Princess Alice Hospice

Patient safety incident response plan

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Contents

Introduction

This patient safety incident response plan sets out how Princess Alice Hospice intends to respond to patient safety incidents over a period of 18 months.

The plan has been designed with flexibility in mind, allowing for a range of learning responses to be used in response to incidents that impact on the care we provide. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

Our services

Who are we?

Princess Alice Hospice is a charity providing free specialist palliative care services to adult patients with life limiting conditions. We support people and their loved ones in parts of Surrey, South West London and Middlesex covering a population of over 1 million people. We are commissioned to provide end of life care services by NHS Surrey Heartlands ICB and NHS South West London ICB.

Our multi-professional team support patients and their loved ones across three different care settings:

In-Patient Unit

We have a 20 bedded in patient unit at our hospice site in Esher. Here, we offer short term admissions for those requiring support for complex symptom management at the end of their life.

Hospice at Home

Our team of clinical nurse specialists, doctors, social workers, therapists and support workers provide expert advice and support for those with life limiting conditions at home. We work alongside other community healthcare professionals such as GPs and district nursing teams to provide effective symptom control and recommendations about care.

Wellbeing Centre

A service offering group and individual sessions to improve symptom control. We offer both face to face and online sessions. We also offer services to support the emotional and practical needs of carers and loved ones of our patients.

How do our strategic aims link to the Patient Safety Incident Response Framework (PSIRF)?

The following table shows how our strategic priorities link closely to the aims of PSIRF. We have identified how adopting PSIRF will help us towards achieving these priorities and improving care.

Table 1. Princess Alice Hospice strategic priorities and PSIRF aims

Princess Alice Hospice strategic priorities	PSIRF aims	How do they link?
Developing and expanding our specialist care	Application of a range of system-based approaches to learning from patient safety incidents Considered and proportionate responses to patient safety incidents	Using a range of learning responses to support incident investigation will help to deepen understanding about how and why things go wrong. This in turn will help to improve our specialist care, and the delivery model of that care. Proportionate responses allow for the appropriate allocation of time and resource on investigations and learning, leading to more opportunity for developing and expanding care.
Empowering people in our communities who are caring for people at the end of life	Compassionate engagement and involvement of those affected by patient safety incidents Considered and proportionate responses to patient safety incidents	Having a greater focus on engaging those involved in patient safety incidents will empower those we care for. It will also ensure that learning focuses on what really matters to people in our communities. It will allow us to ensure that services are developed with the diversity of thought needed to truly represent the communities in our care area, and beyond. It will allow us to apply learning in other services, in addition to the commissioned services that we provide as part of our charitable objectives, e.g. Compassionate neighbours and bereavement.
Enhancing our education, research and learning programmes to encourage and support an environment for innovation.	Application of a range of system-based approaches to learning from patient safety incidents	Upskilling staff and those who investigate patient incidents to use different approaches, including SEIPS to improve effective learning post incidents. Expanding the training on the investigation methodologies to support incident investigation in other areas of the business, such as fundraising and retail.
Enhancing our collaborative influence in palliative and end of life care through leadership and advocacy	Supportive oversight focused on strengthening response system functioning and improvement	Oversight focusing on strengthening systems as a result of an incident will improve the service for all. Collaborating and sharing with stakeholders may help to share improvements further than our immediate reach. These stakeholders would include other healthcare organisations locally, but also regional and national hospice networks and providers.

Defining our patient safety incident profile

Stakeholder Engagement

We engaged with key stakeholders both internally and externally to support and develop our existing knowledge around our safety incident profile. We also worked with the stakeholders to develop our plan.

- Quality Improvement, Development & Patient Safety Committee

Our internal clinical governance and oversight committee for senior clinical leads and the clinical directors, responsible for reviewing clinical activity, incidents and risk. Sub committees focusing on medicines management, tissue viability, falls and clinical audit formally report into this group.

- Clinical & Community Quality Assurance Committee

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 against the annual business plan, raising issues to the Board where necessary.

