



# Patient Safety Incident Response Plan

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## Introduction

This patient safety incident response plan (PSIRP) sets out how St Mary's Hospice intends to respond to patient safety incidents.

This plan is supported by the St Mary's Hospice Patient Safety Incident Response (PSIRF) policy and showing how specific incidents are escalated and shared throughout the organisation. In particular it considers the learning from incidents to be embedded within our culture of quality improvement and governance

This response plan highlights the patient safety incident profile of our organisation demonstrating how the national requirements will be met and the local focus of implementation, learning and improvement.

## Our Services

### 1. Clinical Services

#### ***Inpatient Unit***

Our in-patient unit is an eight bedded unit, four of these rooms with an en-suite. Seven of our rooms have patio doors with most having a small courtyard with amazing views. All rooms have a television (for which there is no charge for) and recliner chairs for maintaining optimum comfort.

The in-patient unit also boasts a spa experience bathroom with jacuzzi bath, mood lighting and music to create whatever atmosphere the patient wishes to feel.

Throughout the unit, there are art and craft facilities, comfortable seating areas along with a dining table and chairs should anyone wish to have their lunches in the company of others.

A family kitchen has all facilities for making hot/cold drink and storage for those 'special patient treats'.

The unit offers short in patient stays for symptom management and control, psychological support, crisis intervention (avoiding acute Trust admission wherever possible) and end of life care.

The in-patient unit works with a host of teams both from within the Hospice and external agencies such as Community physiotherapy. Tissue viability specialists and Adult social care.

#### ***Hospice at Home***

Our Hospice at Home service provides specialist nursing care and support to people who are end of life but would like to be cared for in their own homes. Our service covers the South Lakes and the Furness and Millom areas.

### ***Fast track Service***

This is a new service for those people who are identified as being in their last weeks/ days of life, want to be at home and need support with care needs.

All people assessed and accepted on to the service will be supported with a maximum of four care visits per day by two Home Care Assistants and be based on individual need. Care will be delivered through this 12 week service between the hours of 7.30am – 10.30pm seven days a week.

### ***Family and Bereavement Support***

We understand that life-shortening illnesses affect not only the patient, but also their network of family, friends and carers. Our Family and Bereavement Support Service provides psychological, emotional and spiritual support for patients throughout their illness and for their families and carers, leading up to and following bereavement. People may need varying levels of help at any given time, and we respect this, so the support we offer is tailored to meet individual needs wherever possible. We work to support you through all the varied and often confusing feelings you may experience.

Our Support Service is available to anyone over the age of 18 who is experiencing loss, irrespective of time lapsed, cause or relationship. There is also no requirement to have had previous contact with the hospice services

### ***Admiral Dementia Nurse Service***

St. Mary's Hospice is delighted to launch their new Admiral Dementia Nurse service. Admiral Nurses are qualified dementia specialist nurses. Their professional development is supported by the charity Dementia UK. They are a lifeline for people living with dementia and their families, providing tailored clinical advice alongside psychological and social support which promotes health and wellbeing. Their extensive knowledge of dementia means they can support people through the most complex of situations.

This service is available to any individuals or families who are already using one of our St. Mary's Hospice services and staff will take you through the referral process if your needs meet the referral criteria. However, support and guidance are available for anyone affected by dementia

Our Dementia service also facilitate Dementia Café's across Furness and South Lakes.

### ***Compassionate Communities***

Compassionate Communities is an international approach focused on encouraging and supporting communities in developing ease around discussions of death, dying, and grief. The approach involves a shift away from formal services being 'provided for' people to communities being empowered to support themselves alongside and in partnership with established services such as those provided by St Mary's Hospice.

At St Mary's, we believe by connecting and supporting people, communities, and organisations to harness the power of compassion, we will create a happier and healthier community.

There is already so much wonderful community support available in Furness and South Lakes, often from charities, community groups, and councils, tackling huge issues like loneliness and social isolation. We want to make sure that there's also support on hand for people and their families in the last year of their life or those with a long-term serious illness who aren't going to get better (palliative care).

Our aim is to:

- Build meaningful relationships with our communities, understanding and working to break down the barriers to accessing Hospice services.
- Open up conversations about death, dying, and loss- for example, through events and death cafés
- Work in collaboration with the whole community – connecting with other groups, organisations, networks, and local services
- Deliver community education packages to support awareness and understanding of hospice services as well as sharing knowledge and skills to enable people to support one another.

### ***Living Well Service***

We recognise that you may be facing difficult circumstances and symptoms that are hard to control but more than that, our team acknowledges that this can have a significant impact on you living the life that you want to. Our priority is to help you to live your life well, even if your life may be shorter than you had hoped.

