Policy on Accidents to Residents, Employees or Visitors.	
Developed by: Director of Nursing Office and Clinical Nurse Managers and Risk Advisor for CHO8	**Date Developed: Revised February 2011 Revised February 2015, December 2017 October 2020, September 2023**
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Reporting safety incidents & serious reportable events

All safety incidents must be reported to a line manager. NAEMS is the national system to electronically record all reported incidents. NAEMS enables all incidents, including incidents that might be classified as *"sentinel events"; "serious reportable events"* or *"never events"* to be reported, classified and analysed, to inform local and national safety improvements. It is the policy of the HSE to use the term *"serious reportable events".* A governance group will oversee the list of "serious reportable events" and associated guidance for implementation. The list of *"serious reportable events"* will be reviewed annually. The list of *"serious reportable events"* is included within Appendix 1.

7.2.2.1 Responsibilities of the person who identified or observed the safety incident

Following the identification of a safety incident, the following steps are the responsibility of the person who identified or observed the incident*:*

• Immediately manage, or have someone manage, any immediate safety concerns

Management of immediate safety concerns

The following is a list of essential steps to manage immediate safety concerns following the identification of any safety incident.

• When a safety incident is identified, the first responsibility is to ensure that the safety, health and welfare of the person(s) affected are protected.

• Any care that is required as a consequence of the safety incident must be provided without delay and circumstances reported to the treating clinician or, in the case of a non-clinical incident, to the appropriate manager.

• Any threat to the future safety, health and welfare of service users, employees or others must be removed or minimised as far as is reasonably practicable.

• Relevant materials, equipment or supplies that may have contributed to the safety incident must be preserved and retained. Healthcare records must be preserved and retained in line with HSE Standards and Recommended Practices for Healthcare Records Management

QPSD-D-006-3 V3 (2011).

• Where there is a requirement to photograph a person for investigation purposes, HSE guidelines for data protection and consent should be complied with when creating, preserving or retaining such photographs.

• Maintain or resume normal services as soon as it is practicable and safe to do so.

• Employee(s) may be stepped down to ensure that they receive appropriate care and support following a safety incident. For more guidance please see the HSE/SCA guidance document "Supporting Staff following an Adverse Event: The Assist Me Model" (2013).

• Determine if any individual's actions presents an immediate safety concern. There may be a need for immediate precautionary action (e.g. step-down from duty

• Ensure that counselling and support is provided to employees as soon as possible.

• Ensure that appropriate counselling and support details are provided to patients and their families as soon as possible.

• Ensure appropriate communication with the patient / family. See below for Guidelines for Consideration When Communicating with a Patient or Family in relation to an incident.

Guidelines for Consideration When Communicating with a Resident or Family in relation to an incident

Source: Institute for Healthcare Improvement (2011) "Respectful Management of Serious Clinical Adverse Events"

The following elements are offered for organisations to consider to achieve the goal of never losing sight of the patient and family when responding to a patient safety incident:

• Focus first and foremost on the patient's immediate clinical needs while assembling the facts.

• When communicating about the harm that the patient experienced, state what happened, why it happened, and what's being done to prevent it from happening again.

• Appoint an appropriate (determined case by case) staff member as a patient and family point of contact that is available 24 hours a day, 7 days a week.

• As soon as the organisation has new information about the event, inform the patient and family.

• For incidents resulting in death and serious harm and rated as major or extreme on the

Impact Table arrange for consent to access healthcare records to be sought as soon as possible and provide assurance that this will enable the organisation to investigate fully as soon as possible.

• Engage with those members of the patient's extended care team who may not be directly engaged already, including the patient's primary care physician.

• Never let the patient and family encounter excuses, a dead end, emotional distance, or inappropriate body language.

• Ensure that all communications are culturally and linguistically appropriate.

• **Address any concerns the patient and family have as soon as possible.**

• Report the safety incident to their line manager using agreed local processes.

• An incident report form should be completed by an employee involved in or who observed a safety incident as soon as practicable and at least prior to going off duty

• All completed incident report forms are sent to the designated local manager.

