SAFETY HUDDLES

IMPLEMENTATION GUIDE

NSW GOVERNMENT

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Introduction

Safety Huddles are a multidisciplinary process ensuring that the entire team is mindful of the tasks that need to be completed by each team member. They also bring the awareness to the team of the patients who are not following the expected course. A key element in the Team Stripes, *Team Safety Fundamentals*, Safety Huddles are intended to be carried out at all levels of the health system and can be integrated into any situation. For example, inpatient wards, outpatient clinics as well as community settings.

The use of daily Progressive Safety Huddles has the potential to ensure that all levels of the system, from the clinical unit to facility management through to the LHD executive, are aware before midday each day of the safety concerns and risks occurring in all facilities. With this timely brief view of the system the executive are able to prioritise the high risk issues impacting the facilities that day.

The CEC endorses the widespread use of Safety Huddles across NSW health to increase awareness and focus on patient safety. This is consistent with the NSW Ministry of Health policy, *Work Health and Safety – Better Practice Procedures*. This document provides the background and implementation strategies for Safety Huddles in clinical units and introduces daily Progressive Safety Huddles. Accompanying resources such as script and evaluation guides are available on the CEC website. All information provided is intended as a guide for units a nd facilities to adapt to their local context.

Safety Huddles

Poor communication is a major contributor to adverse events in NSW health. Clinical incident review reveals failures in communication can lead to patient harm and gaps in care including medication errors, delays in transitions of care, delayed or incorrect treatment as well as delayed or incorrect diagnosis.

> ***Collaboration and effective communication between the multidisciplinary team is essential to providing safe patient care[1].***

Among the benefits of Safety Huddles is that they provide dedicated time to communicate and share critical information to the whole team. The questions provide focus and structure but are not restrictive, keeping the conversation current and promoting shared situation awareness within the team[2].

The benefits of implementing Safety Huddles

The implementation of Safety Huddles assist clinicians and other staff involved in patient care, to allocate protected time at least once each shift to focus on specific questions with the overall aim to reduce errors, minimize harm, eliminate preventable harm and create a culture of safety[3].

Safety culture

Fostering a culture of safety is essential for reducing harm and achieving quality care in health care organisations. Teams who engage in Safety Huddles demonstrate improvements in teamwork and multidisciplinary communication. Through a collective awareness of the current situation, Safety Huddles promote a culture of safety which, in turn, reduces the potential for causing preventable harm[4].

Situational awareness

Situational awareness refers to an individual having awareness and understanding of what's going on around them. Improvements in situational awareness have been reported through implementing an early identification risk mitigation strategy such as Safety Huddles[5]. There are three key elements of situational awareness as described by Endsley (1995)[6]:

Perception: Pick up cues and perceive critical elements of the environment e.g. a patient's vital signs and behaviour. Also includes an awareness of the status of patient's under the care of the rest of the team.

Comprehension: Able to make sense of and integrate information contained within the elements. The dynamic nature of health care means team members will need to continually reassess their environment and share that information with colleagues.

Projection: Complete situational awareness also requires that team members are able to harness the available information to gain an understanding of what will happen next in their environment. That is, they are able to predict and therefore act proactively rather than reactively. At the team level, this includes things like agreeing which patients are most at risk of deterioration.

Safety Huddles support shared situational awareness by providing an opportunity for team members to share vital information about a patient or their environment, to discuss, integrate, and make meaning of the information; therefore clinical risks are more likely to be mitigated.

Mindfulness training may help to improve the Situational Awareness of individual team members[7].

Mindfulness is a mental state of being attentive, aware and focused[8]

Types of Safety Huddles

Daily Safety Huddles – A proactive approach

Safety Huddles are a proactive tool. They are held at the beginning of the day when the maximum number of members of the multidisciplinary team is able to attend (usually following the early morning round). They are held again at the end of each shift handover as a brief recap to ensure all staff on each shift are aware of the risks to patient and staff safety and that any risks have mitigation strategies in place.

