1.0 Policy

All incidents, or potential incidents, occurring in The Children's Sunshine Home, CSH Childcare Services and The Children's Sunshine Home Trust operating as LauraLynn Ireland's Children's Hospice (known as the Service) shall be identified, documented, rectified, reviewed and appropriately communicated to the people involved. The Service shall promote a positive and open culture of reporting incidents or potential incidents. The Service shall keep the child, adult or family informed of any related incident or potential incident, provide an expression of regret where appropriate and provide feedback on any investigations completed and the steps taken to prevent a reoccurrence of the incident or potential incident.

The Incident Reporting Policy has been developed in alignment of the principles set out in the HSE's Incident Management Framework (2020) and Open Disclosure Policy (2019) to provide an overarching practical 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 Scope

2.1 The policy applies to all staff, volunteers, children, adults in residence and families, contractors and members of the public.

3.0 Definitions

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

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

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

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

3.5 *Corrective Action:* Action taken to eliminate the cause of incidents in order to prevent recurrence.

3.6 *CPCS:* Children's Palliative Care Services.

3.7 *DRS:* Disability Residential and Respite Services.

3.8 *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.

3.9 *Incident:* An event or circumstance which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events which could result in harm; near misses which could have resulted in harm, but did not cause harm either by chance or timely intervention; and staff or service user complaints which are associated with harm.

Incidents can be clinical or non-clinical and include incidents associated with harm 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

Examples of occurrences that may require an incident report to be raised include (but not limited to) the following:

- Child, adult in residence, staff or member of the public, Trip, Slip or Fall
- Medication errors, including medication near misses; (Ref No: 6.1.6 Medication Error Reporting & Prevention Procedure CPCS & DRS)
- Adverse drug reactions (Ref No: 6.1.2 Administration of Medications Procedure CPCS & DRS)
- Incorrect Documentation
- Behaviours of Concern (Children, Adults in residence, Public, Staff) e.g. self-injurious behaviour, violence, harassment or aggression
- Suspected or actual child or vulnerable person abuse (Ref No: 5.1 Child Protection & welfare Policy and Ref No: 5.2 Management of Suspected or Alleged Abuse for Vulnerable Adults Policy)
- Accident with a Service Vehicle
- Health and Safety Incident (e.g. loose wiring, equipment Ergonomics)
- Defect or damage to adult/children's equipment
- Outbreak of infectious disease
- Injury to a child or adult in residence (including bruises)
- Security breach including confidentially and data protection
- Serious injury to a child or adult in residence
- Unexplained absence of a child or adult from the Service (Ref No: ND017 Missing child/adult procedure)
- Spills or exposures to chemicals or hazardous waste (Ref No: 7.3 Prevention and Control of Health Care Associated Infections Policy)
- Fire or incident where evacuation of the Service took place
- Environmental: Security breach, food safety, general hygiene, water supply etc.
- Staff injury
- Staff factors e.g. Staff resources (unforeseen changes, reductions in staffing)
- Trends identified as part of the Service's continuous improvement process

3.10 *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.

3.11 *Medication error:* Preventable events that may cause or lead to inappropriate medication use or service user harm while the medication is in control of the health care professional or the child or adult's family. These events may be associated with professional practice, health care products, procedures and systems. They include prescribing, order communication, product labelling, packaging, nomenclature, compounding, dispensing, distributing, supplying, administration, education, monitoring and use.

3.12 *National Policy:* Health Service Executive (HSE) and State Claims Agency (SCA) "Incident Management Framework" and "Open Disclosure National Policy".

3.13 *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 service user during the provision of a health service to that service user.

3.14 *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. DCS), but not for Section 39 HSE funded agencies (i.e. CPCS).

3.15 *Open Disclosure:* An open, consistent, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety 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.

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

3.17 *Relevant Person: "*Relevant person", in relation to a service user, means a person –
(a) who is –
(i) a parent, guardian, son or daughter
(II) a spouse, or
(iii) a civil partner of the service user
(b) who is cohabiting with the service user
or
(c) whom the service user has nominated in writing to the service as a person to whom their clinical information may be disclosed

3.18 *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. .

3.19 *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.

3.20 *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.

