The primary objective of incident management is to learn from the incident in order to reduce the risk of recurrence and make care safer for future patients. The goals of incident review are to determine: what happened; how and why it happened; what can be done to reduce the risk of recurrence and make care safer; and, what was learned. This process can be broken down into 6 key steps as set out below:

**Close the Loop**
Share what was learned (internally and externally)

**Avoiding Incidents**
What type of incidents can or have occurred in your service?
Have you systems in place to minimise risk of occurrence?

**Follow Through**
Implement recommended actions. Monitor and assess effectiveness of actions

**Immediate Response**
Care for and support patient/family/staff
Report the incident
Secure items
Begin disclosure process
Reduce risk of imminent recurrence

**Six Steps to Effectively Manage an Incident**

**Review Process**
Understand what happened
Determine how and why it happened.
Develop an action plan to prevent recurrence.

**Prepare for Review**
Preliminary review
Is there need for a more in-depth analysis?
If yes, consult your risk advisor.

While there will be some variation in how different services manage patient safety incidents, the basic steps will be consistent. There is interconnectivity and interdependence between the identified activities and some may take place simultaneously.
Avoiding Incidents
- What types of incident have occurred in the past?
- What incidents have occurred in other services similar to yours?
- Do we consider information about incidents as part of our team meetings?
- Have we a quality improvement plan for commonly occurring incidents?

Immediate response
A patient safety incident can be a very traumatic experience for both the patient and the staff. Generally, the first action, after recognizing that an incident has occurred, is to care for and support the patient and the family, as well as ensuring the safety of other patients who may be at risk. Attending to the safety and well-being of the staff involved and others is also a necessity. The next activity generally includes reporting the incident so that further steps can be taken to manage the incident. Reporting is also the trigger for a chain of internal notifications that will depend on the nature and severity of the incident. Often practical support is needed and contacts should be provided to the patient/family to facilitate good communication. Disclosure, expressions of compassion and offering an apology are important elements of communication helping both patients/families and staff in healing and in restoring trusting relationships. Local actions to reduce the risk of imminent recurrence may need to be taken immediately; additional actions typically follow after a more thorough analysis has been undertaken. Patients and families should be informed of immediate actions.

Prepare for the Review
In order to determine appropriate follow-up to an incident, including the need for analysis, an initial investigation or fact-finding is needed. Once the initial investigation phase has been completed, a determination of next steps follows. In some cases, it will be clear that further system-based analysis is needed, while in less complex incidents any improvement actions required may be easily determined. Local quality or risk staff should be consulted in relation to those incidents that may require system-based analysis.

Review Process
In conducting the review of an incident the basic principles and steps in the analysis process are the same however, the level of detail and the scope of the review required will depend on the impact and nature of the incident. The first priority is to gather information relevant to the incident. This stage of the process is intended to answer the “What happened?” question and will begin to elucidate how the incident occurred. The review process then moves to analysing ‘why it happened’ and looks to identify the key contributory factors which assist in the development of actions required to prevent recurrence, ‘how to prevent it occurring again’.

Follow through
The implementation of recommended actions is an important step in the incident management process. The purpose of implementing system changes is to make the system safer. However, some recommended actions – even well intentioned and well thought changes – may not have the desired effect in practice. Thus the effectiveness of the implemented recommended actions must be monitored to determine if the changes helped make the system safer, had no or limited impact on the safety of the system, or in the worst-case scenario, the changes actually made the system less safe.

Close the Loop
Sharing the learning both within the service (with patients/families, those involved in the incident, the multidisciplinary team and others as needed) and outside the service is key to preventing additional harm and making care safer. Without learning and sharing, the service is still vulnerable as the same or similar incidents could happen again and no other external systems or services have the benefit of the learning.
"The key to looking after persons affected when things go wrong is maintaining trust through good communication."

Maintaining Trust

The establishment of trust begins at the first contact with the service user and continues throughout their care. Trust greatly enhances the ability of all involved to manage the consequences of an incident. The consequences of an incident are two-fold, firstly the primary harm caused by the incident e.g. an injury followed by any secondary harm caused to the service user by things such as poor communication, a lack of empathy or a failure to supply the necessary supports (physical and psychosocial).

