

Marie Curie Patient Safety Incident Response Plan 2024/2026

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 2024) 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 (hospice care at home) 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). From a patient perspective we had input from our patient representative on the Quality Trustees Committee.

We have further work to undertake with patient safety partners. This year we have recruited a new Public Engagement and Patient Experience Lead who will focus and lead on strengthening the patient voice

- **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

- **Patient Safety Culture**

Marie Curie's focus is on closing the gap in end of life to ensure that everyone receives the care they need to life's end. Our aim is to have a positive and just safety culture where staff are able to talk openly when things unintentionally go wrong to change things so that staff feel secure to report incidents without fear of blame.

Prior to implementing PSIRF we worked with Sue Ryder to cross check and benchmark our incident reporting.

Our quality improvement facilitators and practitioners have worked closely with placed based teams in all regions to raise awareness of PSIRF, the importance of systems analysis and not apportioning blame, and to support completion of patient safety learning responses.

We recognise that we have work to do to improve our safety culture and will continue the benchmarking work to check our reporting culture and further improve our patient safety incident investigations (PSII).

We have developed our own just culture guide and training in collaboration with our Human Resources team, to ensure all staff regardless of their job role or directorate are treated consistently and a supportive approach taken. These will be rolled out to all staff within our organisation in the last quarter of 2024.

Additionally, to increase awareness of Freedom to Speak Up (FTSU) and encourage and increase logging of FTSU incidents, mandatory FTSU training for all staff was launched in Quarter 4 2023/2024.

Our monthly safety learning panel includes representatives from all 4 nations that Marie Curie works within. Discussion of patient safety incident investigations and quality improvement plans at our monthly safety panel has enabled us to include learning from good or positive care which is disseminated to all our place-based staff. Our next steps are to further enhance our approach to learning from excellence.

- [Health Inequalities](#)

Our incident reporting system does not currently enable the collection of protected characteristics as part of patient identity data. However, we ensure that the incident response will consider, explore, and respond to potential issues related to health inequalities when conducting an investigation to help us understand whether patients experienced incidents and harm disproportionately in relation to protected characteristics.

Review of current patient safety data alongside feedback from staff has enabled us to undertake some work forward in relation to darker skin tones and pressure damage to improve our policies and training for staff. We plan to take further research forward in relation to the impact of a pressure ulcer risk assessment tool and end of life care.

- [Data Sources](#)

The patient safety incident response framework (PSIRF) was implemented in Marie Curie in November 2023. Data includes incidents occurring under both the previous Serious Incident Framework and the newly implemented PSIRF.

To identify our patient safety profile, organisational data for the period 1 January 2023 – 28 February 2024 was reviewed including:

- [Complaints / Concerns/Compliments](#)

Of the 296 complaints / concerns reported 118 (40%) related to hospices and 178 (60%) to hospice care at home services. No change has been observed to the top 6 complaint categories when compared to data for 2020 – 2022. The top 10 complaint categories are shown in Table 1 below.

During 2023/2024 we developed and delivered a part virtual, part blended delivery 'Person Centred Communication' course for our health care assistants in response to communication and staff behaviour continuing to feature in our top 10 complaint categories.

Table 1 Top 10 Complaint Categories

Complaint/ Concern category	Number recorded 2023-2024
Communication from staff to relative	52
Staff attitude	24
Care not delivered when expected (home patient)	26
Staff/Volunteer behaviour	25
Communication from Staff to Patient	21
Sleeping on Duty	16
Admission, Discharge, Transfer arrangements	15
Clinical judgement	8
Communication from Staff to staff	7
Communication staff to visitor	6

➤ Patient Experience

In 2023/2024 Key Performance Indicators for patient experience were reviewed and updated.

➤ Freedom to Speak Up

Review of freedom to speak up (FTSU) data for 2023 – 2024 revealed that 20 incidents had been logged by staff in this period. Of these 2 patient safety incidents had been logged and no trends or themes identified. The other 18 incidents related to people operations issues.