4.0 Responsibility

4.1 *All Staff*: Are responsible for the following:

- Identification of incidents
- Assisting in identifying solutions and improvements to prevent reoccurrence of such events
- Comply with the services procedures
- Ensure that incidents are reported immediately or at the latest within the first 24 hours of the incident occurring
- Participate in and co-operate with reviews/investigations conducted in accordance with service procedures
- Participate in the introduction of change identified as a consequence of a review/investigation
- Comply with their professional codes of conduct as they relate to incident management

4.2 *CEO:* Responsible for ensuring any required changes are implemented where appropriate in response to incident trends, and, to review and monitor the Incident Management Policy.

4.3 *Health and Safety Committee*: To review any non-clinical incidents and to provide recommendations for implementation.

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

4.5 *Line Manager*: Identification, investigation and rectification of all incidents. Support staff as detailed within section 9.0 of this procedure.

Provide an environment in which staff feel supported in the identification and reporting of an incident or potential incident and also during the open disclosure and review process following the incident or potential incident.

4.6 *Medication Management and Incident Review Group:* is responsible for reviewing all medication incidents and all other clinical incidents, and provide recommendations for implementation.

4.7 *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 regards 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

4.8 *Quality, Safety and Risk Manager*: is responsible for the following:

- Effective management and implementation of the incident reporting process
- Ensuring that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property
- Reviewing of incidents and trending of incidents and reporting trends to the Quality, Safety and Risk Committee and the CEO
- Ensuring that the Service complies with the HSE National Policy

- Ensuring that all employees are aware of, and comply with, the HSE National Policy and the related Open Disclosure Guidelines
- Provide Open Disclosure training to all staff in the service
- Facilitating training for staff where necessary
- Ensuring that staff involved in an incident or potential incident are identified, monitored and provided with adequate support in the aftermath of the incident or potential incident and also throughout the open disclosure and incident review process
- Addressing incidents or potential incidents of non-compliance with the HSE National Policy
- Ensure all external organization(s) are informed of any reportable incidents

5.0 Principles

5.1 The following core principles shall underline the Service's incident reporting system:

- Person-Centred: The needs of persons affected (service users, 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 (service users, staff) 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 to be taken to learn from it
- 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

5.2 Staff members have an obligation under the National Standards for Safer Better Healthcare 2012 and Open Disclosure Policy 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".

5.3 All staff shall be aware that where they make a prompt, full and honest report regarding any incident or potential incident, that they will not be disciplined, except under any of the following criteria where:

- An employee acted criminally, or in a deliberately malicious manner
- Incidents or potential incidents are deliberately concealed
- An employee is guilty of gross negligence or professional misconduct with potential for serious consequences and where the person could reasonably be expected to appreciate the possible results of their behaviour (e.g. Medication Management). Account will be taken of previous knowledge, training and experience when assessing the ability to appreciate the consequences.

Where any of the above incidents or potential incidents arise, this shall be managed as per Ref No: 3.13 Disciplinary Policy.

5.4 The Service shall ensure that consideration is given to the ten principles designed to assist the Service to create and embed a culture of open disclosure (see Appendix 1: The Principles of Open Disclosure).

5.5 Where, after consideration of a near miss event, it is determined that there is a risk of/potential for future harm from the event then this shall be discussed and managed as per 6.0 below.

5.6 Incidents, regardless of their impact, require management in line with the following steps:

- Prevention through a supporting culture where safety is considered a priority
- Identification and immediate actions required (for persons directly affected and to minimise risk of further harm to others)
- Initial reporting and notification
- Assessment and categorisation
- Review and analysis
- Improvement planning and monitoring

6.0 Incident Identification and Immediate Actions Required

6.1 Incidents or potential incidents 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)

6.2 Where an incident or potential incident has occurred, the staff member or volunteer shall take immediate containment action where appropriate. This may involve:

- Making the environment safe
- Ensure wellbeing of child or adult, staff, volunteer or member of the public involved, and direct them for immediate medical review, where required. If they refuse medical attention, this should be recorded in the incident reporting record
- Assess the incident or potential incident and initiate steps to correct immediate causes in order to prevent reoccurrence
- Provide support to the staff/volunteers involved
- Initiate the open disclosure procedure

6.3 Incidents where the impact is Negligible, Minor or Moderate, 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.

6.4 All incidents identified as having a Major of Extreme impact 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.

6.5 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 this 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

6.6 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

7.0 Initial Notification and Reporting

7.1 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 incidents 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 an Adverse Event Reporting form (see Appendix 5) immediately or at the latest within the first 24hrs.
- Consider any internal and external reporting requirements
  - Where the incident is a statutory notifiable event the Director of Nursing (DoN) and Quality, Safety and Risk Manager (QSRM) 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/QSRM, 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 potential incident 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

7.2 All staff, volunteers and members or the public have a responsibility for ensuring that all incidents/near misses are reported **immediately or at the latest within the first 24 hours** of the incident occurring to the Clinical Nurse Manager or line manager. The incident form can be completed, via hard copy.
Where the incident or potential incident is reported orally, it shall be confirmed in writing (by the person reporting the incident) within three working days of the occurrence of the incident.

