

# Farleigh Hospice

Guideline Name:

Patient Safety Incident Response Plan

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Procedure Owner: Medical Director

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## Introduction

This patient safety incident response plan sets out how Farleigh Hospice will respond to patient safety incidents and how learning will occur within the organisation.

Farleigh Hospice is committed to ensuring that patient safety is an organisational priority. To achieve this governance arrangements are structured to address risk, discuss incidents and learn from them, escalating through each level of the organisation.

In line with PSIRF principles, the hospice will remain flexible in considering the specific circumstances in which patient safety issues and incidents occur, and the individual needs of those affected – the patient, families and staff involved in any patient safety incidents.

Trends from patient safety issues will be analysed thematically and benchmarked against the Hospice UK safety metrics to review how safe our care is compared to other Hospices.

## Our services

Farleigh Hospice is an independent charity providing specialist palliative and end of life care to the adult population of Mid Essex, and bereavement support and care to people of all ages in Mid Essex.

Mid Essex has a population of around 405,000 people. It is anticipated that approximately 1% of our local population could be in the last year of life, which equates to just over 4000 people at any one time. Farleigh Hospice has a 10 bedded in-patient unit where people with life limiting illness are admitted for complex symptom control, end of life care, respite, longer term nursing care or rehabilitation. However, the majority of our care occurs in the community – with an average caseload of around 550 patients at any one time. Community support is provided by experienced multi-professional teams based in 3 localities covering Mid Essex both within people's homes and in outpatient services.

Hospice care is holistic and person-centred – meaning that it supports the person with life-limiting illness and their family to live well until, and beyond death. This might include addressing physical, social, emotional, or spiritual needs as well as helping the person and their family to focus on the outcomes that matter most both in the present and for the future.

Adult and children's bereavement services are offered by our specialist bereavement team and can be offered to anyone residing in Mid Essex, regardless of whether they have a pre-existing connection to the hospice.

Farleigh Hospice has several roles experienced in and responsible for patient safety investigations and outcomes as detailed below:

**Chair of Trustees** – responsible for Board Governance and assurance of safe, effective, responsive, caring and well-led services

**Chair of Clinical Governance Committee** (a Trustee) – responsible for governance and oversight of the clinical services, and all patient safety incidents by exception reporting

**Medical Director** – Patient Safety Specialist for Farleigh Hospice, Executive Lead for PSIRF, and member of Clinical Governance Committee

**Director of Care** – responsible for operational management of the Clinical Directorate and Executive Lead for the Clinical Governance Committee. Responsible for assurance and oversight that all patient safety incidents are investigated, action plans are created and monitored, and learning is shared in the system and across the region. Controlled Drugs Accountable Officer. CQC Nominated Individual.

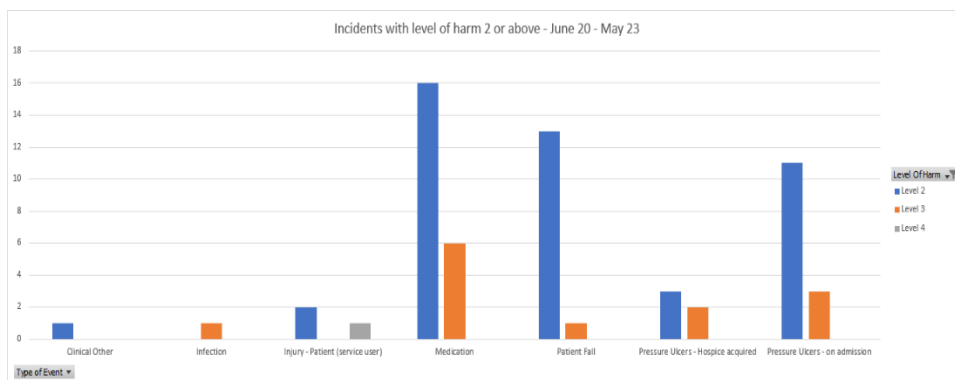
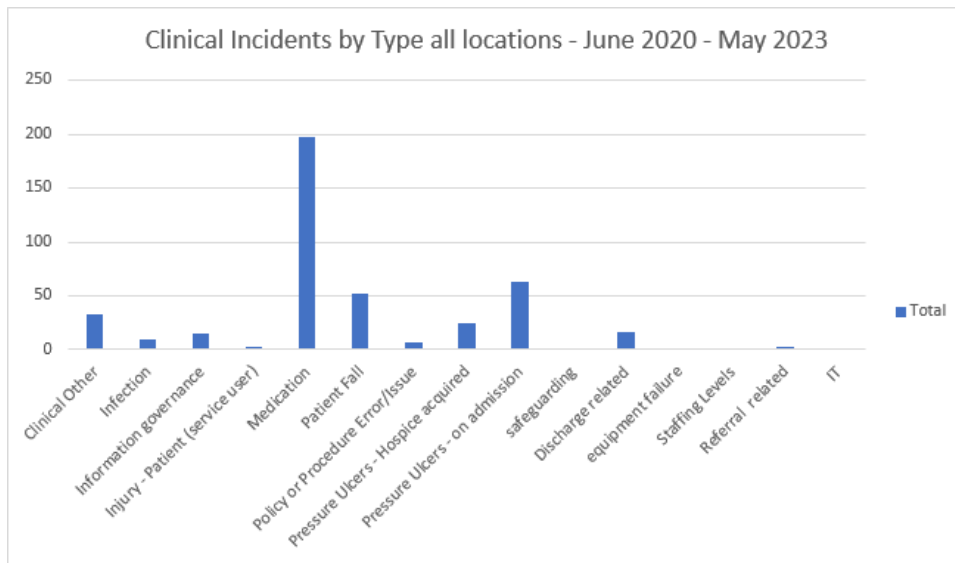
**Head of Nursing and Quality** – responsible for standards of care, and clinical audit to ensure standards are met. Responsible for all actions plans, action after review and learning from incidents. Chair of Clinical Quality Group, Local Risk Group and CQC Registered Manager.

