Conducting Effective Safety Huddles

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Objectives

• Understand the purpose of the daily safety huddle
• Understand the relationship of the safety huddle to the Culture of Safety and High Reliability
• Understand the fundamentals of an effective safety huddle & potential issues to report
High Reliability

• Naval aviation, nuclear power

• Five key characteristics:
  – Preoccupation w/failure
    • Focus on errors/near misses for learning, attention to detail, finding & fixing problems
  – Reluctance to simplify operations
    • Constant “Why?”, invite opinions from others w/diverse experience
  – Sensitive to operations
    • Ongoing concern w/the unexpected – situational awareness, developing teams w/power to speak up, closing loopholes for patient harm, paying attention to front line
  – Commitment to resilience
    • Mistakes happen – but identify them quickly & respond/minimize harm
  – Deference to expertise
    • Front line as experts – empower them w/decision-making

Weike & Sutcliffe, “Managing the Unexpected”
High Reliability

• Safety Huddles are a tool for High Reliability organizations
  – Originated in the nuclear power industry – “safety critical”
Conditions that Create Culture

Top Management’s:
- Beliefs
- Values
- Actions

Perceived Values & Philosophy
- Consistency
- Intensity
- Consensus

Employee’s Beliefs, Attitudes & Behaviors
Expressed as Norms

Communications
- Consistent
- Credible
- Salient

Rewards
- Money
- Promotion
- Approval
- Inclusion
- Empowerment
Daily Safety Huddles

• What is a Daily Safety Huddle?
  – A brief meeting (e.g., “huddle”) of hospital leaders & key team members at the beginning of the day or shift
  – Usually conducted daily M-F at same time each day
  – Builds teamwork through communication & cooperative problem solving
  – Ensures common understanding of focus & priorities for the day
– Increase and maintain situational awareness
  • Improves overall leadership awareness of the status of front-line operations
  • Provides timely recognition and resolution of problems that impact outcomes
  • Provides for alignment & focus of the leadership team around safety and key operational issues
Daily Safety Huddles

• An effective daily safety huddle:
  – Communicates the urgency of resolving safety issues and critical situations
  – Allows the team to plan for the unexpected
  – Allows team members’ needs and expectations to be met
  – Uses concise & relevant information to promote effective communication across departments
Daily Safety Huddles

• Process
  – Schedule at the start of the day – establish a standing time
    • Schedule the time on your calendar and hold to it!
  – Include individuals who know the status of operations in their areas of responsibility
  – Keep it short! 15 minutes at most (“stand-up meeting”)
  – Keep notes on identified issues – assign owner for each - review them daily until loop is closed
  – Don’t get into the weeds!
  – Keep it focused – follow routine, 3-point agenda
Daily Safety Huddles

• Agenda
  – LOOK BACK:
    • Significant safety or quality issues from last 24 hours/last shift
  – LOOK AHEAD:
    • Anticipated safety or quality issues in next 24 hours/next shift
  – FOLLOW UP:
    • On Start-the-Clock Safety Critical Issues
Daily Safety Huddles

• Huddle Leaders are key to the process!
  – Must understand why the process is important
  – Model “Culture of Safety” behavior
  – Set the expectations for attendance, follow-up on issues
  – Facilitate the process – “just the facts”, operational vs. safety issues, assign problem solvers
  – Drive the process to close the loop & hold assigned problem-solvers accountable
Daily Safety Huddles

- Responsibilities for Huddle leaders:
  - Encourage high-reliability thinking
    - How do you know you had no problems?
    - What immediate action did you take?
    - Is this happening in other places? Could it?
    - What other areas does this impact?
    - How are you preparing your team to deal with this issue?
    - What error prevention technique should be used?
  - If any deficiencies noted that impact safe care:
    - Communicate the urgency…“That’s a Safety Critical Issue that requires rapid response…”
    - Keep a record, identify the problem owner & experts, start the clock on the issue & close the loop at the next Huddle
  - Assign a “problem owner”
Daily Safety Huddles

• Prepare to participate – questions to consider:
  – Do we have any high-risk patients or procedures?
  – Do we anticipate any non-routine procedures or tasks?
  – Are we dealing with any situations or conditions that distract our ability to focus or think critically about our patients?
  – Are there any safety issues that I know about that may impact other departments?
  – Do we have what we need to deliver safe, quality care – any deficiencies in information, equipment, supplies or staff that will create obstacles?
  – What conditions outside our unit or outside our hospital could impact our ability to deliver safe, quality care today?
Issues for Reporting

