Two-Minute Safety Huddles

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Manager, Quality, Safety, and Performance Improvement

Objectives

After this session, attendees will be able to:

• State two reasons huddles have become an integral part of the clinician’s work day
• Describe a typical huddle in terms of agenda, attendance, and duration
• Establish a plan for initiating huddles
Agenda

Why Focus?

Mechanics

Implementation
Mistakes Happen

Lack of situational awareness

Prioritizing results over process

Poor planning

More People in the System Yield Greater Opportunity for Error

AND THAT IS WHY WE LIFT ON THREE...

COMMUNICATION

Proprietary & Confidential
Human Factors, Leadership, and Communication Issues Are Common and Repeated Findings in Sentinel Events

Voluntary Reporting of Sentinel Events to The Joint Commission

<table>
<thead>
<tr>
<th>2013 (N=887)</th>
<th>2014 (N=764)</th>
<th>2Q 2015 (N=474)</th>
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</thead>
<tbody>
<tr>
<td><strong>Human Factors</strong></td>
<td>635</td>
<td>Human Factors</td>
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<tr>
<td><strong>Communication</strong></td>
<td>563</td>
<td>Leadership</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>547</td>
<td>Communication</td>
</tr>
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<td><strong>Assessment</strong></td>
<td>505</td>
<td>Assessment</td>
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<tr>
<td><strong>Information Management</strong></td>
<td>155</td>
<td>Physical Environment</td>
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<td><strong>Physical Environment</strong></td>
<td>138</td>
<td>Information Management</td>
</tr>
<tr>
<td><strong>Care Planning</strong></td>
<td>103</td>
<td>Care Planning</td>
</tr>
<tr>
<td><strong>Continuum of Care</strong></td>
<td>97</td>
<td>Health Information Technology-related</td>
</tr>
<tr>
<td><strong>Medication Use</strong></td>
<td>77</td>
<td>Operative Care</td>
</tr>
<tr>
<td><strong>Operative Care</strong></td>
<td>76</td>
<td>Continuum of Care</td>
</tr>
</tbody>
</table>


Strategic Plan
Board Scorecard

When measures of safety and staff development are reflected in Strategic Plans and High Level Scorecards...

Purpose

....safety behaviors are perceived by staff to be a priority, and we design our systems for these outcomes

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Our Patient Care Approach Is Shaped by Many Sources

A Strong Safety Culture Is an Essential Component of a Successful Patient Safety System

Safety Culture:
Unrelenting commitment to safety & to do no harm

Encompasses individual & group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior
**We Need to Create Safer Systems Through a Focus on Human Factors**

Human factors studies the interrelationships between humans, the tools they use, and the environment in which they work.

TJC definition of Human factors includes:
- staffing levels, skill mix, supervision
- staff orientation/ in-service education
- medical staff privileging and peer review
- rushing, fatigue, distraction, complacency bias

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**Most Frequent Errors Are Human; Minimize Errors with Structured Process and Daily Focus**

### Human Error

**Inadvertent Action:** *slip, lapse, mistake*

Manage through changes in:
- Processes
- Procedures
- Training
- Design
- Environment

### At-Risk Behavior

**A Choice:** *Risk not recognized or believed justified*

Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

### Reckless Behavior

**Conscious disregard of unreasonable risk**

Manage through:
- Remedial action
- Punitive action
We Need to Create Safer Systems Through a Focus on Communication

Communication breakdown is a leading source of process failure and inadvertent patient harm.

- “The complexity of medical care, coupled with the inherent limitations of human performance, make it critically important that clinicians have standardized communication tools, create an environment in which individuals can speak up and express concerns, and share common “critical language” to alert team members to unsafe situations.”
- “All too frequently, effective communication is situation or personality dependent.”


Generally, People Want to Provide Good Care

“Incompetent people are 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it's the processes that set them up to make these mistakes.”

- Dr. Lucian Leape, Harvard School of Public Health
### Increase Reliability of Processes with Standardization Throughout Care Settings

- **Standard tools**
  - Checklists
    - Crash cart
    - Preoperative
  - Care bundles
    - Perinatal
    - Ventilator
  - Order sets
    - Insulin protocols
    - CHF
  - Risk assessments and standardized interventions
    - Post-discharge needs
    - Fall precautions
  - Alerts and visual cues

- **Daily behaviors, assignments & communication methods**
  - Assigned roles and responsibilities
    - **Shift Huddles**
  - SBAR
  - Time-out
  - Read-back

- **Equipment & supply standardization**

- **Create Learning Systems**
  - Root Cause Analysis & discussion of near misses
  - Trending
  - Communicating
  - Action planning/PDSA
  - Feedback

