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# Huddle and Safety

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# Team Huddles for Increased Safety

A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

The University of Texas at Tyler

by

Jaelynn Hall

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**Executive Summary**

The purposed evidence-based practice (EBP) project focuses on a nursing intervention (team huddles) to increase safety and reduce inpatient fall rates. Negative outcomes to consider from an inpatient fall are harm and injury to the patient along with increased health care cost for the patient as well as hospital facility. Accrued cost associated with an in-patient injury resulting from a fall is not reimbursed according to the Centers for Medicare and Medicaid Services. The additional cost for hospital-acquired falls is estimated to be $6,694 (95% CI: -$1,277 to $14,665) (Agency for Healthcare Research and Quality, 2017). This was only related to acute care costs such as increased length of stay and diagnostic tests that will not be reimbursed by most insurers including federal programs. The accrued cost could be greater when other outlays such as rehabilitation care or lawsuits are included. Expenses have outpaced revenue for acute-care hospitals in every year but one since 2003; without an intervention to reduce expenses (specifically cost accrued with in-patient falls) the hospital is left financially vulnerable.

The EBP project: to implement a team huddle at the beginning of each shift on the Medical-Surgical floors 1&2 at UTHealth Athens Hospital. The total time purposed for the project is 12-weeks. There will be 3 phases including an evaluation period. A team huddle is a cost-effective intervention with potential to impact overall department safety, improve patient and employee satisfaction, as well as offering financial benefit.

Team Huddles for Increase Safety

At Ardent UTHealth the goal/mission is to provide health care services with compassion for patients and their families, with respect for employees, physicians and other health professionals, with accountability for fiscal and ethical performance, and with responsibility to the communities they serve (Ardent Health Services, 2020). The quest to improve the delivery of quality care continues to evolve as does the evidence to support best practices. On-going challenges within any acute care facility (specifically in rural hospitals) are safety and financial stability. The EBP project purposed here is a nursing intervention with potential to primarily improve patient safety outcomes; a positive financial impact would be secondary for this EBP project.

## Rationale for the Project

Fall prevention is a National Patient Safety Goal for acute care facilities; The Joint Commission specified the importance of preventing falls in a 2009 Sentinel Event Alert (Agency for Healthcare Research and Quality, 2019). In rural areas, there may only be one hospital within 30 miles. Rural American hospitals have seen approximately ten hospital closures per year this decade (Rural Health Research Centers, 2020). Communities depend on accessible acute care and as an inpatient, depend on being provided with quality care. Nurses have a continual presence with patients during a hospital stay and have potential to create the greatest impact toward inpatient safety. My change initiative topic involves a nursing intervention to decrease fall rates by increasing situational awareness.

## Literature Synthesis.

PICOT: In acute care nursing staff (P), how does a group safety huddle at the beginning of each shift (I) as compared to no huddle (C) affect the incidence of patient falls (O) within a 12-weekperiod (T)?

Four health databases (CINAHL Complete, MEDLINE, Cochrane Library) were searched for published literature between January 2010 and January 2020. Keywords used in the search: briefing, communication, huddle, nursing, risk management, safety, safety briefing, safety culture, and team meetings. The goal was to link a nursing intervention (i.e. team huddle) with decreased in-patient falls. Initially, the evidence revealed the effectiveness of post-fall debriefing huddles on identification of missed opportunities to promote safety. While post-fall huddles are an important aspect of ensuring a culture of safety, the aim to decrease in-patient falls should focus on prevention (Rieter-Palmon, Kennel, Allen, Jones, & Skinner, 2015). The incidence of falls during a hospital stay are linked with quality and overall safety; specifically fall rates are influenced by huddles (Brass, Olney, Glimp, Lemaire, & Kingston, 2018). Healthcare communication is one of the many benefits related to team huddles. The Joint Commission Center for Transforming Healthcare accredited miscommunication between healthcare staff as a major denominator for medical errors (Glymph et al., 2015). Huddles create a unique opportunity to distribute individualized patient information pertaining to fall risk including patient cognition, mobilization ability, and fall bundle implementation aspects. Providing patient-specific data, during a huddle at the beginning of each shift enables all participating healthcare providers to identify and prioritize sources of alarms (Dewan et al., 2017). Evidence supports implementation of shared staff education as a strategy to prevent in-patient falls with a postintervention effect (IRR) of 0.77 (95% CI = 0.52-1.12; P = .17) (Hempel et al., 2013). Recurring themes that link the huddle intervention to fall prevention are risk

identification, structured safety briefings, individualized patient care discussion, and an increase in communication, teamwork as well as situational awareness (Ryan et al., 2019). Considering the impact of team huddles on safety outcomes the evidence favors a change.

