adverse publicity. Public and staff confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken possible HSE review/ investigation	National/International media/adverse publicity, > than 3 days. Editorial follows days of news stories and features in national papers. Public and staff confidence in the organisation undermined. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.

Appendix 2: HSE Risk Assessment Tool – Impact Table (cont.)

Impact Rating	1	2	3	4	5
Categories	Negligible	Minor	Moderate	Major	Extreme
Organisational objectives or outcomes	Little impact e.g. Minor delays	Inconvenient delays.	Material delays. Performance behind target (e.g. KPIs)	Significant delays. Performance significantly under target.	Non-achievement of objective/outcome. Total performance failure.
Compliance (Legislative, Regulatory, Policy)	Non-compliance with internal policies. Procedural breach. Evidence of good faith by degree of care/diligence. Unintentional or accidental breaches of security, which may constitute an exposure that needs to be addressed. Non-notifiable breach of data, no adverse outcome.	Material Non-compliance with internal policies. Single failure to meet internal PPPGs. Breach, objection/complaint lodged. Minor harm with investigation. Evidence of good faith arguable. Deliberate and unauthorised breaches of security to gain access to information systems with a notifiable breach of data, readily resolvable.	Repeated failure to meet internal PPPGs. Serious breach. Lack of good faith evident. Performance review initiated. Material harm caused. Misconduct established. Deliberate and unauthorised breaches of security to gain access to information systems with a notifiable breach of data requiring notification to the data subject.	Failure to meet compliance obligations. (e.g. Legislative, Regulatory, Public Policy etc.) Deliberate breach or gross negligence. Formal investigation by external body. Disciplinary action. Ministerial involvement. Serious misconduct. Deliberate and unauthorised breaches of security to gain access to information systems with a notifiable breach of data, requiring notification to multiple data subjects.	Gross failure to meet compliance obligations (e.g. Legislative, Regulatory, Public Policy etc.) Criminal negligence or act. Litigation or prosecution with significant penalty. Dismissal. Ministerial censure. Evidence of criminal misconduct. Deliberate and unauthorised breaches of security to gain access to information systems with a notifiable breach of data, requiring notification to mass data subjects.
Financial (including performance to budget, claims, etc.)	≤ €10,000 loss.	> €10,000 to ≤ €100,000 loss	> €100,000 to ≤ €1,000,000 loss.	> €1,000,000 to ≤ €10,000,000 loss.	> €10,000,000 loss.
	0.33% of budget deficit	0.33 – 0.5% of budget deficit	0.5 – 1.0% budget deficit	1.0 – 2.0% of budget deficit	> 2.0% of budget deficit
Environmental/ Infrastructure/ Equipment	Nuisance Release. No disruption to access or exposure.	On site release contained with minimal intervention. Minimal disruption to access or exposure.	On site release contained with moderation intervention. Short to medium-term restriction of access or exposure.	High level but recoverable, unacceptable damage or contamination of a significant resource or area of the environment. Significant intervention required for permanent cessation of harmful activity' Long-term suspended access, presence or use of resource.	Toxic release affecting off-site with detrimental effect requiring outside assistance. Extensive, very long-term or permanent, significant, unacceptable damage to or contamination of a significant resource or area of the environment. Very long-term or permanent denial of access or exposure.
	Inconsequential damage to buildings/environment/historic resources that requires little or no remedial action.	Recoverable damage to 'non-priority' buildings/environment/historic resources.	Recoverable damage to 'priority' buildings, or loss of 'non-priority' buildings/environment/historic resources.	Permanent damage to priority buildings/ environment/historic resources	Loss of 'priority' buildings/environment/historic resources.
Strategic Programme/Project (objectives/ timeframes) – HSE Executive Use Only	≤ 1% variation to programme/ project deliverables	> 1% to 5% variation to programme/ project deliverables	> 5% to 10% variation programme/project deliverables	> 10% to 20% variation to programme/project deliverables	> 20% variation to programme/project deliverables
	≤ 5% delay (e.g. for a project with a projected timeframe of 3 years an anticipated 2 month over run equals a 5% delay)	> 5% to 10% delay	> 10% to 25% delay	> 25% to 100% delay	> 100% delay

