Trinity Hospice & Palliative Care Services (Trinity)
Patient Safety Incident Response Plan (PSIRF)

Contents

Introduction

The Patient Safety Incident Response Framework (PSIRF) sets out Trinity's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF also aligns to the Care Quality Commission Single Assessment Framework and five key questions.

PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected.
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management.

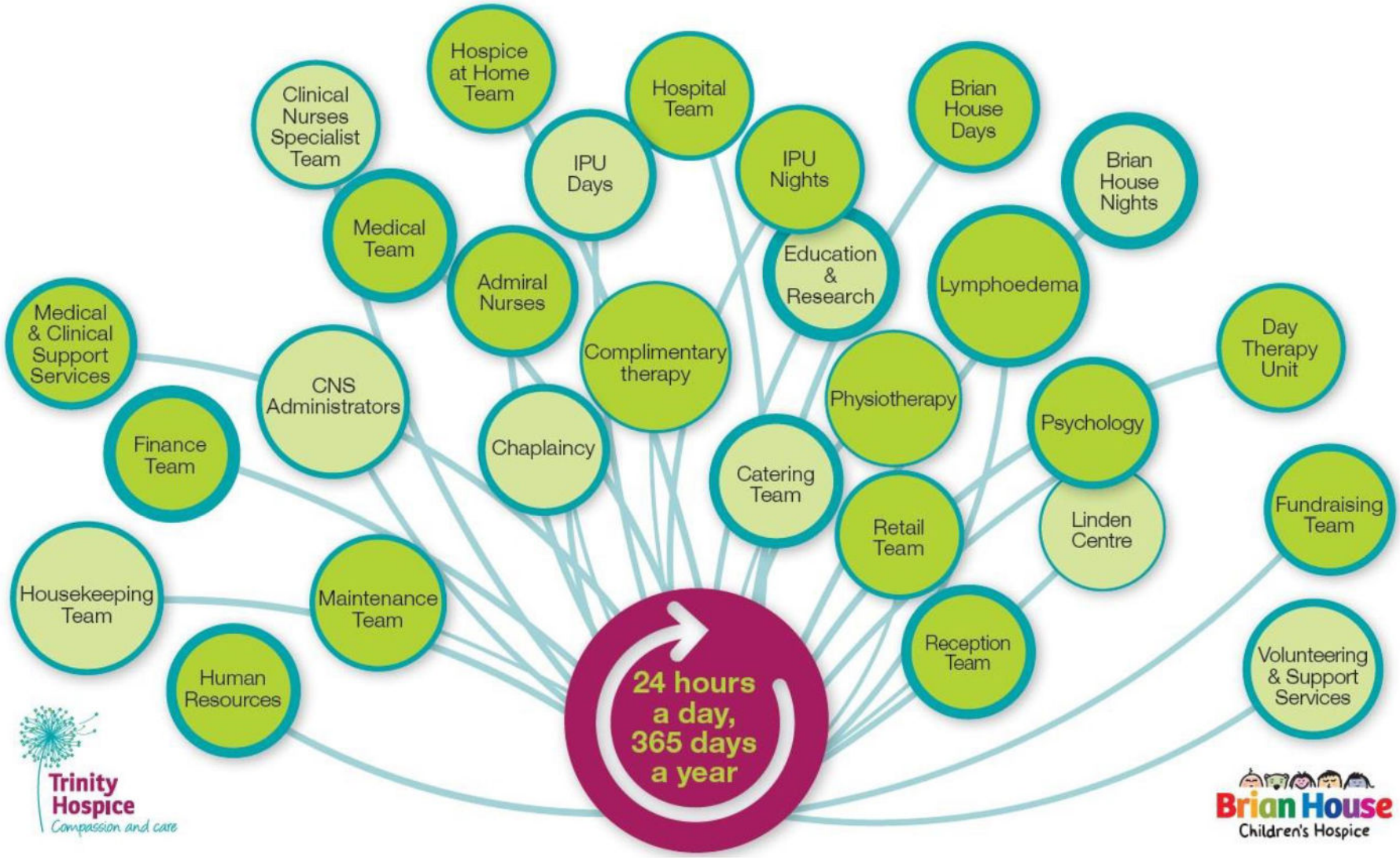
Our services

Trinity & Brian House Children's Hospice has been at the heart of the Fylde coast for nearly 40 years, providing compassionate care for adults and children with life limiting illnesses on their journey towards the end of life. Our dedicated specialist nursing teams touch the lives of thousands of patients and families each year, with one vision for the future – that ***everyone across Blackpool and the Fylde coast has access to timely, high-quality and consistent end-of-life care.***

We have a wide range of services to help people where they're at, based on both the hospice building, but also, and increasingly so, outside the hospice either in the community or in people's own home.

All our services are committed to ensuring that when a patient safety incident occurs, we take a proactive approach to investigating and learning from incidents.

Trinity Hospice - a hospice without walls



Defining our patient safety incident profile

Trinity's governance structure seeks to provide assurance that clinical departments and services are delivering safe, high-quality care by completing audits and by monitoring patient safety incidents. This includes auditing the environment, patient experience, quality improvement, assurance and infection prevention and control.

