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	<b>NAME</b>	<b>TITLE</b>	<b>SIGNATURE</b>	<b>DATE</b>
<b>Author</b>	<b>Robert Mann</b>	<b>Associate Director for Safety and Quality/ Patient Safety Specialist</b>		<b>14 Dec 2011</b>

**Oliver**







## **Integrated Community Health and Social Care Teams**

## **Stakeholder Engagement**

## **Safety & Quality Systems**

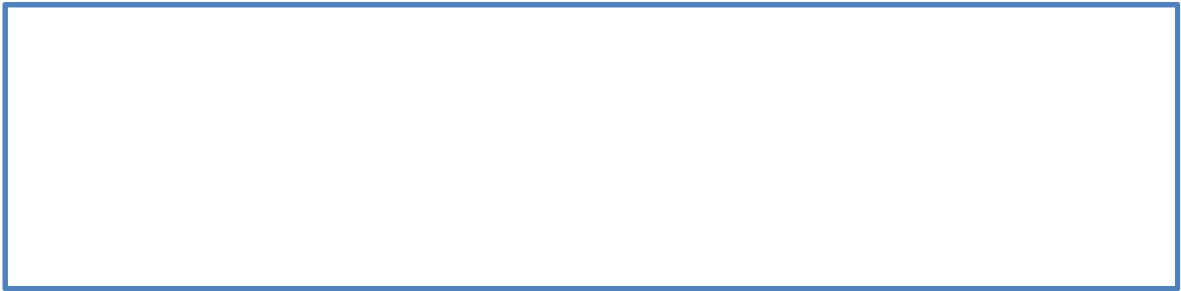














**Our patient safety incident response plan national requirements.**

<b>Patient safety incident type</b>	<b>Required response</b>	<b>Anticipated improvement route</b>
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<b>Patient safety incident type</b>	<b>Required response</b>	<b>Anticipated improvement route</b>
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Patient safety incident type	Required response	Anticipated improvement route
	<p><b>They will consider the scale, risk of harm and potential for recurrence and advise the provider whether to complete the screening incident assessment form (SIAF).</b></p> <p><b>Discussion may be required to agree if a locally led PSII is required alongside any review commissioned by SQAS</b></p>	



<b>Patient safety incident type or issue</b>	<b>Planned response</b>	<b>Anticipated improvement route</b>
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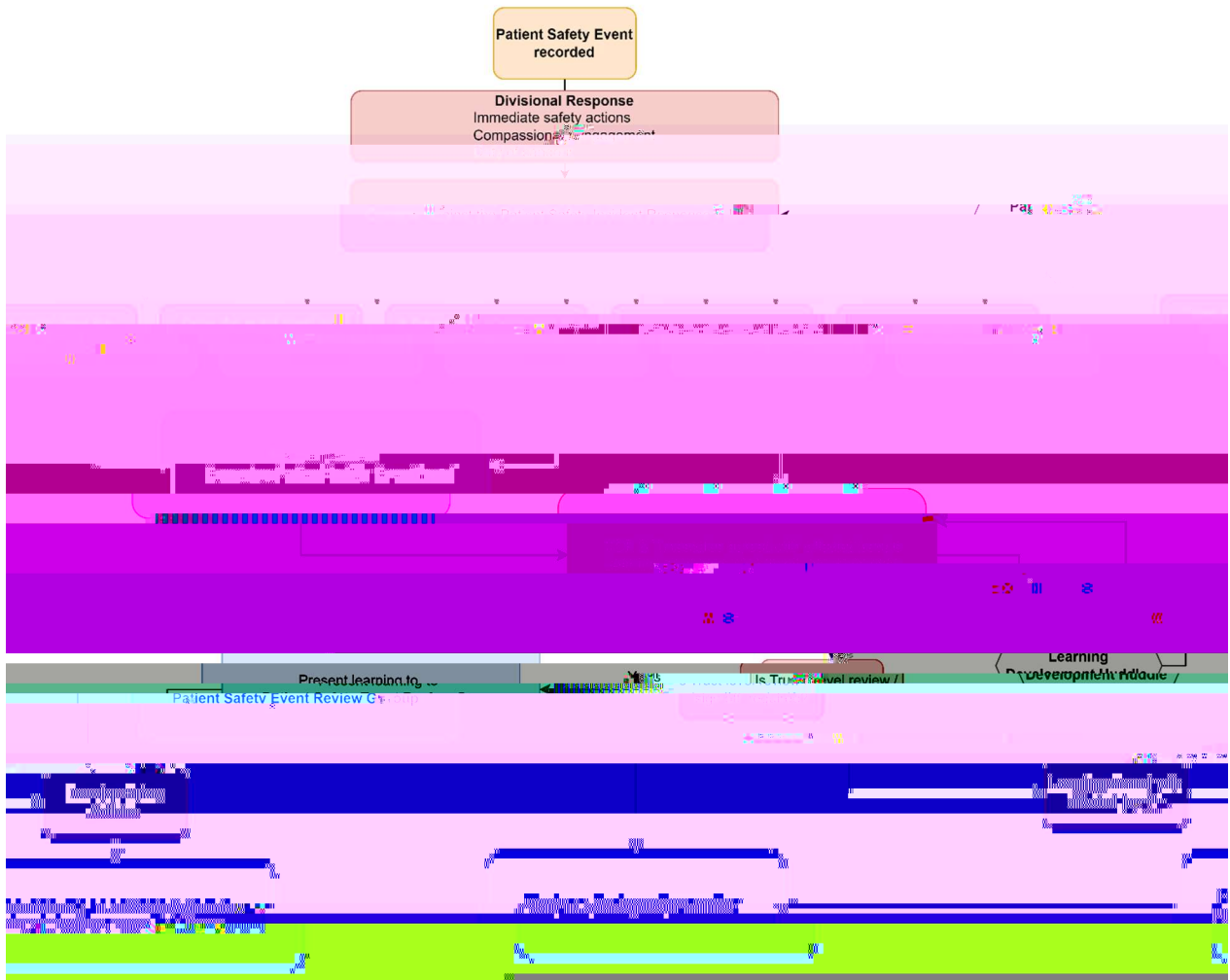
**Falls resulting in moderate**

<b>Patient safety incident type or issue</b>	<b>Planned response</b>	
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<b>Patient safety incident type or issue</b>	<b>Planned response</b>	
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# Appendix One: Patient safety incident response decision making tree











**11. Chest or neck entrapment in bed rails**

**12. Transfusion or transplantation of ABO incompatible blood components or organs**

**13. Misplaced naso- or oro-gastric tubes**