



#### Diagnosis incidents reported on NIMS, the National Incident Management System, 2022-2023

#### **Overview of incidents**



2,590

number of diagnosis incidents\* reported

were reported as

delayed diagnosis



**77.9%** 

of diagnosis incidents were reported as negligible (no harm) in severity



average number of days to report a diagnosis incident



7.3%

over a third of diagnosis incidents were reported under the service of medicine

\*A diagnosis incident is an event or circumstance that could have or did lead to unintended and/or unnecessary harm occurring during the diagnostic process, and which may give rise to a delayed diagnosis, missed diagnosis or misdiagnosis (incorrect diagnosis).

90%

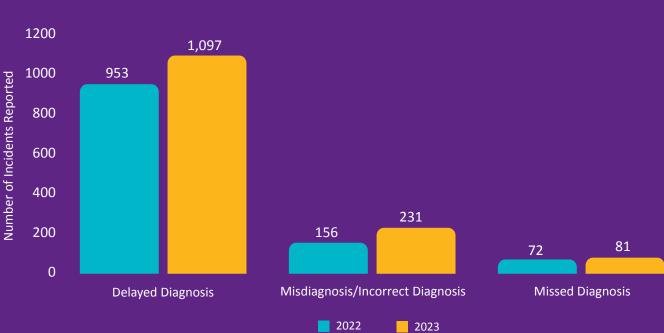
of diagnosis incidents

were reported by

acute hospitals

## Diagnosis incidents in more detail

Diagnosis incidents reported by 'sub hazard please specify' field on NIMS



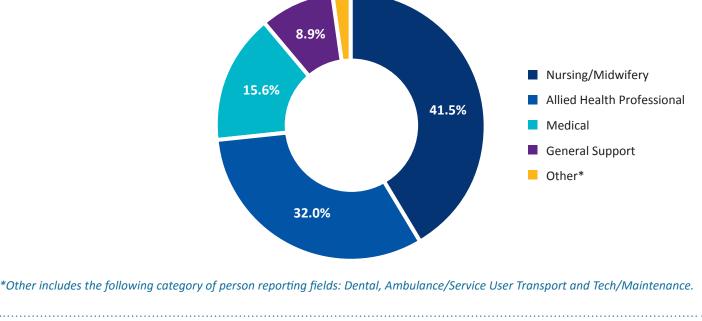


related to delayed access to diagnostic services or delays in receiving diagnostic results, placing service users at risk of delayed treatment or intervention.

The majority of incidents were reported under delayed diagnosis. A number of these

### Diagnosis incidents reported by 'category of person reporting' field on NIMS

2%



Nursing/midwifery reported the highest number of diagnosis incidents followed by allied health professionals. Health and social care professionals should report all diagnosis



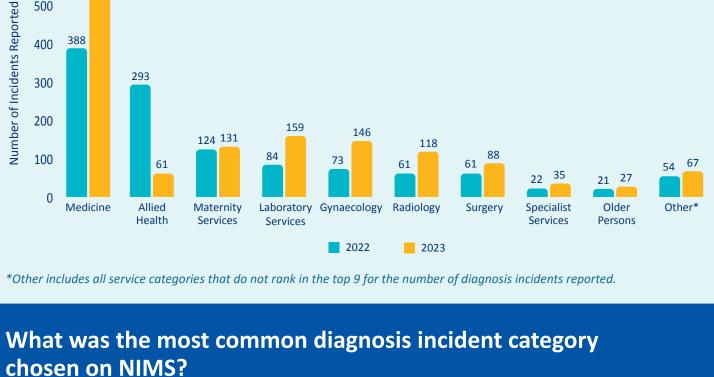
600

577

Which services are reporting diagnosis incidents?

incidents on NIMS in a timely manner, in line with the statutory requirement to report incidents to the State Claims Agency and the HSE's Incident Management Framework.

## 500



# (problem/cause on NIMS) reported was



700

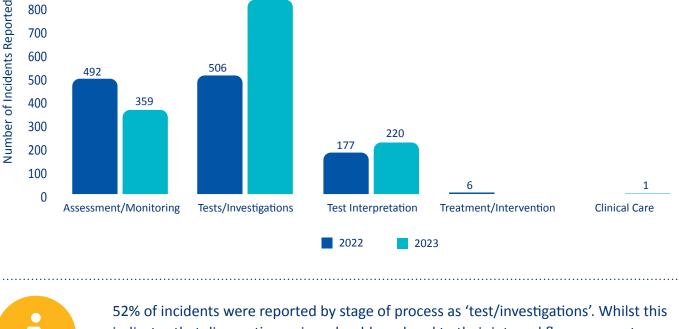
Where in the process did diagnosis incidents occur? Diagnosis incidents reported by 'process' field on NIMS

'not performed when indicated' (55%).

The most common incident category

#### 900 829 800

600 506 492





indicates that diagnostic services should pay heed to their internal flow process to ensure timely access and reporting, it should also be noted that specimen/blood sampling issues accounted for some of these incidents.

Please note that this infographic used service user clinical care data which includes

may not total 100 due to rounding. The data is correct as of 31/12/2023.

public hospitals, community healthcare and related organisations, and national services. The incident create date on NIMS was used to generate the data. Please note percentages

