Leadership Safety Huddles

An Innovative And Promising Commitment To Patient Safety From Al Khor Hospital

Background:

Following the successful implementation of Leadership Safety Walkrounds for more than two years at Al Khor Hospital, the executive team decided to expand and broaden this practice as "organization-wide" safety huddles, to institute and model a culture of safety behavior among staff throughout the facility to solve actual problems in real time and prevent potential problems from cropping up.
In the past, departments were operating in silos with minimal sharing and learning from safety events to mitigate harm leading to inefficient and time consuming problem solving approach.
Our hypothesis was to implement a shared mental model aimed at reducing patient harm, increasing leadership situational awareness of at-risk events or circumstances, promoting transparency and enhancing multidisciplinary team collaboration for a real-time review.
The opportunity of initiating interdepartmental safety huddles was identified based on the results of AHRQ patient safety culture survey, further reinforced by performing a comprehensive literature review.

Objectives:

The key objectives mandated to be achieved from this approach were:

- Senior leadership awareness of frontline operations
- Quick issue resolution – often same day
- Reduced "silo operations" – more teamwork
- Significant learning opportunities "walk in my shoes"
- Safety becomes priority – a culture change
- Encourage reporting of safety concerns and events
- Improved relationships between departments
- Blame-free environment
- Harm prevention
- Staff empowerment

Aim:

- Demonstrate leadership commitment to ensure an effective culture of safety within the hospital through performing leadership safety huddles every week effective June 2016.
- Ensure 100% compliance with safety issues raised and resolved within an appropriate timeframe.

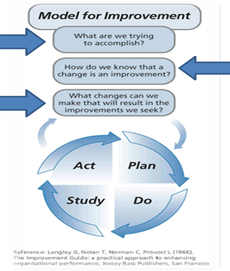
Methodology:

Aim:

Perform weekly Leadership Patient Safety Huddles to create shared awareness on safety issues affecting patient care and determine action plans

Action Plans:

- **Knowledge assessment of intended participants**
- **Sharing of program & expected outcomes**
- **Feedback & redesign of program**
- **Huddle team formation**
- **Establish a plan for the rapid testing of safety-based improvements**



Reference: Langley G, Nolan T, Nonman C, Provost L (1966). The Improvement Guide: a practical approach to enhancing organisational performance. Jossey-Bass Publishers, San Francisco

Process Measures:

- **Number of Leadership Safety Huddles completed**
- **Number of safety issues raised to Leadership Safety Huddles**

Outcome Measure:

- **Percent of issues resolved within timeframe**

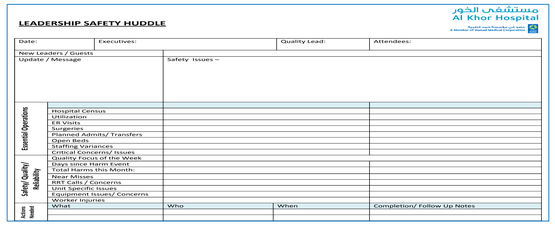
Team Members:

Mr. Mohammed Al Jusaiman – Deputy Chief, GHG & CEO, Al Khor Hospital
Ms. Mary Jyothis Titus – A/Asst. Exe. Director – Quality & Patient Safety, Al Khor Hospital
Dr. Hani Kilani – Medical Director, Al Khor Hospital
Ms. Nadia Fakhouri –A/Executive Director of Nursing, Al Khor Hospital
Mr. Hassan Al Hail – Asst. Executive Director – Support Services, Al Khor Hospital

Design Of The Huddle Program:

