Controlled Drug Accountable Officer's Annual Report

1st September 2023 to 31st August 2024

Executive Summary

Accountability for safe management of controlled drugs sits with Bolton Hospice Board via the Controlled Drugs Accountable Officer (CDAO), which was held by Jenny Gallagher (Clinical Nurse Director) until January 2024 and then taken over by Bharti Macleod (Corporate Services Manager) for the duration of the reporting period highlighted. This report is to provide affirmation that Bolton Hospice is compliant with the current controlled drugs legislation, has effective controlled drugs systems and policies/procedures in place. Also that the hospice ensures all controlled drugs incidents and near misses are reported, fully investigated and externally reported, where required. Importantly too, taking forward the learning opportunities identified both with the individual staff involved and across the wider team, taking forward actions to further strengthen safety and governance.

Within the reporting time frame there were 61 internal controlled drugs incidents, which is an increase of one compared to the same time period 2022-2023, which continues to support a clear and transparent culture and approach to incident reporting. In addition, there were three incidents reported externally to the Local Intelligence Network (LIN), where the reporting criteria was met.

All registered staff are required to complete medicines management training at induction and complete a detailed workbook, which covers numerous subjects including controlled drug management, role of accountable officer and incident reporting.

The Management of Medicines Policy C15 was last reviewed July 2023 with minor amendments with the next review scheduled July 2026. The Controlled Drug related Operating Procedures (SOPs) have all been reviewed within the last three years to ensure they remain fit for purpose.

Purpose of the Report

The purpose of this report is to ensure that "safe management of controlled drugs" is maintained as an organisational priority.

To provide assurance on the systems and processes within Bolton Hospice that lead to safe management of controlled drugs.

To describe the range of incidents reported to the CDAO and where appropriate, the LIN, from 1st September 2023– 31st August 2024.

To demonstrate to the Board of Trustees that Bolton Hospice is compliant with the requirements of the Misuse of Drugs Act (revised 2001), the Health Act 2006 and the Controlled Drugs (Supervision of Management and Use) (Amendment) Regulations 2020 and identify any deficiencies.

Duties of the CDAO include ensuring:

- The organisation is following "adequate and up to date" Standard Operating Procedures (SOPs).
- Appropriate provisions for monitoring and auditing the management and use of controlled drugs.
- Systems exist to alert the CDAO of any complaints or concerns involving the management or use of controlled drugs.
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
- Appropriate provisions in place for analysing and responding to untoward incidents involving the management or use of controlled drugs.

- Relevant individuals receive appropriate training in relation to controlled drugs.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and measuring their performance.
- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
- The assessment and investigation of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
- Appropriate arrangements for ensuring the proper sharing of information.

The NHS England and NHS Improvement Northwest Region – (Greater Manchester [GM]) team CDAO is responsible for co-ordinating the sharing of information through LINs.

Local Intelligence Networks (LIN)

Under the Controlled Drugs (Supervision of Management and Use) Regulations 2013, the NHS England Accountable Officer must form a controlled drug local intelligence network (CDLIN) to share information and intelligence concerning the misuse and safe use of controlled drugs. These meetings are attended by a range of organisations, including hospices.

During the period of the report the CDAO who was appointed February 24 has attended all three virtual Northwest Regional LIN meetings including one National LIN meeting on 5 March 2024.

Actions undertaken since appointment include:

- Sharing of Individual of concern alerts sent to HR and the Volunteers Manager.

Advice shared to Clinical Lead, Advanced Clinical Nurse Practitioner, and Medical Director of the following:

- How to handle suspected Controlled Drugs brought into Hospital
- Sharing of the Gosport report
- Discharge from hospital information shared

Prevention of Future Death Reports

After an inquest, a coroner may issue a Prevention of Future Death Report, sometimes called a 'Regulation 28 Report', when the coroner considers that more preventable deaths could occur if no action is taken to alleviate a recurrence. The report is sent to the person and/or organisation(s) that the coroner believes has the right to take the protective action. They must then respond within 56 days showing how they have made changes according to the Coroner's recommendations, or how they mean to, where relevant. Most reports are published on the Judiciary website.