## Project Stakeholders

The proposed change project is a nursing intervention (team huddles) with evidence to support the impact on safety (specifically inpatient falls). The primary stakeholders are the patients and their families; they stand to benefit the most from improved quality of care. The hospitals and/or acute-care facilities would also be included as stakeholders due to increased reimbursement (e.g. linking quality to payment) and decreased expenses associated with inpatient falls. In addition, evidence supports employee satisfaction positively correlates with a culture of safety; a team huddle provides opportunity for increased communication regarding patient specific data to reduce the incidence of falls (Glymph et al., 2015; Ryan et al., 2019). A review of the literature on patient safety culture identified the following seven subcultures: leadership, teamwork, evidence-based care, communication, learning, just, and patient centered. In addition, the following four significant predictors of Patient Safety Grade (of the Hospital Unit): feedback and communication about errors, organizational learning-continuous improvement, hospital management support for patient safety, and supervisor/manager expectations and actions promoting safety (. The collective research mentioned here connects: patient preferences, quality patient-centered care, evidence-based practice, and the proposed EBP change project (the implementation of a team huddle to reduce inpatient falls).

## Implementation Plan

The proposed change project is for the Medical/Surgical 1&2 (MS1&2) floor at UT Health East Texas Athens (UTHET). There is room for improvement to reduce the incidence of

in-patient falls. Inter-professional collaboration is key to an impactful change initiative and shapes the future vision of any evidence-based practice (EBP) change (Melnyk & Fineout-Overholt, 2015). Stakeholders for the EBP change indicative project are the UTHET facility and affiliates, the patients and their families, nursing staff including but not limited to all who provide direct patient care.

During the planning phase (week one & two) gaps between desired practice and current practice are identified and addressed during a called MS1&2 staff meeting (Melnyk & Fineout-Overholt, 2015). As technology is available the opportunity for multiple department participation is optional moving forward (e.g. Zoom or GoToMeeting). Internal resistance is expected; common themes are perceived threat, impact on relationships, feeling coerced, lack of knowledge, poor communication, and unclear cost-benefit ratio. Processes to counteract barriers can be incorporated into the project such as clear definition of desired outcome, detailed plan of action, and allowance for immerging alternatives leading to shared outcome (Persily, 2013, p. 147-148). The resources required for the project are structural, in that this intervention is dependent on a designated time scheduled into each shift for the team huddle. The call-in process will be utilized during the first two weeks to discuss project details with all MS1&2 charge nurses who will be a key factor in the implementation of the proposed change initiative.

This specific huddle process is set to a time limit of five minutes. During this time patient (those at moderate to high fall risk) specific data will be conveyed to all participating staff. This EBP change project is designed to complement existing procedures for MS1&2. For example, MS1 practices in person huddle and through the EBP change during this time patient specific data is added for moderate to high fall risk patients. In addition, both MS1&2 practices charge nurse-to-charge nurse shift report where patient specific data is shared for all patients on each floor; the

change project would extend details given in that report to be shared during huddle. The call-in phone line is already in place for those in other departments or off site that would like to participate. Overall, there is little risk as compared to potential impact of benefit for implementation of the EBP project to increase situational awareness to decrease in-patient falls.

**Timetable/Flowchart**

The project will have three phases: education/communication, implementation, and evaluation. EBP implementation into daily practice requires multifaceted approach including establishing clear direction toward improved patient outcomes (Melnyk & Fineout-Overholt, 2015).

•Phase one (education/communication): week one and two; following the established pattern for MS2 staff meetings, there will be two required staff meetings over a 2-week period with attendance (either in-person or by phone line) recorded. Rationale for change initiative will be addressed as well as the huddle intervention (time limit and focus safety topic).

•Phase two (implementation): week 3-12; a team huddle will be initiated by the MS1/MS2 charge nurses at the beginning of each shift, identifying the fall risk patients including individualized aspects of patient such as room number, cognition, mobilization factors, and fall bundle procedure. The huddle not to exceed five minutes, attendance with date and time documented.

•Phase three (evaluation): mid-evaluation at 6 weeks, comprehensive evaluation at 12 weeks; huddle intervention consistency will be measured by attendance/date/time documentation (recorded on paper by host of huddle -charge nurse for each shift, given to Department Director then submitted to Risk Management office). In-patient fall incidence will be reviewed through Trideo report generator and compared to historical data from Trideo.

•Time period for entire change project 12-weeks

## Data Collection Methods

To evaluate the impact the change project may or may not have had on the organizational safety culture, evaluation surveys will be emailed to all participating staff (from attendance documentation) during week six and week twelve of the project implementation. Self-evaluation provides opportunity for reflection of individual and team performance as well as lessons learned (Persily, 2013, p. 153). The surveys will be short (a total of 5 questions with allowance for free type/input). Trideo, the online safety tracking tool, will be used to generate reports for trending in-patient falls for weeks three through twelve to be compared with historical data of the same nature. The success of the EBP change project will be determined by a positive correlation between consistent implementation of team huddle as outlined and a reduced number of in-patient falls as compared to historical data pre-implementation. The threshold for determining successful reduction for inpatient fall rates will be Trideo generated quarterly fall tend for Medical/Surgical floor 1 (MS1) of less than 4 inpatient falls per quarter; this is the lowest inpatient fall rate for MS1 2018- spring 2020. The threshold for determining successful reduction for inpatient fall rates for Medical/Surgical floor 2 (MS2) will be a Trideo generated fall trend report of less than 3 inpatient falls per quarter.