Our key aims are:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Pressure ulcers, medication incidents 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 monitoring trends and quality improvement.

Implementation and transformation plan

Trinity is embedding a proactive and positive learning culture and commenced a programme of work during July 2023 to start to adopt PSIRF and a full review of our current policy and procedure commenced. The principles of PSIRF have now been incorporated into our policy and procedure.

The Director of Clinical services, as Trinity Hospice's Registered Manager, works with the Governance and Quality Team to ensure successful implementation.

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

Defining Patient Safety Incidents

Trinity takes seriously any safety incidents that involve patients. Staff are encouraged to report all incidents including those resulting in no harm. All patient safety incidents reported include, where appropriate, the notification of the incident to the patient and their next of kin with the patient's consent. This ensures that we meet the Care Quality Commission Standard – 'Duty of Candour'. Patient falls, pressure ulcers and medication errors are now reported nationally to Hospice UK, so that we can benchmark against other hospices. All incidents are captured on the quarterly governance report and are discussed at a weekly Safety Huddle* and reviewed at Trinity's Clinical Quality Improvement Group**. We also use Statistical Process Control (SPC) Charts*** to monitor and highlight trends in reported patient safety incidents.

*Safety Huddle

The weekly safety huddle is a short meeting involving managers from across all areas of the Hospice both clinical and non-clinical services and teams which proactively enables Trinity to focus on safety and patient safety facilitating communication across Trinity Hospice. The overall goal of the safety huddle is to review the previous week's incidents to proactively identify safety concerns. The purpose of the huddle is to share information and highlight concerns to be followed up, not solve issues. Concerns raised during huddles are then directed to the appropriate person or groups for resolution.

**Clinical Quality Improvement Group

The Clinical Quality Improvement Group meets bi-monthly to support Clinical Governance at an organisational and board level to ensure a robust system is in place to monitor and discuss all aspects of clinical governance and patient safety. The primary role of the Clinical Quality Improvement Group is to monitor and review the quality of the service and promote a culture of continuous improvement and innovation within Trinity Hospice; to ensure that we meet the Care Quality Commission Standards.

The group has the following remit:

- To review clinical risk, quality, and patient safety issues.
- To oversee clinical performance ensuring the hospice responds to issues raised in national/local reports, patient feedback and complaints, patient safety incidents and significant events.
- To plan the audit programme, implement audit findings and complete the audit cycle.
- To foster a culture of service improvement and to enable clinical teams to identify and implement service improvement projects.

***Statistical Process Control (SPC) Charts

Statistical Process Control (SPC) charts are simple graphical tool that enable performance monitoring. They are used to identify which type of variation exists within any process. They highlight areas that may require further investigation when they exceed acceptable variation from the average. We have introduced SPC to monitor trends in patient safety incidents so that we can act in a timely way to any trends over a rolling 12-month period.

We also have a quarterly Governance report which looks at incident prevalence over a 5-year period to look for trends and changes in the incident profile.

Defining our patient safety improvement profile

Trinity has in place systems and processes for the reporting patient safety incidents.

Incidents and near misses are regularly monitored at Safety Huddles*. Patient safety incidents are also discussed at departmental or team meetings.

All patient safety incidents are reviewed by the Director of Clinical Services once they have been closed to ensure all appropriate recommendations and safety actions have been identified and actioned and to determine if any further thematic reviews are required.

The Clinical Governance Committee have oversight of all patient safety incidents via the quarterly governance reports to ensure board oversight.

Trinity is committed to enhancing the workplace and patient/service user care standards. All patient safety incident reports underpin risk management systems and procedures helping to:

- Promote a positive, open, and non-punitive approach to managing risk and integrated governance.
- Promote a 'just culture' within the organisation.
- Ensure that we learn from our mistakes.
- Ensure family & patient engagement in all patient safety incidents.

Stakeholder Engagement - Engaging and involving patients, families and staff

Patient and family feedback is extremely important to us. Historically we have very few complaints so have been looking for other ways in which to capture any service changes that would assist patients and those important to them, even the small things that would have made a difference to them.

In clinical areas we primarily use 'iWantGreatCare' feedback forms both paper and online, making it easy for patients to provide feedback on their care. iWantGreatCare lets patients leave meaningful feedback on their care and its service is independent and secure.

If we were to receive a compliant this would be dealt with under Trinity's Complaints Policy & Procedure.

Staff Training

Staff will be trained to respond appropriately through training and professional development. All clinical staff will complete at least level 1 E Learning for Health (ELfH) Patient Safety Syllabus training. In addition, staff undertaking investigation roles will receive additional ongoing training

and development form the Quality & Clinical Governance Lead who has completed HSSIB Level 2 training - A systems approach to learning from patient safety incidents.

