We are all responsible…and together we are creating a safer healthcare system

**THE SAFETY PAUSE: INFORMATION SHEET**

*Helping teams provide safe quality care*

<table>
<thead>
<tr>
<th>Why</th>
<th>Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Team lead and available multidisciplinary team members.</td>
</tr>
<tr>
<td>When</td>
<td>Any time (aim for a maximum of five minutes).</td>
</tr>
<tr>
<td>How</td>
<td>Focus on things everyone needs to know to maintain safety. Based on one question 'what patient safety issues do we need to be aware of today' - resulting in immediate actions. The four P’s below provide examples to prompt the discussion (any prolonged discussion on specific issues can be deferred until after the safety pause).</td>
</tr>
</tbody>
</table>

**Examples**

- **Patients**: are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients?
- **Professionals**: are there agency, locum or new staff who may not be familiar with environment/procedures?
- **Processes**: do we have: new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections?
- **Patterns**: are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

**Heads-up for today**

- Challenges e.g. illness related leave, staffing levels, skill mix, demand surges.
- Meetings/training sessions staff need to attend e.g. mandatory training.
- New initiatives/information e.g. new protocols; feedback from external groups.
- Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/patient status at a glance (PSAG) board/other communication system etc.

**Patient Feedback**

- Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today?

**Follow-ups**

Issues raised previously (confirm included on existing risk register if appropriate), solutions introduced or being developed. For those involved in the ‘productive ward’ initiative this is an opportunity to review the ‘safety cross’ data and any improvements.

**Team morale**

Recent achievements, compliments from patients and what works well.

---

**Acknowledgements:**

The HSE Clinical Governance Development initiative wishes to thank the National Emergency Medicine Programme for assisting in the development of this information sheet. It has been adapted with permission from Clinical Microsystems “The Place Where Patients, Families and Clinical Teams Meet Assessing, Diagnosing and Treating Your Emergency Department” ©2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden and the IHI Safety Briefing tool Copyright © 2004 Institute for Healthcare Improvement.

An initiative of the Quality and Patient Safety Directorate, May 2013

For further information see [www.hse.ie/go/clinicalgovernance](http://www.hse.ie/go/clinicalgovernance)