Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Understanding the key components of effective morning Hospital Huddles

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Contents

Background

Hospital Huddles form part of daily hospital management providing a focus across clinical and operational aspects of care delivery. Used widely across NHS Scotland, hospital huddles support safe communication and are a key component of the SPSP Essentials of Safe Care. This work aimed to understand the variation in huddles across NHS Scotland and identify core elements to support teams to improve patient safety, flow and communication as part of the morning huddle.

This document outlines the key findings of each stage of the work:

- Huddle components reported in the literature and in NHS board huddle templates
- Themes constructed from huddle observations and conversations with attendees about their perspectives on the purpose and content of their huddle
- Core elements for hospital huddles which bring together what was identified in the literature, the NHS board templates, huddle observations, and intelligence gained from conversations with huddle members.

What we did

Reviewed
7
published templates

Attended
14
Hospital huddles in 6 NHS boards

Attended
2
integrated huddles in 2 NHS boards

10
Huddle templates shared by 6 NHS boards

18
Conversations in 4 boards with more than 30 staff

Huddle components:
combined literature and NHS board templates

	Literature	Board Template
Leader sets out purpose and Hospital at Night report		
Previous 24hrs		
Outstanding issues from yesterday's safety brief		
Hospital at night handover including patients of concern including medical staffing gaps		
Yesterday's activity and performance		
Significant adverse events		
Safety issues		
Patients of concern and plans in place/support required		
Other safety concerns from wards or other services: e.g. IPC, critical equipment downtime		
Near misses/good catches		
Capacity & Flow		
Today's activity		
Current ED activity and performance		
Predicted admissions		
Each clinical area reports: staffing by exception, expected/delayed discharges, boarders, internal transfers, GP calls		
Critical care acuity and activity		
COVID positive, awaiting result, negative		
Overall available beds and site position		
Discharges		
Expected discharges today and EDDs requiring review		
Available community beds and capacity in integrated community assessment services		
Delayed discharges (Total / across system / on site / discharge today)		
Staffing		
Nurse staffing (reporting varies: by exception, RAG rating, raw numbers)		
Medical staffing - unplanned gaps		
AHPs and other services - staffing/activity		
Additional areas update (theatres, discharge lounge, SAS, Social work, integrated huddle update)		
AOB		
Special Announcements e.g. running on generator over the weekend		
Encourage raising of any other concerns e.g. "Are we safe to start?"		
Leader Summary		
Identify priority actions for today and assigns owners and timelines for items needing followed up.		
Follow up actions from previously identified issues		
How to access support between huddles		
Be safe closing message		
Post-huddle		
Huddle report to whole hospital		
Problem solving to begin post-huddle		

Component present

Metrics in huddle literature and templates

Metrics in the huddle	Literature	Board Template
Days since last serious harm event		
Days since last Potential Serious Safety Event		
Days since last staff injury		
Number of rapid response calls		
2222 calls / resuscitation events overnight		
Falls overnight		

Component present

Themes from huddle observations and conversations

The huddle observations and interviews with staff and stakeholders were analysed and organised into the three huddle stages: pre-huddle, in-huddle and post-huddle. A brief outline of the content is provided in the box below.

Pre-huddle	➢ Huddle preparation and sources of information ➢ Pre-population of a template
In-huddle	**Creating the conditions for an effective huddle:** ➢ Huddle structure – use of visuals and template ➢ Advantages and disadvantages of the digital huddle ➢ Huddle membership – missing groups e.g. medics ➢ Psychological safety as critical to huddle effectiveness ➢ Situational awareness as a key huddle benefit ➢ What we learned from integrated care huddles **Huddle content:** ➢ Flow ➢ Safety ➢ Use of the huddle to identify and resolve staffing issues ➢ Use of the huddle to communicate important messages across the site ➢ Summary of huddle priority actions
Post-huddle	➢ Dissemination of huddle report ➢ Problem solving huddle actions using network and mini-huddles ➢ Whole system interface

(See Appendix 1 for further detail on the themes within pre-huddle, in-huddle and post-huddle.)

Hospital Huddles: core elements

The purpose of the hospital huddle is to improve patient safety, flow and communication. The intelligence gathered so far suggests that to be fully effective it should also create cross-site situational awareness.

Pre-huddle

- Preparation takes advantage of existing information e.g. hospital at night handover
- Pre-population of template or visual

In-huddle

Creating the Conditions

- Use of standardised template which is visualised during the huddle.
- Culture of the huddle enables psychological safety.
- Huddle membership reviewed for missing teams/services.
- Consider review of huddle times.

Huddle opening

- Standardised huddle opening which sets the tone for a safe space.
- Actions from previous huddle reviewed for items requiring escalation.
- Invitation to raise any other concerns or issues.

Safety

- Review previous safety issues and follow up actions.
- Identify patients of concern / patients requiring enhanced observations
- Exception reporting of staffing.

Flow

- Cross site flow discussion (front door, main hospital, discharges).
- At lunchtime/afternoon huddles: identify patients anticipated for discharge tomorrow.
- Suggested inclusions: ED activity and performance; predicted admissions and discharges for each clinical area;

Situational awareness

- Consider whether the huddle reports current and future activity

Huddle Summary and Plan

- Safety/emerging issues and actions summarised
- Priority actions and action owner identified.

