# SESLHD GUIDELINE COVER SHEET

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| **NAME OF DOCUMENT** | Post Incident Bedside Safety Huddles and effective use of the HUDDLE UP tool |
| **TYPE OF DOCUMENT** | GUIDELINE |
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| **LEVEL OF EVIDENCE** | National Safety and Quality Health Service Standards (Version 2):<br>• Standard 5: Comprehensive Care (previously Standard 10 – Preventing Falls and Harm from Falls)<br>• Standard 2 – Partnering with Consumers |
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| **AUTHOR** | Carmelle Moses<br>Falls Prevention Program Coordinator |
| **POSITION RESPONSIBLE FOR DOCUMENT** | Falls Prevention Program Coordinator |
| **KEY TERMS** | Safety, post, incident, event, huddles, patient care, falls, pressure injury, medication error, personal security |
| **SUMMARY** | The purpose of this document is to provide recommendations and guidance for staff to complete post incident safety huddles practices using the HUDDLE UP tool effectively and efficiently |


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# SESLHD GUIDELINE COVER SHEET

## Post Incident Safety Huddles and effective use of the HUDDLE UP Tool

## Section 1 - Background

Huddles are a recognised initiative in healthcare which increase the safety and quality of patient care and systems.[1,2] The Institute for Healthcare Improvement (IHI) and the Clinical Excellence Commission (CEC) support safety huddles as a recommended best practice in healthcare settings.[3,4]

Safety huddles improve efficiencies, quality of information sharing and accountability. They foster a sense of community, and create a culture of collaboration and collegiality that increases collective awareness and capacity for reducing harm.[5]

Post incident safety huddles can be completed for any adverse event, including but not limited to falls, medication errors, pressure injury, near misses, aggression/personal security threat and equipment failure.

As the principles and strategies are consistent for management of all adverse clinical events, the need for a standardised, district wide safety huddle tool to guide clinicians through the process was identified.

South Eastern Sydney Local Health District (SESLHD) have developed a tool which is based on recommendations from the IHI and CEC. The 'HUDDLE UP' tool was designed to support clinicians in completing and documenting a post incident safety huddle effectively and efficiently.

# Section 2 - Principles

### Post Incident Safety Huddles

- Completion is **not** mandatory but practice is recommended and encouraged
- Should occur within 24 hours of the incident, where possible
- Huddles are non-punitive; they should reinforce the intent to improve clinical care and prevent a recurrence of a similar incident. Staff members involved in the incident should remain anonymous where practicable
- Huddles aim to ensure the appropriate care and support is provided to those involved in the incident
- The patient/support person should be included in the huddle
- The team leader should check if the patient requires an interpreter (language other than English or deaf) and arrange for one
- Should take place at the site of the incident, if feasible, or otherwise at the patient's bedside
- Should include representation from the multidisciplinary team including nursing, medical and allied health staff, where possible
- For fall incidents: The safety huddle does not replace post fall management documentation or completion of the Falls Risk Assessment and Management Plan (FRAMP). The post fall safety huddle should be done in **addition** to standard post fall management care.

## Section 3 - Definitions

***Post Incident Bedside Safety Huddle:***

- An immediate evaluation of each patient safety incident, by an interdisciplinary team and the patient by the bedside, or in the environment where the incident occurred, with the goal to share information and raise situational awareness to reduce the risk of recurrence.

***Incident:***

- Any unplanned event resulting in, or with the potential for, injury, damage or other loss. This includes a near miss (as per NSW Ministry of Health Policy - PD2014_004 Incident Management Policy)

***Team Leader:***

- Coordinates the location, time and staff attendance at the huddle, as well as signs off that actions were delegated to team members for follow up
- Recommended to be a senior clinician in a nursing or allied health role who is routinely notified of clinical incidents on the ward/service

***Team member:***

- Ward/service based clinicians from nursing, allied health and medical backgrounds
- Includes any other staff members relevant to the particular incident
- The patient and/or support person are considered to be an integral member of the huddle team

