2015

Safety Huddles

Guide to Safety Huddles

A Culture of Safety: BRINGING BOARD MEMBERS, EXECUTIVE LEADERS, AND STAFF TOGETHER

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Creating a Culture of Safety Using Safety Huddles

A culture of safety is built on high awareness of real and potential safety issues at all times and at all levels of organizational operations. Safety huddles, sometimes known as safety briefings, help organizations create a culture of safety by providing a forum for front line personnel to share safety concerns, develop plans, and celebrate successes. They have been shown to result in system-wide and patient-specific changes that promote safety, and to support teamwork and interdisciplinary collaboration[1, 2, 3, 4]. Safety huddles also improve efficiencies, quality of information sharing, and accountability. They foster a sense of community, and create a culture of collaboration and collegiality that increases collective awareness and capacity for reducing harm.[5]

Characteristics of Safety Huddles	Value for Enhanced Culture of Safety
Focused	Improves process for keeping patients and workers safe. [1, 2, 3, 4]
Brief and multi-disciplinary	Allows full worker participation, engagement, and collaboration.[6]
Frequent	Keeps momentum high and enables rapid Plan-Do-Study-Act (PDSA) cycles.[7]
Non-punitive	Encourages open sharing of safety information and team problem-solving.[8]

What is a safety huddle?
Safety huddles are brief and routine meetings for sharing information about potential or existing safety problems facing patients or workers. They increase safety awareness among front-line staff, allow for teams to develop action plans to address identified safety issues, and foster a culture of safety. There are a various types of safety huddles that can be used separately or in combination. (See "What Forms Can a Safety Huddle Take?" below.)

In addition to identifying real-time safety concerns, safety huddles are ideal for reporting back actions taken on identified concerns. They also present opportunities to educate, reinforce and motivate teams on current and future safety initiatives. Successes and examples of "leading" practices could also be celebrated during huddles.

Types of Topics to Address in Safety Huddles:

- Equipment/Supplies
- IT/Telecommunications
- Physical space/Environment
- Behavioral/Restraints/Seclusion
- Radiology/Imaging
- Medication Events
- Near Misses
- Laboratory/Phlebotomy
- Blood/Blood products
- Surgical/Procedural/Anesthesia
- Bed Control/Staffing/Capacity
- Patient/Family complaints
- Workplace Violence
- Security/Privacy

Who attends a safety huddle?
Safety huddles work well for groups of people who work together in a hospital or health system unit, department, clinic, or any other team environment. They should be designed so anyone in a team leader position can call for and facilitate them. Frontline staff are key participants. For leadership huddles, a high level leader such as the chief nursing officer (CNO) should lead. If this person is not available, he or she should assign a colleague, such as the chief medical officer (CMO) or representative to lead.

When should safety huddles occur?
Safety huddles should be timed to accommodate the unique characteristics of the environment and the circumstance of the huddle. They should occur often enough to maintain on-going safety awareness and vigilance but not so frequent they become a burden and interfere with the team's work. In hospital units, a common safety huddle is the daily shift safety huddle which should be scheduled at least twice a day. Daily leadership huddles should occur at least once per day and be held *after* the daily shift huddle so that issues addressed in the daily shift huddle can be addressed. Post-event safety huddles occur whenever there is a safety incident, near-miss, or major concerning event at another healthcare organization or in the news. (e.g. Concerning events may come up in the general media, notices from the Institute for Safe Medication Practices, sentinel event alerts, via The Joint Commission, or other sources.)

Where should safety huddles be held?
Safety huddles should be held in a central location that is convenient for all team members to attend but does not interfere with ongoing activities. Successful strategies include holding huddles near learning or safety boards where the latest safety information is posted.

How should we perform safety huddles?
- ✓ Engage leadership.
- ✓ Keep meetings brief, approximately 5 – 15 minutes.
- ✓ Make sure the team knows the consistent time and place for the huddle.
- ✓ Start with a reminder that the purpose is to increase awareness of and address safety issues.
- ✓ Reinforce the intent to improve care, not to place blame.
- ✓ Encourage everyone to speak up.
- ✓ Use a tool to standardize safety huddle questions and discussions on safety risks and to track identified safety concerns.
- ✓ Develop a process to follow up on safety concerns.
- ✓ Before each huddle, the leader should review safety information since the last huddle and prepare key points to cover.

