Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation and Monitoring of Social Care Services

Guidance on managing notifiable events in designated centres

Guidance for registered providers and persons in charge

Version 2 — March 2025

Safer Better Care

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About this document

This document is published by the Chief Inspector in the Health Information and Quality Authority (HIQA) to guide registered providers (hereafter referred to as 'provider') in managing notifiable events within their centres.

It was produced as part of the LENS Project (**LE**arning from statutory **N**otifications in **S**ocial care). The LENS Project is a research project funded by the Health Research Board [SDAP-2019-005] and hosted within HIQA. The aim of the LENS Project is to undertake research using the statutory notifications received by the Chief Inspector to inform regulatory practice and quality and safety improvements in designated centres in Ireland.

This guidance is intended primarily for registered providers of designated centres for older people (nursing homes), designated centres for adults and children with a disability and children's special care units.

This guidance should be used in conjunction with other reference materials issued by the Chief Inspector and available on the HIQA website: www.hiqa.ie. The most relevant documents are listed below. Click the link to access the documents (**Please note:** that web links can sometimes change and the documents are regularly updated. In the event that a link is broken you can simply enter the document title into a search engine or search for it on the HIQA website homepage www.hiqa.ie).

Useful additional documents for reference
Monitoring notifications handbook - Guidance for registered providers and persons in charge of designated centres for older people
Monitoring notifications handbook - Guidance for registered providers and persons in charge of designated centres for persons children and adults with disabilities
Monitoring notifications handbook - Guidance for persons in charge of children's special care designated centres
Regulation Handbook
National Standards for Residential Care Settings for Older People in Ireland
National Standards for Residential Services for Children and Adults with Disabilities
Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013
Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017

1. Introduction

Accidents and adverse events sometimes occur during the course of providing health and social care services. In Ireland, any service that is a 'designated centre' as defined in the Health Act (2007)[1] is required to notify the Chief Inspector, should certain events occur. These are known as statutory notifications.

There are two categories of statutory notification: those that are required within three/two days of occurrence and those that are required every three months (quarterly). Three/two-day notifications generally refer to higher-risk events such as serious injury or allegations of abuse. Quarterly notifications tend to be notifications about less-serious events.

For the most up-to-date information on which statutory notifications apply to your designated centre, how to determine if an event meets the criteria for notification and how to submit, please visit www.hiqa.ie.

[1] At the time of writing, designated centres include nursing homes, residential disability services and some services specifically for children.

Three/Two-day notifications	Quarterly notifications
▪ **NF01** Notification of the unexpected death of a resident ▪ **NF02** Notification of an outbreak of any notifiable disease ▪ **NF03** Notification of any serious injury to a resident ▪ **NF03** Notification of any serious injury/incident to a resident (Older persons only) ▪ **NF05** Notification of any unexplained absence of a resident ▪ **NF06** Notification of any allegation, suspected or confirmed, of abuse of any resident ▪ **NF06** Notification of alleged or confirmed abuse of any resident (Older persons only) ▪ **NF07** Notification of any allegation of misconduct ▪ **NF08** Notification of any occasion where the Registered Provider becomes aware that a member of staff is subject to review by a professional body ▪ **NF08** Notification of any occasion where the Registered Provider becomes aware that the Person in Charge is subject to review by a professional body (Older persons only)	▪ **NF39A** Any occasion of the use of restraint ▪ **NF39B** Any fire alarm activation ▪ **NF39C** Any recurring pattern of theft or burglary ▪ **NF39D** Any death other than reported on an NF01 (Older persons only) ▪ **NF39D** Any injury to a resident that did not require notification within 3 days (Disability only) ▪ **NF39E** Any pressure ulcer (category 2 or higher) sustained by a resident (Older persons only) ▪ **NF39E** Any death(s) other than those notified under NF01 (Disability only)

▪ **NF09** Notification of any fire, loss of power/heating/water, or unexplained evacuation ▪ **NF09** Notification of any fire, loss of power/heating/water, or unexplained evacuation where residents could not immediately return to the designated centre (Older persons only)	

This guidance is aimed at providers and persons in charge of designated centres. The focus is to support providers and persons in charge in dealing with a notifiable event in their settings.

The occurrence of an accident or adverse event in a service is not necessarily an indication of poor care. Accidents can happen anywhere and at any time and they are sometimes an unavoidable outcome as people go about their daily lives. What is important is how a provider and staff manage and learns from the event.

Statutory notifications are an indicator of quality and safety within a service. They are a source of information on the frequency and types of events that occur within a service, and they also offer an insight into how a service responds when something goes wrong. This information is used by inspectors to informing their monitoring approach. It can also be used by providers to reflect on what happened and to inform quality and safety improvements.