• Nursing Units:
  – Events in the past 24 hours
  – Events of impact in the next 24 hours & plans in place
  • Consider “Situational Awareness List” for reporting – example:
    • Patient w/BMI >40
    • Staff uncomfortable w/pt. condition
    • Unresolved difficulties w/any member of care team
    • Patient/family concerns regarding care issues
    • Patients of focus w/unmet needs – falls, elopement, suicide, new onset confusion/AMS, isolation, etc.
    • Patients w/same or very similar last name
    • Equipment issues adversely impacting patient care
    • Medication shortages impacting unit
    • Unmet critical staffing needs
    • Potential for threatening behavior (staff, pts., visitors)
    • Codes & outcomes
    • Intubation/pressors within 2\textsuperscript{nd} hour post-transfer to ICU
    • Transfer to ICU w/in 4 hrs. of unit arrival
    • Unanticipated deaths
    • Any additional risks to patient safety on your unit
Issues for Reporting

• Non-Nursing Units
  – Events in the past 24 hours:
    • Equipment (shortage, failure, missing, out of service)
    • Supplies (shortage, recall, alternatives)
    • Environmental (situations or conditions)
    • Emergency codes (what was the outcome?)
    • Risk Reports/Serious Safety Events (issues & harm)
    • Guarded patients (incarcerated, psych)
  – Events of impact in the next 24 hours & plans in place:
    • Critical staffing (critical levels impacting pt. care only)
    • Supplies
    • Environmental or equipment concerns impacting patient care

Source: Valley Health Winchester Medical Center – Daily Safety Call Report
Issues for Reporting

• Anything new!
  – Surgical procedures, policies, physicians, equipment, medications, new unit or service

• High-acuity patients
  – Moving between departments – Med/Surg to OR to ICU
  – High-risk OB
  – Patients w/hospital acquired conditions/infections

• Medication shortages/action plans

• Issues that could lead to errors
  – Changing meds in Pyxis – is staff familiar w/change?
  – Patients with special needs
  – Peaks in census/acuity
  – Staffing issues
  – Changes to computer system
  – New physicians – orders that are new/unfamiliar
  – Disruptive behavior from physicians or staff that impedes communication
Issues for Reporting

- Patient safety events/potential safety events
  - Unanticipated deaths
  - Falls
  - Medication errors
  - Adverse drug reactions
  - VAP, CAUTI, CLABSI, C-diff
  - Use of foley w/o appropriate indication
  - Skin breakdown
  - Unexpected injuries – burns, malfunctioning equipment
  - Isolation patients not immediately identified & placed on isolation
  - Patients w/behavioral care/addiction concerns or issues – e.g., violence, elopement, detox, etc.
Issues for Reporting

• Information Technology
  – Computer or communication outages – planned/unplanned
  – Anticipated IT downtimes & impact on operations
  – Change in IT process or policy
  – IT impact on any facility or environmental issue
  – New software implementations
  – Significant hardware deployments
  – Employee safety issues/accidents
  – Resource and staffing concerns
Issues for Reporting

• Facility/environmental issues
  – Renovations to high-acuity areas – OR, OB, ICU, etc.
  – Critical equipment breakdowns that impact OR, ICU
  – Equipment repairs that impact patient care
  – Leaks
  – HVAC issues
  – Electrical outages
  – Snow, ice, fire
  – Patient rooms out of service
  – Areas of hospital having floors refinished
  – Utility issues
  – Fire system testing, Interim Life Safety measures
  – Medical gas or vacuum outages
Issues for Reporting

- Employee safety issues/accidents
  - Slips/Trips/Falls
  - Patient handling injuries
  - Exposures to infectious disease – flu, TB, etc.
  - Combative patients/assaults
  - Burns, cuts, chemical exposures

- Changes in computer process or level of function
  - New screens, triggers, etc.
  - Downtime
  - Orders not crossing over appropriately
  - Reports not crossing over into EMR when dictated
Issues for Reporting

• Issues that cause staff/physicians to develop workarounds
  – Equipment/supply availability
  – Unusually high volumes
  – Bed availability issues
  – Poor process design
  – Poor workflow
  – Computer access/speed
  – Complexity too high/inadequate orientation & training
  – Frequent equipment breakdowns
Issues for Reporting

• Changes to communication capabilities
  – Vocera, telephone system changes, handoff communication processes

• Medical equipment maintenance, failures, or concern
  – CT, MRI, nuclear cameras, cardiac monitoring systems, OR lights, IV pumps, etc.
  – Equipment/supply recalls

• Level of business/criticality/staffing
  – Census, acuity levels, appropriate numbers and mix of caregivers
Consider These

• Reporting “days since last serious safety event”
  – Puts the spotlight on safety & high reliability
  – Makes the daily goal of creating a safe day explicit
  – Gets everyone engaged in maintaining safety

• Share a “safety success story”
  – Good catches, something that made a difference to safety
Daily Safety Huddles
• Consider use of a documentation tool

Daily Leadership & Safety Huddles

Providence Healthcare Network

DATE: 

Daily Leadership & Safety Huddles

Introduction of Guest: 
Number of days since last SSE - 

Past 24 Hours: (Has there been any significant safety/quality issue from the last 24 hours?)