The Relationship between Honesty and Litigation

Some health and social care professionals may fear that complete honesty after an incident will increase the chances of litigation or complaint. Evidence, however, demonstrates that adequate, timely and factual disclosure to the service user can make all the difference in relation to them coming to terms with the consequences of an incident. The desire for information and frustration through not receiving it, are commonly cited as reasons for litigation.

So what do Service Users want?

1. To know that all the required actions have been taken to address any harm that might have occurred to them.
2. To have the incident acknowledged to them.
3. To know and understand what has happened to them.
4. To be offered a sincere apology/expression of regret.
5. To have their questions answered honestly and factually.
6. To have their story heard and staff to listen and understand things from their perspective.
7. To be involved in decisions about their care and be aware of the options available to them.
8. To be provided with factual information which they can understand in relation to:
   • the event
   • actions taken by the organisation following the event
   • actions planned to try to prevent a recurrence of the event
   • reviews which are happening in relation to the event and the outcome of same
   • steps taken in relation to any recommendations made by the review team
   • what supports are available to them, if required, and how to access these support services.
8. To have ongoing communication with the healthcare team.
9. To be provided with an agreed plan and reassurance in relation to their ongoing care and follow up.
Initial Disclosure Discussion

- Acknowledge (with empathy) what has happened
- Apologise/express regret
- Provide factual explanation
- Provide reassurance regarding ongoing care plan
- Address any queries
- Offer practical and emotional support
- Agree next steps

Documentation

- Maintain and provide written records of all discussions
- Record salient points of open disclosure meeting in healthcare record

Supporting Service Users - Overview

<table>
<thead>
<tr>
<th>Incident detection or recognition</th>
<th>Preliminary team discussion</th>
<th>Initial Disclosure discussion</th>
<th>Follow – up discussions</th>
<th>Process completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detection and notification through appropriate systems</td>
<td>Detection and notification through appropriate systems</td>
<td>Verbal and written apology</td>
<td>Provide update on known facts at regular intervals</td>
<td>Discuss findings of review and analysis</td>
</tr>
<tr>
<td>Establish timeline</td>
<td>Initial assessment</td>
<td>Provide known facts to date</td>
<td>Respond to queries</td>
<td>Inform on continuity of care</td>
</tr>
<tr>
<td>Choose who will lead communication</td>
<td></td>
<td>Offer practical and emotional support</td>
<td>Identify next steps for keeping informed</td>
<td>Share summary with relevant people</td>
</tr>
<tr>
<td>Prompt and appropriate clinical care to prevent further harm</td>
<td></td>
<td></td>
<td></td>
<td>Monitor action plan</td>
</tr>
</tbody>
</table>

Documentation

- Provide written records of all discussions
- Record review and analysis relating to incident

Adapted from Being open process National Patient Safety Agency (UK)

Acknowledgement: Angela Tysall, Lead for Open Disclosure, Quality Improvement Division, Donegal PCCC HQ and Ann Duffy, Clinical Indemnity Scheme. Updated 2015.
The Open Disclosure Pathway Algorithm

(Adopted from the Australian Open Disclosure Standard, 2008, p.4)

ADVERSE EVENT OCCURS

Severe? Moderate? Mild?
Minimise risk of further harm. Provide appropriate clinical care. Document clinical facts in service user’s healthcare record.

CLINICAL INCIDENT MANAGEMENT AND REPORTING PROCESS
Statutory reporting requirements

INFORM SERVICE USER/SUPPORT PERSON OF ADVERSE EVENT
Service users should be informed of the occurrence of an adverse event that has resulted in, or is expected to result, in harm to the service user. This includes all sentinel events. Consider if there is a reason to defer disclosure at this time/can disclosure cause additional harm?

INITIATE OPEN DISCLOSURE PROCESS
Initial disclosure to the service user should occur as soon as possible (within 24 hours of the incident if practicable).
First, identify key contact person to aid continuity between hospital and service user/support person. Then identify who will attend and who will lead the Open Disclosure discussion and plan how the meeting will be conducted. Refer to Open Disclosure Team Example for role descriptions.

