Rennie Grove Hospice Care | Peace Hospice Care

Rennie Grove Peace

Patient Safety Incident Response Plan (PSIRP)

Purpose – The purpose of this plan is to set out how Rennie Grove Peace (RGP) will respond to patient safety incidents using the new Patient Safety Incident Response Framework (PSIRF) RGP-699

Scope - This PSIRP applies to all employees of RGP who may be involved in a patient/user safety incident or may be requested to undertake an investigation of an incident.
There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

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Acronyms

PSIRF: Patient Safety Incident Response Framework

RGP: Rennie Grove Peace Hospice Care

RG: Rennie Grove

MDT: Multi-Disciplinary Team of Professionals

H&WE ICB: Herts & West Essex Integrated Commissioning Board

BOB: Buckinghamshire, Oxfordshire and Berkshire West Integrated Commissioning Board

MCA: Mental Capacity Assessment

MASD: Moisture Associated Skin Damage

DTI: Deep Tissue Injury

PU: Pressure Ulcer

EOL: End of Life
IPU: In-patient Unit
PSII: Patient Safety Incident Investigation
CPR: Cardiopulmonary Resuscitation
DOA: Dead on arrival
GP: General Practitioner

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Introduction

The safety of our patients and service users is paramount to everything we strive to deliver in Rennie Grove Peace Hospice Care (RGP) but sometimes things go wrong, resulting in harm and distress for all involved. The emotional and physical consequences for patients, service users and their families can be devastating. For the staff involved, incidents can be stressful, affecting them and other members of the team who may become demoralised. Safety incidents also incur costs through lost time, additional treatment, and litigation. Overwhelmingly patient safety incidents are caused by system design issues, not mistakes by individuals.

To improve the safety of our patients and service users, RGP has adopted the Patient Safety Incident Response Framework (PSIRF) which sets out a new approach to developing and maintaining effective systems and processes in response to patient safety incidents. The new framework provides guidance on how to conduct investigations into safety breaches that are strategic, preventative, collaborative, fair and just. The focus is no longer on Root Cause Analysis of individual patient safety incidents but on system learning, improvement, and engagement by adopting a data driven response and investigation that generates system wide improvement. Implementation of PSIRF requires a cultural shift away from identifying blame to examination of the wider components of the system including the environment, tasks, technology, and people in order to gain a deeper understanding how interdependencies affect patient safety. The PSIRF does not mandate investigation as the only method for learning from patient safety incidents or prescribe what should be investigated.

Implementation of PSIRF requires the organisation to produce a Patient Safety Incident Response Plan (PSIRP) setting out how they intend to respond to safety incidents and outline the methods they might choose to conduct investigations. The plan should include patient safety data, the variety of services offered by the organisation, how it will engage stakeholders, patients/families, what resources will be available to support improvement work and the agreed patient safety improvement profile for the next 12-18 months. Before the plan can be developed, the organisation needs to carry out a patient safety incident profile.

This PSIRP sets out how Rennie Grove Peace Hospice Care will learn from patient and service user safety incidents to continually improve the quality and safety of the care we deliver. The plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues.
- focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- focusing on the quality of investigation rather than the quantity to increase our patients, service users, carers, and staff confidence in the improvement of patient safety through learning from incidents.
- demonstrating the added value from the above approach.

Aim

- Improve the safety of the care we provide to our patients and service users.
- Improve the experience for patients/service users, their families, and carers if a patient safety incident or the need for a PSII is identified.
- Further develop systems of care to continually improve quality and efficiency.
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.
- Engage patients, families, carers, and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors.

Our services

RGP is a registered charity that provides specialist palliative care, end of life advice, support, education, and a wide range of services to people who are registered with a West Hertfordshire or Buckinghamshire GP practice. RGP services are delivered by a multi-disciplinary team of Nurses, Doctors, Allied Health Professionals, Therapists, Support Staff and Volunteers. We always strive to ensure the right service is delivered by the right person at the right time to meet the needs of the people we serve.