### A Safety Huddle Is...

...a very brief, structured team check-in at the start of the shift, to improve situational awareness, plan for high acuity patients, level load work assignments and proactively address risk, so that the workday has less chaos, error and rework for staff, and improved safety for patients
### Benefits of Safety Huddles at Shift Change

<table>
<thead>
<tr>
<th>Develop situational awareness</th>
<th>Proactive management of risks</th>
<th>Facilities cross coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level load work assignments</td>
<td>Improved communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RN: PCA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RN:RN:Mgr</td>
<td></td>
</tr>
<tr>
<td>Creates a learning system</td>
<td>• See something, say something</td>
<td></td>
</tr>
</tbody>
</table>

- Facilities cross coverage
  - Decreases harm to patient

![Learning organizations deliver safe, reliable care](image)

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**Keep Calm AND DO NO HARM**

KeepCalmAndPosters.com
Agenda

Why Focus?

Mechanics

Implementation

The Two-Minute Safety Huddle (Every Shift!)

0600 0630 0658 0700 0730

Rounds by nurses, doctors, patient care assistants

Safety Huddle

Provide care

Always have a nurse and/or patient care assistant on the floor, with patients
The Two-Minute Safety Huddle (Every Shift!)

0600

0630

0658

0700

0730

Provider/ RN Bedside Rounds

RN/ RN Bedside Report

Patient Care Assistant Rounds

Outgoing shift

2 Minute Safety Huddle

• Staff identify high risk patients/ new equipment/ medication/ infection issues

• Staff share strategies to mitigate risk

• Assignments/ level loading

• Shift planning & Q&A

Oncoming shift

Nurse Leader

Unit Secretary

• Nursing Care

• Purposeful Rounding

• Interdisciplinary Care Rounds

• Nurse Leader Rounding

Always have a nurse and/ or patient care assistant on the floor, with patients

Huddle Content: Three Example Lists of Safety Risk Indicators

• Unit staff, including nurses, providers, nursing assistants, ancillary staff and unit clerk should all be invited to create list of criteria

• Some units use their SBAR handoff form to identify at risk patients

• Choose the most simple list that creates situational awareness for your unit

- Patient who is medically unstable
- First 24 hours post-op
- Patient who is unable to use the call bell/light AND agitated/ weak/ unsteady/ incontinent

Change of Shift Handoff Report Template

Hospital

Change of shift Handoff Report

Background

- Patient who is medically unstable
- First 24 hours post-op
- Patient who is unable to use the call bell/light AND agitated/ weak/ unsteady/ incontinent

Assessment

- Patient who is medically unstable
- First 24 hours post-op
- Patient who is unable to use the call bell/light AND any of the following: agitated weak/ unsteady/ incontinent confused
- Patient with a history of falls (within the last month)
- Patient from a service line that is not commonly found on your unit
- Any patient you are very very concerned about (medically/ behaviorally)
Huddle Content: Focused for Nurse Action

1. Is there a patient who requires my immediate attention? Name:___________ Room/Bed: _______

2. Do you believe patients will be transferred out of the unit today? Name:___________ Room/Bed: _______

3. Who has discharge orders written? Name:___________ Room/Bed: _______

4. How many admissions are planned today?

5. What time is the first admission?

6. How many open beds do we have?

7. Are there any patients having problems on the unit?

Specific Things To Consider

<table>
<thead>
<tr>
<th>Problem Identified</th>
<th>Person Assigned To Follow Up</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient scheduling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment availability or problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside patient testing or transportation needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician or nurse staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider skill mix</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Huddle Content: More Time, More Coverage

![Huddle Content Image]

End-of-Shift Huddle Content: Focused on “Catches”

<table>
<thead>
<tr>
<th>QUESTIONS ASKED PM SESSION WITH MORNING SAFETY HUDDLE</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of meeting in Minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ How many people encountered a safety issue related to device-use today?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ How many people had an “almost” or “near miss” with a device today?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ For the “almost” or “near miss” people — how many were caught because of the safety huddle and the focus on safety?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ How many people had patients who asked questions about safety of devices today?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ For those who asked questions, how many were “almost an error” which the patient’s question or comment prevented?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*In this model, there is a start-of-shift-huddle followed by this end-of-shift-huddle Q&A.