NOTIFY THE SERVICE USER
Inform service user of the facts of the clinical incident. Avoid speculation.

APOLOGY
An expression of regret or apology should not include any admission of fault until the facts are known.

SUPPORT
Agree plan for service user’s ongoing care, including identifying ongoing supports as required.

CNM/Consultant to alert Risk Management/Debriefing required for staff?

Identify under what process the incident will be investigated.

Refer to “before, during and after disclosure” checklist.

*Near Miss Event - Assessed on a case by case basis depending on the potential impact it could have had on the service user(s) if it had materialised and considering the potential risk of harm in the future. // *CNM - Clinical Nurse Manager

(Adopted from the Australian Open Disclosure Standard, 2008, p. 4)
Communicating with Service Users and their Families following Adverse Events in Healthcare

It is the policy of the HSE that incidents are identified, managed, disclosed and reported and that learning is derived from them. Research has demonstrated that if we ignore or avoid communicating with service users when things go wrong they are more likely to pursue other routes such as the complaints process or the legislative route to get answers to their questions. Open disclosure is a requirement of the National Standards for Safer Better Healthcare 2012.

What is Open Disclosure?

Open Disclosure is defined by the Australian Commission on Safety and Quality in Health Care as “an open, consistent approach to communicating with service users when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.”

What are the benefits of Open Disclosure?

<table>
<thead>
<tr>
<th>Benefits for Service Users</th>
<th>Benefits for Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourages a culture of honesty and openness.</td>
<td></td>
</tr>
<tr>
<td>Helps to foster an environment where staff are more willing to learn from adverse outcomes.</td>
<td></td>
</tr>
<tr>
<td>Enhances the professional relationship between health and social care services management staff and clinicians.</td>
<td></td>
</tr>
<tr>
<td>Enhances how professionals communicate with each other with regard to clinical outcomes.</td>
<td></td>
</tr>
<tr>
<td>Leads to better relations with service users and service user.</td>
<td></td>
</tr>
<tr>
<td>Leads to improved staff recovery and closure.</td>
<td></td>
</tr>
</tbody>
</table>

The 10 Principles which underpin the Open Disclosure Process:

Acknowledgement - to the service user that an adverse event has occurred.

Truthfulness, timeliness and clarity of information:- factual information provided to the service user which they can understand, ideally within 24-48 hours of the adverse event being known.

Apology/ expression of regret:- for the service user’s experience and their condition and for any errors/failures in care which have been established during the review/investigation process.

Recognising the expectations of service users: The service user may reasonably expect to be fully informed of the facts and consequences in relation to the adverse event and to be treated with empathy and respect.

Staff Support: - providing support to staff involved in the adverse event – the second victims of an adverse event.

Risk management and systems improvement: - to ensure that learning from adverse events occurs and that actions are taken to try to prevent a recurrence of the event.

Multidisciplinary responsibility: - open disclosure involves multidisciplinary accountability and response.

Clinical governance: - the open disclosure process is one of the key elements of the HSE clinical governance system.

Confidentiality: ensuring that all health and social care policies and procedures in relation to privacy and confidentiality for service users and staff are consulted with and adhered to.

Continuity of care: Steps need to be taken to reassure the service user in relation to the management of their immediate care needs and to also reassure them that their care will not be compromised going forward.

Acknowledgments: Angela Tysall, National Lead for Open Disclosure, National Advocacy Unit, Quality & Patient Safety Directorate and Ann Duffy, Clinical Indemnity Scheme.
Health and social care colleagues are often impacted by clinical errors as ‘second victims’, and experience many of the same emotions and/or feelings that the ‘first victims’—the service user and family members experience.

**Signs and symptoms**

Initially, a health and social care worker can be severely affected by the adverse event itself and also by the reactions of the service user and/or family. This effect can be especially severe if the relationship between the healthcare worker and service user is a close or long-term relationship. Subsequently, a healthcare worker can either be helped by an empathetic approach from a line manager and colleagues or harmed further by unsympathetic comments.