Appendix 2: HSE Risk Assessment Tool (cont.) – Likelihood Table / Risk Scoring Matric / Risk Rating Matrix

HSE Likelihood Table

Score	Likelihood	Probability of occurrence	Frequency
5	Almost Certain	> 90%	At least monthly
4	Likely	> 60% to 90%	Bi-monthly
3	Possible	> 30% to 60%	Occurs every 1 to 2 years
2	Unlikely	> 5% to 30%	Occurs every 2 to 5 years
1	Rare	≤ 5%	Occurs every 5 years or more

HSE Risk Scoring Matrix

LIKELIHOOD	1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

IMPACT

HSE Risk Rating Matrix

LIKELIHOOD	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Low	Medium	High	High	High
Likely	Low	Medium	Medium	High	High
Possible	Low	Medium	Medium	Medium	High
Unlikely	Low	Low	Medium	Medium	Medium
Rare	Low	Low	Low	Low	Low

IMPACT

Appendix 3 – Preliminary Assessment Form

Preliminary Assessment Form

Note: Guidance in italic font should be deleted on completion.

Part A – to be completed in advance of the SIMT/Review decision making meeting

A. 1. Incident Details	
NIMS Reference No:	Date entered on NIMS:
Date of Incident:	
Incident Type: (brief description)	
Date Notified to SAO/LAO	
Date of SIMT/Review decision meeting:	
Date Report Completed	

A.2 Background to Incident	*Include detail of:* *The background to the service user e.g. their health status and reason for admissions/attendance* *A brief chronology of the events leading up to the incident.*
A.3 Actions taken to date	*Include detail of the current status of the service user affected and assurance that the following have been addressed:* ▪ *The immediate care needs of the service user and that, if required, a plan for further care is in place.* ▪ *An assessment to identify any immediate actions required to prevent harm to others as a consequence of the incident.* ▪ *The immediate supports needs of persons affected i.e. service users, -relevant person(s) and staff* ▪ *Detail of any meetings held with the service user/-relevant person(s)* ▪ *That Open Disclosure has been initiated or if not that an explanation of why not, is provided.* ▪ *That a named service user/-relevant person(s) and staff designated support persons have been appointed* ▪ *Detail of any questions or issues raised by the relevant person(s) that require consideration by the SIMT/Review decision making meeting.* ▪ *That the incident has been factually documented in the service user's healthcare record.* ▪ *That any equipment or drugs implicated in the incident have been taken out of service and retained for examination.* ▪ *That the incident has been reported onto NIMS and to any other bodies/agencies external to the service.*

Part B – Record of Decision (to be completed at the SIMT/or review decision making meeting)

B.1 Management of Incident to date
Based on Part A and discussions at the meeting include here an assessment of the adequacy of actions taken or planned in relation to the incident. Include also details of any further actions required.

B.2 Appropriate Pathway for Review of Incident Reported
Having considered Part A is the SIMT/Review decision making meeting satisfied that the Incident Management Framework is the appropriate pathway for the management of this issue? ☐ Yes ☐ No
If No, please indicate which alternative review/investigation route is most appropriate. (See making decisions about appropriate reviews/investigations pathways guidance – IMF Guidance Section 3)
If Yes, AND it is also decided appropriate to also conduct a review/investigation using an alternative pathway, please document below the alternative pathway and recommendation in relation to scheduling of the two processes.

B.3 Information required for decision making in relation to review under the IMF
Is further information required to assist a decision to review? Please select one option below: ☐ Yes ☐ No
If Yes, please indicate the type of information required
Healthcare Record Review ☐
Other Specify:

B.4 Approach to review		
Please indicate the decision as to the approach of review to be conducted. Please select one option below:		
Comprehensive Review	☐	If Comprehensive Review is selected, proceed to Part C
Concise Review	☐	If Concise Review is selected, proceed to Part C.
No further Review	☐	If No Further Review selected complete Section B.5 and refer to relevant Quality and Safety Committee for completion of B.6.

