



Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht Stáit um Éilimh
State Claims Agency

National Incident Management System (NIMS): Getting Value

Presentation By:

Pat Kirwan, Deputy Director, State Claims Agency



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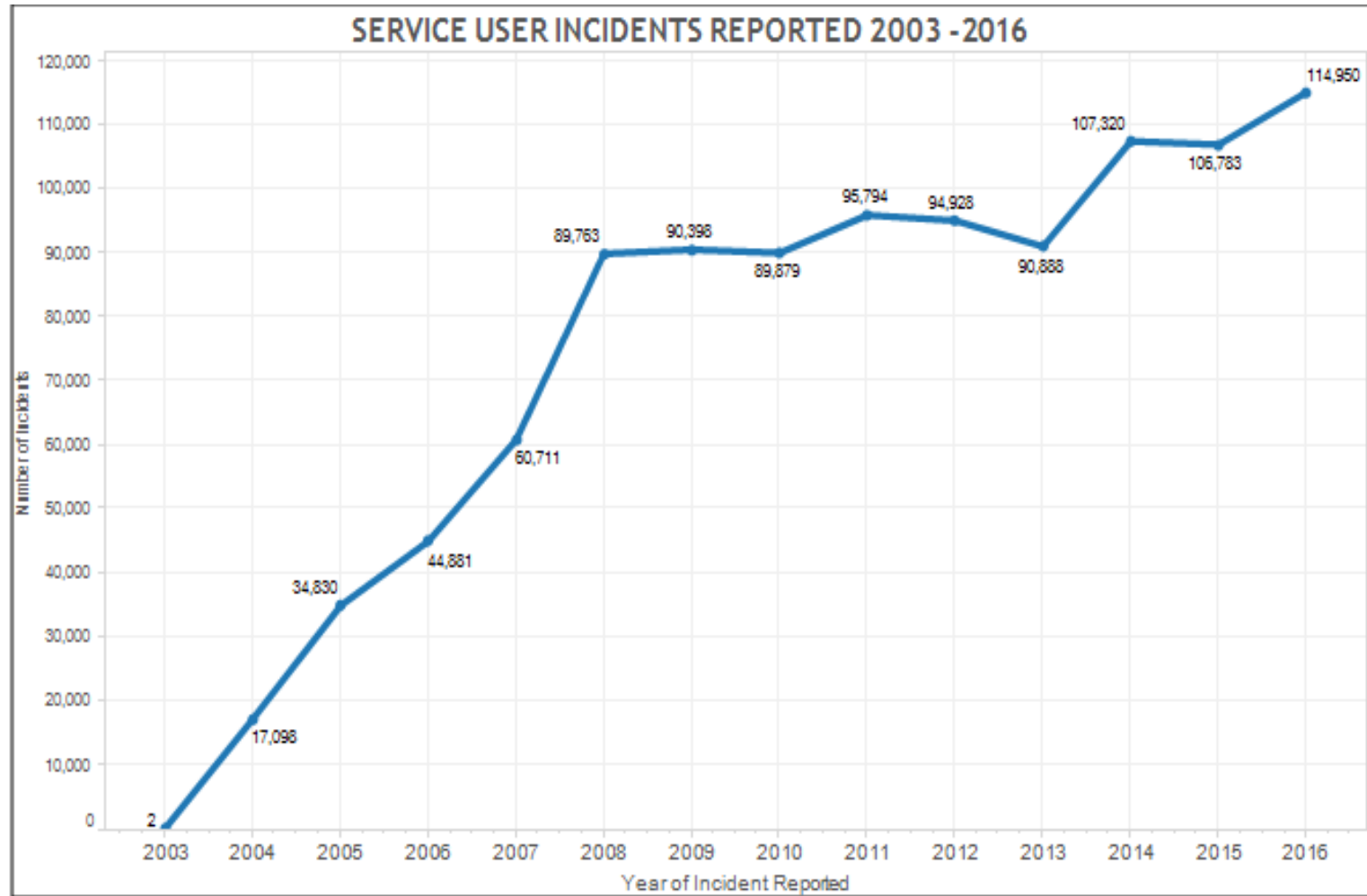
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 **NIMS**

