

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 simplify 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

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

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

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

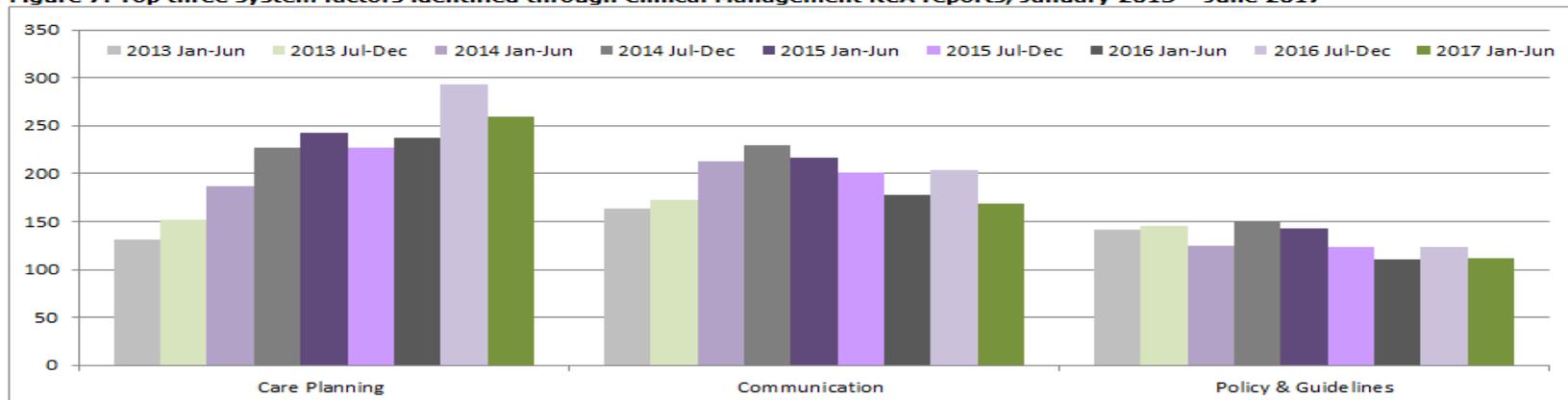
Clinical Management RCA System Factors	2013		2014		2015		2016		2017	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Care Planning	293	260	204	169	123	112	159	108	90	89
Communication	123	112	159	108	90	89	91	86	70	73
Policy & Guidelines	38	65	62	61	55	76	59	72	71	62
Assessment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

Care planning

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

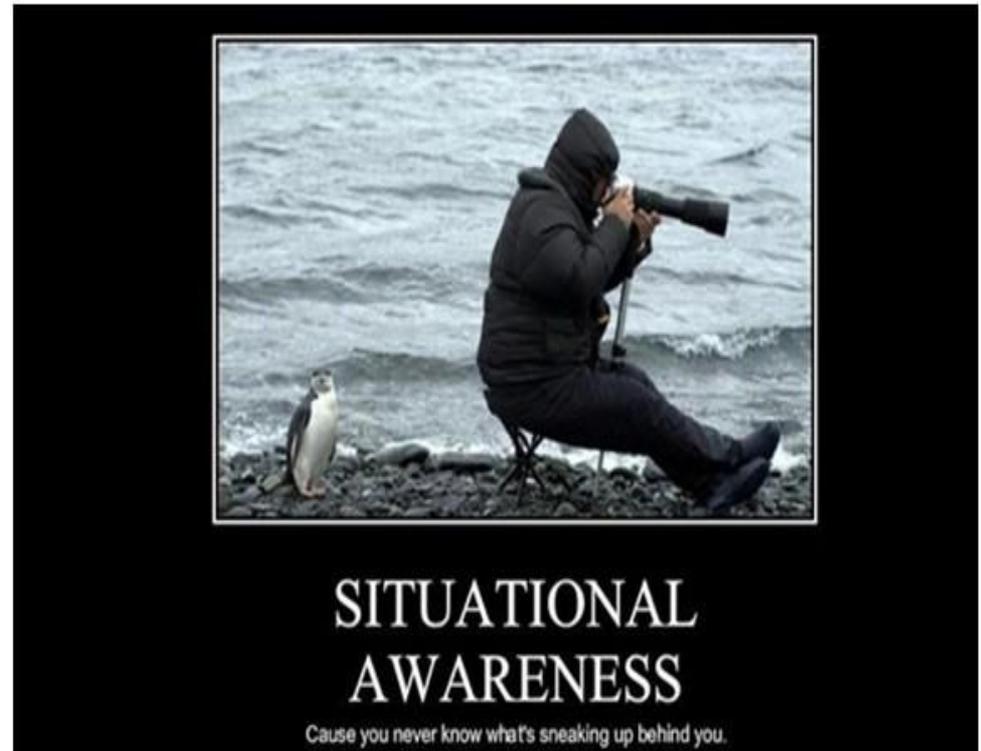
Private health facility RCAs are included, when provided by the private facility and represents RCA reports received during the specified reporting period
 * 'No factors identified' was added as a system factor in January - June 2017

