Marie Curie Patient Safety Incident Response Plan 2023/2024

Purpose

This Patient Safety Response Plan (PSIRP) sets out how Marie Curie will seek to learn from patient safety incidents reported by staff and patients, and those who support them as part of work to continually improve the quality and safety of the care we provide.

Scope

A PSIRP is a requirement for any provider who is commissioned to deliver NHS funded care in England. As a UK wide organisation whilst PSIRF is an English requirement, we will be adopting it across all 4 nations.

This plan sets out how Marie Curie will respond to patient safety incidents for the next 12 – 18 months ensuring we identify areas for improvement and put in place strong safety actions to improve patient safety and prevent future recurrence of any incident or near miss.

The document should be read alongside the Patient Safety Incident Response Framework (PSIRF) (NHS England 2022) which sets out the requirement for a patient safety plan to be developed and published.

Aims

To improve the safety of the care we provide to our patients and those who support them.

Engage and involve patients and those who support them wherever a patient safety incident or a patient safety incident investigation is identified Improve the impact and experience for them.

Engage and involve staff involved in incidents managing the impact on them and ensuring that the focus is on learning and improvement.

Improve the use of valuable Healthcare and Charity resources.

Defining Our Patient Safety Profile

- Our Services

Marie Curie provides expert care and support to people at the end of their life and those who support them, through all stages of dying, death, and bereavement across all four nations of the United Kingdom. We provide specialist care, treatment, and support within our hospices and in people's homes and other health and care settings. Working alongside these services, volunteers provide valuable practical help and emotional support to people in the hospice, at home and in other health and care settings. Furthermore, our Information and Support team provide information and support through our telephone support line and online through web chat, online community, and printed information.

- Stakeholder Engagement

To support development of and define our patient safety profile we have mapped out and engaged with key stakeholders who are integral to the patient safety agenda within Marie Curie including Place-based teams, Nursing and Quality, Medical Directors, Patient Experience, Safeguarding, Infection Control. Learning and Development, People and Organisational Development, Health and Safety and Risk and responded to engagement from local Integrated Care Boards (ICBs).

- Quality Improvement Programme

Marie Curie has an organisation wide programme of patient safety quality improvement work. Quality improvement work is overseen through our clinical governance framework. Locally each of our Places collaborate both internally to share good practice and externally with colleagues across the integrated care system to improve patient safety. The quality improvement work currently includes

- Safety Learning Panel
- Falls Prevention & Management
- Medicines Management
- Tissue Viability
- Infection Prevention and Control
- Sepsis
- Experience of Care and Support
- National Clinical Audit Programme
- Carer and Bereavement Support
- Measuring Impact
- Clinical Record Project

- Data Sources

To identify our patient safety profile, organisational data for the period January 2020 – December 2022 was reviewed including:

- Complaints / Concerns/Compliments

Of the 795 complaints / concerns reported 256 (32%) related to hospices and 539 (68%) to community nursing services. The top 10 complaint categories are shown in Table 1 below.

Table 1 Top 10 complaint categories

Complaint/ Concern category	Number recorded
Communication from staff to relative	106
Staff attitude	96
Care not delivered when expected (home patient)	73
Staff/Volunteer behaviour	70
Communication from Staff to Patient	68
Sleeping on Duty	62
Treatment or behaviour by staff	58
Clinical treatment	50
Communication from Staff to Visitor	24
Cancellation of Care (home patient)	22

- Freedom to Speak Up

Review of freedom to speak up (FTSU) data revealed that only 28 incidents had been reported by staff between January 2020 to December 2022. Due to the low numbers of reported incidents, there were no trends or themes relating to patient safety identified.

- Patient Safety Incidents

Between January 2020 and December 2022 there were 15,249 patient safety incidents reported within Marie Curie. Of these 114 (0.7%) were incidents assessed as being of moderate harm and 3 (0.02%) as severe harm.

Patient safety incident investigation within Marie Curie is predominantly undertaken by our ward managers in the hospices and clinical nurse managers in our community services, supported by the Head of Quality and our Nursing and Quality Team. Whilst numbers of incidents requiring a concise or comprehensive investigation are low, any patient safety incident investigation requires considerable time and effort to complete. Zero incidents reported met the criteria for either Learning from Deaths due to a problem in care or Never Events as shown in the table below.

