



**Wirral Hospice
St John's**

Patient Safety Incident Response Plan

Effective date: September 2026

Estimated refresh date: March 2028

	NAME	TITLE	SIGNATURE	DATE
Author	Christine Sutcliffe	Director of Clinical Services		September 2026
Reviewer	Richard Crockford	Associate Director Nursing & Care (Patient Safety)		7/9/2026
	Josette Niyokindi	Head of System Quality		
Authoriser				

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Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Wirral Hospice St John's (WHSJ) 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 PSIRP details how WHSJ 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.

“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.

Hospices across Cheshire & Merseyside (C&M) worked collaboratively whilst initially implementing PSIRF. They continue to meet to address challenges with implementing PSIRF and to share good practice and learning, supporting WHSJ local focus for quality improvement. Continuing the work that this Network has established will provide a Community of Practice (CoP) for the C&M Hospices to share their thematic work and local improvement plans; the successes that they have had and how they can improve.

Our services

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

C&M 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.

C&M Hospices provides services across inpatients, outpatients, various therapies and support groups, Hospice at Home services and advice lines.

The Hospice supports around 560 service users per quarter.

Wirral Hospice St John's has:

Inpatient services supporting up to 14 patients. This is a short stay unit with the average inpatient stay being around 17 days. 48% of patient admissions end in discharge with many of these patients returning to a domestic home. Patients are generally admitted to the inpatient unit for specialist support of complex symptoms, the lower-than-average Hospice death rate means that most of our patients remain semi-independent and ambulatory during their inpatient stay.

Patients can be admitted to a bed in one of our 3 bedded bays or a single room with en-suite. Allocation is determined by care needs and infection status. All bed spaces have access to a TV. Patients and relatives have access to a communal lounge and garden with pond. Patients can access a patio area on their bed.

Community services comprise of:

- **Wellbeing** services aim is to increase independence and give a level of support to patients who are living at home and being cared for by their GP and / or district nurses. The team provides a variety of groups and sessions to deliver medical and psychosocial support for approximately 104 patients per month.
- **Hospice at Home** services provide quality end of life care to patients wishing to remain at home, providing practical and emotional support to patients, families and carers in a variety of ways. They offer support visits and personal care visits. The caseload ranges from 52-56 patients per month.
- **Outpatient Department** consultant lead clinics are held weekly and include new patients, follow up and pain clinic. We provide an average of 5.5 clinics per week.

Defining our patient safety incident profile

WHSJ has a commitment to continuously learning from patient safety events and has developed an understanding and insight during the implementation of PSIRF.

To determine any priority areas to support the delivery of the new PSIRP, an understanding of the scale of patient related safety activity is required. Data and information from a variety of sources has been gathered and considered.

1 years' worth of incident data was reviewed from the following sources: -

- Incident data (n152)
- Safeguarding concerns (n12)
- Complaints (n2)
- Freedom to Speak Up cases (n0)

We work closely with other hospices in the C&M region and attend and contribute to the C&M Hospice PSIRF CoP meetings by sharing experiences of implementation and learning outcomes from incidents.

Stakeholder engagement around PSIRF

National:

- Hospice UK Patient Safety Group

Regional:

- C&M Registered Managers Community of Practice

Local:

Quarterly meetings:

- Wirral Hospice St John's Board of Trustees
- Wirral Hospice St John's Clinical Governance Committee
- Wirral Hospice St John's Patient Safety Forum
- Wirral Hospice St John's Medicines Management Group

Governance

The Director of Clinical Services (DoCS) has oversight of Patient Safety and is responsible for ensuring that the organisation meets the patient safety incident response standards.

Board and Executive structure:

The hospice is a registered Charity and as such has a Board of Trustees (up to 12), this is led by the Chair of Trustees. The Senior (executive) Leadership Team (SLT) is led by the Chief Executive Officer (CEO) and 5 directors:

- DoCS
- Medical Director
- Finance and Support Services Director
- Income Generation & Marketing Director
- Workforce Director

Meeting Structure:

- Clinical Governance Committee (CGC)
 - Wirral Hospice St John's holds quarterly CGC meetings, chaired by one of the trustees with 2 further allocated trustees.
 - This meeting is attended by the CEO, Medical Director and DoCS as well as for part of the meeting the Clinical Services Managers and the Clinical Quality & Innovation Lead.
 - Incidents numbers, themes and trends are reported at the CGC, including infinity incidents that have met the PSIRP. This report is prepared by the

Clinical Quality & Innovation Lead and reviewed by the DoCS before submission to committee. Significant incidents of greater risk or harm are reported in greater depth and would also be highlighted to Trustees outside of the quarterly structure as required.