The services we provide include:

- Inpatient Unit Care
- Community Palliative and End of Life Care (Hospice at Home and Rapid Personalised Care Service)
- Children's Services
- Physiotherapy and Occupational therapy
- Outpatient Clinics
- Living Well Day Services
- Bereavement, Listening and Talking Therapy
- Supportive Care (including Creative Therapy, Complimentary Therapy and Supporting Hands)

The vision of RGP is to provides support and care to people of all ages who are affected by a life-limiting illness and those who care for them to live as well as possible by providing choice and easy access to a wide range of palliative care and bereavement services across West Hertfordshire and Buckinghamshire.

We work closely with GP's, Acute Trusts and Community Nursing teams in Herts, Beds and Bucks to provide shared care to the population we serve. Our pathways of care start with a GP or Clinical Nurse Specialist to any of our services to offer support and care if required. We receive referrals from acute services for patients requiring end of life care and support for them and their families. We also receive self-referrals and referrals from social care. RGP operates a single point of access coordination centre for all patient and service user queries, advice and referrals.

The safety of our patients and service users is paramount to everything we strive to deliver. RGP promotes a positive culture to the reporting of incidents and staff are encouraged and supported to be open and honest about incidents that have or could cause harm to patients, service users and staff. The organisation operates a just culture where fairness, openness and learning are encouraged.

PSIRF will enhance this culture by creating much stronger links between patient safety incidents, learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to achieve learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight identified when things have gone well and when things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability. Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time and the introduction of a new incident management system in April 2023 which will simplify internal reporting for staff.

Defining our Patient Safety Roles & Responsibilities

Board of Trustees- RGP is a registered charity governed by the Board of Trustees that are accountable to the Charity Commission, the CQC and the Integrated Commissioning Boards for Hertfordshire and West Essex and Buckingham, Oxfordshire & West Berkshire.

The Board of Trustees are responsible and accountable for effective patient safety incident management across the organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) when required.

PSIRF Executive Lead – is the Chief Clinical Officer and an Executive Board member with overall responsibility for quality and patient safety in the organisations. The lead must ensure the PSIRF is central to safety and governance and that patient incidents, learning, actions taken, and improvement are discussed at the Board of Trustee subgroups.

PSIRF Lead – is the Head of Clinical Governance (HCG) and responsible for ensuring systems and processes are in place to monitor patient safety incidents while ensuring appropriate and proportionate actions are taken. The HCG is responsible for the capture of all data including insights from patients, families, and staff to help determine when an investigation or review is required.

PSIRF Learning Response Lead – is the Patient Safety Lead and responsible for managing the investigation, involving key individuals with expertise to coordinate a response that demonstrates learning. The lead will have specific knowledge of systems thinking and systems-based approach to learning from patient safety incidents.

All Staff - are responsible for patient safety and aware of the new PSIRF and how it is implemented across the organisation. The focus will be on compassionate engagement of staff following an incident and learning that will improve patient care.

Patient/user safety incidents are recorded on Vantage, our central digital system providing real time monitoring to ensure prompt action is taken when necessary to keep our patients/service users and staff safe.

All patient/user safety incidents are reported to our Senior Leaders Clinical Governance Meeting to ensure scrutiny of actions and improvements. Further reporting and scrutiny are undertaken at the Trustee Clinical Governance Committee.

RGP is reliant on staff recording incidents and raising concerns about safety as this allows us to deal with issues that affect our patients, carers, staff and volunteers. Staff who feel patient safety concerns are not being addressed through our processes can access the Freedom to Speak up Policy to ensure their concerns are investigated without fear of victimisation, discrimination, or disadvantage. RGP is committed to fostering a culture in which all staff feel safe to raise any concern – a reporting culture is a safe culture.

Preparing and training our staff

In line with PSIRF recommendations, all staff and volunteers will update their patient safety incident training via e-learning provided by NHSE, Blue Stream or attending a presentation.

RGP is planning to have all staff trained before the proposed launch date of 1st September 2023.

The PSIRF lead and learning response will undertake all levels of training to support and oversee PSII and ensure those affected and their families are engaged to uphold Duty of Candour.

The table below outlines the level of training required for all staff and board members.

