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Patient Care Services / Nursing

Huddle Up! Collective Responsibility to Positively Impact Workflow and Patient Safety

Christine Marakovits BSN, RN Lehigh Valley Health Network, Christi_E.Marakovits@lvhn.org

Jessica Beaver BSN, RN Lehigh Valley Health Network, Jessica.Beaver@lhn.org

Beth A. Kessler BSN, RN, BC

Maryann Lubinensky RN Lehigh Valley Health Network, Maryann.Lubiensky@lvhn.org

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Huddle Up! Collective Responsibility to Positively Impact Workflow and Patient Safety 6 Tower Medical Surgical Unit Staff Lehigh Valley Health Network, Allentown, Pennsylvania

Pre Game Warm Up

Background & Purpose

BACKGROUND—The workflow of nursing care delivery changes within minutes. Two concepts formulated outside healthcare offer strategies to proactively address patient safety issues prompted by increasing workflow. The US Army "After Action Review" (AAR) involves knowledge transfer from an individual to a team. 'Crew Resource Management' (CRM), originally used within the aviation industry, pays attention to the cognitive and interpersonal skills needed to manage a team. In this context, cognitive skills are defined as the mental processes used for gaining and maintaining situational awareness, for solving problems, and for making decisions. Interpersonal skills are regarded as communications and a range of behavioral activities associated with teamwork. Merging concepts and strategies from AAR and CRM, safety huddles have been initiated within health care to enhance situational awareness. Huddles provide the care team a chance to recognize there may be a discrepancy between what is happening and what should be happening - often the first indicator an error may be occurring.

<u>PURPOSE</u>—This poster details implementation and outcomes of safety huddles on 30 bed acute medical-surgical unit.

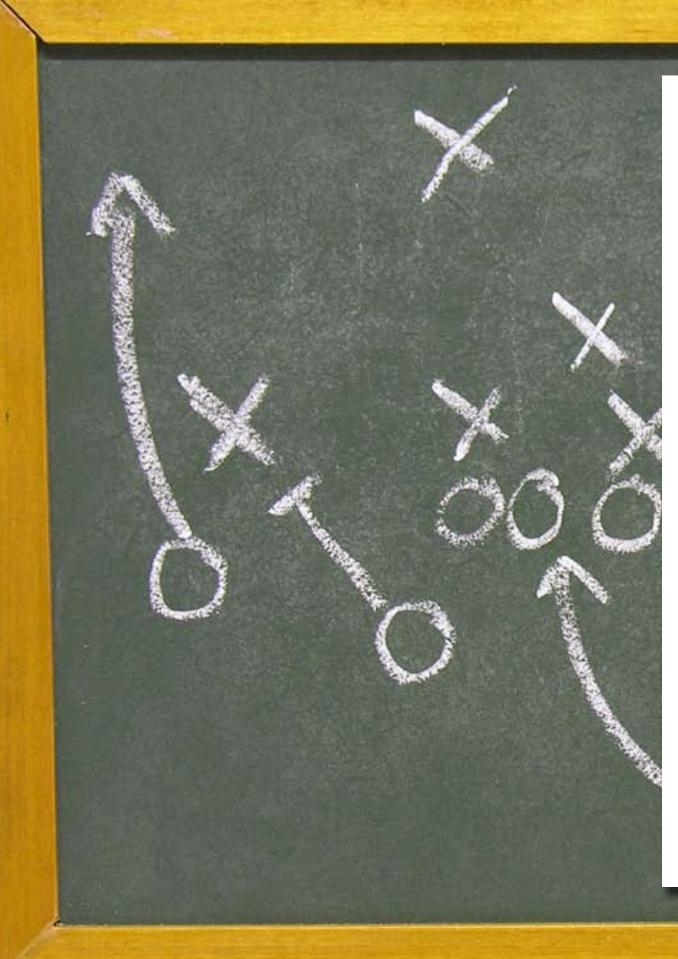
How the Work Was Done

- Planning/Design Team—Unit shared governance Practice Council
- When?
 - 8:00 am & 8:00 pm
 - Impromptu Initiated by any team member for such things as increased workload, patient fall, change in patient acuity
- Format
 - Brief review of all patients
 - Worksheet to prompt appropriate questions and dialog to result in actions impacting patient safety and staff concerns
- Key Factors
 - Sharing of knowledge without fear of embarrassment or recrimination
 - Dialogue to solve problems and make decisions regarding most appropriate interventions









