Safety Huddles : A Catalyst for High Reliability

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Daily Safety Huddle and Objectives

Taking a cue from industry with the goal of being a world class high reliability organization, Fairview Hospital strives to constantly improve our patient safety outcomes. "A good leader analyzes events of harm to determine causes and corrective actions to prevent recurrence." (Stockmeier, & Clapper, 2011).

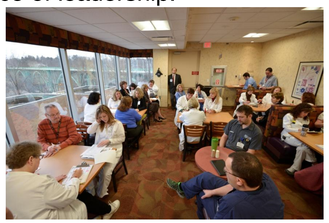
Through this poster the participants will:

1. **Identify the value of safety awareness with storytelling**
2. **Describe the tools and support materials for implementing huddles and practice changes**
3. **Gain an understanding of how to conduct safety huddles using guiding principles**

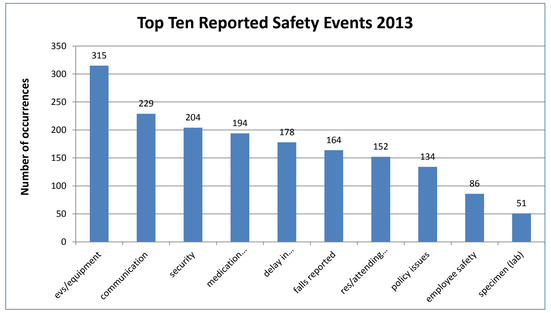
The concept of the Safety Huddle was introduced at daily bed briefing by the Chief Nursing Officer in September, 2012. The standing-room only crowd of hospital caregivers includes a multidisciplinary group of nurse managers, radiology, lab, pharmacy, nutrition, security, risk management, physicians, residents, and the leadership team. This daily communication network provides awareness and real time understanding of what is happening on the front lines. The agenda requires each unit to look back 24 hours to address safety or quality issues that had an impact on staff or patients; to look ahead to anticipate issues that may cause problems in the future; and to follow up on open issues that have been previously addressed. This process empowers caregivers to think safety at all times.

Top Ten Reported Events

The Patient Safety Officer is responsible for the daily 15 minute huddle utilizing a standardized set of questions. The format follows basic rules: present just the facts; no "finger pointing"; and no defensiveness allowed. This non-punitive, non-threatening environment with a focus on Just Culture has increased interdepartmental communication and allows for discussion in the presence of leadership.



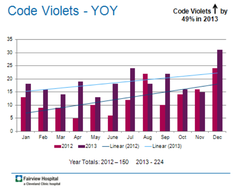
The AHRQ Culture of Safety Survey is used to measure and benchmark the safety culture in healthcare. Based on survey results the safety huddles were implemented to bring awareness to leadership consistently and identify potential serious events or threats.

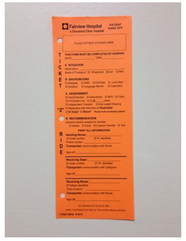


Interventions & Outcomes

The **Chain of Command** policy was reviewed, revised and communicated to all employees. This policy provides a clear path for staff members to escalate patient, provider and hospital concerns to leadership.

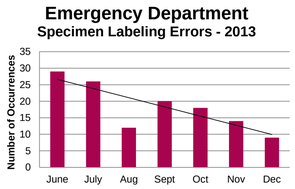
The **Code Violet Committee** was created as a result of increased patient violence and injury to staff members. Non-abusive Psychological and Physical Intervention (NAPPI) training was provided to staff. Post de-escalation huddle forums provide a debriefing venue for staff.





Ticket "2" Ride was generated to prevent serious hand off events. After a near miss, radiology and transport staff championed the tool to improve interdepartmental communication and safe handoffs. The tool provides nursing an awareness of the patient's activity off the unit.

Specimen Labeling
An ED task force developed a process improvement plan to decrease labeling errors using the acronym VOCAL-D a double check process.



Successes

Success is measured by an increase in safety event reporting, decreased serious events and leadership awareness of safety issues identified by the front line staff on a daily basis.

The safety huddles maintain a laser focus on the goals of "just culture" and the need to review system issues. This structure facilitates a strong safety attitude by keeping the emphasis on safe work practices and behaviors. The "patients first" guiding principle and the Cleveland Clinic Core Values: Quality, Innovation, Service, Teamwork, Compassion, and Integrity, provide the foundation for huddle achievement.

References:
Fouche, L. & Toit, R. (2006, May). A needs analysis for a non-abusive intervention programme in the School of Health care sciences at the University of Pretoria. "Curationis;" 77-86.

Stockmeier, C. & Clapper, C. (2011, September/October). Daily Check-in for Safety: From Best Practice to Common Practice. PSQH.com. Retrieved August 16, 2012 , from http://www.psqh.com.