	Level 1: Essentials of patient safety for all staff	Level 2: Access to practice	Essentials of patient safety for Boards and Senior Leadership Teams	Systems approach to learning 2 days/12 hours	Involving those affected by patient safety incidents in the learning process
All staff	✓				
All clinical staff	✓	✓			
PSIRF learning response lead	✓	✓		✓	
PSIRF Lead	✓	✓		✓	✓
PSIRF Executive Lead			✓		
Trustee Board members			✓		

Presentations on PSIRF have already been delivered to RGP Clinical Governance Trustee Committee and the Clinical Leaders Group to ensure senior leaders in the organisation are fully prepared for the new approach to patient safety. Clinical leaders are cascading information to all staff and further promotional work to keep staff updated is planned to take place over July so that all staff are trained by the end of August 2023.

Defining our patient safety incident profile

The patient/user safety incident risks for RGP have been profiled using information from numerous sources:

- Patient/user safety incident reports
- Serious incident reports
- Complaints
- Safeguarding reviews
- Staff survey
- Patient feedback
- Risk assessments
- Audit.

RGP engaged with key internal and external stakeholders to establish the patient safety issues most pertinent to RGP, including:

- Clinical Governance team
- Internal Clinical Governance Group
- Herts and West Essex ICB (HWE ICB)
- Buckinghamshire, Oxfordshire and Berkshire West ICB (BOB ICB)

RGP worked in collaboration with five other local hospices to form a Hospice Patient Safety Group. Some key actions taken by the group include:

- Links with ICB patient safety leads
- Development of PSIRF hospice implementation project plan
- Identification of key stakeholders
- Identification of key lead roles
- Identification of hospice training needs and providers

We examined patient/user safety data over a period of 3-year period (2020-2023) to identify themes, trends, complaints, and user feedback across all hospices. These results were compared and consolidated to create a hospice incident profile based on analysis and provide assurance that RGP was not an outlier for patient/user safety incidents.

RGP continues to work on areas of improvement identified from the key learning actions above. Our Special Interest Focus groups continue to identify areas of concern and have action plans in place to take forward key improvements especially in Tissue Viability, Nutrition and Hydration and Medicines

Management. All our Special Interest Focus Groups report directly to the Internal Clinical Governance Group to provide assurance that actions are improving patient and service user care.

RGP monitors all incidents reported via our electronic system daily to identify themes and trends and ensure actions are being taken to mitigate patient safety risks. Key themes and trends are monitored via our Quality Improvement Plan which is reviewed monthly at our Internal Clinical Governance Group.

Defining our patient safety improvement profile

To comply with the PSIRF, organisations must fully understand their patient safety incident profile and any ongoing safety actions. RGP has undertaken a review of recorded patient safety incidents across all our inpatient and community services over the last three years. The data demonstrates the top three incidents are Pressure Ulcers at all levels, Medicines Management errors/omissions and falls in the ward setting. There were 6 incidents recorded and managed as serious incidents although they may not have met the national framework. These findings support development of our Patient Safety Response Plan.

Pressure Ulcers

YEAR	New MASD	New Grade 2	New Grade 3	New DTI	Unstageable
2020-2021	1	35	9	5	4
2021-2022	5	80	9	7	22
2022-2023	9	63	9	12	6
Total	**15**	**178**	**27**	**24**	**32**

Medication

YEAR	Level 0	Level 1	Level 2	Level 3	Level 4
2020-2021	36	36	7	1	
2021-2022	40	49	8		
2022-2023	14	19	5		
Total	**90**	**104**	**20**	**1**	**0**

Falls

YEAR	No Harm	Low Harm	Moderate Harm	Severe Harm	Death
2020-2021	14	18	1		
2021-2022	15	15		1	1
2022-2023	8	2	1		

Total	**37**	**35**	**1**	**1**	**1**

Incidents treated as Serious Incidents 2020-2023

(NB these do not necessarily meet the threshold for NHS serious incidents however they are treated as serious internally, since they are deemed to have either caused moderate or above harm, or had the potential to cause moderate or above harm)

- Wrong medication/wrong dosage of administered.
- Medication via wrong route
- Toxicity in patient not recognized.
- Infection outbreak during pandemic
- Nurse attended to verify death of patient. Daughter present and collapsed, unresponsive and no cardiac output. CPR administered by nurse. Daughter taken by ambulance to hospital. DOA.
- Safeguarding concerns regarding EOL patient who died at home following allegations of medication abuse by partner. Police involved. Coroner confirmed medication did not speed up death. Case closed.