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)

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

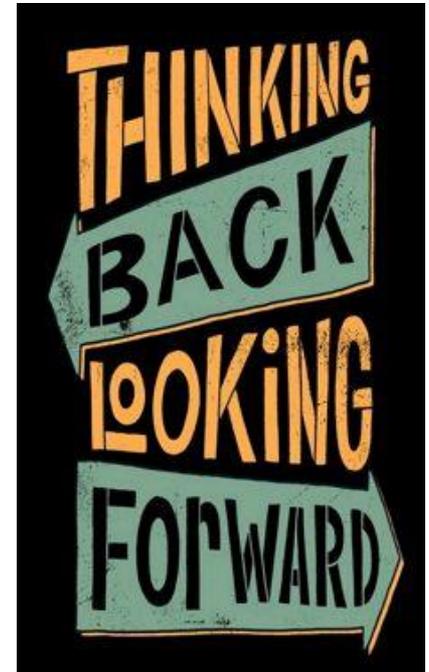
- **Focused**

- 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

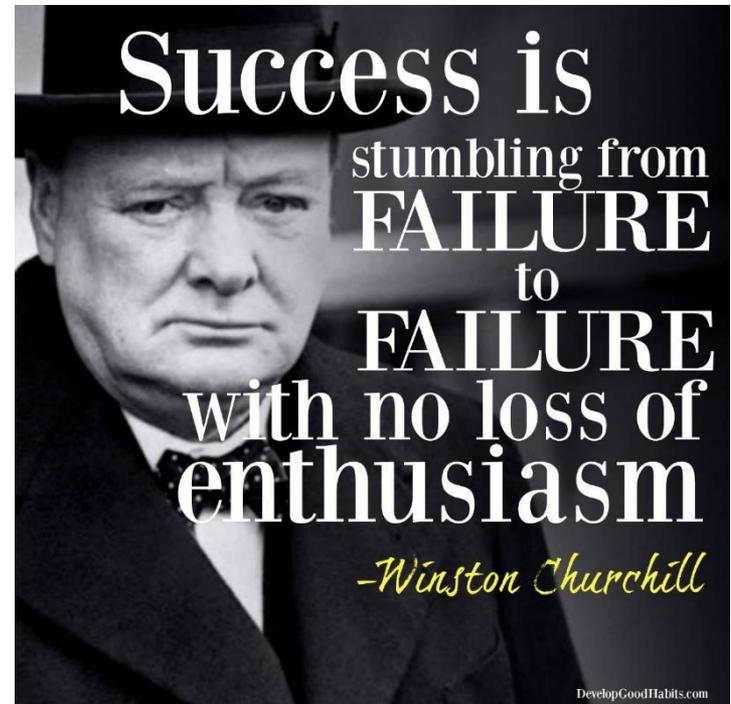
For example:

- 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

Agenda designed by one person	Team designs agenda
Key people not included	Include all relevant staff
One person speaks for the entire time	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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

