TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Incident Management
Guidance

Managing an Incident Guidance

These guidance documents have been developed to act as points of reference for staff when managing incidents.

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There is no expectation that staff need to read all the guidance at one sitting. Rather, staff can select the relevant guidance document based on the step of the incident management journey they currently need to read about.

- Step 1 includes guidance on identification of incidents and immediate management.
- Step 2 includes guidance on reporting incidents to line manager and NIMS.
- Step 3 includes guidance on how severity ratings guide decision making on reviews, which are proportionate to what happened.
- Step 4 includes guidance on review methods.
- Step 5 includes guidance on implementing learning for service improvement.

Further guidance and support on incident management is available from Quality, Risk and Service Improvement (QRSI) teams. In addition, staff should seek specific advice and guidance from regional health and safety advisors for incidents relating to staff health and safety.

Further guidance documents will be added as they are developed.

Incident Management **Steps**

Step 1: Identification and Immediate Management

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- **Guidance 2:** Providing support after an incident
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Identification and Immediate Management

Step 1: Identification and Immediate Management

Guidance 1: Identification and immediate management

Purpose

The purpose of this guidance is to set out what staff in Tusla, the Child and Family Agency (herein referred to as Tusla), and its funded services, should do when an incident occurs, or they are notified that an incident has occurred.

Background

The primary purpose of incident management is to review what happened and determine why it happened to prevent it from happening again. This can't happen if incidents are not identified and reported. Tusla also has a statutory obligation to report incidents to the State Claims Agency on the National Incident Management System (NIMS).

The immediate actions taken following identification of an incident influence the rest of the incident management process. How services respond to the person or people harmed and staff directly affected by an incident or an adverse event is key to successful incident management.

Research shows that poor incident management can lead to a breakdown in trust between the person(s) harmed and the organisation where the incident occurred.[1] Trust can be maintained or even rebuilt if the organisation responds promptly, compassionately and in a way that demonstrates openness to learning and improving. Tusla has a commitment to grow and develop a values-based ethos and learning organisation with a culture rooted in trust, respect, kindness, and empowerment.

Identification and immediate management

Identification

The *Incident Management Policy* defines an incident. An incident is an event or circumstance, which could have or did lead to unintended or unanticipated injury or harm.

[1] National Patient Safety Office Conference 2019, Dublin Castle.

In the case of a service user, this unintended or unanticipated harm will usually have occurred in the course of service provision. For example, a child may experience harm following a slip, trip or fall in a Tusla building. There are some exceptions to this as all serious incidents or deaths of children or young people in care or known to Tusla social work must be notified to the National Review Panel[2] and to the Health Information and Quality Authority (HIQA) in line with national standards and government policy.[3] There are also regulatory requirements for HIQA to be notified about certain incidents that happen in special care units.

For a staff member, it might be an injury sustained following a slip, trip or a fall at work or it might be psychological harm experienced following an incident of verbal abuse.

All staff employed directly or indirectly by Tusla and Tusla-funded services should be aware of what constitutes an incident to detect, disclose and report such incidents when they occur. Table 1 provides examples of incidents that must be reported and managed in line with this policy and procedure. This is not an exhaustive list; the NIRF form and NIMS provide more information.

Immediate management

The first thing that the person who identifies the incident must do is make sure anyone harmed is okay. Your response might range from asking the person if they need to sit down, to calling an ambulance depending on the injury or harm experienced.

Following this, make sure that everyone else is safe from harm. For example, if you identify that a person has experienced harm after tripping over a box of files beside the printer, make sure the box is put away.

Once you are satisfied that you have done as much as you can to address the immediate needs of the person harmed, the next step is to notify your line manager.

Your line manager will ensure that appropriate support is provided to the person harmed. Such support might be informal or formal and will depend on the nature of the incident and the degree of harm experienced.

Table 1. Incidents that should be reported on NIMS

SERVICE USER RELATED
Death of a Child or Young person, known to Tusla social work under the following categories; • A child whose immediate family is known to Tusla social work[4]; • A child known to Tusla social work or a Tusla-funded service[5], or; • A young adult who was in receipt of aftercare services at the time of the incident, under section 45 of the Child Care Act 1991.
Medication error
Self-injurious behaviour (this does not include issues that arise within the Care Plan)
Violence, Harassment and Aggression
Slip/Trip/Fall
Cases of serious communicable disease required by legislation
Allegations of abuse against carers and/or staff
Injury to service user requiring medical treatment
Arrests, conviction or allegations of serious criminal offences against children in care.
STAFF RELATED
Incidents or significant injuries at work (requiring medical treatment)
Violence, Harassment and Aggression
Death in work
Arrests, convictions or allegations of criminal offences
Allegations of gross misconduct
ASSETS RELATED
Serious or significant damage resulting from floods, accident, fire etc.
Significant vandalism or burglary
Any incidence of fire setting
Third party damage
Vehicle damage
Fraud
Theft
NON-COMPLIANCE WITH STANDARDS/REGULATIONS
A poor outcome following a statutory inspection (e.g. HIQA or Health and Safety Authority) e.g. several significant risks identified.
A poor outcome following an internal quality review or audit e.g. number of escalations.
Personal data breach (i.e. notified to the Data Protection Commission).

[2] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/

[3] See standard 2.11 in HIQA (2012) National Standards for the Protection and Welfare of Children and DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/

[4] Open cases or cases which have been closed in the past two years are categorised, for the purpose of this Guidance, as known to the social work department or Agency-funded service.

[5] A Tusla funded service refers to services funded by Tusla in relation to Child Protection and Welfare (CPW), Alternative Care and Fostering, Partnership, Prevention and Family Support (PPFS), and Aftercare.

Step 1: Identification and Immediate Management

Guidance 2:
Providing support after an incident

> **Open disclosure can be defined as a consistent policy of communicating with people harmed when things go wrong in services by expressing regret, providing information and feedback on reviews into what happened and keeping people informed of what is happening to make sure the incident does not happen again.**

Purpose

The purpose of this guidance is to describe how services can offer support to the people that have been directly affected by an incident rated as moderate, major or extreme on the National Incident Management System (NIMS). These are incidents that resulted in the child, young person or adult affected;

- needing medical treatment (moderate),
- sustaining a long term disability or incapacity (major) or
- permanent incapacity or death (extreme).

This document provides guidance for anyone directly harmed (e.g. service user) while also acknowledging that there can be indirect effects on staff or others involved.

Background

While having risk management procedures in place, there are times that when unexpected incidents will occur that cause unintended or unanticipated harm to service users engaging with Tusla services. Service users include children, young people and their families.

It is important to remember that service-related incidents don't just affect the service user but can affect staff that were providing the service.[6]

Supporting children and families: service users

The support you provide to children and families following an incident will depend on the severity of the incident and the nature of the service user's involvement with Tusla.

Research[7] shows that service users expect and want;

- timely contact
- open disclosure on what happened when they have been affected by a service-related incident,
- an understanding of why and
- a discussion on what the service is doing to prevent it happening again.

[6] https://stateclaims.ie/ezine/albert-wu-patient-safety-visionary

[7] https://www.safetyandquality.gov.au/sites/default/files/migrated/Evaluation-of-Pilot-of-the-National-Open-Disclosure-Standard-Final-Report-Nov-2007.pdf

As soon as practicable, the manager who holds the senior officer accountable for the incident role must arrange a meeting with the family to describe how Tusla services manage incidents and to provide available information on the incident. This contact also provides an opportunity for the senior officer accountable for the incident to ensure that families know what supports are available to them.

The senior officer accountable for the incident has overall accountability for incident management in a service, area, or region (see roles outlined below). The senior officer accountable for the incident ensures that an appropriate review takes place in a timely manner.

Identifying the manager who is the senior officer accountable for the incident will depend on the outcome of the incident at the time it happened. This will determine how removed the manager is from the incident. For example:

- A local service manager will be the senior officer accountable for any incident that was rated as negligible or minor. This might be a principal social worker or social care manager.
- The area manager or equivalent for other service areas will be the senior officer accountable for any incident rated as moderate at the time of occurrence.
- The regional chief officer or equivalent for other service areas will be the senior officer accountable for any incident rated as major or extreme.

One of the first actions should be to identify a named staff member who can link with the family throughout the incident management process. The liaison person can provide the family with information on how the incident is being managed throughout the process. In some cases, the senior officer accountable for the incident might ask the liaison person to meet the family on their behalf. However, in the case of the death of a child in care it might be appropriate for the senior officer accountable for the incident to meet the family. In these cases, it will be necessary for the senior officer accountable for the incident and colleagues to use their professional judgement to inform decision making. Support and guidance is also available from QRSI staff within Services and Integration, and Risk and Incident Leads within the Quality and Regulation Directorate.

At the end of the review process, a further meeting can be arranged with the family to advise on how the incident was reviewed and how any actions identified will be implemented. While it will not change the outcome, knowing that some learning has come from an injury or harm can be helpful for some families.

Be respectful of how families want to receive information. Some families might want to receive regular phone updates while others will ask for email contact only.

When framing initial discussions with a family, it can be helpful to think of who, what, when, where, and how.

WHO

If present, the senior officer accountable for the incident should lead the discussion at the meeting with the family. The circumstances of the incident will dictate what other members of the team should be there but whoever will be the nominated liaison person with the family should be present.

WHAT

There may only be preliminary information available on what happened but provide reassurance that the review will gather further information on what happened.

WHEN

Disclosure should be timely even if all the details of the incident are not known. It is helpful to offer to meet families as soon as reasonably possible while emphasising that managing the incident is a process and there will be on-going communication by the named liaison person.

WHERE

The family should be given the option of where to meet. This might be in their home, a Tusla building or an external venue.

HOW

Show empathy for what the family has experienced; understanding the impact the event has had or may have had on the service user and their family.

Supporting staff who work with service users who have experienced harm following an incident

Line managers have a responsibility to their staff and this includes addressing any needs that arise for staff following any adverse events involving service users. Offer opportunities for staff to talk about what has happened. This might be a specific debriefing session for the staff team that worked with the child or young person affected by the incident.

Bear in mind that:

- Everyone responds to adverse events in different ways.
- The appropriate supports offered at the right time will help to alleviate any stress associated with the incident experienced.

Make sure staff know about supports that are available particularly Tusla's Health, Wellbeing and Employee Assistance Programme.

