Patient Safety Incident Response Plan

Introduction

Children's Hospice South West (CHSW) has focused on, and continues to be committed to improving our approach to patient safety incidents. Although we recognise that the vast majority of incidents reported within our organisation are of a no/low harm level, CHSW is dedicated to learning from all incidents to enhance the experience of the children and families we care for and improve our patient safety culture.

The Patient Safety Incident Response Framework (PSIRF) aims to help continuously improve patient safety and build on the foundations of a safer working culture and safer systems.
The PSIRF replaces the current Serious Incident Framework (SIF) and will focus on and support the development of an effective patient safety incident response system that integrates four key aims:

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

This Patient Safety Incident Response Plan (PSIRP) sets out how CHSW will respond to patient safety incidents and learn from them, to continually improve the quality and safety of the care we provide. The plan will also detail how we will capture our successes and share our examples of good practice.
This plan is not a permanent set of rules that cannot be changed. We will remain flexible in our approach and consider the specific circumstances in which each patient safety incident occurred, and the needs of those affected.

Children's Hospice South West Services

CHSW provides hospice care to babies, children and young people (BCYP) living with life-limiting/ life-threatening conditions, and their families across the south west of England. We have three hospice sites Little Bridge House in North Devon, Charlton Farm in North Somerset and Little Harbour in Cornwall, all with teams of specialist professionals committed to enriching and enhancing the lives of the children and families within their care.

Our purpose is to make the most of short and precious lives, putting the children and families at the centre of everything we do, whilst our vision is to provide the highest quality care to every baby, child and young person in the south west who may not live until their 18th birthday.

The support we provide includes:

- Specialist paediatric palliative care including symptoms control and emergency care
- End of Life Care
- Hospice stays and hospice days for the whole family
- Sibling support services
- Bereavement support

Referrals are welcomed from the NHS, Social Services, other organisations and directly from families.

Defining our patient safety incident profile

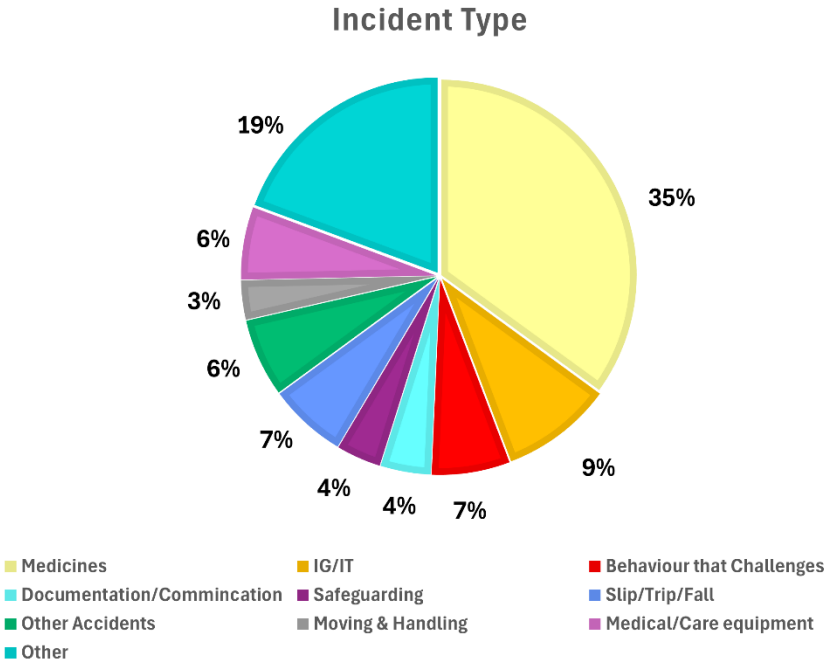
In June 2024 our Senior Care Leadership Team met to review our PSIRF response and formed a Patient Safety Incident Response Team (PSIRT). This Incident Response Team consists of medical, nursing and central care leadership representatives who will respond to any incidents which trigger a Patient Safety Incident Investigation (PSII).
In the event of an incident which causes moderate or severe harm the PSIRT will meet within 24 hours to plan the investigation.
As CHSW has hospices at three different sites, and a central leadership team, investigations will not be led or overseen by members of the team at the site in which the incident occurred.