Symptoms can be similar to those in acute post-traumatic stress disorder, including initial numbness, confusion, anxiety, grief followed by depression, withdrawal or agitation, and re-experiencing of the event. Other associated symptoms related to medical errors include shame, guilt, anger and self-doubt. Lack of concentration and poor memory are also common, and the affected person may be significantly impaired in performing their usual roles. These symptoms may last days to weeks or indeed in a small number of cases may last much longer.

**Supporting Staff**

Interactions with other health and social care colleagues can be critical to the coping process, and without them a health and social care professional may feel isolated. After involvement in an adverse event, health and social care professionals need both professional reaffirmation and personal reassurance. This is often best provided by peers, or by a mentor or supervisor.

Line managers can help by providing empathy and emotional support especially during the review of the incident. Remind all staff that the purpose of the review is to establish how and why the event occurred, to identify any changes that may be required so as to learn from the incident and minimize the risk of it recurring. Line managers may also be able to help meet the informational needs of the “second victim” who is struggling to understand what happened. A proportion of “second victims” can benefit from greater support from being referred to an occupational health clinician although many staff may find this more helpful at a later stage.

Three key actions for line managers in supporting staff

1. **Ask** ‘How are you doing?’
2. **Acknowledge** that this must be really difficult for them. Share a patient safety incident that happened to you. This will reduce their sense of isolation.
3. **Re-assure** them that they are still a good, competent and valued health and social care professional and that the emphasis on reviewing the incident is to establish how and why the incident occurred. This will then inform learning and facilitate measures being taken to try to reduce the risk of other service users/staff members experiencing a similar event.
Checklist for Managers’ Responsibilities

Adverse Event
with potential to be traumatic or stressful for staff

* Remember that staff respond differently to adverse events and may have different individual needs in terms of the amount and type of support required.

Immediate Support

☐ Aim to create an empathetic and supportive environment
☐ Consider whether staff require any immediate treatment or intervention via the Employee Assistance Programme, Occupational Health or the Emergency Department
☐ Consider provision of practical help, e.g. transport home
☐ Provide staff with information about what to expect following an adverse event
☐ Consider the needs of staff who are not directly involved in the event but may be affected by it.

Supporting Staff in Returning to Normal Operations

☐ Discuss the option of returning to duty with the staff involved
☐ Consider whether an employee may need a period of time away from the particular work area
☐ Instruct staff returning to duty in relation to the priority tasks to be achieved. If the incident has taken some time it is unrealistic to expect employees to try to catch up on hours of work.
☐ Provide informal peer support to staff via colleagues/line managers
☐ Consider the need for formal support in the form of psychological debriefing

Ongoing Support

☐ Consider nominating a senior member of staff as the staff support coordinator if a number of staff are affected and the support issues are particularly sensitive or complex and likely to be ongoing.
☐ Offer support to staff during the incident review and during lengthy or delayed processes, e.g. an inquest, court case, or independent inquiry.
☐ Refer employees who have been absent from work to the Employee Assistance Programme or Occupational Health to ensure a safe and supported return to duty

Adapted from:


Acknowledgement: Angela Tysall, Lead for Open Disclosure, Quality Improvement Division, Donegal PCCC HQ and Ann Duffy, Clinical Indemnity Scheme. Updated 2015.
The “ASSIST ME” model of staff support

The importance of support for staff from line managers, colleagues and peers in the aftermath of an adverse event should not be underestimated. Being available for staff and knowing his/her story surrounding the event is crucial. Staff require a safe and confidential space in which to discuss the event and can find this therapeutic.

The “ASSIST ME” model of staff support has been developed to assist managers and staff during this process. This has been adapted by the HSE from the Medical Protection Society's A.S.S.I.S.T model of communicating with service users following adverse events in healthcare.

A  **Acknowledgement** with empathy the event and the impact on the member of staff

Assess the impact of the event on the member of staff and on their ability to continue normal duties

Examples: “I came to see you as soon as I heard what happened. This must be very difficult for you”, “How are you doing? How are you coping? How are you feeling?”

S  **Sorry** - express regret for their experience

Examples: “I am so sorry that this has happened”, “Sometimes despite our best efforts things can go wrong/ errors can occur”

S  **Story** - allow time and space for them to recount what happened using active listening skills.