Huddle Tools: Staff May Use Maps to Identify High Risk Patients

<table>
<thead>
<tr>
<th>Telemetry</th>
<th>2AM</th>
<th>4AM</th>
<th>6AM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Huddle: High Fall Risk Restraints 1:1 Critical/Unstable</td>
<td>344 W</td>
<td>344 D</td>
<td>344 N</td>
</tr>
<tr>
<td>Shift Change: Off-going RNs &amp; All On-coming staff</td>
<td>342 D</td>
<td>342 W</td>
<td>340 N</td>
</tr>
<tr>
<td>Mid-Shift: All Staff</td>
<td>338 D</td>
<td>338 W</td>
<td>338 W</td>
</tr>
<tr>
<td>30700</td>
<td>1100</td>
<td>1500</td>
<td>1900</td>
</tr>
<tr>
<td>2300</td>
<td>Post-Fall</td>
<td>332 D</td>
<td>332 W</td>
</tr>
</tbody>
</table>

Figure: St. Anne’s daily huddle card

Safety Huddles Require Two to Three PDSA Cycles to Meet Needs of the People (Staff/ Patients)

- There is no “silver bullet” list of huddle discussion items
- Set the indicators and the structure with input from your staff
- Start with a shorter, simpler list
- Expect to adjust criteria with new constraints and as staff learn to use the process
Results from Lehigh Valley Hospital


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Results from Iowa Health


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**Agenda**

**Why Focus?**
- Identify the Executive Sponsor
- Identify the need for change
- Initiate communication – *Engage staff with safety stories*
- Identify the process leaders and the backup process leader
- Pilot, measure and observe – *As much as possible during weeks 1 & 2*
- Document the core process that all staff will use
- Executive sponsor “walk the Gemba” every week
- Measure outcomes over time

**Mechanics**

**Implementation**
The Department Huddle – Timing

• Select huddle timing and duration
  ▪ Time of huddle is usually at the beginning of the shift but can be customized to best support the work of the department
  ▪ Huddle starts on time, at a dedicated time, every shift
  ▪ Identify the method or people who will inform the oncoming shift about the experience of the outgoing shift
  ▪ Lasts < 5 minutes

The Department Huddle – Implementation Timeline

- Week 1: Prepare huddle content and pilot by end of week
- Week 2: Continue to gather feedback from the team. Measure process & adjust to make the messages timely and effective
- Week 3: Roll out process to one or more “off shifts”. Evaluate process measures & gather feedback.
- Week 4: Continue to gather feedback from the team & adjust
## Avoid Pitfalls

<table>
<thead>
<tr>
<th>Traditional Huddles</th>
<th>Best Huddles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager designs agenda</td>
<td>• Team designs agenda</td>
</tr>
<tr>
<td>Manager talks for the full huddle</td>
<td>• Staff brief the group on current patient issues/ operations</td>
</tr>
<tr>
<td></td>
<td>• Manager coaches PI moment</td>
</tr>
<tr>
<td></td>
<td>• Manager facilitates and troubleshoots at the end of the huddle</td>
</tr>
<tr>
<td>Topics aren’t meaningful or engaging to everyone</td>
<td>• High attendance because the huddle engages staff with meaningful information</td>
</tr>
<tr>
<td></td>
<td>• Often includes a good safety catch story or “win” with a patient</td>
</tr>
<tr>
<td>Huddle get too long (&gt;5 min)</td>
<td>• Post any announcements that are not critical to daily operations, making sure staff know where to find them</td>
</tr>
<tr>
<td></td>
<td>• Do not use huddles as a staff education session – save this for staff meetings</td>
</tr>
<tr>
<td>Manager doesn’t sustain because it’s not an instant success</td>
<td>• Keep initial huddles brief and useful</td>
</tr>
<tr>
<td></td>
<td>• Keep the huddle going even if few can attend</td>
</tr>
<tr>
<td></td>
<td>• Scope the data topics or PI moments small in scope</td>
</tr>
<tr>
<td></td>
<td>• Seed a good story from a staff member the day prior</td>
</tr>
<tr>
<td></td>
<td>• Expect multiple PDSA cycles</td>
</tr>
</tbody>
</table>

## Something vs. Nothing

Can you have a shift huddle in a department that has staggered shifts?
Generate Patient-Centered Improvement From the Safety Huddle

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Outgoing Nurse Assistants</th>
<th>Incoming Nurse Assistants</th>
<th>Outgoing Nurses at End of Shift</th>
<th>Incoming Nurses at Beginning of Shift</th>
<th>Nurse Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0600 - 0655</td>
<td>Comfort Rounds</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0630 - 0655</td>
<td>Report at the Bedside</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>0655 - 0657</td>
<td>Safety Huddle</td>
<td>X</td>
<td>X</td>
<td>(At least one assistant is on the unit attending to call lights/patient needs)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0658 - 0700</td>
<td>PI Moment of Focus</td>
<td>X</td>
<td>X</td>
<td>(At least one assistant is on the unit attending to call lights/patient needs)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Always have a nurse and/or patient care assistant on the floor, with patients