➤ Patient Safety Incidents

Between 1 January 2023 and 28 February 2024 there were 6701 patient safety incidents logged within Marie Curie. Of these 59 (0.9%) were incidents assessed as being of moderate harm and 0 as severe harm. The numbers of incidents logged has decreased since the initial PSIRF plan was drafted in 2023. The issue for this is two-fold, the decrease in incidence of COVID-19 and the temporary closure of Hampstead Hospice, London for remedial works for reinforced autoclaved aerated concrete (RAAC).

Comparison with the 2020- 2022 incident data confirms that Medication, Slips, Trips and Falls and Pressure Ulcers consistently remain the 3 most frequently reported categories of patient safety incident. This is not an unexpected picture because patients at the end of life often experience deteriorating health with decreasing ability to complete daily activities of living as well. Patients often strive to maintain independence and can fall as a result, or they may not have adapted to limitations on their strength and stamina. Reduced mobility may mean they are more susceptible to pressure damage, but patients often choose to prioritise activities that enhance their quality-of-life experience such as to sit or lie for long periods of time. They also have a corresponding increase in demand for medicines to relieve symptoms such as pain, nausea and vomiting, agitation, delirium, anxiety and breathlessness.

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. Due to the number of low harm incidents, we see in our patient safety profile, we experience few opportunities to participate in multi-organisational or cross system patient incidents. We have made

changes to improve reporting of incidents that should be shared with external agencies, and this is being incorporated into the work to improve our data reporting system.

Zero incidents reported met the criteria for either Learning from Deaths due to a problem in care or Never Events as shown in Table 2 below. Similarly, litigation and cases that go to the coroner are seldom logged and there are no themes or trends.

Table 2: Patient Safety Incidents by Type and Number

Patient Safety Incident Type	Requirement	Numbers 2023 - 2024
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	0
Patient Moderate Harm Incident Requiring Investigation	Concise PSII required Rapid Review	59
Low /no harm incidents requiring local screening (All incidents)	Incident not requiring investigation. Rapid review of incident	6701

The top five combined patient safety incidents for the period 1 January 2023 to 28 March 2024 for hospice at home services and hospices are shown in Table 3

Table 3: Combined Patient Safety Incidents 2023 - 2024

Incident Type	Number incidents	%
Medication	922	29%
Medical / Nursing Notes not Available	797	25%
Slip/Trip/Fall	614	19%
Tissue Viability	541	17%
Other clinical incident involving patient	128	4%

Split by service the top 5 incidents for each service shown in Table 4 are:

Table 4: Top 5 Incidents by Service

Hospice Care at Home	%	Hospices	%
Medication	14%	Medication	33%
Medical/Nursing notes / care plan not available	12%	Tissue Viability	27%
Shift/ appointment change or cancellation	9%	Slip/trip/fall	10%
Slip Trip Fall	9%	Safeguarding	5%
Lone Working including system	4%	Infection Control	3%

Top Three Incidents by Hospice

The data in Table 5 below shows the top 3 most frequently reported incidents by hospice which confirms that all hospices experience similar issues. Edinburgh is the only hospice with integrity breach featuring in their top 3 incidents, although pressure damage is their fourth most frequently reported type of incident. The category of integrity breach is most frequently reported by staff who incorrectly document information for a patient in the patient's electronic record.

Table 5: Top 3 Incidents by Hospice

	Top Incident 1	Top Incident 2	Top Incident 3
Belfast	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Bradford	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Cardiff	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Edinburgh	Medication	Slip/ trip/ fall (patient)	Integrity breach
Glasgow	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Hampstead*	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Liverpool	Medication	Slip/ trip/ fall (patient)	Pressure Ulcer - Single
Newcastle	Medication	Slip/ trip/ fall (patient)	Skin damage (not pressure ulcer or moisture lesion)
West Midlands	Medication	Pressure Ulcer - Single	Slip/ trip/ fall (patient)

- Hamstead Hospice is temporarily closed for remedial works

Top 3 incidents by Hospice Care at Home Service

The data in Table 6 below shows the top 3 most frequently reported incidents by hospice care at home service. Yorkshire is the only service to report lack of adequate equipment or resources in their 3 most frequently reported incidents.