- A formal design of safety huddle program was developed and initiated through the following interventions:
  1) A pre-implementation survey to assess knowledge of the intended participants was conducted.
  2) Following this a brief presentation including the expectations and desired outcomes of the program was delivered.
  3) Huddle team including department leads and executives of the facility was formed.
  4) Complete participation was ensured by engaging the intended leaders in a face to face discussion by the Assistant Executive Director of quality.
  5) Educational materials were provided for seeking further support.
- An effective safety huddle program was redesigned based on the feedback received from the target audience.
- A three point agenda meeting was agreed focusing on issues reported from the previous week, imminent during the next week and a follow up at the next huddle.
- Chaired by the Chief Executive Officer, huddles are conducted weekly utilizing a standard template to address safety issues arising from patient safety, medical equipment / supplies, facility / environment, bio-engineering and information technology.
- Leaders are encouraged to periodically bring in front-line associates for stronger engagement and effective decision making.
- Through this platform, leadership is engaged in an open discussion to emphasize the key facts building a safety culture, observing the rules: present just the facts, no finger pointing and no defensiveness.

Tools:

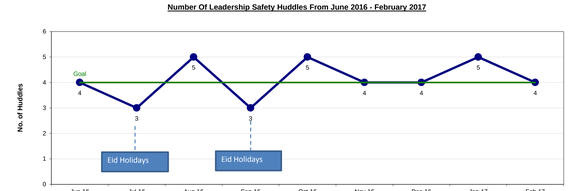


Evidence Of Performance:

- Key performance measures evaluated the effectiveness and trending of performance.
- A central repository to track harm & risk in order to ensure completion and standardization of changes is maintained.
- Actions and results are shared organizationally to promote and encourage the work and involvement of front line staff in the safety huddle process.
- A template is utilized to guide the staff all the steps of the huddle.
- Issues raised during the safety huddle are prioritized for follow-up within 24 or 72 hours, based on their direct impact on patient safety, complexity and the time frame involved for resolution.
- Issues identified as crucial are escalated to the leadership executive meeting immediately.
- Information on issues raised is summarized and shared with executives and departments on a monthly basis.

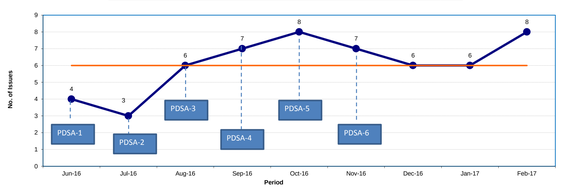
Results:

Number Of Leadership Safety Huddles From June 2016 - February 2017



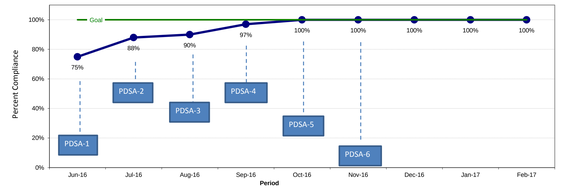
Source: Central data repository collected on flip chart every week during huddles

Number Of Safety Issues Reported to Leadership Safety Huddles From June 2016 - February 2017



Source: Central data repository collected on flip chart every week during huddles

Percentage Resolution Of Safety Issues Within Timeframe (< 24 hrs, < 48 hrs & >72 hours) From June 2016 - February 2017



Source: Central data repository collected on flip chart every week during huddles

PDSA's Undertaken:

Test if pre-implementation survey will help assess knowledge of the involved team on leadership safety huddles and whether department heads are open to discuss patient safety concerns with executives.

- Prepared a survey questionnaire and a briefing on leadership safety huddles
- Delivered a presentation with survey analysis including the expectations and desired outcomes.
- Prepared a scheduled calendar with agreement of huddle team.
- Developed a central repository for entering of all issues raised.
- Developed a report template to document the identified issues and follow-up of action plans / owners with time frame.