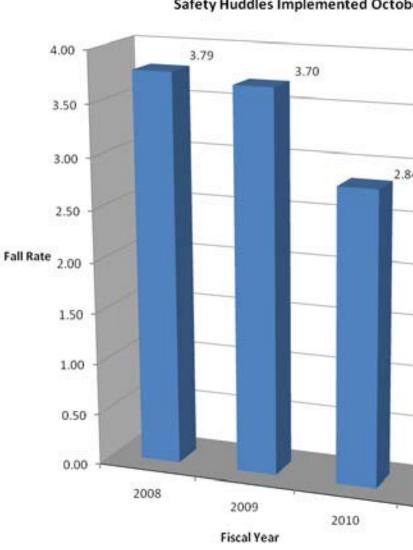
Who Was Involved

• RNs

- Unlicensed assistive personnel
- Clerical Support
- Unit managers
- Students & faculty

Playbook

DATE: 03/22/1	UL: Jaclyn		Tele Boxes: 8 On natie		8 nt / Drawer
Any 1:1's sc	hedule breaks –	1130am 5	5:30pm	2:30 am	
RN/Room	Gina	Nicole	Jess B	Maryann	Terry
TECHS : (Has report been given?)	JOSIE		Brian		Kathy
Foleys	(5) wound	0	0	0	25(neurogenic)
Other Concerns	603 – fell in ICU	8- Droplet r/o flu	617 – 1:1, strong, confused	Insulin gtt 620	26 – family 29 DVT 30 forgetful
	601 - Independent	607 FM - rings	613 FM rings	619 BC FM rings	625 FM rings, bed bound
PU Concerns	602 FM - rings	608 BC, FM - rings	614 FM – rings	620 FM rings	626 FM rings
TQ2 turn q 2 EH elevate heels SB Specialty bed CC – Chair cushion	603 FM - rings	609 FM - rings	615 independent rings	621 independent	627 FM rings
ETC – ET Consult FALLS INTERVENTIONS: Key:	604 FM - rings p/u risk, SB, ET,	610 BC, FM - rings 611 FM -	616 FM – rings	622 independent	628 FM rings
BC: Bed check HLB: Hi low bed	605 FM – rings bed	rings 612 –	617 HLB, FM,	623 independent	629 FM rings
LB: Lap buddy FM: fall magnets M: Matts R: Rings/Does not challenge	bound 606 FM -	independent rings	618 FM - rings	624 FM rings	630 FM rings
C: Challenges	rings			<u>-</u>	
COMPLETES (If more than 3 in section what's the plan for helping Tech)	4,5,2,	8, (bathed on nights) 10 heavy assist	17	0	25
DISCHARGES (Is DCI started? Flu/Pnue given? Case Management aware?)	1,6,4,	11,12,	15,17,	22,24	26
OFF UNIT PROCEDURES	5 OR	0	13 xray 18 OR @ 1400	19 US & Echo 21 & 23 2D echo	28 xray, 30 US kidneys



