



Registered charity no. 515516

Patient Safety Incident Response Plan

01244 851 091

info@hospicegs.com

hospicegs.com

Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
Authors	Lisa Parker	Director of Quality and Improvement		07/05/2025
	Claire Royce	Director of Clinical Services		
Reviewer	Julia Chambers	Patient Safety Lead		07/05/2025
Authoriser	Richard Crockford	Associate Director, Nursing and Care		07/05/2025

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Introduction

This patient safety incident response plan sets out how the **Hospice of the Good Shepherd** intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This patient safety incident response plan (PSIRP) details how the **Hospice of the Good Shepherd** will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide, and in turn improve the experience for all involved.

The Patient Safety Incident Response Framework (PSIRF) sets out the national patient safety approach to developing and maintaining effective systems and processes for responding to patient safety events for the purpose of learning and improving patient safety. It is recognised that there will need to be a shift towards systems-based approaches to a learning culture to allow health care organisations including Hospices to effectively respond to and learn from events, with the purpose of reducing the risk of avoidable harm as low as reasonably possible. The introduction of PSIRF provides health care organisations including Hospices with more autonomy and flexibility in our approach to patient safety events. Patient safety events can be defined as

“Any unintended or unexpected incident which could have, or did, lead to harm for one or more patients’ receiving healthcare”.

Compassionate engagement is a key fundamental of PSIRF. Clear communication with those affected by patient safety events to determine the focus of any review is vital to ensure that the voice of the patient, families/carers, and staff is at the heart of any response and learning. Documentation of clear communication and engagement is vital. It should be acknowledged that PSIRF is a new framework for the identification and response to patient safety events, however, the aims and ethos have been adopted within healthcare for some time. The implementation process will take time to progress and embed, and will require regular review to ensure that health care organisations, including Hospices, can demonstrate positive assurance in improvements and safety. Enhancing data quality and agility will need to be at the heart of the implementation process to ensure continuous progression.

‘The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them’

- Aiden Fowler, National Director of Patient Safety.

Hospices across Cheshire & Merseyside have come together to work collaboratively and share learning during the PSIRF development process. Hospices in Cheshire & Merseyside will continue to meet to address challenges with PSIRF and share good practice, whilst ensuring that the **Hospice of the Good Shepherd** has a local focus for quality improvement. Continuing the work that the Network has established will provide a Community of Practice for the Cheshire & Merseyside Hospices to share their thematic work and local improvement plans; the successes that they have had and how they can improve.

Our services

Cheshire & Merseyside has a population of 2.7 million across 9 local authorities. Within Cheshire & Merseyside there are 16 Hospices providing services for both adults and children.

Cheshire & Merseyside Hospices are registered charities that provides specialist care and support for adults and children with life-limiting illnesses. The Hospices also provide support to the patient's families and loved ones. Hospice care eases the physical and emotional pain of death and dying. Letting people focus on living, right until the end.

Cheshire & Merseyside Hospices provides services across inpatients, outpatients, various therapies and support groups, Hospice at Home services and the Advice Line.

The Hospice of the Good Shepherd provides specialist palliative care services for people and those who are important to them, living in West Cheshire and Deeside with a life limiting illness, including advanced cancer, heart failure, respiratory failure, renal disease, and progressive neurological diseases such as Motor Neurone Disease.

Care is designed to meet the needs of everyone through a combination of expert clinical care, community support, education and partnership working with other organisations. **The Hospice of the Good Shepherd's** specialist multi-disciplinary team includes doctors, nurses, physiotherapists, occupational therapists, social worker, chaplain, counsellor, music and art therapists and complementary therapy practitioners. Care comprises of support with social, emotional, spiritual and psychological issues as well as physical care to help with symptoms such as pain.

We want people to live as well as possible, making sure they get the best possible care at the end of their lives whilst maintaining their dignity and respecting their wishes.