This national service is available to all Tusla staff and provides a range of staff supports including counselling and Critical Incident Stress Management (CISM) services.[8]

Supporting the organisation

Tusla's *Incident Management Policy* sets out how immediate and proportionate action should be taken following identification of an incident.

It is when incidents are not managed well that the person(s) harmed loses trust in the organisation. This can lead to people feeling that they have no option but to take a legal claim against the organisation. In turn, this can lead to public distrust in Tusla's ability to keep children and young people safe.

This requires that all staff understand the incident management process and work together to support a just culture that enables staff to report incidents so that services can learn and improve.

It is important that all stakeholders (i.e., children, families, and staff) see the incident management process as a method of learning and improving when things go wrong. Of course, many incident reviews highlight good practice. This is also important learning for sharing across the Agency.

[8] https://www.tusla.ie/health-wellbeing-and-eap/

Step 1: Identification and Immediate Management

Guidance 3:
Providing support to staff who have experienced harm following an incident.

Purpose

The purpose of this guidance is to describe how services can offer support to staff that have experienced unexpected or unanticipated harm at work.

Background

While having risk management procedures in place, there are times when unexpected incidents will occur that cause unintended or unanticipated harm to people. The person harmed might be someone that is engaging with a Tusla service (e.g., children and families) or someone visiting a Tusla building (e.g., a member of the public). There are also times that staff will experience unanticipated or unexpected harm at work.

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with a very small number rated as extreme.[9]

Providing immediate support

The support you provide to staff following an incident will depend on the severity of the incident and whether the staff member was directly involved (e.g., when they were the subject of verbal or physical abuse).

The key thing to remember is that:

- People respond to adverse events in different ways.
- The appropriate supports offered at the right time will help to alleviate any stress associated with the incident experienced by the staff member.

[9] 2% of incidents were rated as extreme based on incidents reported on NIMS in 2020.

How you and your staff respond immediately following an incident will depend on the specific needs of the person harmed. For example, it may be enough to provide time to listen to the staff member or give them time to have a coffee with a colleague if they have experienced verbal abuse. However, it may be necessary to arrange cover to allow the staff member to go home.

It is important to give staff opportunities to talk about incidents. People are more likely to cope with an incident or adverse event if they can talk about it with their colleagues and managers. Positive support like this can lead to improved commitment to learning and improving from incidents. Bear in mind that staff that were not directly affected may also need support to alleviate any anxiety.

Offer sensitive debriefing as soon as possible after the incident; and make sure both management and colleagues support are available, and offer reassurance to the staff affected. It may also be useful to provide group debriefing. Sharing experiences with others may help people to come to terms with the incident. Remember that some people might not want to talk about the incident or may want to do it after some time has passed.

For more serious incidents, your actions may include:

- Making sure appropriate care has been provided to address physical needs (e.g. first aid / GP etc.).
- Being sensitive to the staff member's wishes whether this is to being left alone in a quiet place to begin to process what happened or arranging for a colleague to bring them home. Before sending a staff member home, consider whether Critical Incident Stress Management (CISM)[10] is required. Also, make sure that staff are aware of the EAP counselling line.
- Notifying relevant Tusla staff (e.g., principal social worker / area manager / chief officer/ service director etc.) and An Garda Síochána if appropriate.
- Ensuring work is covered and restored to normal as soon as possible and that the National Health and Safety Department are alerted to any occupational health and safety incidents.

Longer term support

Make sure staff know about supports that are available particularly Tusla's Health, Wellbeing and Employee Assistance Programme. This national service is available to all staff and provides a range of staff supports including counselling and Critical Incident Stress Management (CISM) services.[11]

Appoint a named person to keep in touch with any staff who experienced unexpected or unanticipated harm while doing their job. This might include keeping them updated on the incident review. This is particularly important for staff who have had to take leave following an incident but is also appropriate for staff who have returned to work so that they know Tusla services are open to learning from adverse events.

Ensure staff are briefed on what the incident review will involve so that they can be reassured that this is a standard process with no inference of blame.

[10] https://www.tusla.ie/health-wellbeing-and-eap/
[11] https://www.tusla.ie/health-wellbeing-and-eap/

Step 2:

Reporting the incident to line manager and ensuring it is on NIMS

Step 2:
Reporting the incident to line manager and ensuring it is on NIMS

Guidance 1:
Reporting
an incident

Purpose

The purpose of this guidance is to outline the reporting process following the identification and immediate management of an incident.

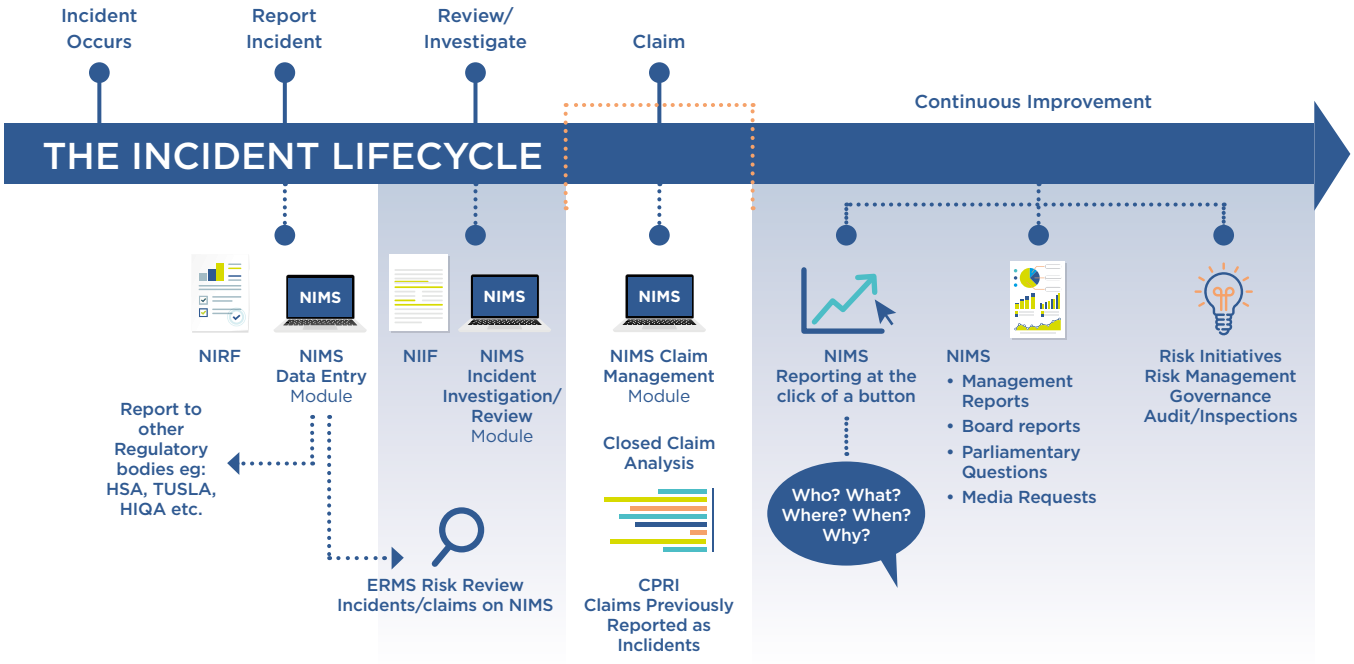
Background

Following identification and immediate action, the staff member's next step is to notify their line manager by completing the National Incident Report Form (NIRF) within 48 hours of the incident occurring or the service being made aware of it (whichever happens first).

Area managers or equivalent managers in other service areas are responsible for ensuring that there is a process in place for reporting incidents on NIMS and for recording key decisions made while managing the incident (e.g. designated NIMS inputters).

Figure 1 sets out the incident management process on NIMS.

Figure 1: NIMS incident management process[12]



Incidents reportable on NIMS

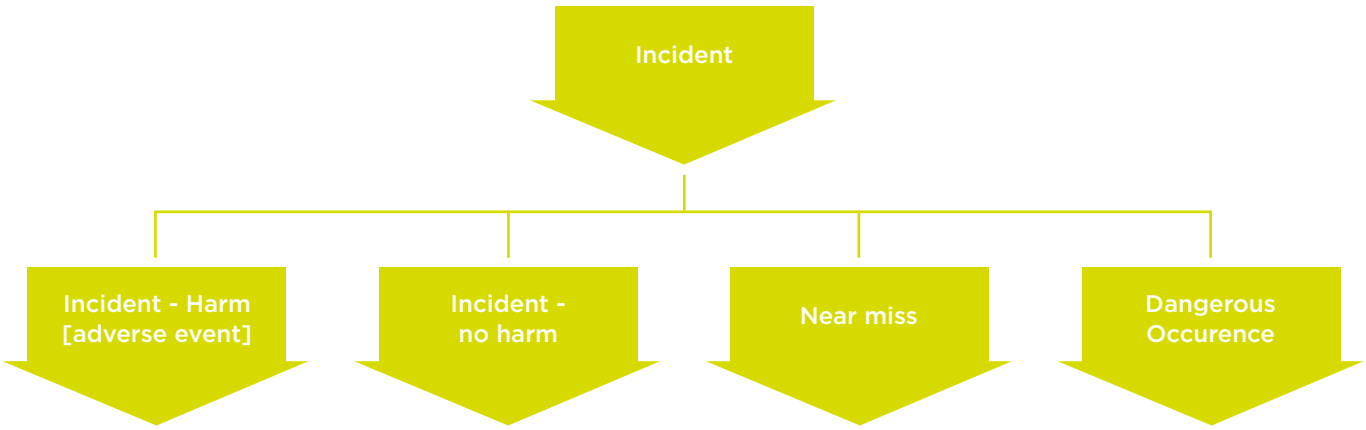


Figure 2: Incidents that must be recorded on NIMS

Figure 2 identifies what incidents or events must be recorded on NIMS.

Material that should not be reported on NIMS include;

- Solicitors' letters, Injuries Board Applications and any other notification of intent of a claim. Such correspondence should be forwarded to the State Claims Agency for management.
- Freedom of Information requests

Completing the National Incident Report Form (NIRF)

Staff must formally report incidents to their line manager on the NIRF by the end of the next working day of the incident occurring or staff member being made aware of the incident.

Ensure you phone your line manager to tell them that you are sending the NIRF to them.