B.5 Sign off of decisions where No Further Review Required
If the decision is NOT to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based, **Reason:**
Please outline below, any learning opportunities identified along with the arrangements required to ensure that these inform relevant care or management practice.
Date:

For Category 1 Incidents Senior Accountable Officer (SAO) Details
Name: Signature:
Date:

For Category 2 Incidents Local Accountable Officer (LAO) Details
Name: Signature: Date:

Decisions where No further Review required must be:

- Submitted for review and ratification by the relevant Quality and Safety Committee or other equivalent committee
- Communicated to persons affected i.e. service user, relevant person(s) and staff.
- Entered onto NIMS and this should include the reason and rationale for same.

These incidents should be incidents in an Aggregate Review process.

B.6 No Further Review Required – Ratification of Decision
Ratified by Quality and Safety Committee or equivalent committee Please select one option below: ☐ Yes ☐ No If No is chosen please outline the reason for this below and submit this form to the SAO/LAO (as appropriate) **Reason:**
Date:

Part C – for Incidents where a decision to further Review has been taken, please complete this section

C.1 Comprehensive Review

A decision has been taken to commission a Comprehensive Review

☐ Yes ☐ No

Note: The Final Report of the Comprehensive Review must be accepted by the Review Commissioner within 125 days of occurrence of the incident.

C.2 Concise Review

A decision has been taken to commission a Concise Review

☐ Yes ☐ No

If the decision is to commission a Concise Review, indicate whether this will be by way of any option below. Please select one below:

Multidisciplinary Team Approach

(Tick appropriate box for methodology to be used)

Systems Analysis ☐

After Action Review ☐

Incident Specific Review Tool ☐

Desktop Review ☐

The Final Report of the Concise Review must be accepted by the Review Commissioner within 125 days of occurrence of the incident.

C. 3 Level of Independence attaching to the review.

Please select one option below

1. Membership of Team internal to the team/department/NAS Operational Region ☐
2. Membership of Team internal to the service/hospital/NAS Operational Area ☐
3. Membership of Team external to the service/hospital but internal to the CHO/HG/NAS Corporate Area ☐
4. Membership of Team involve persons external to the CHO/HG/NAS Directorate ☐

C.4 Scope of the Review

This should set out the timeframe to be reviewed e.g. from admission to incident occurrence, from referral to incident, from X date to Y date.

C. 5 Composition of the Review Team

Whilst it is not necessary to identify by name members of the Review Team at this stage the composition by title/profession should be listed.

C. 6 Contacts in relation to the review process

Review Commissioner (SAO – Category 1 Incidents or LAO – Category 2 Incidents)

Name:

Email:

Telephone:

Service User Designated Support Person

Name:

Email:

Telephone:

Staff Liaison Person

Name:

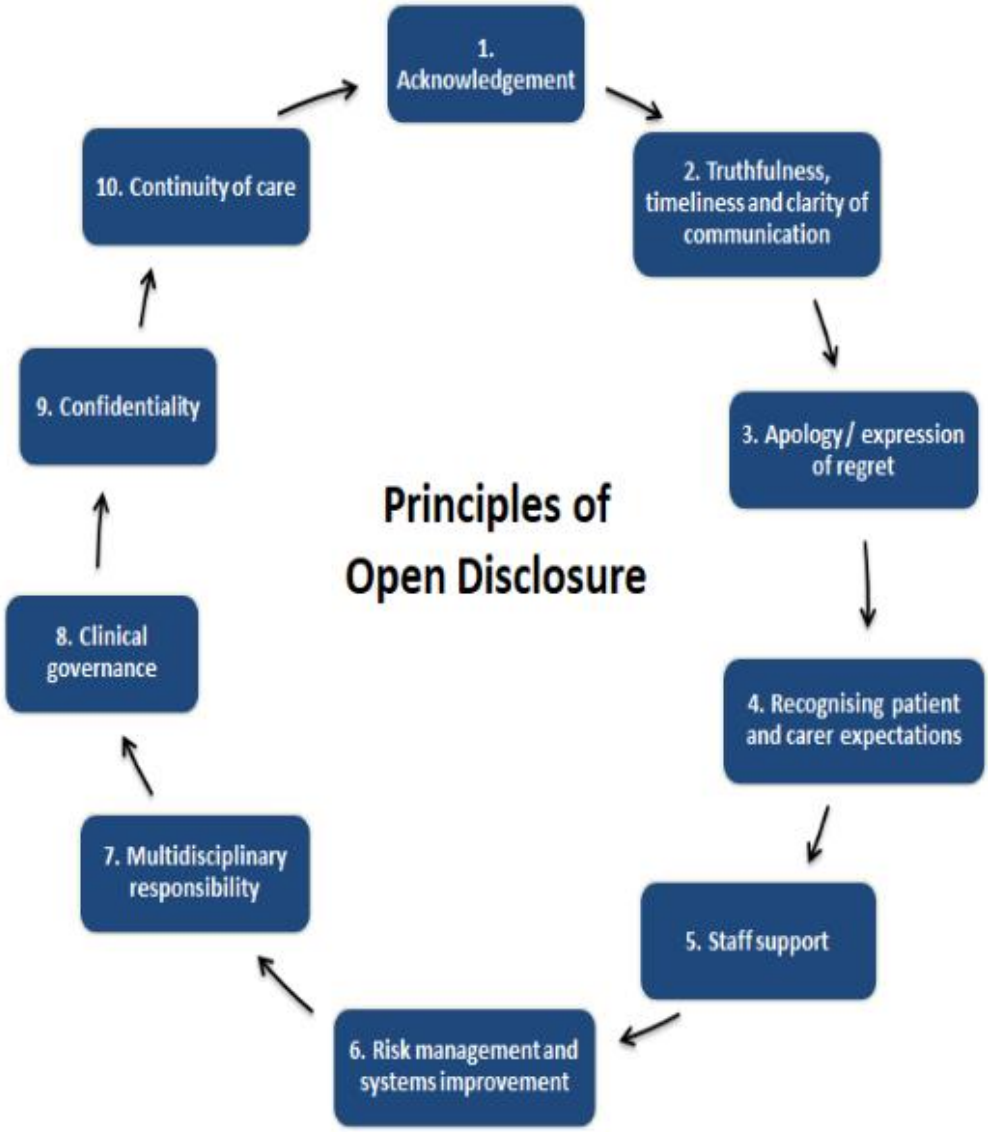
Email:

Telephone:

Appendix 4: The Principles of Open Disclosure

There are 10 principles that underpin the Open Disclosure Process as outlined below.

For detailed information on these principles please refer to HSE Open Disclosure policy Open Disclosure Policy



Appendix 5: HIQA Notifiable Events

Form	Nature of Notification	Timeframe	Person Responsible
3 Day Monitoring Notifications			
NF01	The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre	Within three working days of the incident	Person in Charge
NF02	Outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre	Within three working days of the incident	
NF03	Any serious injury to a resident which requires immediate medical or hospital treatment	Within three working days of the incident	
NF05	Any unexplained absence of a resident from the designated centre	Within three working days of the incident	
NF06	Any allegation, suspected or confirmed abuse of any resident	Within three working days of the incident	
NF07	Any allegation of misconduct by the registered provider or by staff	Within three working days of the incident	
NF08	Any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body	Within three working days of the incident	
NF09	Any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place	Within three working days of the incident	
Quarterly Monitoring Notifications			
NF39 A	Any occasion where restraint was used	Quarterly return	Person in Charge
NF39 B	Any occasion of fire alarm activation	Quarterly return	
NF39 C	Recurring pattern of theft or burglary	Quarterly return	
NF39 D	Any injury to a resident that did not require notification within 3 working days	Quarterly return	
NF39 E	Any death(s) other than those notified under NF01	Quarterly return	
Six-monthly nil-return notification			
NF40	Where no incidents which require to be notified under Regulation 31 have taken place within the preceding six months	Six monthly	Person in Charge

Appendix 6: Shared Leaning Notice

SHARED LEARNING NOTICE

What Happened?	
How did it happen?	
Why did it happen?	
What will reduce the risk?	

EVERYONE is responsible for patient safety

Please bring this to the attention of all staff