Culture of Safety Using Safety Huddles

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Abstract

Healthcare's emphasis on patient safety has increased and is a priority (Krenzicheck, Clifford, Windle, & Mamaril, 2007), Interaction in a critical care unit between members of the team is completely attached to patient safety (Brady et al., 2013). This study mainly aims to establish a clear methodology for safety huddles, identify areas and important topics, and use the correct forms for documenting these huddles and the possibility of applying this by the health practitioners, especially the leaders and those responsible for safety (patient safety). The author in this study has opted to use descriptive methodology. Huddles provide timely proactive check, reduction of operational and clinical risks, and guarantee adequate care for patients. Concluded in this paper recommendations made by the author, and points to consider about huddles such as (place to be held, starting time, maximum time, protection from interruptions, monitoring the attendance, delegation cases, contribution of any member is valuable).

Keywords: Patient Safety, Huddles, Teamwork, Health Care.

1. Introduction

Attaining efficient communication and collaboration persists a major obstacle in healthcare environments and is important for situational understanding (Lancaster, Hayner, Kovacich, & Williams, 2015; Gardner, 2005; Leonard, Graham, & Bonacum, 2004). As per the Joint Commission Center for Transforming Healthcare, inadequate communication is the major source of nearly 80% of medical errors (Braun, et al., 2013). Studies show that teamwork and communication are considered to be the best gadgets for having safe and high-quality patient-care (Leonard, Graham, & Bonacum, 2004; Brady & Goldenhar, 2014; Manser, 2009).

A highly dynamic and multicultural environment allows direct healthcare personnel to have accessibility to an efficient communication and collaboration system to ensure quality care to a quite wide number of patients with different issues (Venkataraman, et al., 2018). Debriefing meetings and safety huddles (Healthcare Utilizing Deliberate Discussion Linking Events) have been efficiently utilized to enhance situational awareness and offer patients safe care (Goldenhar, Brady, Sutcliffe, & Muething, 2013; Kellish, Smith-Miller, Ashton, & Rodgers, 2015; Edelson, et al., 2008).

Patient safety is a widespread concern both for medical professionals and sick people throughout the hospital stay. Since the perioperative duration presents specific hazards to sick people, existing procedures are continuously reviewed to identify aspects throughout the hospital stay to enhance the client's results. This assessment is undertaken to establish an environment of safe procedures all over the scope of perioperative (Setaro & Connolly, 2011).

The Institute for Healthcare Improvement (IHI) describes a culture of safety as an environment of shared trust where all workers can openly communicate about security issues as well as how to address them, with no fear of guilt or penalty. This assessment is undertaken to establish an environment of safe procedures all over the scope of perioperative. The Institute for Healthcare Improvement (IHI) describes a culture of safety as' an environment of shared trust where all workers can openly communicate about security issues as well as how to address them, with no fear of guilt or penalty (Institute for Healthcare Improvement, 2010).

Safety meetings enhance safety consciousness among front-line workers and assist a company to develop a safety culture. Data should be gathered to monitor progress to evaluate whether or not these briefings are effective in achieving those objectives (Institute for Healthcare Improvement, 2019).

2. Safety huddles

Safety huddles are brief gatherings which maximize situational awarness within the clinical staff, assess the situation and incidents, predict and exchange thoughts to guarantee well-coordinated care for patients. Safety huddles are designed to resolve issues before the patient worsens and decrease unforeseen deterioration (Venkataraman, et al., 2018).

Huddles are preliminary and incisive discussions that are scheduled to share information on possible safety concerns. This could help improve the perception of safety among front-line workers and allow teams to establish a risk management strategy (Menon, et al., 2017). Safety huddles also makes it easier to identify potential safety concerns and discusses measures put in place to gain information regarding any inadequacies, creating an incentive and enhancing the team's awareness of the current and prospective safety proposed plan (Yung, Sinha, & Giles, 2019).

2.1 Safety huddles attendees

Individuals who work in a collaborative environment will be able to benefit from safety huddles, those might work in any hospital, and health center. The employees of a corporation must be adequately organized, according to what Lutheran (2010) states, in order to incentivize their safety huddles by a hierarchical individual. The frontline personnel is the primary contributors to safety huddles as shown in figure (1). Therefore, the team must be led by an individual with expertise in the area, according to the assertion of Leone and Adams (2016). The Chief Nursing Officer may, for example, be in charge of the team in a care facility to continue to offer knowledge on the value of safety huddles.

