SAFETY HUDDLE TOOLKIT

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Patient Safety
London Health Sciences Centre

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I. Introduction

The safety huddle toolkit has been developed to provide a framework for initiating safety huddles in your areas. If you have any questions on how to use the toolkit please feel free to contact the Patient Safety at LHSC.

II. Overview

Safety huddles are considered an important mechanism for reporting safety issues that are not always captured in the Adverse Event Management System (AEMS). Healthcare organizations use safety huddles as a proactive approach to help increase staff awareness of patient and staff safety issues and integrate the reporting of safety issues and near misses into daily work. The advantage to a safety huddle, is that it becomes part of the routine way that a work team goes about its business to maximize patient & staff safety. Over time safety huddles help units and organizations create a culture of safety, reduce the risk of errors and improve the quality of care.

Information regarding patient & staff safety needs to be transparent so that everyone throughout the organization can understand the risks and actions to alleviate the safety hazards. Safety huddles is a tool to promote inter-professional collaboration focusing on safety, rectifying a problem rather than blaming.

In a safety culture, safety is a continuous improvement process, not a project that ends once a target or goal has been achieved. It is important to create a safer environment for both patients and employees.

As outlined by the Institute for Healthcare Improvement (IHI), safety huddles has the following goals in mind:

1. Increase staff awareness of safety issues
2. Create an environment where staff freely share information about safety issues without fear of reprisal
3. Improve overall delivery of care
4. Integrate safety into the daily routine
5. Change the culture

Generally, the returns from conducting safety huddles are significant. Benefits include:

1. Near misses are caught and reported before reaching the patients
2. Increased patient and staff satisfaction
3. Unique knowledge can be shared among team members and used in the face of similar circumstances

4. Faster implementation of improvements

III. Getting Started – Your step by step guide

The following is a step by step guide to assist in improving patient & staff safety in your areas. Safety huddles come from an effective dialogue and sharing of knowledge among all participants.

a. Preparation for Safety Huddles

The decision to conduct safety huddles is a team commitment. Participants should:

- Help make connections between problems, issues and suggest changes
- Ensure follow-through on issues at the unit level
- Demonstrate commitment to this process and to safety

Be sure to educate your staff on the purpose, goal and process of safety huddles. Communication with all staff should include what the safety huddles are, what to expect in the process, and why we are doing them. Sharing this information is vital. .

By including your leadership team in both the education and process you will limit the chance of front line leadership feeling disenfranchised or thinking that the safety huddles are a mechanism for senior executives to find fault with them.

b. Scheduling

Safety huddles are most successful when held on a regular basis. Schedule them either at the same time every day or after some defined unit of work, e.g. after morning care is completed. The more frequently you conduct them the more comfortable you will become with learning from experience without placing blame. Routine meetings held frequently may be contributing to keeping the safety huddle brief and highly focused. When scheduling base the timing of the safety huddle on the needs of the unit to promote attendance.

c. Who Should Attend

Everyone involved in direct care should be involved in safety huddles. Each person's information and ideas are necessary to get a full picture of what happened and to generate ideas about how to incorporate the learning into future actions. Not attending will suggest that the safety huddle results are not a product of everyone involved. Consider the following participating: nurses, physiotherapists, occupational therapists, pharmacists, support service worker, dietician.

d. Length of Safety Huddle

Keep the meetings brief. They should not take any longer than 5-10 minutes.

e. Conducting Safety Huddles

In order to ensure meetings are brief, utilize a standardized template of questions. Consider the following questions:

1. What happened to threaten patient or staff safety,

2. What should have happened,
3. What accounted for the difference,
4. How could the same outcome be avoided the next time, and
5. What is the follow-up plan?

Engage in open discussion based on objective facts without blaming individuals.

Departments may also find it helpful to conduct the safety huddle at the nurse's station or an empty patient room. This will allow for the opportunity to involve multiple people and those who just happen to be passing by. Conducting the safety huddles in an empty patient room or classroom may limit the distractions or interruptions that are more likely to occur in an open forum.

Some important points to remember when beginning the sessions are as follows:

- Enhanced awareness of safety throughout the organization
- Intent is to improve the care environments as well as the work environments for staff
- Strictly confidential and purely for patient & staff safety and improvement
- Focus is on the systems you work in and not blaming individuals
- Themes that will be covered:
    a. Teamwork problems
    b. Distractions
    c. Inefficiencies
    d. Problems with protocols/equipment
- Prioritization of concerns may be necessary

Find attached (Appendix 1) a list of questions that you might consider in your safety huddles. If you create your own questions be sure to frame them so that they are open-ended questions and do not avail themselves to yes or no answers.

f. Recording Notes

Keep only informal notes, and make them available to other staff if it will help them to avoid patient errors and staff injuries. Do not formalize notes, nor send them to supervisors. Keep in mind that the focus of safety huddles is to help the team itself learn from its own experiences. One person should be responsible for making sure that corrective actions are taken.

Closing the discussion of the safety huddle is just as important as opening the discussion. It is important to think about how you will bring closure to the meeting. Some points to consider are:

1. Appreciation for honesty, time and effort
2. What will be done with the information gathered
3. How you might determine the most responsible person for following the actions through
4. Accountability for follow up actions
5. Their role for communicating their experience with their peers this experience

g. Measurement / Evaluation

As the safety huddles are implemented, it is important to solicit feedback on the effectiveness of the safety huddles. How will we know that safety huddles are effective? It is important that we track over-all error rates and the effectiveness on safety climates and cultures.

References

Institute for Healthcare Improvement
http://www.ihi.org/knowledge/Pages/ImprovementStories/ReducingHarmfromFallswithTeamworkandFocusedAssessment.aspx

Canadian Patient Safety Institute

http://www.patientsafetyinstitute.ca/English/toolsResources/Presentations/IHI-NationalForum/Pages/SafetyHuddle.aspx

Appendix 1

What happened to threaten patient or staff safety?

What should have happened?

What accounted for the difference?

How could the same outcome be avoided the next time, and what is the follow-up plan?

Who is working on shift today? Skill mix? Knowledge base?

What priorities/goals are set, does staff understand and agree with the priorities/goals?

Does all staff have knowledge on what their roles and responsibilities are related to the priorities and goals?

Does all staff know and understand the plan of care?

Are the right people/equipment available at all times, if not, what is it going to take to have them available?

Is the workload evenly distributed?