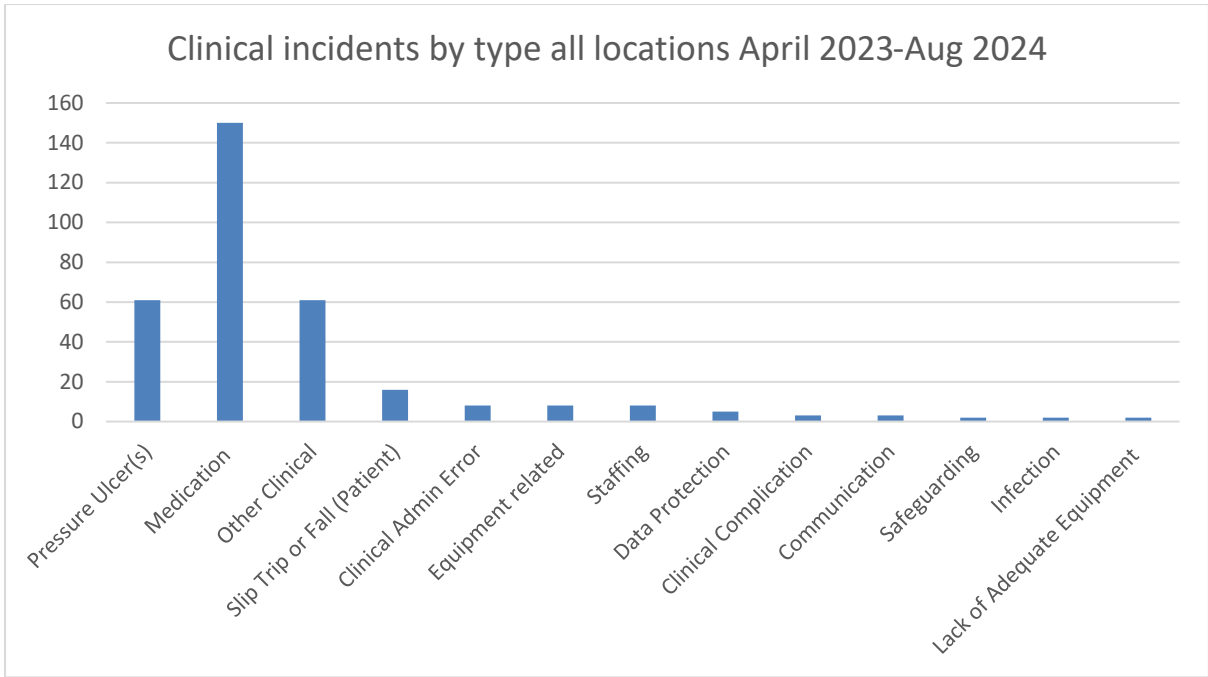
Some of the ways are Living Well Service can help are through:

- Groups Programs such as our Fatigue, Anxiety and Breathless Programme, Mindfulness Program and Chair Based Exercises
- Art Groups focusing on wellbeing and also bereavement support
- Complementary Therapies. Complementary therapies are considered an integral part of our holistic care. St Mary's provides a wide range of complementary therapies to help patients, their families and carers, who may be experiencing feelings of stress or anxiety around a diagnosis, the illness itself and those who may be bereaved. Our complementary therapy team can offer a range of 1:1 and group therapy sessions and complementary therapy are available at any point from diagnosis.

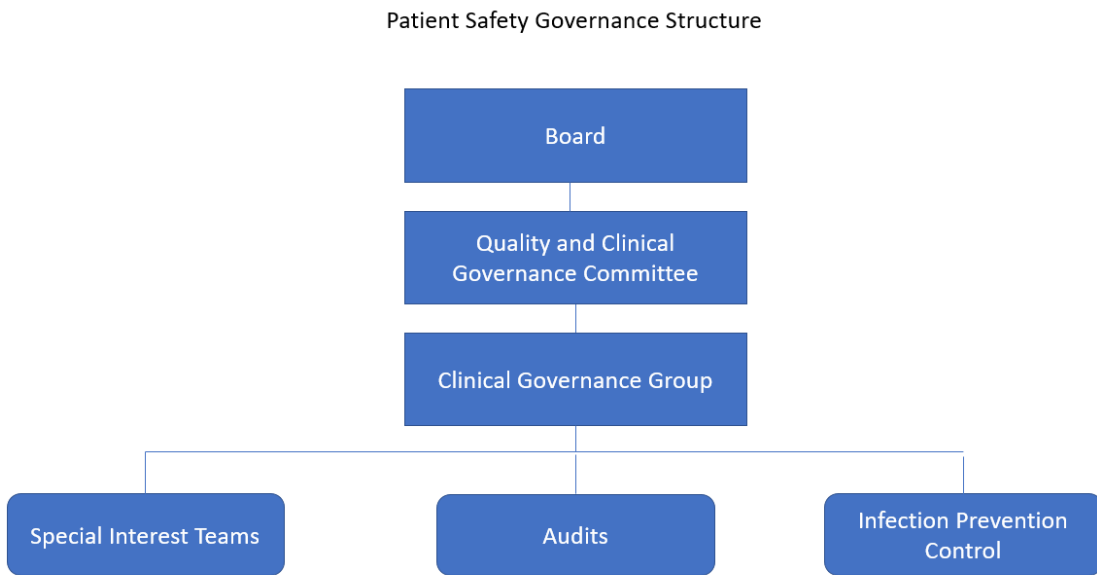
## **Defining our patient safety incident profile**

