Patient Safety Incident Response Plan

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Version control

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001			New document launch.

Because no one should face death or grief alone

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Regulations and standards

Health and Social Care Act 2012	Regulation 12: Safe care and treatment	Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.
	Regulation 17: Good governance	To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. This must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.
	Regulation 20: Duty of candour	The duty of candour requires registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also define 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.
NHSE (National Health Service England)	The NHS Patient Safety Strategy	The NHS Patient Safety Strategy set out how the NHS will support staff and providers to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety.

Organisational objectives and values

Organisational objectives:		Sue Ryder values:		
Better grief support for everyone		Supportive	Equality, diversity and inclusion	
			Our people	☑
Helping people who are dying live well	☑	Connected	Working collaboratively	☑
			Our supporters and volunteers	

Speaking up for people who are dying or grieving	☑	Impactful	Putting people who are grieving or living with a life-limiting condition at the heart of our work	☑
			A sustainable organisation	

Equality statement

Sue Ryder aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been screened and relevant changes made to the policy to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Related Sue Ryder written control documents

This written control document is related to the following written controls within Sue Ryder.

Written control document	Date accessed
Patient Safety Incident Response Policy	March 2024

Patient Safety Incident Response Plan

1. Introduction

1.1 The Patient Safety Incident Response Plan (PSIRP) sets out how Sue Ryder intends to respond to patient safety incidents over a period of 12 months or sooner if required.

1.2 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.

2. Our services

2.1 Sue Ryder offers specialist palliative care and bereavement support services. Our specialist palliative services are included in this plan.

2.2 Sue Ryder services were reviewed by the type of service they provided in the first instance. This was palliative bereavement services.

2.2.1 Bereavement services do not form part of this plan.

2.3 Identification of the services provided showed that most services are based around a discrete location and the specialist nature of the service type.

2.4 The categories of incidents that each service had were reviewed alongside other indicators of quality and safety, including complaints and concerns, and staff surveys.

2.5 Our services were actively engaged through a series of workshops so that a full understanding of incidents and risks was fully understood.

2.6 Our palliative services include inpatient hospice and community services at the following locations:

- Sue Ryder Duchess of Kent Hospice, Berkshire.
- Sue Ryder Leckhampton Court Hospice, Gloucestershire.
- Sue Ryder Manorlands Hospice, Yorkshire.
- Sue Ryder St. John's Hospice, Bedfordshire.
- Sue Ryder Palliative Care Hub, South Oxfordshire.
- Sue Ryder Thorpe Hall Hospice, Cambridgeshire.
- Sue Ryder Wheatfields Hospice, Yorkshire.

2.7 Following the mapping of Sue Ryder's services, this enabled the reviewing of data and the development of the safety profiles.

3. Defining our patient safety incident profile

3.1 The plan has been developed with extensive engagement with stakeholders. This has included networking with similar organisations and importantly, frequent discussion with our services. There has been ongoing communication with external stakeholders.

3.2 Sue Ryder has undertaken networking and engagement as follows:

3.2.1 Our services have each contributed their knowledge, expertise and experience through meetings and workshops. This was a multidisciplinary approach to gather detail about incidents and learning that is not easily available in data.

3.2.2 Commissioners of our services have been engaged during the process, directly in relation to PSIRF and through the regular engagement that our services have with Integrated Care Systems/Boards.

3.2.3 Networks of similar organisations providing services.

3.2.4 Patient representatives have attended quality meetings where PSIRF has been discussed.

3.3 A variety of information and data sources that were proportionate to the organisations scope as well as meeting responsibilities under GDPR have been used to enable Sue Ryder to identify key patient safety priorities for the organisation.

3.4 Background data was produced for all hospices to support development of safety profiles. Data covered the period April 2019 to April 2023 so that comparisons could be made between recent and pre-pandemic data.

3.5 At service level the number of incidents and complaints are low.

3.6 The background data was discussed with one hospice to test how well it would support the development of profiles. Following this it was decided that although the data provides a good starting point for discussion it does not provide the granularity to identify specific themes, or the patient safety issues that 'worry' the services day to day. To address this, workshops were arranged with each service to gather the knowledge and experience needed, directly from the teams.

3.7 Data and information used to develop these priorities are:

3.7.1 Patient safety incident investigation reports.

3.7.2 Serious incident reports and lessons learned.

3.7.3 Root cause analysis – recommendations.

3.7.4 Incident data from our incident reporting system.

3.7.5 Complaints.

3.7.6 Staff survey results.

3.7.7 Data from quality visits.

3.7.8 Data from our integrated quality and performance reviews including Statistical Process Control charts which allow us to monitor service improvement.