Nevertheless, if the individual is not available, their peers like representatives can be assigned the leadership task (Taylor-Watt et al. 2017).

Figure 1 : Members attending Safety Huddle (Goldenhar, Brady, Sutcliffe, & Muething, 2013)

2.2 Safety huddles to create a safety culture

Safety culture is founded on a strong understanding of current and future security concerns through all times and at all stages of corporate activities. Safety huddles, also referred to as "safety briefings" help companies build a safety culture by establishing a platform for the front line staff to discuss safety issues, improve strategies and acknowledge achievements (Wagner, Theel, & Handel, 2015). Safety huddles have been proved to have outcomes related to the enhancement system-wide and patient-specific improvements facilitate the safety and encourage working as a team and multidisciplinary cooperation (Gerke, Uffelman, & Weber, 2010; Leonard, Graham, & Bonacum, 2004; Edelson, Litzinger, & Arora, 2008; Makary, Mukherjee, & Sexton, 2007).

According to Loeppke et al. (2017), safety huddles allow the company to create strategies that can ensure a safe workplace atmosphere for its workers.

The huddles were also used with the aid of the teamwork and coordination for patient particular and system broad to promote safety. Furthermore, safety huddles contribute to the sharing and transparency of quality information and improving efficiency. An analysis has ended up finding that safety huddles improve matters to establish a high energy level to cultivate the culture of safety and help promote the rapid process of the Plan Do Study Act (PDSA).

Safety huddles enable senior members in an organization to have a good care system for the staff through eliminating risks in the job places. This strengthens coordination and makes it easier to avoid damage (Venkataraman, et al., 2018). For example, through the safety huddles briefings, the health facilities can focus on providing caregivers with reasonable working surroundings. The caregivers are indeed capable of offering decent quality services to the clients. Therefore, it was proved that a company can keep the workers secure by utilizing safety huddles.

2.3 The occurrence time of safety huddles

Safety huddles must be designed to suit both the particular environmental conditions and huddle conditions. They must happen frequently sufficiently to sustain continuous understanding and monitoring of safety and not much often as that they would become a concern and conflict with the functions of the team (Wagner, Theel, & Handel, 2015). Inside a corporation, safety huddles are mandated to happen regularly. The safety huddles are scheduled appropriately, every week or on an everyday basis in different companies. Doing so enables the staff to keep updated with the safety measures regarding recognized safety concerns (Panten & Torrance, 2014). To mention an example, for the safety of carers as well as care consumers, safety huddles happen two times a day in health center facilities.

It was noted that safety huddles aid in the creation of safety action strategy to mitigate in the nearest future possible security problems. Therefore, as suggested by Deng et al. (2019), it is mandatory to conduct safety huddles on a routine basis is needed. It assists companies in promoting their activities by holding the safety measure up. The staff is also encouraged to perform in a safe workplace and to deliver excellent service to its clients with guaranteeing safety.

3. Steps of performing safety huddles

Figure (2) below illustrates the steps that must be taken when performing huddles, this figure is based on the work of (Wagner, Theel, & Handel, 2015). With the implementation of a set of steps, corporate leaders execute the safety huddles. The first and only step to be performed by the company is the safety huddle to be conducted by a representative with a standard of competence. The Chief Nursing Officer in a health center, for example, can commence the safety huddle mechanism. A short and concise huddle may be arranged.

The leader must also guarantee that each member of the team is conscious of the fact of the time and place of the meeting. Bender (2016) also noted that the presence of every team member at the meeting makes it easier for the leader to deliver positive results. The leader will then be responsible for ensuring each team member is capable of expressing his ideas and opinions while the safety huddle takes place. For these reasons, the leader is obligated to incentivize the team members to express an opinion.

A mechanism also standardizes the queries and debates on safety huddle and also assesses the best directly comparable safety fears and concerns (Stafos, et al., 2017). This will be accompanied by the implementation of a mechanism to monitor concerns about safety. Ultimately the leader needs to be aware of the latest huddle and coordinate the important topics before continuing with a safety huddle.