Make sure you use the right NIRF:

- NIRF Person/Dangerous Occurrence (NIRF: 01)
- NIRF Crash/Collision (NIRF: 02)

NIMS functions as an electronic file for incident management so there is no need to keep hard copies of NIRFs or reports. Once uploaded onto NIMS, all hard copies of NIRFs, reports or minutes of meetings relating to an incident under review should be shredded or disposed of with confidential waste.

There are also other reporting requirements for some incidents as set out in Guidance 2: External Reporting.

Services may also need to fulfil other internal reporting requirements. For example, the *Need to Know* process is separate to the incident management process as it is an operational requirement. However, issues reported through the *Need to Know* process may also need to be reported on NIMS and managed as set out in the Incident Management Policy.

[12] Source; State Claims Agency

Step 2: Reporting the incident to line manager and ensuring it is on NIMS

Guidance 2:
External reporting

Purpose

The purpose of this guidance is to outline external reporting requirements for certain categories of incidents.

Background

Reporting incidents on NIMS fulfils Tusla's statutory duty to report incidents to the State Claims Agency.[13]

There are other reporting requirements for certain categories of incidents alongside reporting on NIMS. For example, serious incidents and child deaths must be reported to the National Review Panel in line with national standards and policy[14] and occupational health and safety incidents must be reported to the Health and Safety Authority.

External reporting of incidents relating to Service Users and Staff

Table 1 sets out external reporting requirements for certain categories of incident. Table 2 sets out external reporting for the Children's Residential Service (CRS).

It should be noted that the external reporting in these tables is not an exhaustive list and to consult with the Quality and Regulation Directorate for further guidance, if necessary, contact incidents@tusla.ie.

[13] National Treasury (Amendment) Act 2000
[14] See standard 2.11 in HIQA (2012) National Standards for the Protection and Welfare of Children and DCEDIY *Interim Guidance for Tusla on the operation of the National Review Panel* https://www.tusla.ie/national-

Table 1: External reporting

External body	What to report	How to report	Who reports?
An Garda Síochána	Any alleged criminal behaviour involving staff.	Directly to the local Garda station.	Service manager
Coroner's Office	Sudden, unexpected deaths and other deaths listed on www.coroner.ie[15]	Directly to relevant coroner. Each county has a designated coroner listed on the Coroner's Service website.	Area manager
Data Protection Commission	Serious data breaches as per General Data Protection Legislation (GDPR) and related legislation.	Email all data breaches to datacontroller @tusla.ie who will determine whether to report to Data Commissioner.	Data Protection Unit, Tusla
National Review Panel	Serious incidents and child deaths as per 2012 National Standards[16] and DCEDIY *Interim Guidance for Tusla on the Operation of the National Review Panel.*	Email National Incident Report Form (NIRF) to incidents@tusla.ie (Use writable NIRF on Tusla Hub)	Quality and Regulation Directorate
Health Information and Quality Authority	Serious incidents and child deaths as per DCEDIY *Interim Guidance for Tusla on the Operation of the National Review Panel*[18]	Email NIRF to incidents@tusla.ie (Use writable NIRF on Tusla Hub)	Quality and Regulation Directorate National office sends anonymised version to HIQA
Health and Safety Authority[19]	Any injury related to work which leads to an absence of >3 calendar days (not including day of incident but including weekends). Fatal accidents and dangerous	Email healthandsafety@tusla.ie to alert the National Health and Safety Department.	Quality and Regulation Directorate National Health and Safety Department

[15] http://www.coroners.ie/en/cor/pages/deaths%20which%20 must%20 be %20reported % 20to%20the%20coroner
[16] Standard 2.11 of the National Standards for the Protection and Welfare of Children – HIQA (2012).
[17] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/
[18] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/
[19] See flow chart in Table 3 at the end of this guidance document regarding statutory reporting of accidents and dangerous occurrences.

Table 2: External reporting for Children's Residential Services (CRS)

External body	What to report
An Garda Síochána	Any alleged criminal behaviour involving staff.
Coroner's Office	Sudden, unexpected deaths and other deaths listed on www.coroner.ie.[20]
Data Protection Commission	Serious data breaches as per General Data Protection Legislation (GDPR) and related legislation.
National Review Panel	Serious incidents and child deaths as per DCEDIY *Interim Guidance for Tusla on the operation of the National Review Panel*[21]
Health Information and Quality Authority	Serious incidents and child deaths as per DCEDIY *Interim Guidance for Tusla on the Operation of the National Review Panel*[22]
	Outbreak of any notifiable disease
	Any allegation, suspected or confirmed, of abuse of a resident.
	Any fire, loss of power, heating, water, or any incident of unplanned evacuation of the designated centre.
Health and Safety Authority	Any injury related to work which leads to an absence of >3 calendar days (not including day of incident but including weekends). Fatal accidents and dangerous occurrences must also be reported.

[20] http://www.coroners.ie/en/cor/pages/deaths%20which%20 must%20 be %20reported % 20to%20the%20coroner
[21] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/
[22] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/

How to report	Who reports?
Directly to local Garda station.	Service manager
Report to Social Work Department (SWD) who will arrange notification to Coroners Service	Person in charge
Email all data breaches to datacontroller@tusla.ie who will determine whether or not to report to Data Commissioner.	Data Protection Unit, Tusla
CRS notify SWD	Notified to Quality and Regulation Directorate via service directors' offices.
Notify SWD. NF01 NF03	Quality and Regulation Directorate National office sends anonymised version of NIRF to HIQA. Separately, the Person in Charge (PIC) in special care units must notify HIQA of a child death (NF01) or any serious injury to a resident which requires immediate medical treatment or hospital treatment (NF03)
NF02	PIC
NF06	PIC
NF09	PIC
Email health and safety advisor for CRS who will notify healthandsafety@tusla.ie	Quality and Regulation Directorate National Health and Safety Department

Table 3: Additional internal and external reporting for incidents relating to staff with regard to Health and Safety

Incident / Statutory Reporting of Accidents and Dangerous Occurrences Flowchart Summary

Employee is injured or ill

↓

Line Manager / Person in charge ensures employee receives appropriate treatment. This may include first aid locally or medical treatment (e.g. Primary Care Centre, A&E Dept).

A designated Tusla representative accompanies the employee to medical treatment where required.

↓

Employee immediately reports injury/illness to Line Manager/Person in Charge.

- Safety, health and welfare needs of person affected are attended to. Medical treatment is sought where required.
- Ensure area is made safe and others in the area are notified of any remaining hazards.
- Incident is reported to Line Manager.

↓

Line Manager/Person in Charge ensures incident is reported on the National Incident Report Form (NIRF) as outlined in the Tusla Incident Management Policy and Procedures.

The NIRF should be sent to local NIMS inputter to upload onto the National Incident System (NIMS). Please contact your local QRSI Manager for local NIMS inputter details.

Line Manager/Person in Charge must complete an incident investigation locally and implement corrective actions where required and following which, bring any learnings from the incident to the attention of the team and others who may be affected in the workplace.

↓

Statutory Reporting of Accidents and Dangerous Occurrences to the HSA

In addition to completing the NIRF, where the incident or dangerous occurrence becomes reportable to the HSA, Tusla National Health and Safety Dept. will manage this reporting process centrally. The Line Manager must contact the National Health and Safety Department on **healthandsafety@tusla.ie** to advise that there is a HSA reportable incident.

Please include the following information in this email: your workplace location and contact numbers and ensure to have a clear outline of the incident and details of treatment provided and sequence of events following the incident.

Once the Incident Report has been submitted by Tusla National Health and Safety Dept to the HSA, a copy of the form will be issued to the Line Manager for their records.

Step 2: Reporting the incident to line manager and ensuring it is on NIMS

Guidance 3:
Reporting a serious incident or child death to the National Review Panel (NRP)

Purpose

The purpose of this guidance is to outline the reporting process following a serious incident or death of a child as set out in the DCEDIY *Interim Guidance for Tusla on the Operation of the National Review Panel*.[23]

Background

The guidance for reporting these cases was developed by the Department of Children, Equality, Disability, Integration and Youth.[24] As such, there may be certain differences to the definitions for serious incidents and child deaths than those used by NIMS or in Tusla's Incident Management Policy.

Cases that must be notified to the National Review Panel and HIQA

Tusla must report to the NRP within three working days of becoming aware of a serious incident, notifiable as major or extreme[25], or a death, and where the following conditions have also been met in full:

- Where the individual concerned is either:
  - A child whose immediate family is known to Tusla social work[26];
  - A child known to Tusla social work or a Tusla-funded service[27], or;
  - A young adult who was in receipt of aftercare services at the time of the incident, under section 45 of the Child Care Act 1991.

[23] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/
[24] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/
[25] This terminology is based on the National Incident Management System definition used by Tusla, and is defined as follows:

Outcome at time of incident reporting	Severity Rating
5 Long-term disability/Incapacity (incl. psychosocial)	Major
6 Permanent/Incapacity (incl. psychosocial)	Extreme
7 Death	Extreme

[26] Open cases or cases which have been closed in the past two years are categorised, for the purpose of this Guidance, as known to the social work department or Agency-funded service.
[27] A Tusla funded service refers to services funded by Tusla in relation to Child Protection and Welfare (CPW), Alternative Care and Fostering, Partnership, Prevention and Family Support (PPFS), and Aftercare.

In addition, in instances where cases come to light which carry a high level of public concern and where the need for further investigation is apparent, Tusla may at its discretion refer such matters to the NRP for its consideration. Such cases need not be limited to deaths, serious incidents or the cohort of children and young people referred to above and may include cases where:

- A child protection issue arises that is likely to be of wider public concern;
- A case gives rise to concerns about interagency working to protect children from harm; or
- The frequency of a particular type of case exceeds normal levels of occurrence.

The NRP will make the decision to carry out a review of the case notified to it, in line with the guidance within this document. Decisions on whether the NRP will review certain cases (e.g. where deaths are clearly from natural causes and there are no other indicators of concern) will be made by the Chair of the NRP and Tusla will be informed of same. The level of review will be determined by the NRP's Chair and Deputy Chair and may be subject to revision in the event of further information coming to light.

Completing the National Incident Report Form (NIRF)

The NIRF must be signed off by the area manager and regional chief officer or service director.