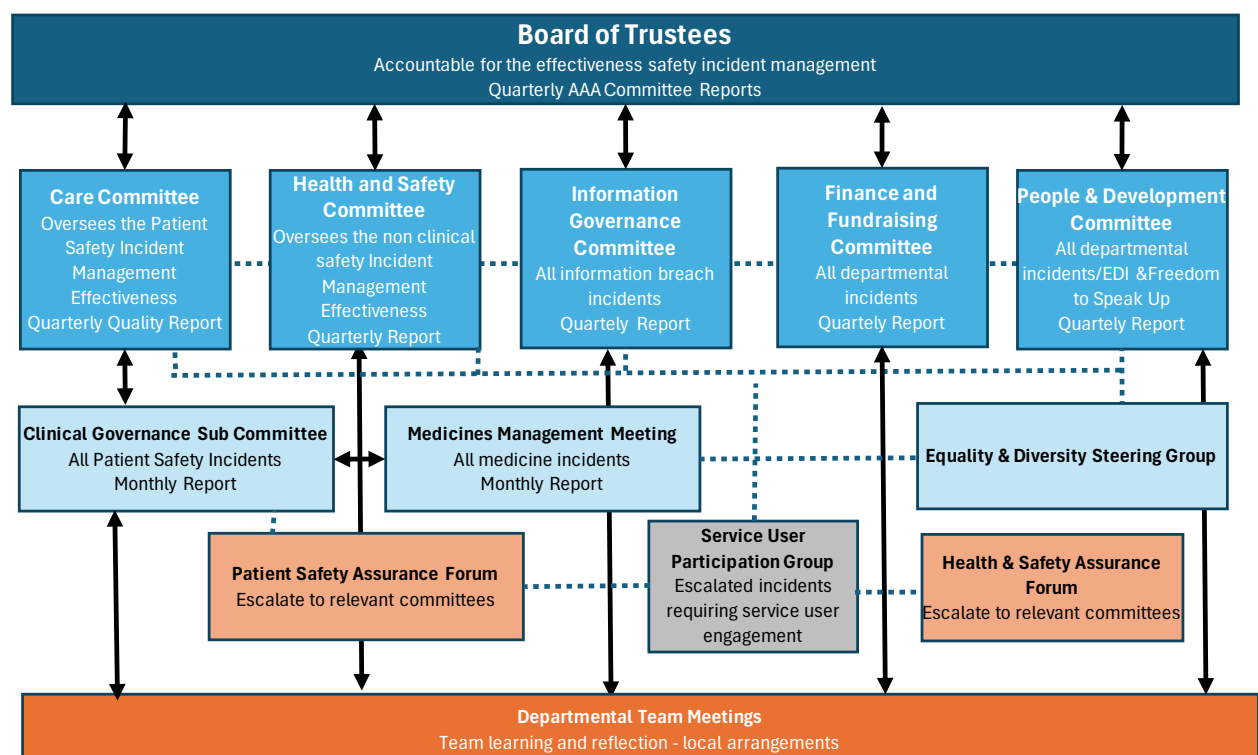
During 2023/2024 the **Hospice of the Good Shepherd** provided care and support to 140 inpatients, 320 patients attending either our Living Well Services or outpatient clinics, 144 carers and 173 counselling clients across West Cheshire and Deeside.

Defining our patient safety incident profile

The Cheshire & Merseyside PSIRF Hospice Network was established to support a collaborative approach to designing the patient safety profile. There were seven Hospices (Appendix A) from across Cheshire & Merseyside who worked together. Some key actions taken by the Network include:

- Links with C&M NHS ICB Patient Safety Leads
- Development of C&M Hospice's PSIRF Plan
- Identification of key stakeholders
- Identification of key lead roles
- Identification of Hospice training needs

The Hospice of the Good Shepherd Governance Framework for safety critical incident management is displayed below:



The Hospice of the Good Shepherd participates in several activities to increase the overall patient safety profile:

- All incidents are discussed at the monthly [Patient Safety Assurance Forum](#). This forum provides oversight, governance and quality monitoring of patient safety incident investigations undertaken by the Hospice of the Good Shepherd. It promotes Safe, Effective and Responsive care to achieve quality and improvement outcomes in unity with the Patient Safety Incident Response Framework. This group ensures that all learning is also communicated with employees across the organisation.
- This group will also play a key role in monitoring and promoting equality and diversity across all incidents. There will be a specific focus on safeguarding the rights and well-being of individuals with protected characteristics who are affected by an incident, examples of this could be: pressure ulcers not recognised on brown skin, or not providing a person with learning disabilities the appropriate communication support to express pain effectively, resulting in an avoidable urgent care transfer to hospital.
- A summary of all incidents and learning themes are presented to the monthly [Clinical Governance Sub-Committee](#) as a further governance opportunity. After Action Reviews will also be reported into Clinical Governance Sub-Committee with significant learning escalated to the quarterly [Care Committee](#).
- A summary of medication incidents are discussed at the bi-monthly medicines management meeting with pharmacy representative and clinical leads for Inpatient Services and Living Well Services.
- The hospice Controlled Drugs Accountable Officer attends the quarterly Local Intelligence Network to share best practice and learning across the Northwest of England. This work is also shared at the hospice bi-monthly medicines management meeting.
- Learning from complaints and service user feedback is monitored by the quarterly [Care Committee](#).
- Where learning from incidents, complaints, concerns and service user feedback has significant impact to the hospice strategic objectives, these are escalated on the strategic risk register via an Advice, Assure, Alert reports through to [Board of Trustees](#).
- The hospice has a clinical audit programme, reviewing all safety critical processes. This is designed and based on national, and regional priorities and internal learning themes gathered from incident data.
- The hospice participates in the [Hospice UK Patient Safety Project](#) aimed to improve patient safety in hospices and accelerate related learning and improvement work.

Data regarding medication, falls and pressure ulcers are submitted quarterly in return of aggregated data report for comparison with other hospices.

- The hospice participates in the online Hospice UK Patient Safety Communication of Practice who facilitate learning events via discussion groups on a Microsoft Teams channel and quarterly meetings.
- The hospice service user participation group meet quarterly to review areas for improvement following service user feedback obtained via surveys and in person from bi-monthly quality and improvement volunteer sessions.
- The Director of Quality and Improvement attends a quarterly Quality Leads meeting with Cheshire Hospices and Integrated Care Board Quality and Safeguarding Managers to share best practice and patient safety initiatives.
- The hospice is a member of the Cheshire and Merseyside PSIRF Network Group. As the group develops there will be opportunities to strengthen cross-system learning from incidents. Where there are multiple organisations involved, the hospice will agree on a lead investigator and/or contribution to produce one overarching investigation report.
- There is an Equality, Diversity and Inclusion Steering Group who meet quarterly to develop and monitor improvements in equality, diversity and inclusion across the hospice.
- The hospice will report internal and external patient safety incidents and record risks and outcomes as well as recording examples of good care that can be used to improve our services via the Learning from Patient Safety Events Service.

One year of incident data was reviewed from the following sources:

- Incident data recorded on the local risk management system Radar Healthcare
- Safeguarding concerns
- Complaints
- Staff interviews
- Staff learning statements

Whilst the data varied for each Hospice there were 4 key incident types highlighted across the C&M Hospice Network:

- Pressure Ulcers developed during inpatient stay
- Falls resulting in harm
- Medication incidents
- Equipment related incidents

At The Hospice of the Good Shepherd [01/04/2024 to 31/3/2025] incident data was reviewed:

Type of Incident	Number of occurrences	% of all incidents	Improvement works underway*
Medication	37	49%	Incidents involving medication remain the most frequent of all incidents. Despite quality improvement work such as: • Nurses wearing Red Dispensing Alerts Tabards when handling all medications. • Improved bespoke electronic patient bedside medication lockers. • Increased staff training in medication management. Documentation errors account for the highest number of all medication errors
Pressure Ulcer	26	34%	Thematic analysis has shown that of the 26 pressure ulcers reported 11 (42%) of them were acquired during admission on the Inpatient Unit. Current improvement work underway includes: • PU categorisation to move in line with community and National Wound Care Strategy • Review care plans - include ASSKING template and red flags as prompts • Consider moving to PURPOSE T as risk assessment tool (currently used in community and highlighted on the National Wound Care Strategy). • Improve quality of photograph by using IPAD's
Falls	7	9%	Falls feature within the thematic analysis as part of the clinical audit programme. Current thematic analysis shows that confusion or terminal agitation are not an overarching contributing factor to patients falling. Falls alarms and bed sensors are utilised effectively,

			however falls alarms are sometimes removed by patients or their visitors. It is noted that, at times, the falls alarm only sounds once the patient has stood up. Work is underway to educate and support patients and their visitors on how to use the alarms. Likewise, a review of the sensor alarm efficiency.
Other	6	8%	

Defining our patient safety improvement profile

Medication Incidents

The total number of medication incidents recorded was **37. 31** (83%) of these relate to Controlled Drugs. Table 1 shows the breakdown of all Controlled Drug incidents by type.