Share personal experience

Examples: “Can I tell you about an experience of my own, how I felt and what I found helped me at that time?”, “You may find helpful to talk about what happened. Would you like to talk about your experience/what has happened?”

I  **Inquire** - encourage questions

**Information** - provide answers/information

Examples: “Do you have any questions?, Is there anything I can help you with at this time?, Would it help if I told you what happens next and what can you expect in relation to the processes involved in the management of this event?”

S  **Supports and Solutions**

Examples: Provide information on the supports available.
(a) Formal emotional support:
- Provide information on debriefing and the benefits of the same
- Organise, with the consent of the staff member, one to one or team debriefing within 24-48 hours of the event occurring.
- Provide information on the other supports available via the Occupational Health Department/Employee Assistance Programme/Mental Health Services/Psychology Services: i.e. counselling, crisis intervention.
- Assess any immediate needs, discuss with the member of staff and arrange, with their knowledge and consent, a referral to the relevant support services, as required.
- Provide the name and contact details for their designated staff support person and arrange contact.
- Provide staff support information leaflets/brochures.

(b) Informal emotional support:  "My door is open for you at all times. I will be checking in with you regularly to see how you are doing. In the meantime if you do wish to talk about this or discuss anything with me please come and see me or give me a call at any time. Can I arrange for someone to collect you from work?".

(c) Practical Support:
- Provide an opportunity for the member of staff to take time out from their clinical duties, if required. Staff should be involved in and have input to any decision made regarding the same. Many staff find it more helpful to remain at work. Allocation to different duties may benefit initially if it is practical to do so.
- Provide practical support and information in relation to the review/investigation process and how the staff member might assist/contribute to this process. e.g. encourage the member of staff to write up their recollection of the event as soon as possible for their own record. Ensure that they are kept updated and involved in the review/open disclosure process.
- Provide information and support in relation to communicating with the service user following the event/preparing for open disclosure discussions.
- Ensure that they are encouraged to provide their insight into the prevention of a recurrence of the event.
- Establish the learning from the event, at individual and organisational level and support going forward.

Travel - providing continued support and reassurance going forward and throughout the investigation/review process and open disclosure process.

Examples: “I am here to support you going forward", “I will be with you every step of the way and I will assist you In any way I can”

Maintain contact
Monitor progress
Moving forward

Examples: Ensure that there is continued contact with the staff member to prevent feelings of isolation. Continually monitor and assess the staff members response to the event and their response to any interventions. Provide guidance and support on their return to normal duties.

End - reaching a stage of closure from the event
Evaluate

Examples: Establish when the staff member has reached a stage of closure from the event as it is important at this stage not to keep re-opening the event with them. Leave your door open to them if they should require any further assistance going forward. Review the support provided with the staff member involved. Consider feedback and establish any learning which may benefit other staff.

Based on the HSE and SCA Open Disclosure: Supporting Staff following an Adverse Event: The "ASSIST ME" Model, October 2013
1. Key Message
Achieving safe quality care requires the vigilance and cooperation of the whole workforce including patients and members of the public. Improving quality and protecting people from harm is all our responsibility – clinical governance delivers the leadership and accountability systems to achieve this.

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

2. What are the Quality and Safety Principles?
Principles can be used to guide; conduct action or decisions.

The principles are:
- Patient first
- Safety
- Personal responsibility
- Defined authority
- Clear accountability
- Leadership
- Multi-disciplinary working
- Supporting performance
- Open culture
- Continuous quality improvement

3. How to use the Quality and Safety Principles
Each decision you make can be tested against the quality and safety principles.

For example, if you:
- Are proposing a change in practice (e.g. change in documentation) or
- Need to make a decision about the best approach to care for a particular patient (e.g. what wound dressing to use).