Figure 2: The way safety huddles do perform

According to Wagner, Theel, and Handel (2015) safety huddle system could be initiated by using the following steps;

➢ Leadership engagement: leaders are needed to support the framework and essence of huddles that are primarily designed to preserve a fair culture. Leaders are also required to incentivize staff to give the huddles the amount of time needed.

➢ Pick up the focus unit-Start introducing the safety huddles in a single unit where the safety huddle can be checked. Lessons from previous experience also would be tailored to safety huddles and would be disseminated to all other units. This would make it possible to customize what is mandated in each unit.

➢ Identification of champions: people who believe in the principles of safety huddles will be needed to encourage and facilitate this with other employees. to initiate a safety huddle system inside the healthcare system, initial concerns are required to be identified and employees should know these concerns if heard by the employees from their peers "the identified champions" is a good way to get them in the process.

- ➢ Usage of a recent safety event for illustrating huddling process - A safety event which has occurred in the past months could be taken as an example for prevention. The methods that could have been used in preventing such situation lead as an example for non-recurrence of similar acts (Makary, Mukherjee, & Sexton, 2007) (Makary, Mukherjee, & Sexton, 2007). Stressing the functional effect which could contribute to a safety huddle would provide room for advancement in healthcare systems.

- ➢ Data use: data can be utilized to recognize trends in safety huddles in the healthcare system. Infectious disease trends, as well as other incidents, could be detected to evaluate improvement.

4. Safety huddles best place to be held

The safety huddles are therefore to be kept at the spot near the safety board where the latest data on safety is displayed. Furthermore, Gallant et al. (2018) noted the need for such safety huddles in places viable for every team member. Safety huddles are held in locations where other agency operations are not interfered with.

While conducting huddles, all staff members of the organization have to give utterance to their opinions to the entire team (Rodriguez, Meredith, Hamilton, Yano, & Rubenstein, 2015). This essentially allows team members to become more open to and appreciate workplace safety standards, allowing the organization's hierarchical community to achieve the best outcomes. The application of safety huddles has been shown to improve matters so that companies improvise the range of outcomes. In fact, the team leaders can use a variety of guides to explain the safety huddles to members of the team, such as flip chart sheets, so that they can show the precautionary measures the members of the team can take.

5. Safety huddles components

Wagner, Theel, and Handel (2015) have concluded the components of safety huddles in 5 components as following

1. Planning: Start by developing and sharing a plan for when huddles will be held, who will be involved, expectations for huddle content and follow up, and documentation or materials that will be needed to ensure that your huddles are efficient and successful. (See Appendix A: Huddle Process Map, adapted from Kittitas Valley Healthcare.)

2. Scheduling: It is a matter of being absolutely positive that individuals who need to participate do not have to be elsewhere during that period. It's about being clear when it comes to when will be the huddles conducted, and for how long they will last. The scheduling of the time set for huddles throughout the hospital is one option to preserve this time and focus on ensuring that other occurrences and conferences are not arranged at the same time. This means that people are not supposed to be able to attend other occurrences or conferences.

3. Documenting and Reporting Action Items: In order to monitor the measures taken on established concerns, safety huddles should been reported. To make absolutely sure that assignments are accomplished, specific tasks are to be delegated and follow-up should be carried out. Standard models for the recording of huddles, such as explanations for unit and leadership huddles in Appendices B and C are beneficial. These may comprise the schedule of the huddle, the incident that led to the huddle (regarding subsequent-event huddles), the names and divisions of the individuals involved as well as the next measures or assumptions.

4. Closing the loop: The loop is entitled to be closed once the goals are accomplished and the responsibilities and responsibilities of all participating entities are completely comprehended. In order to increase the safety and security of health care organizations, Huddles are absolutely critical and parties involved need to ensure that the Huddles are effectively involved and closed. In this way, collective accountability is a fundamental tenet and administrators must ensure that entities do not feel abandoned and therefore their thoughts and ideas.