Incident Type	Incident Number	% of type.
Documentation	16	52%
Administration	7	22.6 %
Dispensing	6	19%
Prescribing	1	3.2%
Calculation	1	3.2%

(Table 1)

Documentation errors remain the highest percentage of recorded Controlled Drug incidents, accounting for half of the total number, followed by administration errors, this is despite the implementation of safe systems, policies, training and audit procedures.

Area of Focus: To explore the underlying reasons for Controlled Drug documentation incidents and identify system factors that contribute to human error, where there is a 2-persons checking procedure in place **(n-6)**

Pressure Ulcers

For the period of 01 April 2024 – 31 March 2025 there were **26** Pressure Ulcer incidents recorded. **11** (42%) were acquired during the In Patient stay, **3** (27%) went on to develop a Category 3 or Unstageable Pressure Ulcer.

Whilst these numbers are small and continue to improve, thematic analysis shows proactive care planning at the time of admission for potential at risk patients can be improved on. Analysis shows that if the patient does not present with a pressure ulcer on admission it is less likely that education around pressure damage risk will be discussed. Moreover, when patients decline to be repositioned there is a need to understand what support and education is given to patients and their families to enhance patient centred care planning, with an emphasis on reducing the risk of pressure sore development.

Area of Focus: Hospice acquired pressure ulcers that result in patients declining to be repositioned, with a particular focus on last days of life. **(n-6)**

Falls

Of the **7** total falls, it was documented that **5** (71.4%) of patients showed no signs of confusion, **1** (14.30%) patient had fluctuating capacity whilst **1** (14.30%) other patient was confused and agitated at the time of the incident.

4 (57.14%) patients fell whilst trying to access the bathroom. 1 (14.28%) patient, reported an unwitnessed fall to staff the following day, explaining that he was trying to close the curtain. 1 (14.28%) patient with fluctuating capacity fell getting out of her chair, while 1 (14.28%) patient who was confused and agitated was witnessed lowering himself to the floor.

Patients with confusion and fluctuating capacity had bed sensor alarms in place. These patients were also nursed in rooms closer to the nursing station, and /or in the observation bay. It is noted that on one occasion the bed sensor had been disconnected by the patient and the family member. In the second instance the sensor only alarmed at the time the patient fell.

Area of Focus: What are the contributing factors for patients who are assessed as being mobile and independent falling and how can this risk be mitigated against? For example: How timely is physiotherapy and occupational therapy assessment support from admission. (n-4)

At the Hospice of the Good Shepherd, there is a strong focus on safety and governance. Robust systems are in place to report and manage incidents effectively. Oversight and scrutiny are provided through Senior Clinical Leadership and the Board of Trustees.

Medication incidents have a dedicated nurse led Task and Finish Group. Pressure Ulcer incidents have a committed Senior Nurse/Practice Development Lead, who directs and supports quality improvement work. All incidents are discussed at appropriate local organisational meetings, such as the Medication Management Meeting Bi-monthly. All incidents are discussed monthly at the Patient Safety Assurance Forum.

Practice Development Nurses support and ensure that all learning and quality improvement initiatives are driven across the clinical areas with senior leadership oversight. More recently we have developed a nursing forum that has allowed for more supportive and engaged discussions relating to patient incidents and learning opportunities.

The threshold for After Action Review reporting is the monthly Clinical Governance meeting and Quarterly Care Committee thereafter, both meetings have Senior Clinical Leadership and Board of Trustee representation.

The Hospice of the Good Shepherd also engages and commits to working with the Integrated Health Board in providing statutory and commissioner quality and governance evidence through the NHS Quality Schedule.

Employee Wellbeing and Training

Ergonomics and the focus on human factors are at the heart of the Response Plan. The Hospice of the Good Shepherd will always work to the key principles of a Just and Generative Culture:

- **Transparency**
- **Learning from Errors**

- **Fairness**
- **Open communication**

Employees will feel confident and supported to report incidents through strong and engaged leadership at every level.