The patient safety incident profile was created using a review of all incident reporting from April 2023 to August 2024.

St Mary's uses Vantage as an incident management database and reports have been run to demonstrate the top safety priorities where either actual patient harm occurred, or where there was a risk of patient harm. From this analysis Medication, Pressure Ulcers and Falls were identified as the top three safety priorities.



Special Interest Teams (SITs) have been established to promote learning and improvement around these themes and form part of SMH 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 fortnightly and results analysed by the Clinical Governance Group. 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.

SMH's Special Interest Teams meet every 8 weeks to review improvement actions plans in these respective areas. Clinical Governance Group and Quality and Clinical Governance Committee have oversight of the plans.

The falls team have been developing training programmes for staff as well as development of new falls risk assessment tool and pathway.

The pressure ulcer team have introduced new equipment which has reduced the incidence of pressure ulcers. They are also introducing teaching session for staff to build knowledge and confidence of pressure ulcer care.

Medication incidents is our largest area of reported incidents and the medication team have been reviewing incidents to establish themes within these incidents. From this work new storage, measuring tools and training have been implemented.

St Mary's Hospice benchmarks against Hospice UK standards so that incident rates can be compared against peers.

## Our patient safety incident response plan: National requirements

Patient safety incident type	Required response	Anticipated improvement route
Never Events criteria	<b>PSII (patient safety incident investigation)</b>	Local investigation by Learning Response Lead supported by ICB.  Reviewed by Quality and Clinical Governance Committee and any identified actions added to action plans.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	<b>PSII (patient safety incident investigation)</b>	Local investigation by Learning Response Lead supported by ICB.  Reviewed by Quality and Clinical Governance

		Committee and any identified actions added to action plans
Deaths of persons with learning disabilities	<b>Refer for Learning Disability Mortality Review (LeDeR)</b>	LeDeR programme
Deaths of patients where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	<b>PSII (patient safety incident investigation)</b>	Local investigation by Learning Response Lead supported by ICB.  Reviewed by Quality and Clinical Governance Committee and any identified actions added to action plans.
Safeguarding incidents in which: <ul style="list-style-type: none"> <li>• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence</li> <li>• adults (over 18 years old) are in receipt of care and support needs from their local authority</li> <li>• the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</li> </ul>	<b>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</b>	Refer to local designated professionals for child and adult safeguarding
Any Incident causing patient harm which are level 3 harm and above	<b>Rapid Review</b>	Create a local action plan following review meeting.

(as defined by LFPSE) to be considered for PSII – (PSII to be considered if wider organisational system issues require investigation)		Review at Clinical Governance Group and longer-term actions monitored.  If PSII required - this will be escalated to Quality and Governance Committee for oversight.
Low or no harm level incidents	<b>Thematic analysis and action planning at Clinical Governance Group</b>	Report to Quality and Governance Committee.

St Mary's 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 St Mary's Hospice will identify the lead organisation to coordinate investigation and involve relevant system partners, including patient representatives or family members. Where required St Mary's Hospice will participate in, and contribute to whole system reviews.

Detail of how incidents are investigated is found in the St Mary's PSIRF policy which is available on the website.

St Mary's Hospice is particularly keen to disseminate key learning themes throughout the organisation. This may be through:

- Team meetings
- Sharing at MDT meetings
- Locally or at whole organisational meetings if considered appropriate

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

- QR code and web-based options for real time feedback which is collated and presented via the Quality and Clinical Governance Committee reports
- 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 at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group and share with Special Interest Teams to inform improvement strategies.
Falls Incident	Rapid review and Thematic Analysis  monthly reviews with thematic analysis at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group and share with Special Interest Teams to inform improvement strategies.
Pressure Ulcer Incident	Rapid review and Thematic Analysis  monthly reviews with thematic analysis at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group and share with Special Interest Teams to inform improvement strategies.

## Review of Safety Incident Response Plan

This plan should be reviewed at a maximum of 18 months to consider if capacity or/ and need exists to change the plan profile.