Although Prevention of Future Death reports are sent to specific individuals or organisations, the valuable information in them about controlled drugs risks must be used to support learning and change across both individual organisations and local health and care systems. At the hospice we have robust policies and procedures which centre on clear record keeping, safe prescribing and monitoring and prompt communication regarding medications prescribed for patients, regardless of whether the service user is seen in outpatients, inpatients or in their own home.

During the reporting period no "Regulation 28 Reports" were sent to Bolton Hospice.

For information, a new revised flowchart for reporting deaths to the Medical Examiner (ME) has been introduced September 2024 with immediate effect.

The key difference is deaths occurring over the weekend, the Medical Certificate of Cause of Death (MCCD) and ME referral paperwork can be completed as usual, however, will be held back and

forwarded to the ME on the Monday morning (unless there is any urgent need to contact the ME over the weekend). This change will not prevent the deceased patient from being transferred to the Funeral Directors.

Controlled Drug Safety

- Bolton Hospice has Medical and Non-Medical prescribing within Outpatients, Inpatient Unit and within the Hospice at Home service. All prescribers have maintained safe prescribing practices, prescribing minimum quantities in line with policy. Communication with the patients General Practitioner (GP) and other key healthcare providers has been maintained in a timely manner, usually within 24 hours of the consultation. Timely communication is recognised as best practice when prescribing for patients to ensure that patient safety is maintained.

- Signatures, storage and distribution: Bolton Hospice has undertaken a vigorous process/system for ordering medication for patients during the report period. Our portering staff who attend the local NHS Trust to collect the medication are all appropriately trained and clear audit trails has medications ordered, collected and received are maintained.

- Bolton Hospice does not use private prescriptions, all our FP10 prescriptions for Schedule 2 – 5 controlled drugs are submitted via the pharmacy that dispenses the medication, to the NHS Business Services Authority. Where Schedule 4 and 5 medications are prescribed on the Inpatient Unit, the pharmacist from the local NHS trust monitors the drug wardex and any concerns regarding inappropriate prescribing, excessive ordering or low stock that cannot be accounted for in the weekly stock check should be reported to the CDAO and internally incident reported with the appropriate investigation. No concerns have been raised with the CDAO during this time period.

- Safe custody does not relate to Schedule 4 and 5 CDs and there is no requirement to keep records in a controlled drugs register. This can create an increased potential option for diversion and misuse of these medications by staff, either for their own use or for onward supply. Good governance, audits and oversight can help to reduce the opportunity for diversion or identify these activities at an earlier stage. In addition, staff support is offered at Bolton Hospice via 1Point confidential counselling service, WHYSUP, Healthcare UK, as well as access to NHS support services.

- In addition, educating staff of the potential harm associated with these medicines and a risk assessments regarding the procurement, transportation and storage of CDs all contribute to minimising the risk of abuse and diversion of these medications.

- Prescribing in Inpatient Unit is under the scrutiny of the Medical Director and Pharmacy personnel and relates to prescriptions for both drugs initiated in the inpatient setting and those prescribed prior to admission.

- A review of prescribing via FP10s was undertaken in last 12 months and prescribing was found to be within the accepted formulary for specialist palliative care by the medical team. There were some learning points which were completed January 2024, the next audit is due November 2024.

- Within the hospice there are three qualified and one Non-Medical Prescriber (NMP) There is a policy and procedure for the staff to follow, including safe use of FP10 stationery and prescribing which is monitored and audited. Where staff are prescribing on FP10 prescriptions the costs are covered by the Integrated Care Partnership (ICP) and assurance has been received that the ICP has processes in place for monitoring CD prescribing.

- Our Advance Nurse Clinical Practitioner, who is overseen by the Medical Director, prescribes on the IPU wardex and in outpatients and no issues have been identified following an audit of prescribing practice.