***Support Person:***

- The person nominated by the patient to attend/participate in the safety huddle, either in addition to the patient or as their designated representative

# Section 4 - Responsibilities

## Team Leaders are responsible for:

- Identifying the relevant clinicians for each safety huddle
- Coordinating the time and place of a huddle with nominated clinicians and patient/support person as soon as possible. Communication of details may be through the use of phone calls, mobile phone text messages, or pagers
- Leading and coordinating the huddle discussion as guided by the HUDDLE UP tool
- Offering an apology to patient/support person on behalf of the ward/service
- Completing the documentation in patient's health care records
- Delegating completion of allocated responsibilities with identified team members

## Team members are responsible for:

- Attending the safety huddle as requested by the team leader
- Actively participating and providing professional expertise/insight to discussions
- Completing all allocated responsibilities within an appropriate timeframe
- Documenting completion of allocated responsibilities in patient's health care records

# Section 5 - Completion of the HUDDLE UP tool

See **Appendix A** for a copy of the tool.
The safety huddle process should include all steps as detailed:

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| **H**<br>**Hello and huddle up** | ***Introduction, explain purpose of huddle***<br>Acknowledge and introduce each person who is present and explain their role.<br>Explain purpose of huddle to patient, which is to try and prevent recurrence of a similar incident. |
| **U**<br>**Understand what happened** | ***Document incident type e.g. fall, aggression, medication error***<br>***Patient/ family member should be given the opportunity to describe the incident from their perspective***<br>Any staff members involved should provide their version of the events. Staff members must be de-identified: refer to position title, not to person's name.<br>Outline any harm/injuries the patient sustained. |
| **D**<br>**Open Disclosure** | ***Offer an apology***<br>Team leader offers an apology to the patient and/or family on behalf of the ward/service for the incident that occurred.<br>***Outline what actions have been taken by team since event e.g. observations, investigations*** |
| **D**<br>**Discuss what contributed to the event** | ***Discuss contributing factors***<br>Examples may be: items inaccessible, bed rails up, wet floor, inappropriate devices, incorrect dose/type of medication given, documentation of risk assessment, communication barriers (interpreter not used).<br>Review the pre-incident documentation to identify gaps in prevention and management of risks. |
| **L**<br>**List the risk factors**<br><br>**E**<br>**Eliminate or manage risk factors** | ***Review and list risk factors***<br>Examples may be: postural hypotension, reduced mobility, cognitive impairment, visual impairment, delirium/dementia, incontinence, sensory impairment, medical devices, equipment, patient speaks language other than English or is deaf.<br>***What will help manage/reduce the risk?***<br>Identify and outline specific strategies.<br>For further support:<br>• Refer to Incident Management PD, Open Disclosure PD, Pressure Injury Prevention and Management PD, Medication Handling PD, Protecting People and Property Information Bulletin<br>• Refer to relevant SESLHD Procedures/guidelines. |
| **U**<br>**Undertake actions and allocate responsibilities** | ***What do we need to do?***<br>• Provide education to the patient employing the 'Teach Back' method, which confirms the patient's understanding of care instructions by asking them to repeat the education using their own words. Interpreters should be used for patients from a Culturally and Linguistically Diverse (CALD) background.<br>• Identify who is responsible for each task to ensure the actions are followed up.<br>• Include IIMS reference number.<br>• Involve and collaborate with patient/ family when developing the plan, where possible.<br>• Handover of all the recommendations provided to nursing, medical and allied health staff caring for patient. |
| **P**<br>**Plan** | ***What have we learned from this event? What will change because of this incident?***<br>• Consider sharing as a case study at team meetings. |

## Section 6 – Documentation

It is the responsibility of the team leader (or a designated clinician) to provide an accurate written description of the post clinical incident safety huddle in the patient's health care records as per SESLHDPR/336 – Documentation in the Health Care Record.

The HUDDLE UP tool is available in electronic and paper versions (see Appendix 1 for a copy of the tool).

