

Implementing Team Safety Huddles

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Background

- 2-3-C is a locked, acute psychiatric unit with 20 male beds and 8 female beds
- Patients have a variety of mental health diagnoses such as depression, schizophrenia, bipolar disorder and substance abuse disorders
- The staff utilizes a team nursing format
- Report given at the start/end of each 8 hr shift

Who are we?

- NM, NPs, RNs, LPNs, NA
- Psychologists, Psychiatrists
- Social Workers
- PT/OT/KT
- Housekeeping Staff



Purpose

- We found a need for improved communication amongst staff between morning and afternoon report
- Complex care of up to 28 patients is coordinated by nursing staff
- Each staff member has unique interactions with patients
- Observations/interactions need to be shared with entire staff so that pertinent information can be passed on to tx team and next shift

Goals of Study

- To initiate daily Team Safety huddles to improve:
 - Staff communication
 - Staff accountability
 - Foster a sense of empowerment
 - Create a sense of community
 - And improve efficiency and quality of information sharing

Literature Review

“Healthcare huddles: Managing complexity to achieve high reliability” (Provost et al 2014)

- “We should spend less time making decisions and more time creating meaning through dialogue, interpretation, observation, reflection on experiences, and construction of explanations.” (Provost et al 2014)
- Huddles shown to have teamwork and operational benefits
- Framework used emphasizes conversation, interpersonal relationships, and culture

Literature Review

“Huddle up for patient safety” Lubinensky 2015

- Recognized that workflow of nursing care quickly changes from orderly to chaotic
- In one acute care setting, nurses were often unaware when coworkers were overwhelmed and in need of assistance
- Huddles heightened awareness of staff and patient needs throughout shift
- Huddles already used post fall/code
 - Implement “proactive” huddles to prevent patient safety issues and staff concerns
- Recommend using a concise template

Literature Review

“Huddling for high reliability and situation awareness”

Goldenhar et al 2013

- Lack of situation awareness (SA) can lead to serious consequences in patient care
- SA is especially important when “information flow is high, continuous, and complex”
- Implementing huddles improves SA while improving a variety of outcomes and reducing patient harm
- Proposed a model based on successful findings
- Format: “Look Back,” “Look Forward,” “Integrate”

In-Service

TEAM SHIFT HUDDLES

WHO participates in a team shift huddle?

All available staff including: Nurse Manager, RNs, LPNs, NAs, SW, Ward Clerk

WHAT is a team shift huddle?

Team shift huddles are short, mid-day briefings used to create a structured, yet open dialogue to enhance staff communication and patient safety. The goal of a team shift huddles is to offer an opportunity for team members to coordinate care, delegate tasks, and troubleshoot issues that have arisen throughout the shift. The use of huddles has been shown to enhance work relationships and provide staff autonomy and accountability.

WHERE do we meet?

Nurse's station

WHEN do we meet?

We suggest between 1 and 2PM, however it is up to charge nurses discretion

WHY is it important?

Communication is a fundamental component of safe patient care. Huddles allow staff to share information among interdisciplinary team members. This makes it possible to clarify unclear information obtained in morning report, manage crisis before they happen, and solve staffing issues. Huddles structure communication between team members.

HOW do we conduct a huddle?

The charge nurse can use Vocera's broadcasting feature to announce the start of a shift huddle. Once staff has assembled, team members can offer reports on events that have occurred prior to the huddle, identify patients at risk for adverse events, upcoming discharges, any concerns regarding their duties, changes in patient condition, etc. At this time, the team can work together to find solutions to problems and the charge nurse can redistribute/delegate tasks. Aim for brief huddles -10 minutes at most- to increase attendance among team members.

Structure:

"Look Back" – What changes have occurred since morning report? (change in pt condition, worsening/improvement in symptoms, events)

"Look Forward" What to expect for the rest of the shift (upcoming discharges, to-do list items to be completed, anticipate potential adverse events)

"Integrate" Encourage staff collaboration (delegate tasks, troubleshoot problems, consider staffing issues)

(Goldhar et al, 2013)

Methods

- We conducted a total of 10 huddles between April and May, distributing surveys each time
- Encouraged charge nurse to lead huddles
- Welcomed all staff to attend via Vocera “broadcast” feature
- Loosely followed format outlined during in-service
- Documented results

Survey

TEAM SAFETY HUDDLE

Date: _____

Position (Please check appropriate box):

 RN

 LPN

 NA

For each statement below, please check the box to the right that best supports your opinion.	Check
Safety Huddles improved staff communication on the unit.	
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	
Safety Huddles improved staff accountability.	
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	
Safety Huddles fostered a sense of empowerment on the unit.	
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	
Safety Huddles created an improved sense of community on the unit.	
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	
Safety Huddles improved efficiency and quality of information sharing.	
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	

Methods

- Quantitative results of our study were collected using a survey we created
- Given to all Team Safety Huddle participants
- Total of 5 questions with answers ranging from strongly agree to strongly disagree
- Simple check boxes used to allow for quick completion to increase number of responses