- Bolton Hospice pays for the support of a Pharmacist from the Royal Bolton Hospital whose hours have recently been reduced from 19 hours to four hours with the current activities and

tasks undertaken as follows: checking drug charts, answering queries, checking TTOs if any are written and ordering medications.
- To support the reduction in the Pharmacists hours, two Registered Nurses have been nominated and formally registered to witness the regular destruction of Controlled Drugs with Bolton Hospice

CD Recommendations from the Care Quality Commission (CQC)

The CQC has overview of the governance regarding controlled drugs and provisions for this can vary across organisations, often in response to the needs of the specifical organisation and the people they care for. The CQC examine and report on how well health and social care providers, and other regulators, work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people through the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

As part of this work, the CQC publish their findings annually, together with recommendations on how the safe use and management of CDs can be improved.

In July 2024, the CQC published their latest annual report: **https://www.cqc.org.uk/guidance-providers/controlled-drugs/controlled-drugs**

The report highlighted the following areas of concern:

1. Organisations to make sure their governance processes are up-to-date and fit for purpose. In the last two years CQC have made recommendations around the importance of governance in the context of controlled drugs and continue to monitor the progress.
2. Make sure prescribing at transfer of care is completed safely. Clinicians must have the relevant medical and medication history before prescribing controlled drugs to patients.
3. Know the identity of your local controlled drugs accountable officer (CDAO) and police-controlled drug liaison officer (CLDO). Any organisation with a responsibility around controlled drugs must have these details and know how to report controlled drugs incidents.
4. Work collaboratively to improve the prescribing, managing and monitoring of controlled drugs.
5. Make sure you have a valid Home Office Controlled Drugs Licence if you are required to have one.

Governance

In response to the areas highlighted in the latest CQC report, the Management of Medicines Policy and SOPs have been reviewed and updated within the last 3 years and shared with relevant staff. The policies include up to date evidence-based processes, to ensure thorough medicines reconciliation is completed before medication is prescribed for patients, as well as sharing prescribing and discontinuation of medication information with third parties in a timely manner. Information regarding the contacts for the local controlled drugs accountable officer (CDAO) and police-controlled drug liaison officer (CLDO) are also included in the policies.

The CDAO undertakes a six-monthly audit of controlled drugs in collaboration with a pharmacist/clinical member of the team, in order to provide assurance to the organisation and CDAO that controlled drugs management and processes are fit for purpose and safe.

During the reporting period two CD audits have been carried out at the hospice, January and April 2024, with the following recommendations/reminders shared across the clinical staff:

- Security - Incident report submitted highlighting no blue bin available for the CD destruction process as delivery was pending – denaturing kit was placed in locked cupboard–
- IPU lead updated SOP 7
- Procedure for destruction of CD / protocol for the destruction of Patient old and expired drugs. Recent review of the process identified denaturing kits should be placed in the secure CD cupboard- for 24 hours pending denature process to be fully completed

The Hospice's current risk assessments - "Discrepancies - CDs stored and prescribed by the Hospice" (RA004) and the "Hospice mini bus collecting and transporting Controlled Drugs" (RA0183) were both last updated March 2024

Bolton Hospice has a clear process for the reporting of all accidents, incidents and near misses, including those involving third party organisations, who are informed as appropriate, to improve safety and outcomes for people. The CDAO is required to ensure accidents, incidents and near misses which fall within the specified external reporting criteria are reporting to the Greater Manchester Controlled Drug Accountable Officer (GM CDAO) via the reporting portal, www.cdreporting.co.uk. The incident reports are completed by a senior clinical staff member as part of the reporting process with the CDAO to be advised of the incident which has occurred. There are additional checks by way Senior Leadership Team Director sign off on all Vantage Incident Reports and also the weekly overview of all incidents by the Chief Executive Officer. A high-level Incident Report is also prepared for the Quarterly Quality and Governance Committee which captures volume and detail, as appropriate, of Controlled Drug incidents and near misses.

