Safety Huddles
Illawarra Shoalhaven Falls Prevention Network Rural Forum
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Team Culture & Communication
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High reliability organisations

Five characteristics

1. **Preoccupation with potential failure**
   - Focus on errors/near misses for learning, finding and fixes problems

2. **Reluctance to simply operations**
   - Constant ‘why’, invite opinions others with diverse experience

3. **Sensitive to operations**
   - Expecting the unexpected, situational awareness, teams with power to ‘speak up’, listening to point-of-care staff

4. **Commitment to resilience**
   - Errors happen, identify and act quickly to minimise harm

5. **Deferece to expertise**
   - Point-of-care staff are the experts, empower them with decision making

FROM: Weike & Sutcliffe, ‘Managing the Unexpected’
Safety Huddles – What?

• A brief, focused, team check-in held at least at the start of each shift
• A tool to:
  • Plan for high acuity patients
  • Proactively address risk
  • Enhance teamwork and communication through a common understanding of focus on priorities
  • To improve overall safety
• By end the whole team is aware of the greatest risks facing them and the plans in place
Safety Huddles – Why?

• Workflow on any unit can go from ordered to chaotic
• Staff are often unaware when their co-workers are overwhelmed
• **Gaps in communication** are a leading source of process failure and inadvertent **patient harm**
• Safety Huddles heighten the awareness of staff and patient needs and allow the team to **plan for the unexpected**
• Helps to create a **culture of safety**
Why? – System factors


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Care planning
- Gaps or failures in collaborative planning;
- Involving multiple teams
- Inpt & community based teams
Safety Huddles- Why?

• Increase and maintain situational awareness (SA)
• SA
  • Know what’s going on around you
  • Having a notion of what’s important
  • Anticipation of possible future consequences of the current situation

Dr Mica Endsley (1995)
Safety Huddles – How?

• **Routine**
  • Consistent time
  • Start of shift
  • Include staff who know what’s going on in their specific areas - MDT

• **Short**
  • 5-10 minutes
  • Standing

• **Focused**
  • Simple 3 point agenda
Safety Huddles – How?

• Look Back
  • Significant safety issues from last 24 hours/last shift

• Look Ahead
  • Anticipated safety issues in next 24 hours/next shift
    • High risk meds, cognition

• Planning
  • Feedback on previous issues raised
  • Allocate accountability
  • Finish with a positive
Points to consider ...

• Patients
  • High risk meds
  • Behavioural/cognition concerns
  • Delirium

• Flow
• Equipment
• Environment
• Duress alarms

• There is no ‘perfect’ list of items
• Work with the team to set the indicators
• Start with a short, simple list
• Adjust the criteria with changes in staff and experience with the process

• PDSA ....
Arrive prepared

For example:

• High risk falls patients
  • What measures are in place?
  • When do falls normally occur in your unit?
• Look at trends
• Address these in your safety huddle
Test, test and test again ...

• You can and should change the way you run safety huddles
• They need to continue to fit your team and goals
• Don’t over complicate the process
# Common pitfalls

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<th>Agenda designed by one person</th>
<th>Team designs agenda</th>
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<td>Key people not included</td>
<td>Include all relevant staff</td>
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| One person speaks for the entire time | • Staff brief the group on current patient issues  
• Team leader facilitates and trouble shoots at the end |
| The topics aren’t meaningful or engaging for everyone | • High attendance because information is relevant and engages staff  
• Includes a good news story |
| They go over time and take too long | Don’t use as a staff education session or for long announcements |
| Not an instant success therefore not sustained | Start small, keep going, expect multiple PDSA cycles |
Post-Event Safety Huddles

• An MDT and patient review following an event, incident or near miss
• The event or incident was unplanned or unintended and could have or did result in harm
• To identify contributing factors
• Ensure risk mitigation strategies
• Often symptoms of a larger problem, we need to treat the cause and not the symptom
High performing teams

• Most frequent errors are human:
  • Inadvertent action – slip, lapse, mistake

• Increase reliability of processes with standardisation, structure and daily focus
  • Daily behaviours and communication methods
  • Clarity of roles and responsibilities
  • Shift Safety Huddles
  • ISBAR
  • Time-out
  • Teach-back
Team Safety Fundamentals

- Safety Huddles
- Leadership WalkArounds
- Quality Learning Boards
- Journey Boards
- Intentional Rounding
- Escalating critical information
- Multi-professional rounds at the bedside
Finally

• Huddles are one of the most simple, powerful and effective tools we can use to promote teamwork and patient safety

• 3 key points:
  1. Keep it short
  2. Schedule frequently and consistently
  3. Use them to surface issues not for discussion
CEC – Resources

Thank you

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