Tusla Incident Management Policy and Procedure

(Incorporating the procedure for "Need to Know" and National Review Panel notifications)

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

Document Information and Revision History

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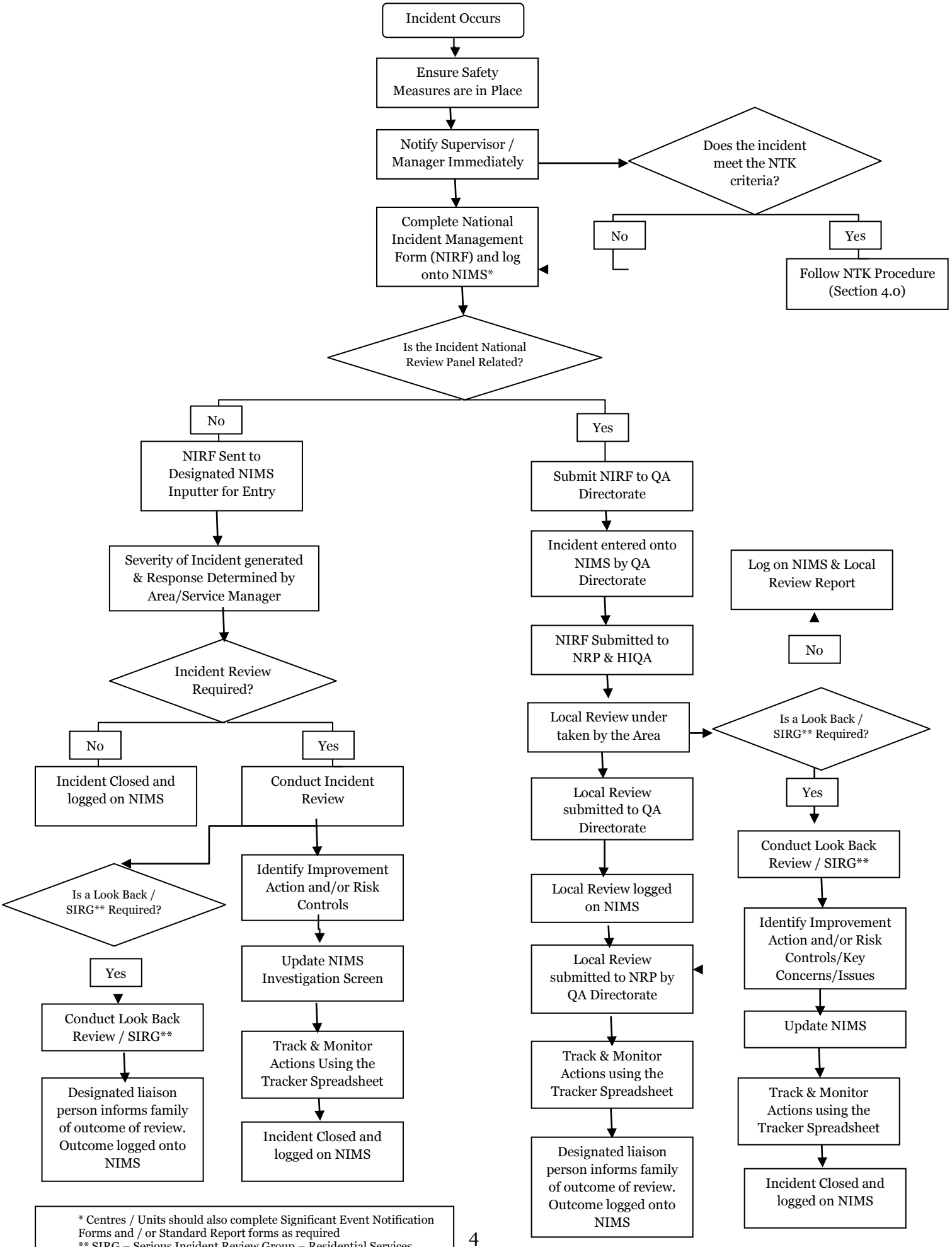

* Centres / Units should also complete Significant Event Notification Forms and / or Standard Report forms as required
** SIRG – Serious Incident Review Group – Residential Services

Introduction

Effective incident management is a key component of quality management activity and can result in better care and support for children and families, reduced likelihood of unexpected event/s, improved resource planning and utilisation and compliance with legislation and standards.

An incident is an event or circumstance which could have (near miss), or did lead to harm. Incidents can be practice related or non-practice related and includes incidents associated with harm to or impact on:

- Service users
- Staff or visitors
- Tusla assets
- Non-compliance with standards or regulations

This policy and procedure document is divided into four sections as follows:

Section 1: Sets out the context for the document, provides definitions and outlines roles and responsibilities for staff within the Child and Family Agency (the Agency)

Section 2: Sets out the guiding principles and good practice in respect of incident management which must underpin the process

Section 3: Provides information on the four stages of the incident management process including:

- Stage 1: Incident prevention and avoidance
- Stage 2: Management and review of incidents
- Stage 3: Reports and recommendations
- Stage 4: Learning from incidents

Section 4: "Need to Know" Procedure

1.0 Context

1.1 Policy Statement

It is the policy of the Agency that all incidents are identified, reported, communicated and investigated, where appropriate, through a robust incident management process. The learning from incidents will be shared to improve services and strengthen governance. This policy applies to all Tusla services and functions. It also applies to all section 56 and section 59 organisations in accordance with contractual obligations.