Medical or Nursing notes/care plan not available refers to lack of access to District Nursing risk assessments and care plans. Action has been taken in 2024 to improve risk assessments within Marie Curie electronic reporting templates. Shift appointment change or cancellation and lone working relate to operational issues and are the subject of operational improvement plans

Table 6: Top 3 Incidents by Hospice Care at Home Service

	Top incident 1	Top incident 2	Top incident 3
East of England	Shift/ appointment change or cancellation	Medical or Nursing notes/ care plan not available	Did not attend patient visit
London	Shift/ appointment change or cancellation	Lone working (including system)	Did not attend patient visit
Midlands	Shift/ appointment change or cancellation	Lone working (including system)	Double booking
North East	Medical or Nursing notes/ care plan not available	Shift/ appointment change or cancellation	Lone working (including system)
North West	Medical or Nursing notes/ care plan not available	Integrity breach	Double booking
Northern Ireland	Shift/ appointment change or cancellation	Lone working (including system)	Did not attend patient visit
Scotland N&W	Medical or Nursing notes/ care plan not available	Shift/ appointment change or cancellation	Slip/ trip/ fall (patient)
Scotland S&E	Shift/ appointment change or cancellation	Slip/ trip/ fall (patient)	Lone working (including system)
South East	Medical or Nursing notes/ care plan not available	Shift/ appointment change or cancellation	Slip/ trip/ fall (patient)
South West	Medical or Nursing notes/ care plan not available	Shift/ appointment change or cancellation	Double booking
Wales	Medical or Nursing notes/ care plan not available	Slip/ trip/ fall (patient)	Lone working (including system)
Yorkshire	Medical or Nursing notes/ care plan not available	Shift/ appointment change or cancellation	Lack of adequate equipment resources

- Our patient safety incident response plan: national requirements

Table 7: National Patient Safety Reporting 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	Comprehensive / Concise Post Infection Review (PIR)	Infection Prevention Control Committee

Table 8: Planned Patient Safety Responses (Local)

Patient Safety Incident Type / Issue	Planned Response	Anticipated Improvement Route
Incidents of Severe Harm	Duty of Candour	Safety Learning Panel
Complex incident with potential for significant organisational learning	Comprehensive Patient Safety Incident Investigation (PSII)	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 Patient Safety Incident Investigation (PSII)	Safety Learning Panel Group appropriate to subject Quality and Performance Meeting.
Pressure Damage	Rapid Review Internal benchmarking	Local Action Plan Tissue Viability Group Quality and Performance Meeting
Falls	Rapid Review Internal benchmarking	Local Action Plan Falls Prevention Group Quality and Performance Meeting
Medication Errors	Rapid Review Internal benchmarking	Local Action Plan Medication Management Group Quality 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 / actions added to existing action plan where required. Investigation not required	Local Incident Meeting

Feedback from our staff has indicated that the planned responses in the table above are sufficient to address the types of patient safety incidents that we experience within Marie Curie. The planned responses identified within the table, however, 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 and after-action reviews or multidisciplinary team reviews considered.

The above priorities have been chosen in line with our most frequently reported themes nationally. All Places have their own placed-based quality improvement plan which is monitored quarterly at the Safety Learning Panel. Each place's plan reflects local differences, and our Place-based teams are asked to include the three national priorities in these local quality improvement plans.

Additionally, each Place has an operational plan to address improvements required for service operations. Furthermore, no 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

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

Help & Support

Further advice on the PSIRF plan can be obtained from the Nursing and Quality team

Legal framework

Governance

Plan Owner	Chief Nursing Officer
Policy Editor/Author	Cecily Cook, Quality Improvement Facilitator
Business Area/Department	A policy may sit in one business area, e.g., HR or Finance. If it crosses over business areas, then simply list the nature of the policy, e.g., Compliance.
Approval Tier Level for Review	Tier 3
Related topic(s)	Patient Safety Incident Investigation Plan
Policies this policy replaces	V1
Policy approved [date]	
Review cycle [date]	3 Years.
Update made to policy after approval date [brief details]	V2 Updated following feedback from Lead ICB
Date of update/s	28 August 2024