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

Incident Management Policy

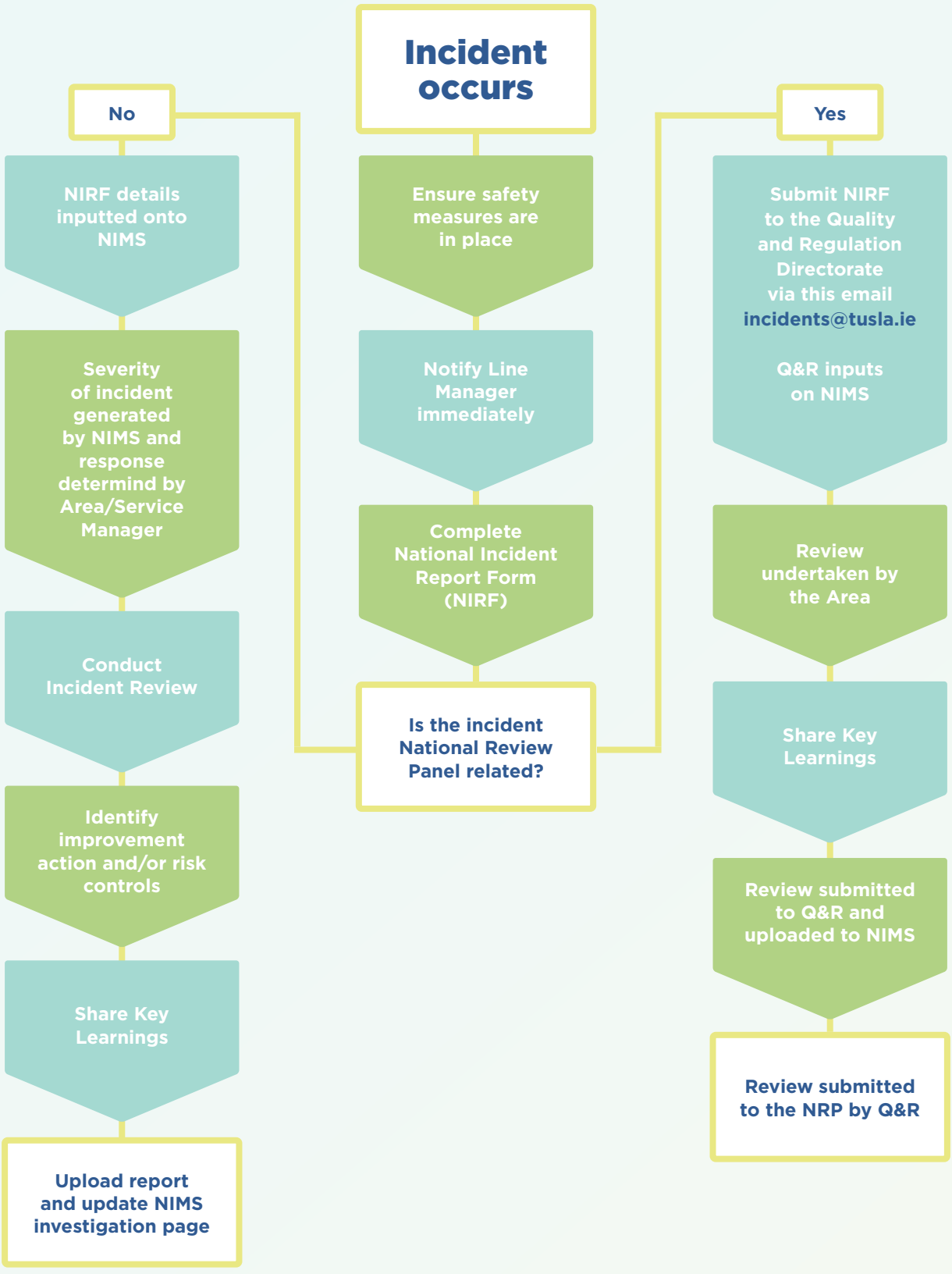
An incident is an event or circumstance, which could have or did lead to unintended or unanticipated injury or harm

Incident Management Policy

Document reference number	
Revision number	V02
Approval Date	
Next revision date	December 2025, unless deemed appropriate to review sooner
Document developed by	Quality and Regulation Directorate (Q&R)
Document approved by	
Responsibility for implementation	All staff in Tusla, the Child and Family Agency; All staff in Tusla-funded services
Responsibility for review and audit	Quality and Regulation Directorate