7.3 The relevant line manager shall be nominated as owner of the Incident and receive a copy of the form no later than 24 hours of the incident occurring. The incident reporting database shall be updated by the Quality, Safety and Risk Officer to reflect the new incident.

7.4 Incident forms shall be referred to the appropriate committee e.g. Medication Management, Incident and Risk Review Group or the Health and Safety Committee.

8.0 **Categorisation and Initial Assessment:**

8.1 The line manager in conjunction with the staff involved shall determine, the actions required, the impact rating, if debriefing is required for staff and other classifications for the incident or potential incident. The line manager shall also delegate responsibility for management of the incident or potential incident stages. These stages may require a systems analysis review to be completed.

8.2 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.
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

HSE's Risk Impact Table is included at Appendix 3

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

8.4 A preliminary assessment shall be carried out on **Category 1** and **Category 2** incidents due to level of harm incurred. The assessment shall support a formal decision being made in relation to the type of review required.

8.5 Category 1 incidents must be referred to the **Serious Incident Management Team (SIMT)** for decision making in relation to their management. Ideally decisions relation 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.

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 in order 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.

8.6 In order to assist decision making at the SIMT on notification of the incident the CEO shall assign an appropriate person e.g. QSRM to gather the information required for the completion of the preliminary assessment. This shall then be presented to the SIMT meeting in order to assist in framing the discussion relating to the need for further review of the incident.

8.7 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 QSRM, to determine the key causal factors and contributing factors to the incident or potential incident. Staff who were involved in the incident shall be informed that a system analysis review is being conducted.

8.8 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

In this case the investigation process may be completed in accordance to the HSE Systems Analysis Guidance for Services (2018), the following may be developed as required:

- Serious Incident Management Team
- Terms of Reference for Investigation
- Incident Management Team Agenda
- Incident Report

These documents will be incorporated as part of the incident management documentation and retained in conjunction with the incident record, which is stored in the Quality, Safety and Risk Department.

8.9 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?

8.10 Where the incident is identified to have a severity rating of Moderate or Low, the Department Manager shall be notified.

The Line Manager shall review the incident and determine in consultation with the Department Manager where required, if a systems analysis review is required.

8.11 Where the incident or potential incident involved a child or adult and has resulted in injury, the child or adult shall be referred to the relevant health care professional e.g. Physiotherapist, Occupational Therapist, GP etc. for review.

8.12 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

8.13 Corrective and preventive actions are identified and assigned for each incident to reduce the identified risk, address responsibility for implementation as appropriate, 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 supports required as a result of the incident or potential incident.

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.
The line manager shall be responsible for determining and assigning appropriate timeframes for completion of the incident, taking account of the particular circumstances and severity rating of the incident. However, a default target date of **28 days** shall be assigned to all incidents.

8.14 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 shall ensure all categories have been completed and that they are satisfied the actions have been implemented.

Once all actions have been completed it is the responsibility of the Quality, Safety and Risk Manager to close out the incident.

8.15 Closed clinical incidents shall be reviewed at the Medicines Management, Incident and Risk Review Group and non-clinical incidents at the Health & Safety Committee, to approve closure.

The incident reporting database shall be updated to reflect the status of the incident.

8.16 The QSRM shall undertake trending and analysis of all incidents or potential incidents on a monthly basis. This information shall be presented in a report for review by the Quality, Safety and Risk Committee.

A full review of the incidents reported, the root-cause analysis completed, adverse levels, pattern and identifiable trends from the data analysis shall be completed as part of the Quality and Safety Management Review.

9.0 Notifiable Events

9.1 Certain incidents are notifiable to HIQA within a certain timeline. For full details of notifiable events please see appendix 3 & 4.

9.2 The QSRM in conjunction with the DoN/ADoN and QSR Officer 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
- 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)

Notifiable events shall also be reviewed in line with the services risk management register.