Córas Náisiúnta um Bainistíocht Teagmhais
National Incident Management System

Incident Reporting Statistics



Original system
procured
and implemented

Original system
in Use

NIMS launch
and
embedding

NIMS is capable of delivering the following solutions:

- Incident intake;
- Support of management of investigations;
- Recording of investigation conclusions;
- Recording of recommendations;
- Supports the tracking recommendations to closure;
- Multiple reporting and analytical tools which can be pointed at all captured data;
- Assists and supports clinical risk, health and safety, claims and other professionals in the day to day management of their workload;
- Provides management information reports on performance within all levels of the organisation and nationally provides analytics tools to allow for deep dive analysis.



NIMS Current Status in Healthcare Sector



**2,775 approx.
Healthcare
Locations**



**6.5m bed days,
65,000+ birth rates p.a.**



*106,783 Incidents Reported in 2015**

*114,950 Incidents Reported 2016**

*Total of 1,125,848 Incidents Reported to date**



*Approx. 3,410 Active Claims on System
Exposure to State of > €1.9 billion**



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**Relates to patient and service users data only.*

Getting Value

- Better understanding of patient safety incidents
- Informs patient safety initiatives
- Reporting culture – drive improvement
- Managerial information at national, group, regional and local level
- Supports investigations – drive improvement, richer data set
- KPI's and benchmarks
- Real time operational data to support clinical risk management
- National studies
- Incident & claim review to identify risk opportunities