All staff involved in patient care, including clinical and non-clinical, are included in Safety Huddles. The discussion during the Safety Huddle is non-punitive and inclusive ensuring all team members feel confident to share. Safety Huddles are not a formal meeting and the brief discussion focuses on three overarching areas which can be enhanced and developed to suit the local context[9]:

1. **Look back**: What safety incidents occurred in the previous 24 hours and have we prevented them from recurring? Acknowledge compliments and good news stories at this point
2. **Look forward**: What patient and staff safety concerns do we need to be aware of today and have we mitigated the risks?
3. **Finalise:** Follow the unit-specific plan for following up safety concerns and assign accountability

Progressive Safety Huddles – A whole of organisation approach

The Progressive Safety Huddle commences with the morning Safety Huddle held by unit level clinicians. Issues that require escalation are progressed through management tiers, commencing with patient flow. The types of issues that are progressed through the system are those that are complex and require escalation beyond the clinical team.

Key points:

- Start the morning Safety Huddle in the clinical unit by 9am
- Safety Huddles at each management tier are no longer than 10 minutes and occur sequentially
- Always start with what went well in the last 24 hours (choose one)
- Only escalate complex issues that cannot be managed at the current tier Safety Huddle
- The Safety Huddle is completed at executive level by midday each day

The Progressive Safety Huddle requires planning and coordination to ensure that complex issues reach the appropriate tier of management early in the day. This process has the potential to enhance communication and accountability as complex issues are rapidly escalated and managed collaboratively[4].

Post-event Safety Huddles – A reactive approach

Post-event Safety Huddles are a multidisciplinary team and patient review following an adverse event, incident or near miss. They are designed to identify the contributing factors and to put in place risk mitigation strategies.

The reactive safety huddles are held as close as possible to the time of an adverse event (for example, a patient fall or medication error) or near miss. Holding post-event Safety Huddles within the same shift or at least within the same 24 hour period ensures detail is captured while memories are fresh.

The team leader or manager, once notified of the adverse event, will call the post-event Safety Huddle and decide which members of the multidisciplinary team need to attend. The priority is to ensure the needs of the patient, their family and carers are met as well as the needs of the affected staff member(s)[10].

Questions to address during the Post-Event Safety Huddle:

- What was the incident?
- Who was affected and or harmed?
- How have we responded?
- What are the needs of the affected patient or staff member?
- Have we apologised?
- What actions are required to prevent a reoccurrence?
- Has the incident and response been documented and notified?

Getting Started

Safety Huddles are straightforward and quick to implement. Through testing and retesting the model is easy to adapt in most environments[10].

- Engaging medical and nursing leads is key, to provide guidance, support and sustainability of the tool.
- Involve all staff and identify champions from across all disciplines; clinical and non-clinical.
- Develop a brief script to use at each Safety Huddle to keep the conversation focused as you begin using the process. Over time as you adjust to the process, the Safety Huddle will become less prescriptive.
- Generate a way of documenting the action items, assigning accountability and follow up to completion of the action items.
- Agree on a time to do the Safety Huddles each day. It might take several test cycles to identify the best time to suit the majority of staff.
- Obtain staff feedback on the process to inform changes.