Ordering

Bolton Hospice obtains Controlled Drugs through service level agreements (SLAs) with two hospitals, Bolton NHS Foundation Trust, who supply named patient drugs (including CDs) and Salford Royal NHS Foundation Trust, who supply all stock medications including CDs, in accordance with national recommendations and requirements. Bolton NHS Foundation Trust do not hold a "Wholesale Dealers Authorisation Licence" so cannot supply the stock medications.

Bolton Hospice does not require a Home Office Licence as we do not supply drugs to other organisations.

Disposal Arrangements

In line with the regulations defined in the Misuse of Drugs Act (revised 2001) the CDAO is required to approve individuals who can observe the destruction of controlled drugs and also ensure that they are destroyed in a way which ensures that they are irretrievable. Within the Hospice there are three staff (including the Royal Bolton Hospital Pharmacist) who are authorised to act as witnesses for the destruction of CDs. In addition, the Waste Regulations requires the Hospice to have a valid T28 exemption for the denaturing of controlled drugs prior to waste disposal. The Hospice has an SLA with a regulated waste removal company, to dispose clinical waste including denatured controlled drugs. Denaturing is carried out by using a Dupe kit, which are stored securely in the pharmacy (controlled by fob access which is monitored by the Senior Ward Clerk and Corporate Services Manager). During the reporting period there were 14 witnessed destructions of CDs in line with policy and procedure.

Trend Analysis

Bolton Hospice LIN Categorisations (internal incidents only)	Sept 20 - Aug 21	Sept 21 - Aug 22	Sept 22 - Aug 23	Sep 23 - Aug 24
Accounted for losses	0	0	0	8
Death	0	0	0	0
Patient and/or public causing concern	6	0	0	0
Patient related	13	18	17	34
Professional individuals of concern	0	0	0	0
Record Keeping/Governance	9	21	37	7
Unaccounted for losses	0	3	8	2
Other				10
Totals	**28**	**42**	**62**	**61**

Of these reports detailed above, three incidents were externally reported to the LIN during the reporting period.

These three incidents were as follows:

1.Unaccounted for Losses- running balance issue between 5-10% discrepancy.-contributary factors- dispensing, administration, interruptions on ward due to staffing issue etc

2 Unaccounted for Losses – lost or missing controlled drugs- 32ml unaccounted for – decanting/spillage not recorded etc.
3 Administration error- wrong drug administered to patient- oxycodone not morphine

Summary

This report summarises the systems and processes in place to provide the assurances that controlled drugs are being managed appropriately within the organisation. In 2023/2024, there were no catastrophic or major incidents reported and no cause to escalate concerns about diversion of controlled drugs to the Police and NHS England.

The overall pattern of incidents involving CDs and relevant people within the Hospice indicate that:

1) Safeguarding and information sharing involving serious concerns across NHS England and NHS Improvement – (Greater Manchester) CD LIN is continuing to work well.

2) The CD incidents reporting rates continue to reaffirm that Bolton Hospice has an open and transparent culture of all types of incident reporting.

3) Assurance that the CDAO has undertaken the quarterly reporting of CD incidents, as required, and also overviewed the trend data of the types and categories, with three incidents, as highlighted within this report falling within the criteria for external LIN reporting at the time of the incident. All other incidents are reported/captured within the quarterly LIN reports.

4) Learning from controlled drug incidents continues to be shared with staff across the organisation, as appropriate.

5) Bolton Hospice will continue to work closely with our pharmacist to enhance medications safety and support safe clinical practice and care for patients, ensuring compliance with the CQC and all CD legislation.

6) Work on the national Patient Safety Incident Response Framework (PSIRF) is underway as one of the GM Hospice Collaborative work streams, led by the Clinical Directors, which will support the patient safety and learning culture in the organisation.

7) In line with PSIRF guidelines, a new Patient Safety Group has been formed as part of the monthly Audit Committee, chaired by the Medical Director. With a new workstream commenced relating to Medicines Management with a detailed Action Plan in progress to support further enhanced care, with a reduction in the number of errors/ incidents relating to CDs and Non-Controlled Drugs.