- Health and Safety Committee

Our internal committee that considers health and safety issues and oversee the reporting on Vantage, our incident reporting system.

- Local Hospice Networks

Quality leads within Surrey hospices, and hospices within the South East of England have collaborated to discuss incident profiles and training discussions. There has also been participation in national Hospice specific conversations, through Hospice UK.

- Patient and public involvement

The developing plan was shared with the Princess Alice Hospice volunteer forum, made of twenty five local people, nine of whom had lived experience of our clinical services as a carer / loved one of someone who was previously under hospice care. The forum members expressed recommendations on the sharing of incident outcomes within the organisation and externally which was been incorporated into the plan (detailed in the existing and planned improvement work section of this plan).

Reviewing Incident Data

2 year's worth of incident data was reviewed from the following sources:

- Incident data recorded on Vantage, our incident reporting system
- Safeguarding Concerns, recorded on our internal safeguarding log

- Pharmacy reported errors – focusing on prescribing and drug charts, recorded on our pharmacy reporting system (LiveView)
- Complaints
- Staff interviews

The data analysis showed the following spread of patient related incidents as described in table 2. Where safeguarding concerns were related to care provided by Princess Alice Hospice (e.g. Medication errors) the data has been collated into the overarching theme. In some cases, incidents were identified and reported by staff at Princess Alice Hospice, but were not caused by the action of Princess Alice Hospice staff or systems (e.g. some safeguarding incidents, GP prescribing errors). In these cases, the data has not been included in the analysis. The only exception to this is pre admission pressure ulcers, which have been included as they are the greatest contributor to patient safety incident recording at Princess Alice Hospice.

Table 2. Occurrence of patient safety incidents at Princess Alice Hospice (April 2021 – March 2023)

Patient Safety Incident type (n = 661)	Percentage
Pre-admission pressure ulcers	29%
Inpatient medication errors	25%
Post admission pressure ulcers	14%
IPU falls	14%
Confidentiality errors	7%
Faulty equipment	3%
Offsite medication errors	2%
IT / Electronic patient records/ Video communication / Telephony	2%
Moving and handling	2%
Other	2%

Defining our patient safety improvement profile

Identifying PSIRF roles and responsibilities

As part of applying the principles of PSIRF at Princess Alice Hospice, we have identified relevant individuals for the defined roles:

PSIRF Oversight Roles:

- Director of Patient Care and Communities (PSIRF Executive Lead)
- Medical Director
- Named individuals on the Board, including the Chair of Clinical and Communities Quality Assurance Committee

Learning Response Leads:

- Head of Quality and Assurance
- IPU Practice and Quality Nursing Lead
- Associate Director of Patient Care and Communities

Patient and Public Engagement Leads:

- Head of IPU
- Quality Officer

In addition to these roles, we will be introducing a new volunteer Patient Safety Partner into the organisation. They will contribute to the development of action plans following investigations, focusing on actions that address the needs and preferences of patients and our local population. We intend to recruit the Patient Safety Partner by July 2024. More information about the Patient Safety Partner role can be found in the PSIRF Policy.

Training

To support the effective role out of PSIRF at Princess Alice Hospice, the identified staff and volunteers above will undertake the following training (Table 3).

Table 3. Staff and volunteer training

	NHS Patient safety syllabus: Level 1 – Essentials for patient safety	NHS Patient safety syllabus: Level 2 - Access to Practice	In house SEIPS training	Systems approach to learning	Involving those affected by patient safety incidents in the learning process	Systems approach to Learning – Oversight
Those without PSIRF defined roles						
All Clinical Staff	✓	(✓)				
Clinical staff involved in low level incident investigations (ie not leading PSIRF learning responses)	✓	(✓)	✓			
PSIRF defined roles						
Those in oversight roles	✓*	✓		✓	✓	✓
Learning response leads	✓	✓		✓		
Patient and public engagement leads	✓	✓			✓	
Patient Safety Partner	✓	✓				

* Level 1 for boards and senior leadership teams

(✓) Optional access

Those with PSIRF defined roles have already completed the specified training in Table 3, with the exception of those in oversight roles who have been unable to access the 'Involving those affected by patient safety incidents' training due to limited access options for independent providers. Our 2 identified engagement leads have attended this course from a recommended provider and have shared their learning with others in Oversight Positions.

