Derian House Children's Hospice
Patient safety incident response plan

Effective date: October 2024

Estimated refresh date: October 2025

	NAME	TITLE	DATE
Author	**Bridget Thomas**	**Clinical Director**	**October 2024**
Reviewer	**Anthony Mohammed**	**Head of Governance and Compliance**	**November 2024**

Contents

Introduction

This Patient Safety Incident Response Plan sets out how Derian House Children's Hospice (Derian House) intends to respond to patient safety incidents over a period of 12 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.

When things go wrong, patients are at risk of harm and many others may be affected. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disengaged.

Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals. This patient safety incident response plan (PSIRP) details how Derian House 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.

This plan will help us measure and improve the efficacy of our local patient safety incident investigations through:

- Identification of interconnected causal factors and systems issues.
- Focusing on addressing these and the use of improvement methodology to prevent or continuously work to reduce repeat patient safety risks and incidents.
- Transfer the focus from the quantity of incidents to the quality of investigations and involvement of our stakeholders (patients, families, carers and staff).

National PSIRF implementation has allowed Derian House to develop support structures and a culture of support and no blame for staff, with patients and families involved in all patient safety incidents as per our Duty of Candour processes. This plan describes how Derian House will respond to patient safety incidents as outlined in the PSIRF Policy.

Our services

Derian House is a registered charity providing care for Babies, Children and Young People (BCYP) with a life shortening or life limiting condition. The care is provided in-house with respite and end-of-life care, including proving a resting place for BCYP following death. In addition Derian House provides advice, support and care in the home, hospital and community settings including the antenatal and perinatal period.

The Hospice provides care to more than 400 BCYP across the North West. In addition, care extends right across the family to siblings, parents and grandparents.

The care Derian House provides is free for families, but services cost £6 million to run every year with under 30% of funding coming from the NHS/Government.

Referrals are taken for BCYPs up to age 19 years but care is provided up to a young person's 26th birthday to plan for transition to an adult hospice and provide support for young people leaving Derian House.

Services are provided to BCYPs from Lancashire, Greater Manchester, Cheshire and Merseyside and some out of area localities.

The Hospice is governed by a Board of Trustees and the Hospice is run by the Chief Executive and the Senior Management Team through delegated authority from the Board of Trustees.

Derian House's Values are linked to our overarching strategic ambition, which is:

'To enhance the quality of life for children and young people with life limiting conditions, through to end of life and in bereavement. We provide a range of high quality, personalised care including planned stays, end of life and wellbeing services for babies, children and young people across the North West, 24 hours a day, 7 days a week, 365 days a year.'

Our 3 Key ambitions in our strategic plan are:

- To be an employer of choice
- Provide excellence across services
- Provide sustainability and growth

These ambitions are linked to the Derian House values:

The safety of our BCYPs and their families are our priority and this links to our PSIRF Policy and procedures to ensure when incidents occur they are thoroughly investigated and learning and improvement is prioritised.

Therefore the Derian Values are linked to our PSIRF aims as follows:

Defining our patient safety incident profile

Derian House has an excellent culture of incident reporting including high reporting of near misses and no harm incidents which allows thematic reviews and links to learning and development programmes for staff. This is underpinned by a strong Governance system with Board assurance given via a range of internal operational and strategic committees.

To define our patient incident profile, we use our existing incident data collated on the Vantage Incident System to establish our most significant patient safety issues.

Data has been collated for a 12 month period from September 2023 – September 2024. A thematic analysis approach has been used to determine which areas of patient safety activity need focus to identify our patient safety priorities. In the 12 month period outlined, there has been **49** clinical incidents with themes as follows:

Theme	No of incidents	Near Miss	No harm/low harm	Minor harm	Moderate harm
Verbal Abuse from parent	1	1			
Communication	1		1		
Environmental	1		1		
Equipment/Device failure	2		2		
Care Plan	8		6	1	1
IPC	1		1		
Medication Error	27	4	20	3	
Policy Breach	1		1		
Slip/trip/fall	6	2	1	3	
Tissue Viability	1	1			
TOTAL	49	8	33	7	1

In summary, the 12 month period Sept 23 – Sept 24 there have been:

- **1** initially graded moderate level incident which, when investigated, was reduced to a low harm incident as appropriate steps were taken to minimise patient harm and ensure patient safety.
- **0** incidents requiring Serious Incident investigation and no externally reportable incidents.
- **0** deaths due to harm.
- **0** never events.
- **0** clinical negligence claims,
- **0** inquests.
- **0** complaints received relating to harm caused by clinical care.

