Introducing Safety Huddles into an Acute Medical Unit

AIM: TO IMPROVE THE SHARING OF SAFETY ISSUES FROM NIGHT- TO DAY-TEAM THROUGH A ‘SAFETY HUDDLE’

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METHODS:
3 PDSA cycles over 6 months. No safety issue handover at baseline.
CYCLE I: doctor-to-doctor handover, patient-issues
CYCLE II: nursing participation, situational & material issues added.
CYCLE III: improved recording & allocation of tasks & attendance.

OUTCOMES/RESULTS:

CYCLE I: 3 patients highlighted for early review/day on average (pDoA)
Huddle completed <5 mins on average

CYCLE II: 2 patients pDoA
STAFFING LEVELS: deficient by average 2 nurses & 1 doctor /shift
MATERIAL ISSUES: faulty blood-gas machine, bleep system crashing, drug shortages
SITUATIONAL ISSUES: bed flow problems & admission spikes

CYCLE III: 1.3 patients pDoA
STAFFING LEVELS: doctor shortages 58% & nursing shortages 42% of shifts
SITUATIONAL ISSUES: specific hospital capacity & bed flow
EQUIPMENT & FACILITIES: bleep system errors, broken equipment, software crashes, imaging service restrictions + 8 others

CONCLUSIONS: SAFETY HUDDLES
Safety huddles are well established in safety-conscious industries. In Acute Medicine they allowed to achieve our aims as they:

1. Improve continuity in the transition from night- to day-shifts
2. Give opportunities for any team-member to raise any safety issue
3. Improve team awareness & co-ordination from the shift start

Support from senior stakeholders with influence over working patterns was crucial to changing routines (e.g. ward round, nurse handover). Participant dialogue helped in improving the process, proforma and identifying barriers.

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