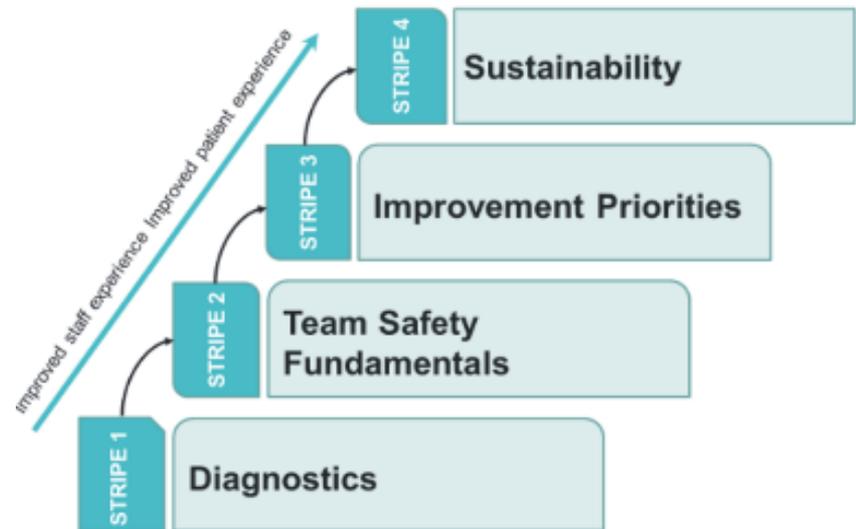
- Most frequent errors are human:
 - Inadvertent action – slip, lapse, mistake
- Increase reliability of processes with standardisation, structure and daily focus
 - Daily behaviours and communication methods
 - Clarity of roles and responsibilities
 - **Shift Safety Huddles**
 - ISBAR
 - Time-out
 - 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

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



SAFETY HUDDLES

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

Safety Huddles are a brief, focused and structured exchange of information about potential or existing safety risks which may affect patients, staff and any person accessing the healthcare environment. A safety Huddle is not a formal meeting or handover.

Safety Huddles are held at the beginning of the day and at every shift changeover. They, allow teams to:

- Develop on the spot action plans to address safety concerns
- Provide an update on the action taken on risks previously identified, and
- Celebrate successes such as compliments

Who Should Attend the Safety Huddle?
All staff involved in the care of patients, clinical and non-clinical including medical, nursing, allied health, pharmacy, ward clerks, clinical support officers and security staff.

Sustaining Safety Huddles
Team agreed ways of working will ensure the effectiveness and sustainability of Safety Huddles. For example, Safety Huddles should be:

- Held at a consistent time**
Safety Huddles are held at the same time each shift. Team members are expected to arrive on time and be prepared.
- Kept to time**
Safety Huddles are brief, 10 minutes maximum. The Safety Huddle leader is responsible for keeping the Safety Huddle to time.
- Held in a consistent location**
They are held in a central location accessible to all team members ensuring workflow is not obstructed and confidentiality is maintained. The ideal location is next to a Quality Learning Board.

- Held standing**
Remain standing to assist with efficiency.
- Establish a Safety Huddle team**
A team leader, in-charge of shift Manager will usually take the lead.
- The input of all team members**
All staff clinical and non-clinical to speak up to share their perps. Safety Huddles are empowerment non-punitive.
- Closing the loop**
A process for action is followed. Huddle so that all action items at the Safety Huddle leader and an agreed.
- Follow a locally developed script**
Develop the script around the the Look Back, Look forward and PII page 2 will help you develop you.

CLINICAL EXCELLENCE COMMISSION

OBSERVER EVALUATION GUIDE

SAFETY HUDDLES

This guide will help a non-participant observer evaluate Safety Huddles in your unit or department. The findings are meant as constructive feedback to be discussed with Safety Huddle leaders and participants to help them improve and get the most out of the process. For the best results, the observer should attend three to five Safety Huddles and provide feedback based on the patterns arising from multiple observations.