9.3 The service is also required to report all incidents relating to the disability services through the National Incident Management System (NIMS) which is managed by the State Claims Agency.

10.0 Incident Reporting Database

10.1 All incidents shall be inputted onto the incident reporting database when an incident occurs.

10.2 The database shall be updated by the QSR Officer on a regular basis to reflect the current status of an incident.

11.0 Staff Education

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

- Identification of an incident or potential incident
- Completion of an Incident Report

11.2 Line managers shall receive internal training on risk rating incidents and conducting a systems analysis review.

11.3 Staff, shall be educated regarding medication errors and near misses and the importance of, and process for, reporting them.

11.4 The Service shall facilitate all staff to receive training in open disclosure.

12.0 Staff Support

12.1 Line managers in conjunction with the QSRM shall:

- Support staff involved in a serious incident/serious reportable events/ near miss, in terms of their compliance with this policy and follow-ups required
- Treat staff fairly and equitably during a review/investigation arising from a serious incident/near miss
- Provide feedback to staff in a timely and honest manner to staff (and relevant child, adult, family or members of the public) on outcome of the 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

13.0 Records

13.1 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.

13.2 Records include:

- Incident reports
- Analysis of incidents/systems analysis reviews
- Child or adult records
- Minutes of meetings

14.0 Audit and Evaluation

14.1 An annual audit shall be undertaken by the QSRM to determine compliance to this policy and procedure, including an audit of implementation and compliance is conducted in the Service for open disclosures. Areas for auditing shall include the following:

- The inclusion of open disclosure in the incident or potential incident management process
- The child or adults' experiences of the open disclosure process
- Staff experiences of the open disclosure process
- Management of open disclosure (as per the Appendix 1: The Principles of Open Disclosure).

The QSRM shall complete this via a review of relevant records, including incident reports, through observation. Results of these audits are presented to the Quality, Safety and Risk Committee.

15.0 Appendices:

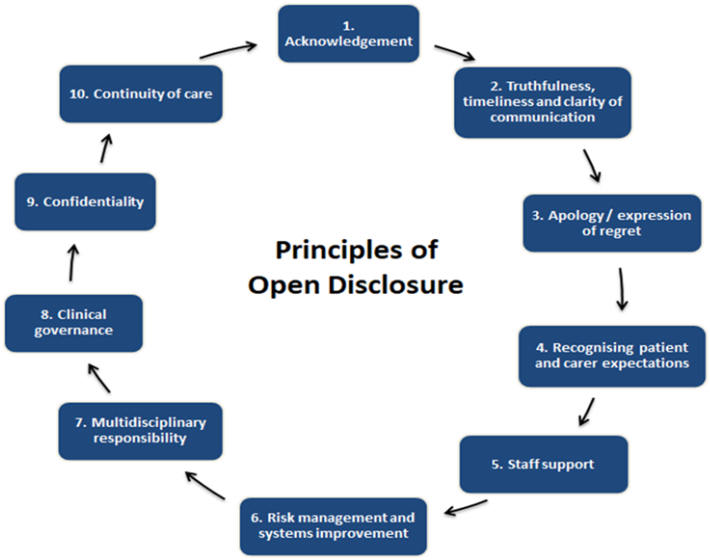
15.1 Appendix 1: The Principles of Open Disclosure
15.2 Appendix 2: Impact Table (Negligible, Minor, Moderate, Major & Extreme) with examples
15.3 Appendix 3: HIQA Notifiable Event
15.4 Appendix 4: Notifiable Diseases
15.5 Appendix 5: Adverse Event Reporting Form

15.1 Appendix 1: The Principles of Open Disclosure

The Principles of Open Disclosure

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology/Expression of Regret
4. Recognise Patient and Carer expectations
5. Staff Support
6. Risk Management and Systems Improvement
7. Multidisciplinary Approach
8. Clinical Governance
9. Confidentiality
10. Continuity of Care

CARE COMPASSION TRUST and EMPATHY



1. **Acknowledgement:** Acknowledge to the child, adult or family that an adverse event has occurred and initiate the open disclosure process, in line with National Policy.

2. **Truthfulness, timelines and clarity of communication:** The child, adult or family shall be provided with information in a timely manner – focusing on the factual information available at the time. Ideally the open disclosure process should commence within 48 hours of the event occurring or the event becoming known and as soon as the child or adult is physically and emotionally available to receive the information.