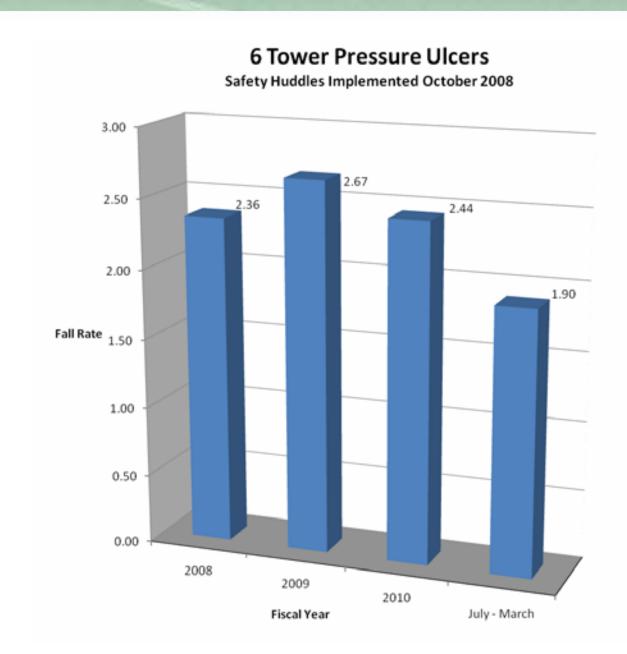
References:

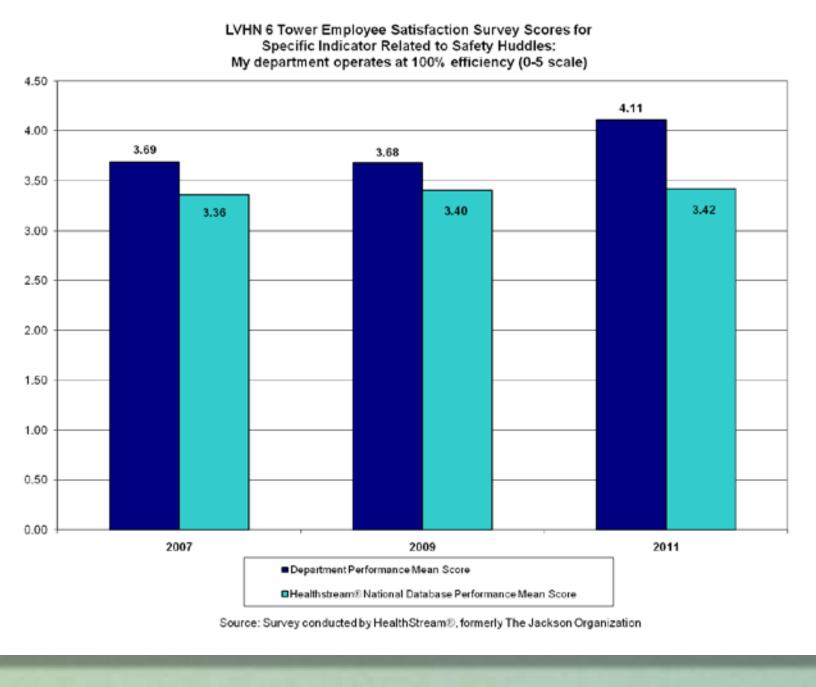
- Oct; 31 (5): 14-8.
- 39 (8): 38-40, 42-4.

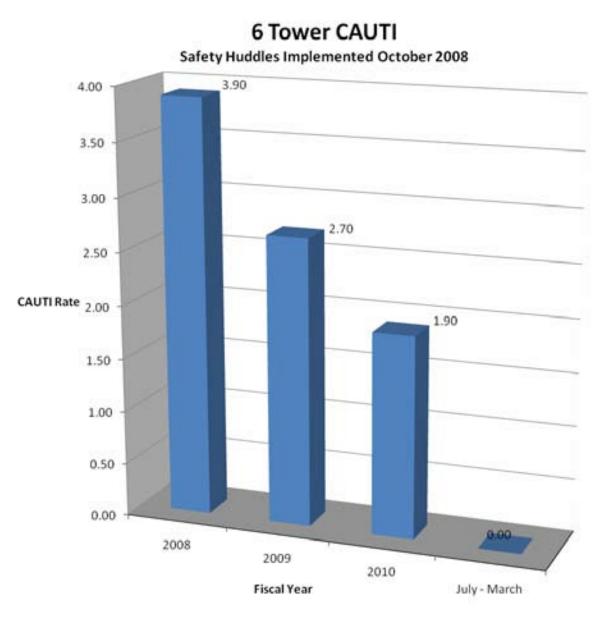


Measurement & Impact









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