Patient Safety Incident Response Plan

Contents

Section	Page
Introduction	3
Our Services	3
Our Patient safety Incident Profile and Plan	5
Defining our Patient Safety Incident Profile	5
Defining Our Patient Safety Improvement Profile	8
Our Patient Safety Incident Response Plan: National Requirements	9
Our Patient Safety Incident Response Plan: Local Focus	12
Review of Safety Incident Response Plan	13

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 service is 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

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.

Our Patient safety Incident Profile and Plan

Defining our Patient Safety Incident Profile

In line with PSIRF guidance, the hospice has adopted a proportionate approach to learning responses, selecting methods that align with the scale, complexity, and nature of the incidents identified within our profile.

St Mary's Hospice incident data from April 2023 to Dec 2025 has been reviewed for the development of this PSIRP.

None of the following incident types were reported in 2023-2025:

- Never Events
- Coroner initiated investigations or Coroner requested signed statements following patient safety investigations
- Patient/Family/Carer complaint related patient safety incidents
- Investigations by independent specialist (commissioned locally or national)
- Referrals to the Health Services Safety Investigations Body (HSSIB).

We have replaced the use of Root Cause Analysis (RCA) process, which had been a tool used frequently in healthcare investigation management, with systems-based investigation tools and the use of Hot and Cold debriefs.

We have also contributed incident data to the Hospice UK Patient Safety Project to enabled benchmarking against other similar hospices. In 2024 the focus of the project reporting changed to focus on quality improvement rather than benchmarking.

Analysis of patient safety incidents reported between April 2023 and December 2025 has identified three predominant categories:

- Pressure damage (including acquired pressure ulcers)
- Patient falls
- Medication-related incidents

All incidents are systematically reviewed using Statistical Process Control (SPC) methods to identify variation, emerging risks, and opportunities to assess the impact of improvement initiatives. SPC charts provide a structured way of analysing data over time, supporting a continuous learning approach and highlighting where further targeted action may be required. Effective quality improvement interventions are typically reflected in a reduction in reported incidents, which should stabilise at a lower, sustained level over time. Additionally, SPC charts enable the detection of gradual trends or sudden spikes—known as special cause variation—indicating areas that may require further investigation or closer monitoring.

Patient safety incidents risks are analysed using data from Vantage incident reporting system each month. These are reviewed at the Hospice's Incident Group meeting.

<u>Medication incidents</u>

Medication incidents, particularly controlled drug (CD) discrepancies, were identified as a recurring incident category. Thematic review identified variation in measurement and documentation processes as key contributory factors.

A standardised system for measuring controlled drugs was introduced to reduce variation and improve reliability. Subsequent monitoring demonstrates a reduction in discrepancy incidents, indicating that system-level changes have led to improvement.

Patient Falls

An increase in patient falls prompted a structured thematic review. This identified that falls were multifactorial in nature, with no single dominant cause, but highlighted the importance of early risk identification and consistent preventative measures.

In response, the hospice implemented:

- An enhanced falls risk assessment within the first 24 hours of admission
- Falls alarms on all beds to improve responsiveness to patient movement

Learning has been supported through both thematic review, specialist improvement groups of staff and debriefs, allowing timely reflection following incidents (hot debriefs) and more considered, retrospective analysis (cold debriefs).

Ongoing evaluation will focus on these interventions and further learning will be shared with those involved in incidents.

Pressure Damage

Incidents involving acquired pressure ulcers were identified as a priority for improvement. Analysis indicated that in Q2 2023-24 that there was an increase in acquired pressure ulcers. In response to this the Hospice implemented:

- Pressure-relieving mattresses
- PURPOSE T risk assessment tool to support a consistent and structured approach

Following these changes, the number of acquired pressure ulcers have reduced. Ongoing evaluation will continue to monitor the effectiveness of these implementations.

In relation to risks affecting both patients and staff, the Departmental Risk Register captures a broad spectrum of risks across hospice services, including those associated with patient care, staff wellbeing, operational effectiveness, and organisational reputation. These risks are not always directly linked to patient safety incidents. In most cases, risk ratings are determined primarily by the potential consequence rather than likelihood, and they are reviewed at least quarterly. The register is dynamic in nature and is updated regularly, with formal reviews taking place at least quarterly or more frequently if required.

Learning from deaths in the NHS (NHSE, 2024) has highlighted that reviewing the deaths of people in their care can help providers improve the quality of the care provision for patients and their families and identify areas for improvement. This guidance is aimed at NHS Trusts; however, the National Quality Board (NQB) recommends that care provided to those patients who are receiving end of life care is reviewed. St Mary's Hospice specifically provides bespoke palliative care as a speciality and measures the quality and safety of its services by monitoring patient and family feedback, and through NICE and Audit processes, and the medical examiner processes as per the Care of a Patient After Death policy

Feedback from patients, families and carers is collected through a range of channels, including face-to-face conversations, telephone discussions, and surveys returned either by post or digitally. During 2024–25, a review of feedback processes was undertaken to expand the methods available and increase response rates. As a result, by Quarter 4 the volume of

feedback had risen by over 400%. St Mary's Hospice values all feedback as an important component of its continuous learning and improvement approach. A comprehensive report of feedback is presented quarterly to the Quality and Governance Committee. Survey results indicate consistently high levels of satisfaction, with no identified patient safety concerns requiring further learning or action.

The Hospice works in collaboration with other hospices and partner organisations to share learning opportunities.

Defining Our Patient Safety Improvement Profile

Following analysis of the data from 2023-2025 the following patient safety incident types are the most reported:

- Pressure Ulcers
- Medicine Management
- Patient Falls

Our primary learning response methods to investigate and learn from these are:

- **Thematic reviews** – used to identify patterns, common contributory factors, and system issues across groups of incidents
- **Hot debriefs** – undertaken shortly after incidents to capture immediate insights and support timely learning
- **Cold debriefs** – undertaken retrospectively to allow more in-depth reflection and identification of system improvements

These approaches support a culture of continuous learning, enabling us to understand how work is carried out in practice and to make meaningful improvements to patient safety.