The priorities identified align with work already ongoing on medication administration with a new policy and additional competency based assessments, which are both classroom and practice based for all staff with additional competencies required for staff new to the hospice.

A deep dive of medication errors presented to Board in June 2024, identified no clusters of themes but rather general low level incidents covering prescribing, transcribing, administration, calculation and storage.

The PSIRF Policy and process provides the framework to enable a more learning focused review for the majority of low level incidents which will align to improvements for staff and patent safety.

Defining our patient safety improvement profile

Derian House is committed to establishing a just culture in response to patient safety incidents. All leaders in Derian House proactively embrace this approach in transitioning to a just culture. All leaders undergo Risk training specific to the Hospice and in line with legislation and statutory requirements.

The implementation of PSIRF is underpinned by the principles of Just Culture to ensure that patient safety is prioritised and staff feel supported to escalate incidents with the knowledge that they will be supported to learn and develop in a no blame environment.

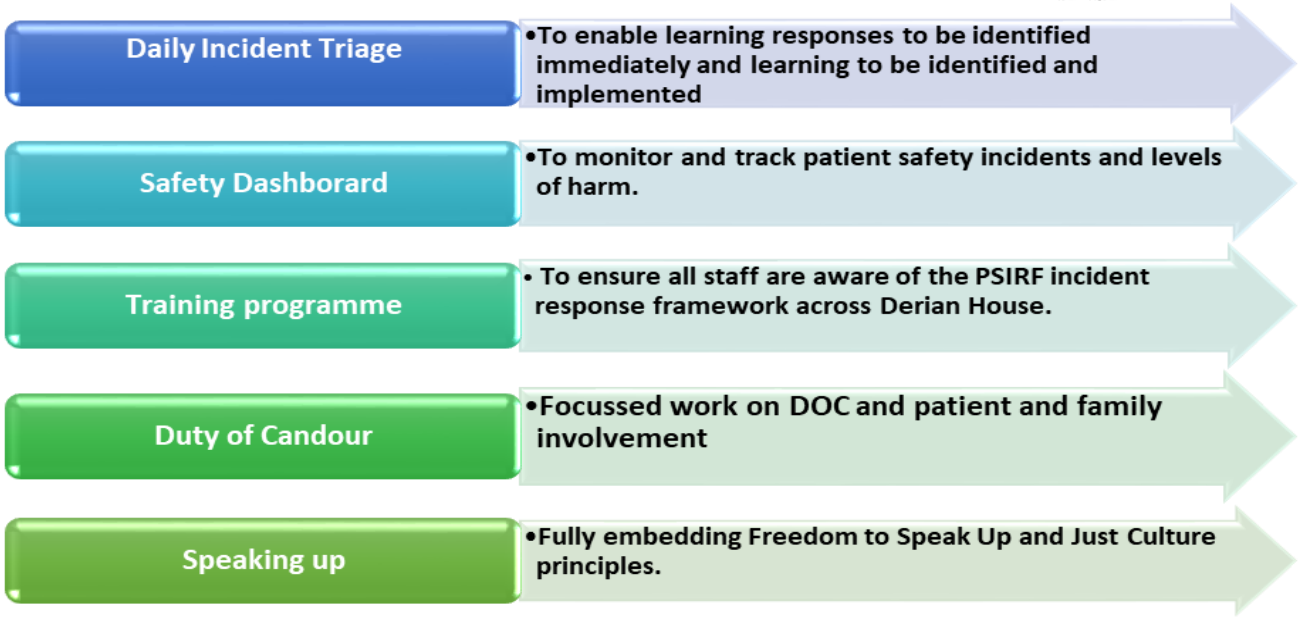
All staff have received a PSIRF briefing and will undertake the training relevant to their role and responsibility.

The principles are outlined as follows and are contained in the PSIRF Policy and training given to all staff.

In addition, the following framework has been embedded to ensure that patient safety and learning from incidents is at the centre of all we do.