An important part of the Tusla incident management process is the statutory requirement to report incidents (National Treasury Management Agency (Amendment) Act 2000) on the National Incident Management System (NIMS). NIMS is a web based system used to manage incidents throughout an incident lifecycle whilst also fulfilling legal requirements to report to the State Claims Agency (SCA).

A glossary of terms is provided in appendix I.

1.2 Purpose

The purpose is to clearly outline the Agency's policy and procedure for incident management.

1.3 Scope

This policy and procedure applies to all staff working in the Agency. All voluntary organisations and private providers that are part or wholly funded by the Agency should operate in compliance with this policy and procedure.

Reporting thresholds have been established within the SEN System to ensure specified incidents within CRS are reported on NIMS and reviewed appropriately in line with this policy and procedure. The SENs that are entered onto NIMS are outlined in Appendix IV.

Policies that are being replaced by this policy and procedure

A number of policies and procedures are superseded by this document, these include:

- Standardised Operation Procedures Risk Systems Administration (Tusla, 2014)
- All HSE policies and procedures in relation to incident management that were adopted by the Agency on establishment on 1 January 2014

These documents will cease to be in operation on the implementation date of this policy and procedure.

The Standardised Operation Procedures (SOP) - Risk Systems Administration (2014) contained procedures for a number of incident and risk types. The procedure to be followed for each of these incidents and risk types is now as follows:

(i) Child deaths and serious incidents is covered by this policy and procedure
(ii) "Need to Know" procedures is covered by this policy and procedure
(iii) Risk alerts is covered by the Agency's Organisational Risk Management Policy and Procedure
(iv) Missing Children Alerts – separate policy and procedure developed covering CRI Alerts, missing children in care alerts and unborn alerts

1.4 Roles and Responsibilities for Incident Management

The general roles and responsibilities for staff and managers in relation to incident management are outlined in table 1.

Table 1 – General roles and responsibilities for staff in relation to incident management

Staff Group	General Responsibility
All Employees (including volunteers and contactors)	All employees have a responsibility: • to comply with this policy • to ensure that incidents are reported, managed and reviewed in a timely manner • to participate in and cooperate with reviews and investigations conducted in accordance with this policy • to participate in the implementation of recommendations arising from reviews and investigations
Line Managers	Line managers have a responsibility to ensure that both they, and employees in their area of responsibility, are aware of, trained in and comply with this policy and procedure. Line managers must ensure that systems and processes are utilised to manage incidents locally, and that these are in line with this policy and procedure, where applicable. They must also ensure that the reporting requirements to external agencies are complied with.
Area Managers / Service Leads or Equivalent	The Area Manager/Regional Manager CRS / National Manager Special Care / Service Lead or equivalent (hereinafter referred to as the Area Manager / Service Lead or equivalent) is responsible for ensuring that their service complies with the systems and processes set out in this policy. This also extends to funded services the Area Manager / Service Lead or equivalent has responsibility for. In the event of an incident, they must ensure that the incident is properly and safely managed and take on any additional actions that may be required; this is of particular importance where the impact of an incident crosses individual service boundaries. The Area Manager / Service Lead or equivalent will oversee and support their respective managers in their role in relation to the incident management process. They must review incident data reports from NIMS to identify patterns, gaps and areas that may require attention. Area Managers / Service Leads or equivalent are responsible for ensuring that all child deaths and serious incidents (NRP Guidance, DCYA, 2014), are reported on the NIRF and for immediately initiating a local review (see appendix III).
Service Director, National Director or equivalent	The Service/National Director has responsibility for: • Assuring that appropriate systems and processes are in place, implemented and complied with in relation to the management of all incidents, that occur, in their area of responsibility • Where the control measures required to effectively reduce the risk of recurrence lie outside the control of the relevant Area Manager / Service Lead or equivalent, the relevant Service Director is responsible for ensuring that mechanisms are put in place to control the risk to a level that is as low as is reasonably practical and to communicate with the National Office in relation to additional actions required that are not within their remit • Ensuring that mechanisms are in place to facilitate learning from incidents to be communicated throughout his/her area of responsibility on a cross functional basis.
Regional Quality, Risk and Service Improvement Manager	Has responsibility to facilitate, support and advise in relation to all aspects of this policy and to assist with the provision of training in incident management. There is also a responsibility to track and ensure progress in relation to recommendations from incident reviews.
National Risk and Incident Manager	Has responsibility for the monitoring of the implementation and evaluation of the policy and procedure.
Director for Quality Assurance	Has responsibility for the development and general oversight of the policy and procedure.

2.0 Key Principles

Documentation

The recording and maintaining of documentation relating to incidents is an important component of incident management. Information recorded should be factual and objective. It is essential that all areas maintain records in keeping with the Agency's current Records Management Policy and in compliance with legislation in relation to the Data Protection Act and Freedom of Information Act.

Incident Disclosure

Disclosure of an incident is an important component of the incident management process. At all stages in the incident management process there is a need to consider disclosure and communication with those affected.

Communication with persons impacted by an incident should be no different when an adverse event occurs. Openness about what happened and discussing incidents promptly, fully and compassionately can help the affected person cope better with the consequences.

All incidents should be disclosed to the person(s) affected, where applicable and appropriate. The line manager, in consultation with their own line manager, will decide who should manage the disclosure discussion with the person affected. The line manager should identify a person to take responsibility for disclosing the adverse event.

Where it is the case that an incident needs to be disclosed to a young person in Children's Residential Services, his/her allocated Social Worker will be consulted by the Centre / Unit Manager before the disclosure takes place.