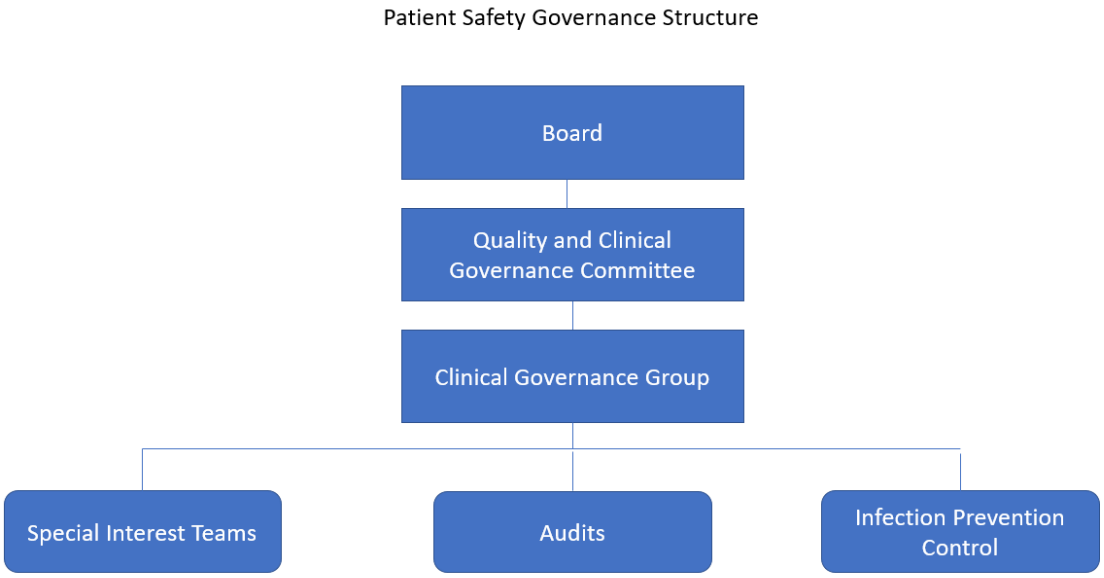
At present, we have not identified incidents that meet the threshold for a Patient Safety Incident Investigation (PSII) and do not anticipate a high volume of such incidents given the nature and scale of our service.
However, we recognise the importance of maintaining access to appropriate expertise. Should a PSII be required, we will seek support from our Integrated Care Board (ICB) to ensure that any investigation is conducted in line with PSIRF standards and with the necessary level of independence and capability.

Our patient safety incident profile will be subject to continuous review to ensure it remains responsive to emerging risks and learning. We are committed to:

- Understanding the system conditions and contributory factors associated with incidents
- Using proportionate learning responses to generate meaningful insight
- Embedding learning into practice to improve the reliability and safety of care

- Reviewing the effectiveness of improvement actions over time

This approach ensures that our patient safety work remains focused on learning and sustained improvement, in line with the principles of PSIRF.



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 by Learning Response Lead supported by ICB. Reviewed by Quality and 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	**PSII (patient safety incident investigation)**	Local investigation by Learning Response Lead supported by ICB.

criteria for patient safety incident investigations (PSIIs))		Reviewed by Quality and Governance Committee and any identified actions added to action plans
Deaths of persons with learning disabilities	**Refer for Learning Disability Mortality Review (LeDeR)**	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)	**PSII (patient safety incident investigation)**	Local investigation by Learning Response Lead supported by ICB. Reviewed by Quality and Governance Committee and any identified actions added to action plans.
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

Any Incident causing patient harm which are level 3 harm and above (as defined by LFPSE) to be considered for PSII – (PSII to be considered if wider organisational system issues require investigation	**Hot/Cold Debrief** **Thematic analysis and action planning at Clinical Governance Group**	Create a local action plan following review meeting. Review at Clinical Governance Group and longer-term actions monitored. If PSII/LFPSE required - this will be escalated to Quality and Governance Committee for oversight.
Low or no harm level incidents	**Thematic analysis and action planning at Clinical Governance Group**	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 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 identity 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

We will use the Learn from Patient Safety Events (LFPSE) service, in line with our PSIRF Policy and Patient Safety Incident Response Plan, to record, analyse and share learning from patient safety events.

LFPSE is the national NHS system for reporting and analysing patient safety events across healthcare settings. It supports organisations to identify themes, learn from incidents, and improve patient safety through shared learning.

Further information about the Learn from Patient Safety Events (LFPSE) service is available at: https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/

Our Patient Safety Incident Response Plan: Local Focus

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Medication Incident	Hot/Cold (Shared) debrief and Thematic Analysis monthly reviews with thematic analysis at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group Share with Quality Monitoring Teams to inform improvement strategies. Use of SPC charts to identify variations
Falls Incident	Hot/Cold (Shared) debrief and Thematic Analysis monthly reviews with thematic analysis at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group Share with Quality Monitoring Teams to inform improvement strategies. Use of SPC charts to identify variations
Pressure Ulcer Incident	Hot/Cold (Shared) debrief and Thematic Analysis monthly reviews with thematic analysis at Clinical Governance Group meetings	Create local safety actions at Clinical Governance Group Share with Quality Monitoring Teams to inform improvement strategies. Use of SPC charts to identify variations

Any incident where it is felt that the opportunity for learning and improvement is significant, or should also be reported through The Learning from Patient Safety Events (LFPSE) portal.

The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare.

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.