Safety Huddles

Illawarra Shoalhaven
Falls Prevention Network Rural Forum
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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. **Deference to expertise**
   - Point-of-care staff are the experts, empower them with decision making

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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

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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

http://www.cec.health.nsw.gov.au/clinical-incident-management

Table 8: System factors identified through Clinical Management RCA reports, January 2013 – June 2017

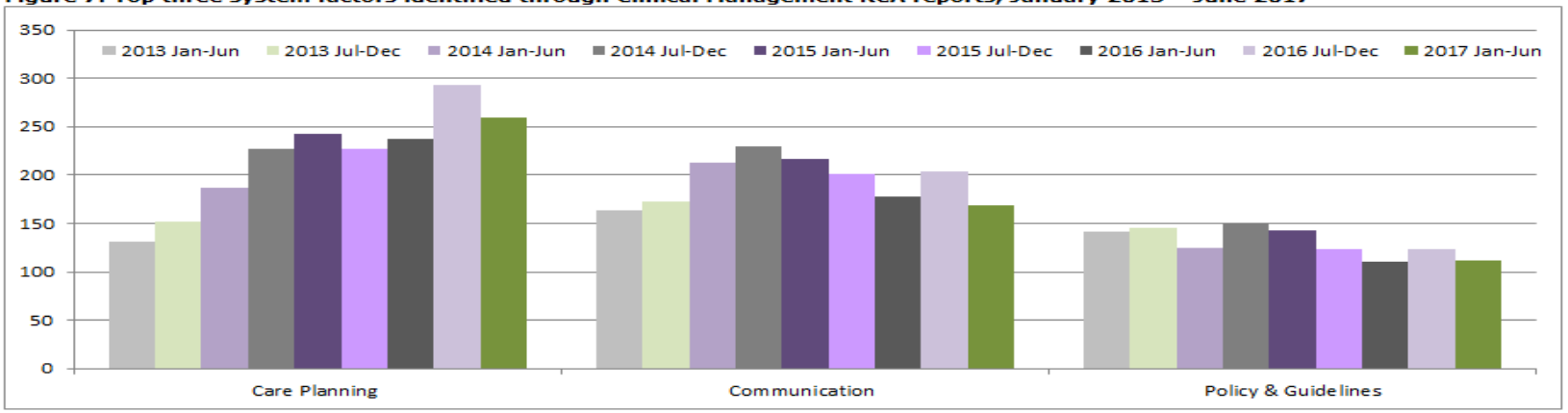
Clinical Management RCA System Factors	2013		2014		2015		2016		2017
								-Dec	Jan-Jun
Care Planning								293	260
Communication								204	169
Policy & Guidelines								123	112
Assessment								159	108
Observations & Monitoring								90	89
Workforce								91	86
Supervision								70	73
Teamwork								38	65
Investigations								62	61
Environment	55	76	59	72	71	62	71	82	43
Equipment	27	42	31	37	33	53	34	40	35
Access	23	16	18	25	26	25	34	57	28
Transfer	10	13	10	14	15	11	8	8	4
No factors identified *	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
TOTAL	**781**	**854**	**889**	**1,087**	**1,102**	**1,032**	**1,076**	**1,317**	**1,134**

Private health facility RCAs are included, when provided by the private facility and represents RCA reports received during the specified reporting period
** 'No factors identified' was added as a system factor in January - June 2017*

Care planning

- Gaps or failures in collaborative planning;
  - involving multiple teams
  - Inpt & community based teams

