

Title: Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center

Authors: Naseema B. Merchant, MD, High Reliability Organization Physician Champion U.S. Department of Veterans Affairs Connecticut Healthcare System; Jessica O'Neal, MSHA, High Reliability Organization Lead, U.S. Department of Veterans Affairs Connecticut Healthcare System; Alfred Montoya, Jr. MHA, FACHE, VHA-CM, Medical Center Director, U.S. Department of Veterans Affairs Connecticut Healthcare System; John S. Murray, PhD, MPH, MSGH, RN, CPNP-PC, CS, FAAN, Executive Leader Coach, High Reliability Organization Support Team, Cognosante® LLC

Objective: The purpose of this quality improvement project was to create a process for the implementation of tiered huddles at a Veterans Affairs Medical Center.

Planning/Research Methods: Prior to planning for the implementation of a tiered huddle process, an extensive review of the literature was completed to explore the experiences of other organizations. A tiered huddle proposal was developed, presented, and approved by the medical center executive leadership team. Based on literature review and feedback, a Tiered Huddles Implementation Guide was created for all stakeholders' system wide. An educational video was developed for all staff members participating in the pilot and offered flexibility of review for staff. Based on input from the staff, whiteboards were used as the visual management system (VMS). The MESS Format which stands for **M**ethods, **E**quipment, **S**taffing and **S**upplies was used to standardize and capture important information on the VMS. The MESS format enables staff to assess whether or not the correct procedures and practices are in place, needed equipment and supplies available, and proper staffing available to provide safe, high quality patient care for the day.

Implementation Methods, Including Sample Sizes: Three services were identified for pilot testing: Primary Care, Anesthesiology and Surgical Intensive Care Unit. During the initial phase, pilot testing was scheduled to occur on two days a week. Tiered huddle champions for each pilot service were identified and were responsible for collecting process (e.g., number of weekly huddles/huddles cancelled with explanation, percent attendance by staff, etc.), outcome (e.g., huddle compliance, number of issues: identified, addressed, closed, remaining open, etc.), and balancing (e.g., number of extended work days due to huddles, staff staying overtime, delays in patient care activities, etc.) measures each time the huddle. The composite data from each of these pilot huddles was analyzed after 10 weeks.

Findings: Out of the possible 120-tiered huddles that could be conducted, 68% (n=81) were completed. The Omicron variant of COVID 19 resulted in some tiered huddles being replaced with unit based COVID huddles. Of the those conducted, 99% (n=80) started and ended on time. Over the 10-week period, there were seven issues identified by frontline staff: coordination of pre-procedural COVID testing, equipment/computer issues, rooms out of service, staffing levels, and lack of responsiveness from other departments. Issues of staffing levels, lack of responsiveness, and equipment concerns required elevation to a higher-level tiers. Delays in patient care, or prolongation of shift hours due to tiered huddles, was low – 2.5% (n=2).

Conclusion: The results of this quality improvement project demonstrated the importance of thoughtfully and carefully creating a robust process for the implementation of tiered huddles, and while the pandemic has the potential to negatively impact the progress of tiered huddles, we have shown that flexibility can allow us to sustain our commitment of continuous improvement on our journey to high reliability.