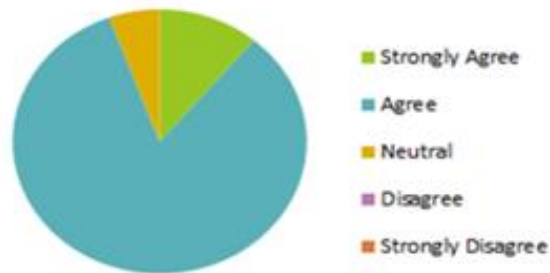
Results

Implementing Shift Huddles

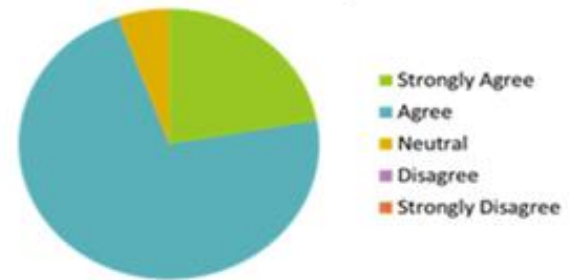
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Totals
Safety Huddles improved staff communication on the unit	3	15	0	0	0	18
Safety Huddles improved staff accountability	3	13	1	0	0	18
Safety huddles fostered a sense of empowerment on the unit	3	7	8	0	0	18
Safety huddles created an improved sense of community on the unit	2	14	2	0	0	18
Safety huddles improved efficiency and quality of information sharing	2	15	1	0	0	18

Results

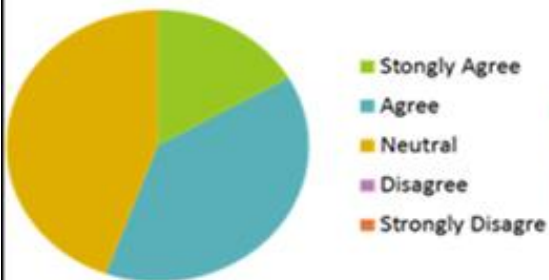
Safety huddles improved staff communication on the unit



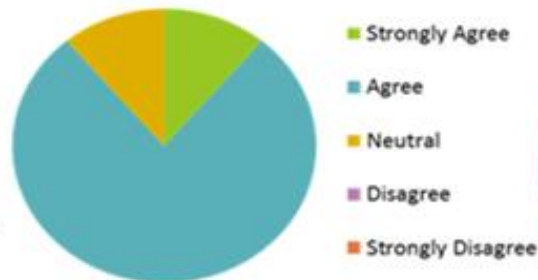
Safety huddles improve staff accountability



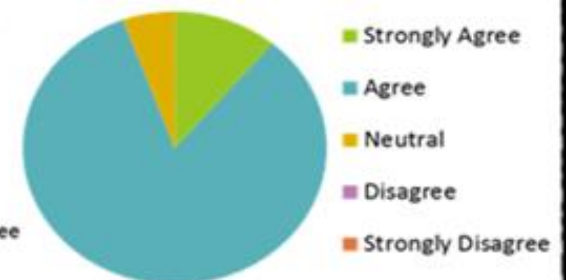
Safety Huddles fostered a sense of empowerment on the unit



Safety huddles created an improved sense of community on the unit



Safety huddles improved efficiency and quality of information sharing.



Survey Monkey

To 2-3-C Staff:

We appreciate all of your support and cooperation with our project.

It has helped us greatly & please feel free to share any comments that you may have.

Thank you very much!!!- Kelly Coughlan & Kathy Nguyen

1. Did you find the safety huddles helpful?

- Yes
 No

Please share recommendations or changes that should be made.

2. What was the biggest barrier to not completing the safety huddle?

3. What benefits did you find from having safety huddles?

4. Please provide us with any suggestions or thoughts on this project.

Done

Feedback from 2-3-C staff

“When the acuity of the unit is high it is very hard for everyone especially the nursing assistants to get together for the huddle”

“Keep it short, Charge Nurse directed, keep it in order and in a private area away from disruptions.”

“Incorporate off tours to follow the same instructions so safety huddles are held on all shifts.”

“Biggest barrier to the huddles was the constant disruptions”

“The acuity of the unit can determine the ability to be able to complete a safety huddle. Finding an appropriate time to conduct a safety huddle so that all staff would be present deemed to be a challenge.”

Feedback from 2-3-C Staff

“It was a great to have an opportunity to have all staff brought up to date on the acuity of the unit and the happenings for each individual patient.”

“Created positive team work and strengthened collaborations with more efficient care, less mistakes related to communication.”

“Its an opportunity to validate or consider altering treatment plans based on the information given from the nursing staff that day.”

“It made the NAs more alert about patients and what to look for during the rounding checks. It made the RNs more aware of patient behaviors, interactions, and wellbeing.”

“Loved it”

“Nursing staff reports are most accurate observation for any patient because of the interaction the job entails with patients.”

Observations

- Created a healthy time and space for staff to communicate and create an open dialogue
- Improved comradery among staff
 - Staff enjoyed huddling and reconnecting
- Nursing staff gained situational awareness when information was shared with entire available staff
- Finding time is challenging, but huddles have proven to be valuable and beneficial for staff and patient care

Barriers and Limitations

- Staff availability
- Lack of routine- Scheduling issues
- Time constraints
 - Potentially inaccurate responses to survey
- Heavy workload
- Missed opportunities for huddles
- Lack of responses/Collection

Recommendations

- Earlier time to incorporate the huddles
- “Repetition and consistency of the huddle become part of the fabric of the organization” (Provost et al 2014)
- Encourage input from nursing assistants
- Incorporate into all shifts
- Encourage impromptu huddles (Lubinensky et al, 2015)

Conclusion

- Safety huddles were overall beneficial to the staff and patients of 2-3-C.
- Met our goal of improving communication on the unit, created a sense of community and enforced staff accountability.
- Must be part of the charge nurse role to secure continuation of huddles
- If more strongly enforced and continued routinely the unit would continue to benefit.

References

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- Lubinensky, M., Kratzer, R., & Bergstol, J. (2015, February 1). Huddle up for patient safety. Retrieved March 20, 2015.
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