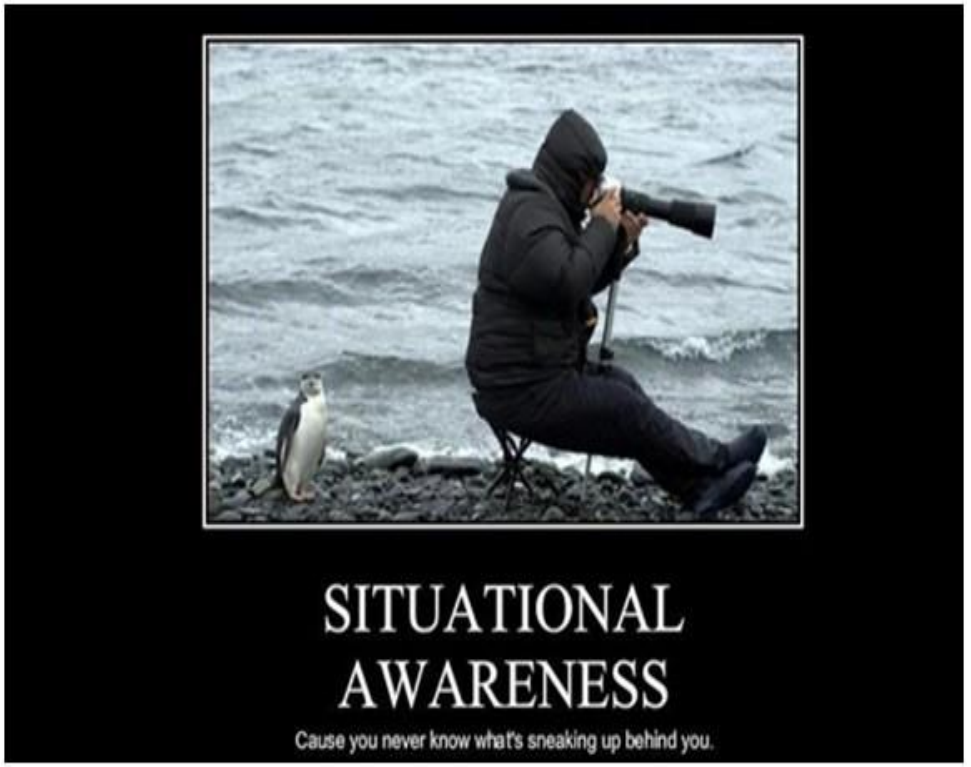
Figure 7: Top three system factors identified through Clinical Management RCA reports, January 2013 – June 2017



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)



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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

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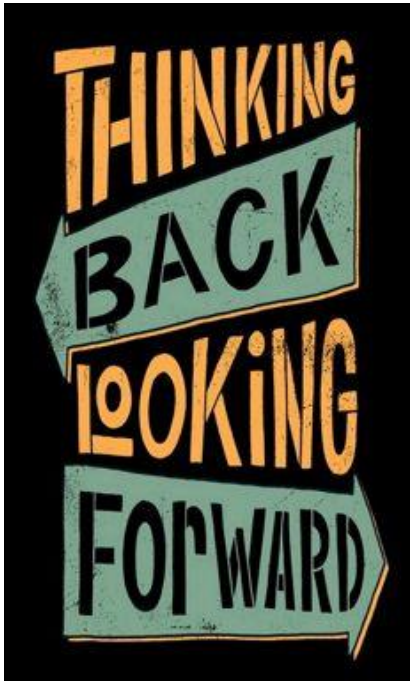
Safety Huddles – How?

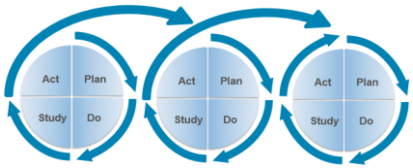
- Look Back
  - Significant safety issues from last 24 hours/last shift
- Look Ahead
  - Anticipated safety issues in next 24 hours/next shift
    - High risk meds, cognition
- Planning
  - Feedback on previous issues raised
  - Allocate accountability
  - Finish with a positive



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 ….



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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

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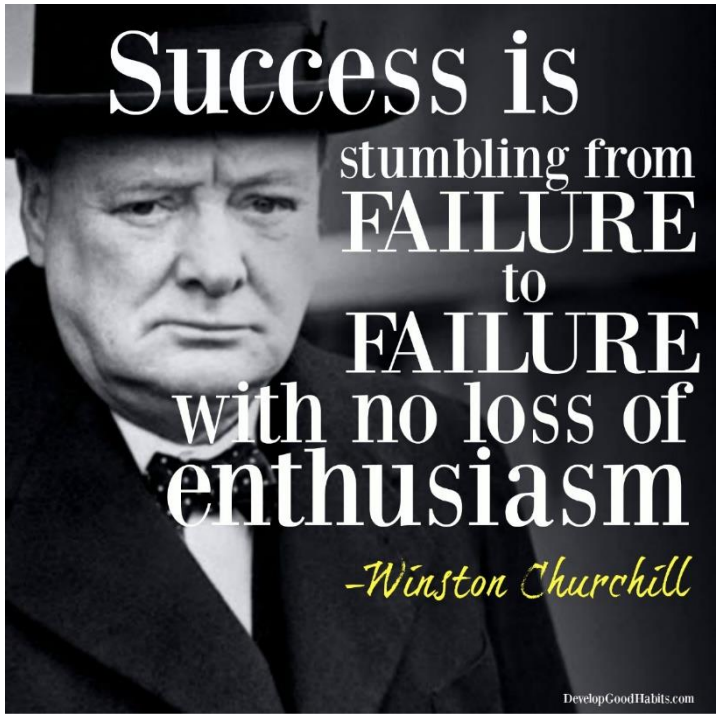
Test, test and test again …

