Patient Safety Incident Response Plan

Plan Information

Author	Sharon Basson
Role	Director of Care
Governing Team	Clinical Services
Version	1
Version Date	13.05.25
Review Date	13.05.25 (as per PSIRF Policy)

Version Control

Reviewed By	Review Date	Version No.	Changes

Table of Contents

Section One

1.1 Introduction

The NHS Patient Safety Strategy, 2019 describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and systems. The Patient Safety Incident Response Framework (PSIRF) forms part of this strategy and is a replacement of the previous Serious Incident Framework, 2015.

This Plan sets out how St Nicholas Hospice Care (SNHC) will respond to patient safety incidents and investigations, beginning 31.03.25.

The SNHC PSIRF Policy confirms an approach rooted in a values led culture, with the absence of apportioning blame and a focus on understanding how systems and processes can support learning and safer clinical care.

1.2 Scope

This Plan is specific to patient safety incident responses conducted for the purpose of learning and improvement at SNHC.

Responses follow a systems-based approach, recognising that patient safety is an emergent property of the healthcare system; that is, safety is provided by interactions between a number of components and not a single component.

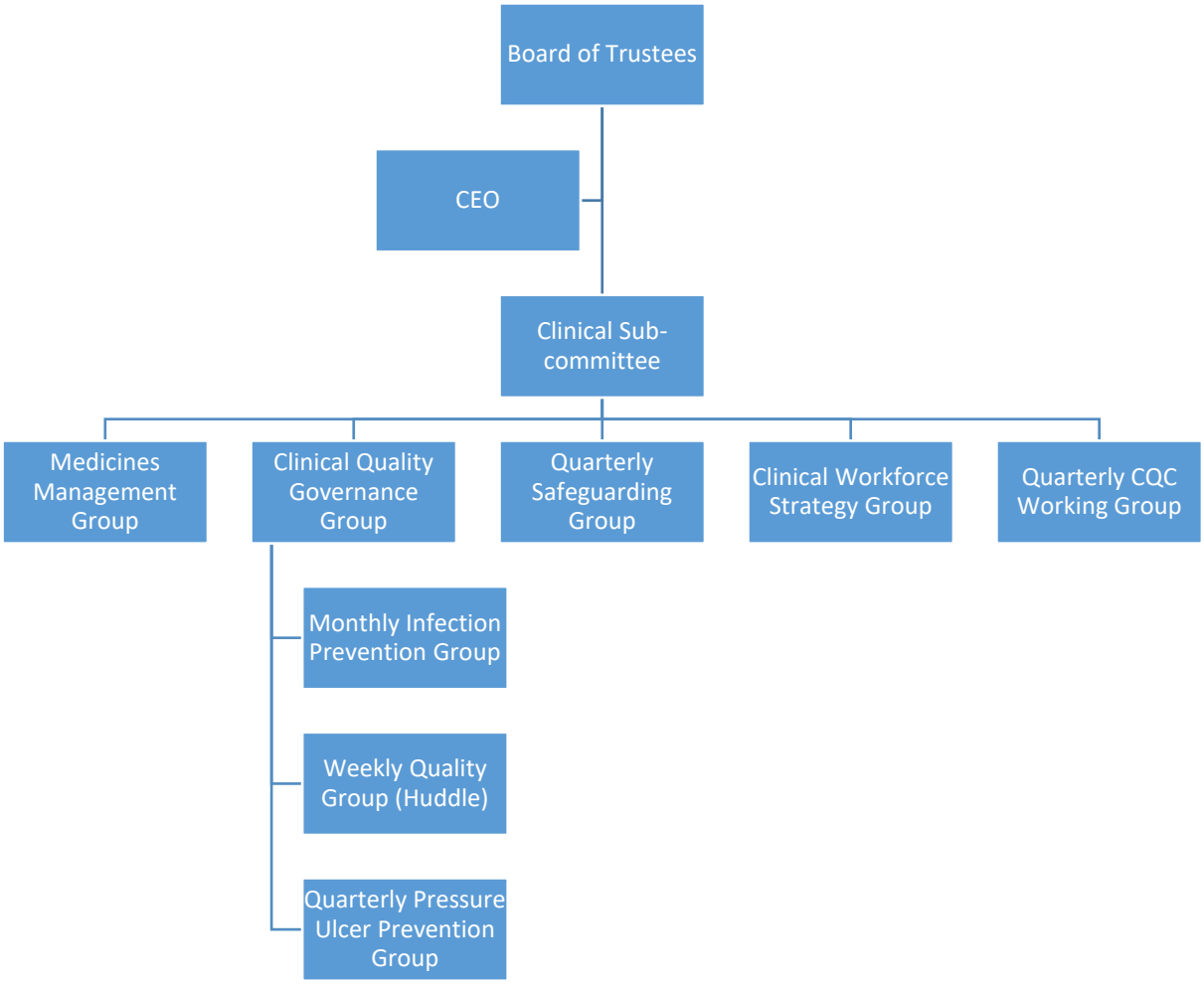
Alternative processes are in place for specific issues, concerns or complaints; these are outside the scope of PSIRF.