The evidence for this guidance is drawn from research using the Database of Statutory Notifications from Social Care in Ireland. This is an anonymised national database of all the statutory notifications received by the Chief Inspector from all designated centres in Ireland. It is objective, empirical evidence, based on current practice observed in designated centres in Ireland.

This research has shown that the vast majority of providers demonstrate excellent care in responding to the needs of residents who were involved in a notifiable event. There were many examples of good practice relating to providing person-centred care that can be shared and learned from in order to improve the quality and safety of services nationwide.

The research has also shown that there is room for improvement in reporting practices relating to statutory notifications. A lack of clarity on what occurred, poor descriptions of actions taken in response and little detail about measures that were put in place to prevent reoccurrence, were noted. If a notification contains poor reporting this often means that the inspector is required to seek further information, creating additional work for the provider or person in charge who must respond.

Factors that contribute to notifiable events were also identified in the research. Knowing the types of factors that often contribute and reviewing notifications to identify factors that contributed to an individual event, mean a provider can put measures in place to prevent a notifiable event from happening in the first place.

As such this guidance outlines good practice in

- providing person-centred care during a notifiable event
- reporting practices
- learning from and preventing future notifiable events.

2. Person-centred responses

The regulations and standards that govern social care services in Ireland emphasise the importance of a person-centred approach to care. Providing care in a personcentred manner is also central to HIQA and the Chief Inspector's commitment to a human rights-based approach to care.

> "Person-centred care and support places each resident at the centre of all that the service does. It provides the right support at the right time to enable residents to lead their lives in as fulfilling a way as possible. A key principle of these standards is that residents in receipt of services are central in all aspects of planning, delivery and review of their care".

National Standards for Residential Care Settings for Older People in Ireland, 2016

Given the potential for a resident to experience injury, trauma or distress arising out of a notifiable event, a person-centred response is particularly important. The impact of a serious injury on a resident may be clear and obvious. However, there are also more subtle ways in which residents can be affected by other notifiable events. For example, the outbreak of an infectious disease, particularly in the aftermath of a pandemic, may cause worry for some. Similarly, the activation of a fire alarm and the need for an evacuation has the potential to create anxiety for some. As such, it is important that providers are conscious of the effect of a notifiable event both on the individual involved and other residents who may be indirectly impacted. A person-centred response is key to ensuring all involved are made to feel safe and are reassured.

The following section outlines some of the key aspects of providing care in a personcentred manner in the immediate aftermath of a notifiable event as identified in our research. This is based on practice that is currently being employed in some services in Ireland. The points below apply across most types of notifiable event.

1. Ensure the immediate safety and wellbeing of the person and those around them

This may entail making the environment or surroundings safe or moving the person to a different location.

Ask them to communicate any particular needs to you and look to provide these where possible. Ensure that the person's privacy and dignity is protected by removing people from the immediate vicinity where they are not required to be there.

2. Assess whether the person requires medical attention

Any such assessment should ideally be done by someone who is suitably trained (for example, a nurse, doctor, first responder, person with first aid training). Where such qualified professionals are not available, take a cautious approach.

3. Continue to monitor and offer reassurance to the person

Monitor the person and the environment. Tell the person they are safe and you are in control of the situation.

Explain what is going to happen next and how this is going to address the issue identified. Where possible, try to ensure that the staff member offering reassurance is someone known to the resident(s) or with whom they are familiar.

4. Keep communicating

Provide updates to the people affected. This is important in the immediate aftermath of an event and on an ongoing basis

If the service's response to an event involves some form of investigation then the outcome of this should be shared with all involved. It may be appropriate to inform family or friends in line with the person's wishes of certain events, with due regard for privacy, data protection and any decision-making legislation.

There is a balance to be struck in terms of maintaining a person's privacy and being transparent and open with family and friends. Any decision to share information should be on a case-by-case basis and done in consultation with the resident.

5. Consultation

It may be necessary to change policy, practice or care plans in a service in response to a notifiable event. It is critical that any proposed changes are evidence-based and informed by relevant stakeholders. This should be done in consultation with the resident. If proposed changes involve more than one resident, those people should also be consulted.

Where a resident does not have the capacity to participate in such a consultation, it may also be appropriate to engage with the resident's representative, family, or an advocate who can represent their views.

A service provider should reflect on any proposed changes in a personcentred manner to ensure minimum disruption.