Category	level 1 Patient Safety training	Level 2 e-learning Access to practice	e-learning Essentials of patient safety for Boards and Senior Leadership Teams
All Clinical Staff	✓		
All Clinical Managers	✓	✓	
All Clinical Leads	✓	✓	✓
Quality & Clinical Governance Lead	✓	✓	✓
Trustee Clinical Governance Board Members			✓

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
E.g. incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
E.g. 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
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents	Referral to local safeguarding lead	Effective response to safeguarding concerns.
LeDeR (Learning Disabilities Mortality Review)	Specialist review	To have a specialist review of the care of a person with a learning disability
Mortality review	Specialist review	Proportionate participation in system wide systematic mortality reviews to support in the identification of any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients.

Our patient safety incident response plan: local focus

Trinity's local plan is to identifying areas of most significant risk and implement systems to prevent incidents or reduce their likelihood.

Trinity's focus on incident management is designed to achieve the following objectives:

- A standardised approach to patient safety incident management across the organisation.
- To ensure that learning from incidents is an integral part of the organisations culture.
- Analysis of trends which may identify the further need for intervention, i.e. a thematic review.
- To improve patient and staff safety by addressing systemic errors.
- To promote a culture of accountability with 'no blame'.
- Provide guidance to staff, encouraging timely and full reporting of near misses and patient safety incidents.
- Ensure the organisation complies with all Health and Safety, and other relevant legislation.
- Ensure that the organisation complies with the Care Quality Commission, NHS and Medicines & Healthcare Products Regulatory Agency requirements and standards for incident reporting in line with the Patient Safety Incident Response Framework.

What Trinity's focus is

- Identifying trends across the organisation.
- Make sure areas of concern are acted on.
- Target resources more effectively.
- Increase awareness and responsiveness.
- Increased family inclusion and engagement.

How outcomes will be monitored

By Identifying:

- The actual impact on the individual and/or organisation.
- The potential impact on the individual and/or organisation.
- The likelihood of recurrence.
- The potential future consequences to the individual and/or organisation of a recurrence.
- Proactive improvements and safety actions from incidents.
- where incidents may re-occur by undertaking a system wide view of causes.

Trinity shares the ethos of the 'Just Culture' which encourages accountability and responsibility. Where staff have made a mistake, error or a misjudgement, truthfulness and admission is fundamental.

A Focus on Compassionate Engagement Following an Incident

Trinity recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place.

Trinity has a focus on prioritising compassionate engagement and involvement of those affected by patient safety incidents.

This has formed part of our Quality Account for 2024-25 under clinical effectiveness, Patient Safety and Patient Experience – Improving Engagement and Involving Patients, Families and Staff Following a Patient Safety Incident In Line With the Principles of NHS England's Patient Safety Investigation Response Framework (PSIRF).

The aim of engagement

Increase engagement with those affected by clinical incidents, including patients, families, and staff, ensuring they are treated with compassion and can be part of any investigation in order to promote systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement, with the aim of learning how to reduce risk and associated harm.

What do we want to achieve?

Review and amend the systems we already have in place to ensure an effective process of engagement and involvement with those affected by patient safety incidents. This should include those affected including staff, the person or patient (the individual) to whom the incident occurred, their family and close relations. This is firstly to ensure immediate needs are met in respect of our duty of care and secondly to improve our understanding of what happened and potentially how to prevent a similar incident in future.

Patient safety incident response	**Method**	**Objective**
Consider immediate safety actions	Incident review and investigation	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Thematic Reviews i.e. Case / Record Reviews	Clinical Documentation Review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care).
Clinical Audit	Outcome Audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring

		practice into line with these standards to improve the quality of care and health outcomes.
Risk Assessment	Proactive hazard identification and risk analysis	To determine the likelihood and severity of identified hazards, and apply sensible measures to control those risks (e.g. clinical, safety, business).

Local Priorities

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Pressure ulcers	After Action Review (AAR) A structured approach for reflecting on the work of a group and identifying what went well, strengths, weaknesses, and areas for improvement. Usually takes the form of a facilitated discussion following an event or activity.	Identify greatest potential for learning. Create local safety actions. Consider whether this incident to be included into a thematic review or ongoing quality improvement work
Patient falls	After Action Review (AAR)	Identify greatest potential for learning. Create local safety actions. Consider whether this incident to be included into a thematic review or ongoing quality improvement work
Medication errors	After Action Review (AAR) /incident review	Identify greatest potential for learning. Create local safety actions. Consider whether this incident to be included into a thematic review or ongoing quality improvement work

Supporting cross-system patient safety incident investigation

Incidents often stem from weaknesses at the interface between different systems: between departments (within the same organisation), between services in different organisations) and between different agencies, e.g. Health and social care.

Working with Patient Safety Partners

Trinity will work with our local partners in Blackpool Teaching Hospitals to respond appropriately to any patient safety incidents, this includes any cross-system incident/issues. In addition they will liaise with Lancashire and South Cumbia Integrated Care Board to ensure patient safety incidents are appropriately escalated and safety actions are shared in a co-ordinated way.

Trinity also actively participates in Hospice UK's Patient Safety Project which aims to improve patient safety in hospices and accelerate the sharing of related learning and improvement work.

We also work collaboratively with Lancashire South Cumbria - Hospices Together in looking at a shared approach to investigating and learning from incidents.