PATIENT SAFETY INCIDENT RESPONSE PLAN

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Next Review Date	August 2026 or when a change to legislation or guidance occurs. This document remains in force after the Review Date if it has not been replaced.
Related Policies/Procedures	Patient Safety Incident Response Policy
Responsible Function	Quality
Version	2025-1

Organisational Responsibilities

The Board of Directors are responsible for the operational management of Colebrook (South West) Limited's policies and procedures.

The Chief Executive Officer is the designated officer on behalf of the Board of Directors responsible for the implementation of the policies and procedures across Colebrook (South West) Limited.

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Introduction

This patient safety incident response plan sets out how Colebrook (SouthWest) Ltd intends to respond to patient safety incidents over a period of 12 to 18 months. The plan outlines our organisational approach and will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our Services

Colebrook offers its services through two service groups, delivering 7 separate services. Funding for these services comes from a range of sources including commissioned services from the NHS and / or Adult Social Care, local authorities, direct payment and self funding.

Our support may be based around support plans provided by the NHS and / or Adult Social Care. Where services deliver to individuals, we focus on reablement, and peer led support. We do not provide clinical health services requiring qualified medical staff nor do we provide personal care as defined by the CQC. As such we are not required to register with the CQC.

Not all of our services are required to be covered by the Patient Safety Incident Report Framework, however, we have set up our systems to ensure that all patient safety incidents, regardless of service or funding source, are responded to in the same way to ensure that any learning is applied equally as relevant.

Support Services – working with vulnerable people to develop independence, skills and realise their goals:

- On Track – commissioned floating support service for mental health and learning disabilities, currently supporting 35 people in their own homes.
- Tailor Made Support (TMS) – commissioned bespoke community based support service for mental health and learning disabilities, currently supporting 92 individuals in their own homes.
- Supported Accommodation Services – commissioned and direct payment led recovery projects, currently supporting 57 individuals across 10 projects.

Community Engagement Services – putting people at the heart of local services and improvements:

- Healthwatch in Devon, Plymouth and Torbay – Health and Social Care consumer champion.
- Headspace – peer led mental health out of hours service to support people at risk of, or experiencing, a mental health crisis, currently supporting an average of 60 individuals per week across 3 venues.
- Community Centres – rented and grant funded projects focussed on skills and development and inclusion.
- St Budeaux and Barne Barton Wellbeing Hub – connecting St Budeaux and Barne Barton residents to wellbeing services, currently supporting an average of 70 people per week.

Defining our Patient Safety Incident Profile

Our patient safety incident profile has been drawn up from information that includes feedback from all levels of the Organisation and clients.

Patient safety incidents (as per NHS guidance) are *'unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients'* and while we don't deliver clinical or care services, we recognise the potential for harm within the work we do.

Data sources –

In identifying safety issues, we first looked at accident and incident reporting data over the last 3 years, alongside safeguarding alerts, complaints, compliments and feedback.

Across the three years we have no patient safety incidents where a patient has been directly harmed as a result (or omission) of an act by Colebrook or any of its staff.

We looked at the data which showed 21 incidences where a client, or someone using one of our services, has experienced any harm during their contact with us. We considered the types and severity to feed into our profile.

Stakeholder engagement -

Stakeholder engagement in defining our profile comes from a number of avenues.

Where our patient safety incident profile is identified predominantly through individual cases, liaison with individuals (and others) involved in each incident, feeds into our incident understanding, organisational response, learning and subsequent improvements.

Discussion of incidents at management and Board level improve our wider picture of patient safety issues. Discussions are informed by:

- Our client engagement forum contributing the patient view on incident response with feedback through the Board Member and Manager who facilitate the forum.
- Feedback from stakeholders including family, professionals and others through Quality Effectiveness Monitoring Tool (QUEMT) monitoring.
- The staff forum with feedback through the CEO who facilitates the forum.
- Annual Questionnaires from staff and clients

In addition, Colebrook delivers our local Healthwatch service so senior management oversight of our patient safety response contributes a Healthwatch view.

Although wider stakeholder engagement doesn't add to our profile in relation to other expected or anticipated incidents, we recognise that the vulnerable people we work with are at risk of harm through areas of poor self-management of medication, lifestyle and behaviours, and understanding (and implementing) ways of staying safe. Many also have complex physical health challenges and long-term illness and disabilities. These are all areas which we support people in and where we have a responsibility to support client safety.

Considering all of the above our incident profile incudes -

- Accidental slips, trips and falls
- Minor cuts or grazes
- Incidences of self-harm or substance misuse whilst using a Colebrook service
- Accidental injury due to the actions of another client/person connected with our service
- Unexpected contact with an allergen.
- Where clients may reside in one of our supported accommodation projects, we have historical (outside of the three year reference period used in this plan), but very limited, experience of a client death in one of our projects, outside of staffed hours, due to physical health complications. While these incidences were not related to (or a result of) the work we do with clients, in recognition of the seriousness of the incidents, we are including these in our profile and planning so that we maintain the learning and continue to plan improvements to reduce the likelihood of it recurring and ensure appropriate response if it does.

Our profile shows a reduction of 2 in the overall number of incidents and improvement activities including reviewed staffing levels and shift arrangements and improved staff awareness have reduced the number of self-harm and accidental injury incidents.

Defining our Patient Safety Improvement Profile

Our patient safety improvement profile was identified by reviewing the Organisation's scheduled and reactive activity in relation to incidents and therefore include regular health and safety and governance activity as well as our response to recorded incidents.