The chief officer/service director's office emails the NIRF to incidents@tusla.ie

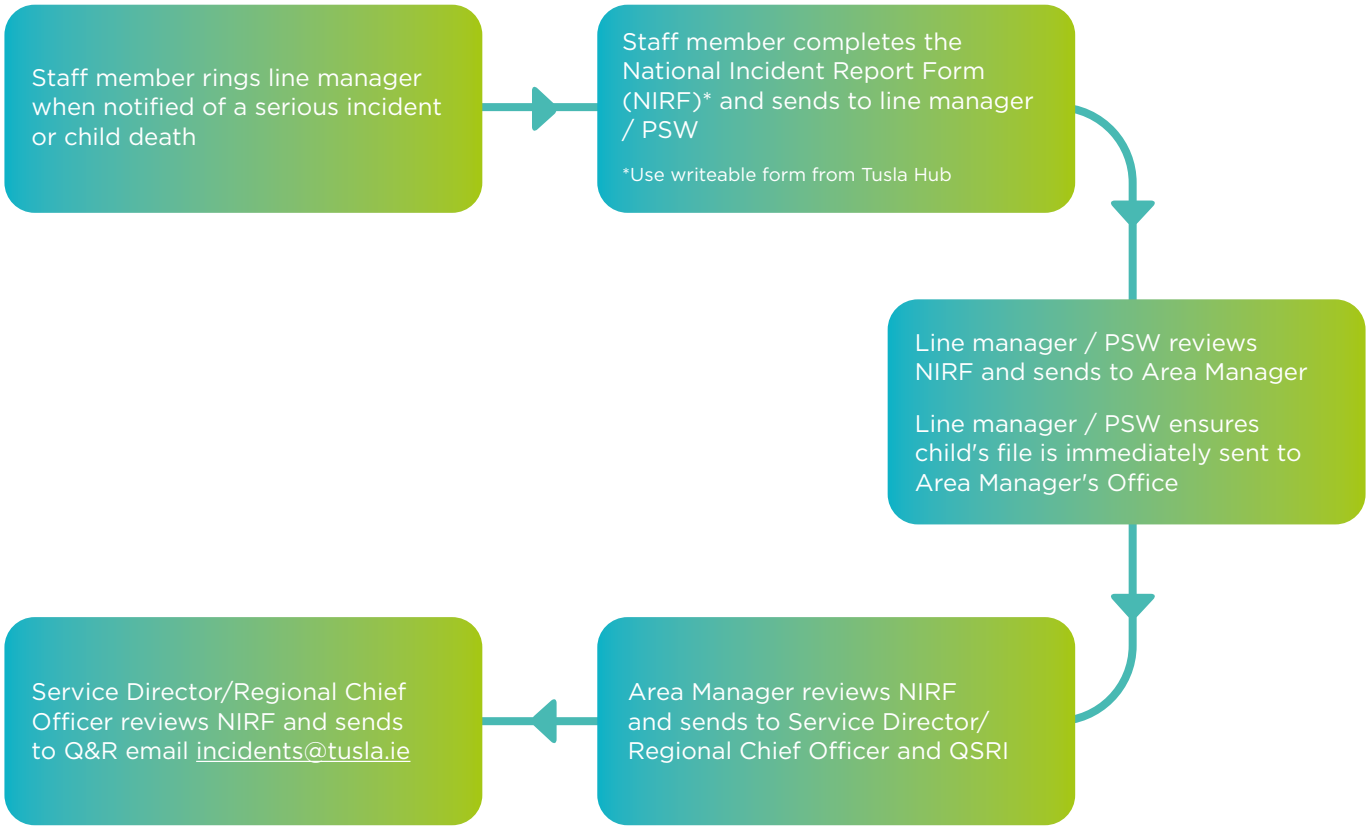
Make sure the form is in WORD or writable PDF Format (this is to allow for anonymisation and submission to HIQA).

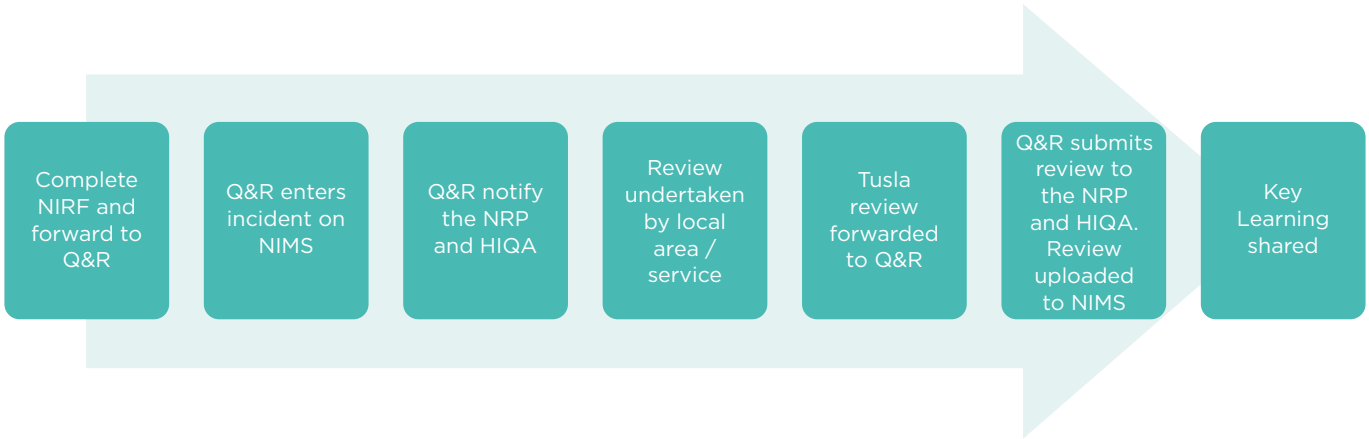
Staff in Quality and Regulation (Q&R) will:

- Review the NIRF ensuring all relevant information is present and make the final decision regarding whether a notification is provided to the NRP and HIQA.
- Ensure the incident is entered onto NIMS (this will be accessible to the relevant staff at a service level).
- Notify the NRP by emailing the NIRF and providing a copy to the CEO's office, Director of Services and Integration, the relevant chief officer/service director and Director of Quality and Regulation.
- Anonymises the NIRF and emails it to HIQA also copying senior Tusla staff as above and Practice Assurance and Service Monitoring (PASM).

Procedure for reporting serious incidents and child deaths to the Quality and Regulation Directorate (Q&R) for submission to the National Review Panel

Please email incidents@tusla.ie if you have any questions and one of the team will give you a call.





The procedure from notification to uploading a review report on NIMS is set out above.

Step 3:

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Determining severity

Step 3: Determining severity

Guidance 1:
Determining severity of an incident to inform decision making on type of review

Purpose

The purpose of this guidance is to describe how the severity rating of an incident informs the decision making on what type of review would be appropriate.

Background

NIMS is the electronic file for managing incidents and rates the severity of the incident at the time it happened. The response to an incident should be proportionate to the outcome at the time of the incident. An incident rated as negligible will be managed differently than an incident rated as major or extreme.

The senior officer accountable for the incident has overall accountability for incident management in a service, area or region. They should ensure that an appropriate review takes place in a timely manner.

The manager, who is the senior officer accountable for the incident will depend on the outcome of the incident at the time it happened.

- For example, a local service manager will be the senior officer accountable for any incident rated as negligible or minor. This might be a principal social worker or social care manager.
- The area manager or equivalent for other service areas will be the senior officer accountable for any incident rated as moderate at the time of occurrence.
- The regional service director or equivalent for other service areas is the senior officer accountable for any incident rated as major or extreme.

Determining severity rating

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with approximately 2% rated as extreme.[28]

It is the severity rating at the time the incident happened that determines how services should manage incidents. In line with the *Incident Management Policy*, services must review all incidents to determine if there is any learning. However, some incidents are also subject to external reviews. For example, incidents rated as extreme are notified to the National Review Panel and may also be reviewed by them.

Figure 1: NIMS severity rating calculation

Bear in mind that the NIMS severity rating might change. For example, an incident that results in the person harmed requiring medical treatment is rated as moderate. However, at the time of an incident the person harmed may not realise that they need medical treatment. This means that the incident could be rated as negligible (not requiring first aid) or minor (requiring first aid) at the time of the incident but might change to a moderate rating as new factors emerge. NIMS can be updated with any subsequent information such as changes to injury. The system will automatically update the severity rating accordingly.

Table 1: Outcome of incident and severity rating

Outcome at time of incident reporting	Severity rating
1 No adverse outcome	Negligible
2 Injury or harm not requiring first aid	Negligible
3 Injury or harm requiring first aid	Minor
4 Injury or harm requiring medical treatment	Moderate
5 Long-term disability/incapacity (incl. psychosocial)	Major
6 Permanent incapacity (incl. psychosocial)	Extreme
7 Death	Extreme

[28] Based on incidents reported on NIMS in 2020

Decision making

A proportionate response means matching the type of review with the severity rating of the incident.

The majority of incidents reported on NIMS have a negligible rating. Rather than reviewing each of these individually, they can be themed and reviewed at meetings. Incidents rated as minor can be managed the same way.

Quality, Risk and Service Improvement (QRSI) staff should provide a monthly NIMS report for a region or area setting out all incidents of violence, harassment or aggression (VHA) rated as negligible for discussion at a regional or an area meeting. Alternatively, a service might select an incident rated as negligible for discussion at a staff meeting. It is important that decisions are recorded, and any learning identified shared to inform service improvements.

It is important that aggregated trends regarding negligible or minor incidents are reviewed on a quarterly basis as they may point to an emerging risk. QRSI teams should support this.

Make sure that any incidents reviewed in this way are closed off on NIMS (e.g., upload notes of discussion, any action plans regarding service improvements or any NIMS forms related to incident reviews). Similarly, record any decisions made regarding the need for further review if new information arises. Record any decisions regarding escalation of review to a more senior manager for management of the incident. For example;

- include the minutes of the meeting noting the discussion and
- an email from the senior manager accepting onward management of the incident.

For incidents rated as moderate or higher, services should take a more structured approach to managing the incident using one of the review methods outlined in Step 4.

Table 2: Severity rating and suggested review method

Incident rating	Senior officer accountable for the incident	Suggested review method
Negligible	Local manager (e.g., PSW or unit manager).	Combined review
Minor	Local manager	Combined review
Moderate	Area Manager	Desktop
		Rapid review
Major	Service Director	Rapid review
		Local review
Extreme	Service Director	Rapid review
		Local review

The Chief Executive Officer or the National Director for Services and Integration or the National Director of Quality and Regulation may take responsibility if there is a perceived conflict of interest or for public interest reasons.