In the event a decision is made not to disclose an incident due to the personal circumstances and consideration of the impact on the person affected, the reasons for this must be clearly recorded with evidence that this decision is supported and has taken place in consultation with other professionals involved with the family (e.g. Mental Health). This decision must also bediscussed with the QRSI manager and/or QA Directorate Incident and Risk Manager.

Employees are expected to report incidents in accordance with this policy. Where an incident is reported promptly, honestly and in full, employees would not be disciplined. However disciplinary action will be taken against an employee if they fail to report an incident in the following circumstances: -

- Where the employee has acted criminally, or in a deliberately malicious manner or are aware of another employee who has acted criminally or in a deliberately malicious manner
- Where the employee has deliberately concealed an incident or are aware of another employee deliberately concealing an incident
- Where the employee has failed to report incidents relating to abuse/neglect of children and/or their families or are aware of another employee who has failed to report incidents relating to abuse/neglect of children and/or their families
- Where the employee has failed to report an incident relating to alcohol or substance misuse or are aware another employee has failed to report an incident relating to alcohol or substance misuse
- Where an employee fails to report an incident whereby another employee may be guilty of gross negligence or professional misconduct **or** is aware of another employee's failure to report incidents of possible gross negligence or professional misconduct with potential for serious consequences, they may be subject to sanction in

line with the relevant disciplinary procedure.

Support for Persons Affected

Support requirements should be considered and planned for at the time of disclosure. The affected person and/or their support person should, through the assignment of a senior contact person, be apprised of the review planned, invited to contribute, liaised with throughout the process and informed of the conclusions and recommendations of the review. Their support requirements should be considered throughout the review phase.

Support for Staff

Staff whether directly or indirectly, affected by an incident may require access to support services. The line manager has a responsibility to ensure that staff are advised of supports available from the Occupational Health Department and the Employee Assistance Programme. A formal record must be kept of this. The line manager should maintain regular contact with the staff member to ensure that line management support is available to the employee. Tusla provide Critical Incident Stress Management (CISM) for staff for incidents that warrant a particular level of support. CISM is a comprehensive integrated multi-component crisis intervention system, designed to prevent and/or monitor the impact of (or mitigate) the adverse psychological reactions which may result from exposure to critical incidents/traumatic events.

Access to this service can be sourced through Human Resources, Health Wellbeing and EAP in Tusla. Please refer to the Hub for information.

Incident reviews can be a stressful time for employees both in terms of the continued emotional impact of the incident itself and in terms of the process of the review. They should be provided with access to assistance, support and the information they need to fulfil their role.

Feedback to Staff

The reporting of incidents by staff should be positively acknowledged in terms of contributing to service improvement and employees should be reassured of the fact that the incident will be analysed as part of a process that is outlined in this document and as part of the relevant Quality and Risk Group or Forum in order to identify possible learning service improvements that may be achieved.

Risk Management

Risks identified by staff members during the course of the management of an incident or in any aspect of their work should be managed in line with the Agency's Organisational Risk Management Policy (Tusla, 2016).

Learning from Incidents

The Agency is a learning organisation which obliges all staff to report incidents promptly and to facilitate any subsequent review or investigation. This will allow the Agency to identify and analyse developing trends and patterns and to work with the services concerned to develop and implement risk mitigation strategies.

Sharing of Learning between Areas and Services

A key component of quality improvement is having effective processes in place to share learning, both within services and between services and areas. This should be facilitated by the establishment of area and regional forums which support reflective practice.

Confidentiality

Legislation regarding data protection and service user record confidentiality must be complied with when managing incidents.

3.0 The Incident Management Process

Overview of Incident Management Process

The incident management process outlined in figure 1 below is a systematic approach to managing incidents and improving quality at all levels within the Agency. The incident management process is a four stage process as outlined in figure 1.

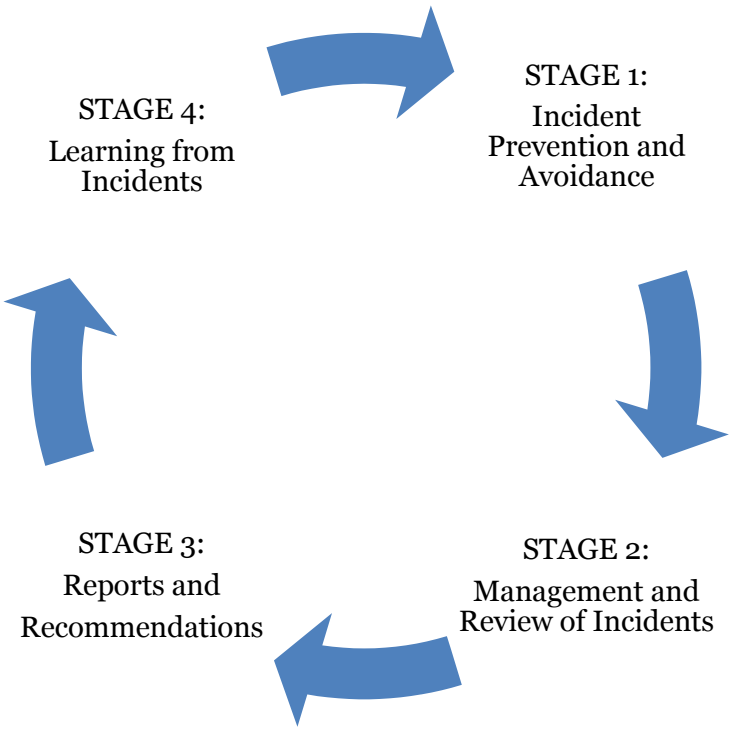

Figure 1 –Incident Management Process

The four stages of the incident management process are outlined in section 3.2 to section 3.5.