Getting Value – Patient Safety Incidents and Safety Culture

114,950

Total reported
2016

Incidents

26.5%

Increase
2013 - 2016

≥8.5

major/extreme per
1,000 incidents

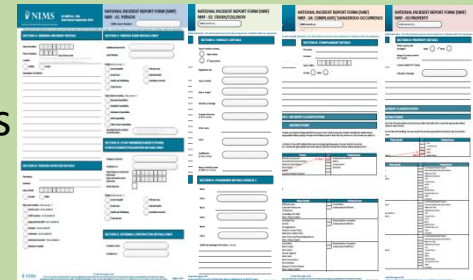
KPI's

20%

Medication incidents
increase 2015 - 2016

NIRF's

Standardise forms
across the
Healthcare



Investigations Completed

27
in 2015

1,000+
In 2017

**National
Studies**

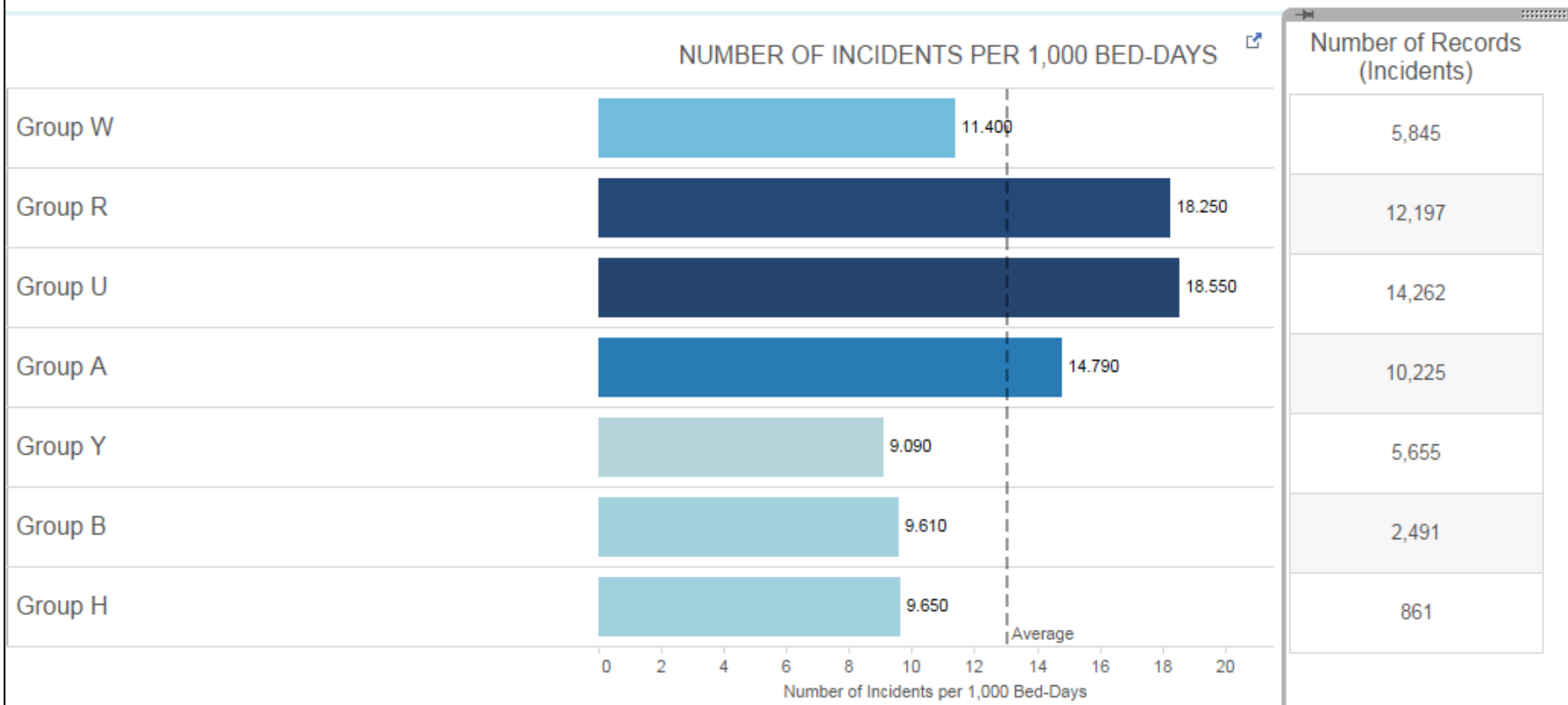


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Getting Value - Hospital Group Level Report From NIMS

INCIDENT REPORTING LEVELS (Incidents per 1,000 bed-days)



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Getting Value – Hospital Level Report From NIMS

HOSPITAL SUMMARY - INCIDENTS REPORTED LAST 12 MONTHS

10.2

Claims per 1000 incidents

4.7

Extreme/Major incidents
per 1000 incidents

74%

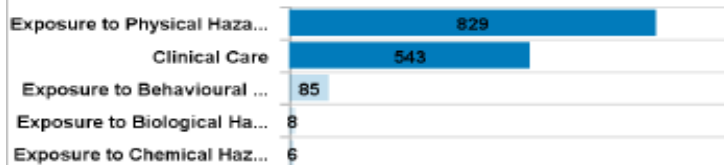
of investigations outstanding - Last 12 months