## Defining our patient safety incident profile

The patient safety incident profile was created by a review of all incident reporting over the last 3 years.

Farleigh Hospice uses Vantage (previously Sentinel) as an incident management database and reports have been run to demonstrate the top three safety priorities where either actual patient harm occurred, or where there was a risk of patient harm.

The top three incident types were falls, pressure injuries and medicine errors.

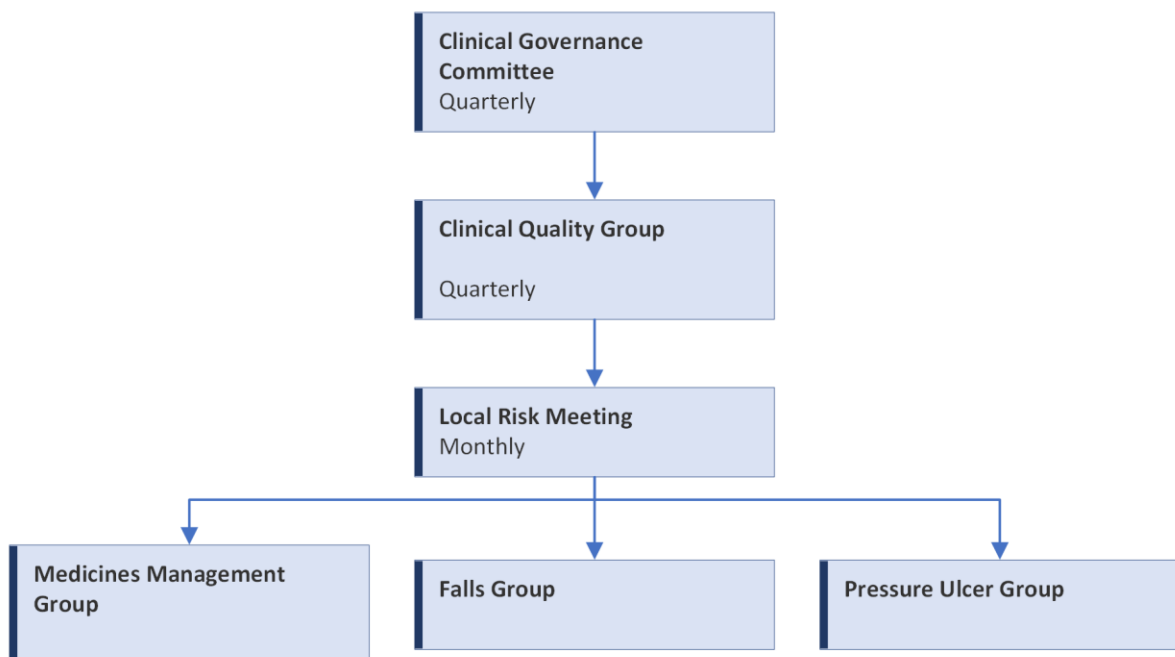


As a response to these themes a falls group has been established. Farleigh Hospice also has a Pressure Ulcer group looking at proactive measures in reducing risk of pressure damage in palliative patients.

All medicine errors are reviewed via the Local Risk meeting, at which the pharmacy provider is present for external scrutiny.

Farleigh Hospice has an accountable officer for controlled drugs who is trained in the role and is registered with NHS England and the Care Quality Commission.

### Farleigh Hospice patient safety Governance Structure



## Defining our patient safety improvement profile

The Vantage database is used to identify all incidents within the organisation. Reports on clinical incidents are run monthly and results analysed at the Local Risk Meeting. Incidents are escalated as required up to Board level.