## Section 7 - Resources

1. SESLHDPR/380 Falls prevention and management for people admitted to acute and sub-acute care
2. SESLHDGL/044 Falls prevention and management for non-admitted patients
3. SESLHDPR/336 Documentation in the Health Care Record
4. SESLHDPR/267 Medicine: Continuity of Management and Documentation
5. SESLHDGL/058 Open Disclosure
6. NSW Ministry of Health Policy - PD2014_004 Incident Management Policy
7. NSW Ministry of Health Policy - PD 2014_028 Open Disclosure Policy
8. NSW Ministry of Health Policy - PD 2014_007 Pressure Injury Prevention and Management
9. NSW Ministry of Health Policy - PD 2013_043 Medication Handling in NSW Health Public Health Facilities
10. NSW Ministry of Health Policy - PD 2015_029 High-Risk Medicines Management Policy
11. NSW Ministry of Health Information Bulletin PD2013_024 - Protecting People and Property: NSW Health Policy and Standards and Security Risk Management

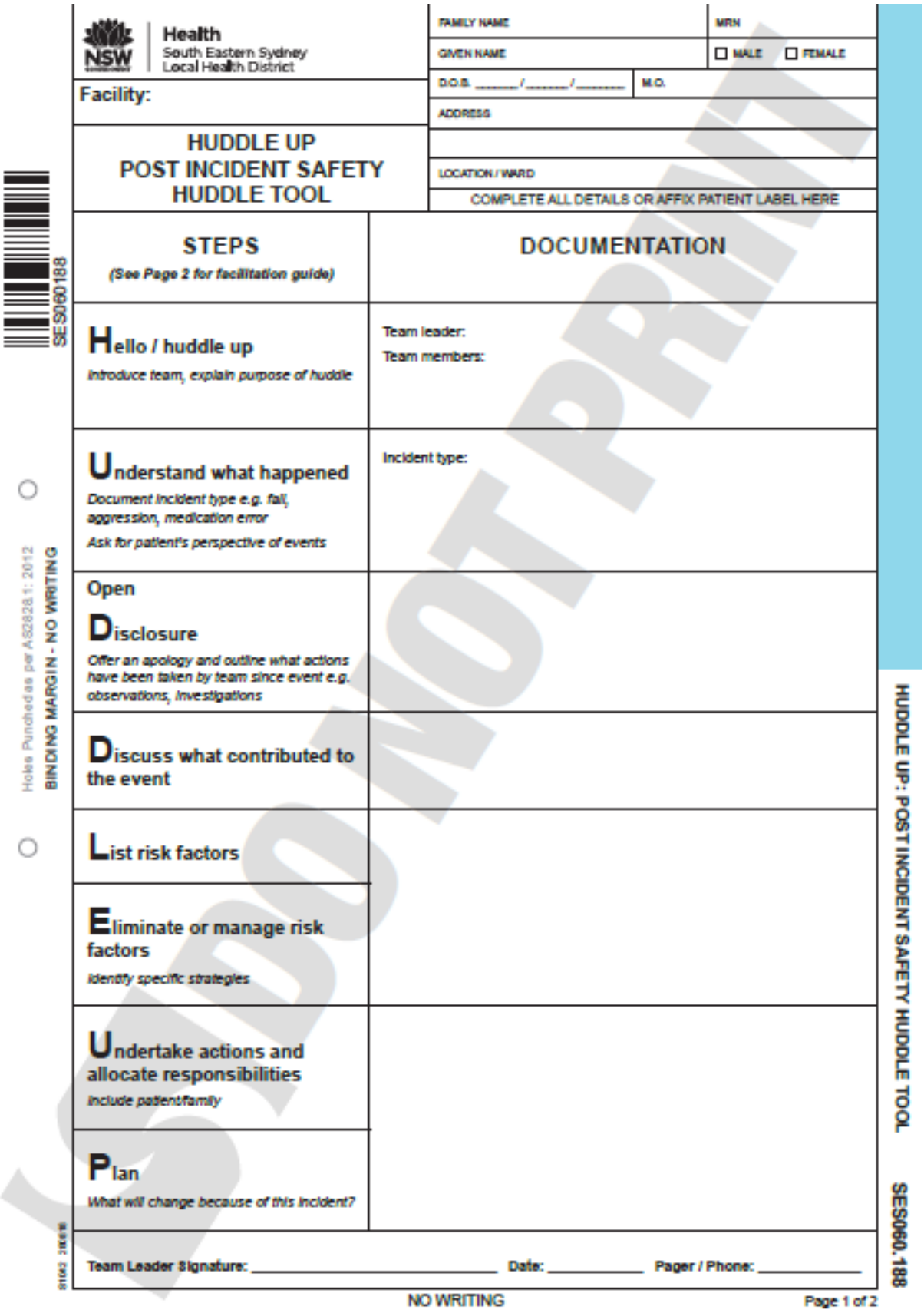
## Section 8 - References

1. Criscitelli, T. (2015). Fostering a Culture of Safety: The OR Huddle. *AORN,102:6*, p 656-659
2. Sikka, R., Kovich, K, and Sacks, L. (2014). How Every Hospital Should Start the Day. *Harvard Business Review.'*
3. Wagner, C et al (2015).*Safety Huddles a Guide to Safety Huddles.* Washington State Hospital Association. Seattle.
4. Clinical Excellence Commission (2017) Safety Huddles Implementation Guide Accessed online 29 October 2018 http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/falls-prevention/lbvc/teamwork
5. Boushon, B., Nielsen, G., Quigley, P., Rutherford, P., Taylor, J., Shannon, D., Rita, S. How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012. Accessed online 29 October 2018 http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx
6. Goldenhar, L.M., Brady, P.W., Sutcliffe, K.M., Muething, S.E. (2013) Huddling for high reliability and situation awareness. *BMJ Qual Saf.* Nov. 22 (11): 899-906