Outstanding	147
Commenced	36
Complete	24

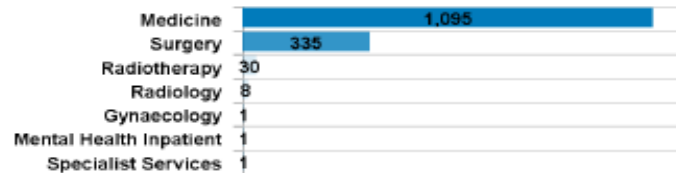
INCIDENTS REPORTS PER MONTH - LAST 12 MONTHS



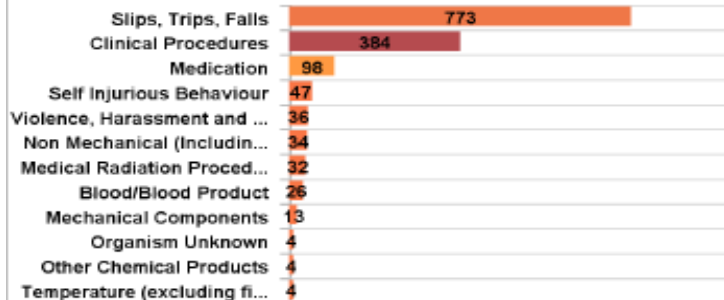
INCIDENTS BY HAZARD CATEGORY – TOP 5



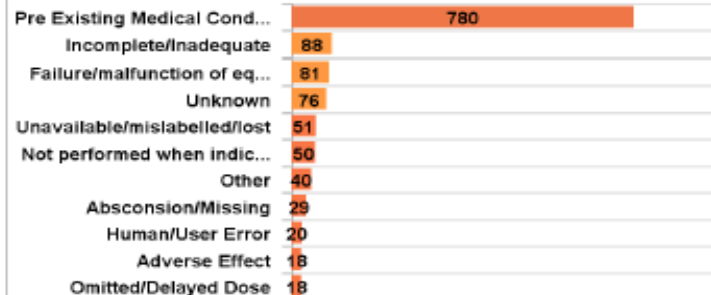
INCIDENTS BY SERVICE – TOP 5



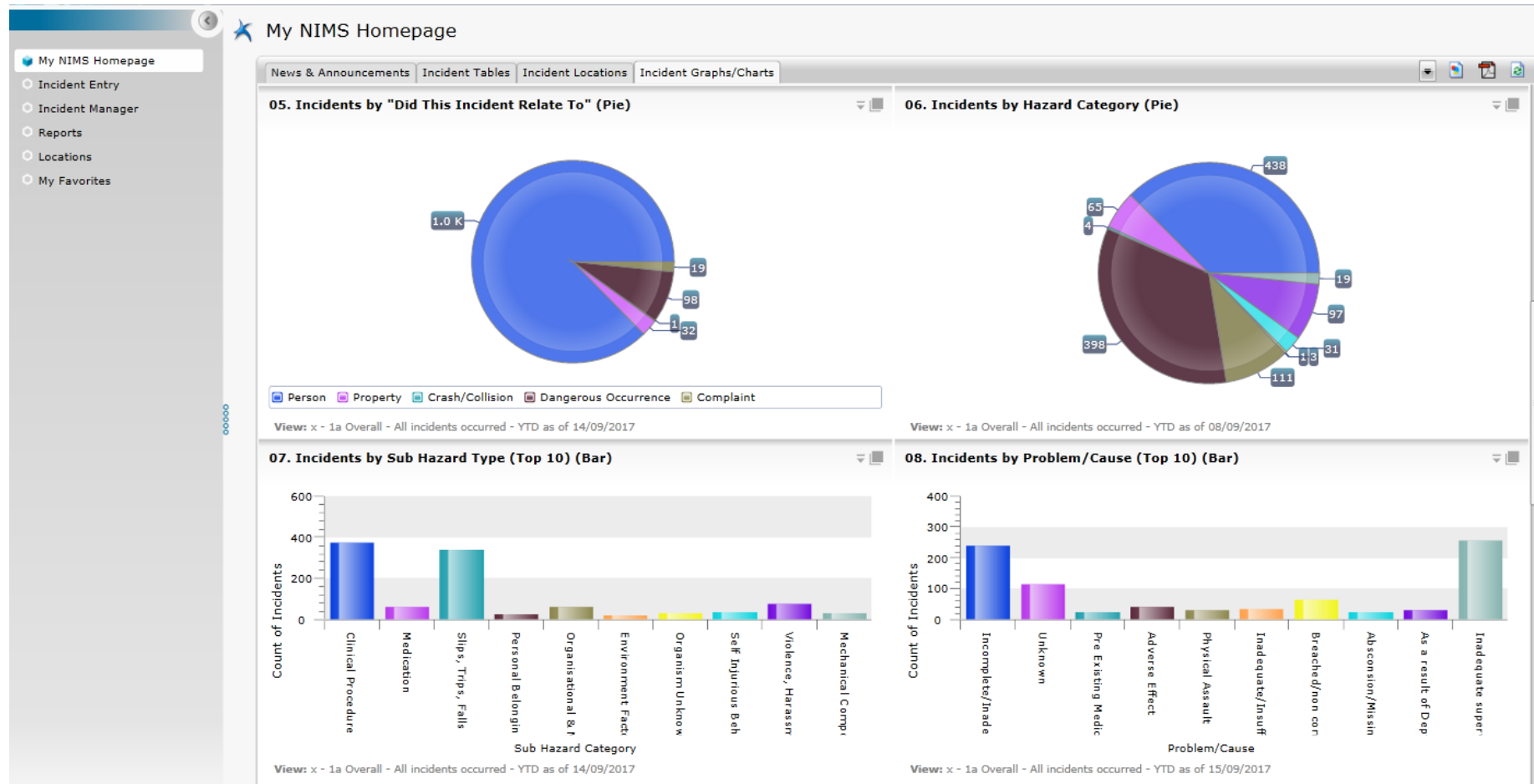
INCIDENTS BY SUB HAZARD – TOP 10



INCIDENTS BY PROBLEM/CAUSE – TOP 10



Getting Value – Operational Reports



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Getting Value – Clinical Interventions

- Medication Safety
 - ▶ Can quantify incident numbers and specific drugs involved using NIMS
 - ▶ Lessons learned patient safety notification
 - ▶ Data driven patient safety and medication agenda with multiple health enterprises
- Pressure sores
 - ▶ Stage 3 & 4 pressure ulcers most frequent SRE on NIMS
 - ▶ Data from NIMS provides an evidence base for important and meaningful collaborations with our external stakeholders e.g. 'Pressure Ulcer to Zero' Committee
- Incident Specific
 - ▶ Alerted on NIMS via SCA Risk Review Process
 - ▶ Patient post seizure aggressive behaviour – risk to self, other service users and staff
 - ▶ Triggered review – mitigation actions identified

Where From Here - Continuous Improvement

2017

- SRE's and Open Disclosure Incident Investigations
- Medication Search
- National Complaints Module
- CHO & Divisional Hierarchy
- National and Hospital Level NI Reports
- Views and Dashboards
- Rollout to S38 Disability Sector

