PATIENT SAFETY TOOL BOX TALKS©

LEADERSHIP, GOVERNANCE & MANAGEMENT

MANAGING INCIDENTS

THE SAFETY PAUSE

v1.2

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.

Aim:	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.
Conducted by	Team lead and available multidisciplinary team members (wider than nurse to nurse handover).
Anticipated duration	Brief, aim for a maximum of 5 minutes.
Approach	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.

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.

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.

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