Patient safety incident response plan

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Introduction and Background

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'.

An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.

Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (e.g. the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a Patient Safety Incident Investigation (PSII) for example mixed investigation remits, lack of dedicated time, limited investigation skills by the staff undertaking them. We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future PSIIs
b. conducting PSIIs purely from a patient safety perspective
c. reducing the number of PSIIs into the same type of incident

d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

The PSIRF approach allows Dorothy House to consider the safety issues that are common to similar types of incidents and, on the basis of the risk and learning opportunities they present and demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or
b. the subject of current improvement work that can be shown to result in progress or
c. listed for PSII work to be scheduled in the future.

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

a. professional conduct/competence – referred to human resource team
b. establishing liability/avoidance – referred to claims or legal teams
c. cause of death – referred to the coroner's office
d. criminal – referred to the police.

Our patient safety incident response plan sets out how **Dorothy House Hospice Care** intends to respond to patient safety incidents. We will remain flexible; the plan is not permanent and will be subject to change and ongoing learning.

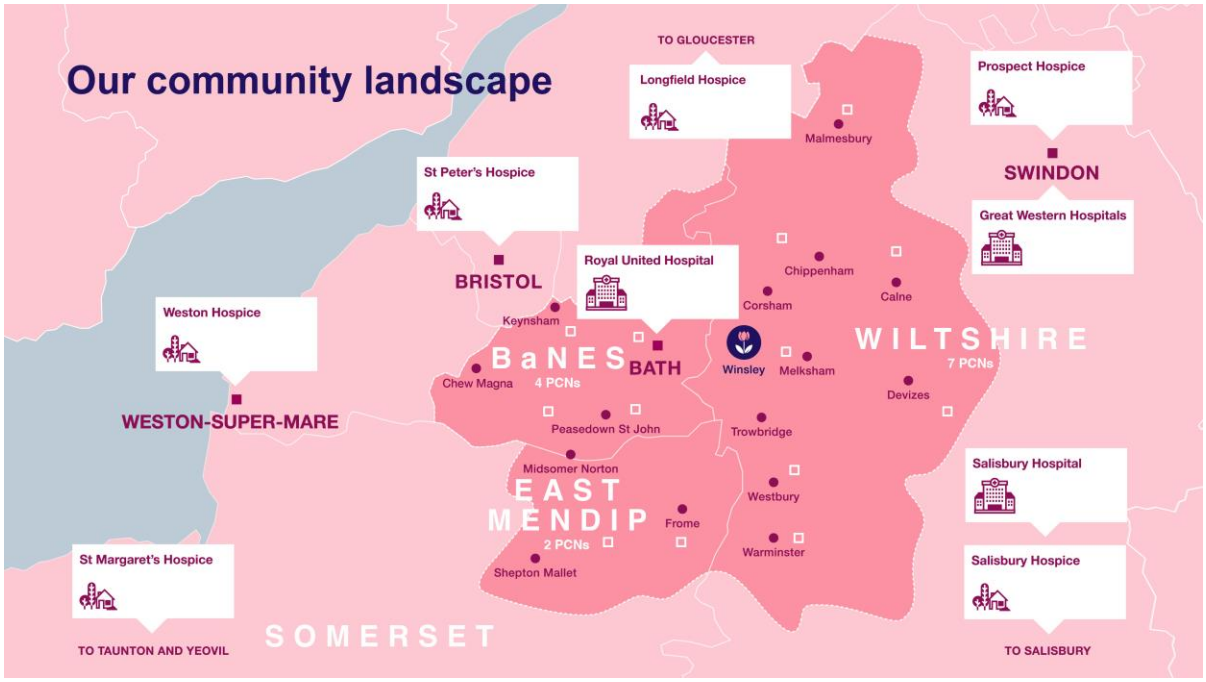
The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a patient safety incident occurs. It is a replacement for the NHS Serious Incident Framework.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Incident Framework which focussed more on process than emphasising a culture of continuous improvement in patient safety.

This framework is designed to focus on undertaking investigations in a collaborative way, led by those who are **trained** to conduct them. It ensures the involvement of patients, their families, carers and staff, is embedded in a system that responds in the right way, appropriate to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with an emphasis on systemic improvement.

Analysis of our current systems has improved our understanding of our patient safety processes and allowed us to use these insights to review our PSIRP.

Our services



Dorothy House Hospice Care is a healthcare charity, which is partially NHS commissioned, providing palliative and end of life care to adults with a progressive, treatable but not curable, life-limiting illness or for those with severe frailty and their family (including children) and carers. We cover a 800sq mile area with a population of around 593,000 across Bath and North East Somerset, parts of Wiltshire and Somerset. In 2024/25, we cared for 4,245 people - patients, their families and carers. As from April 2025 we are commissioned by HCRG.

Below is a list of the services we provide:

Clinical Coordination Centre: A team of Clinical administrators who receive and process all the referrals into Dorothy House.