Appendices

Appendix 1 – Example of Quality & Governance Newsletter circulated across Bolton Hospice within the reporting period.

Governance Newsletter - Aug 20

Appendix 2 – Categories of harm levels distributed to clinical staff.

Bolton Hospice
caring from the heart

DEFINITIONS OF PATIENT PSYCHOLOGICAL HARM

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

NO PSYCHOLOGICAL HARM

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

LOW PSYCHOLOGICAL HARM

*Low psychological harm is when **at least one** of the following apply:*

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department, or clinic visit.
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days.
- distress than did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition.

MODERATE PSYCHOLOGICAL HARM

*Moderate psychological harm is when **at least one** of the following apply:*

- distress that did or is likely to need a course of treatment that extends for less than six months.
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months.
- distress than did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months.

SEVERE PSYCHOLOGICAL HARM

*Severe psychological harm is when **at least one** of the following apply:*

- distress that did or is likely to need a course of treatment that continues for more than six months.
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months.
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months.

DEFINITIONS OF PATIENT PHYSICAL HARM

NO PHYSICAL HARM

No physical harm.

LOW PHYSICAL HARM

*Low physical harm is when **all** of the following apply:*

- minimal harm occurred – patient(s) required extra observation or minor treatment.
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department, or clinic visit.
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- did not or is unlikely to affect the patient's independence.
- did not or is unlikely to affect the success of treatment for existing health conditions.

MODERATE PHYSICAL HARM

*Moderate physical harm is when **at least one** of the following apply:*

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department, or clinic visit, and beyond dressing changes or short courses of medication, but less than two weeks of additional inpatient care and/or less than six months of further treatment and did not need immediate life-saving intervention.
- has limited or is likely to limit the patient's independence, but for less than six months.
- has affected or is likely to affect the success of treatment, without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

SEVERE PHYSICAL HARM

*Severe physical harm is when **at least one** of the following apply:*

- permanent harm / permanent alteration of the physiology.
- needed immediate life-saving clinical intervention.
- is likely to have reduced the patient's life expectancy.
- needed or is likely to need additional inpatient care of more than two weeks and/or more than six months of further treatment.
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than six months) disability, of their existing health conditions.
- has limited or is likely to limit the patient's independence for six months or more.

FATAL PHYSICAL HARM

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth and pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

QUALITY AND GOVERNANCE NEWSLETTER

Department Performance Reports

Equality & Diversity Report will now come under the HR Equality, Diversity & Inclusion (EDI) Committee and will be removed from the Q&G Reports Calendar.

Health and Safety – GH/LV said this was a very comprehensive and excellent report, well done. The Health and Safety Committee works really well.

Clinical Risk Management

Incidents High Level Overview – Report for 01.04.24. – 30.06.24. – The NHS Logistics stock ordering was mentioned which hasn't been the same structure since the Pandemic. This is currently under discussion at Audit Group to catch up and SG is looking at how to systemise this better.

Risk Register – Available, no comments raised.

Quality Measures / Audit Update / New Guidelines

QMC – August 2024 – No comments raised.

Estates / Building / Corporate Services / Patient Safety Alerts

- EMcC will remain as Caldicott Guardian for the Hospice.
- WBH Lift will be refurbished in 2 weeks.
- There will be a service on the main Hospice doors.
- One of the boilers has been repaired.

Patient Safety Alerts – Nothing to report.

Clinical Support Services Updates

Clinical Capacity – Report available. Recruitment is going well. New CSNs and three new SSNs are settling in well. Band 5 and 6 interviews are scheduled. GH commented that she had read that 80% of new nurses have not got jobs. It was also mentioned that some nurses are encouraged to go on to Agency work.