3.2 STAGE 1: Incident Prevention and Avoidance

It is critical to ensure that all necessary measures for the avoidance of incidents are in place in an attempt to minimise, in so far as is practicable, both the likelihood and the impact of incidents occurring. Line Managers have a responsibility to proactively identify potential risks or incidents within their area of responsibility. This enables the service to develop a clear profile of risks and potential incidents and through action planning, address areas of weakness.

3.3 STAGE 2: Management and Review of Incidents

The following are the five steps in managing and reviewing incidents:

Step 1: Incident identification and immediate management
Step 2: Reporting of an incident
Step 3: Assessment of an incident
Step 4: Incident review
Step 5: Monitoring and implementation of recommendations

❖ STEP 1 of 5: Incident Identification and Immediate Management

Incident Identification

All staff employed directly or indirectly by the Agency should be aware of what constitutes an incident in order to detect, disclose and report such incidents when they occur. Table 2 provides examples of incidents that are required to be reported and managed in line with this policy and procedure. This is not an exhaustive list, the National Incident Report Form (NIRF) and NIMS provide more information.

Table 2 –Examples of incidents that are required to be reported and managed

Service User Related
Death of child or young person, known to the Agency under the following categories: • Children in Care • Open cases of children known to the Agency's social work department or the Agency funded services within the previous two years, including young adults (up to the age of 20), where their case was open when they reached the age of 18 • Young people (up to 21 years of age) who were in care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991
Medication error
Nutrition 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 diseases required by legislation (See Appendix IV)
Allegations of abuse against carers and/or staff
Injury to service user requiring medical treatment
Arrests, convictions 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) inspection e.g. several significant risks identified
A poor outcome following an internal quality review or audit e.g. a number of escalations
Serious data breach e.g. laptop/mobile device lost or stolen, information disclosed, discovered or obtained by unauthorised persons[1]

Immediate Management by staff and Line Managers

When an incident occurs, the first responsibility of the **staff member** who identified and/or observed the incident is to:

- Ensure that the safety, health and welfare needs of the person affected are attended to as

[1] Data breach procedures must also be followed including report to Data Protection Commissioner where the threshold for reporting is met.

a priority

- Ensure the safety of the scene and preservation of evidence (NB: where the incident has resulted in a major injury or a fatality, the scene should be left undisturbed and secured for the purpose of examination)
- It is essential to ensure that appropriate care is provided to prevent further harm and to address any effects of the incident
- Ensure emergency procedures are adhered to
- Notify line manager/supervisor of incident where this is in keeping with agreed local/service processes
- Complete the National Incident Report Form (NIRF) and other professional forms as required
- Ensure that any threat to the future safety, health and welfare of service users and/or staff is removed or minimised

It is the responsibility of the **line manager** to ensure that:

- All necessary actions have been put in place to safeguard the health and wellbeing of the person affected and that relevant care support is given, as appropriate
- If equipment or supplies have been suspected as contributing to the incident these should be documented, removed, labelled and securely retained for examination
- Ensure the NIRF has been completed and logged onto NIMS. Where an incident has been designated as Major/Extreme (see table 6) on the NIMS system, this should be escalated to the senior management immediately via the "Need to Know" procedure
- Where appropriate, photographic evidence should be considered to inform any subsequent analysis. Case notes and relevant notes should be preserved and secured (manual and electronic)
- If the action(s) of any individual presents an immediate safety concern, immediate precautionary measures should be taken e.g. administrative leave
- Young people affected and their families have the support that they need
- Staff affected by the incident should receive the appropriate supports
- Check if the incident meets the established criteria for escalation as a " Need to Know" (see Section 4) and escalate as appropriate
- The incident is screened against other relevant policies to ensure appropriate initial response[2]
- Where an incident has been deemed as a major/extreme incident, an incident management team is convened, chaired by the senior manager responsible for the service (see systems analysis review guidance). A system analysis review needs to be considered where there is a need to identify causal factors to inform learning and to improve the safe operation of the service. The incident management team will agree the terms of reference and identify the personnel to conduct the review with clear timescales for the report to be completed

[2] Safety, Health and Welfare at Work Act 2005
Guidance for the Child and Family Agency on the Operation of the National Review Panel (November 2014)
Trust in Care (HSE, 2005)
Disciplinary Procedure (HSE, 2007)
Tusla Complaints Policy (Tusla, 2016)
National Treasury Management Agency (Amendment) Act 2000

❖ STEP 2 of 5: Reporting of Incidents

Internal Reporting Requirements

All incidents must be formally reported to Line Management on the NIRF – National Incident Report Form (see Appendix II for illustration) by the end of the next working weekday of the incident occurring or staff member being made aware of the incident. The NIRF form is available as a separate form on the Tusla Hub.

Tips for Completing the NIRF

- When completing the NIRF, use black ink and ensure your writing is legible
- When recording times it is recommended that the 24 hour clock is used
- If the incident involved more than one person, a separate form should be completed for each person involved
- The incident report should include a factual description of what you know at the time of the incident; details of any equipment involved etc.; the initial assessment of the impact and outcome on the individual, the affected part of the body and any preventative action taken. Do not include any personal opinions
- To protect the anonymity of the persons involved, ensure that names are not inadvertently used except where a name is specifically requested. Do not use abbreviations unless they are specific abbreviations that have been approved by Tusla or have been explained on first use in the main text e.g. Significant Event Notification (SEN)
- Any subsequent additional information relating to the incident e.g. witness statement, medical note is provided to the designated NIMS inputter for your service for entry onto NIMS.