5. Measuring efficiency: The essential component of the total safety huddle is the element of measurement and quantification. Keeping track and question answer and feedback processes are essential to ensure that everyone recognizes the purpose and obligations of the huddles. The survey concludes the huddle, ensuring prioritization of security and safety procedures. This is a critical component of the huddle efficacy assessment procedure by care organizations.

6. Forms of safety huddles

Three types of Safety Huddles could be identified as illustrated in figure (3); leadership safety huddles, daily shift safety huddles and post-event safety huddles.

Figure 3: Forms of Safety Huddles (Dewan, 2018)

6.1 Leadership Huddles

The first type of them is concerned with the leaders of the institution. According to Litano and Major (2016), the organization's productivity is dominated by members. Therefore, the leaders must keep a record of the day to day safety demands or concerns of the respective departments of the organizations, in accordance with leadership safety huddles. Leadership huddles do happen out of work time daily. It assists leaders to recognize the shortcomings so as to minimize them in the future.

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Healthcare workers live in the most dangerous conditions as a result of the nature of the profession and the dangers associated. In order to ensure protection for users of healthcare systems, it is absolutely essential that organizations of this kind have care systems. Healthcare systems focus on providing users with safety and protection. Errors avoidance and preparing for those errors is an integral part of the leadership in safety huddles. For leadership safety huddles, the representatives of every hospital department are strongly advised to exchange progress reports (Leonard, Graham, & Bonacum, 2004).

The officials of each department can render these progress reports for the last 24 hours. In addition, the dissemination of this update would also give rise to measures aimed at addressing critical safety issues. The challenges affecting practically the entire hospital and health systems must be taken into consideration in this update. Further attention should also be paid to following up actions necessary to avoid injury to patients or workers at the hospital (Green et al. 2017). Day-to-day shifts huddle for each leading department must be prepared for the report on security concerns affecting each department. Based on these research results the heads of each department can agree that they have to have favorite actions.

6.2 Daily Shift Safety Huddle

The daily shift safety huddle, on the other hand, places more emphasis on acquainting and providing a stable working environment through the comprehension of safety needs, assisting the team members of the organization to fully realize their positive difference in order to boost workplace safety (Wagner, Theel, & Handel, 2015).

6.3 Post-event safety huddles

The last type is post-event safety huddles which are held after a safety accident at the work, this type emerge when any safety-relevant problem is found. It prepares the staff to solve safety problems in the future. Such forms of safety huddles allow various institutions to facilitate safety for their staff and clients (Goldenhar, Brady, Sutcliffe, & Muething, 2013).

In a team, post-event safety huddles could be viewed as operating in a health system as soon as a safety problem arises in a corporation; the event is performed as quickly as the event occurs and fresh in people's minds. It is a gathering to be held by the team, together with staff and team leaders from a health department. A sub-event huddle, as well as its implications in the fields of patient safety, mechanical malfunction, inadequate care and many others, will eventuate at some point (Wagner, Theel, & Handel, 2015).

The incident of this kind would also tend to happen when wrongdoing is introduced or patient care is opted to leave. The company has to plan a timeframe for post-huddle incidents. This time frame would be exchanged with each department with respect to various severity types. This would make it possible for it to come up with remediation plans which resulted in damage. Those plans will constantly remind the team of the specifics of the plan and make it possible for them to take immediate action. In fact, during the planning of this plan, the damage to patients and services would also be addressed (Wagner, Theel, & Handel, 2015).

This strategy would be put into practice in the corresponding units of all hospitals and the respective teams that is involved in this plan would keep on going to incorporate this plan. In accordance with Gerke et al. perspective, a safety huddle plan is an important component to be carried out by every organization, despite the results of the plan. Huddle plan can also be built for the exchange of safety patterns as and once the company detects them. These developments should be shared so that the members clearly understand the latest safety details.

Last but not least, incidents that have triggered unfortunate situations would also be shared the information with to members to prevent similar occurrences, which would deter more adverse experiences that threaten patients' safety and security.

The personnel employed for the company, who report the safety incidents instantly to the charge nurse or shift supervisor, is obliged to disclose this information with the accountable director or manager. Once this information has been reported, the shift supervisor or nurse is obliged to report the information to the organization's accountable director or manager.

