Soteria Strains

Safe Patient Handling and Mobility Program Guide

Section 3 - Controls

Section 3.4 – Safety Huddles

V1.0 edited July 27, 2015

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STRAINS

A provincial strategy for healthcare workplace musculoskeletal injury prevention.

Table of Contents

Section 3.4 – Safety Huddles 2
Introduction 2
Safety Huddles 2
After Action Reviews 3
Appendix 3.4.1 – Safety Huddle Template 5

Section 3.4 – Safety Huddles

Introduction

Safety Huddles and After Action Reviews (AARs) are designed to help staff better control the risks associated with patient handling and mobility tasks. They are about performance excellence and are part of a culture of continuous learning and improvement.

Safety Huddles and After Action Reviews (AARs) have been shown to be a highly successful method of knowledge transfer, they:

- Promote inter-professional collaboration.
- Increase awareness of safety issues.
- Create an environment in which information is shared without fear of punishment.
- Contribute to a culture of safety within an organization.

Safety Huddles

Safety Huddles are designed to help focus the attention of unit staff on factors that might impact the safety of both staff and patients. They can be incorporated into discussions about care plans or held for the purposes of talking about safety related issues. The safety huddle should allow for a discussion among staff members about issues that may affect their safety and how to reduce the risk associated with patient handling and mobility tasks and other patient care activities.

During Safety Huddles, health care workers should discuss the current situation on the unit in order to identify any factors that may result in an increased level of risk. They should discuss how this risk can be reduced while delivering care to their patients. These huddles are typically short meetings of, ideally, the entire inter-professional team, held at the same time each shift. Safety issues raised may include:

- Patients at high-risk for falling due to changes in mobility status
- Changes to a patient's cognitive functions or behaviours
- Equipment/device issues (maintenance, availability, etc.)
- Environmental concerns (clutter in patient rooms, etc.)
- Staffing complement (numbers, experience levels, etc.)

Safety Huddles should be facilitated by the unit manager, his/her delegate, or the unit peer champion.

Accreditation Canada supports and provides examples of where Safety Huddles are being effectively used in health care across Canada.

Please refer to "Appendix 3.4.1 –Safety Huddle Template" for help documenting the agenda and results.

After Action Reviews

After Action Reviews are designed to identify and control hazardous exposures that have resulted in an incident on the unit. They are intended as learning opportunities where the unit staff involved in the incident meet with the unit peer champion (or another member of the unit selected by those involved) to discuss what happened and how similar incidents can be avoided in the future. The After Action Review should be held as soon as possible after the incident has occurred.

During an After Action Review, health care workers review what happened; what should have happened; what accounted for the difference between expectation and reality (if any); and what recommendations could be made for improvement or to prevent a similar incident. The results of an After Action Review can also help to inform a formal investigation/root-cause analysis, but should not be considered a replacement for these processes.

An After Action Review is centered on the following questions:

- What was expected to happen?
- What actually occurred?
- What went well and why?
- What didn't go well and why?
- What can be improved and how?

An After Action Review features:

- An open and honest professional discussion – this requires a "safe space" to speak honestly without fear of reprisal.
- Participation by everyone involved in the activity and supported by the unit peer champion or a unit staff member selected by those involved.
- A focus on results of an event or action.
- Identification of ways to sustain what was done well.
- Development of recommendations on ways to overcome obstacles.

Here is a simple example to illustrate how an After Action Review works with respect to safe patient handling and mobility:

What was expected to happen?

- Mr. C requires two people to assist him when moving from his bed to a chair. Our plan was get him to sit up at the side of the bed, lean forward, come to a full standing position, and then take a couple of steps and sit in the chair.

What actually occurred?

- While Mr. C was being transferred to the chair from the bed, he slipped and fell.

What went well and why?

- We had a plan and we followed it
- Mr. C was able to sit up at the side of the bed, lean forward, and come to a full standing position.

What didn't go well and why?

- Mr. C was not as stable today as he was yesterday.
- We didn't check his current mobility / stability status before transferring him.
- We didn't ensure he was wearing shoes before transferring him.
- He was only wearing socks which, combined with his decreased stability, resulted in the slip and fall.

What can be improved and how?

- Ensure we check Mr. C's mobility/stability status before initiating any patient handling and mobility task.
- Ensure Mr. C is wearing correct footwear prior to having him perform any weight-bearing movement.

The recommendations arrived at during the After Action Review should be implemented and validated. If the recommendations are beneficial, then these should be shared more broadly to all members of the unit team, across the organization and to other health care facilities in Nova Scotia.

The unit staff involved in the After Action Review should consider the benefit of sharing the lessons learned / recommendations with the rest of their unit during an upcoming Safety Huddle. This should not, however, be a requirement and it should be left up to those involved in the After Action Review to decide.

Remember the Intents of the After Action Reviews:

- They should be brief.
- Do not play the blame game. The After Action Review needs to be a safe place for individuals to identify lessons learned. In larger groups, it helps to nominate a facilitator from the group to ask questions and ensure everyone has an opportunity to share their perspective and have input in the discussion.
- Be informal but remember that results may be documented and shared as and when required – especially if other health care workers may be helping validate the lesson learned.

Appendix 3.4.1 – Safety Huddle Template

Unit:

Date:

Number of Staff Present:

Facilitator of Safety Huddle:

Equipment/Device Issue(s):	Safety Issue(s) Raised	Action Plan
Environmental Issue(s)	**Safety Issue(s) Raised**	**Action Plan**
Patient Factors Impacting Safety (Initials, Room Number, Bed Number)		
High Fall Risk		
Confused (dementia, delirium)		
Bariatric		
Can we safely meet the current care needs?	Safety Issue(s) Raised	Action Plan