Situation Awareness for Everyone (S.A.F.E) toolkit- introduction

Clinical Standards and Quality Improvement team
How can we reduce preventable deaths and error in children’s hospitals? We worked with 50 sites over four years on the S.A.F.E. programme to develop and trial quality improvement techniques. This toolkit supports child health professionals to use these principles at their sites. It can help improve communication and build a safety-based culture. And, it can deliver better outcomes for children and young people.

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About S.A.F.E

It is estimated that 2,000 preventable deaths occur each year in the UK compared to the best performing countries in Western Europe. If hospital staff have access to the correct tools and techniques, the lives of children who unnecessarily deteriorate could be saved.

S.A.F.E stands for Situation Awareness For Everyone. Situation awareness takes the perspective of everyone involved in a child’s healthcare at hospital - doctors, nurses, porters, families and children themselves - so that the clinical team can take the best decisions.

By using S.A.F.E principles, we anticipate that paediatric units can:

- reduce avoidable error and harm to acutely sick children
- improve communication between all healthcare professionals involved in a child’s care - as well as families - to ensure treatment is consistent and of the same high standard regardless of postcode or class
• help close the disparity in health outcomes for children in UK vs other countries as well as between children’s care and adult care
• involve parents, children and young people to be better involved in their children’s or own care.

How to use this toolkit

Situation awareness requires a shared understanding of what is happening. This needs non-hierarchical information and communication. There is no single intervention that can implement situation awareness in a single go. However, there are many different tools and techniques that together can deliver situation awareness in a paediatric or other healthcare setting.

This toolkit provides many, but not all, of the tools you might consider using. It's organised into four main themes, which reflect how S.A.F.E has been implemented elsewhere. You can identify which chapter you wish to start from, depending on the experience of your organisation.

1 - Translating quality improvement into action

Every setting is different, and so an understanding of quality improvement methodology is essential. This will allow you to take ideas, new or existing, and implement them in such a way that they can be modified until they work for you.

Go to module 1

2 - Theories of patient safety and application to the S.A.F.E programme

A key foundation for situation awareness is a safety-based culture, engaging all staff, as well as the patients and their families. This means breaking down hierarchies, a new mental model or way of thinking and accepting that everyone has a different view, all of which need to be considered.

Go to module 2

3 - The S.A.F.E programme: from reaction to anticipation

Knowing exactly what information is needed when talking about a patient means communication is much smoother and the right information is available for decision-making. This will allow the platform for everyone to have a chance to express their view. A factor in the rate of preventable deaths is the failure to recognise and respond to deterioration. Ensuring that we recognise deterioration means we can respond in a timely and effective way, while reviewing cases of unrecognised deterioration allow us to identify new ways to improve.

Go to module 3

4 - Team perspectives

A specific intervention that brings together the key elements of situation awareness, teams have used safety huddles to provide a mechanism for ensuring that all information about a
patient is shared effectively.

Go to module 4

**About the S.A.F.E programme**

Over four years, this programme brought together paediatric units from 50 hospitals across England into four collaborative learning groups. Each ran a local quality improvement (QI) project to improve outcomes for paediatric patients. The units shared their knowledge and experience with other partners; they demonstrated their successes and their failures. And, they co-designed this toolkit.

We will continue to update the toolkit as materials evolve further and new tools are shared from participating sites, with major updates communicated through our [RCPCHQI_IQ on Twitter](https://twitter.com/RCPCHQI_IQ).

The programme was funded by the Health Foundation, and supported by UCLPartners and WellChild.

The Anna Freud Centre quantitatively and qualitatively evaluated the impact of improved situation awareness, aiming to answer the question: "Under what circumstances, by what means and in what ways does increasing situation awareness lead to improved safety, experience and other elements of quality for children under inpatient care?"

**What next**

In 2017, the Health Foundation awarded RCPCH with a grant for a S.A.F.E dissemination and spread project, enabling regional delivery of the programme to new sites across England. We worked with 50 units from November 2014 to April 2018 to support them in developing and sustaining new interventions using the S.A.F.E methodology.

S.A.F.E is a key theme for Making it Safer Together (MiST). This is a national paediatric patient safety collaborative of hospitals that share a vision of achieving harm-free paediatric healthcare. If your site uses the toolkit, we encourage you to engage with MiST and share your experiences and improvements on introducing situation awareness.

**Using the toolkit? Let us know!**

The materials in this toolkit are free to use. We would like to track where and how the pack is being implemented. Do let us know by tweeting us at [RCPCHQI_IQ](https://twitter.com/RCPCHQI_IQ).