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3. Good reporting practices

It is a regulatory requirement that certain events are notified to the Chief Inspector. The preferred and most secure method to submit a notification to the Chief Inspector is electronically using HIQA's Provider Portal Website. In circumstances, where the portal is not available, email and paper forms can be used. Specific guidance on the technical completion of a statutory notification form has been issued by the Chief Inspector and published on the HIQA website. Please search www.hiqa.ie for the latest guidance.

Aside from the technical requirements, it is important that all providers adopt good reporting practices when submitting a notification. The following section offers guidance on how to provide information when submitting a statutory notification.

Necessary

Before submitting a notification it is important to consider whether the event that occurred is a notifiable event. A significant proportion of notifications received from designated centres do not meet the criteria for submission. This is known as overreporting and should be avoided. For example, an injury that was managed through first aid and did not require medical attention, does not constitute a serious injury or incident and should not be reported as one. In the context of disability services, it may be appropriate to notify it as a minor injury in a quarterly notification. Similarly, if reporting an unexpected death, ask whether it meets the criteria, for example, was it sudden? Did the person pass away in a hospice or palliative care setting?

Sometimes notifications are received that state that an event did not occur. For example, a quarterly notification received for a pressure sore that stated there were no pressure sores in the designated centre in the past three months. Submitting a notification that is not required – either because it does not meet the criteria or is a nil return – creates an unnecessary regulatory burden for both the provider and the inspector.

For further information on what events are notifiable and how to decide, please refer to the latest guidance by searching on www.hiqa.ie

Comprehensive and concise

Information provided in a notification must be comprehensive yet concise. Those responsible for submitting a notification should try to refer to notes taken at the time of the event, for example, nursing or daily notes.

Much of the notification form comprises of questions with pre-populated options to choose from. These should be used where possible and the "other" option only used when available options have been checked and found to not be appropriate.

There are also free-text boxes available to enter information such as when requested to enter 'additional details' or provide information on the 'current status' of the resident(s). When writing in free-text fields all relevant aspects of the notifiable event should be described in sufficient detail to allow the inspector understand what has happened and how it was managed. Notwithstanding this, there is no requirement to provide lengthy descriptions as these can be timeconsuming and not useful to the assessment of the information.

Specific

There are certain elements of a notification where it is important to be specific with the description or details provided. This helps the inspector to determine the best course of action. For example, where there is a report of the use of chemical restraint then the provider should clearly identify what drug was administered. The same is true in the case of the outbreak of an infectious disease; a service provider should clearly state what pathogen is suspected or confirmed to be causing the outbreak. Any element of a notification that is missing key details is likely to result in a request for further information from the inspector.

Standardised language

Use of standardised language facilitates common understanding and gives structure to records that facilitate the reuse of data and the comparison within and between care organisations. Currently, there is no standardised language, terminology or lexicon for use in social care. However, common interdisciplinary terminologies include the Systematic Nomenclature of Medicine-Clinical Terms (SNOMED-CT) and NANDA International nursing diagnosis definitions and classifications, are available. Accepted terms from these or other defined terminologies should be used where possible when completing notification forms.

Referral and engagement

The occurrence of a notifiable event may require that the provider engage or consult with other individuals, whether internal or external to the organisation. Any such engagement should be clearly stated in the notification as well as the rationale for doing so, while also not disclosing any personal identifiable information. For example, a notifiable event may require that a person be assessed by a specialist or referred to a specific service. It may also be the case that a service needs to consult with a resident's family or representatives to let them know what happened or to discuss next steps. Any such referrals or engagement are important information for the inspector and specific details should be included.

Outcome for resident(s)

Many notifications require that the provider outline the current status or outcome in respect of the resident(s). The details in the notification should demonstrate that the provider and staff, at all times, was aware of any impact on the resident(s) and responsive to their needs. It should provide enough information to ensure that the inspector is clear on the current status of the resident(s), from a health and wellbeing perspective.

Privacy

Statutory notifications are about an event rather than about a resident(s). Therefore, in accordance with General Data Protection Regulations (GDPR) and HIQA policy, there should be no personal identifiable data submitted with a notification. This is to ensure the privacy of the resident(s) and any other person connected with the event and to comply with the provisions of data protection legislation. Some notifications require that the resident has a unique identifier. This is a code unique to the service that should be traceable only by the service. Any other details that may identify a resident should not be included in the notification. This includes, but is not limited to, resident names, dates of birth, initials, room and ward names or numbers, names of family members, or phone numbers.