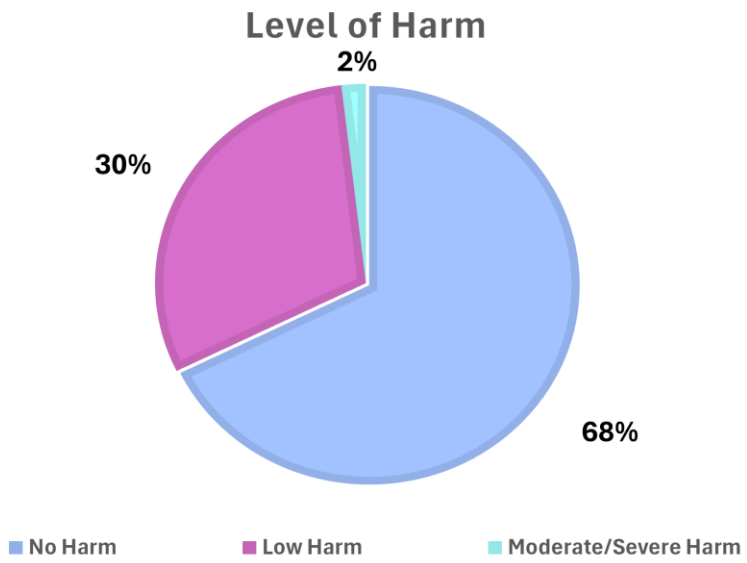
To inform our priorities for this Patient Safety Incident Response Plan, our PSIRT have reviewed our incident reports and figures, and all concerns and complaints raised between April 2023 and March 2024. Our clinical working groups have also contributed to defining our patient safety incident profile.

All concerns and complaints raised during this period were reviewed. Our initial response to all concerns and complaints is engagement with the families and those involved. Across all three hospices there was a total of 12 concerns and 0 complaints raised, none of which were related to patient safety.

CHSW Incident Data April 2023 - March 2024

Between April 2023 – March 2024 there was a total of 292 incidents reported across all 3 hospices. 75 of these incidents had no patient safety implications and were raised in response to parents/siblings/staff having accidents whilst on the hospice sites. Therefore, the below data reflects only the 217 incidents which related to patients in our care.





It is also important to note that the harm level assigned to incidents was not consistently aligned with the PSIRF during this period. This is evident in the recording of 3 moderate harm and 1 severe harm incidents, which would all have been 'no harm incidents' under the PSIRF, as no harm to any patient occurred.
Therefore, of the 217 patient safety incidents raised during this period, none resulted in moderate or severe harm.

Our analysis of incident data has enabled us to see that amendments to our Vantage reporting module are necessary to allow us to accurately and meaningfully analyse our incident reporting data moving forwards. This is why one of CHSW's current priorities is to align our reporting module with the PSIRF, and ensure all teams are adequately trained and supported during our transition to PSIRF.

Whilst recognising inconsistencies in the data due to changes made to the Vantage module affecting categorisation of incidents, our data analysis has contributed to informing our local patient safety priorities and focus set out in this plan.

Medicines have been highlighted as our single largest patient safety risk area, with transcribing and administration of medicines accounting for a large proportion of total medicines incidents raised. Although all of the medicine's incidents raised between April 2023 – March 2024 were no or low harm incidents, themes have been identified which will help inform our focus for improvement.

The recent introduction of our digital care system has also been highlighted as an area of focus for this plan. Feedback from staff has highlighted areas of the system which could be improved to increase efficiency and further improve safety.

Feedback from care teams and incidents raised regarding the use of a vast range of medical equipment, in addition to the national safety alert regarding the safe use of beds and bed rails has contributed to us choosing Medical Equipment Use as a further local focus area. As children are encouraged to bring their own medical equipment from home when staying at the hospice, our care teams are required to have a vast in depth knowledge of a wide variety of medical equipment and devices. Maintaining competence and confidence in this area poses a challenge and we recognise that focusing on this as an area for improvement will positively impact patient safety.

Defining our Patient Safety Improvement Profile

CHSW actively promotes an honest and open culture and fosters a 'just culture' approach. We understand that creating an environment where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety. We encourage and support incident/event reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to harm to patients, family, employees, service and reputation.

We want our teams to feel respected and valued and to know that we welcome their views, suggestions and concerns. We have Freedom to Speak Up champions across all teams at all sites, as well as a Freedom To Speak Up Guardian. All staff are supported by CHSW's Freedom to Speak Up and Whistleblowing policy.