You can use the quality and safety principles to help you make a good decision. The questions you might ask are:

- Am I putting the patient first?
- Is this approach safe – have I identified the evidence to support the decision, the potential risks and controls to minimise the risks?
- Am I taking personal responsibility for this decision – is the patient clear about their responsibilities?
- Do I have authority to make this decision?
- Am I clear about my accountability arising from this decision?
- Am I taking a leadership approach in making this decision?
- Am I collaborating with all relevant members of the team (gaining multidisciplinary input)?
- Will this decision support performance improvement – how will we measure this?
- Will I be open and discuss/disclose/report the outcome of my decision?
- Am I committed to learning from the outcome of my decision and continuously improving services?
## 4. Description of the Quality and Safety Principles

Each decision (at every level) can be tested against the quality and safety principles. A descriptor for each principle is set out below.

### Table 1: Quality and Safety Guiding Principles Descriptor

<table>
<thead>
<tr>
<th>Principle</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient First</td>
<td>Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.</td>
</tr>
<tr>
<td>Safety</td>
<td>Identification and control of risks to achieve effective efficient and positive outcomes for patients and staff.</td>
</tr>
<tr>
<td>Personal responsibility</td>
<td>Where individuals as members of healthcare teams, patients and members of the population take personal responsibility for their own and others health needs. Where each employee has a current job-description setting out the purpose, responsibilities, accountabilities and standards required in their role.</td>
</tr>
<tr>
<td>Defined authority</td>
<td>The scope given to staff at each level of the organisation to carry out their responsibilities. The individual’s authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.</td>
</tr>
<tr>
<td>Clear accountability</td>
<td>A system whereby individuals, functions or committees agree accountability to a single individual.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.</td>
</tr>
<tr>
<td>Multi-disciplinary working</td>
<td>Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Inter-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.</td>
</tr>
<tr>
<td>Supporting performance</td>
<td>Managing performance in a supportive way, in a continuous process, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients experience being central in performance measurement (as set out in the National Charter, 2010).</td>
</tr>
<tr>
<td>Open culture</td>
<td>A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research and improvement, and appropriate action taken where there have been failings in the delivery of care.</td>
</tr>
<tr>
<td>Continuous quality improvement</td>
<td>A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.</td>
</tr>
</tbody>
</table>

Acknowledgement: HSE Quality and Patient Safety Directorate, this document was developed during the clinical governance development initiative, in November 2012, further information can be located at [www.hse.ie/igo/clinicalgovernance](http://www.hse.ie/igo/clinicalgovernance)
This guide is for use by the team at any time and as required. This safety pause aims to enhance communication, prioritise patient safety and experience and embed quality improvement in daily practice. The safety pause assists teams in applying elements of the National Standards for Safer Better Healthcare (2012) and the Quality Framework for Mental Health Services in Ireland (2007) and can be used in any ward, department, clinic, unit or service. For example prior to medical rounds, at the start of an outpatient clinic, at a community or primary care clinic, or team meeting. Some teams may also decide to use this at the beginning or end of patient hand over.

<table>
<thead>
<tr>
<th>Aim:</th>
<th>Enable the team to proactively anticipate any risks to the quality of patient care; prioritise and plan actions based on patient need and available resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducted by:</td>
<td>Team lead and available multidisciplinary team members (wider than nurse to nurse handover).</td>
</tr>
<tr>
<td>Anticipated duration:</td>
<td>Brief, aim for a maximum of 5 minutes.</td>
</tr>
<tr>
<td>Approach:</td>
<td>Non-judgmental, positive, team-building approach. Focused on things everyone needs to know to maintain safety. This brief discussion is based on one question ‘what patient safety issues do we need to be aware of today’ and gives rise to immediate actions. The four P’s below provide examples to prompt the discussion. Any detailed or prolonged discussions on specific issues should be deferred until after the safety pause.</td>
</tr>
</tbody>
</table>

### THE SAFETY PAUSE

**Safety awareness helps teams to be more proactive about the challenges faced in providing safe, high quality care for patients**

**QUESTION:**

**WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY?**

**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 trained to use?); 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 team e.g. notice board/communication book/other communication systems? Patient status at a glance (PSAG) board/communication book 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 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.

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Acknowledgements: The HSE Clinical Governance Development initiative wishes to thank the National Emergency Medicine Programme for assisting in the development of this template. 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 March 2013.