Key learning identified from the patient safety profile include:

- Medication – wrong route/wrong dose/wrong patient/syringe driver checks. Nurse updates to include correct checking methods.
- Medication – signing of administration - charts to be checked at handover / end of shift.
- Safe staffing reviewed.
- Falls – risk assessment, mental capacity assessments and care planning documentation revised.
- Pressure ulcers, risk assessment and care plans. Categorise skin concerns flow chart and PU escalation flow charts to be followed.
- Documentation of consent/capacity/DOLs forms reviewed.
- MCA- All staff must complete MCA if concerns regarding capacity.
- Acquired infection or infection outbreak-policy and process revised.
- Syringe Drivers- Provide clear evidence of assessment and symptom management in patient records. Ensure clear explanation to carers of impact sedatives via syringe driver will create. Review RG syringe pump leaflet for patients and families.
- Symptom management- Holistic assessment of patient symptoms using appropriate tool to be embedded in practice. Medications to be logged by generic name.
- Key learning identified following incidents and education and training modules rolled out to support improvement.

RGP continues to work on areas of improvement identified from the key learning actions above.

Defining our patient safety incident response plan

Patient Safety Incident Investigations (PSII) are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

All incidents will be reported in line with existing patient safety incident reporting guidance and principles described in the PSIRF.

In some cases, incidents may need to be reported to other agencies engaged in the patient's pathway of care. RGP currently works with NHS partners and attend regular triangulation meetings where joint organisational reviews and incidents can be discussed, and learning identified. RGP will maintain established networks with key partners to ensure information is appropriately, sensitively, and confidentially shared to help achieve a system-wide improvement. If a PSII is identified by RGP and other partners are required to be part of the investigation, RGP will take the lead to engage partners to ensure system wide learning is achieved. RGP will include an invitation to the ICB lead patient safety officer to join the group where appropriate. RGP is committed to patient safety and will engage with local providers when required to review multi-organisational incidents to identify system wide learning and improvement.

In line with the PSIRF Standards (August 22), RGP will engage and involve all those affected by patient safety incidents including the individual, families, carers, and staff. All incidents will be recorded on Vantage and managed in accordance with Being Open and Duty of Candour. This will entail ensuring everyone affected is fully informed and enabled to provide their account of what went wrong with the sole purpose of learning and identifying improvements to prevent recurrence.

RGP does not have dedicated patient safety partners as it is a small organisation with limited resources. However, RGP will seek to engage volunteers or Trustees with the specific knowledge and ability to offer challenge in a supportive manner to ensure learning and improvement is identified.

RGP will ensure patients, families, carers, and the staff involved in patient safety incidents are offered appropriate and timely support. This may be via the PSIRF lead, line managers or access to counselling. Staff involved may also access occupational health.

National requirement

Nationally defined incidents as detailed in the table below require local PSII and outcomes will be reported to HWE & BOB ICB.

Patient safety incident type	Required response	Anticipated improvement route

Incidents meeting the Never Events criteria	PSII – as soon as possible after the patient safety incident identified.	Led by PSIRF Learning Response Lead. Completed within 1-3 months from their start date. Reviewed by patient safety review team. Sent to HWE/BOB ICB for external review.
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– as soon as possible after the patient safety incident identified	Led by PSIRF Learning Response Lead. Completed within 1-3 months from their start date. Reviewed by patient safety review team. Sent to HWE/BOB ICB for external review.

Criteria for selection of incidents for PSII:

1. Actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
2. Likelihood of recurrence (including scale, scope and spread)
3. Potential for learning in terms of:
    - enhanced knowledge and understanding
    - improved efficiency and effectiveness (control potential)
    - opportunity for influence on wider systems improvement.

Any request for information about a patient safety incident – by the patient, families and/or staff – will be responded to openly and as much information as possible will be provided regardless of severity of outcome or the type of response required under this plan.

Patient safety incident response plan: local focus

The table below sets out our proposed response to patient safety incidents based on our completed patient safety incident profile. The PSIRF does not mandate investigation of all incidents but requires

a proportionate response using an approach which will maximise learning and improvement to reduce risk and significantly reduce recurrence improvement.