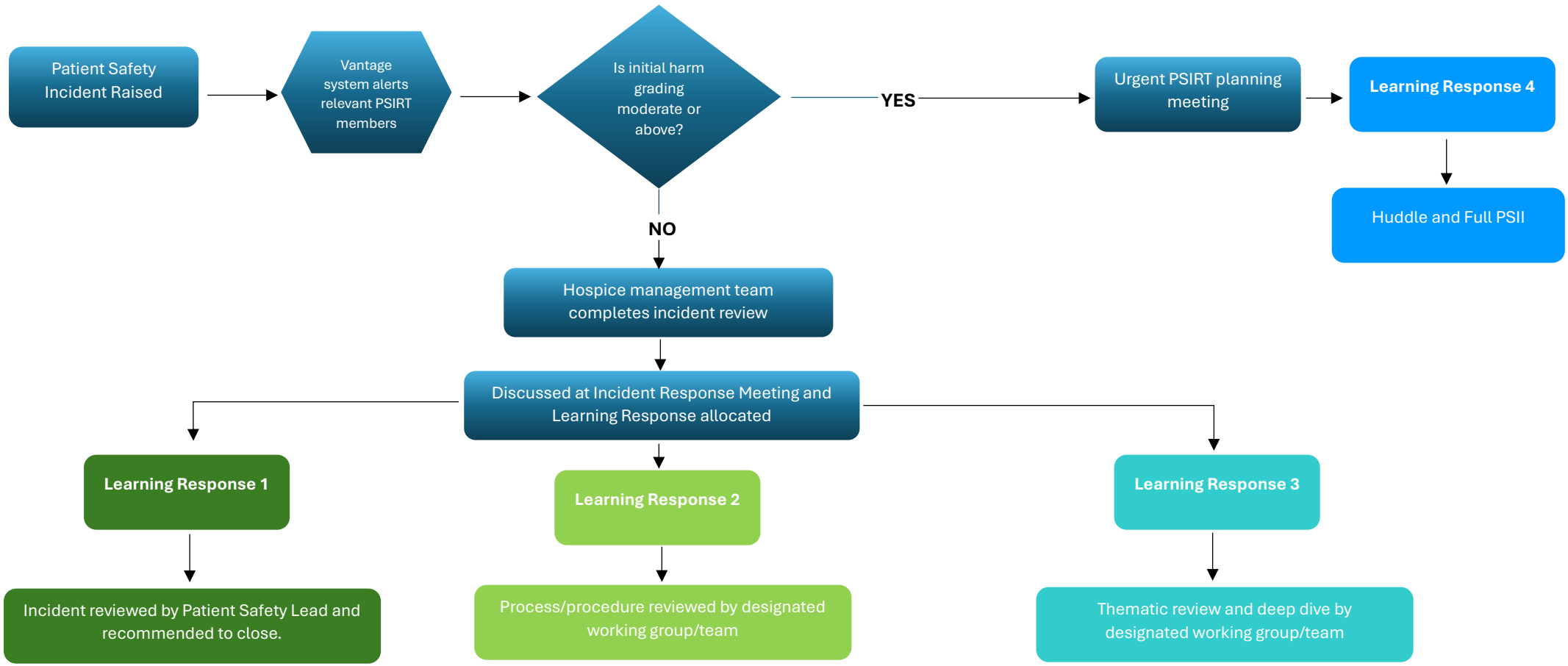
Over recent months our central Senior Management Team have been working to understand the culture within our care teams and promote and inspire openness and transparency through delivering interactive sessions at our Education Conference and hospice whole team site meetings.

We also encourage all families to feedback on their experience of our service, and welcome their view points on how they feel we could improve.

CHSW have routinely reported incidents around patient safety as part of our governance agenda. Collaborative and wider discussion around contributing factors, learning actions and a clear investigation pathway ensures that all incidents are responded to immediately and mitigated or escalated where necessary and managed.

Over recent months we have focused on defining the structure of our weekly Incident Response Meeting, and monthly Learning and Sharing Forums, to ensure that learning is effectively and robustly shared with all members of our teams.

CHSW Patient Safety Incident process:



All incidents are also reviewed quarterly to analyse any themes and contributing factors which may not have been immediately apparent. These reviews are completed by relevant working groups such as Medicines Safey Group for medicines incidents and designated members of the PSIRT for other incident types.

A key area we plan to address over the next year is improving the quality of our incident reporting. CHSW use the Vantage reporting system and work is currently underway to improve the accuracy and quality of our reporting module to ensure consistency and promote proportionate responses, as well as to ensure reporting is in line with Learning From Patient Safety Event (LFPSE) requirements.
Improvements to our Vantage incident reporting module will enable us to use our data in a more meaningful way to enhance our service and improve patient safety.