Changes that have been made

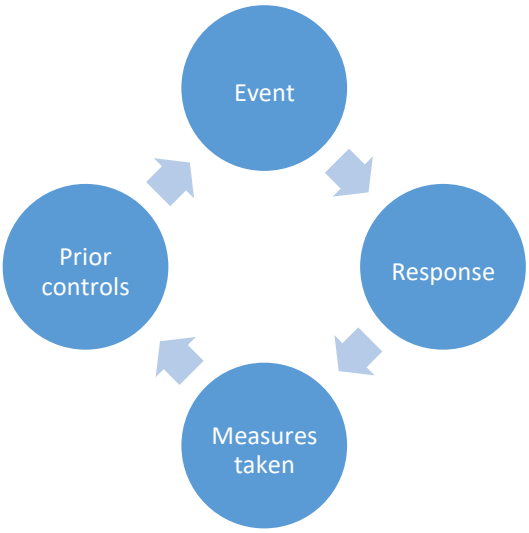
While accidents or adverse events are regrettable they also provide an opportunity for providers to learn and make improvements. It is also possible that a notifiable event captures a potential risk to residents and not actual harm on that occasion. Making changes after such an event can prevent harm in the future.

The circumstances of the event may help identify contributing factors or systemic issues which can be addressed through action by management and staff. An inspector will review a notification to see if the provider has outlined what it has changed or how it will do things differently in the future. Therefore, a provider should describe what has been learned and what, if anything, will change in the future to reduce or manage any risks, for example, when asked for 'additional or other details' in a notification form.

4. Learning and prevention

Recent research into management of notifiable events, carried out by HIQA, identified a cyclical pattern where services implement changes as a result of previous adverse events in their services (see figure 1).

Figure 1 – Response sequence upon occurrence of a notifiable event in designated centres



This naturally occurring pattern can be used to support quality improvement, risk reduction and prevention of future events. A key part to this is reviewing notifications, identifying factors that contributed to the event and learning from the findings.

There are many reasons why a notifiable event may occur. In some cases there may be multiple contributing factors that combine to cause the event. There are various tools or frameworks available to identify factors that contribute to adverse events with a view to preventing reoccurrence. For example, when looking back at events or reviewing notifications for trends, root cause analysis (RCA), human factors analysis (HFA) and "the five whys" are examples of tools that may be used.

Notifiable events present an opportunity to identify risks and minimise future potential harm or disruption for services. It should be noted that notifiable events in a social care context can be different from adverse events in a healthcare setting. An adverse event in a healthcare setting typically refers to something that is avoidable and should not happen. Sometimes a notifiable event can be something that is expected or likely to happen. For example, a death in a social care setting is a notifiable event, but may have occurred due to a terminal illness and therefore be unavoidable. Nevertheless, all of the above are opportunities to learn and implement quality improvement measures, as it is not just about the event but also how the event is dealt with.

Additional research carried out by HIQA assessed the extent to which human factors contributed to a notifiable event using an adapted version of the Human Factors Analysis and Classification System (HFACS). A leading contributing factor for such events was the behaviour and actions of individual residents themselves. This is by no means placing the blame for events on residents of services. Rather, it illustrates that social care services provide residential care to a diverse range of people, many of whom have complex needs. In the case of nursing homes, there may be a sizeable proportion of residents with behavioural and psychological symptoms of

dementia (BPSD). Some of these behaviours, for example, wandering or agitation, may lead directly to a notifiable event such as an unplanned absence or an abusive interaction with another resident. Seen in this light, the risk of a notifiable event occurring is higher in a context where some residents have dementia. A higher likelihood of a notifiable event is also present in disability services that provide care for people with intellectual disabilities and in special care units for children with complex needs. Therefore, such events are more likely to occur in these settings and it is essential that service providers anticipate them by having appropriate risk management procedures in place and by learning from events so they don't happen again or their impact is reduced.

Other contributing factors to notifiable events were also identified. These typically involved staff acting outside of accepted practices or procedures. This may have been due to a lack of training or supervision. In such instances, any remedies put in place to prevent reoccurrence should address these training or supervisory shortcomings for the staff member in question and for all staff. In situations where a notifiable event is found to be contributed to by a staff member who did not provide safe quality care and support or did not adhere to professional standards, the provider should act swiftly, in accordance with its disciplinary procedures, to protect residents. The table below describes some of the contributing factors identified in the research. These are provided as examples of events that have happened within Irish social services and as a prompt for service providers to use to guide thinking when evaluating notifiable events to inform quality improvement.

