

achieved. Questionnaire to patients, carers, and health care professionals to ascertain views about HCAs carrying out skin and wound assessments and applying dressings. Regular interviews with patients and carers to elicit feedback on services, including skin and wound care.

Results Initial and subsequent questionnaires and interviews have shown strong support for HCAs' involvement in wound care.

Conclusions Involving unregistered staff in pressure wound assessment and treatment is an important part of an effective pressure injury prevention programme. Regular training and support can maintain good results over the long-term. Feedback suggests that patients, carers, and health professionals see the benefit of this approach, and job satisfaction and morale among HCAs has increased. Our results demonstrate that this project has brought about significant and permanent improvements in the prevention of pressure injuries.

P-158 **STAND UP AND BE COUNTED: WORKING TOGETHER TO IMPROVE SYSTEMS FOLLOWING MEDICINE DISCREPANCIES**

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Background Routine IPU audits (November 2022) identified medication issues and numerous complicated management systems. In addition, there was an increase in process-related medicine incidents reported. A similar situation in 2018 resulted in increased governance for Zopiclone and communication of concerns resulting in increased staff anxiety. Our learning from Psychological Safety (Edmondson. The fearless organization: creating psychological safety in the workplace for learning, innovation and growth. 2019) encouraged a different approach to the same issue.

Aims To use a systems-based approach (Healthcare Improvement Scotland. Safe management and use of controlled drugs report. 2014; Komashie, Ward, Bashford, et al. *BMJ Open*. 2021; 11: e037667) to encourage engagement with IPU staff to raise concerns, be part of the decision making and integral to the solution to improve the safety of medicines processes.

Methods Nov. 2022 – Multidisciplinary group formed (all IPU registered nurses invited). Dec. 2022 – Three key workflows identified: schedule 3–5 medication governance arrangements, use of patients' own medicines and induction support. Jan. 2023 – Sub-group proposals considered. Feb. and Mar. 2023 – Planning and implementation of new processes and initial audit work. May 2023 onwards – Evaluation and feedback.

Results Governance arrangements: process now covers all schedule 3–5 medicines (Healthcare Improvement Scotland, 2014). Audit (April 2023) identified need for improved recording in registers for additional details within registers – repeat audit (May 2023) provided assurance of safe process in place. Feedback from staff continues and staff have openly discussed trust within medicine management processes (Edmondson, 2019; Jackson. *J Adv Nurs*. 2023 May 10).

Using patients' own medicines: the benefits outweighed any disadvantages (Crowther, Wanklyn, Johnson, et al. *BMJ Support Palliat Care*. 2013; 3:A50) and supported the

organisation's environmental sustainability ambitions. Pharmacy team role developed to include medicines reconciliation process, supporting consistency. Improved induction and support: staff feedback identified the need for enhanced pharmacy support and a clear and extended mentorship structure to ensure consistent messaging to all new staff.

Conclusion Current indications from audit and incident reporting suggests improvement. Opportunities have continued to engage with staff. A systems-based approach 'not hindered by fear' (Edmondson, 2019) has supported joint working between clinical, quality assurance and leadership teams to achieve safer practices.

P-159 **BETTER TOGETHER. PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) THROUGH A COLLABORATIVE APPROACH**

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Background Ensuring patient safety is vital (Vincent. The essentials of patient safety. Notes on introduction. 2011). The PSIRF (Patient Safety Incident Response Framework) was launched by NHS England (August 2022) and sets out a new approach to developing and maintaining effective systems and processes in response to patient safety incidents. The value of collaboration to implement PSIRF was agreed at a hospice regional leader meeting. The importance of collaboration is highlighted in the national Ambitions Framework (Ambitions for Palliative and End of Life Care, 2021).

Aims Link with local hospices to achieve:

- Feedback on materials shared.
- Share thoughts and ideas on implementation plans.
- Highlight issues and barriers to implementation.
- Shared incident response plan and policy.
- Shared learning and networking.

Method In October 2022, the Quality Leads of local hospices were invited to join our patient safety specialist hospice forum. Initially, four hospices responded, and we held our first meeting in February 2023. Challenges of PSIRF were discussed for smaller providers and a joint proportionate approach agreed. A further three hospices joined and collectively we examined three years of safety incidents and complaints which resulted in common safety themes identified. A patient safety lead from an ICB attended one meeting and one hospice shared an explanatory presentation for their Board of Trustees, so that we were all delivering the same message.

Results The group identified: Key stakeholders; Key lead roles; Training needs and providers. And developed: PSIRF implementation project plan; Hospice incident profile; Incident response plan.

Conclusion The group has been an example of open collaboration to problem solve, learn and work together to achieve a united goal. We have been breaking down each task so that it is a series of smaller challenges rather than one large overwhelming one. Our next challenge will be how hospices can involve patient safety partners and engaging families and staff. We are planning to continue working together post PSIRF implementation to improve learning opportunities.