

Hospital Safety Flow Huddle Guidance Document

Achieving your Gold Standard



Where Safety and Flow
become part of the same conversation

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Safety Flow Huddle
Building on Success
How Effective is Your Huddle?
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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.

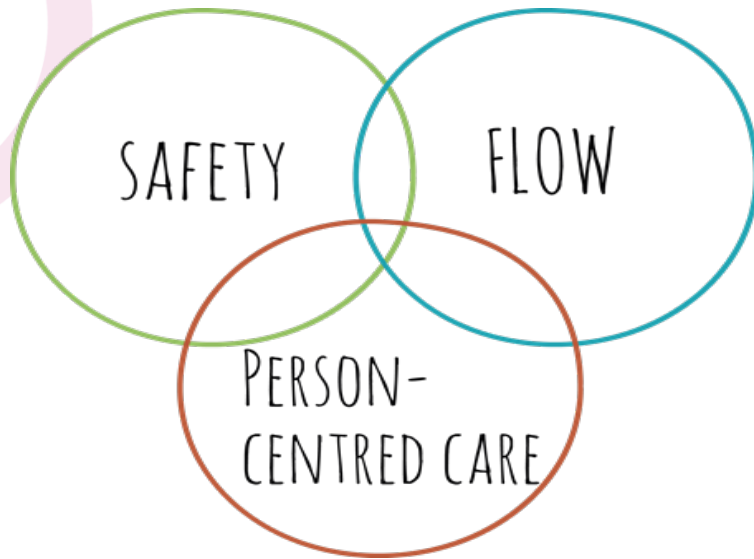
When prioritised by multi professional leaders, well designed Hospital Safety Flow Huddles provide real time information that improves system wide communication and risk management. This approach reinforces a mechanism to resolve issues before they impact on safety or patient flow.

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



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Hospital Huddles aim to:

- establish timely proactive review and mitigation of clinical and operational risks
- ensure patients receive optimal care.

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.

Right Care, Right Time, Right Place, Right Team



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Hospital Safety Flow Huddle

Building on success

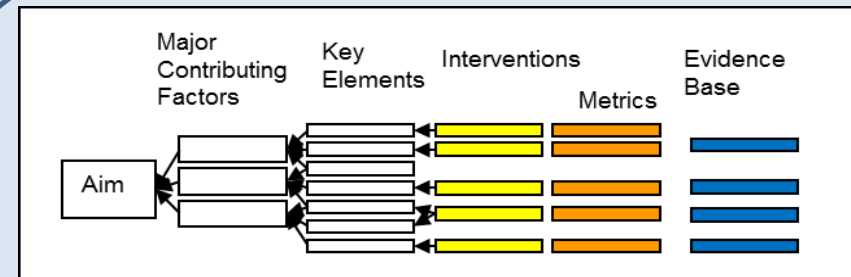
Does your site already hold a Huddle?

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.



**Imperial College London

** <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.



NHS Ayrshire and Arran Hospital Safety Flow 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.

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Hospital Safety Flow Huddle

KEY ELEMENTS

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Aim

To achieve this:

Right Care,
Right Time,
Right Place,
Right Team

Patient receives
optimal care

Major Contributing Factor

Improve this:

Hospital Safety
Flow Huddle

Key elements

By managing these:

System

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Implementation

Impact metrics

Click coloured
boxes throughout
the document for
more information

How do you
currently manage
these key elements?

Hospital Safety Flow Huddle

Assess current practice

Discuss the Key elements

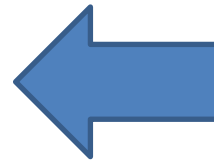
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Impact metrics



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.

