

WEST LIMERICK INDEPENDENT LIVING CLG

Incident Management & Reporting Policy

Policy Reference	WLILP30
Category	Operational Policies — Quality, Risk & Safety
Version	2.2 (records retention cross-referenced to WLILP7D)
Status	APPROVED — by the Board of Directors on 9 October 2026
Supersedes	WLILP30 - Incident Management Policy 2024; WLILP30 - Incident Management and Reporting Policy - DRAFT v2.1
Policy Owner	Board of Directors, West Limerick Independent Living CLG
Applies To	Staff, Service Users, independent contractors and the public
Related Policies	WLILP22 - Protected Disclosures and Good Faith Reporting Policy; Safeguarding Vulnerable Persons at Risk of Abuse Policy; Child Protection Policy; Client Falls Management Policy
Review Cycle	Annually, or sooner if HSE guidance or relevant legislation changes

1. Introduction

This Incident Management Policy sets out, for staff and Service Users of West Limerick Independent Living (WLIL):

- how we enable incidents to be reported
- how these will be investigated
- how we ensure learning is shared with staff and Service Users

2. What Our Commitment Means

We are committed to promoting a culture where all incidents and near misses are reported and appropriately investigated. This is achieved by operating an open and just culture which encourages and supports staff and Service Users in reporting incidents so that learning and improvement can take place. WLIL ensures that different needs in respect of ethnicity, faith, disability, gender, age, sexual orientation, and socio-economic group are taken into account in the reporting and investigation of incidents.

Learning from incidents enables changes to take place to:

- improve the safety of staff, Service Users and visitors
- improve the work environment
- improve Service Users' experience

Supporting the ability to report incidents ensures WLIL can use the information to take appropriate management decisions, identify trends in root causes, and share learning to improve practice.

3. Scope and Purpose

The purpose of this policy is to outline how incidents will be reported. It describes procedures which apply to staff, Service Users, independent contractors and the public.

4. What Is an Incident?

An incident is an event that leads to, or could have caused, loss or harm to an individual or property.

- An incident reported by an individual about their own practice is a reflective incident
- An incident reported by staff or a Service User about another individual's or organisation's practice is a notified incident

5. Who Can Report Incidents?

Incidents can be reported by WLIL staff, Service Users and the public, about their own practice or about incidents occurring within the organisation.

6. When to Report Incidents

- Incidents should be reported as soon as a concern becomes apparent
- Staff and Service Users are encouraged to report all incidents, to gain a true picture of any trends
- All incidents must be reported, including neglect, self-neglect, and any suspicions
- Incidents identifying concern, allegation, disclosure or suspicion of abuse must also be reported under WLIL's Safeguarding Vulnerable Persons at Risk of Abuse policy
- Incidents identifying concern, allegation, disclosure or suspicion of abuse involving children must also be reported under WLIL's Child Protection Policy
- Any accident, incident or "near miss," no matter how slight, should be reported to your Service Coordinator before the end of your shift
- Following a fall or suspected fall, also refer to the Client Falls Management Policy
- A pressure ulcer, or risk factors for one developing, should be reported to your Service Coordinator before the end of your shift

Staff are also required to report occurrences that may not have caused injury but could be dangerous if repeated, including but not limited to: slippery surfaces, equipment malfunction, water or gas leaks, inadequate insulation of circuits, trailing electrical leads, or breaking/collapse of windows, walls or ceilings.

If a report concerns suspected misconduct, fraud, or wrongdoing by a person, rather than a system, equipment or environmental issue, also consider whether WLILP22 - Protected Disclosures and Good Faith Reporting Policy applies — that policy provides additional statutory protection against retaliation for the person reporting. Staff should not worry about identifying the "correct" policy before reporting: the Service Coordinator will help direct a report appropriately, and no report is penalised for initially going through the wrong channel.

7. Management of Incidents

The Situation, Background, Assessment, and Recommendation (SBAR) tool is used to ensure incidents are managed consistently and that important information is shared clearly, effectively and efficiently.

- S = Situation: a concise statement of the problem or what happened

- B = Background: background information pertinent to the situation
- A = Assessment: what was found, analysis of options and risks, and factors that contributed
- R = Recommendation: what action is needed to correct the problem, by when, and any action already taken at the time of the incident

8. Review of Incidents

All incidents once logged will be reviewed by the Service Coordinator. Once an investigation is complete, responses are reviewed by the General Manager and the Quality and Safety Team, and an individual SBAR response is sent to the reporter as required.

Some no/low harm incidents may not always require an individual SBAR response, but all responses are reviewed, themed and shared appropriately with staff and management, using "You said, we did" to share wider learning.

9. Reporting of Incidents

Staff report incidents, including all relevant information, using the SBAR tool.

10. Serious Incidents and Reporting to the HSE

WLIL's Senior Accountable Officer is required to ensure that all incidents relating to Service User care and safety, staff safety, accidents, loss or damage to property, or incidents involving vehicles, are appropriately recorded on the State Claims Agency's National Incident Management System (NIMS), where WLIL has access, or reported to WLIL's designated HSE contact person named in its Service Arrangement.