Post-huddle

- Problem solving occurs outside the huddle
    - Site problem solving
    - Wider system engagement
- Dissemination of information e.g. huddle report
- Whole system interface

Appendix 1: Further detail on huddle themes

Pre-huddle

- Huddle preparation is important and takes time if drawing information from a number of systems.
- The Hospital at Night and management handover has a significant role to play in contextualising the morning huddle.
- Pre-population can support exception reporting within the huddle, and enhance situational awareness.

In-huddle

Creating the conditions for an effective huddle

Huddle **structure:**

- The use and consistent application of a huddle template improved huddle experience for staff.
- Some boards used a visual to structure the huddle. This was particularly effective when it was pre-populated.

The **digital huddle:**

- Use of MS Teams has broadened access to the huddle and is particularly valuable for staff with cross-site responsibility.
- The move to virtual is perceived by some boards to have impacted on team working.
- The in-person huddle is particularly valued as an opportunity for brief side-conversations for advice and support.
- Hybrid huddle models were observed where some services dialled in rather than coming face to face.

Huddle **membership:**

- Almost all the huddles we attended or heard from did not have consistent input from medical teams.
    - It was considered that the huddle could provide valuable situational awareness to medics and that having their regular input could improve timeliness of discharges.
- Allied Health Professionals were represented on all huddles we attended but their potential contribution was considered to be underutilised in some areas.
- Huddle attendance by senior members of the hospital team such as lead nurses was considered important to subsequent escalation and resolution of issues.
- Other teams not consistently represented but considered to boost huddle effectiveness included:
    - Infection prevention and control
    - Pharmacy
    - Scottish Ambulance Service
    - Imaging

Psychological safety as critical to huddle effectiveness:

- The tone and approach of the huddle chair has a significant impact on the culture and openness of the huddle.
- It is important to huddle attendees that respect is given to their clinical judgement in relation to safety and staffing.
- Two huddles provided an explicit opportunity to share items for celebration.

Value of the huddle in providing **situational awareness:**

- All huddles provided the whole site position in terms of demand and capacity.
- Understanding the position across the site in terms of safety and flow was considered valuable across services and professional groups.
- Information from the huddle and post-huddle report was disseminated to help the broader hospital team understand, and in some cases target support, to pressure points in the system.
- Situational awareness was enhanced through sharing of visuals in some boards.

What we learned from **integrated care huddles:**

- Reciprocal sharing of information between acute sites and community based services including:
    - Forecasting of activity for the week.
    - Delayed discharges across the system.
    - Implications of staffing, infection control or activity on capacity to admit patients to community beds.
    - Activity in integrated services.
    - Closed beds and plans for reopening.
- The power of coalescing of the team around whole system issues. The learning from this approach is informing service redesign in one board.
- Acted as a forum in which they built their situational awareness and were able to problem solve collectively.
- The value of developing situational awareness across the system rather than site-specific.
    - Within the huddle there is a sense of team: “We’re all in this together”
    - Beyond the huddle there is sharing of intelligence which teams are then able to use in understanding and accelerating priorities.
    - Consideration given to implications of safety concerns to otherwise unrelated services.

Huddle content

Flow:

- A key focus in almost all the huddles we attended was on flow, particularly the front door and discharges.
- Emergency department activity and performance reliably reported across all huddles.
- Predicted and delayed discharges were consistently discussed with an emphasis on morning discharges and discharge lounge activity where applicable.
- Aspects suggested could improve the huddles ability to support discharges
    - Attendance of medics, pharmacy, social work and the ambulance service
    - Forward planning for the next day's discharges
    - Infrastructure for information flow to community based services e.g. via integrated care huddles.
- Patients boarding out of specialty discussed at some huddles.

Safety:

- Several boards summarised safety issues from the previous day and overnight.
    - In one board emerging issues from the previous day's Datix were considered at the huddle.
- Deteriorating patients and their plans were identified and discussed in different ways across huddles.
- Patients requiring enhanced observations e.g. experiencing delirium or at increased risk of falling were inconsistently reported.
- Inviting staff to raise safety concerns occurred in almost all huddles
    - One huddle invited sharing of issues from the previous day which had a learning outcome.

Use of the huddle to communicate important information across the site:

- Several boards used the huddle to communicate important issues/news e.g. use of the generator over the weekend.
- One board used the huddle as a hub for a weekly focus which was then disseminated from the huddle to teams across the site.

Use of the huddle to identify and solve **staffing issues:**

- Almost all boards spent a significant proportion of the huddle on staffing, with a primary focus on gaps in nurse staffing.
- The way clinical areas declared their staffing to be safe varied within and between huddles.
    - Some huddles used the RAG rating to report staffing but there was variation in its interpretation and application.
    - Raw staffing numbers were provided in some huddles.
    - The influence of patient acuity and ward activity in safe staffing was not always clear.
    - One board used exception reporting for raising unresolved staffing issues.
- Several boards use the huddle to solve staffing issues. This approach was contentious in some huddles where it was perceived to threaten the psychological safety of some staff members.

Huddle **summary:**

- Some huddles summarised the safety issues identified during the huddle and assigned responsibility for emerging actions.
- A number of huddles used the phrase “are we safe to start?” Some people perceived this to be helpful from a governance perspective and to prompt mitigation of risk. Others considered it to be tokenism and suggested it be revised. Alternatives offered included ending the huddle with shared priorities and a plan.

Post-huddle

- Prompt provision of an electronic post-huddle report was valued.
- Some huddles had follow up mini-huddles either within departments or for specific groups of staff e.g. lead nurses and management team. The purpose of the mini-huddles was to make plans or mitigate issues identified in the main huddle. Both formal and informal mini-huddles were described.

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Component present