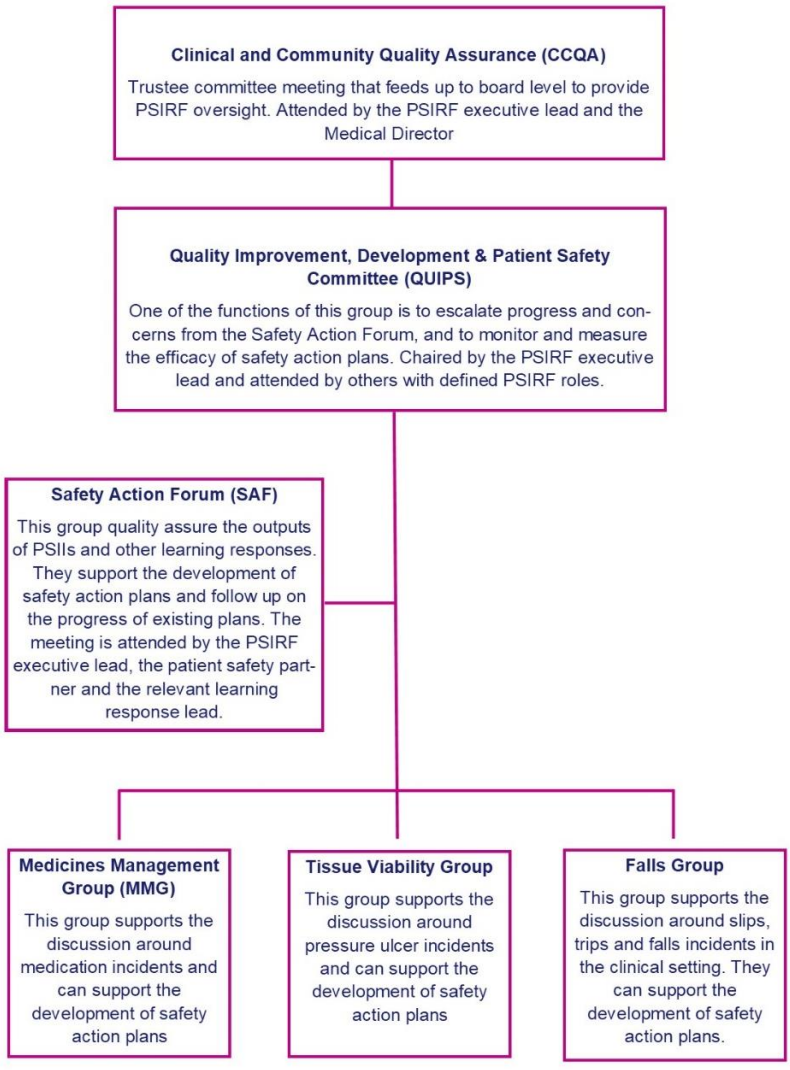
Those without PSIRF defined roles will be required to complete the Level 1 of the Patient Safety Syllabus (Essentials for Patient Safety) by March 2025. This timeframe has been implemented with other organisation wide training priorities in mind. It is not anticipated that this will impact on the transition to PSIRF. In house SEIPS training is underway for clinical staff involved in low level investigations, with all staff being trained by the end of May 2024.

Governance structures around patient safety

Outcomes, or grouped outcomes of lower level incident reviews will come to a relevant committee for the learning, consideration of whether a higher level learning response (eg. PSII) is required and for discussion on safety action planning.

