Havens Hospices

Patient Safety Incident Response Plan

Procedure

Reference: CARE - 203

Version: 1.0

Issue Date: 05/03/2024

Making every day count

Havens Hospices

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Document Control

Document Reference:	CARE – 203
Document Author:	Rachael Marchant
Document Owner:	Rachael Marchant
Responsible Directorate:	CARE
Approved by:	Clinical Quality Group
Approval Date:	21/02/2024
Issue Date:	05/03/2024
Next Review Date:	21/02/2027

This is a:					
New Document	☒	**Updated Document**	☐	**Replacement Document**	☐

Audience

Intended Audience: (To be completed / confirmed by the Document Owner (or responsible directorate) to indicate who should see this document)	☒ **Trustees** ☒ **Senior Leadership Team & All care staff**

Version History

Version Number	Date of Issue	Detail of Changes
V 1.0	05/03/2024	New Document

Associated Documents

These documents should be referenced in conjunction with this procedure:

- PSIRF policy

"Havens Hospices", "The Hospice" refers to Havens Hospice, the Charity, which incorporates the services of Fair Havens & Little Havens.

1. Introduction

This patient safety incident response plan sets out how Havens Hospices intends to respond to patient safety incidents over a period of 12 months, starting from February 2024. 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.

When things go wrong, patients are at risk of harm and many others may be affected. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disengaged. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

This patient safety incident response plan (PSIRP) details how Havens 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. This plan will help us measurably improve the efficacy of our local patient safety incident investigations through:

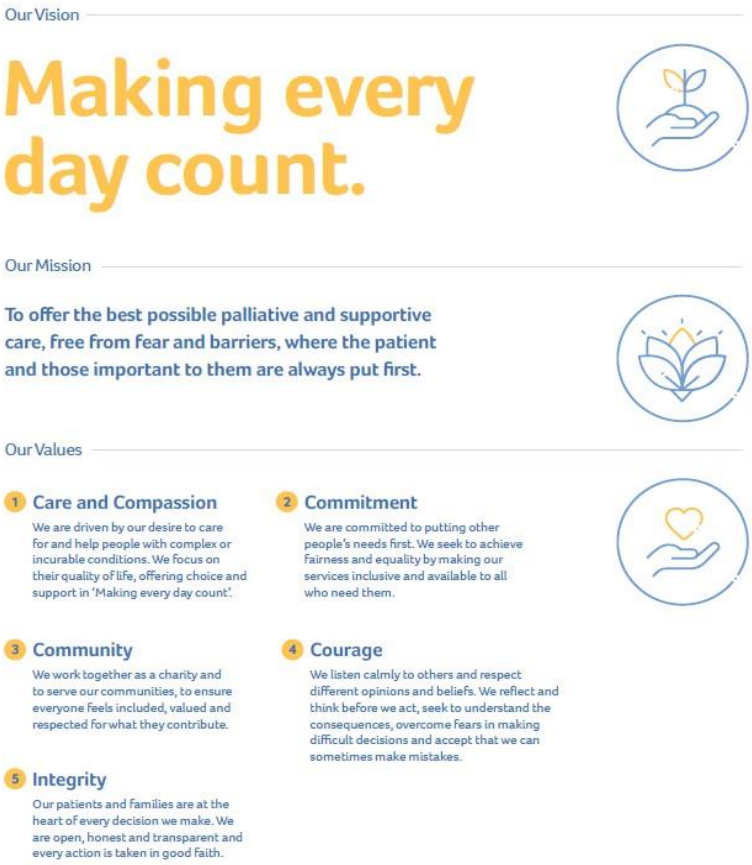
a) rigorous identification of interconnected causal factors and systems issues
b) focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
c) transferring the emphasis from the quantity to the quality of investigations such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
d) demonstrating the added value from the above approach

The Patient Safety Incident Response Framework (PSIRF) recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. This plan provides the headlines and description of how PSIRF will be applied at Havens Hospice.

2. Our Services

Havens Hospices is a registered charity that provides specialist care and support for people of all ages who are living with incurable conditions and their families. We work closely with health and social care professionals to ensure their care and support is the best it can possibly be, so they can get the most from life, and make every-day count.