It is the responsibility of the director and manager to evaluate a safety huddle plan to notify the team leader of the cause of the incident (Edelson et al. 2008) and to identify participants that must take part in this safety huddle case.

The safety and risk control of the patient can also be viewed as a lead in the safety huddle. The risk assessment for patients, personnel, and families would be given preferential treatment. The huddle is necessary to raise a number of questions something that is entitled to be classified as:

- What was the safety issue that happened to eventuate?
- Whom did the issue mostly have an effect on?
- What were the actions taken regarding it?
- What were the demands of the patient, personnel and family as a repercussion of such an issue?
- At this point are notifications required to be present?
- What measures could be taken to avoid such an event?
- Are further meetings needed regarding the same debate?
- Whom is supposed to be held as a speaker on behalf of the family?
- Are further preventive measures in the various areas of the health system necessary to be implemented?

7. Conclusion

Safety huddles could be used to create strategies to promote absolute best practices by developing a safety culture for all clients. By achieving a safety culture, hospitals will guarantee that the patients receive the great quality, safe and effective treatment they expect. The researcher encourages hospital teams to explore this relatively easy and efficient means to promote a culture of safety and to augment collaboration between the team members. It is yet another opportunity to demonstrate leadership role in promoting patient safety in any hospital setting.

Hospital staff could make use of the appendices attached in this paper as they can follow the huddle procedure chart demonstrated in the appendix (A), also the daily template of safety huddles in appendix (B) could be used by the staff, the last appendix (C) is the daily leadership template.

Many rules should be kept in mind when considering safety huddles such as keeping the huddles occurrence in the same spot, be concise with the timing of the huddle, it should be brief up to 10 minutes, huddles must be preserved against any distraction or interruption, attendees should be monitored in each huddle, in cases of emergencies staff can send a delegate on their behalf, lastly, each member should be able to contribute freely in huddles.

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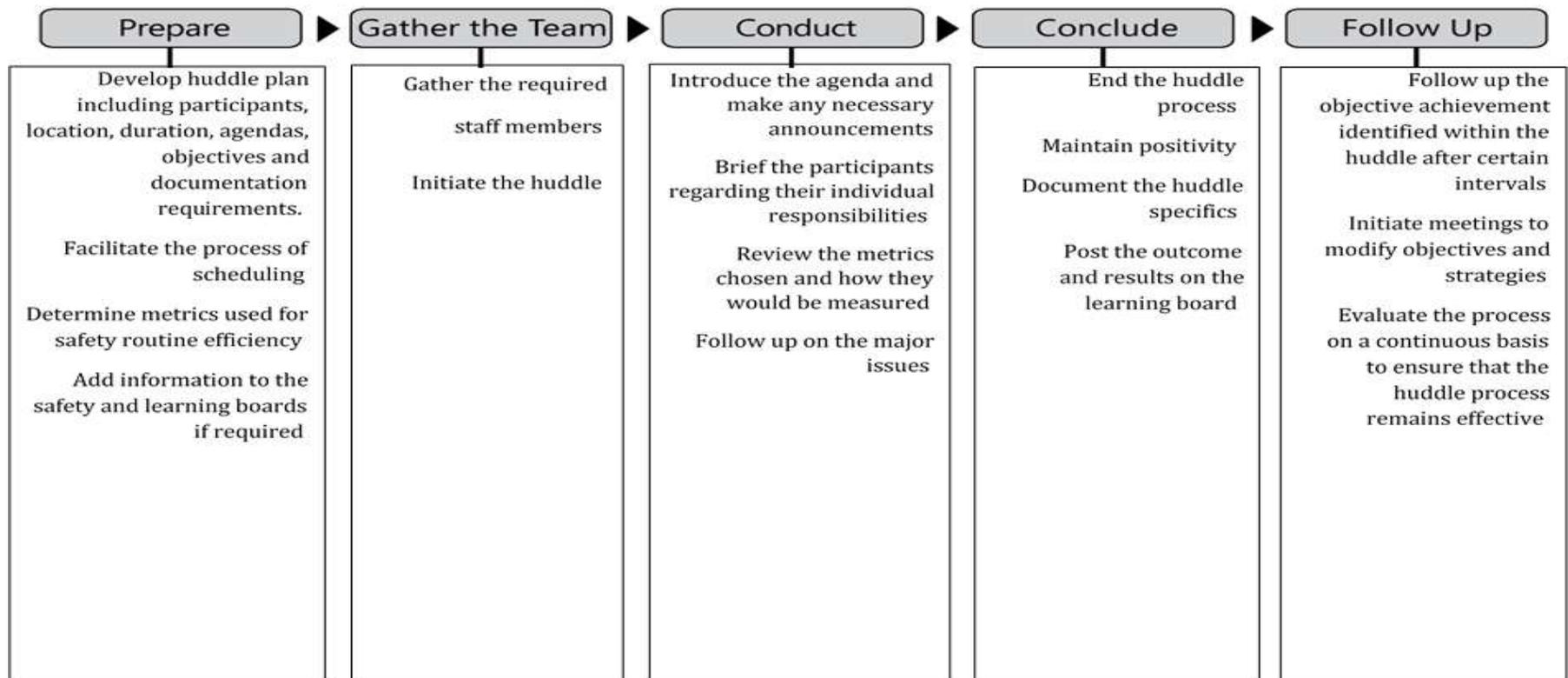
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Appendices

