Huddle Up for Safer Health Care: Reducing Harm and Improving Safety culture

A Case Study of the Partnership between Sue Ryder and the Improvement Academy

What was the aim?

Sue Ryder has a strong commitment to continually learn, improve and innovate to enhance the safety of people using their services, and wished to identify what more they could do to reduce harm, with a particular focus on falls. In 2020 Sue Ryder partnered with the Improvement Academy to adapt and embed safety huddles (Huddle Up for Safer Health Care "HUSH") into their daily routine across their 6 inpatient services, using quality improvement methodology and implementation science. The aim was to reduce falls and enhance staff teamwork and safety culture.

How were safety huddles implemented?

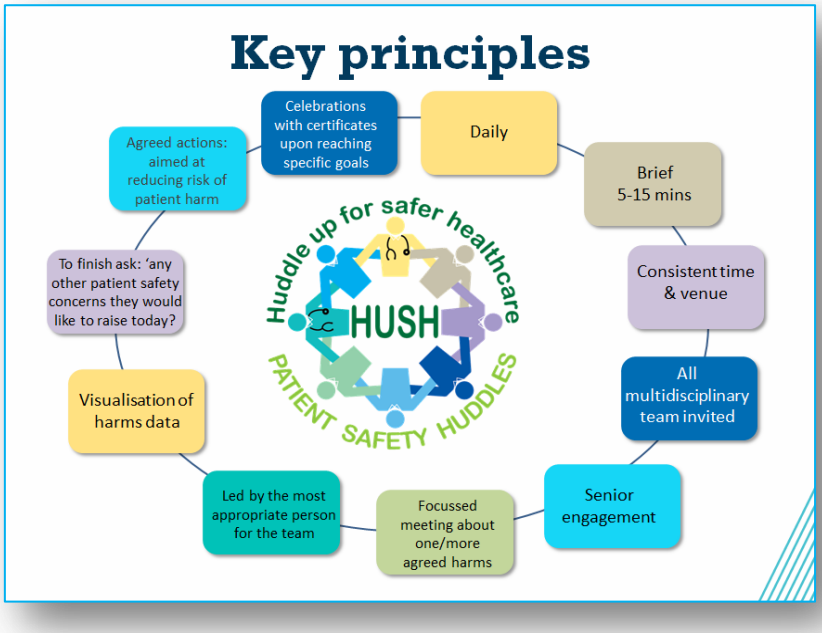
Stakeholder engagement was undertaken with senior organisational leaders, and an individual within Sue Ryder was identified to be trained and supported as a huddle's coach. Measures of impact were agreed, including measuring teamwork and safety culture at unit level before and after implementation of huddles, alongside days between falls at unit level, and falls per week for all Sue Ryder inpatient units.

Two hospice teams were identified to be the first to test and adopt safety huddles into their practice. The coach and representatives from these first two teams attended an Introduction to Safety Huddles Masterclass. This learning event included the following:

- What are the principles of HUSH and key ingredients to safety huddles (see Figure 1)
- How to use Plan Do Study Act Cycles (PDSA) to test and embed huddles in their unit
- How to measure teamwork and safety culture
- Understanding and addressing the barriers and enablers to huddling
- Celebrating success

Each site selected a time to hold a huddle, ensured a huddle lead was appointed and determined where the safety huddle would take place, and the coach supported the team to embed the Core principles into their daily huddle over time.

Figure 1: shows the Key ingredients of "HUSH" huddles each team were supported to embed.



The Improvement Academy provided supporting materials such as a "days between board" (Figure 2) displayed in the area where the team based their huddle, plus a prompt sheet to help guide the huddle. The team updated the days between board daily, to keep track of how many days the team had achieved without a fall. This board included a "best run" box, where the team logged the most number of days between falls currently achieved, to help keep the team motivated and show what they could achieve.

Figure 2: Example days between falls board

Realistic milestones were set, based on the team's baseline data. This meant team members could celebrate when they reached milestones and they were also awarded a certificate; for example, a Bronze certificate for achieving ten days without a fall.