To support the effective roll out of PSIRF the following training will be undertaken by the staff outlined:

Topic	All Hospice Staff	Staff undertaking incident investigations	Patient Safety Specialist & Engagement Lead	PSIRF Oversight Role	Exec Leadership Team / Board	Trustees
Patient safety syllabus level 1: Essentials of patient safety for all staff	✓	✓	✓	✓	✓	✓
Patient safety syllabus level 1: Essentials of patient safety for boards and senior leadership teams				✓	✓	✓
Patient safety syllabus level 2: Access to practice		✓	✓	✓		
Oversight of learning from patient safety Incidents (HSSIB)				✓		
Systems Approach to Learning (HSSIB)		✓				
Involving those affected by Patient Safety Incidents in the Learning Process (HSSIB)			✓			
Continuing professional development (CPD)		✓	✓	✓		

Our patient safety incident response plan: national requirements

Below are events that require a safety investigation response, as recommended by NHS England in their [Guide to responding proportionately to patient safety incidents](#).

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for Patient Safety Incident Investigations)	Patient Safety Incident Investigation	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Patient Safety Incident Investigation	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Clinical Quality/ Governance Group. ICB Quality lead invited to meeting to review.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for	Patient Safety Incident Investigation led by most appropriate Trust

Patient safety incident type	Required response	Anticipated improvement route
	consideration for an independent PSII	
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent Patient Safety Incident Investigation	Patient Safety Incident Investigation led by Maternity and Newborn Safety Investigations (MNSI)
Child deaths	Refer for Child Death Overview Panel review	Follow the Child Death Overview Panel process
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	Consideration for section 42 enquiries led by Local Authority
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	Patient Safety Incident Investigation
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations	Patient Safety Incident Investigation, alongside Police processes

Patient safety incident type	Required response	Anticipated improvement route
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	Domestic abuse related death review led by CSP

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medication incident Where there has been a medication error relating to documentation or administration of Controlled Drugs. Examples could be missed signatures, the lack of second checker vigilance when signing the Controlled Drugs book.	An After-Action Review (AAR) will take place as soon as possible after the incident is identified. The AAR will focus on systems-based learning, following the principles of: • Collective Learning • Structure • Inclusivity and participation • Psychological safety for all participants • Timely and proportionate. Ongoing monitoring via audit and thematic review Continued partnership working with NHS Pharmacy support and Medication Optimisation colleagues.	Create local safety actions and feed these into the quality improvement strategy, ensuring that all safety learning is translated across the organisation as practical and system level improvements. Reviewed by the Patient Safety Assurance Forum and monitored at Clinical Governance Committee.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure ulcer Hospice acquired Pressure Ulcers that result in patients declining to be repositioned, with a particular focus on last days of life.	An After-Action Review (AAR) will take place as soon as possible after the incident is identified. The AAR will focus on systems-based learning, following the principles of: • Collective Learning • Structure • Inclusivity and participation • Psychological safety for all participants • Timely and proportionate. Collaboration with Tissue Viability Nurses. Ongoing Audit to review system efficacy.	Create local safety actions and feed these into the quality improvement strategy, ensuring that all safety learning is translated across the organisation as practical and system level improvements. Reviewed by the Patient Safety Assurance Forum and monitored at Clinical Governance Committee. Working alongside local and regional system partners to triangulate learning.
Inpatient fall Patients who fall who have been assessed as being mobile and independent. What were the contributing factors to these types of falls.	An After-Action Review (AAR) will take place as soon as possible after the incident is identified. The AAR will focus on systems-based learning, following the principles of: • Collective Learning • Structure • Inclusivity and participation • Psychological safety for all participants	Create local safety actions and feed these into the quality improvement strategy, ensuring that all safety learning is translated across the organisation as practical and system level improvements. Reviewed by the Patient Safety Assurance Forum and monitored At Clinical Governance Committee.

Patient safety incident type or issue	Planned response	Anticipated improvement route
	Timely and proportionate Ensuring that all AAR's offer opportunity for wider MDT contribution, particularly therapy colleagues who provide a commissioned service to the hospice.	

Appendix A

The 7 Hospices who contributed to the joint PSIRF plan:

Hospice	Locality
Claire House Children's Hospice	Wirral
Hope House Children's Hospice	West Cheshire
Hospice of the Good Shepherd	West Cheshire
St Joseph's Hospice	Sefton
St Luke's Hospice	West Cheshire
Willowbrook Hospice	Knowsley
Wirral Hospice St John's	Wirral