For further information see: www.hse.ie/go/clinicalgovernance
Quality and safety (clinical governance) prompts for discussion at team meetings
(Further information overleaf).

**Leadership, Governance and Management**

Q1. Who leads our team?
Q2. Who are the members of our team; do we all know each other and understand each others roles?
Q3. Are we clear about our team roles and responsibilities, who we report to, and our lines of communication?
Q4. What arrangements do we have in place, so that we know who is the named consultant /clinician/key worker responsible and accountable for each patients care at all times?
Q5. Are we meeting the code of conduct and expected behaviour of our organisation and professional bodies?

**Person-Centred Care:**
places patients at the centre of all that the service does

Q6. How do we identify and document patient needs and preferences?
Q7. Do we provide accessible, clear and relevant information to patients on their condition and the treatment options available to them?
Q8. How do we seek feedback (comments, compliments and complaints) from patients and members of the public?
Q9. How do we respond to feedback from patients? Do we ensure that the learning from feedback is shared with our team and is implemented?

**Safe Care:**
actively identifying, preventing or minimising risks of harm

Q10. Can any of us raise concerns about the quality and safety of the service? How?
Q11. Have we identified potential risks associated with the care we provide?
Q12. Have we effective safety measures in place to address each risk identified?
Q13. Do we identify, openly disclose, manage, investigate and escalate incidents adverse events and near misses?
Q14. How do we receive and discuss reports on the number and type of incidents?
Q15. Do we learn from incidents and implement quality improvements?
Q16. What are the priorities for our team in protecting patients and improving quality?

**Effective Care:**
consistently delivering the best achievable outcomes for patients

Q17. Have we identified the legislation, standards, guidelines and policies that guide our practice? Do we have easy access to them?
Q18. Are we compliant with the relevant standards, guidelines and policies? - How do we know?
Q19. How do we document care and communicate (including handovers) with patients, members of the team and other teams/services involved in each patients care?
Q20. Are we clear about the criteria and arrangements for escalating the care of deteriorating patients?
Q21. How do we agree and maintain the competencies required to deliver safe and effective care?
Q22. How do we measure patient and service outcomes?
Q23. Are we using resources effectively?

**Better Health and Wellbeing:**
promoting and protecting the health and well being of patients and staff

Q24. How do we support patients in improving their own health and wellbeing?
Q25. Do we have ways of dealing with and resolving issues that arise in our team?
Q26. How do we focus on the health and well being of individual team members and the team?
Q27. Do we know where to access support for staff?

For further information on clinical governance development see [www.hse.ie/go/clinicalgovernance](http://www.hse.ie/go/clinicalgovernance)
Quality and safety prompts for multidisciplinary teams

1. Introduction
The prompts guide local team discussions on quality and safety. Achieving safe quality care requires the vigilance and cooperation of the whole workforce including patients and members of the public. Improving quality and protecting people from harm is all our responsibility – clinical governance delivers the leadership and accountability systems to achieve this.

Clinical governance is the system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For health care staff this means: specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do.

2. Quality and Safety: National Standards for Safer Better Healthcare
The National Standards provide direction and guidance for improving the quality, safety and reliability of health care. These quality and safety prompts are grouped under leadership and governance and the following quality dimensions of the National Standards: i) person centred care; ii) effective care; iii) safe care; and iv) better health and wellbeing. The prompts will support multidisciplinary teams to understand and apply elements of the National Standards within their service area. For mental health services please also refer to the Quality Framework for Mental Health Services in Ireland which is available at www.mhcirl.ie.

3. Quality and Safety: the multidisciplinary team’s role
The focus is on creating the environment and culture where excellence is embraced and can flourish with strong multidisciplinary team collaboration. The objective is that all clinical and social care is aligned within a clinical governance system.

4. How to use the quality and safety prompts?
The sequence illustrated below provides a guide on how to use the prompts - which can be addressed in steps. The prompts can be used as a guide for action on quality and safety using the plan, do, study, act (PDSA) cycle. Your decision can also be guided by the clinical governance development principles (set out on the next page) and the Quality and Patient Safety Clinical Governance Information Leaflet available at www.hse.ie/go/clinicalgovernance