## Section 9 – Revision and Approval History

| Date | Revision no: | Author and approval |
|---|---|---|
| September 2018 | DRAFT | Carmelle Moses, Falls Prevention Program Coordinator |
| October 2018 | DRAFT | Draft for Comment period |
| November 2018 | DRAFT | Final draft endorsed by Executive Sponsor |
| November 2018 | DRAFT | Processed by Executive Services prior to Clinical & Quality Council approval |
| December 2018 | 1 | Approved for publishing by Clinical & Quality Council |

# Appendix A: Post Incident HUDDLE UP Tool



Health
South Eastern Sydney
Local Health District

Facility:

HUDDLE UP
POST INCIDENT SAFETY
HUDDLE TOOL

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES060188

| STEPS (See Page 2 for facilitation guide) | DOCUMENTATION |
|---|---|
| **H**ello / huddle up<br>*Introduce team, explain purpose of huddle* | Team leader:<br>Team members: |
| **U**nderstand what happened<br>*Document incident type e.g. fall, aggression, medication error*<br>*Ask for patient's perspective of events* | Incident type: |
| Open<br>**D**isclosure<br>*Offer an apology and outline what actions have been taken by team since event e.g. observations, investigations* | |
| **D**iscuss what contributed to the event | |
| **L**ist risk factors | |
| **E**liminate or manage risk factors<br>*Identify specific strategies* | |
| **U**ndertake actions and allocate responsibilities<br>*Include patient/family* | |
| **P**lan<br>*What will change because of this incident?* | |

Team Leader Signature: _____ Date: _____ Pager / Phone: _____

NO WRITING

Page 1 of 2

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

HUDDLE UP: POST INCIDENT SAFETY HUDDLE TOOL SES060.188

DO NOT PRINT

Health
South Eastern Sydney
Local Health District

Facility:

# HUDDLE UP
# POST INCIDENT SAFETY HUDDLE TOOL

| | |
|---|---|
| FAMILY NAME | MRN |
| GIVEN NAME | ☐ MALE ☐ FEMALE |
| D.O.B. _____/_____/_____ | M.O. |
| ADDRESS | |
| | |
| LOCATION / WARD | |
| COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |

## FACILITATION GUIDE:

- ✓ Safety huddles should be completed after clinical adverse events such as falls, pressure injuries, certain medication errors and security/safety threats. Clinical judgement must be exercised in clinical event management and completion of safety huddles.
- ✓ Safety huddles are not appropriate in cases resulting in a patient's death, where a Root Cause Analysis (RCA) will be carried out.
- ✓ It is recommended to nominate a senior member of staff as team leader for consistency.
- ✓ Teams should include all members of the multi-disciplinary team.
- ✓ The huddle should occur with the patient and their carer/family member at the location where the incident occurred (if feasible) or at the bedside, and ideally within 24 hours of the adverse event.
- ✓ Please refer to SESLHDGL/072 Post Incident Safety Huddles and effective use of the HUDDLE UP Tool for more information

| | |
|---|---|
| **H**ello / huddle up | *Introduction, explain purpose of huddle*<br>▪ Team leader to coordinate time and place of huddle<br>▪ Introduce team members and explain purpose of huddle, which is to try and prevent recurrence of a similar incident, to patient and / or family |
| **U**nderstand what happened | *Patient / family member should be given the opportunity to describe the incident from their perspective*<br>▪ Outline incident type and any harm / injuries to the patient<br>▪ Any staff members involved should provide their version of the events (staff members must be de-identified: refer to position title, not to name) |
| Open<br>**D**isclosure | *Offer an apology*<br>▪ Team leader offers an apology to the patient and / or family on behalf of the ward / service for the event that occurred<br>▪ Outline what actions have been taken by team since event e.g. observations, investigations |
| **D**iscuss what contributed to the event | *Discuss contributing factors*<br>▪ For example: items inaccessible, bed rails up, wet floor, inappropriate devices, incorrect dose / type of medication given<br>▪ Review the pre-incident documentation to identify gaps in prevention and management of risks |
| **L**ist risk factors | *Review and list risk factors*<br>▪ For example: postural hypotension, reduced mobility, cognitive impairment or dementia, visual impairment, incontinence, sensory impairment, medical devices, equipment |
| **E**liminate or manage risk factors | *What will help manage / reduce the risk?*<br>▪ Identify and outline specific prevention strategies e.g. review medication |
| **U**ndertake actions and allocate responsibilities | *What do we need to do?*<br>▪ If appropriate, provide education to the patient employing the 'Teach Back' method which confirms the patient's understanding of care instructions by asking them to repeat the information using their own words. Interpreters should be used for all Culturally and Linguistically Diverse (CALD) patients<br>▪ Identify who is responsible for each task to ensure the actions are followed up<br>▪ Involve and collaborate with patient / family in plan as feasible<br>▪ Hand over the recommendations to relevant team members |
| **P**lan | *What have we learned from this event? What will change because of this incident?*<br>▪ Consider sharing as a case study at team meetings |

*Acknowledgement to: Clinical Excellence Commission, "Post Fall Huddle: Information for Clinicians and Health Professionals," 2017; Institute for HealthCare Improvement, "How to Guide: Reducing Patient Injuries from Falls," 2012*



NO WRITING

# Appendix B: Suggested Observational Audit Tool

| Does the post incident safety huddle process include: | Yes | No | Action Required |
|---|---|---|---|
| Did the safety huddle occur within 24 hours of the incident? | | | |
| The use of the HUDDLE UP tool? | | | |
| Introduction of team members, explanation of purpose? | | | |
| Is the patient/support person a member of the team? | | | |
| Is the team leader identified? | | | |
| Do both clinicians and patient/support person provide their versions of the events? | | | |
| Does the team leader offers an apology to patient/ support person? | | | |
| Are risk factors listed? | | | |
| Are there specific and individualised strategies outlined to help minimise risk of recurrence? | | | |
| Is the allocation of responsibilities outlined? | | | |
| Are there plans for completion and follow up of responsibilities? | | | |