Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

Deputy Peadar Tóibín
Aontu
Dáil Éireann
Leinster House
Kildare Street, Dublin 2

30th July, 2025

**Re:** PQ 41102/25

Dear Deputy Tóibín,

Thank you for your question:

**To ask the Minister for Health the number of adverse incidents recorded in the health service 2018 to 2025; and the nature of adverse incidents.**

I refer to your parliamentary question above which has been referred to HSE Quality and Patient Safety Incident Management for response. I can provide incident data recorded on the National Incident Management System (NIMS).

**Incident Reporting in the HSE**

The HSE is actively encouraging incident reporting by its staff. High levels of incident reporting, in particular near-miss reporting and no harm incident reporting, are a good indicator for a positive patient safety culture. Whilst there are flaws in relation to incident data, it can be a good indicator for risks in the health and social care system. Importantly, incidents provide an opportunity for learning and improvement.

Over the last number of years the HSE has been driving and encouraging incident reporting through a number of strategies. Primarily, it is a HSE policy requirement for all staff to report incidents as set out in the HSE Incident Management Framework. Additionally, the HSE has established a national platform to share learning from patient safety incidents 'Patient Safety Together (PST)'. PST is freely accessible to all. It closes the loop on incident reporting and demonstrates to staff (and the public) that reporting incidents leads to learning and improvement on a national scale. Another key area the HSE has been focusing on is a Just Culture and psychological safety as described in the Incident Management Framework. Furthermore, the HSE and State Claims Agency work collaboratively to improve the actual incident reporting system, NIMS, to make it more user-friendly and intuitive for staff to use and therefore report incidents more easily. The direct electronic incident reporting function (ePOE) of incidents onto the system by frontline staff has now been rolled out at over 30 sites with many more sites lined up for its roll-out. Such national initiatives are further enhanced by local work to improve patient and staff safety, report incidents and encourage a positive safety culture.

**Incident data**

Whilst the HSE continues to pursue strategies for improving incident reporting, it is recognised that there are a number of factors that impact this. As such it is not intended as a data collection point. Primarily it aids as a system that helps incident management, learning from such events and indicate risks.

There are data limitations and anomalies of the NIMS incident data that include potential duplication of incidents, variance in reporting and limited data validation, etc.

The data included in this response was extracted on the 23rd July 2025 for HSE statutory services - it does not include voluntary services. It includes all person related incidents (patients, staff, external) and near-misses (excluding property, motor crash or dangerous occurrence incidents) for the six HSE Regions for both community and hospital locations. The majority of incidents had no harm or low level harm reported. NIMS is a live system and records are updated constantly which means that there can be variation in data depending on when it is extracted.

**Table 1: Severity Rating: Incidents on NIMS by HSE Community and Acute Hospital Services in 2018-2025 (only January-June for 2025).**

| | Severity | | | | | |
|---|---|---|---|---|---|---|
| **Year** | **Negligible** | **Minor** | **Moderate** | **Major** | **Extreme** | **Grand Total** |
| 2018 | 74,376 | 10,717 | 9,070 | 74 | 574 | 94,811 |
| 2019 | 72,286 | 11,746 | 8,582 | 99 | 593 | 93,306 |
| 2020 | 69,160 | 13,178 | 10,764 | 67 | 780 | 93,949 |
| 2021 | 70,088 | 14,833 | 10,248 | 100 | 694 | 95,963 |
| 2022 | 79,310 | 17,345 | 10,646 | 129 | 579 | 108,009 |
| 2023 | 79,850 | 17,461 | 9,520 | 155 | 542 | 107,528 |
| 2024 | 81,352 | 17,843 | 9,538 | 172 | 502 | 109,407 |
| 2025 | 43,768 | 9,393 | 4,767 | 55 | 228 | 58,211 |
| **Grand Total** | **570,190** | **112,516** | **73,135** | **851** | **4,492** | **761,184** |

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**Table 2: Incident Hazard (the nature of adverse incident): Incidents on NIMS by HSE Community and Acute Hospital Services in 2018-2025 (only January-June for 2025).**

| Hazard Type | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|
| Clinical Care | 30,486 | 30,413 | 31,067 | 33,563 | 33,750 | 40,482 | 44,122 | 25,807 | 269,690 |
| Exposure to Behavioural Hazards | 30,965 | 29,314 | 26,238 | 24,688 | 26,983 | 29,968 | 29,440 | 14,728 | 212,324 |
| Exposure to Biological Hazards | 1,671 | 1,909 | 6,611 | 8,642 | 15,715 | 6,396 | 5,313 | 1,542 | 47,799 |
| Exposure to Chemical Hazards | 282 | 256 | 218 | 188 | 177 | 172 | 239 | 118 | 1,650 |
| Exposure to Mechanical Hazards | | | | | | ≤5 | ≤5 | | ≤5 |
| Exposure to Physical Hazards | 31,362 | 31,363 | 29,774 | 28,808 | 31,321 | 30,264 | 30,000 | 15,913 | 228,805 |
| Exposure to Psychological hazards | 43 | 48 | 38 | 58 | 58 | 228 | 268 | 99 | 840 |
| (blank) and data errors | ≤5 | ≤5 | ≤5 | 16 | ≤5 | 17 | 22 | ≤5 | 72 |
| **Grand Total** | **94,811** | **93,306** | **93,949** | **95,963** | **108,009** | **107,528** | **109,407** | **58,211** | **761,184** |

The types of clinical care incidents can vary from incidents such as a pressure ulcer, medication incident, etc.

I trust this clarifies the matter but please do contact me if you require any further information.

Yours sincerely

Loretta Jenkins
General Manager
Quality and Patient Safety Incident Management