- This committee also reviews clinical audits and actions plans.
- Board
 - Quarterly Board meetings led by the Chair of Trustees.
 - Attended by all Trustees and SLT.
 - The chair of the CGC prepares a quarterly report for Board which would include significant individual incidents or trends causing concern.

Incident management

- All patient related clinical incidents are alerted to the Director of Clinical Services at time of reporting and all incidents are reviewed by DoCS before closing.
- All AARs during investigation and at completion are reviewed DoCS (and Medical Director if required)
- Incidents that meet our PSIRP:
 - Are discussed at a monthly clinical forum (chaired by DoCS and attended by Medical Director, Consultant, Clinical Service Managers and Clinical Quality & Innovation Lead)
 - Are not closed until documentation is signed as completed and reviewed by the DoCS.

Defining our patient safety improvement profile

This is our second PSIRP. Our first plan was developed with the wider C&M Hospice Network which identified 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

Incident data from 2025-26 was reviewed: There were 152 patient safety events, which includes near misses. This is a similar number of incidents to our previous years profiling. Our themes also continue to align, with our previous profiling and our top 3 key incidents are

1. Medication
2. Falls
3. Pressure ulcers

This is expected and aligns both regionally and nationally and will be unlikely to change over time due to the number of medications given, and our cohort of patients are in decline. We will therefore review data thematically to identify key areas of focus.

Most of the events that were reported in 25-26 by staff were no harm and low physical (97%) and psychological harm (99%) events which allowed us to implement learning to limit the number of moderate harm events (2%, n3, Physical harm, and 1%, n2, psychological harm).

Event Type	Number of events	% of all events	AARs	Improvement work underway*
Medication	53 • 21 Directly related to patient care • 36 Controlled Drug (CD) • 17 nonCD)	35%	5 (9%)	Thematic review of 2024 data was undertaken in 2025. This identified themes within the documentation and reconciliation errors that corresponded to continued incident themes. Training was developed in March 2026 and is currently being delivered with a competency for assurance purposes.
Falls	36	24%	3 (8%)	A publication was shared nationally which highlighted the link between caffeinated drinks and increased urgency for toileting needs in care homes. Our Occupational and Physiotherapy team then piloted decaffeinated drinks on our inpatient ward for 12 months. This has resulted in a reduction of toilet related falls by 41.8%. As a result, we now offer decaffeinated drinks as standard, with caffeinated drinks available by request.
Pressure Ulcers	17 incidents reported * • 21 pressure ulcers on admission, five were category 3 and 3 were category 4 • 15 hospice acquired, one of which was category 3 *sometimes more than one pressure ulcer per incident	11%	0	Following review under PSIRF, a range of preventative and improvement actions have been implemented to reduce the incidence of pressure ulcers across the service. These actions included; enhanced skin integrity assessments, increased compliance with risk assessments, staff training and awareness programmes, regular pressure ulcer /skin integrity assessment, strengthened education and greater use of pressure-relieving equipment and documentation.

Event Type	Number of events	% of all events	AARs	Improvement work underway*
Equipment	2	1%		This was added to the clinical incident options in Vantage during the financial year. There was one syringe driver error and one oxygen tubing which was found to be disconnected.
Other		29%		

Medication Incidents Overview

From the analysis of 53 medication incidents reported in 25-26:

- Quarterly analysis showed that of all administrations there was an incident rate of between 0.03 and 0.11% that reached the patient.
- a total, 17 of the incidents related to errors within the task of administration of medication. As both CD and Non-CD themes related to administration of medication, these incidents have been thematically reviewed further to determine if any themes could be identified using the “7 Rights” of administration. This deeper dive revealed the time/frequency was involved in 59% (n10) of incidents.
- 68% were **CD related incidents**. This is not an unexpected finding as our cohort of patients have complex care needs and are often admitted for pain management and controlled drugs are commonly prescribed.
- Many of the CD incidents related to documentation (n11) and reconciliation >5% (n10) inaccuracies with 8 (15%) being administration errors which reached the patient.
- **Non-CD medication incidents** highest incident category was drugs being omitted. This was reported five times (1 critical medication). Prescribing and dosage errors were reported three times each.