The Chief Executive Officer or the National Director for Services and Integration or the National Director of Quality and Regulation may also initiate a review of any incident of any severity rating.

Step 4:

Reviewing the incident and uploading report on NIMS

Step 4:
Reviewing the incident and uploading report on NIMS

Guidance 1:
Methodology or how to review an incident

Purpose

The purpose of this guidance is to describe the methodology for reviewing an incident and outline the steps for all reviews whatever method you use.

Background

There are five steps in the incident management process. This 'how to guide' focuses on **Step 4: Reviewing the Incident**. The incident review is where you gather information to establish what happened leading up to the incident, determine if any wider systemic factors contributed to the incident and if there is any learning that can be put in place to prevent a similar incident occurring again.

This guidance is for staff members who have been asked to review an incident and sets out the three stages of the review;

1) Gathering information

2) Analysing information and

3) Identifying key learning and recommendations.

Before you start the review, you need to make sure that the terms of reference (ToR) are clear. The senior officer accountable for the incident is responsible for setting the ToR. If you do not believe that they are clear, go back to the senior officer accountable for the incident to agree the parameters of the review. It is essential that the scope of the review is clear so that the review focuses on the facts relating to the incident and identification of any factors, which may have contributed to the adverse event. Without a clear ToR, there is a danger that the review might drift into a full case review rather than a review of the incident. The purpose of an incident review is to identify what happened in the lead up to the incident, determine if any systemic factors contributed to the incident and see if there are any measures that can be put in place to prevent a similar incident occurring again in the future. It is not necessary to review every file relating to a child's involvement with a service since referral.

Gathering information

The first part of any incident review is to gather information. This stage involves reviewing information from multiple sources including written information (e.g., the child's file, minutes of relevant meetings, policies, and procedures in place at the time of the incident), electronic information (e.g., NCCIS, NIMS) and verbal information (e.g., talking to the people affected such as the person harmed, family members and staff that were involved).

The purpose of this stage is to determine what happened in the lead up to the incident. One of the best ways to do this is to develop a detailed chronology or timeline leading up to the incident. Ensure you include the source of information in your chronology (see Table 1).

You may be able to develop a detailed chronology based on the case file but often, there will be gaps in information after you have reviewed the relevant files.

You can fill these gaps by talking to staff involved to get a better picture of what happened. You might want to meet staff to discuss what happened if there are significant gaps. However, you could also speak to staff on the phone, or you could email staff if there are only one or two clarifications that you need. It is not necessary to do formal interviews with staff as the process will not always need that level of formality. Depending on the incident, it might be appropriate to speak to a number of staff together about what happened. Remember that the purpose of reviewing incidents is to identify learning and not to find fault. The staff involved are best placed to help you to do this so use the opportunity to ask staff what they think needs to happen to prevent similar incidents occurring again in the future. It is good practice to check in with the manager of a service before setting up any meetings with staff whether on an individual or a group basis.

Table 1: Example of a chronology

Date	Time	What happened	Source	Comment
30/04/2020	10.30	Staff member A met the child and completed assessment tool in line with SoS framework.	Case file.	Example of good practice.
30/04/2020	14.00	Staff member A spoke to young person on the phone and agreed to call again on 1/5/2020 but the next entry in the file is 5/5/2020.	Case file.	Check with staff member A.
01/05/2020	Approx. 17:00	Staff member A told me that S/he called and texted the young person sometime after 5pm but didn't record in the case file because of caseload pressures. S/he was covering for a colleague who was out sick.	Telephone call on 08/04/2020.	Was staffing a contributory factor?

Analysing information

Systems analysis is a widely used methodology for reviewing incidents. Traditional analysis tends to break a complex topic into parts to understand it. However, systems analysis is a method of looking at the bigger picture to understand how each element of the system interacts and works together. Systems analysis is particularly useful when trying to understand complex systems such as child protection and welfare services and other Tusla services.

The mistakes or errors made at the frontline are known as active failures (e.g., a decision made by a staff member, which could be an action or inaction). On the other hand, latent failures are weaknesses or failures that lie dormant or hidden in the wider system (e.g. organisational culture, management decisions, poor procedures or poor training). An incident is almost never the failure of a single system but usually the combined effect of latent failures in the system and active failures by individual staff. There may also be latent failures in the external system such as unintended consequences of national policy and legislation.

There are tools available online that some people find helpful to guide their analysis such as Ishikawa / Fishbone or the Five Whys.[29] These generic tools are designed to help you explore the reason that the incident occurred. A framework developed for patient safety incidents provides examples of questions related to service provision that might be helpful to guide your analysis.[30] While developed for an acute health care setting, it can be adapted for use in any setting. The Yorkshire Contributory Factors Framework prompts reviewers to look at the system rather than the individual. The approach recognises that a staff member at the frontline might make an error that causes an incident, but it is usually weaknesses in the wider system that are the main contributory factors.

Yorkshire Contributory Factors Framework (YCFF)

The framework encourages reviewers to look at the wider system asking questions under five domains including;

1. Situational factors,
2. Working conditions,
3. Organisational factors,
4. External factors and
5. Culture.

It suggests questions that you might want to ask yourself while doing the review or of staff that were involved. Using a framework like this can help to structure your analysis and determine whether any factors contributed to the incident.

Table 2: Example of questions based on YCFF

Domain	Potential Contributory Factors	Examples of questions (add your own)
Situational factors	- Team factors - Individual staff factors - Service user factors	- Did the staff function as a team? - How did staff feel on the day / leading up to the incident – fatigued / stressed / overwhelmed? - Were there any service user characteristics that may have contributed? Complex needs / history of non engagement
Working conditions	- Workload and staff provision - Supervision and roles	- Were there any staff pressures? - Did supervision happen regularly?
Organisational factors	- Support from other departments - Staff training	- Were other departments / agencies involved? How did this work? - Was the staff member provided with sufficient training?
External factors	- Influence of external policies	- Were there any unintended consequences from national policies?
Culture	- Safety and reporting culture - Any communication problems	- Are incidents reported on NIMS? - Are there internal communication problems?

[29] https://www.visual-paradigm.com/project-management/fishbone-diagram-and-5-whys/
[30] https://qualitysafety.bmj.com/content/21/5/369

Your review of information may also highlight issues that you consider did not contribute to the incident but which could lead to service improvements if changes were made. These incidental findings might include issues such as poor record keeping that did not have any bearing on what happened but may need to be highlighted as an area for improvement.

Identifying key learning and making recommendations

The purpose of reviewing an incident is to find out what happened and determine if there were any factors that contributed so that lessons can be learned. Therefore, identifying key learning and making recommendations for change is a key element of the incident review.

Irish research on high profile child protection inquiries suggests that focusing on learning is preferable unless there is a clear case for change.[31] In other words, do not make recommendations for the sake of it as too many recommendations in the system can lead to 'recommendation fatigue.'

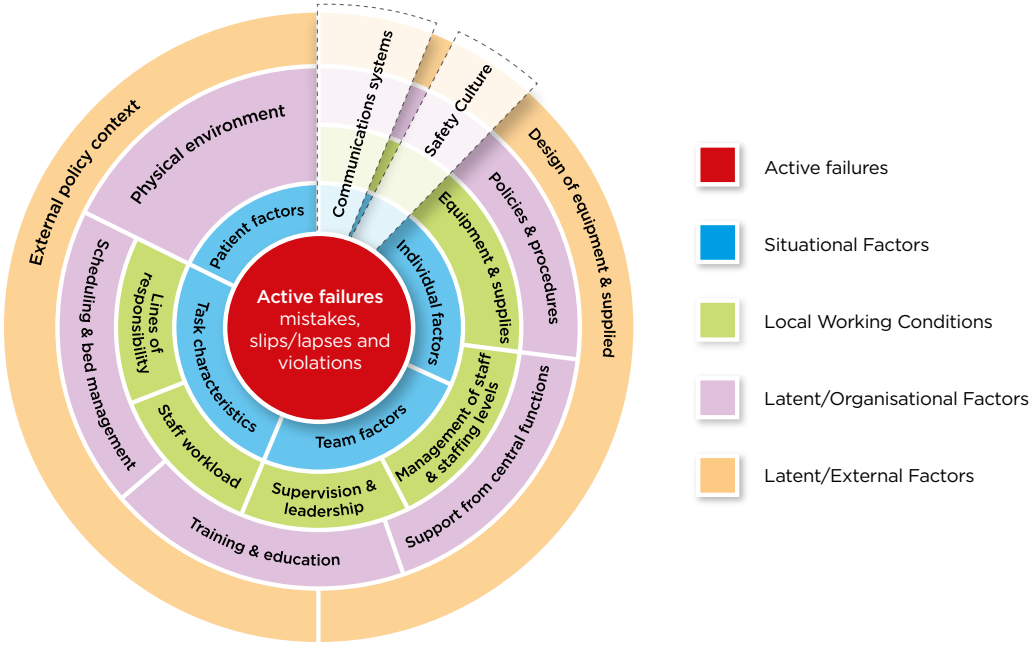
Remember to keep your recommendations specific to the service where the incident happened rather than making recommendations for national implementation. The senior officer accountable for the incident who commissioned the review will determine if any recommendations have national relevance and escalate the report or its findings to the next level as appropriate.

When making recommendations, it can be helpful to collaborate with relevant stakeholders (e.g., staff) to make sure that recommendations will effect change.

Finally, make sure that any recommendations and key learning identified are linked to your findings so that the review report has coherence. Ensure that all recommendations and learning are recorded on the investigation page on NIMS.