Medical Team: Consultants in palliative medicine, speciality doctors, GP trainees and Advance Nurse Practitioners deliver specialist care, training and education.

Inpatient Unit – Specialist Palliative Care: 10-bed specialist unit at Dorothy House, Winsley.

24/7 Advice Line: Clinical advice and support for patients, their families/carers and professional colleagues about any palliative and/or end of life care issue irrespective of a person's diagnosis or whether they are known to us.

Community Palliative Care Teams (CPCTs): Neighbourhood focussed, led by Clinical Nurse Specialists with multi-disciplinary teams supporting patients and their families within

the community, closely aligned to and collaborating with Primary Care Networks, GP surgeries and Community and District Nursing teams.

Hospice at Home (H@H): Experienced healthcare assistants with specialist training in end of life care (Tulip Standard) providing end of life care – day and night - within homes or residential care settings.

Therapies including:

- Physiotherapy
- Occupational Therapy
- Lymphoedema Service
- Complementary Therapy
- Nutrition/dietetics
- Speech and Language
- Admiral Nurse

Family Support Services providing access to:

- Adult social work
- Children and young people's service
- Bereavement services
- Psychological support (pre-bereavement)
- Spiritual support
- Companions service
- Homeless Key Worker
- Creative Arts

Day Services: These include nurse-led services including blood transfusion and other clinics and a growing range of informal wellbeing, relaxation, exercise and social groups across our area.

Open Access Services: Accessed in local venues or online, often delivered in collaboration with local charity partners, these groups are open to anyone in our community affected by a life-limiting illness, loss or bereavement. Examples include:

- The Coffee Connection
- Bereavement Help Points
- Walking Through Grief
- Writing Hour
- Serenity Group

Education, Research & Professional Development: A key pillar of Dorothy House services:

- Leading research to improve palliative and end of life care in the future.
- Professional development and palliative care updates for Dorothy House clinical staff.
- Education programmes for health and social care colleagues in the community and in HE institutions e.g. University of the West of England, University of Oxford etc.

- A facility to host/deliver education programmes and visits and under and post graduate health and social care student placements from a wealth of professional backgrounds.

To enable us to widen our reach, particularly for patients, families and carers with a non-cancer diagnosis we also have:

Admiral Nurse – To support patients their families and carers living with dementia and to provide expert advice to the rest of our clinical teams.

Motor Neurone Disease (MND) Specialist Practitioner- To support patients, their families and carers living with MND and to provide expert advice to the rest of our clinical teams.

Homelessness Link Worker – Promoting our services with under-represented/hard to reach communities.

Speech and Language Therapist (SALT): Providing help to people to develop and improve their ability to communicate effectively, whether through speech, language, or alternative methods. SALT also address eating, drinking, and swallowing problems, known as dysphagia.

Our Care Services are supported by:

- Human Resources (HR) including Health and Safety
- Clinical Quality team including infection, prevention and control
- Education, training and research
- Facilities – including maintenance, housekeeping, catering and reception
- Digital team
- Finance
- Business and programme development team
- Income generation including fundraising
- Retail
- Marketing and engagement
- Governance

Defining our patient safety incident profile

In Financial Year (FY) 2024/25 we recorded 223 patient safety incidents this is an increase of 70% from (FY) 2023/24.

	2023/24	2024/25
Patient falls IPU	37	31
Medication Incidents IPU	23	54
Medication Related Incidents IPU	16	42
Acquired Pressure Ulcers IPU	21	11
Patients Admitted with Pressure Ulcers IPU	51	24
Other IPU	11	16
Other clinical teams	23	47

To understand Dorothy House's profile of patient safety incidents we have reviewed last year's incidents, acknowledging the implementation of a new electronic recording system for Patient Safety Incidents. We have seen an increase in reporting which is a result of introducing PSIRF, having a new electronic reporting system, the new PSIRF training, the awareness of our staff about reporting patient safety incidents and near misses for improving patient care and the culture for learning from patient safety incidents.

Engagement with other Hospices

We benchmark our key patient safety risks from the Inpatient Unit against other hospices; this is managed by Hospice UK:

- Falls
- Medication errors
- Acquired pressure ulcers
- Patients admitted with pressure ulcers

Data is submitted to Hospice UK quarterly and DH receive a report and attend a quarterly seminar to discuss the results.

DH attend a southwest hospices quality and governance forum to discuss patient safety incidents, trends, themes and any learning or change in practice.

We have quarterly meetings with Prospect and Salisbury Hospice to peer review patient safety incidents.

Partner services/organisations:

We engage with our partner organisations regarding patient safety if they are concerned about the care DH is providing or if we are concerned about the care they are providing.

We have quarterly meetings with HCRG Care Group to review any incidents involving both organisations so that system-wide learning can be shared.

DH Clinical Quality Team have linked with the Royal United Hospital NHS Trust Patient Safety Team.