Embed the Safety Huddle within the Shift Huddle

- **2 Minute Safety Huddle**
  - High risk patients/new equipment/medication/infection issues
  - Strategies to mitigate risk
  - Q&A
  - Assignments
  - Shift planning/level loading
  - Q&A

- **Moment of Focus (2 min)**
  - Discussion of customer needs (based on data)
  - Process change to test a new process
  - Gathering feedback about what worked/what didn’t work well on the prior shift, for this test of change

- **Provide Nursing Care**
  - Purposeful Rounding
  - Interdisciplinary Care Rounds
  - Nurse Leader Rounding

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Always have a nurse and/or patient care assistant on the floor, with patients.
**Post Huddle Coaching**

Solicit feedback about the timing and usefulness of information shared at huddle.

Discuss/coach immediately after huddle or at end of shift.

Thank the staff for those elements that were well communicated *each time* you observe.

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**“What we do today should be better than yesterday”**

[Diagram showing the difference between what most people think and what successful people know.]

Image Source: [http://whatsapreport.com/2013/09/01](http://whatsapreport.com/2013/09/01)
Huddle Practice!

**Key Elements of a Huddle**

- **Safety Huddle/Operational discussion** for today:
  - Department flow (e.g., hand off from last shift, schedule, supplies, equipment)
  - Customer needs (e.g., each person arrives and shared current patient/workload)
  - Patient safety (e.g., high fall risk patients, declining vital signs), Staff safety
  - Plan for the day (e.g., level load the work, plan for patient, plan for contingencies)

- Target a single specific reflection about the Improvement Priority for today:
  - How did we do on the last shift? Why? What did we learn?
  - What went well?
  - What new improvement opportunities exist? (PI Board ideas, or Learning from “voice of the customer”)
  - What can we do to improve today?

**Directions:**

1) Work as a group at your table
2) Choose a department (can be clinical or non-clinical)
3) Design a 4 minute huddle with your team
4) Assign a presenter to share the huddle with the group

**Questions**
Steps for Implementing the Shift Huddle

• Identify the Executive Sponsor

• Identify the need for change
  • Why do we need to adjust the status quo?
  • Why is this valuable from the patient perspective?
  • What is valuable to RNs to know, to protect patient safety?

• Initiate communication – **Engage staff with safety stories**
  • Set plan with unit managers, ideally including a check with front line RNs to work out the earliest trouble spots
  • Let all staff know when this will be rolled out and why, and let them know feedback will be requested for design and adjusting during the pilot period.
  • Include time requirements, and staff who will be asked to attend

• Identify the process leaders and the backup process leader
  • Who is going to initiate the huddle each shift?
  • What happens when that person is not available?
  • (Ultimate goal is to have the huddle run at the beginning of all shifts, even in the absence of a leader.)

Steps for Implementing the Shift Huddle (continued)

• Pilot, measure and observe as much as possible for two weeks
  • Adjust process with staff feedback. Maintain regular checks even after the 2-3 week pilot.

• Document the core process that all staff will use
  • Update the core process on each unit with any unique criteria. Use this standard work to evaluate reliability of the process.

• Executive sponsor “walk the Gemba” every week
  • See huddle in action during the first few weeks, monthly or quarterly after that
  • Encourage, motivate team

• Measure outcomes over time
  • Evaluate every success/ variance – use it for process evaluation, use it for learning, not for penalty or performance evaluation
The Department Huddle – Implementation Timeline

- **Week 1**: Prepare huddle content and pilot by end of week
  - Manager/Director drafts huddle elements (timing and content)
    - Set time for huddle
    - Gather feedback from the team about time and content
    - Communicate plan & start date to all team members
  - Identify how the off-going shift will communicate to the on-coming shift
  - Plan to measure process during the implementation period (up to 3 weeks)
    - Did the huddle start on time?
    - How long did it last?
    - Did the team agree that the time was used effectively?
    - What changes shall we make?
  - Initiate huddles on day shift
  - Gather feedback from the team

- **Week 2**: Continue to gather feedback from the team. Measure process & adjust to make the messages timely and effective

- **Week 3**: Roll out process to one or more “off shifts”. Evaluate process measures & gather feedback.

- **Week 4**: Continue to gather feedback from the team & adjust

Questions
The Quorum Difference

The Quorum Difference is the extraordinary combination of consulting guidance and operations experience that enables client healthcare organizations to achieve a sustainable future.

THANK YOU

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.