Huddles
Developing Situational Awareness

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Disclosure

Gary Yates, MD, is President of Healthcare Performance Improvement, LLC

Frank Federico, RPh has no conflict to disclose
Sentara Healthcare

- Formed through a series of mergers of community hospitals
- 11 hospitals; 2,580 beds; 3,825 physicians on staff
- 13 long term care/assisted living centers
- 4 Medical Groups (750+ Providers)
- 450,000-member health plan
- $4.7B total operating revenues
- 26,000+ employees
- AA/Aa2 bond ratings
- Sentara Quality Care Network (SQCN)
- Sentara eCare® HIMSS Analytics Stage 7 and HIMSS Davies Award
- AHA Quest for Quality Award 2004, John M. Eisenberg Award 2005

HPI – Experience

Methods based on science and facts

- Science of human error and event prevention
- Practical experience in high-reliability industries including nuclear power and aviation

Experienced-based mentoring

- Over 500 hospitals
- Consulting team with HRO experience and healthcare experience (clinicians, non-clinicians, and physicians)
High Reliability Organizations

HROs “operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents.”

3 Principles of Anticipation
“Stay Out of Trouble”
Sensitivity to Operations
Preoccupation with Failure
Reluctance to Simplify

2 Principles of Containment
“Get Out of Trouble”
Commitment to Resilience
Deference to Expertise

It’s All About Managing RISK

Risk is a function of probability and consequence.

\[ R = P \times C \]

By decreasing the probability of an accident, HRO’s recast a high-risk enterprise as merely a high-consequence enterprise. HROs operate to make systems ultra-safe.
A Framework for Huddles

- Unit-based huddles feeding into a house-wide huddle help create a daily operating system that increases situational awareness and resiliency throughout the organizations
  - Sensitivity to operations
  - Commitment to resilience
- Sets the stage for enhanced “cause solving” and learning across departments and facilities

Origin of Huddles

- Huddles are frequently used in HROs as a means for frontline staff to
  - share and make sense of current situations, errors and concerns, and
  - to discuss options for resolving or eliminating them in the future
IHI Experience

Nursing Unit Safety Huddles
- Start of the day
- End of shift
- After an adverse event such as a fall

Safety Huddles in Denmark

Safety Briefings

- Help increase staff awareness of patient safety issues
- Create an environment in which staff share information without fear of reprisal, and
- Integrate the reporting of safety issues into daily work
Growth of Briefings

Originally tested on hospital inpatient care units, Safety Briefings are now being used in other hospital departments such as pharmacies and post-anesthesia care units, and in other health care settings, such as home health care and long-term care facilities.

Getting Ready

- Identify a patient care unit for the first test of a Safety Briefing. Choose one where the manager is receptive to testing changes and agrees with the non-punitive approach of the Briefing.
- Meet with the manager to explain the concept and purpose of the Briefing and to ask for support on the non-punitive approach.
- Test the Briefing on a small scale (for example, on the day shift for only one week).
- Decide who will conduct the test with the staff: the Unit Manager, the Patient Safety Officer, the Director of Quality Improvement, or a combination of these individuals.
- On the first few days of the test, someone must lead the discussion and explain the goals to the staff.
- Inform the staff in advance of the plans for the test.

http://www.ihi.org/knowledge/Pages/Tools/SafetyBriefings.aspx
Getting Started

- Must stabilize system
  - Reduce variation
  - Reduce harm such as infections, pressure ulcers, and others
- Make time for participants to prepare
- Make time for participants to participate
- Develop script: three questions want answered
- Document huddle
- Monitor huddle to improve

Situational Awareness

- Perception: able to monitor and recognize cues that increase their awareness of what is happening around them
- Comprehension: integrate information to develop a comprehensive picture of the current status and understand how it may affect goals
- Projection: extrapolate forward to determine if the knowledge obtained might adversely influence the situation both immediately and in the near future
Situational Awareness in Healthcare

- **Perception:** Each huddle participant to systematically report on patients on their unit who they thought may deteriorate in the near future and label them as ‘watchers’
- **Comprehension:** asking senior nurses and physician leads to coach charge nurses on how to integrate their perceptions into an informal severity of illness assessment
- **Projection:** training the clinicians on how to use the information to facilitate prediction and planning for at-risk patients

Horsens, Denmark
### Culture Embedding Mechanisms

**From Organizational Culture & Leadership, by Edgar Schein**

<table>
<thead>
<tr>
<th>Primary Embedding Mechanisms</th>
<th>Secondary Articulation &amp; Reinforcement Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What leaders pay attention to, measure, and control on a regular basis</td>
<td>- Organizational design and structure</td>
</tr>
<tr>
<td>- How leaders react to critical incidents and organizational crises</td>
<td>- Organizational systems and procedures</td>
</tr>
<tr>
<td>- Observed criteria by which leaders allocate scarce resources</td>
<td>- Organizational rites and rituals</td>
</tr>
<tr>
<td>- Deliberate role modeling, teaching, and coaching</td>
<td>- Design of physical space, facades, and buildings</td>
</tr>
<tr>
<td>- Observed criteria by which leaders allocate rewards and status</td>
<td>- Stories, legends, and myths about people and events</td>
</tr>
<tr>
<td>- Observed criteria by which leaders recruit, select, promote, retire, and excommunicate organizational members</td>
<td>- Formal statements of organizational philosophy, values, and creed</td>
</tr>
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</table>

