Quality & Safety

A column by Maureen Flynn

THE SAFETY PAUSE

IN THIS month's column, we focus on the 'The Safety Pause: Information Sheet', which was launched by the Minister of Health, James Reilly, in May at the third National Patient Safety Conference in the Croke Park Conference Centre, Dublin.

The Safety Pause supports healthcare teams in increasing awareness and focusing on patient safety while providing quality safe care. It may also be referred to as the 'safety briefing' or 'safety-huddle'.

The information sheet explains why healthcare teams might consider undertaking a 'safety pause' and how they would go about this.

The key question to be answered as part of a safety pause is: what patient safety issues do we need to be aware of today?

The aim of the practise is to have as many members of the multidisciplinary team as possible participating. The power of conversation supported by a safety pause prompts the identification of potential safety issues. The underlying ethos of the pause is one of mindfulness, being aware of the environment, patients' needs, and potential safety issues.

The pause allows actions to be agreed on immediately addressing any identified patient safety issues. It can be integrated into daily routines – for example, at the start of a clinic, home visit, or ward rounds – and allows information to be freely shared. This in turn supports the development of a culture of openness in the workplace.

Using the safety pause

Based on concepts in aviation and other industries, briefings make safety-consciousness part of the routine, 24 hours a day and seven days a week. It is based on a practical, why, who, when and how approach.

There is no prescribed time for the safety pause, nor is there any specific training required.

In order to be effective, the pause must be brief and easy to operate so that all staff feel confident participating in the procedure. The pause can be undertaken at any time that suits the health team or service.

The four 'P's provide suggestions to prompt the safety pause discussion – any prolonged discussion on specific issues can be deferred until after the safety pause. These are:

Patients

Are there two patients with similar names; patients with challenging behaviours; wandering patients; fall risks; self-harm risks; or deteriorating patients?

Professionals

Are there agency, locum or new staff who may not be familiar with the environment or procedures?

Processes

Is there new equipment or new medicinal products? Are all staff familiar with these? Are there missing charts? Are isolation procedures required, or care bundles for the prevention and control of medical device-related infections needed?

Patterns

Are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

The discussion around the four 'P's incorporates recent patient feedback on their experience and provides a 'heads-up' for the day or night staff.

Over time, safety pauses can help health service providers create a culture of safety, reduce risks and errors, and improve quality of care. All staff, clinical and non-clinical, have ideas to share about patient safety.

The safety pause is improvement-focused and centres around solutions to patient safety problems. The approach is developmental and non-judgemental. Participants should be made feel comfortable in contributing information in the knowledge that the information shared is for learning and improvement purposes.

Opportunity to get involved

Now is the opportunity for you to be involved with the safety pause. You don't need any additional equipment or training to get started. At your next team, ward, unit or department meeting why don't you suggest introducing the pause in your area?

A copy of the document is published here on the page opposite and further copies can be accessed at: **www.hse.ie/go/clinicalgovernance**

We would be pleased to receive any feedback you may have on your experience of using the safety pause, and also any suggestions you may like to offer on how the information sheet might be improved. To submit feedback please email: maureena.flynn@hse.ie

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The INMO and the HSE are signatories to Patient Safety First - the initiative through which healthcare organisations declare their commitment to patient safety. Through participation in this initiative, those involved aspire to play their part in improving the safety and quality of healthcare services. This commitment is intended to create momentum for positive change towards increased patient safety. For further information see www.patientsafetyfirst.ie

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality and Patient Safety Directorate

About the HSE Quality and Safety Directorate: The Quality and Patient Safety (QPS) Directorate of the Health Service Executive (HSE) was established in January 2011, on the appointment of the National Director, Dr Philip Crowley. The role of the QPS Directorate is to provide leadership and be a driving force by supporting the statutory and voluntary services of the HSE in providing high quality and safe services to patients their families and members of the public.

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