4. Defining our patient safety improvement profile

4.1 There are numerous safety improvement and quality initiatives across the organisation, some driven locally in response to identified learning, and others led at an organisational level.

4.2 The data along with extensive engagement with Sue Ryder services has identified core priorities that are reflected in this plan.

4.3 Sue Ryder services led the process of determining their risk and safety profile and the best methods to ensure systems-based learning is achieved and shared across Sue Ryder and the wider community.

4.4 It was clear that there were small numbers of incidents, particularly in community services and as such these were included in each services safety priorities. There will be an increased focus on identification and reporting of incidents in community services.

4.5 The service-led discussions identified priorities which underpin Sue Ryder's safety priorities and learning.

4.6 Medicines

4.6.1 Human factors were raised as an important issue in relation to medicines errors. Prescribing errors were probably under-reported, particularly when a near miss. Although most medicine errors related to administration, these were often because of unclear or incorrect drug charts.

4.7 Falls

4.7.1 Some services identified more specific falls-related incidents, such as those linked to smoking status or falls where delirium was a contributory factor. There was also felt to be a link between falls and Karnofsky performance scores – a score of 20% correlated with an increased risk of falls. These locally identified links would not be possible to identify through the data on Datix.

4.8 Pressure ulcers

4.8.1 It was felt that it was not as helpful to investigate pressure ulcers that occur in the last days of life as this was a result of the dying process. As the lower graded pressure ulcers tended to occur mostly in patients admitted for symptom control, it would be more beneficial to focus the learning on these. Moisture associated skin damage could also be included because; although fewer in number, these have potential for harm. One hospice raised whether pressure ulcers acquired prior to admission needed to be investigated and if they could be reported as a notification on Datix.

4.9 Near miss

4.9.1 Services felt that there were potentially a lot of unreported near misses relating to medicines and prescribing as these tend to be resolved promptly with no concerns. It was felt that reporting via Datix is lengthy which can deter people in reporting near misses. More guidance on what constitutes a near miss would be helpful to improve recognition of when to report and to ensure the standardisation of reporting.

4.10 Safety culture

4.10.1 All services felt they had a good safety culture with reporting incidents on Datix, although more work was needed to improve reporting of near misses and incidents that occur in community services. In some areas there may be a different reporting culture between different staffing groups (e.g. medical, nursing, other clinical staff).

4.10.2 It was recognised that leadership is key to learning from incidents and the senior post vacancies at some services had been a barrier to this. Training and competency are important and it was raised that assessing people's skills once year is not enough. The

structured induction implemented at Duchess of Kent has made a difference in how staff competency is measured as well as supporting new starters.

4.10.3 Identifying potential for harm and likelihood of occurrence was discussed at all workshops. It was suggested at one service that these fields on Datix could be used as a trigger for identifying incidents for learning. Other hospices felt that these were too subjective as staff perceive the risk differently. A correct judgement on risk and harm level is dependent on the skills and knowledge of the reporter.

4.11 Community incidents

4.11.1 Generally, reporting of incidents is low across community services – partly because there are fewer incidents identified, but also because patients are generally under the care of another service (e.g. district nursing). It was felt that community services needed additional support in recognising and reporting incidents.

4.12 Environment

4.12.1 There was a recognition that the environment can have an impact on patient safety, with most services mentioning the layout of the building in general and specifically the inpatient unit (IPU). Issues highlighted included poor visibility of patients' rooms from the nurses' station, rooms without ensuite facilities having implications for those with mobility problems, stairs, narrow corridors so beds cannot be moved, poor ventilation etc.

4.13 Equipment

4.13.1 Some issues were raised about certain equipment that hospices do not own and must hire, such as bariatric equipment. There can often be a delay in receiving these which means a delay in the patient being admitted. Servicing of equipment is dependent on external companies and if they do not turn up when required, there is no alternative but to continue to use equipment which is overdue a service.

4.14 The core priorities relate to falls, particularly those resulting in harm, medicines and pressure ulcer management. There is also recognition that on rare occasions an incident may occur that has a significant impact on a service user or one of our services. This plan enables us to respond proportionately to such an event to ensure we gain maximum learning.

4.15 In addition, some specific priorities and opportunities for learning were identified at different services which are reflected in the local focus section (5.2). This is due to interests of individual services as well as recognising that each service has its own characteristics in terms of the population it serves, the configuration of the environment and the services it delivers. This plan allows the flexibility to ensure that each service learns from the events most relevant to the people who use and work in that service.