What forms can a safety huddle take?
The table below provides an overview of several types of safety huddles:

Type	Lead	Participants	Objective
Leadership Safety Huddles	Executive (e.g. CNO, CMO)	Managers and other leaders from each unit/department in the hospital or health system.	Create shared awareness between departments of safety issues affecting care that day; determine actions needed.
Daily Shift Safety Huddles	Charge Nurse or Manager	All staff in the unit/department and that shift.	Create shared awareness within a unit/department about safety issues affecting care that day; determine actions needed.
Post-Event Safety Huddles	Charge Nurse or Manager	Staff whose work relates to the safety incident or near-miss of concern.	Plan action to remedy immediate patient/family/worker needs and system/process issues after an incident has occurred.

Leadership Safety Huddles
It is recommended that leaders from each department in the hospital or health system meet daily to share updates from the past 24 hours and to determine actions needed to address key safety issues. Issues that

affect the entire hospital or health system as well as issues affecting single departments should be covered, with emphasis on follow up actions needed to prevent patient or worker injury. Each department leader should attend their daily shift huddle and come prepared to concisely report out the main safety issues affecting his or her department, and to ask for follow up actions they deem necessary. (See Appendix A: Advocate Health Care's Daily Safety Huddle Video.)

Daily Shift Safety Huddles

All workers in a department should participate in a daily safety huddle so they have the information they need to work safely and contribute to safety promotion.

Brief discussion during safety huddles should answer the questions:

- ✓ What were the threats to safety in the last 24 hours?
- ✓ What are the threats to safety today?
- ✓ Are we dealing with any situations that distract us from patient care or decrease our ability to think critically about our patients?
- ✓ Are there any high-risk patients or procedures?
- ✓ Are there any deficiencies in equipment, supplies, or staffing?
- ✓ Are there safety issues from any department that affect work in this department?
- ✓ Do we need to notify any other departments about safety issues in our department?

Post-Event Safety Huddles

Post-event huddles take place as soon as possible after a safety incident (e.g. a patient fall, medication event, wrong procedure, equipment failure, escalating patient/family concern) or near miss is detected. Organizations should define the timeframe within which post-event safety huddles should happen for events of different types and severities. This enables the team to quickly develop plans to remedy harm or risk to patients, families, or workers, in the appropriate unit or across the hospital or health system, and to fix the systems/process issues that led to the harm or risk. Huddles can also be held to address concerning safety trends as they are identified, or in response to incidents at another facility to ensure that similar incidents could not occur at your facility[1,6].

Staff should immediately notify the charge nurse or shift supervisor when a safety event has occurred. The charge nurse or shift supervisor will notify the relevant manager and/or director. The manager or director can determine the need for a safety huddle and who should participate, and may call on patient safety or risk management to assist in leading the huddle. The priority is to address the needs of the affected patient, family, and staff.

Questions to address during the huddle include:

1. What happened?
2. Who was affected?
3. How did we respond?
4. What are the needs of the patient, family, or staff?
5. Are any other notifications needed at this time?
6. What actions are necessary to prevent reoccurrence?
7. Who will speak with the family?
8. Is there need for the group to meet again?[1]

9. Is there a need to take preventive action in other areas of the hospital or health system?

How Can I Get a Safety Huddle Program Started?

- **Engage leadership** – Leaders will need to support the spirit and structure of the huddles, protecting a just culture and encouraging staff to take the time needed for huddles.
- **Pick a focus unit** – Start implementing safety huddles in just one key unit or department where you can test processes and tools. Learn from your early experiences, adapt your safety huddle model accordingly, and then spread it to other departments, allowing for customization as needed.
- **Identify champions –** Let staff who believe in the value of safety huddles help explain and promote them to other staff. As with any change, starting a safety huddle program may require addressing initial reservations or concerns. Hearing from peers is a great way to get staff on board!
- **Use a recent safety event to illustrate how huddling could help –** Pick a key safety event from the past several months, and discuss how having safety huddles could have prevented this event, or helped address it. Emphasize the practical impact that safety huddles could have.
- **Use data –** Find updated data that illustrates a safety issue, such as infection trends, to share at huddles so that progress can be tracked.