For non-NRP related incidents the NIRF is then submitted to the designated NIMS inputter in their area/service for entry on the National Incident Management System (NIMS) within 48 hours of completion of the NIRF. The process for submitting the NIRF regarding NRP related incidents is outlined on page 16.

"Need to Know" Reporting Requirements

Incidents meeting the criteria as a "Need to Know" (NTK) should be escalated in line with the reporting requirements set out in Section 4.0 of this document.

External Reporting Requirements

Some incidents require reporting to external bodies if specific thresholds or criteria are met. Further information in respect of the reporting requirements and responsibilities are set out at table 3. All internal reporting processes must be followed if these thresholds are met.

Table 3 – Reporting requirements to External Agencies

External agency	What needs to be reported	Responsible person
Health Information and Quality Authority (HIQA)	• Child Death Notifications and Serious Incidents as per Table 4. The Tusla NIRF is used for reporting. • Notification of incidents, Part 9, section 23 of the Special Care Regulations	Authorised person – QA Directorate Person in Charge (PIC) of Unit
National Review Panel	• Child death notifications and serious incidents as per table 4.	Authorised person – QA Directorate
An Garda Síochána	• Potential criminal offences	Responsible Line Manager
Data Protection Commissioner	• Data protection breaches e.g. laptop/mobile device lost or stolen, information disclosed, discovered or obtained by unauthorised person	Data Protection Officer(s)
Health and Safety Authority	• Accidents, where a staff member is injured at a place of work and cannot perform their normal work for more than 3 consecutive days, not including the day of the accident • Road traffic / vehicle accident involving staff where the person was injured while driving or riding in the vehicle in the course of work, and cannot perform their normal work for more than 3 consecutive days, not including the day of the accident • General injuries involving members of the public related to a Tusla place of work or a work activity where a person requires treatment from a medical practitioner are reportable. Accidents related to medical treatment or a pre-existing medical condition are not reportable • A work accident resulting in the death of an employee • Certain dangerous occurrences, which have the potential to cause serious injury, whether or not they did cause serious injury	Responsible Line Manager
Insurers	• All incidents reported on NIMS on a monthly basis via a monthly report	Authorised person – QA Directorate
Department of Children and Youth Affairs (DCYA)	• In relation to NTKs (or other serious incidents) the Chief Executive will make a determination on whether a NTK is required to be escalated to DCYA under the 'Early Warning Notification' system.	Authorised person – Office of the CEO

Reporting of child deaths and serious incidents to the National Review Panel (NRP)

In relation to child deaths and serious incidents table 4 outlines the criteria for reporting such incidents to the NRP. These criteria are in line with the *Guidance for the Child and Family Agency on the Operation of the National Review Panel* (DCYA, 2014).

Table 4 – Criteria for reporting of cases involving children and young people to the NRP

Where a serious incident or death occurs of children or young people under the age of 18 years (other than in the case of a young person eligible for aftercare support) known to the Agency, a report must be made to the NRP and HIQA within 48 hours of the Agency becoming aware of the incident/death. The following categories of children apply:

- Children who have been in care during the previous two years
- Open cases of children (prior to their 18th birthday) known to the Agency's social work department or a Tusla funded service
- Young adults (up to 21 years of age) who were in the care of the Agency in the period immediately prior to their 18th birthday or were in receipt of or entitled to aftercare services under section 45 of the Child Care Act 1991

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, the Agency may 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
- The frequency of a particular type of case exceeds normal levels of occurrence

Under the NRP guidance the following definitions apply:

A **serious incident** is defined as a potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development.

A child known to the Agency is defined as a child who has had episodic and regular contact with Agency services over a period of years but, does not include instances where cases have been closed for a period in excess of two years. This includes young adults up to the age of 20, whose case was open to services when they reached the age of 18.

When a child death or serious incident meets the criteria outlined in table 4 the following steps in relation to reporting and reviewing the case must be followed:

- The NIRF must be fully completed and signed off by the Area Manager and Regional Service Director (The NIRF is available on the Tusla Hub)
- The Service Director must submit the NIRF by email to the Quality Assurance Directorate to qa@tusla.ie. The form must be returned in WORD, not as a PDF
- The authorised person in the Quality Assurance Directorate must review the NIRF to ensure all relevant information is present and make the final decision regarding whether a notification is provided to the NRP and HIQA
- The authorised person in the Quality Assurance Directorate shall ensure the incident is entered onto NIMS (this will be accessible to the relevant staff at a service level)
- The authorised person in the Quality Assurance Directorate shall notify the NRP and HIQA if the notification meets the required thresholds outlined in table 4 by submitting the NIRF. The Chief Executive, the Chief Operations Officer, the relevant Service Director and the Director of Quality Assurance shall be copied in this notification to the NRP and HIQA. The form will be submitted to HIQA using a unique identifier to ensure confidentiality. The unique identifier list including the name of the child/young person and area will be submitted to HIQA separately
- The local area must conduct a ***Local Review*** in line with the procedure outlined in appendix III. No other review should be undertaken without the formal approval of the Director of Quality Assurance. This is to ensure that there is no undue impact on the NRP review process

- If the local review establishes that there may be one or a number of other children that may have been exposed to a specific hazard a "look back review" should be conducted in order to identify if any of those exposed have been harmed and what needs to be done to take care of them. This needs to be determined by the Area Manager and approved by the Service Director (see the Tusla 'Look Back Review' Guidance).

