Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how **Willowbrook Hospice intends** to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This patient safety incident response plan (PSIRP) details how **Willowbrook Hospice** will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide, and in turn improve the experience for all involved.

The Patient Safety Incident Response Framework (PSIRF) sets out the national patient safety approach to developing and maintaining effective systems and processes for responding to patient safety events for the purpose of learning and improving patient safety. It is recognised that there will need to be a shift towards systems-based approaches to a learning culture to allow Hospices to effectively respond to and learn from events, with the purpose of reducing the risk of avoidable harm as low as reasonably possible. The introduction of PSIRF provides Hospices with more autonomy and flexibility in our approach to patient safety events. Patient safety events can be defined as

"Any unintended or unexpected incident which could have, or did, lead to harm for one or more patients' receiving healthcare".

Compassionate engagement is a key fundamental of PSIRF. Clear communication with those affected by patient safety events to determine the focus of any review is vital to ensure that the voice of the patient, families/carers, and staff is at the heart of any response and learning. Documentation of clear communication and engagement is vital. It should be acknowledged that PSIRF is a new framework for the identification and response to patient safety events, however the aims and ethos have been adopted within healthcare for some time. The implementation process will take time to progress and embed and will require regular review to ensure that Hospices can demonstrate positive assurance in improvements and safety. Enhancing data quality and agility will need to be at the heart of the implementation process to ensure continuous progression.

''The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them''

- Aiden Fowler, National Director of Patient Safety.

Hospices across Cheshire & Merseyside have come together to work collaboratively and share learning during the PSIRF development process. Hospices in Cheshire & Merseyside will continue to meet to address challenges with PSIRF and share good practice, whilst ensuring that **Willowbrook Hospice** has a local focus for quality improvement. Continuing the work that the Network has established will provide a Community of Practice for the Cheshire & Merseyside Hospices to share their thematic work and local improvement plans; the successes that they have had and how they can improve.

Our services

Willowbrook Hospice is a Charity providing free specialist palliative care to Adults with a Life Limiting illness across St Helens and Knowsley.

The philosophy of Willowbrook Hospice is to treat each individual patient as a whole person and each patient is the focus of our attention from the moment they arrive with us. Through consultation and discussion with the patients, families, and those people important to them, we aim to:

(a) Provide free Specialist Palliative Care through the expertise of our Multi-professional Team to those patients referred to us, irrespective of diagnosis, by their GP, Hospital Consultant or Member of the Multi-professional Team.

(b) Support each patient to live with dignity and to achieve the best quality of life, where possible.

(c) Encourage patients, their families, and those people important to them to make informed choices and to take an active part in their care. We always attempt to discuss individual care as sensitively and privately as possible.

Our services are provided via a 24-hour in-patient unit and an Outreach support service that comprises wellbeing groups, home visits, virtual support, and individual outpatient clinics. Our outpatient clinics, which include medical, nursing, and various therapies, operate on a variable schedule from Monday to Friday. In response to the pandemic, we have adapted our services to include virtual, telephone, and face-to-face consultations. We also offer care and support for families through our family support service, with assistance from Child Bereavement UK for families with young children.

We provide pre- and post-bereavement support to our patients and families within the St Helens and Knowsley area who are known to our specialist palliative care team. This support can be accessed through individual, group, or remote sessions.

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Defining our patient safety incident profile

STAKEHOLDER ENGAGEMENT

The Cheshire & Merseyside PSIRF Hospice Network was established to support a collaborative approach to designing the patient safety profile. There were seven Hospices (appendix A) from across Cheshire & Merseyside who worked together, some key actions taken by the Network include:

- Links with C&M NHS Integrated Care Boards Patient Safety Leads
- Development of C&M Hospice's PSIRF Plan
- Identification of key stakeholders
- Identification of key lead roles
- Identification of Hospice training needs

Quality Assurance Group

Our internal Clinical Governance group for senior clinical leads and Heads of Departments, responsible for reviewing clinical and non-clinical activity, incident, and risk. Sub committees focusing on medicines, tissue viability, falls and clinical audit formally report into this group.

