'Safety Pause In Action'
A Quality Initiative

Gillian Mullervy (CNM 1)
Mary Traynor (CNM 2)

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Introduction

- The background to the Safety Pause
- Steps taken to Introduce it.
- Why and when it is used.
- Audit and Evaluation Results
- Staff Evaluation
- Conclusion
Background

The Health Services Executive launched the ‘Safety Pause‘ in May 2013.

The aim of the Safety Pause is to help the healthcare provider become mindful of potential safety issues, with a view to reducing risk and improving quality of care.

Featured in an article in the INMO magazine (Maureen Flynn). (October 2013)
What is the Safety Pause?

- The Safety Pause is a Quality Initiative which puts structure around a potential or actual patient safety risk.
- This is done using the 4 P’s
  1. Patients
  2. Professionals
  3. Processes
  4. Patterns
Changing Practice

- Risk was always discussed at handover but in an ad-hoc way and it was not always acted on immediately.

- The ‘Safety Pause’ gives structure.

- All staff use the same format when discussing potential risk.
The First Step!

- A lead nurse was identified to support the introduction of the ‘Safety Pause’ on the ward.
- Information sessions were delivered to the staff to inform them of the process.
- Prompt Cards were developed and circulated.
<table>
<thead>
<tr>
<th><strong>4 P’s Prompt Cards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety Pause</strong></td>
</tr>
<tr>
<td><strong>Patient</strong></td>
</tr>
<tr>
<td>Increased acuity /Similar names</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
</tr>
<tr>
<td>New junior staff/relief</td>
</tr>
<tr>
<td><strong>Processes</strong></td>
</tr>
<tr>
<td>New equipment /charts /isolation</td>
</tr>
<tr>
<td><strong>Patterns</strong></td>
</tr>
<tr>
<td>Near misses /incidents</td>
</tr>
</tbody>
</table>
# Why use the ‘Safety Pause’

<table>
<thead>
<tr>
<th><strong>Why</strong></th>
<th>Helps provide safe, high quality care for patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who</strong></td>
<td>Multi-disciplinary team</td>
</tr>
<tr>
<td><strong>When</strong></td>
<td>Any time (not more than 5 minutes)</td>
</tr>
<tr>
<td><strong>How</strong></td>
<td>Based on one question. <strong>What patient safety issue’s do we need to be aware of today?</strong>—Resulting in immediate actions.</td>
</tr>
</tbody>
</table>
When is it Done?

Following change of shift handover.

Any time circumstances change
Our Lady's Ward
Crumlin Children’s Hospital
How is it Done?

- We use the prompt cards to guide us on the 4 P’s.

- We then start with the question, “What Safety Issues do we need to be aware of today”??
Patients

- Are there any patients on the ward with the same or similar names?
- Are there unfamiliar sounding names/maybe incorrectly spelt?
- Are there any patients on the ward with challenging behaviours/at risk of falls/self harm risk?
- Have you any deteriorating patients/is the acuity high?
Professionals

- Do you have any concerns regarding staffing levels/skill mix?
- Are there any new staff/students on the ward who are unfamiliar with the environment?
- Do you have sufficient staff cover at break times/demand surges/staff meetings?
- Are there new protocols to be made aware of?
Processes

- Are staff familiar with the equipment on the ward?
- Is training required?
- Are there new or unfamiliar drugs?
- Are there any missing charts?
- Are there infection control risks?
- Is isolation required?
Patterns

- Are there any recent safety issues/trends.
- Have there been any recent near misses??
Follow ups and Team Morale

- Staff are made aware of solutions to recent issues.
- Recent achievements, compliments from patients/parents are relayed and what works well.
Audit and Evaluation

- Recurring issues were identified under the 4 P’s and immediate corrective action was taken.
- This immediate response was identified by all staff as a strength of the safety pause.
- Identified the 5th P
# Prompt Card

## The 5 P's

<table>
<thead>
<tr>
<th>Patients</th>
<th>Ill patient, similar names.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>New junior staff</td>
</tr>
<tr>
<td>Processes</td>
<td>New equipment; charts; isolation</td>
</tr>
<tr>
<td>Patterns</td>
<td>Near misses; incidents</td>
</tr>
<tr>
<td>Pressure Areas</td>
<td></td>
</tr>
<tr>
<td>Patients at risk</td>
<td></td>
</tr>
</tbody>
</table>
Findings

1. Patients

- **Patient identification**
  - Incorrect patient details / Patients with same or similar sounding names nursed in rooms beside each other.

- **Accommodation:**
  - Children nursed in an inappropriate room and location on the ward, EG: unstable patient, child at risk of harm, inadequate space for wheelchair user.
Findings
2. Professionals

New staff /students:

Issues with skill mix (Difficulty balancing staffing resources with patient activity)
Staff unfamiliar with the ward equipment.

Absenteism:

Relief staff unfamiliar with the ward, equipment and complex surgical patient
Findings
3. Processes

**Healthcare Record.**
Missing charts/ incorrect or missing details.

**Consent.**
Absent /incorrect/ not signed by legal guardian.

**Isolation.**
Use of incorrect PPE/ Appropriate use of isolation.

**Medication**
Unfamiliar or similar sounding medication.
Findings:
4. Patterns

Greater awareness among staff of risk and increased action by staff to resolve a potential risk issue.
Findings; Increase in Reporting & Decrease in incidents
Staff Evaluation

It helps me be aware of my scope of practice as a student

“......more confident that the ward and patients are managed safely”
Staff Evaluation

“....I found it really easy to use and it has increased my awareness of patient safety and risk management”

“....I really found it helpful when the safety pause identified the patients requiring isolation and the correct PPE to use. “
Conclusion

- The Safety Pause is a formalised approach to identifying patient safety issues.

- It has improved patient outcomes and contributed to safer quality care.

- Since its introduction on our ward, patient safety is now at the forefront of communication on our unit.
Conclusion

- The Safety Pause has now been introduced to a further 5 areas in the hospital with plans to roll it out to all wards.
• Questions
References

- Further information can be obtained at www.hse.ie/go/clinicalgoverance.