Date:	Start time:	Started on time? <input type="checkbox"/> Y <input type="checkbox"/> N	Huddle end time:	≤ 10 minutes <input type="checkbox"/>
Observer:	Safety Huddle leader:			
Observation:	N/A			
Number of team members in attendance:	Multidisciplinary representation			
There is a common understanding of the goals to improve safety for staff and patients	<input type="checkbox"/>			
All team members actively contributed and included their suggestions and concerns	<input type="checkbox"/>			
Action items are documented on a visual display board (Quality board for example)	<input type="checkbox"/>			
Action items arising from previous Safety Huddles are reviewed	<input type="checkbox"/>			
Accountability is assigned to follow up action items	<input type="checkbox"/>			
Chout out and/or patient complaint shared	<input type="checkbox"/>			
Reminders or announcements (such as planned education sessions that shift)	<input type="checkbox"/>			
Summary				
The huddle ended on a positive note - (Days since last incident)				
Team member engagement and participation in the huddle (Brief description)				

SAMPLE EVALUATION QUESTIONS

SAFETY HUDDLES

Safety Huddles are a routine part of practice in our facility. By answering these questions you will help us to tailor the Safety Huddles to suit our environment and to ensure everyone feels included. You don't need to include your name on the survey but if you would like to discuss any aspects of Safety Huddle please speak to the NLM or a member of patient safety.

How often are Safety Huddles held in your unit?	
How often do you attend Safety Huddles?	
Do you think Safety Huddles are worth attending?	Y/N
Are you aware of improvements that have happened as a result of a Safety Huddle discussion?	
Would you recommend the Safety Huddle process to colleagues in other units?	
What would make the Safety Huddles in your unit more valuable?	
Other comments:	

Thank you for completing this evaluation.

Always start with an introduction to ensure all participants understand the purpose and process.

The focus is always on processes and not people as safety events are usually symptoms of a larger problem.

About Team Culture and Communication
The CEC's Team Culture and Communication aims to enhance teamwork and communication at the point of care and support clinicians to create the conditions to allow quality and safety improvement to occur.

For further information, please visit <http://www.cec.health.nsw.gov.au>

Program Lead Team Effectiveness
CEO Team Effectiveness@health.nsw.gov.au
02 92859515

POST-EVENT SAFETY HUDDLES

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

A post-event Safety Huddle is a multidisciplinary team review which takes place as soon as possible after a safety incident or a near miss is detected (ideally before the end of the shift, while the event is still fresh in people's minds).

Post-event Safety Huddle happen after incidents/ events has been provided to the affected individual and occur on the following incidents and events such as:

- A patient fall
- A medication error
- Patient complaint
- Threats to staff safety
- Equipment failure
- Concerning trends arising in IIMS

Purpose of post-event Safety Huddles

- Uncover the contributing factors leading to the safety event.
- Allow staff to quickly develop plans to prevent a recurrence and prevent future harm to patients, families and staff.
- Identify whether the harm or harm risk was related to patient factors, or systems and processes.
- Provide reassurance that something is being done.
- Enhance teamwork and communication ensuring everyone is on the same page.

What do Post-Event Safety Huddles look like?
Post-event Safety Huddles are a safe space encouraging open and honest conversation. They are an opportunity to accept responsibility and learn from errors, and are facilitated by a team leader, such as the nurse in-charge, an experienced clinician, or the Unit Manager.

Post-Event Safety Huddles Information for Clinicians and Health Professionals
Revised October 2017 © Clinical Excellence Commission, 94/95, 10/166

IMPROVING PATIENT CARE THROUGH SAFETY HUDDLES



Safety Huddles are brief, focused and structured. They are an opportunity to share information about potential or existing safety risks which may affect patients, staff and any person accessing the health care environment.

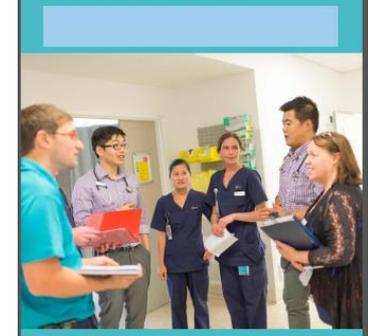
What do Safety Huddles look like?

- They are brief, 10 minutes maximum.
- They are held standing to assist with efficiency.
- They are held in a central location accessible to all team members ensuring workflow is not obstructed and confidentiality is maintained.
- All staff clinical and non-clinical to speak up to share their perps.
- The input of all team members.

Address 3 Focus Areas

- Look back and learn**
Over the last 24 hours what safety incidents occurred and how we can prevent them from re-occurring?
- Look forward and plan**
What are we doing to prevent safety incidents from re-occurring?
- Plan**
Celebrate and share the success stories for following up safety risks.

SAFETY HUDDLES



Held every day at

Thank you

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