

Compton Care

specialist palliative and bereavement support

REDUCING AVOIDABLE HARM IN HOSPICE CARE:

IMPROVING FALLS, PRESSURE INJURY AND MEDICATION SAFETY THROUGH PSIRF

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BACKGROUND

Hospice patients present with advanced disease, clinical complexity and an expected trajectory of deterioration, meaning not all incidents are avoidable. However, reducing avoidable harm remains a key priority. At Compton Care, incident data relating to falls, pressure injuries and medication incidents identified variation in both outcomes and reporting quality. The introduction of the Patient Safety Incident Response Framework (PSIRF) enabled a shift from counting incidents to understanding why harm occurs and how systems can be improved.

AIM

To reduce avoidable patient harm and strengthen organisational learning by improving the management, investigation and prevention of falls, pressure injuries and medication incidents.

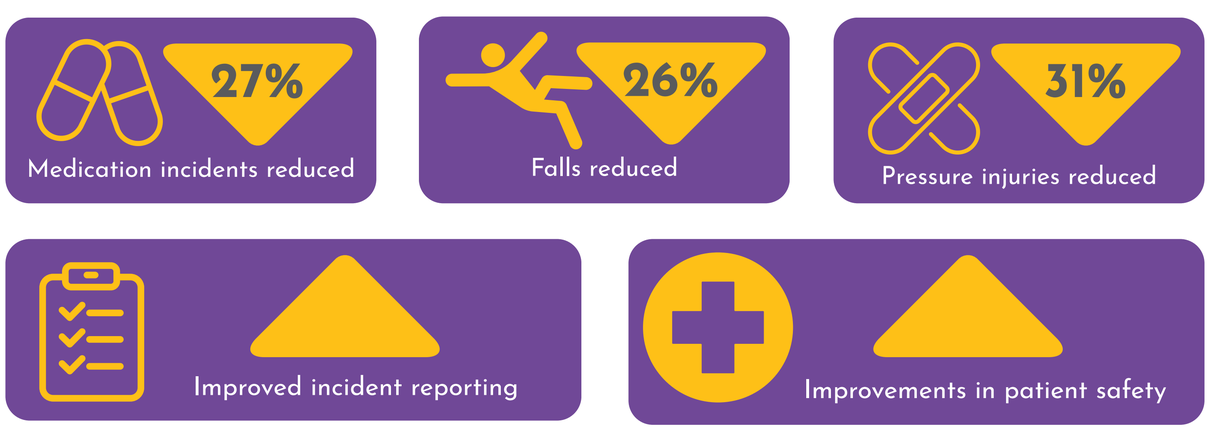


METHOD

A hospice-wide, PSIRF-aligned approach was implemented across inpatient, community and outreach services, supporting consistency of safety practice across settings, including:

- Promoting a just culture and open reporting of incidents and near misses to support learning
- Strengthening structured, proportionate incident investigations
- Thematic review of incident data (falls, pressure injuries and medication incidents) to identify patterns, contributory factors and unwarranted variation
- Enhanced multidisciplinary oversight through Clinical Governance Sub-Committee and Medicines Management Group
- Targeted improvement actions including staff training, policy updates, audit tools and investigation templates with strengthened medicines governance.

RESULTS



- Medication incidents reduced by 27%
- Falls reduced by 26%, with improved identification of contributory factors such as environment, staffing and patient complexity
- Pressure injuries reduced by 31%, with clearer classification and improved prevention strategies aligned to best practice
- Improved quality and consistency of incident reporting, supporting more robust learning and assurance
- Year-on-year improvements in patient safety supported by PSIRF-aligned governance and reporting.

CONCLUSION

In a hospice population where some deterioration is unavoidable, PSIRF has supported a clear focus on reducing avoidable harm. By strengthening reporting culture, improving investigation quality and embedding thematic learning, meaningful improvements in patient safety have been achieved. This approach demonstrates how hospices can adopt PSIRF to move from reactive incident management to proactive, system-based learning in complex palliative care environments.



KEY LEARNING POINTS

- Focusing on avoidable harm is critical in palliative care settings
- A just culture and open reporting underpin meaningful safety improvement
- Thematic, system-based analysis has greater impact than isolated incident review
- Strong governance and multidisciplinary oversight enable sustained improvement
- PSIRF is transferable and effective within hospice care models.