Our vision, mission and values below support our aims:



Havens Hospices includes Fair Havens – Adult Inpatient Unit, Little Havens -Children's and Young People's Inpatient Unit. There are also separate community teams for both services who provide care and support to people with complex palliative care needs in their own homes.

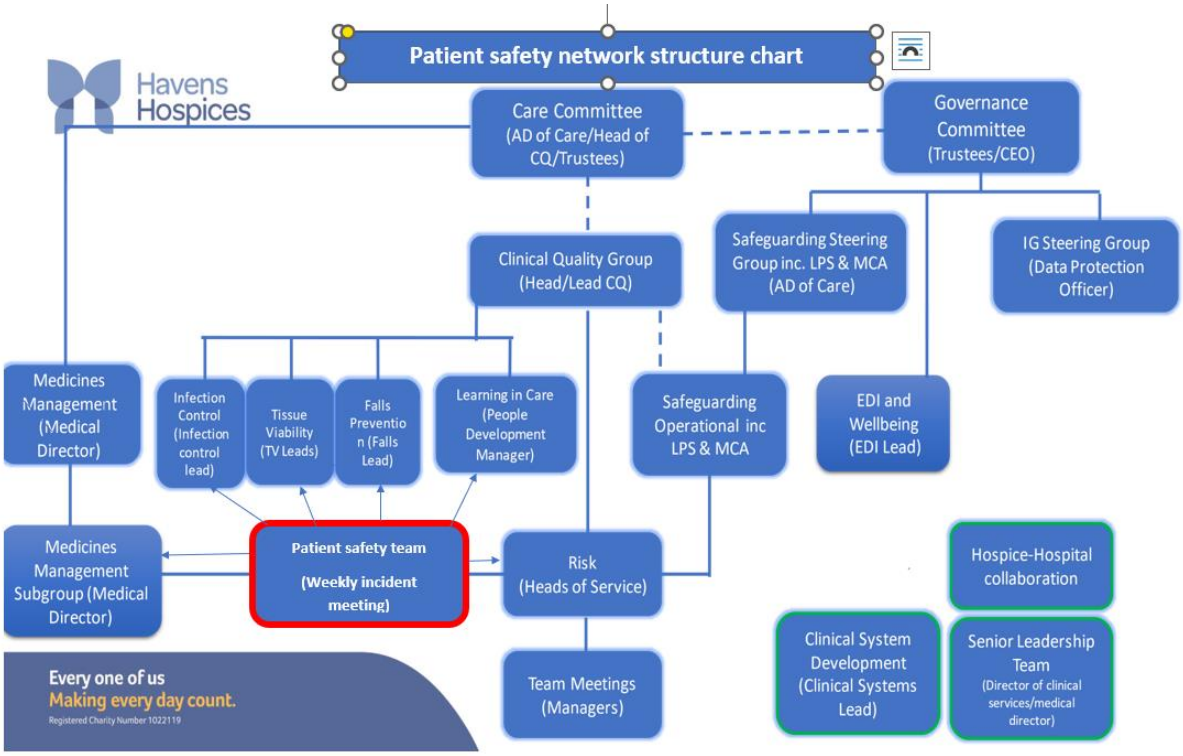
Our hub and wellbeing services are therapist led and support people in a wide range of ways and are accessible to those living with serious, long term or life-limiting conditions and those close to them. The service offers a variety of groups, sessions and courses designed to support people to cope with a long-term condition. Our hub and wellbeing teams include fully qualified social workers, counsellors, physiotherapists and Occupational therapists and a wide range of support staff.