[31] https://onlinelibrary.wiley.com/doi/full/10.1002/car.2323

Appendix A: Yorkshire Contributory Factors Framework (Lawton et al 2012)[32]



Factor	Definition
Active failures	Any failure in performance or behaviour (eg, error, mistake, violation) of the person at the 'sharp-end' (the health professional)
Communication systems	Effectiveness of the processes and systems in place for the exchange and sharing of information between staff, patients, groups, departments and services. This includes both written (eg, documentation) and verbal (eg, handover) communication systems.
Equipment and supplies	Availability and functioning of equipment and supplies
External policy context	Nationally driven policies / directives that impact on the level and quality of resources available to hospitals
Design of equipment and supplies	The design of equipment and supplies to overcome physical and performance limitations
Individual factors	Characteristics of the person delivering care that may contribute in some way to active failures. Examples of such factors include inexperience, stress, personality, attitudes.
Lines of responsibility	Existence of clear lines of responsibilities clarifying accountability of staff members and delineating the job role.
Management of staff and staffing levels	The appropriate management and allocation of staff to ensure adequate skill mix and staffing levels for the volume of work
Patient factors	Those features of the patient that make caring for them more difficult and therefore more prone to error. These might include abnormal physiology, language difficulties, personality characteristics (eg, aggressive attitude)
Physical environment	Features of the physical environment that help or hinder safe practice. This refers to the layout of the unit, the fixtures and fittings and the level of noise, lighting, temperature etc.
Policy and procedures	The existence of formal and written guidance for the appropriate conduct of work tasks and processes. This can also include situations where procedures are available but contradictory, incomprehensible or of otherwise poor quality
Safety culture	Organisational values, beliefs, and practices surrounding the management of safety and learning from error
Scheduling and bed management	Adequate scheduling to management patient throughout minimising delays and excessive workload
Staff workload	Level of activity and pressures on time during a shift
Supervision and leadership	The availability and quality of direct and local supervision and leadership
Support from central functions	Availability and adequacy of central services in support the functioning of wards/units. This might include support from Information Technology and Human Resources, portering services, estates or clinically related services such as radiology, phlebotomy, pharmacy.
Task characteristics	Factors related to specific patient related tasks which may make individuals vulnerable to error
Team factors	Any factor related to the working of different professionals within a group which they may be able to change to improve patient safety
Training and education	Access to correct, timely and appropriate training both specific (eg, Task related) and general (eg, Organisation related)

[32] https://qualitysafety.bmj.com/content/21/5/369

Appendix B: Terms of Reference Template

Incident Review Terms of Reference

This Incident Review is being established by *{insert Service/ Area}* to agree the parameters of this review. It is essential that the scope of the review is clear so that the review focuses on the facts relating to the incident and identification of any factors, which may have contributed to the adverse event.

1. Membership

The membership of this incident review is based on the incident rating given by NIMS. The rating of this incident is *{insert incident rating}*. The senior officer accountable for the incident and responsible for this review is: *{insert name of senior officer accountable for the incident}*

2. Meetings

This incident review will be held as follow as: *{insert the frequency/date of the incident review meeting(s)}*

3. The duties of the Incident Review are

- To identify what happened in the lead up to the incident,
- To determine if any systemic factors contributed to the incident,
- To determine if there are any measures that can be put in place to prevent similar incidents occurring again in the future.
- *{if required, insert additional duties of the Incident Review team as the team deems appropriate}*

Step 4:
Reviewing the incident and uploading report on NIMS

Guidance 2:
Combined review

Purpose

The purpose of the guidance prepared for Step 4 is to describe methods that services can use to review incidents.

Background

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with approximately 2% rated as extreme.[33]

The response to the incident should be proportionate to what happened. A common methodology underlying most review methods or approaches to incident reviews is systems analysis.

The purpose of reviewing an incident is to find out what happened, why and if there is any learning that can be put in place to minimise the risk of a similar incident happening again in the service.

[33] Based on incidents reported on NIMS in 2020

Combined review

Combined reviews are appropriate for incidents that have a negligible rating on NIMS.

This involves gathering information from NIMS on groups of incidents that share a theme. For example, a service might decide to look at all incidents reported in the last month related to violence, harassment and aggression, that were rated as negligible, at a staff meeting.

The senior officer accountable for the incident (i.e., the person responsible for commissioning the review) assigns a staff member (reviewer) to facilitate a team discussion and write up a report. The senior officer accountable for the incident may decide to ask someone from the QRSI team to support this.

The reviewer prepares for the meeting by writing a series of questions on flip chart paper or something similar with the following headings:

- What happened?
- What should have happened?
- Why was there a difference?
- Is there any learning?

After the meeting, the reviewer drafts a report (1-2 pages) based on the discussion and circulates it to the group within a week requesting feedback. The reviewer submits the final report to the senior officer accountable for the incident who arranges for it to be uploaded onto NIMS.

The senior officer accountable for the incident is responsible for sharing the learning and ensuring that any actions identified for the service are implemented.

Step 4: Reviewing the incident and uploading report on NIMS

Guidance 3:
Desktop review

Purpose

The purpose of the guidance prepared for Step 4 is to describe methods that services can use to review incidents.

Background

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with approximately a small number rated as extreme.[34]

The response to the incident should be proportionate to what happened. This means choosing an appropriate review method.

A common methodology underlying most review methods or approaches to incident review is systems analysis.

The purpose of reviewing an incident is to learn and improve when things go wrong in services rather than to attribute blame to individual staff members. Using systems analysis as your underlying methodology acknowledges that errors made at the sharp end or front line are often influenced by decisions made by policy makers or managers and that it is system change that leads to sustainable service improvement.

[34] Based on incidents reported on NIMS in 2020

Desktop review

A desktop review is one method of reviewing an incident. It is used for reviews where it is not necessary to meet the person harmed and/or staff involved.

The primary purpose of meeting or interviewing people harmed and / or staff involved in an incident is to clarify any gaps in information gathered from the file and other documentary sources. A desktop review might take place if people involved are not available (e.g., legacy cases) or when sufficient information is available on file (e.g., incidents rated as minor/ negligible).

Desktop reviews are appropriate for incidents that have caused negligible or minor harm to a child, young person, or staff member.

The purpose of any review including desktop reviews is to look back at what happened to learn while looking forward to anticipate what might make the service safer. The process involves gathering information, analysing the information, and identifying any learning that can be applied to make the service safer.

When the review is complete, it should be submitted to the senior officer accountable for the incident (i.e., whoever commissioned the review).

The senior officer accountable for the incident is responsible for:

- Making sure that the review report is uploaded on NIMS.
- Providing a copy for the person(s) harmed.
- Ensuring that any learning identified is shared and tracked to inform service improvement.

Step 4: Reviewing the incident and uploading report on NIMS

Guidance 4:
Rapid review

Purpose

The purpose of the guidance prepared for Step 4 is to describe methods that services can use to review incidents.

Background

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with approximately 2% rated as extreme.[35]

Whatever method is selected to review an incident; it is important to understand what happened at the time of the incident in the context of any systemic factors that contributed to it.

The primary purpose of reviewing incidents is to identify any learning that can be put in place to improve the service where the incident happened, to avoid a similar incident happening to someone else. Therefore, it is not always necessary to review all the files associated with a child's involvement with Tusla services.

Rapid review

A rapid review involves gathering preliminary information for a group to discuss and determine if a more comprehensive review is needed (e.g., a local review).

The senior officer accountable for the incident (i.e., service director/ chief officer) and the area manager agree that a rapid review is appropriate for the case. This decision can be guided by QRSI staff who can support the process.

[35] Based on incidents reported on NIMS in 2020

There are no hard and fast rules about what cases suit this method and it is up to the service or areas professional judgement. For example, some areas will decide that it is an appropriate method to review a death of a young person in aftercare whereas others might opt to do a local review if it is deemed too soon for staff involved to participate in a rapid review. Alternatively, the service director may determine that the complexities of the case warrant a more in-depth local review.

The area manager assigns a case officer for a rapid review. The case officer is someone in the area who will take on the role of gathering preliminary information and providing updates on the review. This is generally a staff member that worked with the child,young person or supervised staff that did (e.g., SWTL).

The case officer is responsible for gathering preliminary information that will inform decision making at a Rapid Review Team meeting (see Appendix 1 for form to use – Part A).

The Area Manager is responsible for convening and chairing the Rapid Review Team meeting, which takes place within 30 working days of Tusla becoming aware of the serious incident or child death.

The Area Manager assigns someone to complete Part B of the form (see Appendix) at the meeting (e.g., QRSI staff).

The Area Manager approves Part A and B and both forms are amalgamated and sent to the service director (i.e., the senior officer accountable for the incident) for approval. There is no need to include minutes of the meeting. However, they can be uploaded onto NIMS (which acts as the electronic file for incident management) and are available if further information is needed at any time.

Once approved, the service director's office emails the report (i.e., Part A and B together) to the Quality and Regulation Directorate using the incidents@tusla.ie email. Q&R staff will then provide the report to the National Review Panel and HIQA and upload it onto NIMS.

Appendix 1: Rapid Review Report

Part A: Case Officer's Report

The purpose of the case officer's (e.g., SWTL or local Q&R lead) report is to set out a preliminary overview of the information about Tusla services provided to the child or young person. This preliminary information aims to inform decision making at the Rapid Review meeting. It is not intended to be a comprehensive review of the case but to provide a report on the information that can be gathered in the days and weeks following the serious incident or child death to inform the Rapid Review Team's decision making. The outcome of the rapid review meeting may be that a more detailed look at the case is warranted and the group can recommend that a local review is carried out, but this meeting looks at the events and circumstances leading up to the serious incident or child death and is not a review of all files. The case officer attends the Rapid Review Team meeting to present Part A of the report. Quality, Risk and Service Improvement (QSRI) staff are available to support the area manager's nominee for this role.

Incident details

NIMS Reference Number	
Date of serious incident / child death	
Date notified to Q&R Directorate	
Date of Rapid Review decision meeting	

1. Describe the serious incident / child death

Include details of how the area learned of the serious incident / death

2. Does the case fit the criteria for review by the National Review Panel?[36]

Does the case involve:

- A child whose immediate family is known to Tusla social work[37];
- A child known to Tusla social work or a Tusla-funded service[38], or;
- A young adult who was in receipt of aftercare services at the time of the incident, under section 45 of the Child Care Act 1991.

Yes ☐ No ☐

If no, how is the child / young person known to Tusla?

3. Provide a brief overview of service involvement

Include details of any Tusla services involved, length of involvement, key dates and any other agency involvement

[36] As defined in the DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/

[37] Open cases or cases which have been closed in the past two years are categorised, for the purpose of this Guidance, as known to the social work department or Agency-funded service.

[38] A Tusla funded service refers to services funded by Tusla in relation to Child Protection and Welfare (CPW), Alternative Care and Fostering, Partnership, Prevention and Family Support (PPFS), and Aftercare.

4. Provide a preliminary view on Tusla's management of the case

Include your preliminary view on Tusla's management. For example, do you think that the service provided was adequate? Is there any learning from this case that is immediately obvious?