1.3 Governance Structures

Clinical governance structures provide accountability and assurance from floor to Board level of high quality care. At SNHC the Registered Manager and Head of Nursing and Quality lead on clinical quality matters.

Clinical governance structures are in place as follows, with reporting occurring each quarter, first through quality groups, into Clinical sub-committee and ultimately, to the Board of Trustees, as follows:

1.4 Table 1: SNHC Clinical Governance Structures – at 31.03.25



2. Patient Safety Profile

SNHC is fortunate to receive largely positive feedback on our services. However, we are aware that when things do go wrong in palliative and end of life care, the results can be devastating and have a significant impact upon the person in our care, bereaved people, and staff.

We have used our incident management software tool (RADAR) to review patient safety incidents, serious incidents, complaints, safeguarding concerns and our risk register, in order to develop this plan.

3. SNHC PSIRF Plan

3.1 See table below for the SNHC approach, which includes:

- Incidents resulting in severe harm, either people in our care/staff, physical and psychological
- Medicines Management
- Pressure Ulcers (>Category 2)
- Falls
- Safeguarding
- Some Formal Complaints
- Themes or incidents identified as 'red flags' or potential for harm.

Patient Safety Incident Type	National Priority/SNHC Required Response	Anticipated Improvement Route
Incidents meeting a national priority due to their severity, such as Never Events & those meeting the Learning from Deaths criteria	**Daily Oversight** by Clinical Manager on Call. Swarm-based Huddle – SNHC refer to this as an **Immediate Debrief.** **Patient Safety Incident Investigation (PSII)** – as soon as possible after the patient safety incident is identified.	**Immediate Debrief** held as soon as possible post-incident. Led by most senior clinician on duty, and involving subsequent communication with wider teams who may not be present. May need to be repeated to ensure all necessary staff are able to access. Immediate patient safety actions or mitigations agreed. If event takes place during out of hours period, the Clinical On Call Manager to support. Duty of Candour considered. PSII led by Director of Care, Head of Nursing & Quality and/or Medical Consultants. Completed within 1 – 3 months, no longer. To be reviewed by CQGG and Clinical Sub-committee. ICB Head of Patient Safety and CQC to be informed of event and plan.

		Director of Care leads on presenting to team and meeting with patient/family, on completion of report.
Patient related incidents resulting in moderate or above harm (including near misses)	**Daily oversight** by Clinical Manager on Call. **Immediate debrief**. **Weekly Quality Huddle** – agree appropriate and proportionate response which could include PSII or AAR	Immediate Debrief, led by most senior clinician on duty. Should be proportionate to the level of incident. Any immediate patient safety actions agreed at Daily Safety Huddle (Sylvan Ward) or Community Huddle. Investigation to be reviewed by CQGG.
Category 1 pressure ulcers	N/a	If reported via RADAR, immediate closure with no further action.
Pressure ulcers Category 2 (in our care)	**Daily oversight** by Clinical Manager on Call. Audit quarterly. Care Gap Analysis approach to be adopted to investigation.	Led by Ward Manager, delegated as appropriate. Completed within one month from reporting date. Themes to be identified by Pressure Ulcer Prevention Group and themes shared at CQGG meeting. Shared learning published Quarterly Learning from RADAR newsletter or C.R.E.W.S. News. Assurance provided to Clinical Sub-committee.
Pressure ulcers Category 3 and 4	**Daily oversight** by Clinical on Call Manager. **Immediate Debrief** **Weekly Quality Huddle** - agreement of	Immediate Debrief, led by most senior clinician on duty. Response should be proportionate to the incident.

