| Name of Initiative | Improving Patient Safety -in Just 15 Minutes A Day<br>Bassett Medical Center, Cooperstown, New York |
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| Project Description | Emerging worries about Bassett Medical Center's culture of safety became apparent in mid-2014. Patient safety event reporting was "stalled out" and near-miss reporting was declining. Leaders were not communicating in a meaningful way about safety concerns. Event investigation and resolution were significantly delayed. The organization was aware of the concept of leadership safety huddles as a way to address many of these challenges. However, staff also was aware that a number of hospitals had struggled with sustainability following the initial safety huddle "honeymoon." This organization embarked on developing a safety huddle structure that employed a number of novel approaches in order to encourage and sustain engagement and accountability. The daily leadership safety huddle was created to promote situational awareness of issues within the previous 24 hours as well as current issues that have the potential to impact the upcoming day. The huddle provides directions about the prioritization and responsibility for problem resolution. Further, the follow-up of investigations and actions taken in response to previously reported events are communicated at the huddle.The Bassett staff believes that use of safety huddles is a major driver for safer care. The safety huddles have assisted in providing safe, quality care to patients by reducing the risk of system or process failures. Through "huddling," the medical center has created a blame-free environment where teamwork is enhanced, the staff is engaged, and harm is prevented. There have been numerous improvements in practice and process changes based on issues identified in safety huddles. |
| Outcomes | • Incident/event reporting has increased (and been sustained) by 51 percent over baseline from previous years. Near-miss reporting has increased/sustained by 86 percent over baseline.<br>• More than 1,500 issues raised/reviewed at safety huddles during 2015.<br>• On average, 20-30 issues identified resulted in systems changes each quarter.<br>• Turnaround time for analysis and action related to events has decreased from seven days at beginning of safety huddle to an average of 48 hours.<br>• 88 percent of huddle participants surveyed report that safety and quality issues are reported, investigated and corrected more quickly since the inception of safety huddles.<br>• 89 percent of huddle participants surveyed report that it is considerably easier to connect face to face with colleagues about issues and events because of the huddles.<br>• 86 percent of huddle participants surveyed report that organizational teamwork has improved because of the huddles. |
| Lessons Learned | • Executive support and visibility: CEO and senior administrative and medical staff leadership visibility at the daily huddle is the number one key to success.<br>• Recognition and reward: Each month, huddle attendees receive a small gift with a message of thanks. In addition, each person recognized for a "good catch" or providing outstanding care receives a signed certificate of appreciation. When staff members do something especially noteworthy, their supervisor brings them to the huddle to recognize them. They are thanked by the entire safety huddle team.<br>• Feedback mechanisms: A quarterly newsletter, *The Safety Huddle Spotlight*, is sent to all staff. This gives everyone a chance to hear what issues have been raised and what action has been taken. Typically, the newsletter includes an educational article that covers a topic that has been raised at a safety huddle and needs heightened staff awareness. |

| Program Impact | The safety huddle potentially impacts each and every patient touching the entire health care system continuum. Typically in health care organizations, patient safety work is focused primarily on inpatient areas; through the safety huddle structure, all ambulatory care and |
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service areas are also reporting daily, which provides rich information and perspective previously not tapped into.

By reporting and addressing issues in a more efficient and effective manner, near-miss events can be addressed before patient harm occurs. Actual events can be addressed systematically to prevent harm to another patient. Trends can be more quickly identified and corrective action implemented. For example:

1) Following the review of an outpatient fall in one health center, an environmental assessment of all health centers was conducted. As a result, a number of customized, proactive corrective actions occurred in a number of locations (e.g., painting curbs; increasing handicapped parking spaces; putting a call box in a parking lot, so patients can request assistance going to and from their car).
2) At a huddle, an event was shared involving a nurse who was unfamiliar with a new medication and did not recognize an adverse reaction her patient was having to the medication she had given. Fortunately, there was no patient harm. However, as a result, the nursing education department developed a brief education module for all nurses about the new medication.
3) At the huddles, several cases were raised where ED patients were transferred to inpatient units without receiving needed care (e.g., antibiotics, blood products). As a result, a prompt was added to the transfer portion of the EMR that requires nursing staff to verify that medications and treatments have been given. There have been no additional instances since implementation of this system.

Many issues raised during a safety huddle lend themselves to rapid-cycle improvement methodology; several have resulted in organizationwide performance improvement projects (e.g., patient identification, advance directives), and a number became the focus of Lean Six Sigma projects (stat antibiotics for sepsis, influenza vaccination).