3. **Apology/expression of regret:** An apology/expression of regret, regarding the condition of the child, adult or family and for what has happened as a result of an adverse event, it is important and should be forthcoming. When it is clear, following a review of the adverse event, that the service is responsible for the harm to the child or adult it is imperative that there is an acknowledgement of responsibility and an apology provided as soon as possible after the event.

4. **Recognising the expectations of a child or adult and the carer:** The child, adult or family/carer may reasonably expect to be fully informed of the facts and consequences in relation to the adverse event and to be treated with empathy and respect.

5. **Staff support:** The Service shall promote the development of a "just culture" as staff will be encouraged and willing to report incidents/potential incidents/adverse events/near miss events. Staff shall expect to be supported by the Service following an adverse event and throughout the open disclosure and incident or potential incident review process.

6. **Risk management and systems improvement:** The investigation of adverse events shall be undertaken in line with the services Risk Management Policy and Procedure and be inclusive of the review of recommendations to ensure that any recommendations/actions taken are effective and that they will reduce the likelihood of a recurrence of the event.

7. **Multidisciplinary responsibility:** Open disclosure involves multidisciplinary accountability and response. Health and Care Professionals shall be identified to lead in and support the process.

8. **Clinical governance:** The open disclosure process is one of the key elements of the Services governance system. The Service is required to have appropriate accountability structures in place which ensure that open disclosure occurs and that it is integrated with other clinical governance systems and processes, including clinical incident reporting and management procedures, systems analysis reviews, complaints management and privacy and confidentiality procedures.

9. **Confidentiality:** The information collated following an incident is often of a sensitive nature and therefore child or adult confidentiality is paramount. Child or adult information is generally held under legal and ethical obligations of confidentiality. All policies, procedures, and guidelines in relation to privacy and confidentiality for child or adults and staff should be consulted with and adhered to.

10. **Continuity of care:** Steps need to be taken to reassure the child or adult in relation to the management of their immediate care needs and to also reassure them that their care will not be compromised going forward. Transfer of care to another facility may be requested by the child's or adult's family and should be facilitated where it is possible to do so. A member of staff should be identified who will act as a contact person for the child or adult to keep them informed of the situation and to maintain open channels of communication between the child or adult and the Service.

15.2 Appendix 2: Impact Table (Low, Minor, Moderate, Major & Extreme) with examples (HSE, 2014)

	Low (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Injury	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning	Minor injury or illness, first aid treatment required <3 days absence < 3 days extended hospital stay Impaired psychosocial functioning greater than 3 days less than one month	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardaí (violent and aggressive acts). >3 Days absence 3-8 Days extended hospital Stay Impaired psychosocial functioning greater than one month less than six months	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Impaired psychosocial functioning greater than six months	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or member of the public Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being to talked to & treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week)	Unsatisfactory service user experience related to poor treatment resulting in long term effects	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision
Compliance with Standards (Statutory, Clinical, Professional & Management)	Minor non-compliance with internal standards. Small number of minor issues requiring improvement	Single failure to meet internal standards or follow protocol. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / Regulations (e.g. Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Business Continuity	Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service.	Short term disruption to service with minor impact on service user care.	Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect

	Low (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Adverse publicity/ Reputation	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No Review /investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on staff morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in Dail. 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 & features in National papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dail. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.
Financial Loss	<€1k	€1k – €10k	€10k – €100k	€100k – €1m	>€1m
Environment	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

15.3 Appendix 3: 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

15.4 Appendix 4: Notifiable Diseases and their respective causative pathogens specified to be Infectious Diseases under Infectious Diseases (Amendment) Regulations 2018 (S.I. No. 567 of 2018) (Dec 2018)