Peer learning from these first teams as "early adopters" was then shared with other Sue Ryder inpatient units, supported by the Executive team at Sue Ryder. A timeline was agreed for the coach to support the remaining 4 hospice teams, and these team members attended the HUSH Masterclass. As each team grew in confidence the internal coaching support was transferred to the next hospice team ready to adapt and test huddles.

Each team undertook teamwork and safety culture surveys as they started huddles and after they were embedded. The results gave each team an overview of the dynamics and culture within their unit, how they work together, and how they perceive patient safety within their working environment. The results of these surveys were fed back to the teams in a facilitated discussion.

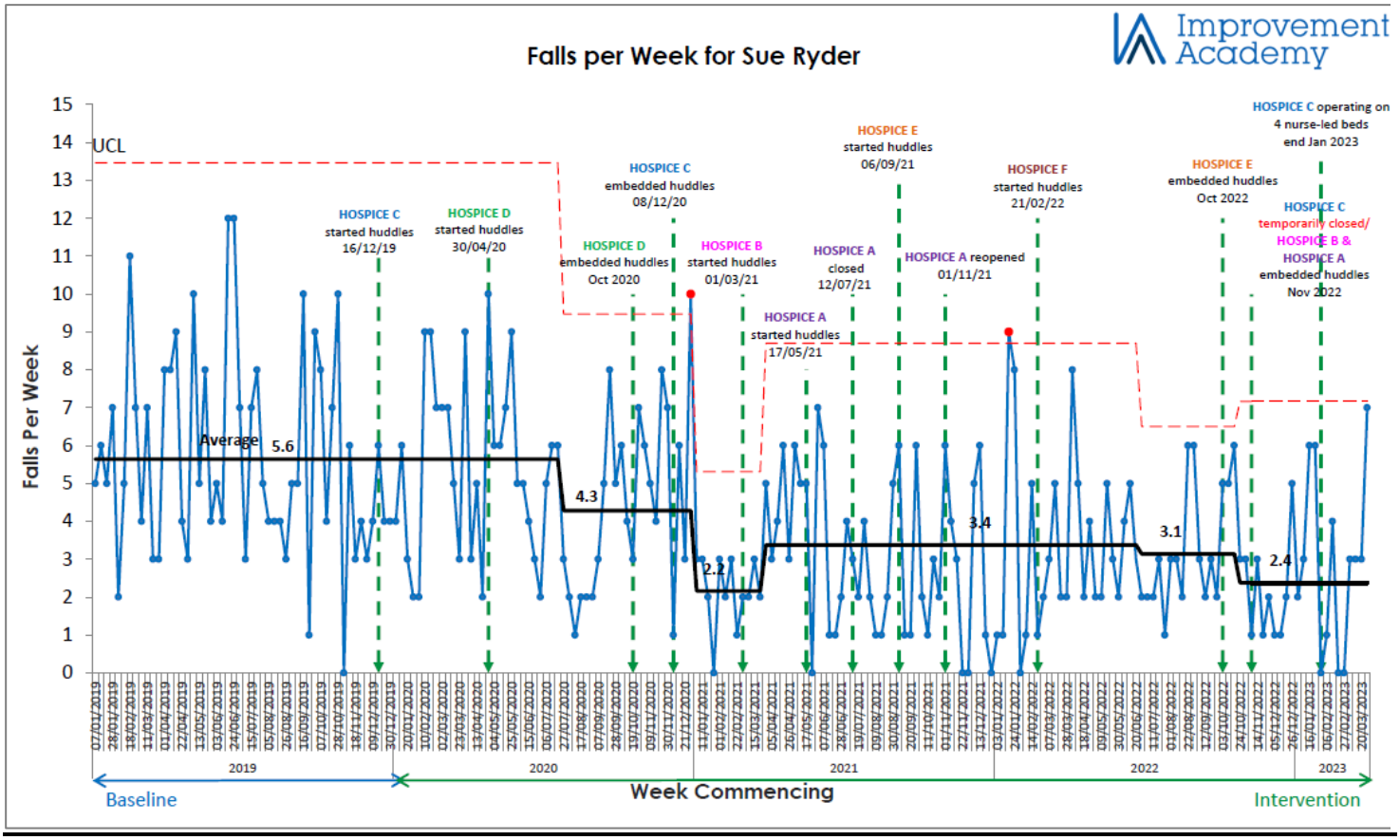
What has been the impact?