### Leveraging Senior Leaders

**Leverage** the use of a small initial investment to gain a very high return in relation to one's investment, to control a much larger investment, or to reduce one's own liability for any loss

**High Leverage Tools & Techniques for Executives**

- Core Value 5:1 Feedback
- Round To Influence
- Daily Check-In
- Top 10 List

<table>
<thead>
<tr>
<th>Impact</th>
<th>Investment</th>
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</thead>
<tbody>
<tr>
<td>Low Visibility, Relevance Degree of Influence</td>
<td>Low Time, Money, Other Resources</td>
</tr>
<tr>
<td>High Core Value 5:1 Feedback Round To Influence Daily Check-In Top 10 List</td>
<td>High</td>
</tr>
</tbody>
</table>

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Plan of the Day (POD) Meeting in the Nuclear Power Industry

30-minute meeting of operational leadership to provide situational awareness of plant operations and command and control for issue prioritization, ownership, and resolution

Agenda
- Emergent safety issues
- Status of Top 10 Problem List
- Routine reports (operations priorities, operations workarounds, alarms not working, alarms locked-in, temporary modifications)
- Priorities for the day
- Critical questions

Daily Check-In Agenda
1. LOOK BACK – Significant safety or quality issues from the last 24 hours/last shift
2. LOOK AHEAD – Anticipated safety or quality issues in next 24 hours/next shift
3. Follow up on Start-the-Clock Safety Critical Issues

"Talking about safety should not be an event."
Barbara Summers, President Community Hospital North

9:00-9:15 AM, Monday-Friday
All departments directors
100% attendance expectation – "step out of meeting to attend"
Facilitated by senior leader
Shared Situational Awareness

Past

LEADER

Future

Current

Operations
Realities & challenges of the front line

Leadership
Core value focus & prioritization

Here & Now

Benefits of Daily Check-In
A House-wide Safety Huddle

Leadership Awareness
- For the senior leader: awareness of what’s happening at the front line by staying in touch with your people
- For operational leaders: awareness of “what’s going on” in other areas and cross-department impact
- Mental organization – a chance to “plan your day”

Problem Identification & Resolution
- Early notification of issues
- Breaking down silos – all directors to pool ideas and resources in solving problems and potential problems

Accountability for Safety
- “Talking about perfect care has become easier” – more aggressive in leadership for Zero events
- Dialogue about how we are at risk, how we can reduce our risk, and how we can support each other
- Transparency – “A patient fell on my unit last night and broke an ankle”

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**Look Back – Any Events of Harm?**

**Patient Safety Events**
- Serious Safety Events & Precursor Safety Events

- Injuries to patients
- Treatment delays or deficiencies
- Falls
- Medication errors
- Incidents of skin breakdown
- Incidents of VAP

**Employee Safety Events**

- Slips/trips/falls
- Exposures to infectious disease
- Assaults
- Injuries to non-clinical staff
  - Maintenance – equipment incidents
  - Environmental Services – chemical incidents
  - Food Services – burns, cuts

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**Look Ahead – Any Threats to Safety?**

- Do we have any **high-risk patients or procedures**?
- Do we anticipate any **non-routine procedures or tasks**?
- Are we dealing with any situations or conditions that distract our ability to focus or think critically about our patients?
- Are there any safety issues that I know about that may impact other departments?
- Do we have what we need to deliver safe, quality care? Are there any **deficiencies in information, equipment, supplies, or staff** that will make it hard to deliver safe, high quality care?
- What conditions **outside our unit or outside our hospital** could impact our ability to deliver safe, quality care today?
**Lines for Leaders**

- How do you know you had no problems?
- What immediate actions did you take?
- Is this happening in other places? Could this happen in other places?
- What other areas does this impact?
- How are you preparing your team for that task?
- What Safety Behavior error prevention technique should be used?
- If any deficiencies that impact safe care:
  - *That's a Safety Critical Issue that requires Rapid Response...*

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**Keep Risk Awareness High**

![Risk Awareness Graph]

- Complacency
- Event

> How do you increase risk awareness without having to have an event?
Daily Check-In Roll Call

Days since last serious safety event reported each day

Status of selected issues on the Safety Top 10 List reviewed each Friday
Daily Check-In Roll Call *Projected*

Daily Check-In Note Pad

with permission of Spectrum Health

with permission of VCU Health System
Daily Check-In

1) What benefits will Daily Check-In bring?

2) What challenges do we anticipate in starting Daily Check-In?