In March 2024, we also began the first stage of our digital transformation in care at CHSW. This stage involved the implementation of a Computer Information System for all current patient care plans and notes.

In defining our priorities for this plan, we engaged with our Senior Care Leadership Team, analysed incident data, explored staff feedback and feedback from families and other professionals. We also engaged with our internal clinical working groups to explore areas highlighted as having potential patient safety implications.

CHSW Patient Safety Incident Response Plan: National Requirements

Patient safety incident type	Required response	Improvement action
Incidents meeting the Never Events criteria	Locally led 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))	Locally led PSII	Create local organisational actions and feed these into the quality improvement strategy
Child Deaths	Refer for Child Death Overview Panel review Locally led PSII (or other response may be required alongside the panel review- organisations should liaise with the panel	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to local designated professionals for child and adult safeguarding

We acknowledge that there are other reporting requirements, for example, reporting to the Accountable Officer, Care Quality Commission and the Charity Commission, and these processes will continue in line with our registration requirements.

CHSW Patient Safety Incident Response Plan: Local focus

Priority Area:	Actions already taken:	How this strengthens our response:	Future work planned:
Overview of Patient Safety	• Vantage System in place for incident reporting • New format for weekly Incident Response Meetings • Monthly Learning & Sharing Forums introduced • PSIRF training for staff • PSIRF policy	• Immediate alerts sent to delegated team members • Structured, efficient and consistent responses to incidents • Learning shared effectively across teams	• Reporting to LFPSE • Re-design of Vantage incident reporting module to align with PSIRF and enable more consistent data analysis • Introduction of new Vantage module to record good practice events • Staff training to improve consistency, accuracy and compliance in incident reporting • Collaborate with other service providers and contribute to wider PSIRF networks • Establish family engagement group
Medicines – Accounted for 35% of all incidents reported 2023-24	• Established Medicines Safety Group • Established Medicine Policy Working Group • Introduction of Non-Medical Prescribers (NMP's) at two hospice sites	• Medicines incidents and themes reviewed and improvemen to practice/ process defined • Proactive risk management	• New Transcribing policy to reflect 'Together for Short Lives' best practice guidance • Review of Medicine Policy

Particular focus on transcribing		• Responsive to changes in guidelines	• Increase number of NMP across all 3 sites. • Scoping of electronic prescribing system
Medical Equipment Use – Focus on safety of beds and sleep systems Potential for severe harm incidents if equipment used incorrectly	• Introduced system to share national/local Safety Alerts • Equipment competencies for care staff	• Awareness of alerts • Ensure compliance and confidence	• Review staff training • Full review of bed and bed rail risk assessments • Establish Medical Device Safety Working Group • Review competencies
Digital Transformation –	• All paper clinical notes/care plans for current referred children transferred to a digital system	• Increased consistency in record keeping • Information sharing is more effective	• Improve efficiency of processes within the digital system • Siblings record to be transferred to digital system • Bereavement notes to be transferred to digital system • Continue scoping work on Medicines Management Module • Introduction of 'People Planner' to replace care database

Our Patient Safety Incident Response Team have worked to define different responses to incidents to ensure that all incidents raised are dealt with in a systematic and proportionate way, which maximises the opportunity for learning and quality improvement.

Response 1 – After Action Review (AAR).

- For incidents which meet no/low harm criteria, and no similar incidents have occurred previously.
- All immediate actions taken at time of incident and overseen by Duty Manager.
- Incident reviewed at weekly Incident Response Meeting (IRM) and can be closed once Deputy Director satisfied that managers section and any in house actions have been completed.

Response 2 – Fact finding and review

- Any PSI which relates to process concerns where there have been similar near misses/occurrences previously and a process/policy/ procedure may need to be reviewed eg. Documentation errors.
- Incident response team will decide which team/working group would be best placed to fact find and review. Patient Safety Lead will oversee this review.

Response 3 – Thematic review, deep dive and shared learning

- Any groups of no/low harm PSI's where there are similar themes or contributing factors, or where there is potential for learning.
- The incident response team will decide which group would be best placed to undertake the review and deep dive. Outcomes and learning will be shared at the monthly Learning and Sharing Forum.

Response 4 – Huddle and Patient Safety Incident Investigation

- Any incident which results in moderate or above harm will require a full patient safety incident investigation (PSII)
- Immediate actions will be overseen by the Hospice Duty Manager and a huddle/debrief involving all team members involved will take place as soon as possible after the event has occurred.
- An initial meeting involving relevant members of the Patient Safety Response Team will take place to plan the investigation within 24 hours of the incident occurring.