- 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



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Common pitfalls

Agenda designed by one person	Team designs agenda
Key people not included	Include all relevant staff
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


STOP
SOTR

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

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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

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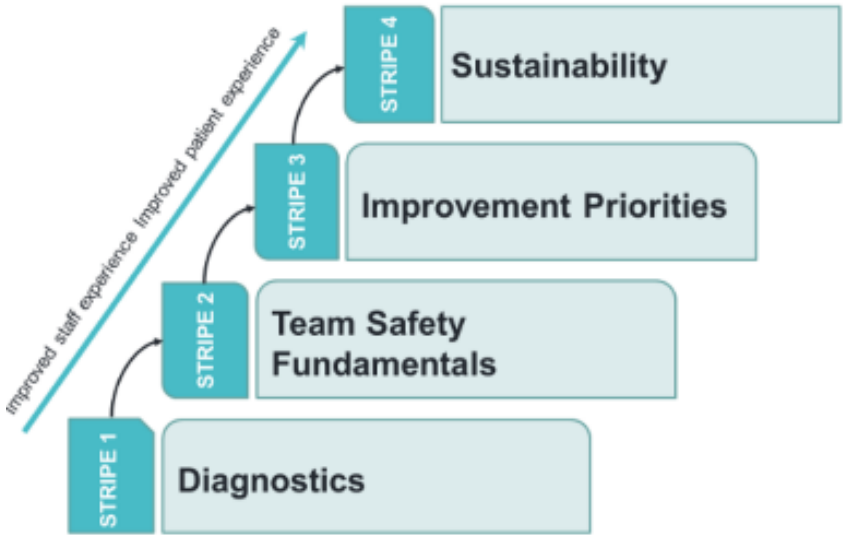
Team Safety Fundamentals

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



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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

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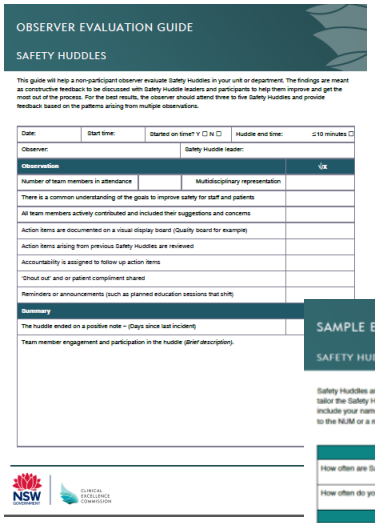
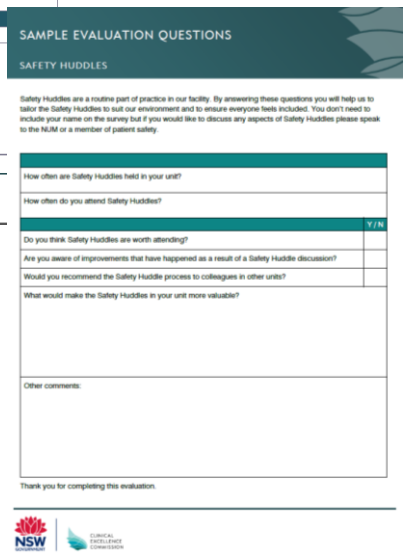
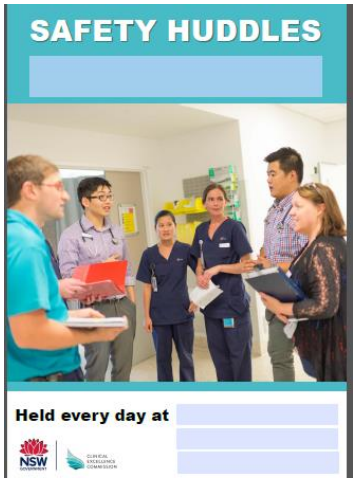
CEC – Resources

http://www.cec.health.nsw.gov.au/quality-improvement/team-effectiveness/team-stripes/team-safety-fundamentals/safety-huddles







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Thank you

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