Our strategic priorities and where they link to help to formulate our PSIRF aims:

Strategic improvement	PSIRF aims
To increase the Number of people we support across all services	• To improve our service availability to reach a wider number of people who can benefit from safe and effective services.
Together let's be outstanding for those we care for and CQC	• Act in a timely manner on feedback from patients, families, carers and staff about their concerns. Review, and act on feedback mechanisms such as 15 steps. • Respond to patient safety incidents purely from a patient safety perspective • Transfer the emphasis from quantity of investigations to a higher quality response to patient safety incidents • Implementation of meaningful, smart actions that lead to demonstrable change and improvement. • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors which promotes Duty of Candour. • Act on feedback from staff about their experiences and concerns about safety

	issues including through anonymous "you said, we did" feedback • Use "Bright Ideas" quality improvement to promote continuous quality improvement and address concerns proactively.
Prepare to support those that will need us in 2030	• Consider patient safety in our planning for the future.
Improve learning to better support the people we care for	• Roll out PSIRF training to our teams • Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. • Support and involve staff in patient incident responses, such as swarm huddle, as this will support better insight and understanding of the contributing factors.
Develop more collaborative projects that benefit our community	• Continue with collaborative case reviews across the system to support our local system learning from case reviews. • Explore opportunities within our local hospice collaborative to support each other with PSIRF implementation
Make our supporters money go further	• Reduce the number of duplicate RCA/ PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors

Patient Safety Network:



PSIRF Executive lead: Medical Director

PSIRF Engagement lead: Head of Clinical Quality and professional standards.

Introduction of a new patient safety team holding a weekly incident meeting which will feed into Havens Hospices previously existing governance structure to support the PSIRF agenda.

3. Defining our patient safety incident profile

Havens Hospices 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.

Our data analysis identified the following key patient safety activity:

National priorities requiring patient safety incident investigation 2023-2024	Patient safety incident investigation into Never Events	0
	Mortality Reviews (inc. Structured Judgement Reviews)	0
	Incidents **referred** for independent PSII	0
	Deaths of persons with learning disabilities	1
	Adult safeguarding incident reviews	5
	Child safeguarding incident reviews	7
Patient safety incident investigations conducted Locally 2023-2024	Coroner initiated patient safety incident investigations	0
	Patient/family/carer complaint-incident investigations	10
	Level 3 Serious Incident investigations (Investigations under the current NHS Serious Incident Framework and reported to StEIS)	0

Type of incident	Percentage of incidents Jan-Dec 2023
Accident including falls	**16.84%**
Slip trip or fall	9.12%
Moving and handling patient	0.70%
Injury	1.05%
Cuts and grazes	2.81%
Burns	0.35%
Collision	0.35%
Other	2.46%
Clinical incident	**71.93%**
Medication/Drug error	32.98%
Pressure ulcer (single)	11.58%
Pressure ulcer (multiple)	4.21%
Moisture Associated Skin Damage	6.67%
Clinical admin error	2.81%
Clinical complication	5.26%
Medical/nursing notes not available	1.05%
Patients care plan procedure not followed	4.21%
Unclear/inadequate communication	3.16%
Safeguarding	**3.86%**
Data Security and protection	**3.51%**
Environmental	**2.46%**
Equipment/Device failure	**1.40%**

Pressure ulcers, medication and falls are the three highest reported patient safety incidents and are currently benchmarked through Hospice UK. These will be key areas of focus for Havens Hospices.

Havens Hospices have also had recent infection control audits conducted by an external expert and identifying some key areas for improvement alongside some excellent practice. Infection control will also be a key patient safety area.

4. Improvement and transformation work

PSIRF is a whole system change to how we respond to patient safety incidents and will be fundamental to the wider improvement work Havens Hospices is already undertaking. A key component of this will be the greater involvement and interactions of staff and patients with patient safety incidents leading to improved teamwork and a just culture.

Havens Hospices has identified the following key patient safety leads:

- PSIRF Executive Lead – Medical Director
- PSIRF Learning Response Leads – Heads of care services, All care staff Band 7 and above
- PSIRF Engagement Leads – All care staff Band 6 and above
- PSIRF oversight – Head of Quality and professional standards with delegation to other members of the quality team as appropriate.
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5. Training

All staff will receive training in accordance with national requirements. Core staff will be trained by 30th March 2024 with remaining relevant staff trained by end of June 2024.

