Hospital Safety Flow Huddle Guidance Document

Achieving your Gold Standard

Where Safety and Flow become part of the same conversation
Hospital Safety Flow Guidance Document

Introduction

One challenge for frontline care givers and organisations who deliver care, is how best to integrate processes that enable the six pillars of quality (safe, timely, effective, efficient, person centred, equitable).

In Scotland, we recognise that Patient Flow has consequences for Patient Safety and vice versa and therefore suggest that neither Safety nor Flow should be seen in isolation. We want Safety and Flow to be part of the same conversation, to learn and emulate best practice that supports integration into the system at micro, meso and macro level.

Hospital Huddles and debriefs at key points in the day have been identified as an ideal opportunity for the wider multidisciplinary team to discuss, prioritise and action issues of flow and safety. While creating an environment of psychological safety supports collective responsibility developing a highly reliable culture for learning and quality improvement.

When prioritised by multi professional leaders, well designed Hospital Safety Flow Huddles provide real time information that improves system wide communication and risk management. This approach reinforces a mechanism to resolve issues before they impact on safety or patient flow.

This Guidance Document aims to support teams implement, improve and spread best practice in achieving your Gold Standard for Hospital Safety Flow Huddles.
Hospital Safety Flow Huddle

Principles for success
Organisations should utilise Huddles to:
- Understand the overlap between Safety, Person-Centredness, Flow and Quality of Care,
- Utilise problem solving techniques, not just information sharing,
- Confirm Senior Clinical and Strategic Leadership,
- Recognise early morning as a key transition point for people,
- Support psychological safety,
- Be part of a 24/7 system,
- Be committed to driving quality improvement.

Hospital Huddles aim to:
- establish timely proactive review and mitigation of clinical and operational risks
- ensure patients receive optimal care.

Right Care, Right Time, Right Place, Right Team
Hospital Safety Flow Huddle
Building on success

Does your site already hold a Huddle?
Are you planning to introduce Huddles on your site?

This Guidance Document has been developed with the purpose of setting out generic improvement methodology to support your organisation introduce, design improve or spread best practice for Hospital Huddles.

How effective is your Huddle?

Use the information provided within the following Action Effect Diagram as a guide to identify current status of your Hospital Safety Flow Huddles, areas of best practice and areas where improvement may be made.

** http://www3.imperial.ac.uk/aboutimperial
Supportive paper http://m.qualitysafety.bmj.com/content/early/2014/10/15/bmjqs-2014-003103.full
Hospital Safety Flow Huddle

How effective is your Hospital Huddle?
Take a temperature check.

The following pages set out the **Key Elements** evidenced as the major contributing factors or Gold Standard associated with an effective Huddle.

As a team **discuss the key elements** and **investigate the interventions** linked to each element. Any gaps identified will support the development of a coherent **action plan** for quality improvement and an effective Hospital Safety Flow Huddle.
Hospital Safety Flow Huddle

**KEY ELEMENTS**

**Aim**
To achieve this:

Right Care, Right Time, Right Place, Right Team
Patient receives optimal care

**Major Contributing Factor**
Improve this:

**Key elements**
By managing these:

System

Structure

Implementation

Impact metrics

How do you currently manage these key elements?

Click coloured boxes throughout the document for more information
Hospital Safety Flow Huddle
Assess current practice

Discuss the Key elements

System
Structure
Implementation
Impact metrics

Consider your current approach and the teams confidence for the interventions that contribute to the key elements for success.

The following pages present the evidence base for each of the individual key elements.
Hospital Safety Flow Huddle

Key element
System

Interventions
(a) Integration with the wider system
(b) Effective Leadership
(c) Thresholds or triggers

(System)

(integration boxes below for more information)
Hospital Safety Flow Huddle

System

Key element

Interventions
(click boxes below for more information)

Evidence Base
- Things within your control

Demonstrate a system approach at 3 levels
- Micro - Unit
- Meso - Hospital
- Macro - Whole system
  ✓ Hospital-wide
  ✓ Community Beds
  ✓ Social Care and carers
  ✓ Transport

Participation necessary from whole system stakeholders
- promotes networking and decision making
- Follow up of non-attenders
- Follow up briefs during day

Supported strong Clinical Governance
- structure across whole system
- Risk awareness 24/7

Strengthen effective communication
- Sharing organisational expectations
- Building an environment ensuring psychological safety

a) Integration with the wider system

b) Effective Leadership

c) Thresholds or triggers
Huddles depend upon people and participation - essentially prioritised by leaders and take place every day:

- Require 24/7 site management / Senior Site Director
- Demonstrate open appreciation of resilience and team work, recognition of difficult times and creating an opportunity for learning and resolution within context
- Provide consistent chairperson, executive commitment, medical, nursing and clinical leads
- Focus on joint responsibility to get people in the right place at the right time

Essential capability, skills and expertise within the room to address:

- Safety awareness
- Risk awareness
- Improvement skills
- Improvement owned by wider team
- Learning through assimilation
- Aligning strategic plan with front line
- Senior medical leadership
- Consistent effective delegation

Decision making: expertise and ability to problem solve:

- Whole System Stakeholder Engagement and ownership
Hospital Safety Flow Huddle System

Key element

System

Interventions (click box below for more information)

c) Thresholds or triggers

Evidence Base
- Things within your control

A system which responds to risk and increased demand
- Seeking and arranging help across the system
- Appreciation of effort and support
- Risk is owned by frontline staff

Communication and appreciation of system information
- Information demonstrating whole system position
- Situational awareness tool that is shared across system
- Visual templates and scripts

Safety status
- What are your safety issues?
- What are your safety risks?
- Consistent definition to declare safety

Flow status and forward planning
- Capacity bed management
- Boarding and up to date care plans
- Bed availability to meet demand
  - Timely AM and PM discharges
  - Discharge tools
  - Smoothing elective admissions
  - Accurate predicted activity

Collective responsibility for mitigation and resolve
- Collective mindfulness and learning
- Perception of events and forward planning
- Comprehension of consequences
Hospital Safety Flow Huddle

Structure

Key element

Structure

Interventions
(click boxes below for more information)

a) Purpose

b) Process

c) Problem Solving

Proactively managing our discharges has reduced our delayed discharges by 18-25%.

NHS Ayrshire and Arran
Hospital Safety Flow Huddle

Structure

Key element: Structure

Interventions:

a) Purpose

- Where harm reduction is owned by frontline staff:
  - Waking flow up in the morning
  - Early review of boarders
  - Developing processes for system wide understanding of harm, e.g. Cardiac arrest, Falls, HAI, delayed discharge

b) Process

c) Problem Solving

Evidence Base

- Things within your control

Where every department and every member of staff appreciates their contribution to patient safety and flow
Hospital Safety Flow Huddle

Structure

Key element

Interventions
(clic k boxes below for more information)

Evidence Base
- Things within your control

Providing consistent and reliable format to collate data that supports decision making and prediction.

- Agreed script to feedback ward information
- Chairperson notes outlining script
- Electronic template to capture whole system position

Commitment to address safety and flow as an organisation and not compartmentalise.

- Willingness to support and respond to other departments and teams.

Shaping time to model and learn new behaviours:

- Look forward - predictions for the day, what’s expected
- Look back - did our prediction match our actual activity?
- Potential risks identified and managed
- Link with downstream hospitals - appreciate the wider organisation

Lessons learned - what went well, could we do better?

- Summary of expected challenges with clear goals
- and confirm later review
Hospital Safety Flow Huddle
Structure

Key element

Interventions
(click box below for more information)

Evidence Base
- Things within your control

Flow is a real thing... principally and a number one safety problem

Authority and responsibility
• Executive reinforcement at the front line
• Ability to make decisions
• Managing by prediction rather than reaction

Tools and levers
• Sensitivity to operations
  ▪ Clinical priorities
• Deep knowledge of the system
  ▪ Learning to find the cause
  ▪ Deference to expertise
• Real time information/data
• Collective mindfulness and responsibility
• Mechanism to resolve outstanding issues
• Feedback and learning

Escalation
• Timely
• Triggers of system pressures
• Reliable processes
• Executive responsibility
• Monitoring impact of escalation

- Structure
- System
- Implementation
- Metrics
- Resources
- Contact Information

- Introduction
- Safety Flow Huddle
- Building on Success
- How Effective is Your Huddle?
- Key Elements
- Assess Current Practice
- Authority and responsibility
  • Executive reinforcement at the front line
  • Ability to make decisions
  • Managing by prediction rather than reaction
- Tools and levers
  • Sensitivity to operations
    ▪ Clinical priorities
  • Deep knowledge of the system
    ▪ Learning to find the cause
    ▪ Deference to expertise
  • Real time information/data
  • Collective mindfulness and responsibility
  • Mechanism to resolve outstanding issues
  • Feedback and learning
- Escalation
  • Timely
  • Triggers of system pressures
  • Reliable processes
  • Executive responsibility
  • Monitoring impact of escalation
Hospital Safety Flow Huddle
Implementation