Clinical Assurance Group

Our Board sub committee made of Board of trustee members, and expert committee advisors is responsible for overseeing clinical strategy, delivery of care and education and research. It monitors clinical activity, performance, and risks, raising issues to the board when necessary.

Health and Safety Group

Our internal group considers health and safety issues and oversees the reporting on the hospice incident reporting system.

Patient Safety and Quality Group

Our internal patient safety group will undertake a thorough review of all incidents and complaints to identify themes and areas for improvement (actions and learning)

Patient and Public involvement

Development of the plan will be shared with volunteers, some of which have lived experience as a carer /Loved one of someone who has previously used the Hospice services.

Willowbrook Hospice has an existing culture of incident reporting including high reporting of near misses and no harm incidents. We used our existing incident data to establish our most significant patient safety issues. These correspond to those where Hospice UK benchmarking incident data is available supporting the view that these are common patient safety areas of concern for hospices. We will scope interest in collaboration with our local hospice collaborative for the next iteration of this plan.

We reviewed all our incident data for the past year and used this to define our patient safety profile Incident data recorded on our current local risk management system. These included.

- **Safeguarding concerns**
- **Complaints**
- **Staff interviews**
- **Medication incidents -Focusing on prescribing, recording and administration.**

Defining our patient safety improvement profile

Whilst the data varied for each Hospice there were 4 key incident types highlighted across the C&M Hospice Network:

- Pressure ulcers developed during inpatient stay.
- Falls
- Medication incidents
- Hospice acquired Infection.

At Willowbrook Hospice 12 months of incident data was reviewed:

Table 1. Occurrence of patient safety data incidents at Willowbrook Hospice for 12 months (2023/24)

Type of Incident	Number of occurrences	% of all incidents	Improvement works underway*
Falls	15	14.15%	Review of patient falls form. Falls Form uploaded into the hospice EPR-SystmOne this will flag to the Medical Team to review the patient. The Doctor then sends a task to the Pharmacist who reviews the patient's medication regime and identifies any meds that could be causing increased risk of falls. Meds can then be rationalised as necessary. Review of falls equipment and purchase of additional falls alarms and assistance devices for people who are unable to use the nurse aid call, e.g. large buzzers activated by the head or heel of the hand. Following a recent meeting with the falls team at the local acute trust, we plan to

			purchase anti-slip socks for at risk patients. Imminent implementation of new digital reporting system [Vantage] for reporting of all patient incidents, including falls - streamlining systems. Easier to identify trends and complete SWARMS and enable robust summary of findings and actions, which can be shared easier amongst the team.
Hospice acquired infection	4	3.77%	WBH has had a recent refurbishment to reconfigure the patient rooms and made all bedrooms single, thus reducing the risk of outbreaks of infection. WBH have an ultra-violet lightbox to assist in hand hygiene training.
Medication incidents Controlled Drugs	49	46.23%	WBH has a supportive culture and a positive approach to reporting of all errors and near misses. We encourage staff to see this as an opportunity for learning rather than taking a negative approach. Reflective process by the individual practitioner reviewed to ensure learning is improved and so reduce likelihood of further or escalating errors. All errors and near misses are reviewed monthly and any themes shared with the team in a newsletter put together by Practice Development Facilitators and Medicines Management Champions. WBH are in the process of introducing a new risk management reporting

			system “Vantage” where errors can be reported easily and actioned promptly if any changes to practice are needed for patient safety. Introduction of new roles for WBH- Practice development facilitators. They have facilitated training and competency assessment for Single Nurse Administration of Controlled Drugs with the aim of reducing errors caused by complacency when there is a second checker. Training includes a workbook to ensure knowledge and competence with medications, interactions, and calculations and competency sign off.
Medication Non-Controlled Drugs	28	26.42%	As above. Competency assessments also in place for administration of non-CDs New drug trolley and storage of patients own medications to avoid multiple trips to drug room and multiple storage areas of medications to avoid distractions while administering medications.
Hospice acquired Pressure ulcers	10	9.43%	3 nursing staff have recently completed an 18-month course facilitated by the Society of Tissue Viability. They are currently consolidating their learning and resources and devising a wound care formulary, reviewing all patient