Incidents that require a PSIRF style learning response will come to the Safety Action Forum (SAF) for safety action planning and quality assurance of the investigation itself. SAF is attended by the PSIRF executive lead, the medical director and the patient safety partner. The relevant engagement lead will also be present to represent the patient and their loved ones. It will also be attended by the relevant learning response leads. Progress with Safety Action Plans will be discussed here and escalated to Quality Improvement, Development and Patient Safety Committee (QUIPS). The efficacy of safety action plan outcomes will be monitored by QUIPS.

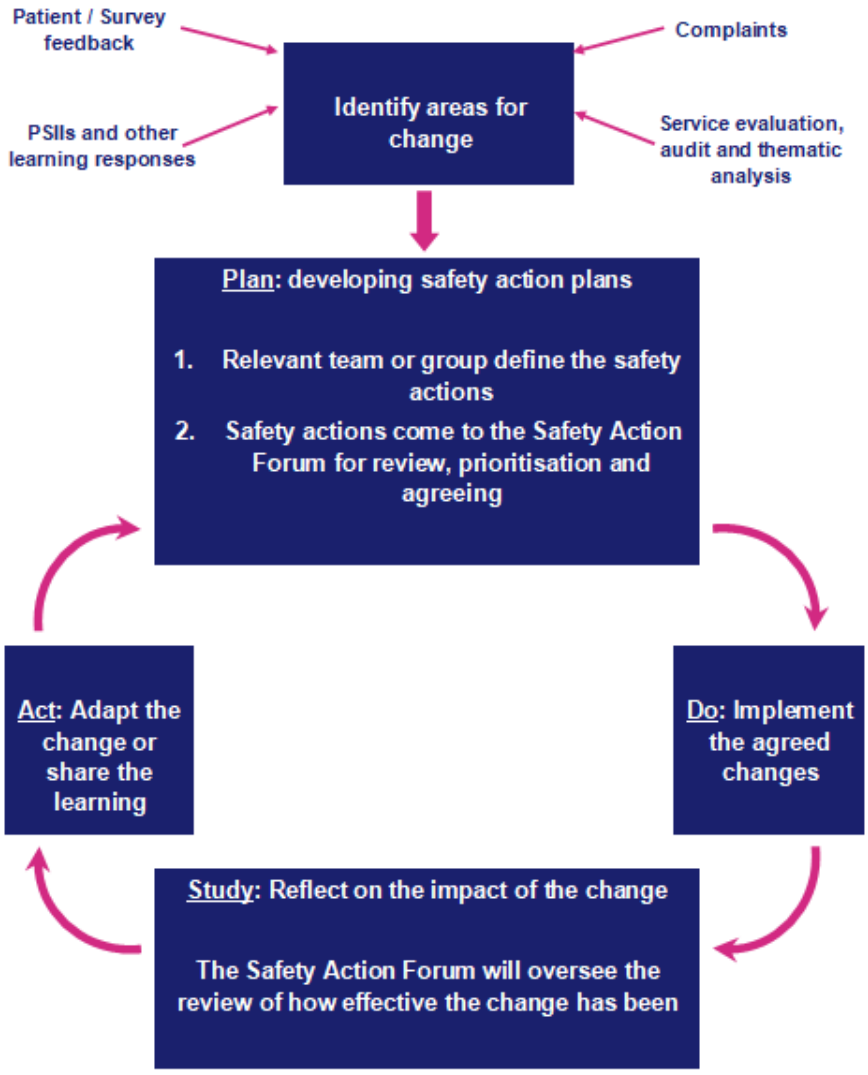
CCQA is a sub-committee of the Board of Trustees. It will provide overall oversight for PSIRF, including providing assurances on the adoption of just culture at Princess Alice Hospice. More detail about governance around PSIRF can be found in Appendix 7 in the PSIRF policy.



Patient Safety Work: Our Approach to Improvement Work

The following diagram shows a summary of Princess Alice Hospice's approach to defining and implementing quality improvement work. A Plan, Do, Study, Act approach is taken at the hospice towards quality improvement projects. For larger identified projects, support will be sought from the Head of Service Design and Continuous Improvement. Oversight of projects will occur both at the SAF and at QUIPS. Significant improvement projects will be put onto the organisational 'Project Tracker' which will have additional oversight from the Senior Leadership Team.

