Prospect Hospice
together making every day count

Patient Safety Incident Response Plan

1 Foreword

Prospect Hospice has focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

We have made significant progress over the past few years in developing and fostering a restorative just culture in which people feel psychologically safe in reporting incidents and concerns. We recognise that a supportive patient safety culture enables individuals to openly talk about and raise patient safety concerns, without fear of blame, reprimand, or intimidation, ensuring teams, and the broader NHS, can learn from patient safety events to make care safer.

It helps to shift to a just and restorative culture where the focus is on understanding and learning. This maximizes opportunities for learning, so underlying issues around safe systems and ways of working can be identified and addressed.

We recognise that changing culture is complex, and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak.

PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture where people are confident about patient safety events and to simply express their opinion. The hospice also has a PSIRF policy which supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Prospect Hospice's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

2 Introduction

Prospect Hospice is a centre of excellence for end of life and palliative care for Swindon and north Wiltshire. Our commitment is that each patient is treated with respect and dignity and most importantly of all, as a person.

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a patient safety incident occurs. It is a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP) and sets out how Prospect Hospice will respond to patient safety incidents.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Incident Framework which focuses more on process than emphasising a culture of continuous improvement in patient safety. This framework is designed to focus on collaboratively doing investigations, led by those trained to conduct them. It ensures the involvement of patients, their carers, families, and staff in an embedded system that responds in the right way, appropriate to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with an emphasis on systemic improvement.

Essential to this, has been fostering a patient safety culture in which people feel safe to talk. The latest staff survey showed that staff felt they were able to make suggestions and make improvements to their area of work, care for patients is the top priority, and staff felt secure if they needed to raise concerns.

Prospect Hospice recognises the benefits of carrying out investigating incidents with the main objective being to learn and further improve, but also to share findings, speak with those involved, work in collaboration with staff when developing changes for improvements, validate the decisions made in caring for patients and facilitate psychological closure for those involved.

Analysis of our current systems has improved our understanding of our patient safety processes and allowed us to use these insights to develop our Patient Safety Incident Response Plan (PSIRP).

3 Scope

There are many ways to respond to an incident. Our PSIRP covers responses conducted solely for the purposes of systems-based learning and improvement.

Patient safety incidents are any unintended or unexpected incident that could have, or did, lead to harm for one or more patient's receiving healthcare.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims, and inquests.

4 Resources

The resources needed to support this plan, are as follows:

- Capacity to ensure training is undertaken as dictated under PSIRF.
- Capability and capacity to enable staff to develop and learn to ensure further improvements are in place.
- Capability and capacity to allow staff to undertake responses outlined below.
- Capacity to implement and monitor safety actions.
- Capacity for the members of the new quarterly response and learning meetings to work effectively to ensure the terms of reference are being met.

5 Defining our patient safety incident profile

To determine any priority areas to support the delivery of the new PSIRP, an understanding of the scale of patient related safety activity was required.

We used a thematic analysis approach to determine which areas of patient safety activity we focused to identify our patient safety priorities. Data and information from a variety of sources has been gathered.

In the last year (April 2022 to March 2023), there have been 101 patient safety incidents with two of these being investigated as a Serious Incident, as per the Serious Incident Framework. In this time, we have not had any deaths or never events. The breakdown of the incidents which have been identified as a priority for Prospect Hospice were as follows:

- Falls - there were 23 reported in this period with one reported as severe, one reported as moderate, the remainder rated as no or low harm.
- Pressure ulcers – there were 28 new pressure ulcers reported of which 14 were graded as category 2 and 2 graded as category 3.

There have been no clinical negligence claims, inquests, or PALS-related enquiries. There were eight complaints for the period April 2022 to March 2023 were, but there were no common themes from this analysis.

The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting for many years. As locally defined priorities, PSIRF allows us to focus on these risks with our framework for patient safety incident response.

6 Our Patient Safety Incident Response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) require a locally led PSII. Any incidents which require a PSII will need to be reported to the Integrated Care Board.

Table 1 below sets out the local or national mandated responses.

	National priority	Response
1	Incidents that meet the criteria set in the never events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led
3	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR review
4	Safeguarding incidents in which:	Refer to local authority safeguarding lead.