Despite the challenges of the COVID-19 pandemic, between 2020 and 2022 five hospices managed to embed safety huddles into their daily schedule.

After embedding huddles seven days per week, the first hospice reached 74 days without a fall, which was their highest achievement to date.

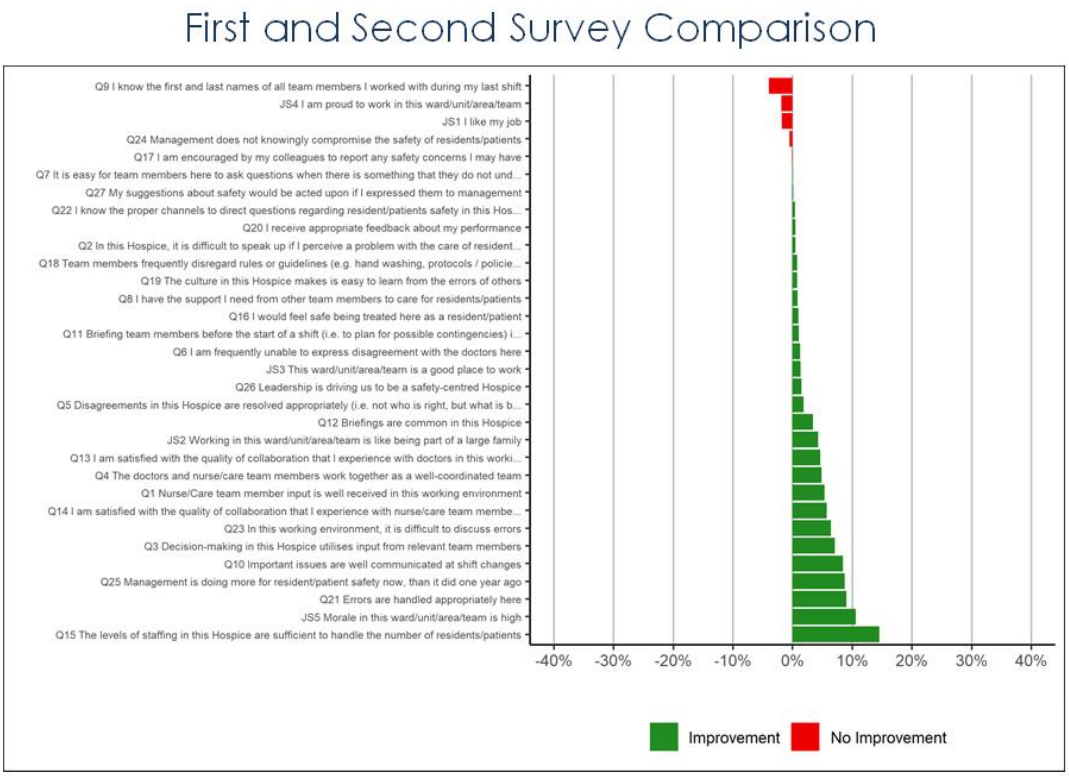
Statistical Process Control (SPC) charts showed a mean of 5.6 falls per week across the Sue Ryder organisation prior to huddles being implemented. This reduced to a mean of 2.4 falls per week when 5 of the 6 units had embedded huddles into their daily practice (Figure 3); implementation of huddles in unit 6 is underway,