			documentation pertaining to tissue viability and pressure ulcer management and devising a training package for staff. WBH have recently invested in additional specialist equipment for prevention and management of pressure ulcers for bariatric patients in our dedicated bariatric room.

Medication Incidents

From the analysis of medication incidents, it identified the majority were Controlled Drug related incidents. This is unsurprising given the number of complex patients needing a high level of intervention to address pain and agitation symptoms. However, the majority are related to documentation and missing signatures with very few being administration errors that reach the patient. The hospice has undertaken a review and has also looked at research in this area and will be implementing single nurse administration (SNA). The research demonstrates that staff tend to be more diligent and less distracted when checking and documenting medication administration on their own. There will also be a competency workbook and sign off process to ensure staff are confident and safe to undertake SNA.

Another highlighted area of concern is the number of non-Controlled drug and controlled drug medication incidents where medication has been omitted or administered late without any documented clinical rationale - this incident type will benefit from further thematic analysis.

From the number of incidents reviewed over a 12-month period 6 incidents would fit the criteria for PSIRF.

Falls

Despite investment in falls prevention and a thorough falls assessment undertaken on admission there are still a number of patients who have multiple falls, the majority of these are when they are alone and unsupervised by staff and undertaking activities such as getting up to go to, on their way to or whilst using the toilet.

This will benefit from further AAR review and further thematic analysis to understand why preventative measure already in place are not working.

From the number of incidents reviewed over a 12-month period 4 incidents would fit the criteria for PSIRF

Pressure Ulcers

Some patients that come into the hospice have complex symptoms and may have either stopped eating or are unable to eat and drink, this can result in skin integrity being compromised due to a lack of nourishment that can help with skin healing. In patients that are in the last days of life movement can also feel uncomfortable and painful and the benefit of moving patients can sometimes be outweighed by ensuring patients are comfortable, pain free and settled. The hospice has invested in high level pressure relieving mattresses to try and prevent pressure ulcers from happening and three nursing staff have recently completed an 18-month course facilitated by the Society of Tissue Viability. They are currently consolidating their learning and resources and are devising a wound care formulary, reviewing all patient documentation pertaining to tissue viability and pressure ulcer management and devising a training package for staff.

Whilst there is a decreasing number of pressure ulcers being reported the concern is the patients who are not actively dying and in the last days of life developing pressure ulcers whilst an inpatient in the hospice. This needs to be better understood and continued monitoring and exploration is required when a patient's skin breaks down to a greater extent than the expectations resulting from the risk assessments and care plan. A thematic analysis will support this area of concern

From the number of incidents reviewed over a 12-month period 2 incidents would fit the criteria for PSIRF

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Training

To support the effective roll out of PSIRF the following training will be undertaken by the staff outlined:

Topic	All Hospice Staff	Staff undertaking incident investigations	Patient Safety Specialist & Engagement Lead	PSIRF Oversight Role	Exec Leadership Team / Board	Trustees
Patient safety syllabus level 1: Essentials of patient safety for all staff	✓	✓	✓	✓	✓	✓
Patient safety syllabus level 1: Essentials of patient safety for boards and senior leadership teams				✓	✓	✓
Patient safety syllabus level 2: Access to practice		✓	✓	✓		
Oversight of learning from patient safety Incidents (HSSIB)				✓		
Systems Approach to Learning (HSSIB)		✓				
Involving those affected by Patient Safety Incidents in the Learning Process (HSSIB)			✓			
Continuing professional development (CPD)		✓	✓	✓		

