

Huddle up for safer healthcare: how frontline teams can work together to improve patient safety

Authors: Alison Cracknell,¹ Alison Lovatt,² Anna Winfield,¹ Sofia Arkhipkina,¹ Eileen McDonagh,³ Angela Green² and Michael Rooney²

Aims

This project aimed to:

- > examine the effect of safety huddles on empowering ward teams to reduce patient harm
- > establish if safety huddles enhance multidisciplinary working and team safety culture
- > determine if they can be widely embedded into ward routines.

Methods

Using quality improvement methodology, safety huddles were tested with four front-line teams in one large acute hospital trust. The wards focused on a harm area to improve; this was determined by the teams and was initially to reduce inpatient falls. Key huddle principles were developed by these teams and included: being senior clinician led, daily, non-hierarchical, brief, with data visualisation focused on the chosen harm. The specific harm was monitored (using Statistical Process Charts) and a safety culture survey was performed before and after implementation.

Results

On the first four wards to adopt huddles, falls reduced significantly from 12.4 to five falls per week. In addition, culture surveys showed improvements in 23 out of 27 parameters, including 'would you feel safe being treated as a patient on your ward?'

These teams have continued to develop their huddles, and now focus on a second harm important to the team (including pressure ulcers, medication delays and patient deterioration).

Successful adoption led to an appetite for other clinical teams to test safety huddles; natural spread has occurred:

- > Five further wards in this hospital have embedded safety huddles and reduced falls significantly from nine per week to less than five.

- > Within this trust, a further four wards are currently testing huddles and, within the region, the work has spread to seven other trusts.

Local ownership, celebrating milestones (for example, achieving 30 days without a fall) and adaptability of safety huddles to the ward environment were key to its sustainability.

Conclusions

This work has shown the positive impact patient that safety huddles can have on reducing harm. Safety huddles improve safety culture on wards that are 'early adopters'. This work has exciting implications for future learning, due to the multiple positive impacts seen on a small scale. Understanding how to embed and scale up safety huddles throughout and across organisations is currently underway, supported by the Health Foundation. The authors believe that safety huddles are a key tool for reducing patient harm, empowering the team to act, and improving ward safety culture. ■

Authors: ¹Leeds Teaching Hospitals NHS Trust, Leeds, UK;

²Yorkshire and Humber Improvement Academy, Bradford, UK;

³University of Bradford, Bradford, UK