	proportionate response which could include PSII or AAR	Any immediate patient safety actions/mitigations agreed. PSII (if agreed approach) to be led by Head of Nursing and Quality. Completed no later than 3 months after event. External regulatory reporting to take place for Category 3 and 4 and SDTI's which develop into Category 3 and 4 pressure ulcers. Statutory Duty of Candour completed, as appropriate.
Medicines related incidents resulting severe harm (including near misses) Hospital treatment or longer length of stay, but recoverable.	**Daily oversight** by Clinical Manager on Call. **After Action Review.** **PSII**	Immediate Debrief, held as soon as possible post-incident. Led by Head of Nursing and Quality/Medical Consultant. Incident reported to East of England CDAO by Director of Care, or deputy. PSII led by Head of Nursing/Medical Consultant. Statutory Duty of Candour completed. Quarterly reporting to NHSE Local Intelligence Network. Reviewed by Quarterly Medicines Management Group. Reported at Clinical Sub-committee, including summary of safety actions taken and learning outcomes. Internal and external learning shared.
Medicines related incident with moderate harm level	**Daily oversight** by Clinical Manager on Call. Care Gap Analysis.	Led by Ward Manager, in partnership with Medicines Management Lead. Completed within one month of reporting.

Minor amendment to treatment plans, no extended length of stay.	Audit quarterly – thematic analysis	Care Gap Analysis approach. Quarterly reporting of Controlled Drugs incidents to NHSE Local Intelligence Network.
Slips, trips, falls with no harm/low harm	**Daily oversight** by Clinical Manager on Call. Audit quarterly	Led by Ward Manager, delegated as appropriate. Care Gap Analysis approach. Reviewed by CQGG. Reported into Clinical Sub-committee, including learning and actions.
Multiple incidents with potential for harm identified as emerging need for further investigation ie. Multiple near miss falls/medication related incidents, considered 'red flags'. Adoption of SEIPS approach.	**Daily oversight** by Clinical Manager on Call. **After Action Review.**	Led by Head of Nursing and Quality. Agreed at Weekly Quality Group (Huddle). Completed within two months of identifying trend. May seek external support from ICB Quality Leads. Reviewed by CQGG. Reported at Clinical Sub-committee. Learning outcomes shared.
IT / Information Governance (IG) incident resulting in data breach	**After Action Review.**	Led by DPO (Data Protection Officer) Completed within 5 days of start. Reported to ICO when necessary. Duty of Candour considered. Reviewed by CQGG. Reported at Finance, Risk and Resources Sub-committee.

Themes from incidents with potential for harm or improvement identified by CQGG as requiring thematic review using SEIPS methodology.	**SEIPS**	Completed by Head of Nursing & Quality or Director of Care. May seek external support from ICB Quality Leads. Learning outcomes shared.

3.2 Review of Plan

SNHC will review this plan in line with the PSIRF Policy.

4. Glossary

Daily Oversight (DO)

Clinical On Call Manager reviews all incidents reported during previous 24 hour period. All incidents shared at Weekly Quality Huddle at handover of On Call Manager duties.

Care Gap Analysis (CGA)

Focused questioning to elicit early responses to potential root causes of incidents, useful to identify incidents which may require proportionate response due to lapses or omissions in care, or interventions.

Clinical Quality Governance Group (CQGG)

Internal governance forum, attended by senior clinicians and reporting into the quarterly Clinical Sub-committee.

CREWS News

Clinical newsletter, Caring, Responsive, Effective, Well-led, Safe. Sharing news and updates with SNHC clinical teams.

After Action Review (AAR)

A structured and proportionate approach for reflecting on the work of a group and identifying strengths & weaknesses and areas for improvement. May take the form of a facilitated discussion following an event or activity in forums such as planned Team Meetings, or reporting outcomes to teams in the form of Quarterly Learning From Radar. It enables understanding of the expectations and perspectives of all those involved and captures learning, which can then be shared more widely.

Not restricted to incidents, can be used for any activity or event that has been particularly successful or unsuccessful and aims to capture learning to promote successful future outcomes. Can include developing plans of care or ethical discussion. May also support the psychological care of staff.

Swarm-based Huddle – Immediate Debrief

Swarm based huddles are known as Immediate Debriefs at SNHC. They 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 the risk. May need to be repeated to ensure all necessary staff are involved. May vary in size, depending on type of incident and number of staff involved.

MDT (multidisciplinary team) 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.

PSII (Patient Safety Incident Investigation)

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, which may result in organisational change.

SEIPS (System Engineering Initiative for Patient Safety)

SEIPS (System Engineering Initiative for Patient Safety (SEIPS) is a useful 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).

SNHC

St Nicholas Hospice Care.