

CHAPTER 15

Situational Awareness, Shift Planning, Daily Check-ins, and Safety Huddles

AS HIGH-RELIABILITY ORGANIZATIONS, healthcare entities need to be sensitive to activities or situations (e.g., high census, low-volume or high-risk procedures, new processes or procedures, staffing problems, equipment or medication shortages) that can lead to an increased chance of error. This attention requires leaders to have situational awareness about frontline issues. Throughout all levels of the organization, executives and managers must have current knowledge and understanding about operational issues, the level of risk a situation or activity poses, and potential trends for future risks and consequences. One widely adopted tactic to support situational awareness among leaders is to conduct an organization-wide standup check-in every 24 hours.

ORGANIZATION-WIDE HUDDLES

This practice originated in the nuclear power industry, where each day begins with a plan-of-the-day meeting of plant leaders. In the healthcare organization, this daily safety huddle or check-in is led by a C-suite executive, with the lead executive rotating periodically.

Each department or service line sends a manager or another representative to attend, and each attendee reports back on any issues that arose in the past 24 hours and any high-risk concerns for the upcoming 24 hours (Stockmeier and Clapper 2011). Examples of such issues include the following:

- Implementation of a new process or procedure
- Installation of a new piece of equipment
- IT downtime or major system upgrade
- A scheduled high-risk, low-volume procedure
- A patient presenting with an unusual condition or illness

In this reporting process, special attention needs to be paid to those issues or incidents that can occur in other areas. High-risk issues that can have a major impact on the organization should be assigned to a designated individual for follow-up, with the expectation that he or she will update the group in the next 24 to 48 hours.

The executive leading the daily safety huddle or check-in is responsible for reviewing any barriers the unit leadership encounters in addressing the cause of the risk or event. Many organizations also use the daily huddle to discuss any census, staffing, and throughput issues. Hot spots for the day, such as staffing issues, patients at risk for deterioration, new or infrequent diagnoses or procedures, new technology, and high census, are discussed, and solutions are driven by consensus to ensure the safest approach is taken.

Generally, one attendee takes notes so that issues can be tracked and trended. These notes are sent to the leaders for their review to confirm the details and reinforce action plans. A telephone conference line may be set up for those who cannot attend, especially in large organizations whose leadership is spread out geographically. While this accommodation facilitates wide participation, in-person attendance is strongly encouraged, as a secondary gain from this style of huddle is that the managers get to see each other face-to-face and take part in impromptu discussions, thereby building strong collegial relationships. Executives and department directors should

keep track of attendance and follow up with any managers who fail to attend regularly or to send a designee and address any barriers faced in their ability to participate.













DEPARTMENT-LEVEL HUDDLES

At the department or unit level, shift huddles and shift overviews are held with all caregiving staff to help continually build situational awareness. One tool for conducting these huddles is the daily improvement board, from the Lean performance improvement toolbox. A white board is marked to show columns, or swim lanes (see exhibit 15.1). The first lane shows the unit's current state, including census; number of admissions in the past 24 hours; number of discharges anticipated in the next 24 hours; staffing levels; and high-risk, "watcher" patients. (*Watcher* is a term coined by Cincinnati Children's Hospital for patients who need frequent assessment and intervention due to their symptomology [Brady et al. 2013]).

The second lane conveys information on safety, such as issues or incidents experienced in the past 24 hours that all staff need to be aware of; recognition of staff members for good catches; recent safety data, including safety culture survey results; and follow-up regarding concerns about any risks identified earlier by the staff. The fourth lane focuses on the staff and may include staff satisfaction data, additional recognition for staff, and teamwork information and data. The final lane documents data on the patient experience, including patient and family experience survey findings, improvement work related to the patient experience, a featured patient story, and patient feedback and suggestions.

The third lane on the daily improvement board lists quality or process improvement metrics. These measures can include hospital-acquired condition information, progress to date on current PDSA cycles, information about other process improvement work, highlights from the previous 24-hour rounding, and any findings from recent accreditation or regulatory audits.

Exhibit 15.1: Example of a Huddle or Daily Improvement Board

Current State	Safety	Quality/ Process Improvement	Staff	Patients and Families
Census: 25	Incidents/ issues	HACs CLABSI: last date 5/25/17	Staff satisfaction survey results	This week's patient story
Admissions: 4				
Discharges: 5	Safety culture survey	Falls: last date 6/1/17	Recognition	Patient experience data
Watchers: Room 204 Room 210				
	Good catches	Rounding feedback:	Staff suggestions	Patient/family feedback
		1 — 2 — 3 —		
	Incident/ issue follow-up:			
				
	Joint Commission visit starts August 1!			

Note: CLABSI = catheter-associated bloodstream infection; HAC = hospital-acquired condition.

Unit-based shift huddles should last approximately 15 minutes and be facilitated by unit leadership. The unit quality improvement specialist and safety specialists can assist by providing much of the data. New information is briefly reviewed, and staff are encouraged to speak up about any concerns or make suggestions for improvement.

The participative nature of the daily shift overview and accompanying documentation on the white board allow all staff who work on the unit to be aware of safety activities and issues. All disciplines should participate in the huddle to further ensure that each member of the team has a good working knowledge of the risks that are present for the upcoming shift. On units that span a large physical area, these huddles may occur in multiple locations. For example, different surgical services staff may huddle in the preoperative area, surgical suite, and recovery area.

LEADERSHIP ROUNDING

Another way to increase situational awareness is through leadership rounding. Rounding to influence behavior is discussed at length elsewhere in the book as a leadership tactic to support high reliability. While this approach is primarily intended to influence staff and physician practice behaviors, it also informs leaders about the pulse and tone of the units. Executives can learn the overall as well as specific concerns of the staff and physicians and uncover barriers to safe care. When these issues are addressed in a timely fashion, staff recognize that the organization supports the staff and that patient and employee safety really is a core value.

When unit-based leaders, including physicians, round on the units, they can become aware of latent, or hidden, system weaknesses as they are voiced by the staff, physicians, and patients and families. If space on the unit's huddle board is dedicated to documenting issues that arise during rounding, a trip to the huddle board following a rounding session can further raise awareness for executives and unit leadership as these issues are addressed by team

members. It also serves as a means to recognize staff in real time for providing feedback.

TRANSPARENCY AND A SUPPORTIVE CULTURE

The report *Shining a Light: Safer Healthcare Through Transparency* (Lucian Leape Institute 2015) indicates that three main cultural elements are key to improving transparency among clinicians, CEOs, other leaders, and staff. The first component is a supportive culture in which caregivers can be transparent with and accountable to each other. The second element is a comprehensive set of multidisciplinary processes and forums for reporting, analyzing, sharing, and using safety data for improvement. The final component is the creation of processes to address noncompliance by building accountability practices. (Building accountability practices is discussed in more detail in chapter 31.)

When these cultural elements are present in an organization, each individual feels responsible, accountable, and safe to provide accurate information on departmental issues (Lucian Leape Institute 2015).

Once executives, leaders, physicians, and staff all accept responsibility for discussing their concerns, areas of risk, errors that have occurred, and patient stories, situational awareness has taken hold at the highest level. Rounding, huddle boards, and organization-wide daily safety huddles and check-ins provide comprehensive support for all members of the organization to practice a culture of safety.