4.16 Through the annual Quality Account reports, Sue Ryder identifies priorities for improvement. In the last year there were four priorities:

- Service user safety – patient engagement: As part of the implementation of the Patient Safety Incident Response Framework (PSIRF) we will focus on the engagement and involvement of patients, families and staff following a patient safety incident. We will embed the role of Patient Safety Partners in our services and develop a programme of support to ensure all voices are heard.
- Service user safety - e-prescribing: Following the successful implementation of e-prescribing in two of our hospices, we will enhance our medicines management further by implementing the system in another three of our hospices.
- Clinical effectiveness – osteoporosis management: To ensure the safety of our service users and protect them from injury, we will focus on the prevention and management of osteoporosis. We will review current risk assessment tools and develop a programme of education to improve staff knowledge in recognising those at risk.
- Clinical effectiveness – pressure ulcer management: To ensure that the prevention and management of pressure ulcers at end of life achieves best practice. We will research current best practice and implement the findings. In addition, we will develop a programme of education to improve staff knowledge.

4.17 Sue Ryder services have implemented quality improvement plans and initiatives in response to incidents and feedback and continually looks for ways to improve care for the people who use our services.

4.18 This has included improvements in pressure ulcer identification and management, safe use of equipment, dynamic risk management of those at risk of falls. A Just Culture is an important priority for Sue Ryder and there has been a programme of work an ongoing focus in the coming years.

4.19 Sue Ryder is committed to using the most proportionate and appropriate learning responses to improve care for service users. As the PSIRP is reviewed in coming years we will look to make use of further learning responses such as After-Action Reviews.

5. PSIRP

5.1 National requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Create local organisational actions and feed these into the quality improvement strategy
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	Create local organisational actions and feed these into the quality improvement strategy

5.2 Local focus

5.2.1 All local services

Patient safety incident type or issue	Planned response	Anticipated improvement route
Patient falls resulting in fracture, head injury or other significant injury (moderate harm and above).	Patient Safety Incident Investigation (PSII).	Create local and national safety actions and feed these into the quality improvement strategy.
Patient falls not resulting in fracture or serious injury	Rapid Review for a cluster of five.	Create local and national safety actions and feed these into the quality improvement strategy.
Medicines incidents are minimal harm dependent on severity and potential for harm. Medicines near misses as identified.	Rapid Review for minimal harm or where there is potential for significant harm. Concise or PSII for moderate harm and above.	Inform ongoing improvement efforts. Create local and national safety actions and feed these into the quality improvement strategy.

Pressure Ulcers/ Tissue Damage Cat 3 and 4 and SDTI	Rapid Review.	Inform ongoing improvement efforts. Create local and national safety actions and feed these into the quality improvement strategy
Moderate/ Severe incidents not elsewhere classified	Concise investigation	Allows services to respond appropriately and proportionality to unforeseen or incidents not described in the plan.

5.2.2 Sue Ryder Duchess of Kent Hospice, Berkshire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medicines incidents in relation to the use of SDCI including near misses.	Rapid review for every five incidents.	Create local and national safety actions and feed these into the quality improvement strategy.

5.2.3 Sue Ryder Leckhampton Court Hospice, Gloucestershire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medicines incidents in relation to omissions and denaturing CD's.	Rapid Review.	Inform ongoing improvement. Create local and national safety actions. Improvement plan.
Delays in admission and treatment.	Rapid Review.	Create local actions.

5.2.4 Sue Ryder Manorlands Hospice, Yorkshire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medicines management focussing on patches and omissions.	Rapid Review.	Inform ongoing improvement. Create local and national safety actions. Build case for improvement plan.

5.2.5 Sue Ryder St. John's Hospice, Bedfordshire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medicines incidents in relation to syringe drivers. (Data to be reviewed).	Rapid Review.	Inform ongoing improvement. Create local and national safety actions. Improvement plan.
Delays in admission and treatment.	Rapid Review.	Create local actions.

5.2.6 Sue Ryder Thorpe Hall Hospice, Cambridgeshire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medicines management. Prescribing incidents	Rapid Review.	Inform ongoing improvement. Create local and national safety actions.

5.2.7 Sue Ryder Wheatfields Hospice, Yorkshire

Patient safety incident type or issue	Planned response	Anticipated improvement route
Falls linked with delirium.	Rapid Review.	Inform ongoing improvement. Create local and national safety actions.
Medicines incidents in relation to insulin and patches. Omission/ incorrect prescribing etc.	Rapid Review.	Inform ongoing improvement. Create local and national safety actions and feed these into the quality improvement strategy.

6. Summary

6.1 Sue Ryder has undertaken extensive review of patient safety related data and has engaged with staff, stakeholders, and commissioners to develop this plan.

6.2 Priorities for learning and investigation have been identified in partnership with our colleagues and others and will support Sue Ryder services in learning from incidents.

6.3 The plan will be reviewed annually and gives flexibility to allow a proportionate response to incident management whilst maximising system-based learning.