Patient Safety Incident Type	Requirement	Numbers 2020 - 2022
Deaths due to a problem in care	Meets the learning from deaths criteria Requires a Patient Safety Incident Investigation (PSII)	0
Never Event	Meets criteria within the Never Events framework and requires PSII	0
Severe Harm Incident Requiring Investigation	Comprehensive PSII required	3
Patient Moderate Harm Incident Requiring Investigation	Concise PSII required	114
Low /no harm incidents requiring local screening	Incident not requiring investigation. Rapid review of incident	15,132

The top five combined patient safety incidents for the period 1 January 2020 to 31 December 2022 for community nursing services and hospices are

Incident Type	**Number incidents**	**%**
No notes in the home	3175	21%
Medication error	1999	13%
Slip/ trip/ fall	1885	12%
Notifiable disease[i]	941	6%
Pressure Ulcers	738	5%

Split by service the top 5 incidents for each service are:

Community Services	**%**	**Hospices**	**%**
No notes in the home	36%	Medication error	25%
Notifiable disease	7%	Slip/ trip/ fall	22%
Shift/ appointment change or cancellation	6%	Pressure Ulcers	12%
Slip Trip Fall	5%	Notifiable disease	5%
Medication error	4%	Confidentiality breach	3%

- Our patient safety incident response plan: national requirements

Patient safety incident type	Required Response	Anticipated Improvement Route
Incidents meeting the Never Event criteria	PSII	Safety Learning Panel
Deaths due to a problem in care (meets learning from deaths criteria)	PSII	Learning from Deaths Safety Learning Panel
Death of a Person with Learning Disabilities where there is reason to believe death was contributed to by one or more patient safety incidents / problems in the healthcare of a service commissioned by the NHS	PSII Leder Review	Safeguarding Assurance Group Learning from Deaths Safety Learning Panel
Safeguarding Incidents	As recommended by Safeguarding Requirements	Safeguarding Assurance Group Safety Learning Panel
Notification of Infectious Disease	Post Infection Review (PIR)	Infection Prevention Control Committee

Patient Safety Incident Type / Issue	Planned Response	Anticipated Improvement Route
Incidents of Severe Harm Complex incident with potential for significant organisational learning	Duty of Candour Comprehensive PSII	Incident Learning Panel Group appropriate to incident Quality Trustees Committee
Incidents of Moderate Harm where action plan is not currently in place. Less complex incident with potential for significant organisational learning.	Duty of Candour Concise Investigation	Incident Learning Panel Group appropriate to subject Integrated Governance and Performance Meeting.
Pressure Damage	Rapid Review Internal benchmarking	Local Action Plan Tissue Viability Group

		Integrated Governance and Performance Meeting
Falls	Rapid Review Internal benchmarking	Local Action Plan Falls Prevention Group Integrated Governance and Performance Meeting
Medication Errors	Rapid Review Internal benchmarking	Local Action Plan Medication Management Group Integrated Governance and Performance Meeting
Low / No Harm Incidents	Rapid Review for incident categories with a current action plan or potential for learning and new action plan developed. Investigation not required	Local Incident Meeting

The planned responses identified within the Table are a guide and should there be an unexpected trend or cluster of incidents then a different incident response to that indicated in the table may be required.

The above priorities have been chosen in line with our most frequently reported themes. This does not include notifiable disease which has been skewed by the Covid-19 pandemic. In addition, no notes in the home is subject to a quality improvement programme not dependent on numbers of patient safety incidents that are being recorded to monitor the impact of measure put in place.

Should an incident be RIDDOR reportable, as a minimum, a rapid review will be carried out to meet HSE expectations should they follow up the RIDDOR. If more detailed information or investigation is required, the Health and Safety Team will advise the relevant Head of Operations / Head of Quality and Clinical Practice.

Whilst staff communication is recorded as one of our most frequently reported complaint themes. It is a broad category that is a thread within all our patient safety incidents. Staff attitude and behaviour is monitored monthly through incidents and patient feedback data and is subject to separate quality improvement.

Implementation & Controls

Monitoring

Patient safety investigations will be presented to the Safety Learning Panel or relevant patient safety group to ensure safety actions are fed into the quality improvement programme.

All local action plans will be monitored through local governance meetings with escalation to the Caring Services Integrated Performance Group. A quarterly report on progress

against actions will be made to the Quality Trustees Committee.

Communication/Dissemination

The patient safety incident response plan will be published on the Marie Curie website and will be circulated to staff by the Nursing and Quality team.

Training

Required training for staff and managers to conduct patient safety incident investigations is detailed in the Patient Safety Incident Investigation Policy.

Governance

Version	*1*
Type	*Patient Safety Response Plan*
Policy owner	*Director of Nursing & Quality*
Support contact(s)	*Associate Directors of Quality and Nursing*
Contact department	*Nursing and Quality*
Author	*Cecily Cook. Associate Director of Nursing & Quality*
Relevant for	*Clinical Services*
Related topic	Incident Management
Plan this Plan replaces	*25.4.23 First draft of plan*
Ongoing approval/review process	
Review cycle	Annual
Ratified/approved by	Document Approval Group
Date of audit	October 2023
Valid to	April 2024
Required for intranet migration	
Key words	*To enhance search function – 3 single words max.* 1. _Patient Safety 2. Incident Investigation 3. Plan_
Description	*This Patient Safety Incident Response plan sets out how Marie Curie will respond to patient safety incidents*

[i] This data is drawn during the Covid-19 pandemic and therefore notifiable disease incidents are much greater than usually expected.