Medications Incident investigations

Thematic review of 2024 data was undertaken in 2025. This identified themes within the documentation and reconciliation errors that corresponded to continued incident themes. Training was developed in March 2026 using examples from incidents. This is currently being delivered, with a competency for assurance purposes.

Four incidents reported in 2025-26 met our PSIRP threshold for AAR investigation.

- Three of these incidents (386, 410 and 416) were CD incidents where the wrong medication had reached the patient and involved errors between oxycodone and morphine. Morphine was given in error for two incidents and oxycodone was given in error for one incident. Although these incidents occurred in close succession, they had different learning.
- One critical medication (dexamethasone) was missed (543). When this was realised, it was too late to give.

We also chose to do an additional AAR despite the incident not meeting our PSIRP criteria for AAR (511), as it involved a prescribing error where the incorrect medication was administered 5 times before the error was identified. We felt that this incident would benefit from AAR as this had slipped through our safety mechanisms. This incident involved an error being made when selecting the medication to be prescribed as the name of the intended antibiotic was very similar to the antibiotic that was selected. When the error was realised, the medication was reviewed and as the patient had improved, they could be stepped down to oral antibiotics.

The key learning which has come from these AARs and the actions taken are shared below.

Inc. #	Key learning points	Combined Actions
386	• Electronic safety mechanism already in place to highlight medication no longer prescribed. • Gaps in documentation. • Second checker can be used if needed.	• New pharmacy training and competency developed from incident themes includes the role and responsibility of the second checker and documentation. Delivery began in April 26 • New electronic rostering system takes skill mix into account.
410	• Error made although second check was made prior to administration. • Ensure staff teams ensure balance of skill mix in teams	• Medication lockers are inspected monthly as part of a new Patient Environmental Inspection which was launched in October 2025.
416	• Medication remained in the patient bedside locker for 10 days after being deprescribed. • Staff were unclear who could remove medication when deprescribed.	• Information disseminated to teams and patient safety alert shared in November following inspection findings. • Ongoing oversight and monitoring regarding medication in patient lockers in Medicines Management Meetings.
511	• It can be easy to mis-select a medication when prescribing when the name is similar to other medications.	• Findings shared to EPR supplier to consider altering how medication is listed to match pharmaceutical labelling e.g cefTRI...
543	• Electronic safety mechanism already in place to highlight "due medication" but the process is not documented in the SOP. • Administration process interrupted due to staff member needing to attend to MDT.	• Training for prescribers has been updated to ensure that they search for a longer string when prescribing to minimise the selection list and risk of selecting the incorrect medication. • Medicines Management documentation to be updated to include electronic processes.

Medications Incidents Learning and improvement work

- Patient medication is securely stored in the patient's bedside locker. One incident found that medication had been deprescribed and remained in the patient's bedside locker for 10 days before being administered in error.
 - A monthly Patient Environmental Inspection has been developed to incorporate learning from incidents and audit to provide assurance that the identified learning has been implemented in practice.
 - A check of the patient lockers is included in the inspection.
 - Findings showed that the learning had not been put into practice and that further refinement and communication was required. The inspection keeps the conversation going post incident and allows us to keep reviewing new processes until we have assurance that processes are embedded.
 - This also highlighted the impact of a change in Pharmacy staffing which has been further refined.
- Second nurse checking was identified as in need of refresh training.
 - Full process for second nurse checking with incident examples was included in the Pharmacy training and competency.
 - Including the competency provides assurance that the training has been understood and allows further support to be provided if this is not passed.
 - Records are kept by the education team to ensure that all staff attend and pass this training.
- Electronic medicines management was implemented in SystmOne in 2021. Documentation (policies and procedures) had not been updated with the new electronic processes. We are in the process of reviewing documentation and adding these new processes to them.

Area of concern: to better understand incidents when medication is administered at the incorrect time or omitted.