Contents

Incident Process Map



Glossary of Key terms and definitions

Term	Definition
Adverse event	An incident that resulted in harm.
Harm	Harm to a person: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury[1]. Harm to an asset: Damage to an asset may include damage to facilities or systems (e.g. environmental, financial, data protection breach etc.)
Incident	An event or circumstance which has caused unintended or unanticipated injury or harm to someone.
Near miss	The prevention of an unintended or unanticipated injury or harm either by chance or timely intervention.
Open disclosure	This involves an open, consistent approach to communicating with service users when things go wrong in service provision.
Risk	The effect of uncertainty on service objectives.
Senior officer accountable for the incident	This person has overall responsibly for management of the incident in accordance with governance within the Agency and ensuring that incidents are reviewed in an effective and timely manner. The senior officer accountable for the incident is impartial and sufficiently removed from the incident.
Serious incident	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
Systems analysis	Systems thinking is a way of thinking about and a language for describing and understanding the forces and interrelationships that shape the behaviour of systems. This discipline helps us to see how to change systems more effectively[2].

[1] The definition of harm is taken from a World Health Organisation (WHO) framework (2009) https://www.who.int/patientsafety/taxonomy/icps_full_report.pdf

[2] Section 13 Systems Analysis Guidance, Incident Management Framework (2020) HSE https://www.hse.ie/eng/about/qavd/incident-management/hse-2020-incident-management-framework-guidance.pdf

Introduction

Tusla, the Child and Family Agency (herein referred to as 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.

This policy document aims to support this commitment by setting out what Tusla services must do when people are affected by incidents that occur while they are;

- engaging with Tusla services (e.g. children, young people and families)
- or providing them (e.g. staff).

This includes acting quickly and respectfully to provide support for those affected by adverse events and identifying any learning that might prevent a similar incident from happening again. This document replaces *Tusla's Incident Management Policy and Procedure (incorporating the Procedure for 'Need to Know' and National Review Panel Notifications)* launched in January 2017.

In the context of incident management and as a learning organisation, Tusla promotes a positive safety culture by:

- Accepting that incidents and adverse events may happen due to the complexity of services provided to children and families.
- Supporting a just and open culture where staff can talk about incidents in the knowledge that there will be a constructive organisational response.
- Treating incidents as opportunities for services to learn and improve.

For the purpose of this policy, **an incident is an event or circumstance, which could have or did lead to unintended or unanticipated injury or harm.**

Incidents include adverse events, which resulted in harm, near misses which could have resulted in harm but did not, either due to chance or timely intervention, and staff or service user complaints, which are associated with harm.

A service user incident

A service user incident is an incident that occurs during the provision of a service. Potential outcomes the service user may experience are;

- **Harm**-When the adverse event caused an unintended or unanticipated injury or harm to the service user.
- **No Harm**-When the adverse event did not result in actual injury or harm to the service user but was one that in the service provider's view, the service user was placed at risk of unintended or unanticipated injury or harm.
- **Near Miss**-When the adverse event did not result in unanticipated or unintended injury or harm because it was prevented either by timely intervention or by chance.

The principles that underpin this policy are the themes outlined in the national standards and include:

GOVERNANCE AND ACCOUNTABILITY:

Effective governance structures and accountability arrangements for safety are essential for effective incident management.

PERSON-CENTRED:

Supporting people affected by incidents is an important aspect of incident management. This includes identifying immediate support needs at the time of the incident but also identifying if there are long-term support needs for the children, families or staff affected. It also means keeping people affected informed on how the incident is being managed and the outcome. A person-centred approach helps to maintain trust between the people affected and the organisation.

WORKFORCE:

Staff members who are tasked with reviewing incidents must be supported to undertake this role through training and protected time to undertake reviews.

REVIEWS:

Services undertake reviews that are proportionate to the incident, procedurally fair and completed in a timely manner. Reviews outline;

- **what happened,**
- **why it happened and**
- **identify any learning that can be put in place to make the service safer.**

SHARING THE LEARNING FOR IMPROVEMENT:

There are structures in place for learning to be shared locally and nationally, this drives Agency wide improvements.

Applying these core principles to incident management will mean that Tusla services can manage incidents effectively.

Incident management does not need to be a long, complicated process as the primary purpose is to identify learning. This is most effective if it takes place as soon as possible after the incident so that improvements can be made.

Once immediate safety needs are met, managers need to ensure that staff are provided with appropriate informal and formal supports.