Key element
Implementation

Interventions
(click boxes below for more information)

a) Agreement
b) Conditions
Hospital Safety Flow Huddle
Implementation

Key element
Implementation

Interventions
(click boxes below for more information)

Evidence Base
- Things within your control

Whole System agreement to commence and support:
• Early mornings are the key transition point for hospitals
• Daily (including weekends) at 08:00 with a duration of no longer than 30 minutes.
• Huddles followed by debriefs taking place later in the day re-assess earlier prediction, update progress and provide real time information
• Multi-site boards engaging in briefs benefit from increased early discharge and improved patient flow
• Clear roles and responsibilities
• Clear aims and expectations at micro, meso and macro level

Supporting representation from all departments and services i.e. Emergency Department, All Wards, Critical Care Areas, Community Services, Hospital at Night, High Dependency Units, Medical Receiving, Day Surgery Unit, Theatre, Discharge Team, Endoscopy, Allied Health Professionals, Bed Management, Estates, Laboratories, Phlebotomy, Diagnostics, Social Work, Pharmacy, Surgeons, Physicians, Care of the Elderly Rehabilitation Teams, Infection Control Team, Page Holders, Nurse Practitioners, Patient Flow Co-ordinators
Hospital Safety Flow Huddle

Implementation

Key element

Implementation

Interventions

(click box below for more information)

Evidence Base
- Things within your control

A venue
- Providing common ground away from clinical areas

Psychological safety
- No blame culture, confidence to assess and articulate safety and flow within area

Commitment
- to attend and to address safety and flow as an organisation and not compartmentalise

Sharing the right information in an effective and timely manner
- Completed scripts relevant to clinical area or department providing consistent and reliable format to collate data that supports decision making and prediction

Model for continuous improvement
- High functioning teams
- Multiple improvements taking place simultaneously

Organisational debrief at key points in the day
- i.e. 12:30, did we achieve what we set out to do this morning?
- Early preparation for tomorrow’s activity
- Mitigation of on-going issues
- Clear plan supporting safety and patient flow

Overlap of safety and patient flow
Hospital Safety Flow Huddle

Metrics

Key element

Metrics

Interventions

(click boxes below for more information)

a) Process

b) Outcome

We need to identify patients in a timely manner and not stock pile and move all at once because they are going to be breech.

NHS Borders
Hospital Safety Flow Huddle

Metrics

Key element

Interventions
(click boxes below for more information)

System
Structure
Implementation
Safety
Flow
Person Centred

The measurement and monitoring of safety:

The Healthcare Quality Strategy for NHSScotland:
http://www.gov.scot/Topics/Health/Policy/Quality-Strategy

a) Process

b) Outcome

Assess Current Practice
How Effective is Your Huddle?
Key Elements
Assess Current Practice
System
Structure
Implementation
Metrics
Resources
Contact Information
## Hospital Safety Flow Huddle

### Process Metrics

<table>
<thead>
<tr>
<th>Safe (S)</th>
<th>Effective (E)</th>
<th>Person Centred (P)</th>
<th>Managing the key elements</th>
<th>Identified areas of improvement to support evidence base</th>
<th>Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Integration with wider team</td>
<td>Demonstrating a system approach</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Effective Leadership</td>
<td>Prioritised by leaders</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Thresholds or Triggers</td>
<td>Risk management</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Purpose</td>
<td>Harm reduction owned by frontline staff</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Process</td>
<td>Providing consistent and reliable format to collate data</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td></td>
<td></td>
<td>Problem solving</td>
<td>Authority and responsibility</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td>Agreement</td>
<td></td>
<td></td>
<td>Whole system agreement to commence and support</td>
<td></td>
</tr>
<tr>
<td>S, E, P</td>
<td>Conditions</td>
<td></td>
<td></td>
<td>Venue</td>
<td></td>
</tr>
</tbody>
</table>

- **System Structure Implementation**
  - Hospital Safety Flow Huddle
  - Process Metrics

- **Key Elements**
- Assessment Current Practice
- Resources
- Contact Information
## Hospital Safety Flow Huddle
### Outcome Metrics