Shared Accountability	Acknowledgment that **safety responsibility extends from frontline workers to leadership**. Every individual within the Derian House plays a role in ensuring patient safety.
Open Communication	Encouraging **open communication** is crucial for the success of Just Culture. Incidents are reported without fear of retribution, fostering transparency and creating opportunities for learning from mistakes.
Focus on Systems	**Errors are viewed as indicators of systemic flaws** rather than individual failings.
Supportive Environment	Staff members who make **mistakes are not punished** but given support and guidance for learning and improvement.

Our safety culture within Derian House is a key organisational priority, with the following implemented as part of the PSIRF framework to ensure focus is maintained on all levels of incidents to ensure that the most appropriate actions are taken in a timely manner following a robust assessment and on a daily basis.



In addition the following systems and processes are cross referenced to ensure a joined up process across the Hospice.

- Complaints and compliments
- Clinical Negligence Claims
- CDOP feedback
- Multiagency debriefs
- Freedom to Speak Up data
- Mortality reviews / Learning from deaths
- Safeguarding cases
- Staff survey results
- Risk registers and Board Assurance Frameworks
- Staff competence breaches and any NMC breaches
- CQC inspection Actions and Activity.
- NICE Guidelines
- NPSA safety notifications
- Clinical Audit data

We engaged with other Children and Adult Hospices across the country to identify best practice in implementation of PSIRF into children's hospice environments which is significantly different to the clinical environment of a hospital and with limited resources to develop, embed and monitor the implementation of PSIRF.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required Response	Anticipated improvement route
Events that meet the criteria set in the Never Events list 2018	Patient Safety Incident Investigation	Never event is identified and an appropriate PSII response is Undertaken.
Any incident meeting the learning from deaths criteria i.e. death thought more likely than not due to problems in care	A child admitted to the Hospice for End of Life care would be referred to CDOP and an MDT debrief would be held.	All child deaths are reviewed internally as part of a hot debrief and all deaths are reviewed via a multi-agency debrief as part of the CDOP process.
All child deaths including death of child with learning disabilities	Patient Safety Incident Investigation	Referral to CDOP and LeDER
Safeguarding incidents in which: Babies, children, and 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 by their local authority. The incident relates to FGM, prevent radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Incidents must be reported to the Safeguarding lead for the hospice and local authority.	Contribute to any external reviews or enquiries e.g. Safeguarding Children Review, Section 42 investigation, Domestic Homicide Review as required by the Local Safeguarding Partnership (for children) and local safeguarding adults boards, or Safety Partnership.
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	Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)	Respond to recommendations as required from external referred agency Contribute to any external investigation.

Our patient safety incident response plan: local focus

Derian House has the following Patient Safety Reviews in place as outlined in the PSIRF Policy that can be aligned to extract learning as appropriate from any incident.
These are:

- Patient Safety Incident Investigation (PSII)
- Swarm Huddle incorporating hot and cold debriefs following a child death
- After Action Review
- Multidisciplinary Team review (MDT)
- Thematic Review
- Horizon scanning

Our local patient safety priorities require a Patient Safety Review (PSR) and include several methods to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected child, young person, family, carer, or staff. This is not an

exhaustive list but aligns to the analysis of incidents recorded in a 12 month period from September 2023 – September 2024.

Patient Safety Incident	Planned response	Comments
Medication Error	• PSII • Swarm Huddle • Thematic Review	• Review at Triage • Assign correct level of harm • Assess type of review depending on level of harm score • Follow DOC process
Care Plan	• PSII • Swarm Huddle • Thematic Review	• Care plan audit to be embedded. • Training on care database for all staff. • Themes and learning from reviews shared across the Care team.
Slip / trip / fall	• PSII • Swarm Huddle • Thematic Review	• Review at Triage • Assign correct level of harm • Assess type of review depending on level of harm score • Follow DOC process
All other incidents	Review will depend on type of incident	• Review at Triage • Assign correct level of harm • Assess type of review depending on level of harm score • Follow DOC process

Reviews will be determined on a case by case basis with full understanding of the details of the incident and involvement of staff involvedwhen the incident occurred. This will allow a robust plan for the correct level and type of review aligned to the framework and the local policy.