How Tusla processes incidents

When managing an incident staff must be aware of the following;

- All incidents must be reported on the National Incident Management System (NIMS) and reviewed to identify;
  - what happened,
  - why it happened, and
  - if there is any learning that could be put in place to prevent a similar incident happening in the future.
- Incidents are rated in terms of the severity of harm experienced at the time of the incident. It is this incident rating that determines how incidents are managed. NIMS rates severity according to the outcome of the incident at the point of occurrence. Severity ranges from negligible (no adverse outcome) to extreme (permanent incapacity or death).
- The majority of incidents reported by Tusla services are rated as negligible with a small percentage rated as extreme.[3]
- Incidents rated as extreme generally relate to child deaths, which are reported to the National Review Panel (NRP). The NRP is an independent panel that operates according to guidance developed by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).[4]
- A central aim of managing incidents is to learn and improve. Services need to have systems in place for sharing learning and monitoring the effectiveness of any actions put in place following an incident review. See guidance developed for Step 5 of the incident management process – Learning and improving.

An important element of Tusla's incident management process is using the National Incident Management System (NIMS) as an electronic file to record key decisions regarding incident management.

Key things to know about NIMS are;

- It is an external incident management system,
- It is operated by the State Claims Agency,[5]
- It offers an end-to-end risk management tool, which allows Tusla to manage incidents throughout an incident lifecycle whilst also fulfilling its legal requirement to report incidents to the State Claims Agency.[6]
- It is also a useful tool which Quality, Risk and Service Improvement (QRSI) staff can use to generate reports to inform learning on key themes and trends regarding incidents locally and regionally.

A further element of Tusla's incident management process is the requirement to report specific incidents to external agencies such as, but not limited to;

- the Health Information and Quality Authority (HIQA),
- the Health and Safety Authority (HSA),
- An Garda Síochána,
- The Department of Children, Equality, Disability, Integration and Youth (DCEDIY)
- the National Review Panel (NRP), and
- other regulatory bodies.

[3] 2% of incidents were rated as extreme based on incidents reported on NIMS in 2020.
[4] DCEDIY *Interim Guidance for Tusla on the operation of the National Review Panel* https://www.tusla.ie/national-review-panel/about-us1/
[5] https://stateclaims.ie/uploads/publications/National-Incident-Management-System-NIMS-Getting-Vale-Pat-Kirwan.pdf National Incident Management System; Getting-Value
[6] National Treasury Management Agency (Amendment) Act 2000. https://www.irishstatutebook.ie/eli/2000/act/39/enacted/en/html

Details of external reporting requirements to these and other agencies are set out in the guidance document (Reference Step 2 of the guidance document).

Incidents notifiable to HIQA and the NRP must be submitted via the Tusla incident inbox incidents@tusla.ie

Services should be aware that there may be overlap with other Tusla processes such as the Need to Know (NTK) notification system. This may include, on occasion, the Executive notifying the Board of the Agency or the DCEDIY of an incident.

Quality and Regulation Directorate (Q & R) staff are available to support Tusla services to implement this policy.

Operational support is available from;

- Regional and local Quality, Risk and Service Improvement staff and
- Tusla's Health and Safety staff

Purpose

This document and accompanying guidance aim to provide a framework to facilitate Tusla and Tusla funded services to manage incidents in line with a five-step process.

Five steps of incident management

1. Identification and immediate management,
2. Reporting the incident to line manager and ensuring it is on NIMS,
3. Assessing the severity of the incident on NIMS to guide decisions on review,
4. Revieiwing the incident and uploading the report on NIMS,
5. Learning and improving.

Further guidance on each of these steps has been developed to support incident management. These guidance documents can be found on the Tusla website and are intended to be used as a reference for staff throughout each step of the incident management journey from identification and immediate management (Step 1) to learning and improving (Step 5).

Scope

This policy applies to;

- all Tusla staff,
- applicable Tusla-funded services[7],
- anyone who has a contract with Tusla to carry out work or to provide a service,
- agency workers,
- staff seconded to Tusla,
- students, and
- volunteers.

Tusla and its funded services comprise a wide range of services that include:

- Child Protection and Welfare,
- Alternative Care,
- Adoption,
- Tusla Education Support Services,
- Family Support,
- Children Services Regulation,
- Domestic, Sexual and Gender-Based Violence services.

The policy and related guidance apply to all services, whether provided directly by Tusla or on its behalf.

The senior officer accountable for the incident in these services should ensure that all staff understand their responsibilities. Staff in these services that have responsibilities in quality, risk and service improvement should ensure that local policies are developed setting out governance of incident management.

[7] This refers to services funded under Sections 56 and 59 of the Child and Family Agency Act 2013.