Reporting of death and serious harm incidents

In addition to the steps outlined in the section above, all safety incidents which result in death or serious harm must be reported to the senior accountable officer **within 24 hours**. These include incidents categorised as 'major' and 'extreme' on the Impact Table of the Incident, accident Risk management Template

7.2.2.3 Actions taken by managers on receipt of an incident report form

It is the responsibility of each manager to assess and manage minor incidents locally and inform their line manager as required. The following actions must be taken by managers on receipt of an Incident

Report Form in as timely a manner as is possible:

• Review the Incident Report Form.

• Seek assurance that any actions required to ensure that immediate safety concerns have been addressed (including communication and caring for those affected see section).

• Conduct a preliminary assessment to determine the level and type of investigation required

• Communicate / escalate incidents of death and serious harm to the level of management determined by local/national division processes.
• Consider if it is necessary to report factual information to external agencies/authorities as per HSE reporting requirements .
• Ensure all necessary people are informed e.g. senior managers, counselling and support services, and communications personnel. It is essential to involve communications personnel with the management of incidents, particularly with regard to incidents of death and serious harm. Communications personnel assist in the preparation of draft press statements and assist with responses to media queries at local, regional and national level.
• All Incident Report Forms once complete will be sent to the designated local manager and be communicated, if required as per local processes.
• Ensure that all elements of the safety incident management process are followed.

Notifications to the State Claims Agency.

1.0 PURPOSE

To describe the notification requirements of the Clinical Indemnity Scheme for Adverse Events and Near Misses by participating enterprises.

2.0 SCOPE

All enterprises covered by the CIS have a statutory duty to;

 Report all adverse events to the SCA.

 Furnish relevant information when requested to do so.

 Preserve relevant evidence.

 Permit and facilitate SCA investigation to include furnishing when requested to do so by the SCA, complete and properly ordered healthcare records.

This applies to all enterprises covered by the Clinical Indemnity Scheme as listed in S.I. No. 63 of 2003 *National Treasury Management Agency (Delegation of Functions) Order 2003* (Appendix 1) and *National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.*

3.0 RESPONSIBLE PERSON

Risk Advisor/Manager or other HSE / delegated body designated person.

4.0 PROCEDURE:

 Any adverse event or near miss directly related to service user treatment or care which did or could have resulted in an adverse outcome must be reported to the CIS via the National Adverse Event Management System (NAEMS) (formerly STARSWeb) by those enterprises that are "live" on the system, and by paper notification for all other enterprises.

 The adverse event is reported to the local Quality & Risk department or local designated office responsible for managing incident reporting in accordance with the applicable Incident Management Policy and Procedure.

The incident reports are reviewed by the local Risk Advisor or other designated person. Any follow up action is taken, any further information required is sought and the information, including the incident risk rating, is entered on NAEMS incident reporting database within 4 weeks of event occurrence.

 Serious adverse events (Refer to 'Rapid Notification of Serious Adverse Clinical Event & List of Never Events) available on CIS website or those considered likely to result in a claim should be notified to the CIS Clinical Risk Advisor within **48 hours** of their occurrence in tandem with routine notification on NAEMS.

 The incident report should include a factual description of what happened; details of any equipment involved or medication; the initial assessment of the impact and outcome on the individual, the affected part of the body and any ameliorating action taken. This information should be entered on NAEMS.

 To protect the anonymity of the patient/client/resident ensure that the name of the patient/client/resident is not inadvertently used in the "Further Details of Event" field or in any document/note attached as an "Attachment", or in any other free text field on NAEMS.

 Any subsequent additional information relating to the adverse event is to be entered as an attachment to the incident on NAEMS.

 When corresponding with the CIS always quote NAEMS reference number. Do not send any documentation, (other than original solicitor's letter of claim) to the CIS, whether records request, complaint letter, healthcare records etc, unless specifically requested by the CIS.

 When a review of a serious adverse event has been carried out by an enterprise, a copy of the report should be attached to the incident on NAEMS and a notification email sent directly to the relevant CIS Clinical Risk Advisor.

Notifications to the Health and Safety Authority.

What Regulations Apply to the Reporting of Accidents?