The Senior Accountable Officer should notify WLIL's HSE Disability Services contact, who will communicate the information to the relevant personnel within HSE Mid West Community Healthcare, including the Quality, Risk and Patient Safety Business Manager. As confirmed in WLIL's current HSE Section 39 Service Arrangement (Part II — Healthcare Provider Specific Requirements 2026), this contact is currently:

Fearghal Gray, Service Lead — Head of Service Office, HSE Mid West, Pearse House, Pearse Road, Raheen Business Park, Limerick, V94 1R71. Tel: 087 8319324 / 061 464061. Email: fearghal.gray@hse.ie.

This is a named external contact, not a WLIL role, so it falls outside the general "roles, not people" rule in WLILP1 — WLIL does not control who the HSE appoints. It should nonetheless be re-verified against WLIL's current Service Arrangement at each annual review, since the HSE's own nominated contact can change independently of anything WLIL does.

A Serious Incident is an incident rated major or extreme on the HSE's Risk Impact Table. Serious Reportable Events (SREs) are a defined subset of incidents which are either serious, or which should not occur if available preventive measures have been effectively implemented (see Appendix 2).

11. Mandatory Open Disclosure

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, commenced 26 September 2024, made open disclosure mandatory — not voluntary — for a specified list of serious patient safety incidents ("notifiable incidents"). Before this Act, open disclosure operated on a voluntary basis under Part 4 of the Civil Liability (Amendment) Act 2017.

- Where an incident falls within the Act's list of notifiable incidents, WLIL is legally required to make open disclosure to the Service User and/or their family — this includes an apology where appropriate, and comprehensive, timely information about what happened

- WLIL is also legally required to notify a notifiable incident to the appropriate regulatory body (such as HIQA or the Chief Inspector of Social Services) within 7 days
- The Minister for Health may add to the list of notifiable incidents by regulation, so this list should be checked for updates as part of this policy's annual review

Many of the notifiable incidents specified under the Act, and the Serious Reportable Events in Appendix 2, were originally drafted with acute hospital settings in mind. WLIL's Quality and Safety Team should review both lists against WLIL's actual home support service to identify which specific categories could realistically arise in practice, and reflect that in staff guidance and the incident reporting form (Appendix 3), rather than this policy assuming every category applies equally to a home support context.

Once the Health (Amendment) (Home Support Providers) Act 2026 is commenced, HIQA's Chief Inspector of Social Services will regulate home support providers directly, which is expected to make the open disclosure and notification requirements in this section even more directly relevant to WLIL. This section should be reviewed again at that point.

12. Records Retention

Incident reports, SBAR records, and related documentation generated under this policy are retained in accordance with WLILP7D - Data Retention, Rectification and Erasure Policy, which is the single authoritative source for WLIL's retention periods. This policy does not set its own retention period for incident records, to avoid the same drift between documents identified and corrected in WLILP46 - Records Management Policy.

13. Review

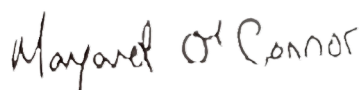
This policy will be reviewed by the Board annually, or sooner if HSE guidance, the list of notifiable incidents, or relevant legislation changes.

This policy reflects the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 and HSE incident management guidance, checked as accurate as of drafting. It is not a substitute for clinical governance or legal advice. The HSE contact details in Section 10 are current as verified against WLIL's 2026 Service Arrangement, but should be re-checked at each annual review, since they are set by the HSE, not WLIL.

Approval

Approved by the Board of West Limerick Independent Living CLG on 9 October 2026.

Signed on behalf of the Board, on its instruction, by the General Manager:



Margaret O'Brien O'Connor, General Manager

Date signed: 09-10-2026

Appendix 1 — Incident Management Relevant Policies, Procedures, Protocols and Guidelines (PPPGs)

Key PPPGs

- Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (commenced 26 September 2024)
- Incident Management Framework and Guidance (HSE, 2020)
- Service User Falls — A Practical Guide for Review (HSE, 2022)
- Pressure Ulcers — A Practical Guide for Review (HSE, 2018)
- Systems Analysis Guidance (HSE, August 2016)
- Integrated Risk Management Policy and Guidance (HSE, 2017), Parts 1–3
- Serious Reportable Events (SREs), HSE Implementation Guidance Document (HSE, 2015)
- Open Disclosure: National Guidelines (HSE, 2013) — largely superseded in effect by the mandatory regime under the 2023 Act for notifiable incidents, though it remains relevant for incidents outside that Act's scope

Related PPPGs

- A Board's Role in Improving Quality and Safety (HSE, 2017)
- Quality and Safety Committees Guidance and Sample Terms of Reference (HSE, 2016)
- Framework for Improving Quality in Our Health Services: Part 1 (HSE, 2016)
- Guideline on Conducting Look-Back Reviews (HSE, 2015)
- Policy for Preventing and Managing Critical Incident Stress (HSE, 2012)

Current versions of all HSE guidance documents above should be sourced from [hse.ie](https://www.hse.ie), as HSE guidance is periodically updated.