Suggested focus areas to include in the discussion

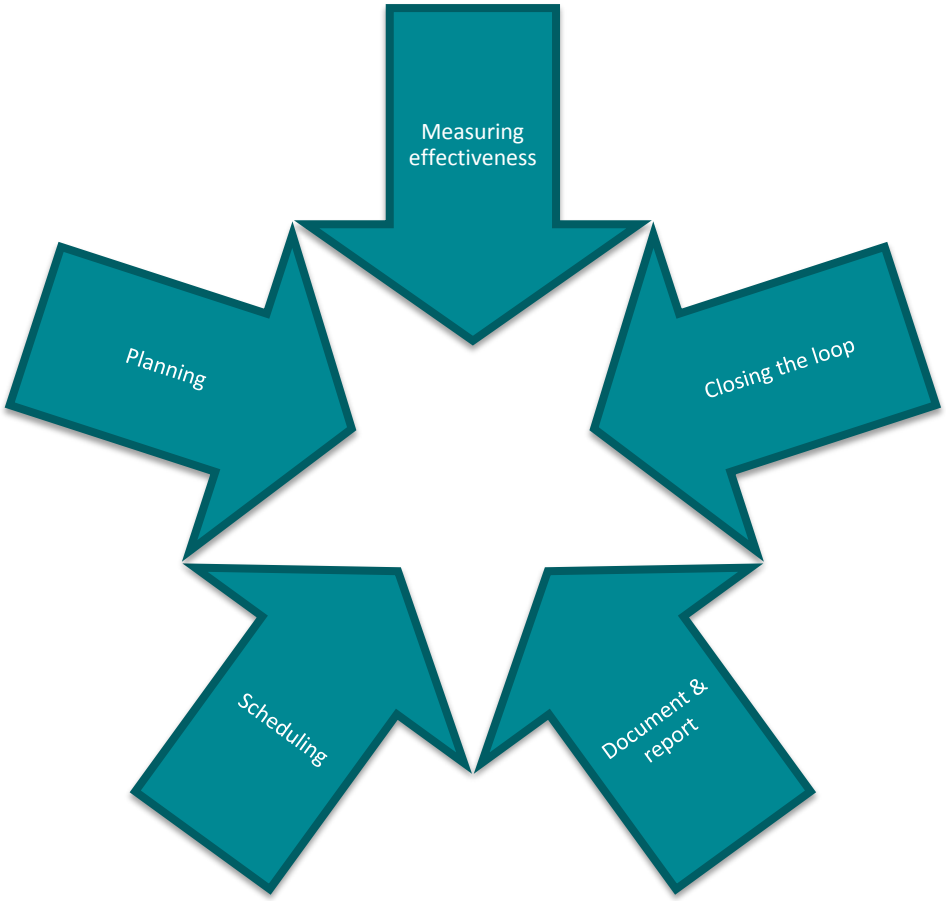
- **Patients:** with same or similar surname, prescribed high risk medications, delirium, behavioural or cognition concerns, high falls risk, patients at risk of deterioration, scheduled for procedure/surgery, flow, community outbreaks (Norovirus or other infectious diseases), recent IIMS and mitigation strategies, multiple teams involved in care
- **Staff:** sick leave, increased agency staff, new staff/new term, skill mix, shortages in other areas impacting care
- **Processes:** new equipment, new medicines, planned downtimes/outages (electronic systems) which could impact safety
- **Environment:** broken equipment, loose tiles, air conditioning faults, security (increased thefts), closed patient areas, location of duress alarms

Closing the loop

- A system for communicating how safety concerns have been addressed will keep staff engaged and ensure they value the process.
- Document identified safety concerns and assign accountability. Review the safety concerns daily until resolution (allocate time frame).
- Ways to document and communicate actions are to hold Safety Huddles next to a Safety Cross or a Quality Learning Board10.

See sample action documentation sheets in this toolkit.

Continuous improvement focus



Key points for success

- **Preparation**: All team members need to come to the Safety Huddle prepared to prevent omissions or conversations going off onto another tangent.
- **Leadership**: led by a team leader or an experienced member of staff to ensure the Safety Huddle ground rules are observed and that all action items are delegated.
- **Consistency**: held at the same time and in the same location. This may change through frequent testing until an ideal time and location is agreed.
- **Accountability**: a member of the leadership team needs to be present at all Safety Huddles. As many staff as possible or an assigned delegate are in attendance.
- **Closing the loop**: follow up on identified issues until they are resolved using a transparent reporting system such as a Quality Learning Board.
- **Practice, adapt and improve**: Test and adjust the process to suit the unique needs of the clinical unit.

Measuring Effectiveness

The three questions in the Model for Improvement are a useful way to test and measure the effectiveness of Safety Huddles[2].

What are we trying to accomplish? (Aims)

- Increase awareness of safety issues which could impact patients and staff
- Build a collective awareness of the current safety issues and how to mitigate
- Reduce adverse events causing harm
- Foster a culture of safety
- Improved patient and staff experience

How will we know that a change is an improvement? (Measures)

- Number of near misses reported by staff
- Use of voluntary reporting (IIMS)
- Attendance of clinical and non-clinical staff at Safety Huddle
- Percentage of staff who report Safety Huddles as valuable

What change can we make that will result in an improvement? (Changes)

- Conduct Safety Huddles at least daily

At the end of the Safety Huddle, staff on duty should raise any safety concerns that need clarification or immediate action.

They should also know:

- Who is the sickest patient today
- What plans are in place for patients at risk of deterioration
- About any patient and carer concerns
- Who the outliers are and what medical teams are involved

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