Disease	Causative Pathogen
Acute anterior poliomyelitis	Polio virus
Ano-genital warts	Human papilloma virus
Anthrax	*Bacillus anthracis*
Bacillus cereus food-borne infection/intoxication	*Bacillus cereus*
Bacterial meningitis (not otherwise specified)	
Botulism	*Clostridium botulinum*
Brucellosis	*Brucella* spp.
Campylobacter infection	*Campylobacter* spp.
Carbapenemase producing *Enterobacteriaceae*, infection or colonisation	Carbapenemase producing *Enterobacteriaceae*, infection or colonisation
Chancroid	*Haemophilus ducreyi*
Chickenpox – hospitalised cases	Varicella-zoster virus
Chikungunya disease	Chikungunya virus
Chlamydia trachomatis infection (genital)	*Chlamydia trachomatis*
Cholera	*Vibrio cholerae*
Clostridium difficile infection	*Clostridium difficile*
Clostridium perfringens (type A) food-borne disease	*Clostridium perfringens*
Creutzfeldt Jakob disease	
variant Creutzfeldt Jakob disease	
Cryptosporidiosis	*Cryptosporidium parvum, hominis*
Cytomegalovirus infection (congenital)	Cytomegalovirus
Dengue fever	Dengue virus
Diphtheria	*Corynebacterium diphtheriae* or *ulcerans* (toxin producing)
Echinococcosis	*Echinococcus* spp.
Enterococcal bacteraemia	*Enterococcus* spp. (blood)
Escherichia coli infection (invasive)	*Escherichia coli* (blood, CSF)
Giardiasis	*Giardia lamblia*
Gonorrhoea	*Neisseria gonorrhoeae*
Granuloma inguinale	*Klebsiella granulomatis*
Haemophilus influenzae disease (invasive)	*Haemophilus influenzae* (blood, CSF or other normally sterile site)
Hepatitis A (acute) infection	Hepatitis A virus
Hepatitis B (acute and chronic) infection	Hepatitis B virus
Hepatitis C infection	Hepatitis C virus
Hepatitis E infection	Hepatitis E virus
Herpes simplex (genital)	Herpes simplex virus
Herpes simplex (neonatal)	Herpes simplex virus
Human immunodeficiency virus infection	Human immunodeficiency virus
Influenza	Influenza A and B virus
Klebsiella pneumoniae infection (invasive)	*Klebsiella pneumoniae* (blood or CSF)
Legionellosis	*Legionella* spp.
Leprosy	*Mycobacterium leprae*
Leptospirosis	*Leptospira* spp.
Listeriosis	*Listeria monocytogenes*
Lyme disease (neuroborreliosis)	*Borrelia burgdorferi*
Lymphogranuloma venereum	*Chlamydia trachomatis*
Malaria	*Plasmodium falciparum, vivax, knowlesi, ovale, malariae*
mcr-positive *Enterobacteriaceae* infection or colonisation	*mcr*-positive *Enterobacteriaceae* infection or colonisation

Disease	Causative Pathogen
Measles	Measles virus
Meningococcal disease	*Neisseria meningitidis*
Mumps	Mumps virus
Non-specific urethritis	
Novel or Rare Antimicrobial-resistant Organism (NRAO)	
Noroviral infection	Norovirus
Paratyphoid	*Salmonella* Paratyphi
Pertussis	*Bordetella pertussis*
Plague	*Yersinia pestis*
Pseudomonas aeruginosa infection (invasive)	*Pseudomonas aeruginosa* (blood or CSF)
Q Fever	*Coxiella burnetii*
Rabies	Rabies virus
Respiratory syncytial virus infection	Respiratory syncytial virus
Rotavirus infection	Rotavirus
Rubella	Rubella virus
Salmonellosis	*Salmonella* spp. other than *S.* Typhi and *S.* Paratyphi
Severe Acute Respiratory Syndrome (SARS)	SARS-associated coronavirus
Shigellosis	*Shigella* spp.
Smallpox	Variola virus
Staphylococcal food poisoning	Enterotoxigenic *Staphylococcus aureus*
Staphylococcus aureus bacteraemia	*Staphylococcus aureus* (blood)
Streptococcus group A infection (invasive)	*Streptococcus pyogenes* (blood, CSF or other normally sterile site)
Streptococcus group B infection (invasive)	*Streptococcus agalactiae* (blood, CSF or other normally sterile site)
Streptococcus pneumoniae infection (invasive)	*Streptococcus pneumoniae* (blood, CSF or other normally sterile site)
Syphilis	*Treponema pallidum*
Tetanus	*Clostridium tetani*
Toxoplasmosis	*Toxoplasma gondii*
Trichinosis	*Trichinella* spp.
Trichomoniasis	*Trichomonas vaginalis*
Tuberculosis	*Mycobacterium tuberculosis* complex
Tularemia	*Francisella tularensis*
Typhoid	*Salmonella* Typhi
Typhus	*Rickettsia prowazekii*
Verotoxigenic *Escherichia coli* infection	Verotoxin producing *Escherichia coli*
Viral encephalitis	
Viral haemorrhagic fevers	
Viral meningitis	
West Nile fever	West Nile virus
Yellow fever	Yellow fever virus
Yersiniosis	*Yersinia enterocolitica, Yersinia pseudotuberculosis*
Zika virus infection	Zika virus