Vantage identifies that medication incidents, pressure ulcers and falls are the three main reasons incidents are reported. A local medication management plan has been implemented and completed (with the exception of electronic prescribing), as this area showed the highest level of incidents. This has included the introduction of CCTV, patient own medication lockers and new medication trolleys. Whilst this list is not exhaustive, constant review in Local Risk Meetings will identify any further actions required.

A falls team have been investigating how best to promote safety in the community setting, alongside the development of patient literature, staff training and signposting to additional community services.

Pressure ulcer incidence has significantly reduced in the in-patient unit following the introduction of the "Asskin bundle". As Farleigh Hospice is also a community care provider, work is now underway to develop the services offered in the community, including additional training for Health Care Assistants, improved documentation and patient information.

A key improvement to address over the next year is improving the quality of incident reporting, Vantage (previously Sentinel) has been used for 2 years now and a process is underway to review efficiency and accuracy in reporting in line with LFPSE requirements.

Farleigh Hospice benchmarks against Hospice UK standards so that incident rates can be compared against peers. An audit is underway to see whether Farleigh Hospice reporting is meeting national standards.

Farleigh is part of a Hospice Collaborative Partnership so incidents can be compared and contrasted with our geographical neighbours.

## Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Never Events criteria	PSII (patient safety incident investigation)	Local investigation and escalation through ICB quality and safety committee  Consider escalation to SOAG – seek advice of ICB safety leads
Any incident causing patient harm  Level 3 harm and above to be considered for PSII- (PSII to be considered if wider organisational system issues require investigation)	Rapid Review	Create local action plan following action after review meeting – timely response at the time of the incident for immediate actions required.  Longer term actions monitored via Clinical Quality Group with governance oversight at Clinical Governance Committee (and escalation to Board if needed)  PSII if required – This will be escalated up from Local Risk to the Clinical Governance Committee for oversight.
Incidents causing low levels of harm, or no harm	Thematic analysis and action planning at Clinical Quality Group	Exception reporting to Clinical Governance Committee

Farleigh Hospice will involve the patient or family in investigating a serious patient safety incident, learning from an incident or reviews of ways to improve patient safety or experience.

Where themes for improvement are identified, it may be necessary to involve our Patient Safety Partners to work with the Hospice on specific patient safety improvement projects or investigation oversight groups. We may also seek to engage current service users as part of a service user action group – this could be carried out in real time with a group

of service users or families who are engaged and consent, rather than having a patient experience review board.

Where the nature of an incident is cross system or multi-organisational the Farleigh Hospice will identify the lead organisation to coordinate investigation and involve relevant system partners, including patient representatives or family members. Where required Farleigh Hospice will participate in, and contribute to whole system reviews.

Detail of how incidents are investigated is found in the Farleigh Hospice PSIRF policy which is available on the website

Farleigh Hospice is particularly keen to disseminate key learning themes throughout the organisation. This may be through:

- Learning from Incidents Templates sent by email
- Team meetings
- Sharing at MDT meetings
- Locally or at whole organisational meetings where considered appropriate

Positive patient and family engagement is a vital element of service development and improvement for Farleigh Hospice. There are a number of mechanisms of engagement including:

- PATH group – People Advising the Hospice. These groups are formed when a development is required resulting from either feedback, suggestion, or Farleigh Hospice wants to make an innovation to services
- QR code and web-based options for real time feedback which is collated and presented via the Clinical Quality Report
- Service User groups – as a temperature check for services or pilot services which are running. These are either one of or a series of groups which inform development
- I Want Great Care – Farleigh is looking to adopt this platform to enable us to benchmark against other organisations and increase accessibility for engagement
- Farleigh Hospice often works with partner organisations such as the ICB or Healthwatch Essex when seeking wider engagement with both service users and the wider community
- Use of real time service evaluation tools such as MS teams surveys, use of Social Media for community engagement to inform strategic planning

## Our patient safety incident response plan: local focus

<b>Patient safety incident type or issue</b>	<b>Planned response</b>	<b>Anticipated improvement route</b>
Medication Incident	Rapid review and Thematic Analysis  monthly reviews with thematic analysis in quarterly Clinical Quality Group	Create local safety actions in Local Risk Group and feed these into the quality improvement strategy
Falls	Rapid Review and Thematic Analysis  monthly reviews with thematic analysis in quarterly Clinical Quality Group	Create local safety actions in Local Risk Group and feed these into the quality improvement and patient information strategy
Pressure Ulcers]	Rapid Review and Thematic Analysis  monthly reviews with thematic analysis in quarterly Clinical Quality Group	Create local safety actions in Local Risk Group and feed these into the quality improvement and patient information strategy