❖ STEP 3 of 5: Assessment of Incident

Once reported on NIMS, incidents are given a severity rating which will determine how they are reviewed and managed. NIMS automatically calculates the severity of the incident based upon the injury sustained, to maintain and ensure objectivity. NIMS map the following injury outcomes to the following severity ratings:

Table 5: Incident Severity Rating Table

Outcome at time of incident reporting	Severity Rating
1 No adverse outcome	Negligible
2 Injury or illness **not requiring** First Aid	Negligible
3 Injury or illness, **requiring** First Aid	Minor
4 Injury requiring medical treatment	Moderate
5 Long-term disability/Incapacity (incl. psychosocial)	Major
6 Permanent/Incapacity (incl. psychosocial)	Extreme
7 Death	Extreme

The severity rating determines the incident management response as outlined below.

STEP 4 of 5: Incident Review and Investigation

Table 6 outlines the review/investigation requirement in response to an incident. This is based on the severity rating determined from table 5. The person who can commission a review or investigation is also provided in table 6.

Table 6 – Responses to incidents based on the incident severity rating

Severity Rating	Incident Review/Investigation Requirement	Responsible/Review Commissioner
Negligible or Minor	• The line manager should ensure that immediate actions have been implemented. • It should be confirmed that the incident has been reported on NIMS. • Review incident at local team level as part of staff meetings and agree any remedial actions required. If during the review of the incident it is identified that the incident requires further review, it must be managed as a high level incident thereafter. • Close off incident on NIMS – when the review process is completed and the relevant senior manager is satisfied that the necessary corrective and preventative measures are in place. • It is important that aggregated trends regarding negligible or minor rated incidents are reviewed on a quarterly basis as they may collectively point to an emerging risk.	Area/Service Manager/Head of national service
Moderate	• Conduct desktop review (for non-NRP related incidents). A desktop review is conducted where no staff or service users or other involved in the incident are interviewed. • The desktop review may trigger a Look-Back Review or Serious Incident Review Group if the desktop review identifies that a number of people may have been exposed to a specific hazard to identify if any of those exposed have been harmed and what needs to be done to take care of them (separate guidance document available on the Tusla Hub).	Service Director or National Director over service
Major or Extreme	• NRP reported child death and serious incidents: A Local Review should be conducted (see guidance in Appendix III). A systems analysis review may be conducted if deemed necessary by the relevant Service Director and/or the Chief Operations Officer or the Director of Quality Assurance. The decision to proceed with a systems analysis review must be approved by the Director of Quality Assurance. • System analysis review for non-NRP related incidents – this process is initiated to identify the casual factors and address the contributory factors from an incident to prevent future harm arising as far as is reasonably practicable (separate guidance document available on the Tusla Hub). • Look-Back Review - this process is initiated where a number of people have been exposed to a specific hazard in order to identify if any of those exposed have been harmed and what needs to be done to take care of them (separate guidance document available on the Tusla Hub). The requirement to conduct a Look-Back Review may be identified in the course of conducting a systems analysis. • The terms of reference for all reviews and investigations in the major and extreme category require approval by the Director of Quality Assurance.	Service Director or National Director over service The Chief Executive or the Chief Operations Officer or the Director of Quality Assurance may take responsibility if there is a perceived conflict of interest or for public interest reasons

The following should also be considered when reviewing or investigating incidents:

- The Chief Executive, the Chief Operations Officer or the Director of Quality Assurance may initiate a review of any incident of any severity rating. This will supersede any other review being undertaken.
- All independent/external reviewers must be approved by the Agency's Senior Management Team and must be in line with procurement policies and procedures. Members of the NRP must not be involved in any internal incident reviews or investigations.
- Reviews should only be undertaken by suitably qualified and trained staff.

Case Reviews are different from Systems analysis reviews. Case review is the review of a service users care history to ensure that the service provided meets the necessary requirements of the Agency. A systems analysis review on the other hand, reviews an adverse event/incident in a systematic and systemic manner to identify contributory factors that may have impacted on the eventual outcome of the adverse event.

❖ STEP 5 of 5: Monitoring and Implementation of Recommendations

All actions arising from incidents that were reviewed should be monitored by the service manager or designate to ensure actions identified have been implemented or if not to identify barriers to implementation that may need to be addressed. Actions should be monitored and tracked using the Agency's tracking system (Procedure for Tracking, Measuring and Verification of the Implementation of Recommendations of Internal and External Reports, 2016).

3.4 STAGE 3: Reports and Recommendations

All incidents must be properly recorded, reported on, managed, severity-rated and reviewed, where appropriate, to determine contributory factors, root causes and any actions required.

3.5 STAGE 4: Learning from Incidents

All incidents provide an opportunity for learning and quality improvement agency-wide. The NIMS system can support the development of aggregate reports to identify trends and further opportunities for learning, risk reduction and quality improvement. Aggregate reports should be produced on a quarterly basis at a Service/Area, Regional and National level for discussion and analysis at the relevant meetings/forums.

4.0 "Need to Know" (NTK) Procedures

A "Need to Know" (NTK) is process by which an incident or event that is likely to attract immediate public, political or media attention is escalated to senior management to ensure they are informed in a timely manner. For an incident or event to be categorised as NTK at least one of the following criteria must have been met:

- Has a probable Agency-wide impact
- Has immediate national media interest
- Has potential to expose the Agency to significant corporate risk or litigation
- Involves a number of other governmental or state Agencies

The NIRF should be used to report NTKs (available on the Tusla Hub).

The process for the notification and escalation of NTKs is outlined below:

Notification Requirements for Local/Area Office/Service/Children's Residential Centre

All NTK notifications should be escalated to the relevant Service Director or National Service Manager and Regional Quality, Risk and Service Improvement Manager or equivalent.