This PSIRP will ensure a proportionate response to investigation that delivers the highest level of improvement over the next 12-18 months. All investigations undertaken will use the national templates and be overseen by the PSIRF learning Response Lead to ensure robust reviews are carried out.

Patient safety incident type or issue	**Specific risk**	**Planned response**	**Anticipated improvement route**
Incident resulting in serious harm or emerging pattern of potential serious harm.	Falls with serious harm. Themes/trends of PU's with high impact harm.	Initial response to gather information. Report to CQC. PSII instigated by Patient Safety Group. TOR/Scope/learning & improvement to be identified. Led by Patient Safety Executive.	• Investigation undertaken by Patient Safety and supported by the Assistant Director. • Recommendations, Learning & improvement identified. • Shared with Internal Clinical Governance group and Clinical Leaders. • Shared with HWE/BOB ICB for external review. • Improvement action plan monitored by Internal Clinical Governance Group with escalation to Clinical Governance committee
Incident resulting in moderate harm or potential serious harm.	Infectious outbreaks in IPU	Swarm Huddle with individuals including patient and families directly involved in the incident as soon as possible after the event. Quick response to gather information	• Led by Assistant Director/Medical lead/Head of and/or PSIRF Learning Response Lead. • Completed within 1-3month from start date. • Reviewed by Patient Safety Group. • Improvement identified.

		and establish what happened. Support identified for individuals involved including staff.	• Shared with Internal Clinical Governance group and Clinical Leaders. • Shared with HWE/BOB ICB for external review. • Improvement action plan monitored by Clinical Governance committee
Pressure Ulcers	All patients with pressure ulcers that have developed or deteriorated in RGP care. (Including children & young people)	Grade 2 or 3 pressure ulcers and DTI will be reviewed by the line manager and the outcome recorded on Vantage. Serious incidents of Pressure ulcers above grade 3 where harm is deemed significant will be subject to an AAR. MDT (multi professional approach) will take place to carry out an in-depth process of review when a number of similar incidents occur identified by monitoring themes/trends. Engaging with all disciplines will help identify safety themes, pathways and process while facilitating discussion to enable	• Led by the line manager/team lead/Head off and ratified by the Assistant Director of the service before closure. • Led by Assistant Director/Medical Lead/Head of and/or PSIRF Learning Response Lead and supported by Executive Lead for PSIRF. • Reviewed by patient safety team. • Improvement identified. • Shared with Internal Clinical Governance group and Clinical Leaders. • Shared with HWE/BOB ICB for external review if appropriate. • Improvement action plan monitored by Clinical Governance committee. • Audit programme to monitor improvements.

		understanding of the system.	
Medication level 1-3	All patients where an administration or prescribing error has occurred resulting in potential or actual harm. (Includes children & young people)	After Action Review (AAR) – as soon as possible after the incident occurred with the individuals involved. Structured review of what should happen and what did happen. Pharmacy lead included to offer an expert view. Provides staff with a safe, reflective environment to learn.	• Led by Assistant Director/Medical Lead/Head of and/or PSIRF Learning Response Lead or a member of the MDT who has undertaken AAR training. • Reviewed by patient safety team. • Improvement identified. • Shared with Clinical Governance group and Clinical Leaders. • Improvement action plan monitored by Clinical Governance committee. • Audit programme to monitor improvements.
Falls resulting in low/moderate harm	All patients who have a fall resulting in potential or actual harm.	All falls with no or minor harm will be investigated by the line manager. All patients with actual harm will be reviewed by undertaking a Swarm Huddle with all individuals including patient and families directly involved in the incident as soon as	• Led by the line manager and ratified by the Assistant Director of the service before closure. • Led by IPU sister or senior lead. • Supported by PSIRF Learning Response Lead. • Completed within 1 month from start date. • Reviewed by patient safety team. • Improvement identified. • Shared with Clinical Governance group and Clinical Leaders.

		possible after the event. Quick response to gather information and establish what happened. Support identified for individuals involved including staff.	• Shared with HWE/BOB ICB for external review if appropriate. • Improvement action plan monitored by Clinical Governance committee. • Audit programme to monitor improvements.