Testing the efficacy of an implemented plan will be the responsibility of SAF as part of the 'Study' action. Appropriate measures to test the effectiveness of a safety action will be identified. As part of the 'Act' action, we will decide if the action should continue to remain or be abandoned. We will share the learning and outcomes of the improvement work internally, but also with other hospice colleagues, commissioners and networks as we see appropriate.



Patient Safety Work: Existing and Planned Improvement Work

Improvement work	Description
Re-design of Incident Reporting System (Vantage)	Review of reporting template to improve data collection at point of reporting. This will improve the incident review process for those reviewing incidents that do not meet the criteria for a PSIRF response, but still require a lower level of investigation.
Patient safety as part of the induction programme for all new starters within clinical services	In addition to the Patient Safety Syllabus training that all existing and new staff will complete, all new starters in clinical roles will meet with a PSIRF lead to help embed the organisation's stance on just culture and patient safety.
Using local PSIRF networks	Joining a PSIRF network for independent providers – to share learning and support effective roll out of using PSIRF methodology
Using statistical process control when reviewing clinical incident occurrences	Reviewing patient safety and quality metrics using statistical process control will help to identify where trends in incident occurrences may be occurring, or where spikes in occurrences outside of normal variation is occurring. This will help with oversight of incidents from both Quality Improvement, Development and Patient Safety Committee (QUIPS) and Clinical Communities and Quality Assurance Committee (CCQA), but additionally, support learning response leads to know where additional investigation may be required.
Supporting other parts of the organisation to understand PSIRF and how learning responses can improve outcomes	Via appropriate forums within the organisation (eg. Other committees such as information governance and the Extended Leadership Group) share the different learning response methodologies so that other areas of the business (that do not provide care / regulated activities) can also benefit from this approach.
Increase collection of patient feedback and experience data.	In the last year we have relaunched the VOICES survey which is a validated survey used in palliative care to collect the feedback and experience of bereaved people who loved ones were under the care of the hospice. We will focus on collating and utilising the data from this survey to help us understand feedback in those for whom safety incidents didn't occur. It will provide us with a broader picture of what it is like to be under the care of the hospice and identify where changes in care may be beneficial. We will look at the full suite feedback: comments, concerns, complaints and compliments.
Sharing the actions and improvements of incident reviews.	Via our website, we plan to communication actions and improvements in care that have occurred due to complaint reviews or incident reviews.

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
Death thought more likely than not due to problems in care	If it is an identified problem in care from Princess Alice Hospice, a PSII should be carried out by learning response lead. The death should also be referred to the medical examiner +/- coroner. The investigation should be commenced as soon as possible after the incident has been identified. In the event that the problems in care occurred prior to transfer to the Hospice, the death should be referred to the medical examiner +/- coroner. The Patient safety teams at the relevant organisation should be contacted so that they can commence their own investigation which can be supported by a Princess Alice Hospice learning response lead.	ICB Quality Lead / Patient Safety Specialist to be invited to a SAF review meeting. Sharing should be provided if they are unable to attend. Findings and action plan to come to QUIPS and CCQA for oversight. In the event that problems in care occurred before hospice admission, ask relevant organisation to share learning for relevant points to be discussed at relevant committees for action (ie QUIPS).
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	If it is an identified problem in care from Princess Alice Hospice, a PSII should be carried out by learning response lead. The death should also be referred to the medical examiner +/- coroner. The investigation should be commenced as soon as possible after the incident has been identified.	ICB Quality Lead / Patient Safety Specialist to be invited to a SAF review meeting. Sharing should be provided if they are unable to attend. Findings and action plan to come to QUIPS and CCQA for oversight.