3) Who will lead at each site?

4) What time will we hold Daily Check-In?

5) Who will participate at each site?

6) How will we introduce Daily Check-In at our site?

7) How will we provide for ourselves observation and coaching on our facilitation of Daily Check-In?

8) What does Mike expect to learn from Daily Check-In?

Daily Check-In Checklist

- Standing time
  - Held 7 days a week

- Senior leader facilitates
  - Led by the CEO

- Mandatory for all department leaders
  - Includes ALL – clinical and non-clinical department leaders

- Standing agenda – (1) any safety issues in the past 24 hours and (2) any threats to safety in the next 24 hours
  - Daily Check-In begins with “days since last safety event”

- Everyone checks in – no “report by exception”
  - Standing check-in order
Patient Exposure

Outpatient visits occur 25 times more frequently than hospital admissions

Office Practice Daily Check- In

- Any sound alike names on the schedule
- Any workload and any individual illness/fatigue/distraction issues
- Staffing for the day and any unusual coverage situations
- Any unusual requests, infrequently performed procedures, high-risk, or complex tasks planned for the day
- Any pertinent equipment issues
- Any recent or pertinent patient/ family complaints and compliments
- Any safety events/ safety issues from previous days
- Any changes in policies or procedures

Provide periodic reinforcement of a safety behavior
Encourage questions; Help manage the authority gradient
An Evolution in Perspective…

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<thead>
<tr>
<th>Setting Expectations</th>
<th>Broadening Perspective</th>
<th>Differentiated Response</th>
<th>Shared Ownership for Safety</th>
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</thead>
<tbody>
<tr>
<td>&quot;Every day – all departments.&quot;</td>
<td>&quot;Safety is about more than just staffing and bed flow.&quot;</td>
<td>&quot;This is a safety critical issue – page me by 3:00 PM with the status.&quot;</td>
<td>&quot;How can I help with that?&quot;</td>
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**Stage 1**
Overcoming Resistance
"Every day? Even when I don’t have any issues?"

**Stage 2**
Focusing Attention
"We’re talking about safety issues – not everything else."

**Stage 3**
Deference To Expertise
"Who’s the best person to own this?"

**Stage 4**
Preoccupation With Failure
"Does this condition exist in your department?"

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Table 1: Cincinnati Children’s Hospital Medical Center huddle development and implementation timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Huddle-related activities</th>
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<tr>
<td>2005–2006 Pre-implementation</td>
<td>Began speaking with people in other high-reliability organizations (HROs)</td>
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<tr>
<td>2007–2008</td>
<td>Concentrated learning about principles of HRO and situation awareness (SA)</td>
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<tr>
<td>2007–2008</td>
<td>Joint Agency for Healthcare Readiness and Safety (JAHRS) and Human Error Learning Network (HELP) initiative</td>
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<tr>
<td>2007–2008</td>
<td>Initiated huddles — focus on patient flow and staffing</td>
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<td>2007–2008</td>
<td>Began measuring and analyzing data on patient flow and staffing</td>
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<td>2007–2008</td>
<td>Initiated data analysis with executive teams</td>
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<tr>
<td>2007–2008</td>
<td>Attended Institute for Healthcare Improvement conference</td>
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<td>Initiated data analysis with executive teams</td>
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<tr>
<td>2007–2008</td>
<td>Staffed team and identified SA failures related to systems</td>
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<td>2007–2008</td>
<td>Initiated outside SA experts to consult</td>
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What If It Starts to Feel “Stale”?*

- Check to see what is really happening at the unit level
- Opportunity for leadership message and coaching
- Can expand reporting to include other areas of concern
  - Employee harm
  - Service issues

Are you ready?

- Have you reduced harm in your organization?
- Have you reduced variation using standardization?
- Have you developed a script?
- Have you set aside time for the participants to huddle?
- Have you set rules for the huddle?
- Do you have a way to follow up on concerns raised during the huddle?
- Are you monitoring huddles to identify ways to improve?
Resources

- Use Regular Huddles and Staff Meetings to Plan Production and to Optimize Team Communication
  http://www.ihi.org/knowledge/Pages/Changes/UseRegularHuddlesandStaffMeetingsToPlanProductionandtoOptimizeTeamCommunication.aspx
- WIHI: Situational Awareness and Patient Safety
  http://www.ihi.org/knowledge/Pages/AudioandVideo/WIHI-SituationalAwarenessPtsSafety.aspx
- Use Regular Huddles and Staff Meetings to Plan Production and to Optimize Team Communication
  http://www.ihi.org/knowledge/Pages/Changes/UseRegularHuddlesandStaffMeetingsToPlanProductionandtoOptimizeTeamCommunication.aspx

Resources

- Daily Check-In for Safety: From Best Practice to Common Practice
- Huddles at CCHMC (Video)
  http://seraph.cchmc.org/mediasiteex/Viewer/?peid=50a48b3628c047538923e61e9e74f893
- Huddling for high reliability and situation awareness