**Execution Techniques**

[5] Kotter, John P. and Cohen, Dan S. The Heart of Change. Boston: Harvard Business School Press

The safety huddle program at Bassett Medical Center was developed using the principles of John Kotter's 8-step model of change. The safety huddle concept itself is not new; however, the experience of many organizations was that early enthusiasm quickly dwindled and huddles either stopped or reduced in frequency. Staff at Bassett needed to find a way to prevent this from happening.

Creating a climate for change was a key first step. The Bassett CEO was new to the organization and remarked that it felt like safety issues were taking far too long to resolve. A review of data demonstrated a decline in staff reporting actual and near-miss events. As a result, the vice president for patient safety and performance improvement called an urgent leadership meeting to introduce the idea of the safety huddle and ask for help in developing a sustainable program. Leaders came together to determine the time of day the huddle would take place, create the attendance list and set the guiding principles for the huddles (which are also posted in the huddle conference room as a reminder to all):

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| | 1. **COME ON TIME!** Each member of the huddle should arrive on time.<br>2. **PLAN AHEAD!** Each member should appoint a designee if he or she cannot be present. Sign-in sheet will be used, so members can calculate percent attendance.<br>3. **GET AN EARLY START!** Each member should touch base with his or her team prior to the huddle to gather appropriate information<br>4. **COME PREPARED!** Each member is responsible for knowing the information brought to the huddle; present it clearly and concisely via the agenda format noted below<br>5. **STICK TO THE FACTS!** If there is nothing to report, the member will state "I have nothing to report at this time."<br>6. **NOT A DISCUSSION FORUM!** Members should refrain from the urge to discuss. The huddle is NOT intended as a venue for problem solving or discussion.<br><br>Once the safety huddles began at Bassett Medical Center, the work of engaging and enabling the whole organization could commence. There were frequent advertisements of the huddles, and these emphasized that "all staff are welcome." If front-line staff and physicians have a concern or suggestion, or just want to observe, they are encouraged to attend. During the planning for this work, a great deal of time was spent reviewing the expectation that this is a judgment-free zone. There should be no defensiveness or rebuttal if someone raises an issue. The person will be thanked heartily for bringing an issue forward at the huddle itself. After the huddle, the vice president for performance improvement or patient safety officer follows up in person and also thanks the staff member for bringing the issue forward. This has empowered staff at the "sharp end" of care to bring forward issues either at the safety huddle itself or through event reporting, which allows them to be part of the solution. This work has engaged staff in a dramatic way.<br><br>Finally, staff could hear John Kotter's voice saying "Don't let up! Make it stick!" as they worked to sustain this program into the fabric and culture of the organization. All of the efforts at communicating the wins, recognizing staff, ensuring senior leadership visibility and tracking issues to completions have helped to embed the program. On occasion, a member needs to be reminded to be on time, so they can hear what their colleagues are reporting and be respectful of the larger group, but this is fairly rare. |
| **Sustainability** | The safety huddle program has been in place at Bassett Medical Center for nearly 15 months. During that time, 100 percent of departments expected to attend and report have attended. That equals a total of 9,000 individuals total reporting during safety huddles. The vast majority of huddle attendees continue to arrive on time and come prepared. To be ready to report out at 0800 means leaders must have rounded on their units and received updates from staff well before that time.<br>There are four main drivers of sustainability of the safety huddle:<br>• <u>Standardization:</u> The huddle happens every day (Monday–Friday) in exactly the same way. Departments report out in a structured sequence. People know what to expect and what is expected of them.<br>• <u>Single method of communication:</u> After several months, some attendees asked for a conference "call-in number" so they could dial into the huddle. This request was rejected, as it would defeat the goal of leaders rounding on the units before the huddle, as well as eliminate face-to-face contact for leaders to review issues. Had this been offered as an option, it is strongly believed that people would have drifted away from attending the live huddle.<br>• <u>Recognize and celebrate the work and accomplishments of the workforce</u>**,** |

