Humber Teaching
NHS Foundation Trust

SAFETY HUDDLE GUIDELINES

Guideline Reference	G437
Version Number	1.0
Author/Lead **Job Title**	Kate Baxendale, Deputy Director Nursing, Allied Health Professionals and Social Work Professionals
Date of Last Changes (This Version)	11 September 2024
Date of Next Review	September 2027
Approved by: **Date**	Quality and Patient Safety Group (QPaS) 11 September 2024

VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*Sept 24*	*New Guideline. Approved at QPaS (11 September 2024).*

Contents

1. INTRODUCTION

Poor communication is a major contributor to adverse events in health care. Failures in communication are often cited in research, as a major factor which can lead to patient or staff harm and gaps in care.

Safety Huddles are a patient safety tool that can be used to enhance the safety culture within a clinical area, through the promotion of teamwork, multi-disciplinary communication, enhancing psychological safety and promoting civility and respect.

A safety huddle is a proactive approach to clinical risk management and the reduction of harm which provides dedicated time for the multidisciplinary team to communicate and share critical information to promote safety. They also support a shared understanding of the situation and key risks regarding patient safety.

Safety Huddles support shared situational awareness by providing an opportunity for team members to share vital information about a patient or their environment, to discuss, integrate, and make meaning of the information; therefore, clinical risks are more likely to be mitigated.

The purpose of this guidance is to provide teams with a framework to successfully implement safety huddles in their team and thereby improve patient and staff safety.

2. SCOPE

The guidance is aimed at all patient facing teams across the organisation. It includes both registered and unregistered staff who are permanent, temporary, bank or agency staff.

Safety Huddles are intended to be carried out at all levels of the health system and can be integrated into any situation. For example, inpatient wards, outpatient clinics, primary care as well as community settings.

Examples of patient incidents that teams can proactively discuss the management of, to reduce/prevent occurrence using safety huddles are:
Violence and aggression, self-harm, fire incidents, verbal abuse, missing service user, falls, pressure ulcers, cardiac arrest, recognising the deteriorating patient.

This list is not exhaustive.

Teams should use their data from DATIX to determine their high-risk areas along with perceived risks on the day to determine the scope of a safety huddle discussion on any given day.

3. PROCEDURES

3.1. Definition of a Safety Huddle

Safety Huddles are a brief (≤ 10 minutes), focused exchange of information about potential or existing safety risks which may affect patients, staff and any person accessing the healthcare environment. They are multidisciplinary, occur at the beginning of every shift and follow a three-point agenda.
(Ref: Clinical Excellence Commission)

Safety Huddles are not a formal meeting. Good huddles are focused, and fact based. They are lean and to the point. The pace is fast and unhelpful or side conversations should be challenged. Every minute of the meeting should be adding value to the team.

In summary they are a brief discussion which focuses on:

1. What safety incidents occurred in the previous 24 hours, and have we prevented them from recurring?
2. What patient and staff safety concerns do we need to be aware of today and have we mitigated the risks?
3. The plan for following up safety concerns and assigning accountability

3.2. When Should a Safety Huddle Occur

Safety Huddles are a proactive tool.

They should be held when the maximum number of members of the multidisciplinary team are able to attend.

To ensure the focus is on patient safety only, they should not be 'tagged' on to an existing meeting.

They are held 7 days per week, in a consistent location.

Safety Huddles are best held with staff who are present standing as this helps to assist with focus and efficiency.

3.3. Who Should be Involved

All staff involved in patient care, including clinical and non-clinical, are included in Safety Huddles. This includes, but is not limited to:

- Clinical lead
- Medical staff
- Administration/reception staff
- Team leaders
- Matrons
- Service managers.
- Nurses
- Health care support workers
- Allied health professionals
- Domestic staff
- Psychology staff
- Support staff.
- Activity workers

Discussion during the Safety Huddle is non-punitive and inclusive, ensuring all team members feel confident to share their concerns/views and that their perspective will be valued.

A safety huddle should be led by a senior clinician on shift.

