Emergency department safety huddles: Implementation guide

Introduction

Fostering a culture of safety is essential for reducing harm and achieving quality care in healthcare organisations. Emergency department (ED) safety huddles are a multidisciplinary process carried out in the ED to support the delivery of safe patient care. They support situational awareness in the team and should support local escalation processes to manage risks.

ED safety huddles can be used at the beginning of each shift to identify and escalate risks about any safety concerns occurring in the ED. They are used by all levels of the system, from the clinical unit to facility management. The timely but brief view of the ED enables the management team to prioritise high risk issues impacting patients and staff and provide support.

Safety huddles assist clinicians and other staff involved in patient care to allocate protected time at least once each shift to specific questions with the overall aim to reduce errors, minimise harm, eliminate preventable harm and create a culture of safety.[1]

If emergency departments currently practice safety huddles, it is recommended to use this time to include discussion of emergency care assessment and treatment (ECAT) in that safety huddle.

The benefits of implementing safety huddles

Teams who engage in safety huddles demonstrate improvements in teamwork and multidisciplinary communication. Safety huddles create a collective awareness of the current situation and promote a culture of safety which, in turn, reduces the potential for causing preventable harm.[2]

Situational awareness

Situational awareness refers to an individual having awareness and understanding of what's going on around them. Improvements in situational awareness have been reported through the implementation of an early identification risk mitigation strategy such as safety huddles.[3] There are three key elements of situational awareness:[4]

1. **Perception**: Pick up cues and perceive critical elements of the environment, e.g. a patient's vital signs and behaviour. Also includes an awareness of the status of patients under the care of the rest of the team. Information from the patient/family/carer should be received and used as part of this process. Collaboration and effective communication between the multidisciplinary team is essential to providing safe patient care.[5]
2. **Comprehension**: Able to make sense of and integrate information contained within the elements. The dynamic nature of healthcare means team members will need to continually reassess their environment and share that information with colleagues.
3. **Projection**: Complete situational awareness also requires that team members can harness the available information to gain an understanding of what will happen next in their environment. That is, they can predict and therefore act proactively rather than reactively. At the team level, this includes things like agreeing which patients are most at risk of deterioration.

Including ECAT in ED safety huddles

What is ECAT?

Emergency Care Assessment and Treatment (ECAT) is a statewide, co-designed program that proposes to standardise nurse-initiated emergency care, reduce unwarranted clinical variation and improve patient experiences and staff satisfaction. The NSW Agency for Clinical Innovation (ACI) and its pillar partners have led the development of 73 clinical ECAT Protocols covering a range of adult and paediatric presentations, prerequisite education modules, an education and recognition of prior learning guide and a policy directive.

Shift safety huddles

Safety huddles are a proactive tool. They are held at the beginning of the shift when the maximum number of members of the multidisciplinary team can attend (usually following the handover round). They are held again at the end of each shift handover as a brief recap to ensure all staff on each shift are aware of the risks to patient and staff safety and that any risks have mitigation strategies in place.

All staff involved in patient care, including clinical and non-clinical, should be included in safety huddles. The discussion during the safety huddle is non-punitive and inclusive, ensuring all team members feel confident to share. Safety huddles are not a formal meeting, and the brief discussion focuses on three overarching areas which can be enhanced and developed to suit the local context:[7]

1. **Look back:** What safety incidents occurred in the previous 24 hours and have we prevented them from recurring? Acknowledge compliments and good news stories at this point.
2. **Look forward:** What patient and staff safety concerns do we need to be aware of today and have we mitigated the risks?
3. **Finalise:** Follow the unit-specific plan for following up safety concerns and assign accountability.

Setting up your ED's ECAT-focussed safety huddle

For your ED safety huddles, follow the steps below:

- Identify safety huddle champions (2-3 depending on the size of your ED).
- Educate staff on the safety huddle purpose, process and outcomes (information sheet, team updates).
- Schedule agreed shift huddle time.
- Promote attendance of the nursing unit manager (NUM), medical director or doctor in charge, clinical nurse consultant (CNC) to reinforce importance by their attendance.
- Use the ECAT-focussed script to look back, look forward and finalise.
- Stick to time.

Suggested focus areas to include in the discussion

- **ECAT protocols**: How many ECAT protocols have been initiated? Do they need to be handed over? Were there any points of escalation or switching protocols? Were there any missed opportunities?
- **Patients**: With same or similar surname, prescribed high-risk medications, delirium, behavioural or cognition concerns, high falls risk, at risk of deterioration, scheduled for procedure or surgery, flow,

community outbreaks (norovirus or other infectious diseases), recent incident management system (ims+) and mitigation strategies, multiple teams involved in care.