Review of DH data from a range of sources

To help determine any priority areas to support the delivery of PSIRF, an understanding of the scale of patient related safety activity for the year 2024/25 has been reviewed.

There were 7 formal clinical complaints and the main learning and changes in practice has been:

- Adapting the pressure ulcer leaflet used on the In-Patient Unit for patients and families in the community.
- Ensuring early escalation to a senior colleague in the Hospice @Home Team if patients or families are refusing to allow the carer to follow the care plan in the community.
- Appropriate communication for Hospice @Home Carers during visits – They must remain professional and boundaried.
- As an organisation we must be clear about what we do and do not offer.

DH had a CQC inspection in June 2022 where we received an outstanding overall rating.

DH compile a quality improvement plan annually that is part of the Quality Account available on DH website.

DH have Freedom to Speak Up Guardians and there have not been any investigations.

Mortality reviews are conducted by the medical examiners at the Royal United Hospital who report back with any concerns. Zero concerns 2024/25.

All our investigations undertaken from accidents and incidents, complaints and concerns, safeguarding and by the Medical Examiner are presented at the DH quarterly clinical governance committee.

Dorothy house has had:

Zero Clinical Negligence Claims 2024/25
Zero Legal – Inquests 2024/25

Defining our patient safety improvement profile

2023/24 PSIRP highlighted the increase in **falls**. This led to a falls group being commenced and a piece of work completed by a non-clinician as part of their apprenticeship. For the year 2024/25 there has been a **reduction in falls by 16%** on the Inpatient Unit.

In the year 2024/25 there has been a **reduction in acquired pressure ulcers of 48%** in patients on the Inpatient Unit.

The number of medicine patient safety incidents has increased by 146% in 2024/25 but all No Harm or Low Harm. This level of incident is not recorded and reported on by Hospice Uk Benchmarking so is difficult to know an average for a 10 bedded hospice.

The below table shows identified themes and action plans that have been introduced and ongoing work 2025/26.

Theme	Action Plan
An increase in medication and medication related patient safety incidents.	• A medicines safety incidents group has been commenced with staff from the IPU to look at reasons why there is an increase. To report into medicines management and Clinical Governance meetings. • Round table and After-Action Reviews have been held post themes of medication incidents these have led to changes including: ✓ A new transdermal patch chart ✓ Training sessions for staff on Benzodiazepines ✓ Administering medicines down PEG training ✓ Reminding staff of the Rights of medication administration ✓ Daily opioid check for all patients ✓ 120mg dose of Morphine and above double checking ✓ Review of medication patient safety incidents quarterly with IPU team – now being completed monthly

There were no themes from the 'other' patient safety incidents on IPU during the year 2024/25.

The number of patient safety incidents across other teams has increased by 104%. This is as a result in an organisation restructure of the Hospice @ Home (H@H) Team and the Community Palliative Care teams (CPCT) with staff attending patient safety incident meetings and having a greater understanding of patient safety incidents, the introduction of RADAR and the Patient Safety Incident Response Framework training. Some examples of the improvement work from these include:

- The Clinical Coordination Centre Team sending messages to the appropriate workforce member by text and Teams to make sure they are being received.
- The CPCT being more aware of who to contact if a patient is referred at the very end of life with an Implanted Cardioverter Defibrillator that needs to be switched off.
- H@H have written a policy to support staff who are entering properties with pets, due to a couple of incidents with dogs either biting or being aggressive towards our workforce.

Our patient safety incident response plan

How we will respond to National and local Patient safety incidents

			Event Improvement →	Approach →	
Patient Safety Event Occurs	Patient Safety Incident Investigations	National Priorities	Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Respond to recommendations from external referred agency/organisation as required.
			Death thought more likely than not due to problems in care		
			Unexpected death of person with learning disability	Reported & reviewed by Learning Disabilities Mortality Review (LeDeR)	
			Safeguarding incidents meeting criteria	Reported to DH named safeguarding lead	
		DH Priorities	Dorothy House Priorities; • Patient Falls • Medication • Pressure Ulcers Emergent area of risk	Patient Safety Incident Investigation where agreed (detail in DH policy)	A fortnightly meeting - Patient safety incident review meeting, attended by all teams to discuss any concerns, themes, learning from patient safety incidents.
		Local Level	Incidents resulting in moderate or severe harm to patient	Statutory Duty of Candour and Chronological timeline	Update DH thematic analysis of patient safety risks
			No/low harm patient safety incident	Confirmation of facts at local level – thematic analysis	

Dorothy House use a system called RADAR for recording all patient safety incidents across the organisation and we are working on linking to Learning from Patient Safety Events (LfPSE).

Any identified quality improvements from accident and incident investigations are discussed at the above-mentioned fortnightly meeting and where applicable can be added to our Quality Improvement Plan.

Next Steps

Link to LfPSE and continue to embed PSIRF across the organisation.