5. Provide a brief description of actions taken by the service/ area since becoming aware of the serious incident or child death

Include immediate actions including:

- Any taken to prevent further harm to any child/young person or others and support offered to people involved (children/young people / families / staff).
- Details of any meetings / contact with the family.
- Confirmation that the National Incident Report Form (NIRF) has been sent to incidents@tusla.ie for notification to the National Review Panel, HIQA and recording on the National Incident Management System (NIMS)

6. Provide a preliminary view on the next steps needed

Include your view on whether the actions taken to date are adequate or if there are any gaps that need to be addressed. The purpose of this section is to provide assurance that the incident is being managed appropriately or to identify areas where actions are outstanding such as support for a child, young person, family and/or staff member(s)

7. Name, title and contact details of person completing part A

Name	
Title	
Date	
Mobile	
Email	

Part B: Rapid Review Meeting

The purpose of Part B of the Rapid Review Report is to record the decisions taken at the Rapid Review Meeting. The meeting should take place within 20 working days of the area becoming aware of the serious incident or child death. The Area Manager (or other senior manager nominated by the service director) chairs the meeting. Possible participants might include the area's chair for Child Protection Conference (CPC) or the Foster Care Committee, as they are independent of the local social work case management structure. However, the senior manager for the service involved should also attend to provide the service's perspective on what happened and why.

Immediately following the Rapid Review meeting, the completed form (parts A and B) should be emailed to the Service Director's office for approval and then to incidents@tusla.ie Q&R will submit the report to the National Review Panel and HIQA (copy to service director and QRSI manager).

1. Name, title and contact details of attendees at meeting[40]

Name	Job title	Mobile	Email
	Area Manager (Chair)		
	QRSI Manager		
	Service Manager		

2. Immediate actions taken

Based on the case officer's preliminary report and discussions at the meeting, is the Rapid Review Team satisfied that the incident has been managed appropriately to date?

Yes ☐ No ☐

If no, outline gaps in incident management to date and actions needed. Please include the Rapid Review Team's view as to whether another process is required (e.g. Trust in Care, Tell us etc)

3. Is there learning that can be identified now?

Based on the case officer's preliminary report and discussions at the meeting, is the Rapid Review Team satisfied that there is enough information to identify learning that can inform service improvements now?

Yes ☐ No ☐

If yes, outline key learning and details of any action plan for the service to implement same. Make sure actions are specific, measurable, achievable, relevant and time-bound (SMART).

[40] The Area Manager chairs the meeting. Attendees include services directly involved that can discuss what happened and identify any learning required to improve the service. The Area Manager can invite frontline staff to attend for part of the meeting if required. The QRSI Manager or Q&R staff are available to support the process during the rapid review.

4. Is a more comprehensive review needed?

Based on the case officer's preliminary report and discussions at the meeting, is it the Rapid Review Team's view that a more comprehensive review is needed?

Is a more detailed local review needed?

Yes ☐ No ☐

*If yes, proceed to section 5.

The primary purpose of a review is to identify any learning needed to inform service improvements. It is up to the Rapid Review Meeting to determine whether a more detailed review is required or whether the learning identified as part of the rapid review is sufficient.

If the Rapid Review determines that a local review is not necessary because sufficient learning has been identified, the area manager must ensure that the decision is:

1. **Approved by the relevant service director.**
2. **Entered onto NIMS (this form can be uploaded).**

Following service director approval, the area manager is responsible for ensuring that learning identified from the rapid review and any changes needed to improve the service is communicated to the people affected including children, young people, families and staff.

5. Is a local review recommended? (i.e. Tusla review)

The Rapid Review can recommend that the service director commission a senior manager that did not have supervisory responsibility for the case to undertake the local review. This decision must be recorded on NIMS (this form can be uploaded). The local review should be completed within three months of Tusla becoming aware of the serious incident or child death.

The Rapid Review may determine that an incident does not meet the criteria for notification to the NRP but may decide that a local review should take place because the incident raises important issues for the area (e.g. good practice or poor practice or where a 'near miss' has occurred. A near miss is an event that could have caused harm but because of the actions of a staff member or service, the person affected did not experience harm.

6. Rapid Review Chair Details

Name of Chair (area manager or more senior)	
Address	
Email	
Mobile	
Date form submitted to incidents@tusla.ie	

Step 4: Reviewing the incident and uploading report on NIMS

Guidance 5:
Local review

Purpose

The purpose of the guidance for Step 4 is to describe methods that services can use to review incidents.

Background

The National Incident Management System (NIMS) rates incidents based on the degree of harm experienced at the time of the incident. This rating scale ranges from negligible (no harm or low harm) to extreme (death). The majority of incidents reported on NIMS are rated as negligible with approximately 2% rated as extreme.[41]

Whatever method is selected to review an incident; it is important to understand what happened at the time of the incident in the context of any systemic factors that contributed to it.

The response to the incident should be proportionate to what happened. In some cases, this will warrant a comprehensive review (i.e., local review) by a staff member who was not involved with the case.

Local review

The senior officer accountable for the incident (i.e., service director) and the area manager agree that a local review is appropriate using their professional judgement. Alternatively, a rapid review previously carried out can have recommended that Tusla carry out a local review.

The area manager assigns a reviewer who is sufficiently removed (i.e., no involvement in case management or supervisory role).

[41] Based on incidents reported on NIMS in 2020

Local reviews should be based on reviews of case materials and may include discussions or consultations with practitioners and managers from the different services involved.

Avoid interviewing staff in detail as part of the review if possible, as they might later need to be interviewed by the NRP. If any individuals or services provide written submissions to the local review, these should be appended to the report.

Reports should focus on the service provided by Tusla and others as well as the chronology of events and should provide:

- A brief summary of the case covering the main points, sufficient to illustrate the child or young person's situation; why he or she was in contact with the services, dates of their involvement, the circumstances around the death or serious incident and any significant events in the recent past.
- A list of the names of social workers allocated to the case, dates of their involvement and their current whereabouts and contact details if they have moved. Periods where the case was held on duty or had no allocated social worker should be listed.
- A list of names of all the other professionals and services involved with the child or young person and the dates of their involvement and their current whereabouts and contact details.
- A chronology of services provided, if the period of involvement has been lengthy, it could be divided in terms of phases, each one consisting of a number of years.
- Analysis of the quality of service provided, the elements of service to be evaluated should include:
  - Initial response to the case when referred and the level of concern that was reported or revealed,
  - Quality of initial and further assessment if relevant,
  - Compliance with regulations,
  - Quality of interaction with the child/ young person and his or her family including the relationship that developed, frequency of contact, observation of progress, response to child/ young person's and family's requests or attention to significant events, openness to and use of new information,
  - Dates of case conferences and review conferences, child in care reviews etc,
  - Decisions of these meetings and whether or not the recommended actions were taken on board,
  - Obstacles to progress and what attempts were made to overcome them; management – supervision, inter-agency collaboration, local policy etc,
  - Conclusions based on the analysis,
  - An outline of key learning,
  - Actionable recommendations.

The local review should be completed within three months of the date on which the serious incident or child death occurred or became known to the service or area.

Step 4: Reviewing the incident and uploading report on NIMS

Guidance 6:
Writing an incident review report

Purpose

The purpose of this guidance is to set out how to write an incident review report. When the report is finalised and has been accepted by the commissioner it is uploaded onto the National Incident Management System (NIMS).

Background

There are five steps in the incident management process. This 'how to guide' focuses on the incident report, which is completed in step 4 but is key to informing the most important step in the process, which is about learning and improving.

The incident report is key to closing the loop as it sets out the facts of what happened, determines what systemic factors contributed to the incident and what needs to happen to prevent a similar incident occurring again in the future. A good report is an essential part of the incident management process and uploading it on the National Incident Management System (NIMS) signals that the incident review has concluded and the service can move to the learning and improvement phase.

How to write an incident review report

The incident report does not have to be long. A short report is easier to read and can be more effective particularly if you are going to share it to inform service improvements. It takes more skill to write a short report than a long one but remember the purpose is to present the salient points of your review – not to detail everything. Consider developing a short summary of key points if your report extends over four pages.

It is a good idea to start drafting the report as soon as you begin the review as the format of the report reflects the stages of the review.

The success of the incident review and consequently the incident review report depends on the Terms of Reference (ToR) for the review. The senior officer accountable for the incident (commissioner of report) sets the ToR. This can be done in consultation with the QRSI manager and/or other members of the regional management team that are sufficiently removed from the incident.

However, it is important that reviewers agree that the ToR are achievable. For example, the ToR should reflect a review of an incident rather than a full case review. Therefore, it should not be necessary to review all case files from the time the child and family were referred to the service. Rather, the ToR should reflect the time leading up to the incident.

An incident report needs to answer questions relevant to who, what, where, when, and why. A good report also sets out your methodology including the;

- documents that you reviewed,
- the staff that you met and
- anything you used to help your analysis (e.g., contributory factors framework).

Table 1: Questions that need to be answered in the incident review report

Who	Who was the person(s) harmed? - anonymised Who is the senior officer accountable for the incident / commissioner of report? Who is reviewing the incident?
What	What are the terms of reference? What happened? What service was involved? What immediate actions were taken? / What supports were provided to the person(s) harmed? What was the incident severity rating at the time of the incident? (i.e. negligible, minor, moderate, major or extreme?).
Where	Where did the incident happen?
Why	Based on the information reviewed, why did this incident happen? Consider if there were any contributory factors. Were there systemic factors at play that contributed to the incident? Rather than seek to find fault with the decisions made, reviewers should focus on what systems were in play that made any decisions taken make sense at the time.
What	What needs to happen to prevent a similar incident occuring again in the future? Do not forget to specify who is responsible and when does the action need to be completed by?

While incident reports are not published, it is important that they are appropriately anonymised to protect privacy and confidentiality for the person harmed and for staff involved. The NIMS reference number must be included on the front page of the report, however the report pseudonyms must be used for the persons harmed and staff involved. Make sure that you have a list of staff names and pseudonyms that is stored securely on a password protected file, which can be sent to the commissioner with the final report. All incident reports should be anonymised including rapid or local review reports provided to the National Review Panel.

Your report also needs to set out the steps you took to ensure due process or procedural fairness for anyone involved in the review. This means making sure that you provide staff members with a draft copy of any section of the report that refers to them so that they can provide feedback as to its factual accuracy. This ensures that people have a right to reply about any text that mentions them before anyone else sees it.