A secondary factor of success will be positive feedback of staffs' perception of increased situation awareness.

Step 1: Collect/gather attendance documentation from department directors. Attendance for each safety huddle will have been documented with a sign-in form that was submitted to the department director's office.

Step 2: Email Evaluation Survey to all staff members who participated in the safety huddle; Sample (below) of Evaluation Survey.

Reply to email and answer questions below pertaining to the implementation of a safety huddle to reduce the incidence of inpatient falls.

1. Is safety huddle being held before each shift? Yes or No
2. (From your perspective) Has safety huddle been held in accordance with requirements?
    - Provides patient specific data: level of fall risk (high or moderate) yes or no

    a) room number/location? Yes or no

    b) Mobility limitations? Yes or no

    c) Cognitive limitations? Yes or no

    - Within time limit (5 minutes)? Yes or no
    - Conducted at the beginning of each shift? Yes or no
    - Not deviating from focused topic (safety/fall risks)? Yes or no
3. (From your perspective) Has the inpatient fall rate on MS1&2 decreased? Yes or no
4. (From your perspective) Does a shift safety huddle increase situational awareness?

Yes or no

5. What changes (if any) would you make to the safety huddle and/or the implementation process? Free text:

Step 3: A Trideo report will be generated for the weeks that the safety huddle was practiced as well as 12-weeks prior to the intervention implementation, and for the same dates/time frame a year prior. The rationale for the historical data at 12-weeks and a year prior to safety huddle implementation is gain a broader perspective as to compare the same length of time directly prior to implantation and during the same portion of the year/season (a year prior).

Descriptive statistics:

- Historical data: For MS1&2 - Trideo generated fall rates for 12-weeks, same dates as EBP project implementation except for the prior year. And fall rates for the 12-weeks directly prior to EBP project implementation.
- For MS1&2 - Trideo generated fall rates for 12-week period in which EBP project was implemented.
- Number of emails sent to staff (that attended safety huddles); Number of emails returned/replies received.
- Number of documented safety huddles compared to number of shifts within 12-weeks
- Staffs' perception: number of "yes" to "no"
- Narrative statistics for free-text responses.

Inferential statistics:

From the descriptive statistics themes will be identified and compared. These will only take into consideration the staff members present for safety huddles during the specified 12-week implementation period and will not include complete/all staff members if they did not attend or work MS1 or MS2 during this time. Only the participating staff members will receive evaluation surveys.

## Cost/Benefit Discussion

UT Health East Texas Athens 2019 Fall Trends Report revealed approximately thirty-eight inpatient falls. Using the given statistics, in-patient falls in 2019 cost UTHET Athens an

average of $254,372.00 in one year alone. Expenses have outpaced revenue for acute-care hospitals in every year but one since 2003; rural American hospitals (similar to UTHET Athens) have seen approximately ten hospital closures per year this decade (Rural Health Research Centers, 2020).

- Cost: time > communication > education > training. Laminated huddle outline.
- Benefit: employee satisfaction, patient/family satisfaction, reduced financial liability (facility/hospital).

## Discussion of Results

The nursing intervention of a safety huddle is being proposed to increase inpatient quality of care. Quality of care is used as an umbrella term for a magnitude of aspects; the focus with this EBP project is safety. There is a direct positive correlation between safety, patient perceived quality of care, and hospitals' financial stability (i.e. quality based reimbursement). A safety huddle is a specific nursing intervention that has the potential to positively impact inpatient safety. Consequences for absence of a safety huddle results in reduced situational awareness, declining safety culture, increase in incidence of inpatient falls, and ultimately financial deficits for hospitals.

This EBP change project is being submitted as a benchmark assignment due to policy/procedure changes around personnel working remotely and reducing COVID 19 exposure risk. In addition, the employee turn-over has been substantial which has fractured communication and continuity of project development. However, these alterations enhance the need for increased attention on safety, team-work, and patient-centered care. Communication with the employee stakeholders, such as Risk Management and department directors could reignite buy-in with promise of implementation.

## Conclusions/Recommendations

The adoption of an evidence-based practice intervention change project by healthcare organizations reflects value for teamwork, accountability, and supports a culture of patient safety and quality. The effectiveness of team huddles is a low/minimal cost intervention with a potential for positive impact in decreasing the incidence of in-patient falls. Recommendation: implementation of nurse lead safety huddles at the beginning of each shift for the Medical/Surgical floors 1 & 2 at UTHealth Athens Hospital with evaluation and reassessment each quarter.

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# Team Huddles and Safety

Evidence-Based Benchmark Project

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Fall 2020

# Appendix B

## Flowchart

Appendix C

# Instrument