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

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**Collective Responsibility to Positively Impact Workflow and Patient Safety**

6 Tower Medical Surgical Unit Staff

Lehigh Valley Health Network, Allentown, Pennsylvania

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**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.

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

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**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

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**Game Time**

**Playbook**

**Final Score**

**Measurement & Impact**

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**Who Was Involved**

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

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**References:**