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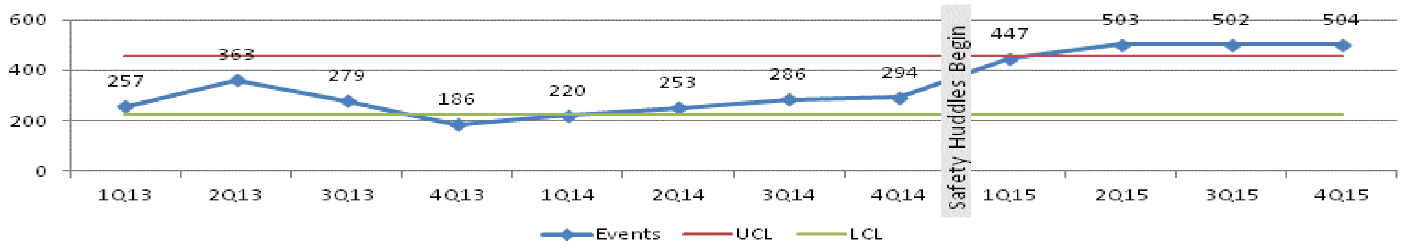
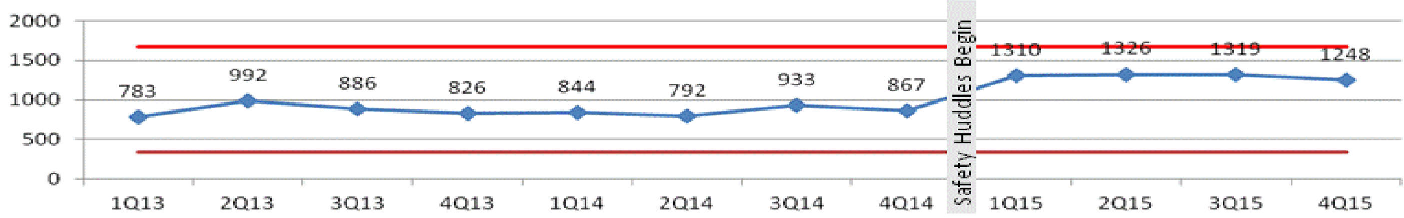
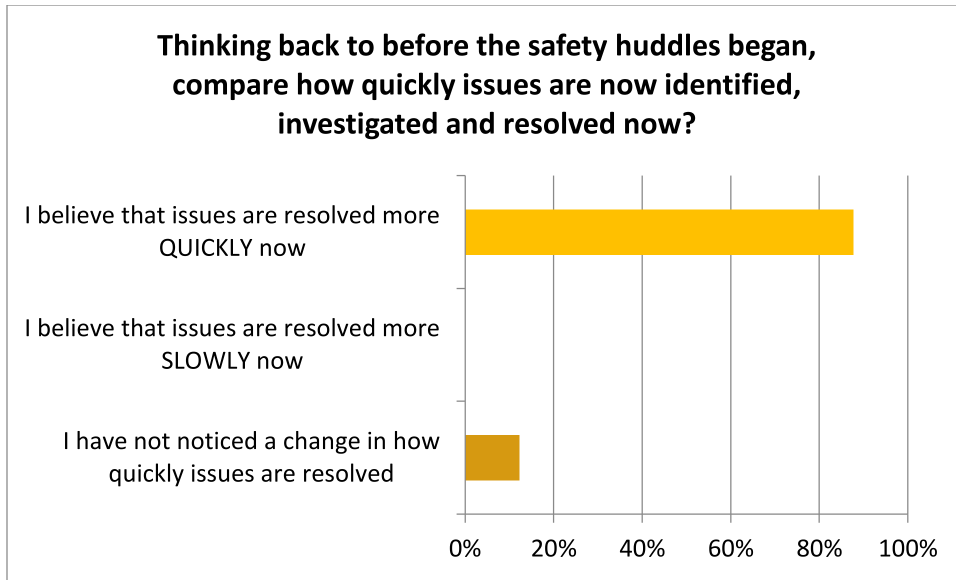
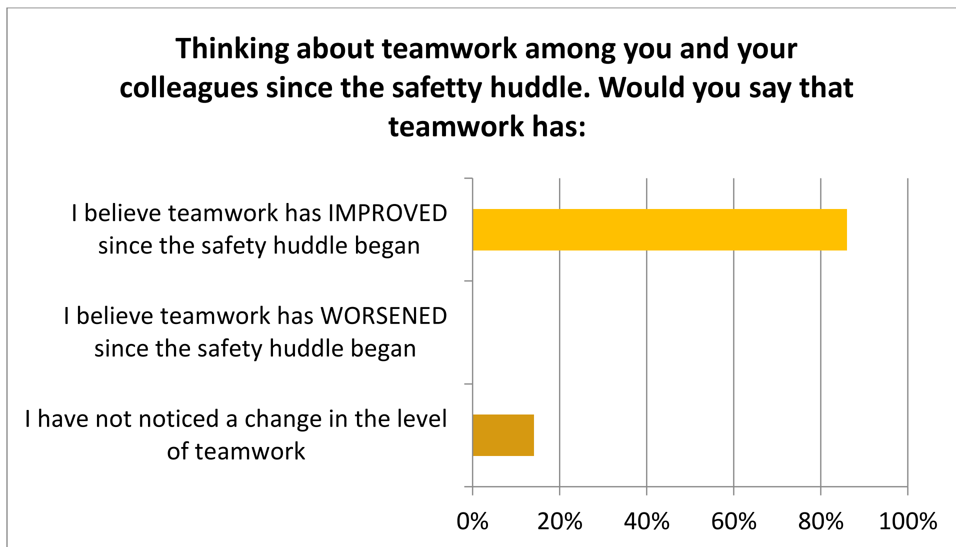
| | <u>regularly and with high visibility:</u> This correlates with recommendations in the NPSF Lucian Leape Institute report "Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care." Staff are now encouraged, recognized, and thanked for reporting concerns and errors (even their own). The involvement of staff at the sharp end of care has significantly improved, as evidenced by increased and sustained levels of actual and near-miss event reporting.<br><u>Regularly connect the work back to the mission:</u> The huddles are designed to improve care and safety for the patient, as well as improve the experience of the entire workforce. Each huddle is concluded by an attendee being randomly selected to share their thoughts about what they heard at the huddle from either the patient's or employee's perspective. This is the huddle's "I am your patient or I am your colleague" segment. It is a daily reminder of why the huddle is a critical part of the mission. |
| **Potential for Replication/Scale** | The safety huddle structure and processes can be easily replicated by any organization looking to advance patient safety. There are virtually no expenses associated with the program. Organizations will need to select a department to champion the work and to oversee logging and tracking of issues, generating "good catch" certificates, publishing the quarterly safety newsletter and more. Typically, this work would be done by the risk management or quality department.<br>There are a number of tools and templates that can be easily adapted:<br>• Daily safety huddle white board, which is updated daily with the key metrics being tracked and displays the huddle guiding principles<br>• Daily safety huddle report, which communicates essential issues identified during the huddle (distributed widely to the organization)<br>• Quarterly *Safety Huddle Spotlight* newsletter<br>• "Good catch" awards and "good catch" staff parking spot<br>• Safety huddle issues/action tracker sheet and "good catch" tracker sheet<br>• Monthly "safety huddle anniversary" token gift given to attendees<br>• "I am the patient" and "I am the colleague" signs (which are given randomly to one attendee each day)<br>For organizations that found previous attempts at embedding the safety huddle concept were unsuccessful, using this methodology may help redesign and reinvigorate their programs. |