	Level 1 e-learning: Essentials of patient safety for all staff	Level 2 e-learning Access to practice	e-learning Essentials of patient safety for Boards and Senior Leadership Teams	Systems approach to learning 2 days/12 hours	Involving those affected by patient safety incidents in the learning process	Systems approach to Learning – Oversight
All staff	X					
All clinical staff	X	X				
PSIRF learning response leads	X	X		X		
PSIRF Engagement Leads	X	X			X	
PSIRF Oversight (including delegated responsibility)	X	X		X		X
PSIRF Executive Lead			X			X
Trustee Board members			X			

6. Defining our patient safety incident profile

The patient safety team which includes key patient safety leads will attend a weekly incident meeting to review the incidents that have had a completed patient safety review and will decide as to whether the incident is closed, or further action is needed.

The following groups will also meet to support PSIRF:

a) Tissue Viability group – Monthly
b) Falls group – Monthly
c) Medicines Management – Quarterly or in response to incident review meeting (Medicines Management subgroup meeting monthly)
d) Infection Control group – Quarterly or in response to incident review meeting
e) Safeguarding Operational group – Monthly or in response to incident Review Meeting
f) Risk meeting - Monthly
g) Clinical Quality group- Quarterly

Any incidents that meet the criteria for a patient safety incident investigation (PSII) will be identified by the patient safety team and the appropriate people determined to investigate and manage them.

Any incident that has been categorised as moderate harm or above will have a PSII completed using System Engineering Initiative for Patient Safety (SEIPS) thinking. Once the PSII has been completed, this will be reviewed and an ICB quality lead will be invited to attend the review.

7. Steps needed to embed PSIRF

- Provide appropriate training to all clinical staff as per table above
- Establish new patient safety team to meet weekly at incident meeting
- Use patient safety meeting as the sounding board to encourage the use of appropriate learning tools to look at incidents.
- Produce new documentation for patients, families and staff members involved in patient safety incidents.
- Identify people to act as patient liaison support for PSII and ensure they are appropriately skilled and trained

8. Engaging and involving patients, families and staff

We will have a compassionate engagement approach to involve patients, families and healthcare staff in patient safety incidents. The PSIRF Engagement Lead will be notified of all patient safety incidents which meet the criteria for a PSII. Engagement and level of involvement will be in keeping with the wishes of those affected as far as possible, using the four steps of engagement process.[1]

When the expectations of those affected are not met, families and staff will be given meaningful, truthful, and clear explanations as to why this was not possible. Patients and families will be offered the opportunity to complain in line with the hospice complaints procedure. If the complainant is in agreement, the complaint investigation and patient safety incident investigation will be combined so that the patient/family get all the answers they are seeking together.

Supporting families and staff

Families and staff will be signposted to support during engagement or involvement in a learning response.

Sources of support for families will include the hospice wellbeing team, together with external bereavement and mental health services as well as via independent advocacy services.

In addition to the above, staff can also access support from their manager, a member of the Hospice Patient Safety team, the Employee Assistance Programme and the hospice occupational health service. Havens Hospices also has an appointed Freedom to Speak up Guardian who can support staff if they feel unable to do so by other routes.

Second Victim is a website with useful support information for staff involved in patient safety incidents and has links for a range of support.

Working with system partners

The hospice will actively engage partner organisations that provided care to the patient(s) involved where that care may have played a role in the incident being examined.

We will work together and co-operate with any learning response that crosses organisational boundaries.

9. Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII – as soon as possible after the patient safety incident identified.	Led by PSIRF Learning Response Lead (Not involved or directly line managing those who are) Completed within 1-3 months from their start date. Reviewed at a specific review meeting, clinical quality and care committee. 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 patient safety incident investigations (PSIIs))	PSII– as soon as possible after the patient safety incident identified	Led by PSIRF Learning Response Lead (Not involved or directly line managing those who are) Completed within 1-3 months from their start date. Reviewed at a specific review meeting, clinical quality and care committee. ICB Quality Lead invited to meeting to review
Deaths of patients where the Mental Capacity Act (2005) applies, where there is reason to think that the death maybe linked to problems in care	PSII– as soon as possible after the patient safety incident identified	Led by PSIRF Learning Response Lead (Not involved or directly line managing those who are) Completed within 1-3 months from their start date.

