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 41104/25

Dear Deputy Tóibín,

Thank you for your question:

To ask the Minister for Health the number of adverse incidents recorded in each hospital group 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 hospital locations. As the NIMS system is aligned to the six HSE Regions we present the data for the acute services in each Region. We note the Hospital Group structure was removed from NIMS starting July 2024 and replaced by the Regions.
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.

Please note there were a few changes in the NIMS structure between the old Hospital Groups and the current Region.

Table 1: Changes in NIMS structure between Hospital Groups and Regions

Hospital	Hospital Group	Region
Midland Regional Hospital, Mullingar	Ireland East Hospital Group	HSE Dublin and Midlands Region
CHI at Connolly	Children's Health Ireland	HSE Dublin and Midlands Region
CHI at Crumlin	Children's Health Ireland	HSE Dublin and Midlands Region
CHI at Tallaght	Children's Health Ireland	HSE Dublin and Midlands Region
CHI at Temple Street	Children's Health Ireland	HSE Dublin and Midlands Region
Our Lady's Hospital, Navan	Ireland East Hospital Group	HSE Dublin and North East Region
Mater Misericordiae University Hospital	Ireland East Hospital Group	HSE Dublin and North East Region
National Orthopaedic Hospital Cappagh	Ireland East Hospital Group	HSE Dublin and North East Region
Lourdes Orthopaedic Hospital, Kilcreene	South South-West Hospital Group	HSE Dublin and South East Region
Tipperary University Hospital	South South-West Hospital Group	HSE Dublin and South East Region
University Hospital Waterford	South South-West Hospital Group	HSE Dublin and South East Region

Table 2: Severity Rating: Incidents on NIMS by HSE Acute Hospital Services in 2018-2025 (only January-June for 2025).

	Severity					
Year	Negligible	Minor	Moderate	Major	Extreme	Grand Total
2018	31,851	5,127	6,347	52	252	43,629
2019	32,381	5,336	6,327	62	268	44,374
2020	32,397	6,633	7,720	41	303	47,094
2021	34,858	7,754	7,421	61	312	50,406
2022	39,148	8,290	7,690	89	257	55,474
2023	40,013	9,296	7,008	103	243	56,663
2024	41,584	9,493	6,808	129	256	58,270
2025	23,871	5,388	3,599	35	134	33,027
Grand Total	**276,103**	**57,317**	**52,920**	**572**	**2,025**	**388,937**

Table 3: HSE Region: Incidents on NIMS by HSE Acute Hospital Services in 2018-2025 (only January-June for 2025).

Region	2018	2019	2020	2021	2022	2023	2024	2025	Grand Total
HSE Dublin and Midlands - HSE - Hospitals (DMHG)	7,118	6,667	6,924	6,933	8,262	8,724	9,387	4,903	58,918
HSE Dublin and North East - HSE - Hospitals (RCSI)	6,340	6,276	7,778	9,884	8,050	7,919	7,961	4,152	58,360
HSE Dublin and South East - HSE - Hospitals (IEHG)	9,230	9,272	9,442	9,762	11,913	11,959	13,220	6,020	80,818
HSE Mid West - HSE - Hospitals (ULHG)	4,634	5,246	5,192	5,171	6,309	5,871	5,951	3,251	41,625
HSE South West - HSE - Hospitals (SSWHG)	5,879	6,105	6,357	5,947	6,556	7,130	7,411	3,205	48,590
HSE West and North West - HSE - Hospitals (Saolta)	10,428	10,808	11,401	12,709	14,384	15,060	14,340	11,496	100,626
Grand Total	**43,629**	**44,374**	**47,094**	**50,406**	**55,474**	**56,663**	**58,270**	**33,027**	**388,937**

Table 4: Incident Hazard (the nature of adverse incident): Incidents on NIMS by HSE 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	24,456	24,578	25,852	27,933	28,133	33,105	35,270	20,351	219,678
Exposure to Behavioural Hazards	5,119	5,426	5,019	4,783	5,592	6,165	6,285	3,931	42,320
Exposure to Biological Hazards	1,385	1,641	3,630	4,498	6,551	3,150	2,820	1,043	24,718
Exposure to Chemical Hazards	93	76	64	71	75	84	121	75	659
Exposure to Mechanical Hazards						≤5	≤5		≤5
Exposure to Physical Hazards	12,546	12,612	12,502	13,066	15,072	13,948	13,619	7,533	100,898
Exposure to Psychological hazards	30	40	26	49	51	202	141	91	630
(blank)		≤5	≤5	6		8	11	≤5	30
Grand Total	**43,629**	**44,374**	**47,094**	**50,406**	**55,474**	**56,663**	**58,270**	**33,027**	**388,937**

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