Need to Know notifications relating to young people placed in Children's Residential Services are the responsibility of Social Work Services to address while notification relating to the Centre / Unit or Residential Service in a broader sense is the Responsibility of the relevant Regional Manager CRS / National Manager Special Care and / or Director Children's Residential Services to address.

Notification Requirements for Regional Office or National Service Office

Where the event in question is deemed or assessed to meet the criteria set out above it should be escalated by the Service Director/National Service Manager to the Chief Operations Officer or relevant National Director, by email and copied to the Quality Assurance Directorate at qa@tusla.ie.

The Chief Operations Officer or National Director will make a determination on whether to escalate the NTK notification to the Chief Executive.

Notification Requirements for the Chief Executive

The Chief Executive will determine if escalation to the Chair of the Board and/or the Department of Children and Youth Affairs (Early Warning Notification) is required. The Chief Executive will notify the Chief Operations Officer, Communications Department and Quality Assurance Directorate of the decision.

In consultation with the Office of the Chief Executive the Tusla Communications Department will liaise with the Communications Department of the Department of Children and Youth Affairs to ensure consistency of media or other communications response to any reportable event, serious incident or child death which is the subject of an Early Warning Notification.

Logging NTKs

All NTK should be logged onto NIMS by Area/Service it originated from by the designated NIMS inputter.

Appendix I – Glossary of Terms

Term	Definition
Accident	An unplanned, unexpected, and undesired event, usually with an adverse consequence.
Adverse Event	An incident that resulted in harm.
Harm	1. Harm to a person: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury 2. Harm to a thing: Damage to a thing may include damage to facilities or systems; for example environmental, financial, data protection breach, etc. 3. Harm to a child as defined by Children First Act 2015: 'assault, ill treatment or neglect of the child in a manner that seriously affects or is likely to seriously affect the child's health, development or welfare or sexual abuse of the child'
Hazard	A circumstance, agent or action with the potential to cause harm.
Incident	An event or circumstance which could have, or did lead to unintended harm. Incidents include adverse events which result in harm; near-misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be practice related or non-practice related and includes incidents associated with harm to: • Service users, staff, contractors, volunteers, and visitors • The attainment of Tusla objectives • ICT systems • Data security e.g. data protection breaches • The environment • Financial
Look-back Review Process	A process consisting of three key stages: Preliminary Risk Assessment, Audit and Recall. This process is initiated where a number of people have been exposed to a specific hazard in order to identify if any of those exposed have been harmed and what needs to be done to take care of them.
Serious Incident Review Group (SIRG) (Childrens Residential Services)	SIRG are multidisciplinary fora concerned with serious incidents involving young people placed in Children's Residential Services. The aims of the Serious Incident Review Groups are: – To review a serious incident / a number of interrelated serious incidents – To identify opportunities for learning about the causes of that incident / those incidents and about care practice at Centre / Service level generally – To ensure that learning is operationalised in respect of that incident / those incidents i.e. that risk is managed, underlying issues are addressed and future occurrences of same are prevented wherever possible.
Near-miss	An incident which could have resulted in harm, but did not occur either by chance or timely intervention.
NIMS	The National Incident Management System (NIMS) is a confidential, highly secure, web based incident management system used to manage incidents throughout an incident lifecycle whilst also fulfilling legal requirements to report to the State Claims Agency (SCA). This includes: • Reporting of incidents (including Serious Reportable Events) • Management of investigations • Recording of investigation conclusions • Recording of recommendations • Tracking recommendations to closure • Analysis of incident, investigation and recommendations data and other functionality
NRP	The National Review Panel is an independent body, which reviews the death and serious incidents of children in care, aftercare or known to child protection services.

Term	Definition
NTMA	Under the National Treasury Management Agency (Amendment) Act, 2000 the management of personal injury and third party property damage claims against the State and of the underlying risks was delegated to the National Treasury Management Agency (NTMA). When performing these functions the NTMA is known as the State Claims Agency (SCA).
Risk	The chance of something happening that will have an impact on objectives.
Serious Incident	A serious incident is defined as a potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development.
Systems analysis investigation of an incident	A methodical investigation of an incident, which involves collection of data from the literature, records (general records in the case of non-practice related incidents and records in the case of service user incidents), interviews with those involved where the incident occurred and analysis of this data to establish the chronology of events that led up to the incident, identifying the key causal factors that had an effect on the eventual adverse outcome, the contributory factors, and recommended control actions to address the contributory factors to prevent future harm arising as far as is reasonably practicable.

Appendix II – Illustration of National Incident Report Form (NIRF)

NIRF available on the Hub

NIMS
National Incident Management System

TUSLA NIRF 01 – V01
Date issued: N / A 2016

NATIONAL INCIDENT REPORT FORM (NIRF)

NIRF – 01/02 PERSON , DANGEROUS OCCURANCE AND CRASH/COLLISION

NIMS record Number:

Incident: An event or circumstance which could have, or did lead to unintended and / or unnecessary harm. Please complete this form to the best of your knowledge at the time of reporting the incident.