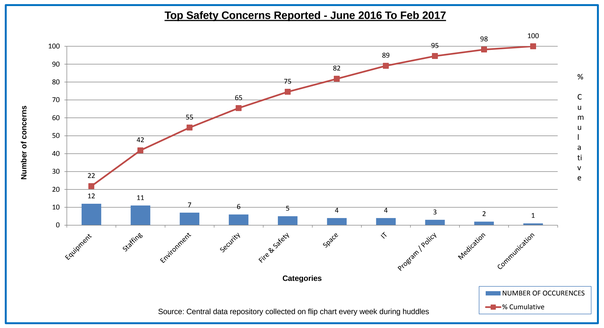
Test if reinforcement conducted by the AED-Quality with the huddle team will further encourage raising issues & concerns within multidisciplinary setting with executives.

- Test if 1:1 discussion with department leaders including video presentation will improve the communication of safety concerns from unit/departmental level safety briefing to a safety huddle platform.
- Test if briefing on leadership safety huddles and pamphlet distribution helped staff to understand more on safety culture and improving the open communication to executives.
- Test if concerns raised are discussed immediately in the executive meeting (following in the next hour) will further fast track the resolution.
- Test if a developed action tracker to track the completeness of the identified issues and follow-up in the following huddle will increase the percent of actionable items identified are completed.

Test if involvement of second tracker help in follow-up and timely completion of agreed action plans for safety concerns and ensure timely feedback is provided to the concerned departments / units.

- Test if a reinforcement email from Chief Executive Officer will encourage the active engagement of multidisciplinary team in the safety huddles.
- Test if a reminder system will help timely attendance of all leaders / key staff.

Top Safety Concerns Reported - June 2016 To Feb 2017



Source: Central data repository collected on flip chart every week during huddles

Conclusions:

- The leadership safety huddles are more than just a tool for enhancing leadership situational awareness and staff engagement emphasizing strong safety attitude. This initiative has been a major driver for safer care by reducing the risk of system or process failures through providing a more focused and standardized methodology for addressing safety issues.
- Huddles have increased staff understanding on issues and systems contributing to unsafe. Staff members in direct patient care roles feel more empowered to bring forth concerns and propose solutions. This non-punitive and non-threatening environment enables caregivers to think safety as a priority. Value is added by patients and family engagement.
- Safety huddles do not take place behind closed doors in a meeting room; but are quickly moved from passive to active actions by a unique way of integrating different Departments. Significant learning opportunities identified by problem owners, start the clock and close the loop by follow-up at the next huddle.
- Unknown or unresolved problems are better addressed under the direct supervision of the Hospital Chief Executive Officer.
- At the end of the day, the staff has embraced the theme, "We can do better and we must do better."

Next Steps :

Impact analysis of the huddle program shall be conducted over time by:

- Statistical analysis of pre and post implementation of changes in safety event reporting as evidenced by an overall decrease in serious events as the success of the project.
- Staff perception of safety culture through repeating AHRQ safety culture survey.
- A flipchart for the staff to provide their input on safety concerns for inclusion in the huddle discussion.
- Promoting this practice where the staff, the interdisciplinary team, the patients and families will embrace and integrate it into their everyday roles.

Summative Statement:

A culture of safety is built on high awareness of real & potential safety issues at all times, at all levels of organizational operations. We believe one of the most important key lever driving safer care is leadership safety huddles which have assisted in providing safer, quality care to our patients by reducing the risk of system or process failures. Leadership safety huddles are brief and routine multidisciplinary meetings **("stand-up meetings")** to assess **potential or existing safety concerns** faced by patients or workers and prevent recurrence. They increase safety awareness among front-line staff, allowing teams to develop action plans and foster a culture of safety. In addition to identifying real-time safety concerns, safety huddles are ideal for reporting back actions taken, present opportunities to educate, reinforce and motivate teams on current and future safety initiatives. Successes and examples of "leading" practices could also be celebrated during huddles.

References:

- AHRQ Patient Safety Culture Survey by HMC – 2015
- HMC – IHI Best Care Always Campaign
- A Culture of Safety, Bringing Board members, Executive, Leaders and Staff together – 2015, Washington State Hospital Association
- Hospital Safety Flow Huddle Guidance Document , Scottish Patient Safety Programme

In Collaboration with