

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

Why	Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.
Who	Team lead and available multidisciplinary team members.
When	Any time (aim for a maximum of five minutes).
How	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).



THE SAFETY PAUSE	QUESTION: WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY?	Examples <ul style="list-style-type: none"> ■ 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 <ul style="list-style-type: none"> ■ 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 <ul style="list-style-type: none"> ■ 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.

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