What are the Basic Components of an Effective Safety Huddle Program?

The Basic Components of an Effective Safety Huddle Program Include:
1. Planning
2. Scheduling
3. Documenting and Reporting of Action Items
4. Closing the Loop
5. Measuring Effectiveness

1. Planning

Start by developing and sharing a plan for when huddles will be held, who will be involved, expectations for huddle content and follow up, and documentation or materials that will be needed to ensure that your huddles are efficient and successful. (See Appendix B: Huddle Process Map, adapted from Kittitas Valley Healthcare.)

2. Scheduling

Be clear about what time huddles will be held, and how long they will last. Make sure that the people who need to be involved are not required to be elsewhere during that time. Scheduling designated time for huddles throughout your hospital is one way to protect this time and ensure that other events and meetings aren't scheduled at the same time.

3. Documenting and Reporting Action Items

Safety huddles should be documented to allow tracking of actions taken on issues that are identified. Tasks should be clearly assigned and follow up should be conducted to ensure their completion. Standard templates for documenting huddles, such as the examples in Appendices C and D for unit and leadership

huddles, are helpful. They may include the date of the huddle, event that prompted the huddle (for post-event huddles), participants' names, roles, and departments, and next steps or conclusions.[1]

Holding huddles in front of "learning boards", or bulletin boards where safety information is posted, can help keep huddles focused on key safety topics. Learning boards might contain updated reports of safety events, results of safety surveys or analyses, and reminders about current safety initiative action steps to take. The learning board may also contain space where staff can post issues that need to be addressed, so that those can be reviewed and discussed during the huddle.

4. Closing the Loop

It's important to communicate with all relevant staff about how issues brought up during huddles have been addressed. This demonstrates to staff that information shared during huddles is valuable, and that huddles make a difference in safety for patients and staff. Action steps that have not been taken can also be shared, along with reasons why the action could not be taken yet, and when the action will be taken.

5. Measuring Effectiveness

The first step in evaluating the impact of safety huddles is to understand how they are being used. Review records of how many huddles have occurred, in what departments, and with what leaders and participants. Review action steps that were agreed upon and whether they were completed. Consider using the matrix in Appendix E: Safety Huddles Assessment and Planning Tool, adapted from Legacy Health to assess where your hospital or health system lies along the continuum of huddle implementation levels. Aim to reach higher levels of implementation over time.

Sample Huddle Evaluation Questions:

- Have safety huddles routinely been held in your department/unit?
- Do you feel comfortable sharing your questions or concerns about safety during huddles?
- Do you think safety huddles are worth the time they take?
- Can you think of any improvements that have been made because of safety huddles? (If so, please describe.)
- What would make your safety huddles more valuable?

Ask or survey staff about their perceptions of the impact of safety huddles. (See suggested questions, at right.) Pay special attention to whether staff feel comfortable bringing up safety issues during huddles without fear of punitive response. Consider using culture of safety surveys such as the Agency for Healthcare Research and Quality Hospital's Hospital Survey on Patient Safety Culture[9] to measure changes over time in what staff report about safety culture.

Appendices:

Appendix A: Advocate Health Care's Daily Safety Huddle Video (Via Health Research and Educational Trust website. August 13, 2013.)
Appendix B: Huddle Process Map, adapted from Kittitas Valley Healthcare
Appendix C: WSHA Daily Shift Huddle Template
Appendix D: WSHA Daily Leadership Huddle Template
Appendix E: Safety Huddles Assessment and Planning Tool, adapted from Legacy Health

Additional WSHA Resources:

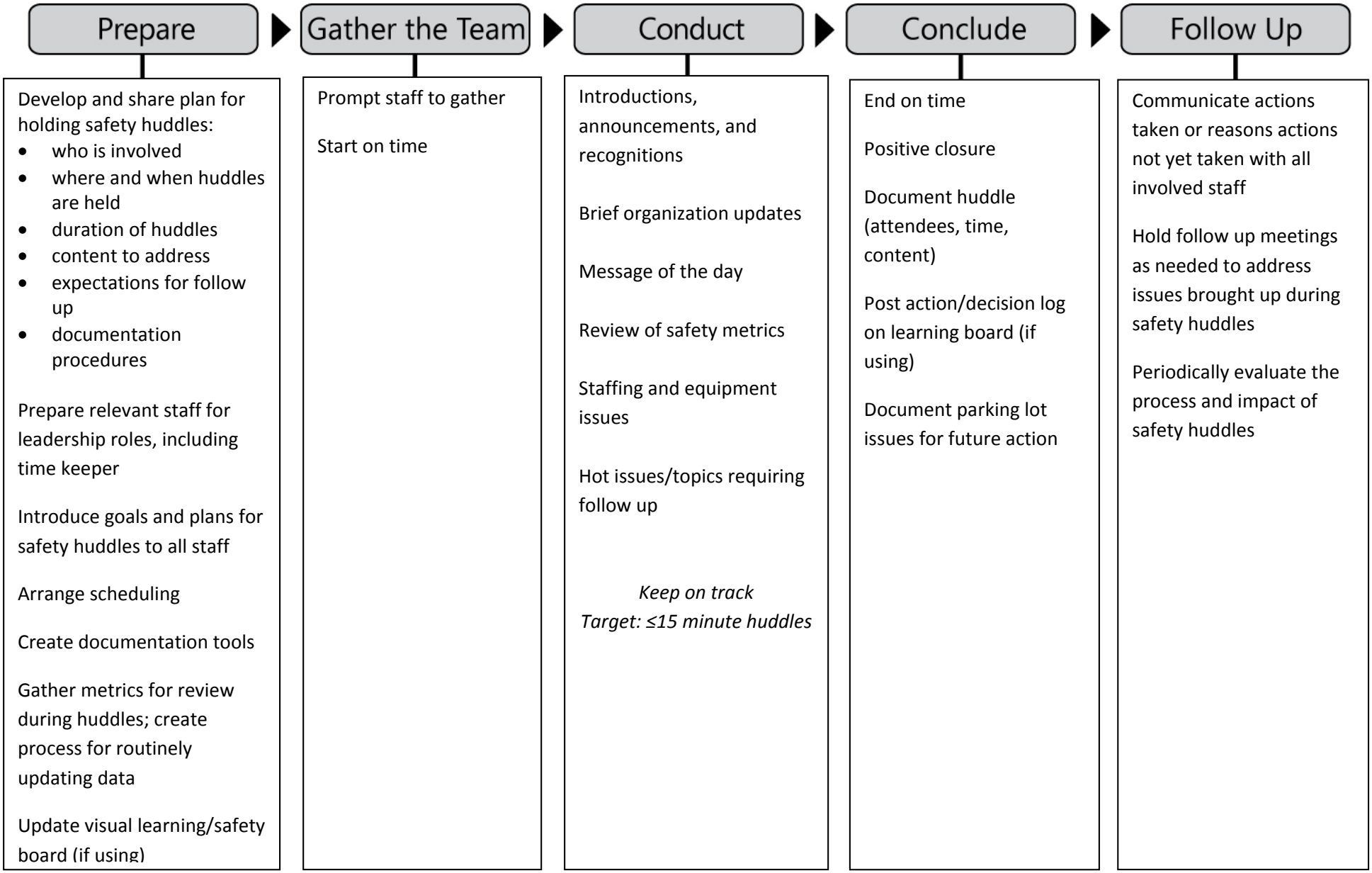
- Toolkit: Patient Safety Culture – Effective Leadership for the Delivery of Health Services
- Executive Rounding for Safety Video (Includes a segment on how safety huddles complement executive rounding for safety.)
- Executive Rounding for Safety Toolkit

References:

1. Gerke ML, Uffelman C, Weber Chandler K. Safety Huddles for a Culture of Safety. *Patient Safety & Quality Healthcare*. May/June 2010. http://www.psqh.com/mayjune-2010/516-safety-huddles-for-a-culture-of-safety.html
2. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care*. Oct 2004; 13(Suppl 1): i85–i90. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1765783/pdf/v013p00i85.pdf
3. Edelson DP, Litzinger B, Arora V, et al. Improving in-hospital cardiac arrest process and outcomes with performance debriefing. *Arch Intern Med*. 2008; 168:1063-9. http://archinte.jamanetwork.com/article.aspx?articleid=414230
4. Makary M, Mukherjee A, Sexton J, et al. Operating room briefings and wrong-site surgery. *J Am Coll Surg*. 2007; 204: 236-43. http://www.journalacs.org/article/S1072-7515(06)01585-7/pdf
5. Goldenhar LM, Brady PW, Sutcliffe KM, Muething SE. Huddling for high reliability and situation awareness. *BMJ Qual Saf*. 2013 Nov. 22 (11): 899-906. http://qualitysafety.bmj.com/content/22/11/899.full.pdf+html
6. Gerke ML, La Fleur M. Safety Huddles: Patient Safety and Staff Engagement. (presentation) Gundersen Lutheran, Aug. 5, 2010. http://www.wsha.org/files/GundersenLutheran_Safety%20Huddles_Example.pdf
7. Institute for Healthcare Improvement. Huddles. 2004. http://www.ihi.org/resources/Pages/Tools/Huddles.aspx
8. Panten N, Torrance A. Just Culture: The Missing Ingredient in Patient Safety. *Advance Healthcare Network: Executive Insight*. 2014. https://healthcare-executive-insight.advanceweb.com/Editorial/Content/PrintFriendly.aspx?CC=274450
9. *Hospital Survey on Patient Safety Culture*. June 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

Appendix B: Huddle Process Map Adapted from Kittitas Valley Healthcare

Safety Huddle Process Map



Adapted from Safety Huddle Process Map from Kittitas Valley Healthcare

Hospital Name and Logo

Washington State Hospital Association

Daily Shift Safety Huddle			**Date: _____**	**Unit: _____** **Attendees: _____**
Message of the Day / Celebrate Successes				
Introduce New Staff / Guests				
Operations		**Day:**		**Night:**
	Staffing Variances			
	Projected Admits			
	ED / OR Activity			
	Open Beds			
	Planned Discharges			
	Unit Metrics #1 (i.e. LOS)			
	Unit Metric #2			
Safety / Quality / Reliability	Quality Focus of the Week			
	Days since Harm Event			
	Total Harms this Month: *(Add organization descriptor here)*			
	Near Misses			
	Worker/Patient Safety/Quality Concerns			
	Cautions / Risks *(e.g. foley, central lines, surgeries/procedures, high fall risk, contact precautions, delirium, mobility)*			
	Medication/Pharmacy Concerns			
	Equipment Issues/Concerns			
Action Needed	**What**	**Who**	**When**	**Completion/Follow Up Notes**

NOTE: Topics included here are suggestions; this template is meant to be tailored to each organization's particular needs and priorities.

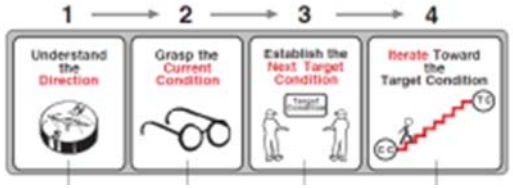
Name and Logo

Daily Leadership Safety Huddle		**Date: _____**	**Leader:**	**Attendees:**
	Introduce New Leaders / Guests			
	Organization Update/Message			
Essential Operations		**Day:**		**Night:**
	Hospital Census			
	Utilization			
	ER visits			
	Surgeries			
	Planned Admits / Transfers			
	Open Beds			
	Staffing Variances			
	Critical Concerns / Issues			
Safety / Quality / Reliability	Quality Focus of the Week			
	Days since Harm Event *(Add organization descriptor here)*			
	Total Harms this month:			
	Near Misses			
	RRT Calls / Concerns			
	Unit Specific Issues			
	Equipment Issues / Concerns			
	Worker Injuries			
Action Needed	**What**	**Who**	**When**	**Completion/Follow Up Notes**

NOTE: Topics included here are suggestions; this template is meant to be tailored to each organization's particular needs and priorities. Examples of other topics you may want to include: % patients who left ED without being seen, # anticipated obstetric deliveries, security officer concerns, unit-specific kudos.