Appendix 2 — Summary List of Serious Reportable Events

Based on the HSE's Serious Reportable Events framework (2015). WLIL's Quality and Safety Team should confirm which categories are realistically applicable to a home support setting (see Section 11).

1. Surgical Events

- Surgery performed on the wrong body part, wrong patient, or the wrong procedure, by a healthcare service provider
- Unintended retention of a foreign object in a body cavity after surgery or another procedure
- Intra-operative or immediate postoperative death in a patient with no known medical problems

2. Product or Device Events

- Patient death or serious disability associated with contaminated medications, medical devices or biologics
- Patient death or serious disability associated with a medical device used or functioning other than as intended
- Patient death or serious disability associated with an intravascular air embolism

3. Patient Protection Events

- A child or other dependent person discharged to the wrong person
- Patient death or serious disability associated with a patient absconding from a healthcare facility
- Sudden unexplained death or serious-disability injury of an inpatient/resident in a mental healthcare facility

4. Care Management Events

- Patient death or serious disability associated with a medication error (excluding reasonable differences in clinical judgement)
- Wrong formulation or route of administration of chemotherapy
- Intravenous administration of mis-selected concentrated potassium chloride
- Patient death or serious disability due to administration of incompatible blood or blood products
- Maternal death, or perinatal death or encephalopathy of a normally formed term neonate
- Patient death or serious disability associated with severe hypoglycaemia (excluding neonates)
- Death or serious disability (kernicterus) from non-detection of hyperbilirubinemia in a neonate
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare/social care residential facility
- Patient death or serious disability due to spinal manipulative therapy
- Patient death or serious disability associated with a restrictive intervention (physical, mechanical, manual or environmental restraint, including seclusion)
- Diagnostic error causing death or serious disability, e.g. a mislabelled pathology specimen
- Non-utilisation of a donor organ deemed suitable for transplantation, or death of a living organ donor

5. Environmental Events

- Patient death or serious disability associated with an electric shock, a burn, or a fall while being cared for in a healthcare service facility or during a clinical intervention (including in the community, pre-hospital care, or the Ambulance Service)
- A gas line delivering the wrong gas, or contaminated by toxic substances, to a patient

6. Criminal Events

- Care ordered or provided by someone impersonating a healthcare professional
- Abduction of a patient of any age while being cared for in a healthcare facility
- Sexual assault on a patient or other person within or on the grounds of a healthcare facility
- Death or serious injury of a patient or other person from a physical assault within or on the grounds of a healthcare facility

Appendix 3 — Incident / Serious Reportable Event Report Form

Identify what section you are reporting from: Section 38 ☐ Section 39 ☐ Private Provider ☐

Name of organisation: _____

Name and address of the service relating to the incident: _____

Incident Management Reference Number: _____

Date the incident occurred: _____

Date the incident was notified to WLIL's Senior Accountable Officer (SAO): ____

Name and title of the SAO: _____

Contact details of the SAO: _____

Name of person completing this form and date of completion: _____

Division the incident is communicated to within the HSE (choose one): Disability Division ☐ Older Persons Division ☐ Mental Health Division ☐ Primary Care Division ☐

Name and title of key contact person: _____

Date reported to key contact person: _____

1. Impact assessment (HSE Risk Impact Table): Negligible ☐ Minor ☐ Moderate ☐ Major ☐ Extreme ☐

2. Is this incident a Serious Reportable Event (SRE)? No ☐ Yes ☐ — if yes, which SRE:

3. Is this incident a notifiable incident under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023? No ☐ Yes ☐ — if yes, mandatory open disclosure and notification to the relevant regulator within 7 days applies (see Section 11)

4. Briefly describe the safety incident (what harm occurred, numbers involved, date and location — do not include details that could identify a patient or person):

5. Has Open Disclosure occurred with the Service User and/or relevant person? No ☐ Yes ☐ Date: _____

6. Has a Designated Support Person been appointed to the Service User? No ☐ Yes ☐ Date: _____

7. Has a Staff Liaison Officer been appointed to the staff member? No ☐ Yes ☐ Date: _____

8. Describe arrangements/actions put in place to address immediate Service User/carer/public/staff needs:

9. Is there a requirement to report this incident to any external regulator, agency or insurer (e.g. HIQA, HSA, An Garda Síochána, Tusla, Safeguarding and Protection Team, Mental Health Commission)? No ☐ Yes ☐ — if yes, name regulator(s)/agency and date(s) of notification: _____

10. Does this report also raise a concern under WLILP22 - Protected Disclosures and Good Faith Reporting Policy (i.e. does it concern suspected misconduct or wrongdoing by a person, rather than a system or environmental issue)? No ☐ Yes ☐ — if yes, also notify the Complaints Officer under WLILP22