	In the event that the problems in care occurred prior to transfer to the Hospice, the death should be referred to the medical examiner +/- coroner. The Patient safety teams / PSIRF leads at the relevant organisation should be contacted so that they can commence their own PSII, which can be supported by a Princess Alice Hospice learning response lead.	In the event that problems in care occurred before hospice admission, ask relevant organisation to share learning for relevant points to be discussed at relevant committees for action (ie QUIPS).
Incidents meeting the Never Events criteria, as defined by NHS England	A PSII should be carried out by the learning response lead	Safety action plan should be developed in SAF. Action plan to come to relevant oversight committee (QUIPS +/- CCQA) for oversight.
Deaths of people with learning disabilities	Complete National LeDeR notifications for deaths of any patients with learning disabilities and/or autism. Support the ICBs Disability Mortality Review (LeDeR) if need identified. Where other criteria is met for completion of PSII (eg never event), then it should be completed by Princess Alice Hospice learning response leads in collaboration with the ICS LeDeR team.	Safety action plan should be developed in SAF. Action plan to come to the relevant oversight committee (QUIPS +/- CCQA). Information also to be shared with equality and diversity lead at Princess Alice Hospice.
Safeguarding incidents	Refer to the relevant local safeguarding authority. Contribute towards safeguarding investigation from local authority as required. If care or Princess Alice Hospice involvement has contributed to a safeguarding event, for involvement from a learning response lead, and possible PSII.	Safety action plan should be developed in SAF. Relevant findings and actions to come to the Princess Alice Hospice safeguarding forum. Action plan to come to relevant oversight committee (QUIPS +/- CCQA) for oversight.

There are other events that have a recommended response (mental health related homicide, maternity and neonatal incidents, child deaths, deaths in NHS screening programmes, death in custody and domestic custody). These have not been separately stated in this PSIRP as they are

unlikely to occur due to the nature of care offered by Princess Alice Hospice. Should such an event occur, the recommended action set out by NHS England will be followed.

Our patient safety incident response plan: local focus

Local criteria for instigating a learning response

All clinical incidents should have an initial review on Vantage using the pre-set investigation template. The initial investigation should be done with the System Engineering Initiative for Patient Safety (SEIPS) framework in mind, to support effective investigation.

Historically, 'in depth' investigations have been reserved for incidents leading to moderate harm, or above. In designing our local focus, we will consider the following criteria:

Criteria	Examples
Potential for learning	• There is a potential to inform improvement • Initial review suggests there may be system wide factors that have contributed to the incident • Impact on quality of care, or the capacity/delivery of service
Likelihood for reoccurrence	• 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 as defined below.

Patient safety incident type or issue	Planned response	Anticipated improvement route
FALLS: All falls on the Inpatient Unit	Swarm huddle as soon as possible after the event (same day). Thematic analysis of falls	Immediate huddle to mitigate risks Themes of fall to be pulled by learning response lead and collated, using a SEIPS approach. Analysis of thematic data to be supported by the Service evaluation and audit committee. Learning to come SAF to generate an appropriate action plan, with the support of the falls group. Then to come to QUIPS for oversight.

FALLS: Falls on the Inpatient unit that meet local criteria after initial mitigation from the swarm huddle	PSII to follow the initial swarm huddle	PSII by learning response lead SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SAF and Falls group for development of action plan. Then to QUIPS for oversight.
MEDICATION INCIDENTS: Medication incidents that meet local criteria	After Action Review MDT review with thematic analysis PSII	Investigation will be led by a learning response lead. SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SAF and Medicines Management Group for development of action plan. Then to QUIPS for oversight.
PRESSURE ULCERS: Pressure Ulcers that meet local criteria	MDT review PSII	Investigation will be led by a learning response lead. SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SAF and Tissue Viability Group for development of action plan. Then to QUIPS for oversight.
HOSPICE AT HOME: Clinical incident within the Hospice at Home service that meet local criteria	After Action Review MDT review PSII	From our 2 year incident review, we know that fewer incidents occur in our hospice at home service. In view of this, we need to take a pragmatic approach to identifying the incident response type, which will be dependent on the incident itself. Outcomes of the investigation will come back to the relevant subcommittee of QUIPS and SAF for agreement of the action plan. Due to the multiagency nature of hospice at home work, the investigation may be shared directly with patient safety leads at other relevant organisations (e.g. relevant hospital trust, community provider).