Appendix A: Huddle procedure chart, adapted from Kittitas Valley Healthcare

Prepare	▶	Gather the Team	▶	Conduct	▶	Conclude	▶	Follow Up
Develop huddle plan including participants, location, duration, agendas, objectives and documentation requirements. Facilitate the process of scheduling Determine metrics used for safety routine efficiency Add information to the safety and learning boards if required		Gather the required staff members Initiate the huddle		Introduce the agenda and make any necessary announcements Brief the participants regarding their individual responsibilities Review the metrics chosen and how they would be measured Follow up on the major issues		End the huddle process Maintain positivity Document the huddle specifics Post the outcome and results on the learning board		Follow up the objective achievement identified within the huddle after certain intervals Initiate meetings to modify objectives and strategies Evaluate the process on a continuous basis to ensure that the huddle process remains effective

Appendix B: Daily Shift Huddle Template

Daily Leadership Safety Huddle	Date: _____	Leader:	Attendees:	
Essential Operations	Introduce New Leaders / Guests			
	Organization Update/Message			
		Day:		**Night:**
	Staffing irregularities			
	Estimated admittances			
	Emergency processes			
	Vacant Beds			
	Estimated Discharges			
	Grievance register			
	Unit Metric #2			
	Primary agenda			
Safety / Quality / Reliability	Harm events			
	Monthly harm rate			
	Close calls			
	Patient and employee safety requirements			
	Identified risk factors			
	Medicine and drug concerns			
	Concerns related to devices and equipment's			
	Staffing irregularities			
Action Needed	**What**	**Who**	**When**	**Completion/Follow Up Notes**

Appendix C: Daily Leadership Template

Date: _____

Aspect of Safety Huddles	Ideal State	Current State	Plan for Reaching Ideal State
Engaging the leadership	Complete managerial efficiency	Minimal efficiency	Increase coordination and improve cross functionality
Departments involved	All the core departments and tertiary departments	Core departments only	Take departmental heads and devise strategies to improve positioning
Frequency	Three huddles on a daily basis	Once	Communicate the importance of huddles and ensure all the team members are aligned
Huddle duration	Fifteen minutes	Variable depending upon the requirements	Ensure standardization and individual efficiency
Attendance by employees	Regular attendance	Partial attendance based on free schedules	Identify the reasons for overlapping schedules and eliminate them.
Levels of participation	Proactive participation by the members involved	Limited participation	Build confidence among the staff members through team building programs
Tools integrated	Audiovisual integration along with learning boards for updating information	Absence of additional tools	Identify benefits that can be obtained through the mentioned tools and allocate budgets efficiently
Communication process	Transparent communication channels without noise factors	Limited communication with most of the inputs by departmental heads	Improve aspects of communication and ensure that all the individuals contribute in an equal manner
Evaluation process	Accurate identification of metrics and success factors of safety protocols and their healthcare implications	Poor identification of key metrics	Collaborate with industry experts and ensure that