Appendix A Report template

1. Background

- Provide a summary of the incident
- Include detail of who commissioned the report and reviewers
- Terms of reference
- Outline methodology – include details of what documents were reviewed and any meetings held with the person(s) harmed and staff.
- Set out due process procedures that include providing a draft copy of the report to anyone mentioned so that they can provide feedback regarding factual accuracy.

2. Chronology (what happened?)

- This section of the report sets out what happened in the lead up to the incident.
- Include a summary of the chronology. While you will need to develop a detailed chronology or timeline to determine what happened, there is no need to include all of it in the report. If you don't want to leave it out consider including it as an appendix.
- Include a summary of what happened after the incident particularly any supports put in place for the person(s) harmed including staff that were involved.

3. Findings and analysis (why?)

- This is the most important section of the report as it contains the analysis of why the incident might have happened. Use the contributory factors framework to guide your analysis here.
- Ensure that there is an **analytic thread** so that the analysis is based on the information gathered. This is where you set out the factors that you believe contributed to the incident.
- You can also include any incidental findings that you don't feel contributed to the outcome but if in place would improve the service.
- You can also comment on any aspects of good practice that you found.

4. Key learning and recommendations

- Ensure that key learning and recommendations are linked to any contributory factors highlighted in your analysis.
- Keep your recommendations to the specific incident and service that you reviewed rather than generalising to the wider Agency.

Step 5:

Learning and improving

Step 5: Learning and improving

Guidance 1: Learning and improving

Purpose

The purpose of this guidance is to describe some ways of sharing learning from incident reviews to inform service improvements.

Background

The fifth and final step of the incident management process is about 'closing the loop' and sharing any learning identified in the review of the incident that might prevent the incident happening again. There must be an appropriate balance between the resources applied to reporting and reviewing individual incidents and those applied to implementing and embedding learning to prevent recurrence of avoidable harm.

The commissioner of a review is responsible for ensuring that any learning identified from incident reviews is actioned but QRSI staff have a key role in supporting this.

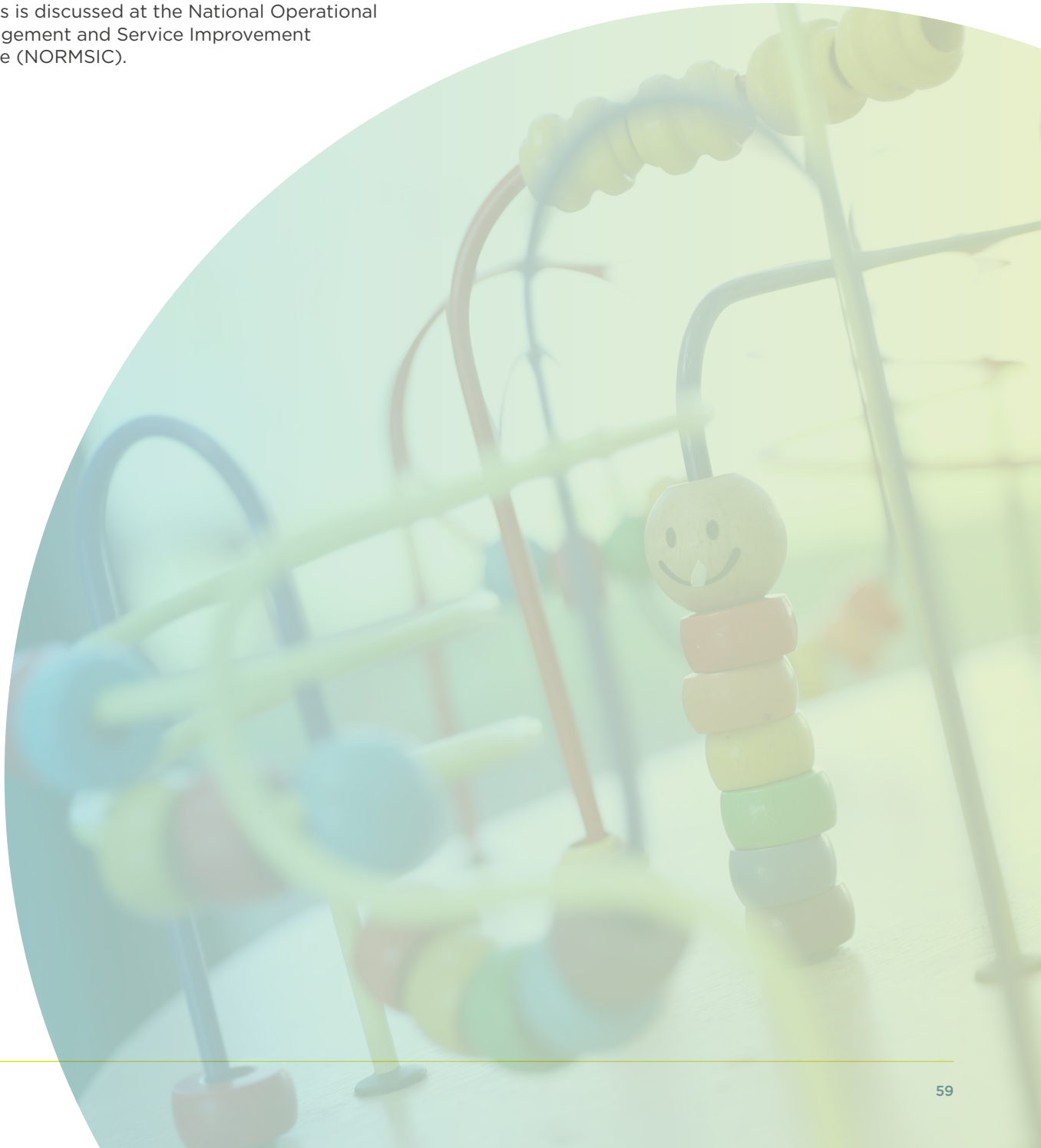
Regional and local QRSI staff have a key role in ensuring that learning from incidents is shared locally and regionally. This can include identifying trends from NIMS and sharing learning from review findings at local and regional governance structures in place such as QRSI regional meetings. Health and safety staff at regional and national level have a key role in disseminating learning related to health and safety incidents.

Sharing learning

The commissioner of the review report determines whether review reports can be shared on a case-by-case basis. Commissioners may ask reviewers or QRSI staff to develop learning alerts or learning notices following an incident review. This allows for key learning to be shared.

At a minimum, review findings from incidents need to be discussed at regional QRSI forums to ensure that any findings and/or recommendations are shared internally.

QRSI managers should ensure that any learning identified from incidents rated as major or extreme that could be used to inform service improvement in other Tusla areas is discussed at the National Operational Risk Management and Service Improvement Committee (NORMSIC).



Step 5:
Learning and improving

Guidance 2:
How to develop a seven minute briefing

Purpose

The purpose of this guidance is to describe how to develop a seven minute briefing.

Background

Seven minute briefings are based on the idea that it is only a short period of time to take from a scheduled staff meeting.

Seven minute briefings are a useful way to deliver a short briefing to staff on key learning from incident reviews. They can be used to support reflective discussion.

The idea is that people can focus better because it is a short period of time.

While you won't be able to cover everything in seven minutes, the idea is that the information in the briefing can act as a catalyst to prompt someone to look up further information on the topic.

How do you develop a seven minute briefing?

There are no hard and fast rules on this. You can develop a text briefing or a visual one using a chart from PowerPoint to outline each heading.

One format, that is known to be beneficial, is to choose a limited number of headings to cover the material and spend a minute on each heading. You can repeat one of the headings if you want to spend another minute on it.

- Background
- Why it matters
- Information
- What to do
- Questions to consider
- Next steps

Appendix A: Seven Minute Briefing Managing an Incident

Seven minute briefings are a useful way to deliver a short briefing to staff on key learning from incident reviews. They can be used to support reflective discussion

1. Background

Tusla's *Incident Management Policy* has been revised. Similar to the last policy, all incidents should be reviewed and managed appropriately.

2. Why it matters

We know that adverse events are inevitable in complex services. We need to use them as an opportunity to learn so that we can prevent the incident happening to someone else.

3. Information

Tusla's *Incident Management Policy* sets out a five step approach for managing incidents. An incident is an event or circumstance, which could have or did lead to unintended or unanticipated injury or harm. These five steps are;

1. Identify and immediate management.
2. Report the incident
3. Determine severity to guide review.
4. Review (gather info, analyse it and identify any learning)
5. Learn and improve.

4. What to do

Make sure you look after the person harmed first (e.g. first aid / GP etc.). The person harmed can be a service user or a staff member (or anyone visiting a service).

Then, report the incident using the National Incident Report Form (NIRF) available on the Tusla HUB.

5. What to do

Talk to your manager and tell them you are sending them your completed NIRF. Send the NIRF to your manager. Your manager will review and ensure it is reported on the National Incident Management System (NIMS) in line with statutory obligations (National Treasury Management Agency Act). NIMS determines if an incident is negligible, minor, moderate, major or extreme. In turn, this determines the type of review that is appropriate.

6. Questions to consider

- Is there a positive reporting culture in my service?
- How do we implement learning from incident reviews?

7. Next steps

Make sure the team know what an incident is, where to record it and to whom they need to report it to. There are specific reporting requirements for serious incidents and child deaths (as per DCEDIY *Interim Guidance for Tusla on the operation of the National Review Panel*)[42]. Support is available from QRSI staff and the national Risk and Incident team. Specific support on health and safety related incidents is available from the Health and Safety Department and regional health and safety advisors.

[42] DCEDIY Interim Guidance for Tusla on the operation of the National Review Panel https://www.tusla.ie/national-review-panel/about-us1/

Appendix B:
Seven minute briefing: Managing an incident

Appendix C:
Example of template to record team discussion of learning and action plan

Name of learning event (e.g. seven minute briefing)

Name	Service / Team

Learning points or recommendations	
From your discussion, identify a learning point or a recommendation that is relevant to your team	1.

Action Plan	
From this learning or recommendation, agree an action to improve practice: (be SMART)	1.
• What needs to happen?	
• Who will do it?	
• By when?	
• How will you know when it has been done?	
• How will you know if it has worked?	

Please ensure you keep a copy of this discussion and plan for your records

Date of discussion

Manager	Contact details

2.	3.

2.	3.

Please ensure you keep a copy of this discussion and plan for your records

TUSLA

An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

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