Falls

Out of 36 patient falls reported in 25-26, 30 (83.3%) falls related to activities of daily living to remain independent. The most frequent reported tasks were:

- mobilising to the bathroom for toileting needs (6)
- reaching down for items, to wipe floor or accessing locker (5)
- during transfers (wheelchair to dining chair, bed to chair, to toilet from standing and transfer to wheelchair from toilet). (4)
 - 3 of these were transfers without staff present.
- mobilising/walking (4)
- for 3 of the falls, it was not clear what the patient was doing before they fell.

Falls incident findings and audit identified recurring themes of inconsistency with:

- risk assessment
- taking lying and standing blood pressure,
- post falls management.

Falls Incidents Overview

A thematic review of 2024 incident data included a case study of a patient who experienced multiple falls. This work identified that medication could be a factor in falls.

Four incidents met our PSIRP threshold for AAR, after consideration, 3 AARs were completed. One was excluded from review as the reason for repeated falls was due to the medical condition and AAR would not have yielded additional information than the initial review completed.

Through AAR we have made a number of improvements which are shared below.

Inc. #	Key learning points	Actions
380	• Falls alarm did not activate at the time of the fall. This was checked and the sensor had not been altered to bed setting after the patient had been transferred from the chair • Falls safety video was not shown at admission • Risk assessment and care plans had not been updated following fall • Falls Prevention Policy mentions “appropriate footwear” but does not elaborate further	• Physio and CSM to worked collaboratively to combine falls and mobility care plans to ensure these are updated following a fall • To ensure all patients watch the safety video on admission – this is on the admission checklist and on risk assessment /care plan • We reviewed what is meant by “appropriate footwear” • Staff reminder that alarms need reactivated to the appropriate chair/bed
366	• The call bell log was difficult to access and understand and an hour out due to error when installed. • Call bell sounded the same for falls alarm alert as calling for assistance so staff could not differentiate and prioritise calls. • Risk assessment and care plans documentation gaps. • SEIPS Template didn't give sufficient space for recording details required – needed separating	• Call bells and falls alarms are now included in servicing plans and tested monthly within the Patient Environmental Inspection. • Falls risk assessment and care plans updated to include the falls sensor has been checked and on and working • New falls mats were trialled but not installed. When the call system is replaced, we can revisit incident learning. • Call bell audit to be designed and introduced to ensure we regularly review logs and ensure servicing and connectivity. • SEIPS template updated into Excel to ease completion

		• Falls risk assessments were updated so that they share the same coding as pre admission to ensure that falls risk history pulls through. • Care planning forms have been amended and will be audited to ensure that they are being completed appropriately.
412	• Limited space in the room to mobilise with 3ww. • The layout of the room is difficult for mobilisation and the use of manual handling aids. Due to the location of sockets and medical gas supply, doors, sinks, windows, it is difficult to move the beds to alternative positions to maximise floor space and not cause another issue. • Some single occupancy rooms have more reduced space at the foot of the bed due to room size. Radiators are located in this position also and bed controls which further impede on the space available to mobilise. • In addition, piping for the mattress can also pose a risk of catching on mobility aids. • Staff feedback that they were unfamiliar with equipment (Raizer chair) to aid patient from the floor.	• As there is not much that can be done about the layout at this time it would be beneficial to risk assess rooms and guide staff about these considerations for adaption with dynamic risk assessments on a case-by-case basis • Key staff to be included when there are to be any changes that may impact on floor space in rooms (moving TV, changing mattress/ beds, or refurbishments). • For the Raizer chair the team are holding sessions during quiet hour and during the night shift to ensure all team members can familiarise themselves how to use it. • The team will then consider other equipment that is not used frequently and continue this work.

Falls Incidents Learning and improvement work

AARs have identified that servicing of call bells was not in place, following investigation, this has been implemented. Call bells and falls alarms are now included in our monthly Patient Environmental Inspection. When our call bell and falls alarm system is due to be replaced, the learning from incidents will be used during the procurement process.

Following thematic review of 2024 falls data, medication reviews have been increased since October 2025. Medication is now reviewed;

- on day 3 of admission - this includes non-palliative medications.
- post fall – resulting in medication changes.

Since the increase in medication reviews there appears to be a reduction in both the frequency of patients who experience a subsequent fall and overall falls. We will continue to review the data to monitor the effectiveness of this change via our Patient Safety and Medicines Management Groups.

Themes have been discussed at our quarterly Patient Safety Forum and has resulted in a review of organisational factors.