Appendix E: Safety Huddle Assessment and Planning Tool, adapted from Legacy Health

Measuring Implementation Effectiveness: SAFETY HUDDLE ASSESSMENT & PLANNING TOOL



Washington State Hospital Association

Date: _____

NOTE: This template is meant as a starting point, and should be tailored for each organization's particular needs and priorities.

Aspect of Safety Huddles	Ideal State (Example shown)	Current State (Example shown)	Plan for Reaching Ideal State (Example shown)
Leadership engagement	Full executive, management, and board support and participation.	Partial executive engagement, no board engagement.	Orientation to safety huddle process and goals, schedule attendance for all executives and board members as appropriate.
Departments implementing	All departments.	Pilot department or departments chosen.	Have champions from departments currently doing safety huddles coach leadership from departments to newly start doing safety huddles.
Frequency	Daily leadership huddles; twice daily shift huddles.	Biweekly leadership huddles; daily shift huddles.	Arrange scheduling and communicate new frequency expectations.
Length	5-15 minutes.	Inconsistent, sometimes up to 30 minutes.	Stick with standard agenda, identify plan for follow up conversations, as needed.
Attendance	Consistent attendance by all relevant staff.	Inconsistent, partial attendance.	Communicate attendance expectations, arrange schedules, document attendance, determine reasons for any gaps in attendance.
Active participation	All participants freely contribute observations, suggestions, and concerns.	Partial participation; some participants never speak during huddles.	Survey of staff to determine perceptions of culture of huddles.
Common understanding of goals	Goal to improve safety for staff and patients is understood by all.	Partial understanding; some may believe goal is to share instructions.	Survey of staff to determine perceptions of culture of huddles.
Perceptions of culture of huddles	Common perception that huddles are non-punitive, productive, collaborative.	Some may believe huddles can be punitive.	Survey of staff to determine perceptions of culture of huddles.

Appendix E: Safety Huddle Assessment and Planning Tool, adapted from Legacy Health

Aspect of Safety Huddles	Ideal State (Example shown)	Current State (Example shown)	Plan for Reaching Ideal State (Example shown)
Standard scheduling	Huddles happen at routine times and schedules are arranged to facilitate participation.	Huddles happen at inconsistent times, and sometimes conflict with other meetings.	Work with administrators to designate standard huddle times and ensure no conflicting meetings are scheduled.
Standard content	Agenda focuses on performance and improvement work.	Agenda usually focuses on staff shortage and supplies.	Develop standard agenda.
Standard process for follow up	Action items from huddles are documented and status tracked and shared.	No way to track what has been brought up for action items during huddles, or what current status is.	Develop action item documentation and tracking system accessible by all relevant staff.
Use of data	Up-to-date safety data is routinely shared during huddles and used to inform improvement plans.	Safety data is occasionally shared during huddles. Data is sometimes out-dated.	Develop a process for getting up-to-date data prepared and delivered before scheduled huddles.
Use of standard tools and visual aids	Agenda, current data, and status of action items posted for all to see near huddle area.	No standard use of tools or visual aids.	Draft templates and establish "learning board" in huddle area. Use red, yellow, and green color code to indicate status of action items.
Communication of follow-up	Follow-up steps planned and taken after safety huddles are readily reviewable by all participants.	No structured process for communicating follow-up steps planned and taken back to participants.	Establish centrally-accessible listing showing follow-up planned and completed for issues identified in safety huddles.
Evaluation process	Safety huddle process and outcome measures, including changes in safety culture, are monitored and used to inform improvement efforts.	Inconsistent monitoring of safety huddle implementation and impact.	Designate safety huddle evaluation team; report on process and outcomes measures monthly until ideal state is achieved. Then report quarterly.

(This tool was adapted from Legacy Health's Safety Huddle Current Condition Assessment, 2014)