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System

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Key element

System

Interventions

(click boxes below for more information)

a) Integration with the wider system

b) Effective Leadership

c) Thresholds or triggers

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Key element

System

Interventions

(click boxes below for more information)

a) Integration with
the wider system

b) Effective Leadership

c) Thresholds or triggers

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

Hospital Safety Flow Huddle System

Key element

System

Interventions

(click boxes below for more information)

b) Effective Leadership

c) Thresholds or triggers

Evidence Base - Things within your control

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

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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

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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

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Structure

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Key element

Structure

Interventions

(click boxes below for more information)

a) Purpose

b) Process

c) Problem Solving

Evidence Base

- Things within your control

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

Where every department and every member of staff appreciates their contribution to patient safety and flow

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Key element

Structure

Interventions

(click boxes below for more information)

b) Process

c) Problem Solving

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

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Key element

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Interventions

(click box below for more information)

c) Problem solving

Evidence Base

- Things within your control

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

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

Jason Leitch

Hospital Safety Flow Huddle

Implementation

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Interventions

(click boxes below for more information)

a) Agreement

b) Conditions

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Interventions

(click boxes below for more information)

a) Agreement

b) Conditions

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

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Interventions

(click box below for more information)

b) Conditions

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

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Metrics

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Interventions

(click boxes below for more information)

a) Process

b) Outcome



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Interventions

(click boxes below for more information)

a) Process

b) Outcome

System

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Implementation

Safety

Flow

Person Centred

The measurement and monitoring of safety:

<http://www.health.org.uk/publication/measurement-and-monitoring-safety>

The Healthcare Quality Strategy for NHSScotland:

<http://www.gov.scot/Topics/Health/Policy/Quality-Strategy>

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Process Metrics

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Safe (S) Effective (E) Person Centred (P)	Managing the key elements	Identified areas of improvement to support evidence base	Quality Measures
S,E,P	Integration with wider team	Demonstrating a system approach Participation from whole system Clinical Governance Effective communication	
S,E,P	Effective Leadership	Prioritised by leaders Capability, skills and expertise Decision making	
S,E,P	Thresholds or Triggers	Risk management Communication and appreciation of system information Safety and flow status, management and forward planning Collective responsibility	
S,E,P	Purpose	Harm reduction owned by frontline staff Appreciation of individual contribution	
S,E,P	Process	Providing consistent and reliable format to collate data Commitment to address safety and flow as an organisation Shaping time to model and learn new behaviours	
S,E,P	Problem solving	Authority and responsibility Tools and levers Escalation	
S,E,P	Agreement	Whole system agreement to commence and support Representation from all departments and services	
S,E,P	Conditions	Venue Psychological safety Commitment Information sharing Model for improvement Organisational debrief	

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Outcome Metrics

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Safety (S), Flow(F) Person Centred (P)	Measure	How to measure	Data source/Topic
S,P	Improved staff experience	Local survey	Local http://www.gov.scot/Publications/2014/12/8893
S,P	Improved patient and family experience	Complaints and compliments	Local http://www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey http://www.gov.scot/Topics/Health/Policy/Patients-Rights
S,F,P	Improved communication	Staff experience , Patient surveys.	Local
S,F,P	Increased compliance with Expected Date of Discharge/Anticipated Length of Stay	Y/N Criteria Led Discharge review of predicted against actual	Local http://www.gov.scot/Publications/2007/09/13094244/5
S,F,P	improved compliance with 4 hour emergency access standard	Trak % within 4 hours	http://www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/4hrAESTandard
S,F,P	Reduction in boarding	Adhere to local definition Bed capacity	Local http://www.acutemedicine.org.uk/wp-content/uploads/2014/11/Plenary-5-1030-Wrong-Place-Anytime-Why-Boarding-is-Bad-for-Patients-Hospitals-and-Healthcare-Systems.pdf
S,P	Reduced staffing related incidents	Incident reporting platform -Datix	Local
S,F,P	Increased morning discharges	% of discharges prior to noon	Local http://www.nhsperforms.scot/
S,F,P	Increased focus on deterioration patient	Reliable response to elevated Early Warning Scoring Number of Cardiac arrests	Local http://www.gov.scot/News/Releases/2009/09/22162842
S,P	Decreased harm	Adverse events: Falls ,Cardiac arrest, Infection control, Mortality review	Local http://www.gov.scot/Topics/Health/Policy/Patient-Safety

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

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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

Annex 1 - Supporting the declaration of safety

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

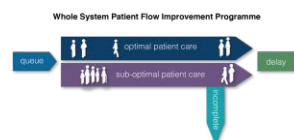
Exemplar Template

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<http://www.qihub.scot.nhs.uk/quality-and-efficiency/whole-system-patient-flow/hospital-huddles.aspx>



Person-Centred Health and Care



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