Following the thematic review of 2024 data which included a case study, along with the AARs completed we feel that we have gained a lot of insight into patients who fall repeatedly and falls in general. We can see that we have identified improvement areas within the falls management process, from risk assessment to post falls management. We have formed a multidisciplinary Falls Working Group which formed in June 2026 to make improvements to: training, risk assessment, care planning, falls management, policy and processes. Therefore, our focus on falls at this time will be on progressing with these improvement areas.

Pressure Ulcers

In 25-26 we had 17 pressure ulcer incidents reported of these we had:

- 11 Hospice acquired;
 - 9 stage 2
 - 2 stage 3 or above
- 16 found on admission
 - 7 stage 2
 - 9 stage 3 or above

Pressure ulcer incidents at WHSJ have reduced, this is largely due to improvement actions in patient management and equipment available for use to prevent pressure ulcers developing.

Ongoing monitoring, learning from incidents, and assurance processes continue to support sustained improvement and the delivery of safe, high-quality patient care.

Key actions implemented:

- Enhanced pressure ulcer risk assessment and early identification.
- Improved compliance with repositioning and skin inspection as per skin bundles/ASKKING.
- Increased availability and appropriate use of pressure-relieving equipment including new mattresses and chairs.
- Targeted staff education and competency assessments.
- Regular audits
- Multidisciplinary review of patients at highest risk.
- Sharing of learning from incidents and best practice across teams.

Falls Incidents Overview Learning and improvement work

No incident met our PSIRP threshold for AAR, no patient experienced a level of damage to skin that was inconsistent with the patient's risk status for pressure ulcer development.

There has been an improvement in sharing pressure ulcer information when patients are transferred into our inpatient services

Incidents identified gaps in safeguarding processes. We have updated our incident reporting system to include a direct link to the Department of Health and Social Care adult safeguarding decision guide which allows staff to assess the skin and the need to refer to safeguarding services. This has improved staff confidence with this process and the reporting rates.

All pressure ulcer incidents will continue to have a managerial investigation, and this will include reviewing that skin checks have been completed in line with the frequency identified in risk assessments and care plans and has been reported externally where required.

Training

To support the effective management of PSIRF, the following training requirements for staff is outlined below:

Topic	All Hospice Staff	Staff investing incidents that do not meet PSIRP	Staff investing incident that meet PSIRP (AAR etc)	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)						
Systems Approach to Incident Investigation Workshop (in house)		✓				
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 [b1465-3-guide-to-responding-proportionately-to-patient-safety-incidents-v1.3.pdf](#)

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria 2018, or its replacement.	Proportionate learning response	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Patient Safety Group or Medicines Management group and reported and to and reviewed by Clinical Governance Committee. ICB Quality lead invited to meeting to review.
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII reported to LfPSE	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by patient Safety Group or Medicines Management group and reported and to and reviewed by Clinical Governance Committee ICB Quality lead invited to meeting to review.

Patient safety incident type	Required response	Anticipated improvement route
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 meeting the learning from deaths criteria)	Locally-led PSII reported to LfPSE	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by patient Safety Group and reported and to and reviewed by Clinical Governance Committee ICB Quality lead invited to meeting to review.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required Reviewed by patient Safety Group and reported and to and reviewed by Clinical Governance Committee
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	PSII led by most appropriate Trust
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority	Refer to HSIB or SpHA for independent PSII See also Appendix B of NHS England guidance	PSII led by MNSI

Patient safety incident type	Required response	Anticipated improvement route
(SpHA) criteria when in place		
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	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. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	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 See: Guidance for managing incidents in NHS screening programmes	PSII

Patient safety incident type	Required response	Anticipated improvement route
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. Healthcare organisations must fully support these investigations where required to do so	PSII alongside Police processes
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. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	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 Medication administered early, late or omitted	Thematic review when there have been 5 incidents. Supported with the introduction of swarm huddles to provide us with greater information at the time of the event when relevant staff are present. Review with learning / themes from previous AARs and thematic analysis AAR will be conducted to support the investigation if this approach better meets the complexity of the event.	Identification and action related to any trends identified. Findings to be discussed at Patient Safety Forum and Medicines Management Group Create local safety actions and feed these into the quality improvement strategy. Reviewed by Clinical Quality/ Governance Group. Identification and action related to any trends identified