Response 5 – Good Practice AAR

- Where examples of good practice are highlighted these will be recorded on Vantage and reviewed as part of Team Meetings. Any shared learning which results from these good practice examples will be shared as part of the monthly Learning and Sharing Forum.

The incident Response Team will work collaboratively to determine the most appropriate response to each incident during the weekly Incident Response Meeting. It is important to note that in addition to the harm level and potential for learning, the response decision will also take into account the views of those affected including the families involved, what is known about the factors that led to the incident, and whether there is already improvement work underway in relation to any contributing factors.

All incidents can be reviewed at any time and responses can be escalated where this is deemed appropriate.

At CHSW we are committed to learning from Good Practice and positive care experiences. We have recently re-designed our Incident/Event reporting module and have created a separate module where staff are encouraged to capture their successes and record examples of good practice and positive care experiences. These reports will be analysed and explored by our Incident Response Team and will be used to inform process and procedure improvements where appropriate. Learning will also be shared during our Monthly Learning and Sharing Forum.

Roles and Responsibilities

The overall responsibility for effective risk management in the Hospice, including incident reporting and management lies with the Chief Executive (CEO). At an operational level, the Deputy Directors of Care are the people designated with responsibility for governance and risk management. Responsibilities in respect of incident reporting and management are:

- Notifying the Trustees Board of incidents reported as Never Events
- Notifying the Board of Directors of incidents considered as meeting the criteria of a PSII
- Presenting reports to the Quality Governance committee of any Patient Safety Incidents Investigations identifying issues of concern, outcome and learning and assurance.

All CHSW staff are responsible for:

- Reporting incidents and near misses promptly. Staff working in the hospice on a locum or agency basis, or as a contractor or volunteer must also report incidents via the Vantage system and inform their manager. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf.
- If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their manager, and completing an incident on Vantage.
- Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence.
- Engaging in the investigation of incidents and providing information where required.

Engaging and involving patients, families and staff following a patient safety incident

At CHSW we are committed to upholding our organisational core values of respect, honesty, accountability, excellence and team work. We will ensure that we achieve compassionate engagement and involvement with those affected by patient safety events by ensuring that we continually review and amend our systems and processes to ensure effective engagement and involvement with those affected by patient safety incidents.

Involving the staff and volunteers involved in patient safety incidents in a compassionate way is a fundamental part of our patient safety culture.
PSIRF does not seek to apportion blame but is a route to identifying learning and areas for improvement. Engagement with those involved is key to the development of systems which enhance patient safety.

We are committed to creating a no blame culture and have redefined our Incident Response Meeting structure and process to reflect this and create an environment which encourages participation and a collaborative approach.

All staff are also encouraged to undertake CHSW's staff survey on an annual basis. This survey is completed anonymously, and the information gathered provides an insight into staff views of our organisational culture, as well as informing our areas for improvement. Our line management structure also supports staff through regular supervision and our one-to-one process.

We will provide practical advice to support compassionate engagement with those affected by patient safety incidents as well as provide practical advice to enable meaningful involvement as part of a patient safety incident investigation (PSII).
Where an incident does not meet the threshold for a PSII we will endeavour to support and engage those involved by including them in them in all aspects of the learning response process. This will enable us to obtain rich and meaningful information on crucial aspects surrounding each patient safety incident, including contributing factors and resulting outcomes, which will help inform our improvement direction.

Following all patient safety incidents families will be welcomed to provide feedback and will be supported by their assigned contacts within the care team, Team Leader for Family Support and Lead for Children and Families. Staff will be supported by way of supervision and will be encouraged to undertake reflective practice and discussions and participate in debriefs and hot huddles.

Our Lead for Children and Families will assist in coordinating family engagement, and at present we are exploring how Patient Safety Partners could work in a meaningful and proportionate way within our organisation. We are currently in the initial stages of developing a Family Advisory Board (FAB) which will help form part of this agenda.

As part of our patient safety culture we welcome all feedback including concerns, complaints, suggestions for improvement and positive feedback from all stakeholders.

Cross System Collaboration

Where an incident occurs which involves multi-organisational and cross system working, CHSW are committed to involving, working with, and learning from all organisations involved. Collaboration with external organisations will bring diverse perspectives and will help create innovative solutions and enhance learning.

Learning from incidents is paramount for continuous improvement, and sharing incident information and insight with other organisations encourages a transparent and open culture which maximises learning.