<table>
<thead>
<tr>
<th>Safety (S), Flow(F) Person Centred (P)</th>
<th>Measure</th>
<th>How to measure</th>
<th>Data source/Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>S,P</td>
<td>Improved staff experience</td>
<td>Local survey</td>
<td>Local <a href="http://www.gov.scot/Publications/2014/12/8893">link</a></td>
</tr>
<tr>
<td>S,P</td>
<td>Improved patient and family experience</td>
<td>Complaints and compliments</td>
<td>Local <a href="http://www.gov.scot/Topics/Statistics/Browse/Health-InpatientSurvey">link</a> <a href="http://www.gov.scot/Topics/Health/Policy/Patients-Rights">link</a></td>
</tr>
<tr>
<td>S,F,P</td>
<td>Improved communication</td>
<td>Staff experience, Patient surveys</td>
<td>Local</td>
</tr>
<tr>
<td>S,F,P</td>
<td>Increased compliance with Expected Date of Discharge/Anticipated Length of Stay</td>
<td>Y/N Criteria Led Discharge review of predicted against actual</td>
<td>Local [link](<a href="http://www.gov.scot/Publications/2007/09/130942">http://www.gov.scot/Publications/2007/09/130942</a> 44/5)</td>
</tr>
<tr>
<td>S,F,P</td>
<td>Improved compliance with 4 hour emergency access standard</td>
<td>Trak % within 4 hours</td>
<td><a href="http://www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/4hrAEStandard">link</a></td>
</tr>
<tr>
<td>S,P</td>
<td>Reduced staffing related incidents</td>
<td>Incident reporting platform - Datix</td>
<td>Local</td>
</tr>
<tr>
<td>S,F,P</td>
<td>Increased morning discharges</td>
<td>% of discharges prior to noon</td>
<td>Local <a href="http://www.nhsperforms.scot/">link</a></td>
</tr>
<tr>
<td>S,F,P</td>
<td>Increased focus on deterioration patient</td>
<td>Reliable response to elevated Early Warning Scoring Number of Cardiac arrests</td>
<td>Local [link](<a href="http://www.gov.scot/News/Releases/2009/09/2216">http://www.gov.scot/News/Releases/2009/09/2216</a> 2842)</td>
</tr>
<tr>
<td>S,P</td>
<td>Decreased harm</td>
<td>Adverse events: Falls, Cardiac arrest, Infection control, Mortality review</td>
<td>Local <a href="http://www.gov.scot/Topics/Health/Policy/Patient-Safety">link</a></td>
</tr>
</tbody>
</table>
Hospital Safety Flow Huddle
Annex 1 - Supporting the declaration of safety
Declaring your department “Safe to Go”
a trusted and consistent approach

“Are you safe?”
Using the traffic light system will help identify risks to safety and patient flow. Hospital Safety Flow Huddles support solutions to these in a timely manner.

“We have…

Red – an issue(s) effecting safety or flow that requires immediate resolve.

Amber – impending issue(s) that will impact on safety or flow and the quality of care within the next 12 hours.

Green – no safety or flow issues at this time, our department is safe.
Hospital Safety Flow Huddle
Annex 1 - Supporting the declaration of safety

When declaring safety status for your department consider the “Five Dimensions to Safety”

1. Past
   - Learning from past events
   - Continuous quality improvement
2. Reliability
   - Policy and reporting procedures in place
   - Challenging issues and receiving feedback
   - Effective communication
3. Sensitivity to operations
   - Be alert to changing risk and risk indicators
   - Organisational/service change
4. Anticipation and readiness
   - Thinking ahead
   - Accuracy in prediction
   - Escalation plans
5. Integration and learning
   - Whole System level

Developed from Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013
Hospital Safety Flow Huddle

Framework of contributing factors

Institutional factors
• Economic context

Work environment factors
• Equipment

Team factors
• Staffing
• Skill mix
• Staff resilience
• Knowledge and ability
• Clinical Leadership
• Workload

Patient factors
• Complexity
• Social factors
• communication

Is care safe today?
• Hospital Safety Flow Huddle
• Visible site management team and responsive escalation plans
• Safety walk-rounds
• Designated patient safety facilitators
• Structured handovers and ward rounds
• Day-to-day conversations
• Patient interviews to identify threats to safety
• Staffing levels

Is Patient Flow Safe today?
• Hospital Safety Flow Huddle
• Operations management
• Culture for continuous quality
• Day of Care Survey
• Criteria Led Discharge
• Morning discharges
• Estimated date of discharge
• Eliminate delayed discharge
• Boarding plans and mitigation
• Out of Hour Capacity
• Patient and family satisfaction
• Staff satisfaction/morale

Resources:
- Exemplar Early Morning Script
- Exemplar Chairperson’s Script
- Exemplar Template

Annex 1 - Supporting the declaration of safety
Exemplar Early Morning Script
Exemplar Chairperson’s Script
Exemplar Template

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