3.4. Discussion in a Safety Huddle

The following are templates to support safety huddle discussions:

Template 1:

- What is the safety concern we are going to focus on today?
- Who are we most worried about- patients, staff?
- What problems have been experienced in the last 24 hours?
- What improvements do we want to see?
- What is the plan- input from all staff?
- What are our options?
- Who can help with what?

Template 2:

Daily patient safety huddle	**Date:**
Who is present for the huddle?	
Are staffing levels sufficient today? Is everyone here that needs to be? What is your role today?	
Environment: Any equipment issues?	
Patient related issues: Risks to patient safety today?	
Team Well-being: Any issues or additional stresses to share?	
Any other updates or concerns? Are any reasonable adjustments required?	

Template 3:

Looking Back (over the last 24hrs)

- What did we do well?
- What safety incidents occurred?
- How have we prevented it/them from being repeated?

Consider Emerging Threats

Patients

- Prescribed high risk medications; increased falls risk; same/similar surname; behavioural/cognition concerns; delirium.
- Are there any patients who pose a risk to staff (aggressive patients or relatives)?

Flow

- Movement of patients from or to high acuity or other areas

Staff

- Agency staff; skill mix; shortages in other areas impacting care (radiology; pharmacy; non-clinical services)

Equipment

- Outages (IIMS; eMR); failures (pressure relieving mattresses); supplies.

Environment

- Loose tiles; water leaks; air conditioning; thefts Duress alarms
- Are duress alarms working? Personal duress alarms are being used as appropriate

Looking Forward (this shift):

- What patient safety issues do we need to be aware of today that will distract us from patient care?
- Are there any family or carer concerns?
- Are there any staff safety issues such as risks posed by patients?
- How have we mitigated the risks?

Planning

- Follow the unit-specific plan for follow-up of safety concerns Assign accountability using closed loop communication.

By the end of the huddle all staff should know:

- Who we are worried about today
- What plans are in place for patients at risk of deterioration
- Any patient and carer concerns
- Who is involved

3.5. Documenting Safety Huddles

The Safety Huddle discussion does not need to be documented. However, it is important to assign accountability and to use a system to track outcomes from actions taken on identified risks.

It can be written on a board in a mutual staff area, but it is essential that patients and visitors cannot see this information, in order to ensure confidentiality.

Any changes to patient care/new relevant information becoming known following discussion in safety huddle must be reported in the patients record.

3.6. Measuring effectiveness

The following questions can be beneficial in determining whether Safety Huddles are being effective:

- Is there increased awareness of safety issues which could impact on patients and staff?
- Is there a collective awareness of the current safety issues and how to mitigate?
- Are we seeing a reduction in adverse events causing harm?
- Is there improved patient and staff experience?

The measures which can be used to provide evidence in respect of the questions above are:

- Number of near misses reported by staff.
- Reduction in specific incidents being reported related to specific issue or individual (ie reduction in falls, reduction in incidents of violence).
- Attendance of clinical and non-clinical staff at Safety Huddle.
- Percentage of staff who report Safety Huddles as valuable.

There is an expectation that teams will adopt these principles and have local standard operating procedures for adopting safety huddles within their services.

4. REFERENCES/DEFINITIONS

improving-patient-safety-culture-a-practical-guide-v2.pdf (england.nhs.uk)

Safety Huddles - Improvement Academy

Safety Huddles - Clinical Excellence Commission (nsw.gov.au)

NHS England » Huddle sheets and supporting guidance

5. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Patient Safety Incident Response Policy N-075

Patient Safety Incident Response Plan

Patient Safety Incident Analysis Using Swarm Huddle Methodology SOP23-039

Risk Management Strategy

Clinical Risk Assessment Management and Training Policy N-015

Appendix 1 – Safety Huddle Summary

Appendix 2 - Feedback Questions for Staff Involved in Safety Huddles

How often are safety huddles held in your unit?	
How often do you attend safety huddles?	
	Y / N
Do you think safety huddles are worth attending?	
Are you aware of improvements that have happended as a result of a safety huddles discussion?	
Would you recommend safety huddles to other colleagues in other units?	
What would make the safety huddles in your unit more valuable?	
Other comments:	