Legislation and other related policies

Incidents must be managed in line with all relevant legislation and related policies including, but not limited to;

- child protection,
- data protection legislation,
- health and safety legislation, and
- ICT incident management.

Key legislative and policy requirements include;

- Tusla's statutory duty to report incidents to the State Claims Agency (SCA) using NIMS and
- reporting serious incidents and child deaths to the National Review Panel (NRP) and
- the Health Information and Quality Authority (HIQA).

There are other external statutory reporting requirements such as the need to report certain occupational incidents to the Health and Safety Authority (HSA). The Incident Management Guidance document has been developed and sets out these and other reporting requirements.

Incident management must also be viewed in the context of **related Tusla policies**. For example, staff dealing with complaints under Tusla's *Tell Us* policy need to identify if a complaint refers to an unexpected or unanticipated injury that caused harm to a service user and ensure that it is managed under this policy.

The purpose of reviewing an incident is to identify learning to prevent recurrences of similar incidents in the future. Tusla's *Organisational Risk Management Policy* is therefore a key related policy, as any risks to Tusla service objectives identified in an incident review should be captured in the risk management process.

The *Need to Know* (NTK) notification system is a mechanism for services to inform senior managers about local issues but may at times include an issue that requires incident management. Services should review NTK forms carefully as some of them may contain information that indicates an incident has occurred. Regional Quality, Risk and Service Improvement (QRSI) managers and the national risk and incident team are available to support services with any queries or signpost queries regarding NTK's to the appropriate directorate (e.g. Office of the Director of Integration and Services).

Roles and responsibilities

Primary responsibility and accountability for effective incident management lies at the organisational level where the incident happens.

The senior officer accountable for the incident has overall responsibility for the incident in a service, region or area ensuring that an appropriate review takes place in a timely manner.

The senior officer accountable for the incident are expected to be;

- impartial, and
- sufficiently removed from the incident (i.e. did not undertake direct work with the child and/or family or directly line manage the staff member working with the child/family).

The Tusla manager that takes on the role of senior officer accountable for the incident will change depending on the severity of the incident (see guidance developed for Step 1 of the incident management process).

The senior officer accountable for the incident, is responsible for monitoring performance related to incident management in their area of responsibility including:

- Ensuring incidents are reported on NIMS in line with statutory obligations,
- Monitoring that NIMS is used as an electronic file to record key decisions,
- Verifying services comply with relevant;
  - policy,
  - procedures,
  - guidance, and
  - legislation while reviewing incidents (e.g. data protection),
- Ensuring that appropriate governance structures are in place to oversee incident management (e.g. quality and safety committees),
- Ensuring that there is a named staff member supporting the incident management process including NIMS.

General roles and responsibilities for all staff in Tusla and Tusla funded services are outlined in Table 1 at the end of this document.

Enforcement

This is the formal policy of Tulsa. It is a requirement on all staff to implement this policy in accordance with the terms of their employment.

Table 1: Roles and responsibilities

Staff group/role	General Responsibility
All staff (including students, volunteers, and contactors)	Comply with this policy by ensuring incidents are reported promptly. Engage in any incident review or investigation. Commit to implementing any learning identified and recommendations.
Line managers	Ensure that all staff in areas of responsibility are supported to implement the policy and any related procedures. All systems and processes used to manage incidents are aligned with the policy framework.
Senior officer accountable for the incident (i.e. managers).	Ensure that all staff in areas of responsibility, including funded services, are supported to implement the policy and any related procedures. All incidents are properly and safely managed and identifies who is responsible for leading a review if an incident occurs across a service boundary. Oversee and support managers in their role managing incidents and ensure that data reports from NIMS are reviewed regularly to identify trends or areas that need attention. Ensure serious incidents and child deaths are immediately notified to the service director's office.
QRSI team	Facilitate, support, and advise the region / service relating to all aspects of this policy and support training provision for incident management. Support national, regional, and local areas to ensure incidents are reported on NIMS and NIMS is used to record key decisions about incident management. Track and ensure progress regarding any learning and recommendations identified from incident reviews.
Health and safety staff	Facilitate, support, and advise services in aspects of this policy that relate to health and safety incidents.
National Risk and Incident Team	Support QRSI teams and services regarding policy implementation. Policy review and evaluation.

Table 2. Acronyms and abbreviations

Acronym or Abbreviation	Full terminology
NIMS	National Incident Management System
NIRF	National Incident Report Form
NRP	National Review Panel
HSA	Health and Safety Authority
HIQA	Health Information and Quality Authority
Q&R	Quality and Regulation Directorate
QRSI	Quality Risk and Service Improvement
SCA	State Claims Agency

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