2018 and on..

- GDPR (May 2018)
- Clinical and Maternity Procedures
- Challenging behaviour
- Electronic Point of Occurrence (EPO)
- Mobile Apps
- Audit
- Data Discovery and Predictive Analytics
- Values and Electronic Health Record



Vision

Have one common powerful picture of patient safety which underpins and evidence all patient safety initiatives.

The diagram illustrates the progression of patient safety initiatives across four stages, from Reporting Culture to Safety Culture. Each stage includes a list of activities:

- Reporting Culture:**
 - Lessons Learned
 - Local Reporting
 - Local Incident Capture
- Local Reporting Culture:**
 - Lessons Learned
 - Reporting Group/Regional/National Level
 - Incident Capture Group/Regional/National Level
 - Local Reporting
 - Local Incident Capture
- Investigation Culture:**
 - Lessons Learned
 - Reporting Group/Regional/National Level
 - Incident Capture Group/Regional/National Level
 - Local Reporting
 - Local Incident Capture
- Safety Culture:**
 - Lessons Learned
 - Risk Register
 - Audit
 - Root cause Analysis
 - Recommendations and Task Management
 - Benchmarks and Reporting
 - Operational and MI Incident Investigation
 - Incident Review
 - Patient Safety Investigation/Values Reporting
 - Group/Regional/National Level
 - Incident Capture Group/Regional/National Level
 - Local Reporting
 - Local Incident Capture

Thank you Questions?



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