Next 24 Hours: (Anticipated safety or quality issues in the next 24 hours)

• High-Risk, non-routine procedures, risk situations/conditions
• Deficiencies in equipment, supplies, or staffing that will make it hard to deliver safe, high-quality care

Op. Beds: 

Discharges: 

Other: 

Great Catch: (Safety success story about practices or safe behaviors in last 24 hours)


Service Recovery: (Is there anyone in the organization that would not give us a 9 or 10 on our patient satisfaction survey? 7 or 8?)

SAFE - T

SAFETY AWARENESS FOR EVERYONE TODAY
Issue-Specific Huddle Form - Falls

Clinic/Outpatient Huddle Form
Other Safety Huddles

• **Immediate huddle**
  – When a serious safety event has occurred
  – Multidisciplinary group meets to assess *why* events occur and *prevent* them from happening again
  – Work to address system/process issues that may have led to event

• **Concerning Trend huddle**
  – Trends/patterns of events that could cause harm

• **Proactive Huddle**
  – Based on literature, media reports, etc.
  – Ensure that same event does not occur at *your* facility!
  – Review current process, assess for gaps, fix issues found
Examples of When Huddles Can Be Effective

- “Never Events”
- Sentinel Events
- Any injury to patients or family
- Medication issues
- Wrong procedure done or ordered
- Unable to resolve escalating patient/family concerns
- Trends in safety
- Patients at risk for falls
- Patients at risk for skin breakdown per Braden Scale score
- Patients w/pressure ulcers
- Patients on restraints
- Total care patients (heavy patients)
- Possible discharges
- Patients who must be accompanied to leave unit for tests
• Gunderson Lutheran – Lacrosse, WI
  – Issue: 15-year-old first-time mom received epidural medication via IV at another hospital
  – Led to seizure & subsequent death
  – Prompted review at Gunderson – “it could happen here”
  – Issue raised at Safety Huddle – team formed to review
  – Made changes to med delivery system
Medication label changed to have 5 “rights” bolded: Right patient, Right medication, Right dose, Right route, and Right time

Pharmacy added red lock stopper to all narcotics and anesthetics. Red lock is snapped over IV access port of all narcotics (including epidurals, narcotic drips & PCAs) prior to dispensing. Provides additional distinction between narcotics/anesthetics and other infusions.

Pharmacy places a yellow “For Epidural Use” sticker over the second port (changed to blue). Anesthesia has to tear off the yellow sticker/prior to connecting. Color helps distinguish different route of tubing.

Other Success Stories

• Addressed issues related to falls:
  – New guidelines developed to assure high-risk patients not left alone in bathroom
  – Creation of trigger tool for staff to use when looking at why falls occurred or how to prevent them before they happen
• New process to notify inpatient units immediately of new case of MDRO to ensure proper precautions put in place
• Phone added in hospital lobby to assure quick access for emergencies
• Algorithm created for proper equipment use for patients w/high risk for pressure ulcers
• AEDs added to freestanding clinics
• New form & communication system for direct admissions to assure complete information handoff to inpatient nurse

Daily Safety Huddles

• Key points for success:
  – Leadership
    • Led by Senior Leadership – CEO, CNO, etc.
  – Consistency
    • Same time, every day
  – Accountability
    • Attendance is mandatory for leadership
    • Consider call-in line or a substitute if cannot attend
    • Assign problem solvers for identified issues
  – Close the loop
    • Follow up on identified issues until they are resolved
    • Keep focus on safety-critical issues
Future State – Post Implementation

- Senior Leadership awareness of what’s happening at the front line
- Increased awareness of other departments’ activities & issues
- Quick issue resolution – often same day
- Reduced “silo operations” – more teamwork
- Significant learning opportunities for participants – “walk in my shoes”, “understand my issues”
- Increased departmental leadership situational awareness of their department/staff issues
- Safety becomes a priority – culture change achieved
- Increased staff & manager satisfaction
- Planning/focus vs. chaos – i.e., “chasing the rabbit”
Best Practice

• Baptist Health Care Safety Huddle Video

• http://vimeo.com/22710345
Questions

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