(Events meeting the learning from deaths criteria)		Reviewed at a specific review meeting, clinical quality and care committee. ICB Quality Lead invited to meeting to review

10. Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Incident resulting in moderate or above harm	Swarm Huddle and PSII - as soon as possible after the patient safety incident identified.	Led by a PSIRF Learning Response Lead. Completed within 1 month from start date. Reviewed by patient safety team with oversight from risk meeting and escalation to clinical quality where needed. Involvement of patient/client/relatives and staff in developing safety actions and improvement plans ICB Quality Lead invited to meet to review
Incident that had potential to result in moderate to severe harm to patient	After action review	Analysis of work as planned/work as done through observational and walk through tools. Developing Safety Actions and improvement plans where needed
New / Deteriorating Pressure Ulcer Category 3 or above and multiple grade 2. DTI's once they break skin or fail to resolve and/or it is evident that deep tissue damage is present	After Action Review (AAR) – as soon as possible after incident identified	Led by Service Matron, manager or Tissue Viability Link Nurse Notification to Care Quality Commission (CQC) Reviewed by patient safety group and tissue viability group.
Medication level 0-2	After Action Review (AAR) – as soon as possible after incident identified	Led by Service Matron, Ward Manager, Medical Director or prescribing Nurse. Completed within 5 days from start date Reviewed by patient safety team

	Biannual thematic analysis as routine	Summary reviewed by Medicines Management group. All Controlled Drug incidents submitted to NHSE via CD reporting website by CDAO.
Slip trip, falls no and low harm	After Action Review (AAR) – as soon as possible after incident identified	Led by Service Matron, Ward Manager or Falls Link Nurse. Completed within 5 days from start date Reviewed by patient safety team and falls group. Thematic analysis annually at least.
Increase or multiple theme incidents identified as need for further investigation	MDT review SEIPS	Led by a PSIRF Learning Response Lead. Completed within 1 month from start date. Reviewed by patient safety team May involve multiple stakeholders including patient representatives.
Delayed or failed admission, discharge or transfer into community	After Action Review (AAR) – as soon as possible after incident identified	Led by Service Matron, Ward Manager or Deputy. Completed within 5 days from start date Reviewed by patient safety team.
IT/Information Governance (IG) incident resulting in data breach	After Action Review (AAR) – as soon as possible after incident identified	Led by Data Protection Officer. Completed within 5 days from start date Reviewed by Information Governance Committee quarterly.
Theme identified by Hospice Patient Safety Group as requiring further Investigation	Thematic Review Horizon Scanning	Learning from Incident Response Developing Safety Actions Improvement Plans.
Good or positive examples of care	After Action Review (AAR) – as soon as possible after good practice identified	Led by PSIRF Learning Response Lead. Completed within 5 days. Reviewed by patient safety review team and disseminated to wider staff through patient safety bulletins and team meetings, and Friday round ups.

11. Tools for patient safety review of incidents

After Action Review (AAR)

An After-Action Review (AAR) is 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 tasks to avoid failure and promote success for the future.

Multidisciplinary Team (MDT) review

The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

Patient Safety Incident Investigation (PSII)

A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Swarm Huddle

Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Thematic Review

A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can use qualitative (e.g. open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) as well as quantitative data to identify safety themes and issues.

SEIPS

SEIPS (System Engineering Initiative for Patient Safety (SEIPS) is a framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool (eg. to guide how we learn and improve following a patient safety incident, to conduct a horizon scan, and to inform system design).

In addition to the responses outlined in the table above Havens Hospices is already committed to and will continue to:

- Review all pressure injuries category 2 or above obtained while solely in our care at our tissue viability meeting
- Review all falls in our monthly falls meeting

- Carry out a 6 monthly desk top thematic review of all medication incidents

12. Updating this plan

In the years ahead, post 24-month roll-out, Havens will use up to date data and insight from stakeholders to inform potential future categories for local patient safety incident investigation and system improvement.

Key stakeholders for this work would include

- Commissioners
- Members of staff
- Care committee
- Medical consultant team
- Patients, families and carers
- NHS England/ national patient safety team

The plan will be updated biannually taking these insights into account and addressing new emerging patient safety risks where needed.

13. Links and references

NHS England patient safety learning response toolkit [NHS England » Patient safety learning response toolkit]

14. Additional Information and Help

For advice on any aspect of this policy/procedure document, please contact:

Rachael Marchant

Medical Director

Havens Hospices