- **Staff**: Sick leave, increased agency staff, new staff or new term, skill mix, shortages in other areas impacting care.
- **Processes**: New equipment, new medicines, planned downtimes or outages (electronic systems) which could impact safety.
- **Environment:** Broken equipment, loose tiles, air conditioning faults, security (increased thefts), closed patient areas, location of duress alarms.

Closing the loop

- A system for communicating how safety concerns have been addressed will keep staff engaged and ensure they value the process.
- Document identified safety concerns and assign accountability. Review the safety concerns daily until resolution (allocate time frame).

Key points for success

- **Preparation**: All team members need to come to the safety huddle prepared to prevent omissions or conversations going off onto another tangent.
- **Leadership**: Led by a team leader or an experienced member of staff to ensure the safety huddle ground rules are observed and that all action items are delegated.
- **Consistency**: Held at the same time and in the same location. This may change through frequent testing until an ideal time and location is agreed.
- **Accountability**: A member of the leadership team needs to be present at all safety huddles. As many staff as possible or an assigned delegate are in attendance.
- **Closing the loop**: Follow up on identified issues until they are resolved using a transparent reporting system such as a quality learning board.
- **Practice, adapt and improve**: Test and adjust the process to suit the unique needs of the clinical unit.

Measuring effectiveness

As ECAT-focused safety huddles become a part of routine practice in emergency departments, it is important to create an opportunity for measuring effectiveness. Some points to consider are listed below.

What are we trying to accomplish? (Aims)

- Increase awareness of safety issues that could impact patients and staff
- Build a collective awareness of the current safety issues and how to mitigate
- Reduce adverse events causing harm
- Foster a culture of safety
- Improve patient and staff experience

How will we know that a change is an improvement? (Measures)

- Number of near misses reported by staff
- Use of voluntary reporting (IIMS)
- Attendance of clinical and non-clinical staff at safety huddle
- Percentage of staff who report safety huddles as valuable

What change can we make that will result in an improvement? (Changes)

- Conduct safety huddles at least daily

At the end of the safety huddle, staff on duty should raise any safety concerns that need clarification or immediate action. They should also know:

- Who the sickest patient is at the time of the huddle.
- What plans are in place for patients at risk of deterioration.
- About any patient and carer concerns.
- Who the outliers are and what medical teams are involved.
- Which patients are currently on an ECAT protocol.

Post-event safety huddles: A reactive approach

Post-event safety huddles are a multidisciplinary team and patient review following an adverse event, incident or near miss. They are designed to identify the contributing factors and to put in place risk mitigation strategies.

The reactive safety huddles are held as close as possible to the time of an adverse event (for example, a patient fall or medication error) or near miss. Holding post-event safety huddles within the same shift or at least within the same 24-hour period ensures detail is captured while memories are fresh. The team leader or manager, once notified of the adverse event, will call the post-event safety huddle and decide which members of the multidisciplinary team need to attend.

The priority is to ensure the needs of the patient, their family and carers are met as well as the needs of the affected staff member(s).[7]

Questions to address during the post-event safety huddle:

- What was the incident?
- Who was affected and or harmed?
- How have we responded?
- What are the needs of the affected patient or staff member?
- Have we apologised?
- What actions are required to prevent a reoccurrence?
- Has the incident and response been documented and notified?

References

1. Provost S, Lanham H, Leykum L, et al. Health care huddles: Managing complexity to achieve high reliability. Health Care Management Review. 2014;40(1): 2-12 DOI: 10.1097/HMR.0000000000000009
2. Goldenhar L, Brady P, Sutcliffe K, et al. Huddling for high reliability and situation awareness. BMJ Qual Saf. 2013;22(11):899-906. DOI: 10.1136/bmjqs-2013-002322
3. Brady P, Muething S, Kotagal U, et al. Improving situation awareness to reduce unrecognised clinical deterioration and serious safety events. Pediatrics. 2013;131(1):e298-308. DOI: 10.1542/peds.2012-1364
4. Endsley M. Measurement of situation awareness in dynamic systems, Human Factors. 1995;37(1) 65-84. DOI: 10.1518/001872095779049
5. Glymph D, Olenick M, Barbera S. et al. Healthcare Utilizing Deliberate Discussion Linking Events (HUDDLE): A Systematic Review, AANA Journal. June 2015;83(3):183-88.
6. https://www.ahrq.gov/teamstepps/index.html
7. Wagner C, Theel A, Handel S. Safety Huddles: Guide to Safety Huddles. Seattle: Washington State Hospital Association; 2015 [cited 12.4.2024]. Available from: https://www.wsha.org/wp-content/uploads/Worker-Safety_SafetyHuddleToolkit_3_27_15.pdf

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Development

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