The Safety Health and Welfare at Work (General Application) Regulations, 1993

Extracts are included below:

58. Interpretation of Part X:

'responsible person' means:

a. in the case of any event required to be reported under Regulation 59 involving an employee at work, his employer;

b. in any other case, except where subparagraph (c) applies, the person having control of a place of work for the purpose of any trade, business or undertaking (whether for profit or not) at which the accident or dangerous occurrence required to be reported under Regulation 59 occurs; and

c. where a self-employed person is fatally injured at a place of work, the person who owns the place of work or, in the case of a tenancy existing in respect of the place of work, the tenant or, in a case where the fatally injured person is the owner or tenant, the next of kin.

(2) In this Part, a reference to an accident or a dangerous occurrence arising at or in connection with work includes a reference to an accident or dangerous occurrence which is attributable to the manner of conducting the undertaking concerned or to any article or substance used for the purposes of the undertaking concerned or to the condition of any part of the place of work where the undertaking concerned is carried on.

59. Notification of Accidents and Dangerous Occurrences:

(1) Where:

a. any accident occurs at a place of work as a result of which any person carrying out work at that place of work dies or is prevented from performing his normal work for more than three consecutive days, excluding the day of the accident but including any days which would not have been working days, or

b. in the case of any person who is not at work but who as a result of an accident related to a place of work or a work activity dies or suffers any injury or condition as a result of an accident which results in the person requiring treatment from a registered medical practitioner or treatment in a hospital as an in-patient or an out-patient, or

c. there is a dangerous occurrence, the responsible person shall:

i. in the case of a death, supply the Authority by the quickest practicable means with the name of the deceased, brief particulars and the location of the accident, and

ii. as soon as practicable send a written report in the approved form to the Authority of the death, injury, condition, accident, or dangerous occurrence.

(2) Where as a result of an accident at work an employee or a self-employed person sustains an injury or suffers a condition which is required to be reported under this Regulation to the Authority, and as a result of that accident the employee or self-employed person dies within a year of the accident, the responsible person shall, as soon as possible after the death comes to his knowledge, inform the Authority in writing of the death, whether or not the accident has been reported under paragraph (1).

(3) In the case of a responsible person who is a self-employed person, it shall be sufficient compliance with paragraph (1) if the self-employed person makes arrangements with some other person for that other person to make the notification or report required by that paragraph on behalf of the self-employed person.

(4)

a. Where an accident which is notifiable under paragraph (1) occurs and causes loss of life to a person no person shall disturb the place where it occurred or tamper with anything thereat before;

i. that place has been inspected by an inspector, or

ii. the expiration of three clear days after notification, in accordance with paragraph (1), of the accident.

b. Nothing in this Regulation shall prohibit the doing of anything by or with the consent of an inspector.

c. In any proceedings taken in respect of a contravention of this paragraph consisting of the doing of any act, it shall be a defence to prove that the doing of the act was necessary for securing the safety or health of any person.

61. Application of this Part:

(1) The provisions of Regulation 59 relating to a death, injury or condition do not apply to a person who, at the time death occurs or injury is sustained or a condition is suffered, is a patient undergoing treatment in a hospital or in a doctor's or dentist's surgery and is not undergoing treatment for an accident at a place of work or for an injury due to a dangerous occurrence, unless the cause of death or injury is unrelated to the patient's pre-existing medical condition or the treatment being provided.

(2) The provisions of Regulation 59 relating to the death, injury or condition of a person as a result of an accident shall, in the case of an accident arising out of or in connection with the movement of a vehicle on any public road, apply only if that person:

a. was killed or suffered an injury as a result of driving or riding a vehicle in the course of work, or

b. was killed or suffered an injury or condition as a result of exposure to a substance or injury from an article being conveyed by a vehicle,

c. was either himself engaged in, or was killed or suffered an injury or condition as a result of the activities of another person who was at the time of the accident engaged in, work connected with the loading or unloading of any article or substance onto or off a vehicle, or

d. was either himself engaged in, or killed or suffered an injury or condition as a result of the activities of another person who was at the time of the accident engaged in, work on or alongside a road, being work concerned with the construction, demolition, alteration, repair or maintenance of:

i. the road or the markings or equipment thereon;

ii. the verges, fences, hedges or other boundaries of the road;

iii. pipes or cable on, under, over or adjacent to the road; or

iv. buildings or structures adjacent to or over the road.