	National priority	Response
	Babies, children, and 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 by their local authority. The incident relates to FGM, prevent radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews, and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local safeguarding adults boards
5	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 (incidents meeting the learning from deaths criteria)	Locally led PSII in which the event occurred with STG/ESTH participation if required
6	Mental health-related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII. Locally led PSII may be required with mental health. provider as lead and STG / ESTH participation
7	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. When the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

7 Our Patient Safety Incident Response plan: local focus

Patient safety incident response activity can be divided into three overarching categories depending on the key objective, the three being:

- learning to inform improvement (where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome),
- improvement based on learning (where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local

improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation,
- assessment to determine required response (for issues or incidents where it is not clear whether a learning response is required).

Patient safety incident type or issue	Planned response and improvement route
Patient falls - moderate and severe harm incidents.	**Learning to inform improvement** - Hot debrief to be performed immediately after a fall and after-action review (AAR) no more than five days following a fall. Where an incident occurs and contributory factors are not well understood, a safety actions plan will be drawn up. Where a subsequent incident occurs, the safety actions for this will be compared with the previous incident's safety action plan and will inform an overarching safety improvement plan. **Improvement based on learning** - for falls whereby a patient has fallen more than once, a thematic review will take place.
Pressure ulcers – Grade 3 and Grade 4 (new)	**Improvement based on learning** - Themes analysis. Where an incident occurs and contributory factors are not well understood, a safety actions plan will be drawn up. Where a subsequent incident occurs, the safety actions for this will be compared with the previous incident's safety action plan and will inform an overarching safety improvement plan.
Pressure Ulcers grade 2 (new)	**Improvement based on learning** - Themes analysis. Continue to monitor and update as appropriate and review themes at quarterly incident response and learning meetings.

Exploring everyday work, to supplement finding out what happened, will be considered as it is recognised that this shifts the focus from developing quick fixes to understanding wider system influences and is central to any learning response conducted to inform improvement.

Prospect Hospice in response to PSIRF has set up quarterly incident response and learning meetings which will undertake themes analysis and review themes from learning. They will also provide assurance that learning, and quality improvement changes have been embedded in identified cases. The incident response decision-making flow chart will also be used to determine future responses – see annex 2.

This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk or incidents that don't fall into the outlines national or local categories. Prospect Hospice will take a pragmatic approach and a proportionate response to maximise learning.

8 Review of the plan

Prospect Hospice will review this plan every 12-18 months in line with national guidance. If there is a change to the plan, Prospect Hospice will notify the ICB to agree to sign off on the change. Where there is a cluster or unexpected significant number of incidents, ICB may ask for an earlier review of the plan as appropriate. A review will take place with key stakeholders as required.

Annex 1 - 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 effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will conduct 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. The benefit of this is to enable learning together and to balance effort between learning and responding to incidents or exploring issues and improvement work.

AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.
It is based around four questions:

- What was the expected outcome/expected to happen?
- What was the actual outcome/what actually happened?
- What was the difference between the expected outcome and the event?
- What is the learning?

Thematic Review

A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The 'top tips' document provides guidance on how to approach a thematic review.

Never event

Patient safety incidents that are considered to be 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' 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 plan or following reported concerns about care or service delivery.

SEIPS – Systems Engineering Initiative for Patient Safety

Systems Engineering Initiative for Patient Safety (SEIPS), helps investigators to consider the full range of contributory factors across a system and to identify important findings. Considering the hierarchy of controls, recommendations should be targeted at system changes which are more likely to produce sustained safety improvements, rather than at individual behaviours or training, which are less likely to influence future safety. Systems-based safety investigations can positively influence safety culture in organisations.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues for example, reviewing output from learning responses undertaken in relation to single incidents collectively when it is felt that there is sufficient understanding of the underlying, interlinked system issues.

Safety actions

Developing safety actions that respond to underlying system issues starts with identifying and understanding aspects of the work system that need to change to reduce risk and potential for harm (i.e. areas for improvement or system issues). Actions to reduce risk (i.e. safety actions) are then generated in relation to each defined area for improvement. Organisations should seek to reduce duplicative and/or disconnected safety actions, for example, by maintaining a wider safety action log that is referred to when developing safety actions and/or conducting regular reviews of ongoing safety actions as part of patient safety incident response planning.

Annex 2 – Incident response Decision Flowchart