SECTION A: GENERAL INCIDENT DETAILS

Date of incident D D M M Y Y Y Y

Time of incident H H : M M *Use 24 hour clock*

Location *E.g. Room in residential facility*

Offsite? ☐

SECTION B DID THIS RELATE TO...? (tick one only ✓)

☐ **Person** *(Go to Section C)*

☐ **Crash/Collision** *(Go to page 4)*

☐ **Dangerous occurrence** *(Go to page 3 Section K)*

Description of incident

SECTION C: PERSON AFFECTED DETAILS

First Name

Surname

Date of Birth D D M M Y Y Y Y

☐ **Female** ☐ **Male**

SECTION D: WHO WAS INVOLVED...? (tick one only ✓)

☐ **Service user – Go to section E**

☐ **Staff member/agency /panel staff – Go to section G**

☐ **Volunteer/ Student – Go to section G**

☐ **External Contractor – Go to section H**

SECTION E: SERVICE USER DETAILS ONLY

How is the person known to TUSLA? (Tick one only ✓)

☐ **Incident relates to a child or young person in care please specify below:**
(A) Residential Service
(B) Foster Care

☐ **Incident relates to a child or young person known to a service funded or procured by the Child & Family Agency.**

☐ **Child Protection and Welfare Service.**

☐ **Incident relates to a child or young person known to the Child & Family Agency Child Protection Services.**

☐ **DSGVB (Domestic Sexual and Gender Based violence).**

☐ **Incident relates to child or young person in receipt of aftercare services under Section 45 of the 1991.**

Other: (please specify)

Please give a brief history of involvement with Child & Family Agency:

Please go to Section F...

SECTION F:THIS INCIDENT INVOLVED... (tick one only ✓)

☐ **ACTS**
☐ **Adoption**
☐ **Aftercare**
☐ **Child Protection**
☐ **Domestic Violence**
☐ **Children Seeking Asylum**
☐ **Education Welfare Service**
☐ **Other please specify below:**

☐ **Family Support**
☐ **Fostering**
☐ **Inspectorates**
☐ **Residential** (tick one only ✓)
- ☐ High Support
- ☐ Out of State
- ☐ Private
- ☐ TUSLA Provided
- ☐ Special Care

SECTION G: STAFF MEMBER / AGENCY / PANEL STAFF / STUDENT / VOLUNTEER DETAILS ONLY

Category of person *E.g. Social Worker*

Employee no.

Date absence commenced (if known) D D M M Y Y Y Y

Date returned to work (if known) D D M M Y Y Y Y

Work days lost ☐

SECTION H: EXTERNAL CONTRACTOR DETAILS ONLY

Company name

Company no.

Appendix III - National Review Panel Process for Local Reviews

Local reviews should be conducted by a senior manager who did not carry supervisory responsibility for the case. They 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's situation, why he or she was in contact with the services, how long, 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 long, 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 and his or her family including the relationship that developed, frequency of contact, observation of progress, response to child and family's requests or 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 recommendation actions were taken
    - 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 six weeks of the date on which the serious incident occurred. No other form of review should be undertaken in relation to these cases without approval from the Director of Quality Assurance.

Appendix IV

Notifiable Diseases to Health Protection Surveillance Centre

- Bacterial Meningitis
- Chickenpox (hospitalised cases)
- Gonorrhoea
- Hepatitis A (acute) infection
- Hepatitis B (acute and chronic) infection
- Hepatitis C infection
- Hepatitis E infection
- Herpes simplex (genital)
- Human Immunodeficiency Virus Infection (HIV)
- Influenza
- Legionellosis
- Measles
- Meningococcal Disease
- Mumps
- Salmonellosis
- Staphylooccal food poisoning
- Viral meningitis

Please see www.hpsc.ie for a full listing of all notifiable diseases

Appendix V

Guidance for Incident Reviewing of Minor and Negligible incidents

Incident Review Format for Minor and Negligible Incidents

Incident No:_____ Date Of Review:_____

Reviewed By:_____

Note:

Discussion regarding incident should be focused on educational rather than fault finding. The following questions may be useful to answer

Discuss what happened – stick to the facts only

Next analyse Contributory Factors that may have contributed to the outcome of the event -

1. Issues around the task/procedure
2. Issues about how the team worked together
3. Equipment issues
4. Issues around work environment/conditions
5. Issues around training/education
6. Issues around communication systems
7. Issues around guidance notes, policies, procedures, protocols
8. Issues around the organisation's strategic objectives
9. Issues around errors of omission or commission
10. Had the hazard/potential risk been identified during risk management process? Were controls in place? Were they adequate or inadequate?
11. Who else needs to know about this incident?

Possible Outcomes

1. If insufficient information is available regarding an incident, further information should be sought for following incident review meeting

2. If a deficiency in the system is identified consideration needs to be given to identifying actions to improve the system and where available based on best practice, such as: -

    i. A new or revised practice
    ii. A new or revised protocol
    iii. Improved lines of communication
    iv. Staff Training – induction, specialised, refresher
    v. Equipment repair/maintenance/replacement
    vi. Other actions relevant to the incident.
3. If the incident is a cross service one, contact should be made with the relevant department to get an agreed resolution
4. If a broader system/organisational issue is identified it should be reported to line management.

Outcome

In accordance with the Incident Management Procedure, low level incidents are reviewed at local level. From review, there are two possible outcomes

1. A plan of action is agreed and reviewed at the following meeting or
2. A decision is made to escalate the incident to more senior management for further consideration.

Reasons for referring incidents to more senior management

1. A trend or pattern in incidence occurrence emerges
2. It may be necessary to document the trend/cluster and inform the line management.
3. Identify events in individual cases that have been critical (beneficial or detrimental to the outcome) and to improve the quality of care from the lessons learnt.
4. There are additional resources required to manage the situation that need to be sanctioned by more senior management.

Learning from the Incident Reviewed

1.
2.
3.
4.
5.
6.

Action Plan & Person Responsible

1.
2.
3.
4.
5.
6.

Signature: _____

Signature: _____