- See more at: http://www.hsa.ie/eng/Topics/Accident_and_Dangerous_Occurrence_Reporting/#sthash.IQzLTcxW.dpuf

FORM OF NOTIFICATION OF A DANGEROUS OCCURRENCE

Approved under the Safety, Health and Welfare at Work (General Application) Regulations, 1993
Form No. IR3 (Before completing this form, please see instruction below) **S.I. 44 of 1993**

EMPLOYER / SELF-EMPLOYED INFORMATION

Name of business or company name: Phone Number:

Address of head office Date of incident:

Address of establishment where incident took place if different from above: Approximate number employed at establishment: Approximate total number employed by business:

Appendix One.

List of Serious Reportable Events (SRE)

1 Surgical Events

A Surgery performed on the wrong body part by a healthcare provider.
B Surgery performed on the wrong patient by a healthcare provider.
C Wrong surgical procedure performed on patient by a healthcare provider.
D Unintended retention of a foreign object in a patient after surgery or other procedure performed by a healthcare provider.
E Intra – operative or immediately post operative death of a normal health patient with no known medical problems after surgery or other procedure performed by a healthcare provider.

2 Product or Device events

A Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by a healthcare provider.
B Patient death or serious disability associated with the use or function of a device in patient care provided by the healthcare provider in which the device is used or functions other than as intended or anticipated.
C Patient death or serious disability associated with intravascular air embolism that occurs while being cared for by a healthcare provider but excluding death or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

3 Patient protection Events

A Child or other dependent person discharged to the wrong person by a healthcare provider
B Patient death or serious disability associated with patient absconding from a healthcare facility whilst under medical supervision but excluding where the patient advises the healthcare provider that he or she is leaving against medical advice.
C Patient suicide, or attempted suicide, resulting in serious injury or disability while receiving health services from a healthcare provider.

4 Care Management Events

A Patient death or serious disability associated with a medication error by the healthcare provider but excluding reasonable differences in clinical judgement involving drug selection and dose.
B Wrong route administration of chemotherapy by a health care provider.
C Intravenous administration of mis–selected concentrated potassium chloride by a healthcare provider.
D Patient death or serious disability associated with a haemolytic reaction due to the administration of incompatible blood or blood products by a healthcare provider.
E Maternal death or serious disability, occurring within 42 days post delivery, associated with labour or delivery in any pregnancy while being cared for by a healthcare provider.
F Death or serious injury of a neonate associated with labour or delivery in a low-risk pregnancy.
G Patient death or serious disability associated with hypoglycaemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
H Death or serious disability (kernicterus) associated with failure by a healthcare provider to identify and treat hyperbilirubinermia in infants within the first 28 days of life.
I Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility but excluding progression from stage 2 to stage 3, if stage 2 was recognised upon admission.
J Patient death or serious disability due to spinal manipulative therapy by a healthcare provider
K Artificial Insemination with the wrong donor sperm or wrong egg by a healthcare provider.

5 Environmental events

A Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility but excluding events involving planned treatment such as electric

countershock or elective cardioversion.
B An incident in which a line designated for oxygen or other gas to be delivered to a patient while being cared for by a healthcare provider contains the wrong gas or is contaminated by toxic substances.
C Patient death or serious disability associated with a burn incurred within a healthcare facility.
D Patient death or serious disability associated with a fall while being cared for in a healthcare facility.
E Patient death or serious disability associated with the use of physical restraints or bedrails while being cared for in a healthcare facility.

6 Criminal Events

A Any instance of care ordered by someone impersonating a healthcare professional.
B Abduction of a patient of any age while being cared for in a healthcare facility.
C Sexual assault on a patient within or on the grounds of a healthcare facility.
D Death or serious harm of a patient or other person resulting from a physical assault that occurs within or on the grounds of a healthcare facility.
E Patient death or serious disability associated with physical assault while being cared for in a health care facility.

Please see the Quality and Patient Safety Section of the HSE Website for any updates in relation to Serious Reportable Events (SRE).