Figure 3: Sue Ryder all Hospices SPC chart for falls per week



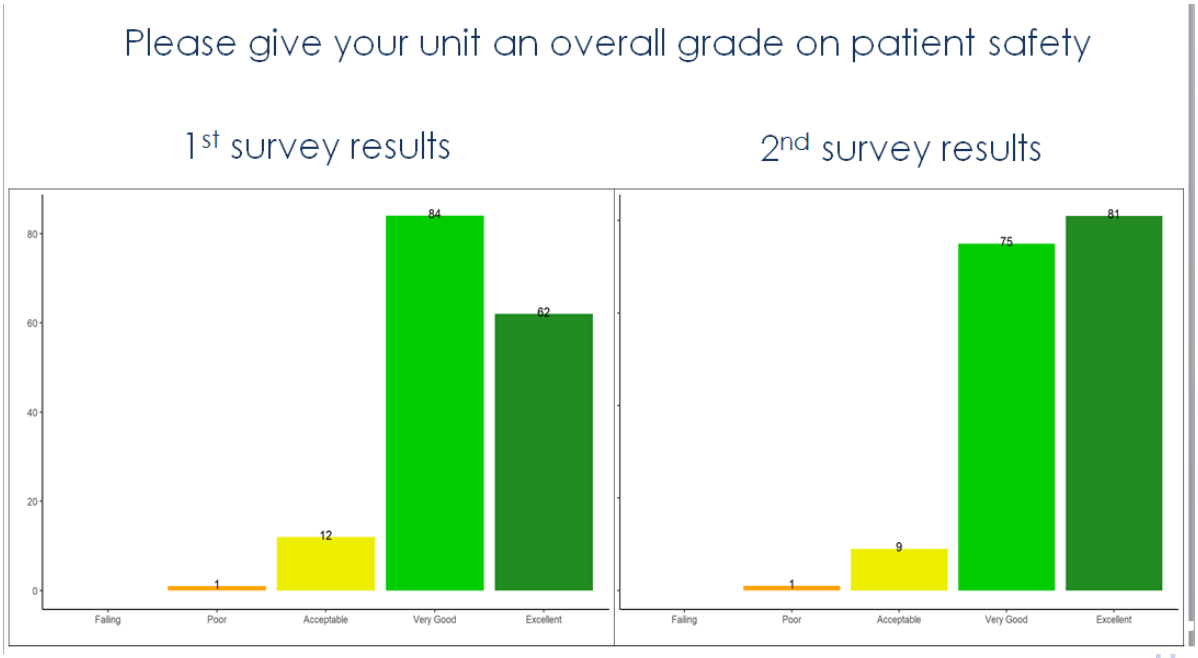
Teamwork and Culture survey results showed excellent team working and good patient safety culture. However, despite this, the comparison between the first survey (pre-huddles) and second survey (post-huddles), across five combined units, demonstrated further improvement with 27 out of 32 safety culture questions becoming more positive after huddles were embedded (Figure 4).

Figure 4: 1st and 2nd survey comparison at organisational level – all questions



In addition, staff were asked to give an overall grade on patient safety for their unit and this demonstrated a positive shift towards excellence after huddles were embedded (Figure 5).

Figure 5: Question 28 comparison between 1st and 2nd surveys at organisational level



What has been the learning?

This collaboration between Sue Ryder and the Improvement Academy challenged the notion that improvement work cannot progress in time of national upheaval such as the COVID-19 pandemic. In fact, it demonstrated that improvements can be made. During this time healthcare services saw high rates of sickness and low morale in many sectors; however, this initiative enabled the teams to be recognised for their achievements and demonstrated their valued role, and gave an opportunity to be positive. A 'hands-off' approach ensured teams were completely in control of all aspects of their own huddle, building a relationship of trust and respect between the team and the coach, and knowing when to step away and return for support was crucial to success.

Embedding the fidelity of the HUSH (Huddle up for Safer Health Care) approach has been pivotal in the development of a safety culture where the multi-professional team are able to incrementally learn and improve care within a supportive environment. Throughout this process, the Improvement Academy learnt about the various challenges that faced the hospice staff whilst working on safety huddles.

> "The programme has been really successful here at Sue Ryder. We give staff the tools to get going and then step back and allow them to develop it. They need to choose the right room, the right time and the right leads for their setting.
>
> There's no right or wrong way of doing things and if it's not working for them initially they have a rethink and try a different approach…
>
> It's a really collaborative approach to service user safety, and the fact that our teams have had such success in such a difficult year is really something to celebrate."
>
> ***Sharon Roberts – Interim Head of Nursing and AHP's. Quality & Governance, Sue Ryder Care***

The partnership has been shortlisted for a 2023 HSJ Patient Safety Award in the Quality Improvement Initiative of the Year category