Our patient safety incident response plan: national requirements

Below are events that require a safety investigation response, as recommended by NHS England in their Guide to responding proportionately to patient safety incidents.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSIIs)	PSII	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	PSII	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required
Mental health-related homicides	Referred to the NHS England Regional	PSII led by most appropriate Trust

Patient safety incident type	Required response	Anticipated improvement route
	Independent Investigation Team (RIIT) for consideration for an independent PSII	
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	PSII led by MNSI
Child deaths	Refer for Child Death Overview Panel review	Follow the Child Death Overview Panel process
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead	Consideration for section 42 enquiries led by Local Authority
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	PSII
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent	PSII alongside Police processes

Patient safety incident type	Required response	Anticipated improvement route
	Office for Police Conduct (IOPC) to carry out the relevant investigations	
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	Domestic abuse related death review led by CSP

Our patient safety incident response plan: local focus

Local Criteria for instigating a learning response.

All clinical incidents should have an initial review on the hospice incident reporting system by a Head of department. Any initial investigation should be done with the System Engineering initiative for patient safety framework in mind (SEIPS) to support an effective investigation.

Criteria	Examples
Potential for learning	• There is potential to inform improvement. • Initial review suggests there may be system wide factors that have contributed to the incident. • Impact of quality and care, or the capacity /delivery of service
Likelihood of recurrence	• There is a persistent risk. • There was potential for the incident to escalate. • The frequency of events has been higher than usual

If either of these criteria are met, we will complete an appropriate review using one of the learning response methods defined below

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medication incidents, both CDs and Non CDS that involve actual administration or omission of a drug to the patient.	After Action Review (AAR) as soon as possible after incident identified. To gain greater insight into lack of adherence to policy and process Thematic analysis of medication incidents	Investigation Led by Ward sister/charge nurse. Themes of medication incidents to be collected by learning response lead and collated, using a SEIPS approach. Reviewed by PSIRF team. Summary with safety actions fed into Medicine management group, Quality Assurance group and Trustee led Clinical Assurance group.

Pressure ulcer. developed during inpatient stay for patients who are not in the last days of life with a rapidly deteriorating condition	Thematic analysis of pressure ulcers	Notification to Care Quality Commission (CQC) for grade 3 and above that develops whilst at the hospice. Themes to be collected by learning response lead and collated, using a SEIPS approach. Reviewed by PSIRF team. Summary with safety actions fed into Quality Assurance group and Trustee led Clinical Assurance group.
Unsupervised Falls that result in patient harm	After Action Review (AAR) as soon as possible after incident identified. Thematic Analysis of inpatient falls	Investigation will be led by Ward sister /Charge nurse. Themes to be collected by learning response lead and collated using a SEIPS approach. Review by PSIRF team. Summary with safety actions fed into Quality assurance

		group and Trustee led Clinical Assurance group

Following a baseline review, we estimate to have approximately 13 clinical incidents over the next 12 months that meet our PSIRF local priorities

Note: All incidents will continue to be reported to relevant regulators and the CQC.

To maintain commissioner assurance around governance and learning, Willowbrook Hospice will extend an invite to the ICB quality lead to attend internal meetings at Willowbrook Hospice for a collaborative approach in reviewing reports and findings. Willowbrook Hospice would maintain internal oversight.

Appendix A

The 7 Hospices who contributed to the joint PSIRF plan:

Hospice	Locality
Claire House Children's Hospice	Wirral
Hope House Children's Hospice	West Cheshire
Hospice of the Good Shepherd	West Cheshire
St Joseph's Hospice	Sefton
St Lukes Hospice	West Cheshire
Willowbrook Hospice	Knowsley and St Helens
Wirral Hospice St John's	Wirral

Glossary

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address system factors and help deliver safer care for our patients effectively and sustainably.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

AAR – After action review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

Never Event

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Deaths thought more likely than not due to problems in care

Incidents that meet the ‘Learning from Deaths’ (LfD) criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient’s care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.