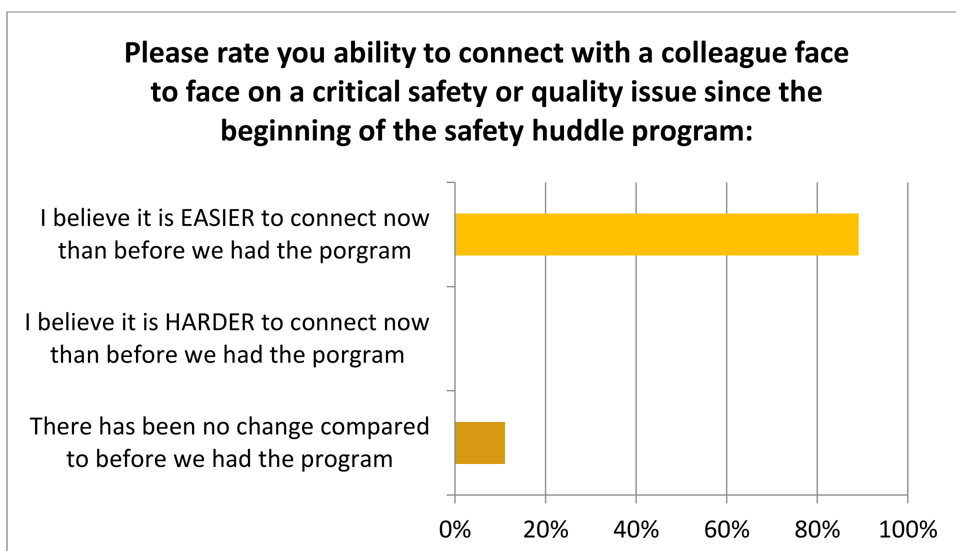


Source: Bassett Medical Center RL6 Incident Reporting System – Data as of January 2016



Source: Bassett Medical Center Safety Huddle One Year Impact Survey Feb 2016