Where there is a choice of more than one learning response methodology, the three trained learning response leads will come together to make a decision on which methodology is most appropriate. They will give consideration to the information already collected as part of the baseline Vantage investigation when making their choice, which includes the SEIPS framework.

Infection Control and Prevention incidents

Although our retrospective review of incidents does not reflect healthcare acquired infections (HCAIs) to be a known/existing issue at Princess Alice Hospice, due to the significant nature of these and potential impact on the inpatient clinical setting, we will complete a PSII or After Action Review in response to episodes of HCAIs where we consider there is wider learning and/or the potential for recurrent similar episodes to occur. The investigation will be completed by a learning response lead in conjunction with the Infection Prevention and Control (IPC) lead for the hospice. Outcomes of the investigation will be fed back to QUIPS for oversight. This will not change our methods for mandatory reporting.

Episodes of good or positive care

Reviewing episodes of good or positive care can inform safety action planning, to help achieve consistent, improved care. At Princess Alice Hospice, we have a number of diversity and inclusion workstreams looking at improving care, and access to care for those we currently underserve. We are particularly interested in reviewing cases that are good examples of care offered to:

- People with learning disabilities
- Ethnic minorities
- People experiencing homelessness
- LGBTQIA+ community
- People with dementia and their carers
- People for whom English is not their preferred language and people with barriers to communication.

Cases can be identified by any clinical staff (via our routine collection of good care examples, as well as stories shared routinely at our internal clinical governance meetings). An after action review or MDT review will be completed by a learning response lead. The case will be presented to the Safety Action Forum for action planning, monitoring and oversight.

Appendix 1: Glossary

- After Action Review (AAR):

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.

- Care Quality Commission (CQC):

The regulators for health care services

- Clinical & Community Quality Assurance Committee (CCQA):

A clinical sub-committee of the Board, attended by trustees, board advisors and some staff in positions that provide oversight regarding PSIRF.

- Health Care Acquired Infection (HCAI)

Infections that can develop as a direct result of healthcare interventions, such as medical or surgical treatments, or from being in contact with a healthcare setting. These infections cover a wide range of conditions and pose a serious risk to patients, staff, and visitors. Examples include methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile).

- Infection Prevention Control (IPC)

The approach which health care settings take to prevent the transmission of avoidable infections, including health care acquired infections.

- Multidisciplinary team (MDT) review:

A discussion with multiple professionals to understand incidents and why the outcomes differed from the expected. The MDT review can be used to look at groups of incidents rather than single episodes. Can be used to understand the "work as done" when it may be more difficult to collect staff recollections.

- Patient Safety Incident Response Framework (PSIRF):

The NHS's approach to handling patient safety incidents. This approach replaces the previous Serious Incident Framework and represents a significant shift in how the NHS responds to incidents.

- Patient Safety Incident Investigation (PSII):

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

- Quality Improvement, Development & Patient Safety Committee (QUIPS):

A committee that provides oversight for clinical issues, incidents and development at Princess Alice Hospice. It is chaired by the Director for Patient Care & Communities, who is the PSIRF Executive Lead.

- Safety Action Forum (SAF):

A clinical group responsible for developing safety action plans following a learning response, in particular PSIIs. The meeting is attended by those in a position to provide PSIRF oversight, the learning response lead, the engagement lead (to represent the perspective of the patient / family) and the Patient Safety Partner.

- Swarm Huddle:

A meeting that occurs immediately after an event happens. Staff 'swarm' to the site to quickly analyse what happened and how. They decide what needs to be done to reduce risk.

- System Engineering Initiative for Patient Safety (SEIPS) Framework:

A framework that helps you understand how a multifactorial work system may have contributed to a process (work as done) and the eventual outcome.

- Thematic Analysis:

Collating themes from similar incident reviews / observations to identify common themes that may contribute to the risk of those incidents occurring again.