Using the data above, we reviewed incident follow up at overall organisation level and segmented by type of harm, service and severity of outcome. We also reviewed individual circumstances to identify where organisational change to working practice, policy or procedure could have reduced the occurrence or severity of the incidents.

Scheduled patient safety improvement measures –

We have an established risk management approach where risk assessments are reviewed regularly (at least annually), both at individual and service level.

- Annual reviews of policy and procedure support our improvement profile and an annual staff training programme covering health and safety ensures an up to date, consistent approach and positive culture.

Responsive patient safety improvement measures –

Individual incidents are signed off by Service Managers, and actions and follow up reviewed and monitored within teams. Depending on the incident, our improvement work includes the following –

- Individual risk assessment and management
- Staff guidance and training
- Liaison with statutory partners to improve individual care management and mitigate risks
- Review of service staffing levels and capacity
- Service risk assessment updates
- Procedure reviews
- Consideration of appropriateness of service and unmet needs
- Use of first aid and improvements in process.

Accident, incident and safeguarding reporting and monitoring also occurs regularly at management and Board level as part of our QUEMT. Responses at an organisational level are discussed and improvement work can include -

- Policy review and associated changes to staff training
- Working with partners in statutory and/or emergency services at a service level
- Review of resources, funding and activities
- Service developments and improvement plans

Our Patient Safety Incident Response Plan: National Requirements

Example of patient safety incident types that require a National response.

Patient safety incident type	Required response	Anticipated improvement route
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

The national response requirements are specific and criteria for reporting either relates to clinical services which Colebrook do not deliver or activity that falls considerably outside of Colebrook's remit. However, we maintain response plans in the event they are needed to support any national response relating to people we work with.

In addition, we will work alongside partners and providers to contribute to any multiagency reviews and investigations surrounding patient safety responses as required. This includes liaison with the Learning Disability Mortality Review Programme where a death relates to a person with learning disabilities or contributing to the review of the death of a person with mental health problems as led by statutory services.

Our Patient Safety Incident Response Plan: Local Focus and Priorities

Our planned response to any incident is built around discussing the incident with client, staff and others to understand causes and any ongoing support needs, identifying how ongoing support will be implemented, then specific actions dependent on the type of incident are taken as below:

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**	**Quality Management Process**
Accidental slips, trips and falls Harm – some incidents may cause moderate harm	• Staff awareness of client mobility needs and challenges as part of support and risk management • Project staff monitor, report and resolve hazards that may cause trips and falls • Review of individual client needs in response to incidents.	• Feed into QUEMT • Review as part of project checks and monitoring schedule	• Incident Report • Huddle – where incident suggests additional care needs may be needed
Minor cuts or grazes Harm – some incidents may cause moderate harm	• Review individual support requirements regarding food preparation • Staff reminders and coaching • Ensure related support plans include safe use of kitchen equipment • Individual risk assessment related to use of sharp objects where needed.	• Consider service wide support aims focused on safe use of sharp objects • Feed into SAT improvement plans • Feed into QUEMT	• Incident Report
Incidences of self-harm or substance misuse whilst using a Colebrook service	• Review staffing levels to ensure services running safely • Update individual risk assessments and management guidelines	• Feed into QUEMT • Safeguarding review and discussion at	• Incident Report • Huddle – where incident

Harm – likely to cause moderate or more severe harm	• Alert partner agencies and safeguarding to improve joint working and ensure clients linked to appropriate services • Staff and team training to reflect on incidents	management level and with lead.	suggests additional care needs may be needed
Accidental injury due to the actions of another client/person connected with our service Harm – some incidents may cause moderate harm	• Review of service procedures • Review of service risk assessment • Team training re changes	• Feed into QUEMT • Team meeting service operational discussion	• Incident Report
Unexpected contact with an allergen. Harm – likely to cause moderate or more severe harm	• Update client records re possible allergens • Consider need for risk assessment depending on situation • Staff training on client risks and responses • Review first aid equipment and needs	• Feed into QUEMT • Team meeting service operational discussion	• Incident Report
Client death in one of our projects Harm – death but may be due to natural causes	• Liaison with partners and emergency services • Contact NOK and emergency contact • Review of contact, support and client care leading up to death • Involvement and support in multidisciplinary review • Support for staff, other clients and anyone involved • Review of organisational involvement and learning • Associated procedure and risk assessment reviews and staff training, roll out	• Feed into QUEMT • Board discussion and monitoring of situation, follow up and any organisational changes	• PSII (where an act or omission by Colebrook staff may be contributory*) • PSII (led by other organisation where an act or omission by their staff may be contributory) • Huddle

*As Colebrook does not deliver any clinician led care or care requiring a CQC registration, this has never happened.

Incident Report – an After Action Report used across Colebrook
Huddle – a swarm huddle where everyone goes to the site of the incident to review and includes multi-agency
PSII – Patient Safety Incident Investigation, used for the most serious incidents including death

Provision of Ongoing Support

Ongoing support will be offered to those involved by:

Clients

Increased support in service
Links to partner agencies involved to support
Use of OnCall for out of hours follow up

Staff

Debrief
Supervision
Referral to counselling
Use of our Employee Assistance Programme for critical incident support, coaching or counselling
Additional support time with manager

Implementation, Monitoring and Review of this Plan

The Chief Executive Officer has overall responsibility for implementing and monitoring this plan, which will be reviewed regularly following its implementation and additionally whenever there are relevant changes in legislation or to our working practices. Any queries or comments about this policy should be addressed to the CEO.