Neurodiversity
ASSESSMENT

Patient Safety Incident Response Policy

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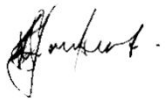
	NAME	TITLE	SIGNATURE	DATE
Author	Lesia Joubert	Practice Manager		1 February 2026
Reviewer	Eli Joubert	Director		1 February 2026
Authoriser	Eli Joubert	Director		1 February 2026
Updated following comments from Devon ICB	Lesia Joubert	Practice Manager		8 July 2026

1. Introduction

Purpose:

As patients are only seen online in our service, it is not envisaged that any physical harm can come to a patient directly as a result of working with the team. Our service does not prescribe any medication.

However, we identify and address all patient safety incidents.

This framework aims to systematically address patient safety incidents to minimise harm, promote a culture of safety, and enhance the quality of care. It serves as a guide for clinicians in the team to follow when incidents occur.

Scope:

This framework applies to all staff, including both clinical and administrative areas.

2. Definitions

Patient Safety Incident: An event that results in or has the potential to result in unintended harm to a patient. This includes adverse events, near misses, and serious/never events.

Adverse event: any unintended or unexpected incident that could have caused, or did cause, harm to a person while receiving healthcare.

Near Miss: An incident that did not reach the patient, but could have led to harm if it did.

Reporting near misses is critical for prevention.

Serious/Never event: An adverse event where the consequences for patients, families, staff, or the NHS are very severe. This includes events where the outcome is unexpected death, major permanent harm, or widespread service disruption that compromises patient safety.

3. Incident Reporting

Encouragement of Reporting: This service holds a non-punitive stance aimed at encouraging staff to report incidents without fear of retaliation and actively promoting transparency and accountability.

Reporting Mechanisms:

Complaints: Our complaints procedure is set out in the Complaints Policy.

Anonymous Reporting from staff: Due to the relatively small size of the team, it would be difficult to absolutely assure anonymity. However, every effort will be made to encourage staff to discuss any matter with the Practice Manager or Managing Director.

Direct Reporting: Staff are encouraged to report incidents directly to any member of the senior leadership team (SLT).

Timeliness: Any incident should be reported ideally within 24 hours, but certainly no later than 48 hours. This will help to ensure timely investigation and response.

4. Initial Response

Immediate Patient Care: Any investigation will focus on assessing and addressing any immediate harm to the affected patient(s), as a starting point.

Notification: All relevant parties, including clinical teams and management, will be informed as soon as possible and as soon as appropriate. The Managing Director will always be informed.

5. Investigation Process

Incident Review Team:

The review team will include all involved in the incident and must include the Investigation Lead (Practice Manager) who is a member of the SLT and everyone else involved in the incident. This includes compassionate engagement with the patient, family and/or carers.

Data Collection:

Data collection includes all appropriate methods of collecting information, such as interviews with staff involved, review of clinical records and reports, and analysis of workflows to gather comprehensive data.

Findings will be documented meticulously to ensure thorough understanding.

Analysis and Learning:

Various Learning Response Tools (LRTs): Tools are selected based on the specific incident and include team debriefs and multidisciplinary reviews.

Compassionate Engagement: Patients, their families, and staff members involved are compassionately engaged and included in the learning response process from the start.

Root Cause Analysis (RCA): Where appropriate and useful, a root cause analysis will be conducted.

System-Based Approach: The complex healthcare system factors surrounding the incident will be analysed rather than assigning individual blame.

Mandatory Investigations: Certain specific incidents, such as nationally defined Never Events or deaths meeting the Learning from Deaths criteria, will follow standardised Patient Safety Incident Investigations.

Cross organisation learning responses: If the opportunity arises, we will share/contribute and engage in cross organisational learning responses.

7. Action Plan Development

Recommendations: Based on the findings of an investigation, an actionable list of required responses and improvement routes are contained in the Patient Safety Incident Response Plan.

Implementation:

Specific responsibilities will be assigned to staff for implementing each recommendation.

A timeline and action list will be developed to ensure the completion of tasks.

Education and Training:

Where appropriate and helpful, training sessions will be offered to staff which might focus on new procedures, policies, or technologies introduced as a result of the incident.

8. Monitoring and Evaluation

Follow-Up: Follow-up meetings will be scheduled to assess the status of the action plan implementation and to address any barriers encountered.

Key Performance Indicators (KPIs):

KPIs, such as the number of incidents reported, completion rates of action items, and reduction in incident rates over time will be established and monitored.

Data will be used to analyse trends and identify areas for further improvement.

9. Communication and Improvement

Internal Communication:

Staff will regularly be updated on incident outcomes and lessons learned through team meetings, and/or e-mail.

Open discussions about safety incidents will be encouraged to ensure continuous learning.

External Communication and Sharing of Learnings:

If incidents affect patients or their families, findings and corrective actions will be communicated transparently.

Templates for communicating with affected parties will ensure that sensitivity and confidentiality will be maintained.

A summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigations into such Incidents, as agreed with the Co-ordinating Commissioner are reported monthly to the Contracts Manager of Devon ICB.

Sharing with Commissioners in monthly reporting, with addendum if necessary.

When necessary, reporting on NHS England LeDeR (Learning from lives and deaths – people with a learning disability and autistic people)

(https://www.england.nhs.uk/learning-disabilities/health-and-wellbeing/learning-from-lives-and-deaths/)

NHS England Safeguarding rules and reporting principles will be adhered to. (https://www.england.nhs.uk/safeguarding/)

Continuous Improvement:

The SLT review and consider trends and identify areas for improvement during the weekly meeting that is chaired by to the Director.

Learnings will be integrated through training to ensure quality improvement initiatives.

Staff will be encouraged to share innovative ideas for improving patient safety.

Staff training plan:

All staff are required to complete the following training annually:
Safeguarding Adults L3
Safeguarding Children L3
Mental Capacity Act
Mental Health Act

The Investigation Lead (Practice Manager) will complete Patient Safety Training at minimum level 1 and 2.

10. Review and Update Policy

Annual Review:

A process is in place for annually reviewing this policy, incorporating feedback from staff, new evidence-based practices, and regulatory updates.

Stakeholder Feedback:

Input from commissioners, staff (at all levels) and patients about the effectiveness of the policy will be considered.

Feedback will be used, where appropriate and helpful, to make necessary adjustments to policies and procedures.

11. Conclusion

This Patient Safety Incident Response Policy provides a comprehensive approach to managing patient safety incidents. By emphasising timely reporting, thorough investigation, communication, and continuous improvement, we are better able to ensure a safer environment for patients and enhance overall care quality.