Please refer to the case definitions for the above diseases. The up-to-date list of diseases and case definitions are available on the HPSC website at www.hpsc.ie/notifiablediseases

15.5 Appendix 5: Adverse Event Reporting Form

Risk Database No _____

Section 1. General Information

Date of occurrence (dd/mm/yyyy) ____/____/____ Time of occurrence (24hrs) ____:____hrs
Date event reported (dd/mm/yyyy) ____/_____/____ Location_____ Specific Area_____

Individual affected:
Name_____ LLIN: _____ D.O.B (dd/mm/yyyy) ____/____/____ Gender M ☐ F☐

Staff ☐ Child ☐ Adult ☐ Volunteer ☐ Family Member ☐ General Public ☐ Agency ☐ Contractor ☐

Section 2. Details of the incident

Safety Incident/Adverse Event ☐ Near Miss ☐

Brief factual description of the incident (If you need to add more information use an additional page):

_____
_____
_____

Incident type

☐ Medication Incident	☐ Discharge Incident	☐ Records / Documentation Incident	☐ Equipment / Device Incident	☐ Theft / Fraud
☐ Diagnosis Incident	☐ Client Absconsion	☐ Infection Control Incident	☐ Inappropriate Behaviour	
☐ Treatment incident	☐ Environmental	☐ Unexplained Injury/ Unknown cause	☐ Other Unplanned Events	
☐ Client Self-Harm	☐ Slip / Trip / Fall	☐ Violence / Harassment / Aggression	☐ Consent / Confidentiality Incident	

Section 3. Outcome at the time of the incident (rated as per the HSE's Risk Impact Table)

Category 3 (Low/Minor)	Near Miss e.g. Nearly given wrong drug
	No Injury e.g. Wrong drug given but no harm occurred
	Injury not requiring first aid
	Injury or illness, requiring first aid
Category 2 (Moderate)	Injury requiring medical treatment
Category 1 (Major/Extreme)	☐ Long-term disability / Incapacity (incl. psychosocial)
	☐ Category 1 Permanent Incapacity (incl. Psychosocial)
	☐ Death

Part of the body injured (If applicable)

☐ Arm/Elbow	☐ Face/Neck	☐ Foot/Ankle	☐ Respiratory System	☐ Other
☐ Back	☐ Eye	☐ Hand/Wrist	☐ Multiple Sites affected	
☐ Chest/Shoulder	☐ Head	☐ Leg/Knee/Hip	☐ Whole Body (Systemic effects)	
☐ Ear	☐ Finger(s)/Toe (s)	☐ Pelvic Area/Abdomen	☐ Psychological	

Injury/Damage caused (please supply details):

_____
_____

Initial Action Taken

☐ First Aid Given ☐ Reassurance Given ☐ Referred to Nurse, GP or A&E ☐ Other (Specify*)

☐ Observation ☐ Parents/Next of Kin Informed ☐ Sent Home/Off Duty

Section 4. Contributory Factor(s)

Primary_____

_____

_____

Secondary_____

_____

_____

Section 5. Corrective / Preventive Actions

Type of action

☐ No action required ☐ Minimal action ☐ Moderate action ☐ Major action

Action(s)	Responsible Person(s)	Closed by (date)

Recommendations to prevent incident from reoccurring

_____

_____

Section 6. Report Closure (Signed on completion of all corrective actions/incident report closure)

Reported by (Name):_____ Title: _____ Signature: _____

Reported to (Name): _____ Title: _____ Signature: _____

Witness (Name): _____ Title: _____ Signature: _____

Reviewed by Clinical Nurse Manager (Name): _____

Reviewed by Risk Review Group: ____/___/____ Date Logged ____/____/____ Closed/Open: _____
NIMS No (If applicable): _____ Date logged ____/____/____

Section 7. Review by QRS Manager/Line Manager
Were all the corrective actions implemented? Yes___ No___

Has open disclosure happened? (tick one only) ☐ Yes ☐ No

If No, please specify: _____

_____

QRS Manager (Name): _____ Signature_____