Information Governance / Service User Feedback

- CD reported that the **DPST** has been submitted and wanted to thank all involved.
- **Mandatory training has currently hit 95%** - well done to the teams and we need to keep this momentum.
- Following the **Data Breach** earlier in the year, which was reported at the time to the ICO, AA received comments from one doner that it had been very scary for her elderly mother receiving news of this and therefore a learning, should a similar situation arise in the future, is how to soften wording whilst remaining honest and transparent. It's important to note that whilst the data breach risks were minimal, as guided by the ICO, we felt it important to make people aware of the situation.
- **Patient Safety Incident Response Framework (PSIRF)** launched throughout the NHS a couple of years ago. A working group has been formed across GM Hospices to support implementation in each organisation. The framework includes new learning which has now been launched across the hospice, with a request for everyone to complete their required training. A new policy is being prepared and CD and other nominated people in the hospice are requested to register on the new Learning from Patient Safety Events portal (LfPSE). GH asked if Vantage had been looking at collectively doing something that all can use but whilst questions have been asked by a few hospices, at the moment this can't be connected so there will be some duplication.
- **Patient and Family Feedback** – There have been no surveys completed in this quarter, but we have over 30 received so far for the next quarter. A request is made for the teams to continue to seek patient feedback on a regular basis acknowledging of course, sensitivity and appropriateness.

Our People

This year's **staff survey facilitated by Birdsong** was very positive on the whole, summary report and action plan will be developed with HR EDI Committee.

Provider Visit – JB reported in HW's absence and said that this was very positive. They talked to a variety of staff including Fundraising to see how the new Deputy CEO post had affected them. It was all very positive with some good ideas.

KEY:
LV - Leigh Vallance **CD** - Catherine Doyle **EMcC** – Ellie McCann **HW** – Helen Wall **JB** – Judith Bromley **GH** – Grace Hopps
SG - Sue Gooden **QMC** – Quality Monitoring Calendar **BH** – Bolton Hospice LIN – Local Intelligence Network

Incident Examples

DRUG INCIDENTS

Controlled Drug BH – not LIN reportable – 10
Controlled Drug – not LIN reportable third party – 4
Non-controlled Drug BH – 7
Non-controlled Drug third party – 4
Non-controlled Drug shared with third party – 1

EQUIPMENT AND DEVICES

- Lack of 1ml insulin needles to support administering of medication. Stock obtained from A&E by BH Porter which unfortunately delayed the administration.
- Lab contacted BH to advise blood culture bottles had expired in January 2024. Unfortunately, bottles had not been checked and no others were available in the hospice. Replacements obtained from RBH.
- No syringe pump giving sets (new lines) stock available in Pharmacy.

PRECRIBING INCIDENTS

Various prescribing incidents relating to updating and re-writing wardex resulting in medications not being given in a timely manner or further clarification of medications required.

PATIENT SLIP / TRIP / FALL

No Harm – 2
Low Harm – 4
Moderate Harm – 1
Total - 7

Learning Lessons

The review of Accident, Incident and Near Miss reporting for the period 1st April 2024 to 30th June 2024 highlights the following key specific areas of focus and learning opportunity for the Hospice Team:

- A number of incidents recorded over the last two quarters highlight the importance of a quality stock control process, ensuring the minimum levels of stock held are appropriate, and that checking of levels and expiry dates is undertaken on a regular basis, with timely ordering when needed. In adherence to PSIRF, a new Patient Safety Group has been formed within the Audit Group and one of the actions being taken relates to a new workstream supporting enhanced Medicines Management, whilst acknowledging that the Hospice's performance, care and service provided is already at a very high standard. Thank you to all the team for continuing to record all accidents, incidents and near misses which ensures a thorough investigation and, most importantly, the opportunity for learnings and continuous improvement to take place.
- Being ever conscious of the impact of our behaviours and language on others, both patients and everyone we encounter during our day, remaining professional at all times, displaying role model hospice values – **Collaboration, Compassion, Excellence, Inclusivity, Professionalism and Respect.** Seeking help, guidance and support when needed.
- The importance of accurately recording complaints received (both informal and formal), including categorisation, ensure visibility and transparency, with timely investigations and responses to all those involved.

Thank you and well done to everyone who has raised an incident and for following our Hospice Policy, living our values every day in ensuring transparency and visibility. Together with enabling learning opportunities to be taken forward.