Contributing factor	Description	Examples
Organisational influences	How processes and culture within an organisation can impact on the quality and safety of care.	no risk assessments in place inappropriate placement of resident emergency plan not effective.
Unsafe supervision	Inadequate oversight and supervision, poor planning and failing to correct known problems.	unclear if staff aware of procedures inadequate staffing at night time.
Preconditions for unsafe acts	Limitations of staff or management, whether physical, mental or skillbased; as well as poor resource management.	staff member failed to report an allegation of abuse staff found sleeping while on duty front door left unlocked.
Unsafe acts	Errors on the part of staff or management which may be caused by inexperience, poor decision-making or violations of established practice or policy.	inappropriate physical contact between staff member and a resident nurse gave medical advice to a resident's family member inappropriately staff failing to evacuate residents on activation of a fire alarm.
Patient factors	Behaviours or choices of service users that are symptoms of their medical or care needs (for example, dementia or intellectual disability)	resident refused all assistance and refused to attend hospital self- injurious behaviour resident injured during an epileptic seizure.

Where a provider identifies a contributing factor to a notifiable event that was beyond their control, they should escalate this finding to the relevant person. For example, a provider might identify that a factor that contributed to ongoing abusive

peer-to-peer interactions between two residents is the inappropriate placement of one person. If such events continue, then a contributing factor is the inability, whether on behalf of the registered provider or the wider health service, to source a suitable alternative service for the person in question. In such instances, the service provider should ensure that the responsible person(s) within the health service are made aware of this.

It is a matter for individual providers to determine what method of review or analysis is appropriate to use to learn from notifiable events. The following points outline some of the common principles found in such methods and should be considered regardless of the method or tool chosen.

- **Define the scope of the review** – Define what exactly the review or analysis is trying to accomplish. Determine what you want to produce as an outcome (for example, recommendations for improvement or a new policy or procedure). Perhaps you only wish to review a single notifiable event, one type of notifiable event or review events that occurred during a defined period of time. Clearly defining the problem will keep the review focussed and prevent time being spent on matters that are out of scope.
- **Good data** – You should retain a copy of all submitted notifications (all notifications submitted via portal are remain available for review) and feedback from inspectors, preferably in an electronic format, for easy access and analysis. Before beginning any review, you should ensure that you have all of the relevant data available.
- **Look for patterns or trends** – Ask yourself if there are any similarities in your notifiable events. Do they only happen on certain days or at certain times? Are there certain staff members or residents that feature regularly? Do these events typically happen in certain locations within the service? Identifying any patterns can help produce solutions.
- **Gather views and opinions** – Ask staff and residents for their views on what is contributing to notifiable events. They may have some useful insights that can help to address these problems. Perhaps seek out expert opinions, for example from other allied health professionals to inform your views.
- **No blame culture –** Any review should, in so far as is practicable, be an exercise in quality improvement as opposed to seeking to find someone or something to blame. When a no blame culture exists it is more likely that people will contribute in a positive manner in the knowledge that they will not be punished for something that went wrong.
- **Realistic solutions** – Ensure that any solutions or recommendations identified as part of the process are realistic and easily understood. Consider

assigning responsibility for implementation of the solutions to a suitable person. Where solutions are identified that are outside of the control of your service and wider organisation, seek a means by which they can be communicated or escalated to the appropriate body.

- **Monitor** – When any new interventions are introduced, a service should monitor the implementation to ensure effectiveness. This may involve gathering feedback from residents and staff or there may be some other measure available to track improvements. Where an intervention fails to have the desired effect the service should further consider what can be done to improve the situation.

5. Summary

Registered providers regulated by the Chief Inspector are required to submit notifications when certain events occur in their centres. This guidance presents useful information for providers in responding to notifiable events in their centres. These notifications are an important indicator of quality and safety.

Providers and their staff must respond in a person-centred manner and ensure that supports are provided, both in the immediate aftermath and on an ongoing basis, to keep people safe and promote their wellbeing.

Good reporting of statutory notifications is important. It helps inspectors develop a clear picture of what has happened, how the service has responded, and how the residents have been affected. Good reporting also reduces the likelihood that inspectors will have to seek further information or clarification on a notifiable event.

Notifiable events are also an opportunity to learn and improve quality in services. A review or analysis of a single event may identify some key improvements that can be introduced in a service. Similarly, looking back over several incidents might help identify patterns or trends that can inform quality improvements.

This guidance offers support and guidance for service providers around managing and responding to notifiable events. It should be used in conjunction with other reference materials that are available on the HIQA website: www.hiqa.ie and linked to at the beginning of this guidance.

6. Revision history

Revision number	**Description of change**
Version 1	June 2022 — first published
Version 2	March 2025 — changes made to reflect the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2025

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