Effective Huddles and Debriefs: How to Facilitate Learning at the Frontline

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Acknowledgement

C A P T U R E Falls

Collaboration and Proactive Teamwork Used to Reduce

http://www.unmc.edu/patient-safety/capturefalls/

Objectives

1. Identify best-practices in conducting post-fall huddles that facilitate immediate learning by front-line workers

2. Identify key challenges to conducting effective post-fall huddles and how to overcome these barriers to team learning

3. Learn and practice effective leadership and facilitation behaviors for post-fall huddles in particular and debriefs in general

What is a Post-Fall Huddle?

A <u>post-fall huddle</u> is a brief meeting immediately after a fall that includes staff caring for the patient and (ideally) the patient and family

Useful to multiple stakeholders:

- Patient and family
- Core team
  - Nursing
  - PT/OT
  - Pharmacy
  - Quality Improvement
  - Providers
- Administration/Management

Purpose of a Post-Fall Huddle

To guide critical thinking about a fall event for an individual patient with the overt goal of discovering the root cause of the fall

To decrease the risk of a future fall for the patient who has fallen by changing the plan of care for that particular patient

To apply what is learned in the huddle to other patients and the system in general, especially when trends emerge over time

Secondary Purpose of a Post-Fall Huddle

To improve teamwork and cohesion among bedside personnel (core team) in the hospital

To improve collaboration and coordination among inter-professional teams in the hospital

What do we know about post-fall huddles?

2014 survey of post-fall huddle behaviors in 15 Nebraska CAHs assessed perceptions of…

- Huddle attendee behaviors
- Huddle leader behaviors
- Satisfaction with huddles
- Effectiveness of huddles

Photo citation: http://www.cmpa-acpm.ca/cmpapd04/docs/ela/goodpracticesguide/pages/communication/Team_Communication/team_communication-e.html

What do we know about post-fall huddles?

Opportunities to create a safe post-fall huddle environment where staff can be open and honest, share information, accept responsibility, recognize successes and learn from mistakes.

Huddle Attendee Behaviors	% Agree	Low Hos.	High Hos.
1. I felt like I was asked for my honest feedback.	87	68	100
2. I felt like I could be open and honest.	92	50	100
3. I felt like I could share things without fear of retribution.	91	50	100
4. People usually accepted responsibility.	84	62	100
5. I could approach others to try and find out how I could do better next time.	85	62	100
6. No one on my team was overly critical.	90	75	100
7. My team was very supportive of one another.	90	75	100
8. I felt like I could speak freely.	90	75	100
9. We discussed when something went wrong and offered specific ideas on how to correct the problems in the future.	91	75	100
10. My team did a good job of outlining what we need to work on.	88	75	100
11. It was acknowledged when we did things well.	81	62	100
12. Our successes were praised	75	62	100
13. I felt like our time was utilized well.	84	57	100

What do we know about post-fall huddles?

Opportunities to identify staff roles related to a fall, recognize successes and identify errors, and ensure staff learn from the fall to prevent similar events in the future.

Huddle Leader Behaviors	% Agree	Low Hos.	High Hos.
1. Gave praise where it was deserved.	78	60	100
2. Commended us for the good things we did.	81	60	100
3. Pointed out mistakes to improve on in the future.	83	40	100
4. Talked about what went wrong.	92	80	100
5. Allowed everyone involved in the huddle a chance to speak.	92	80	100
6. Encouraged us to voice our concerns.	91	80	100
7. Discussed everyone's role during the fall.	82	60	100
8. Talked about what can be learned from the fall.	89	60	100

What do we know about post-fall huddles?

Better huddle attendee and huddle leader behaviors are related to improved satisfaction with huddles.

Satisfaction with Huddles	% Agree	Low Hos.	High Hos.
1. I feel satisfied with the way in which my last huddle was conducted.	81	25	100
2. I feel satisfied with the procedures used in my last huddle.	81	25	100
3. I feel satisfied about the way we carried out the activities in my last huddle.	82	25	100
4. I feel satisfied with the things we achieved in my last huddle.	81	25	100
5. When the huddle was over, I felt satisfied with the results.	82	25	100
6. Our accomplishments in our last huddle give me a feeling of satisfaction.	77	25	100

What do we know about post-fall huddles?

Better huddle attendee and huddle leader behaviors are related to greater huddle effectiveness.

| Effectiveness of Huddles	% Extent	Low Hos.	High Hos.
1. Efficient	94	50	100
2. Productive	94	50	100
3. Effective	94	50	100

Improving the success of post-fall huddles:
- Enhance huddle attendee and leader behaviors
- Greater satisfaction with and effectiveness of huddles
- Greater perceptions of group and organizational safety norms

What makes for a successful huddle?

Several steps and inputs to consider:

1. What is the purpose…fill out a form or draw out the story of what happened?

2. Who to include?

3. When to hold the huddle?

4. Where to hold the huddle?

5. Who facilitates the huddle?

6. What huddle form to use?

7. How to manage attendee behavior?

8. How to manage leader/facilitator behavior?
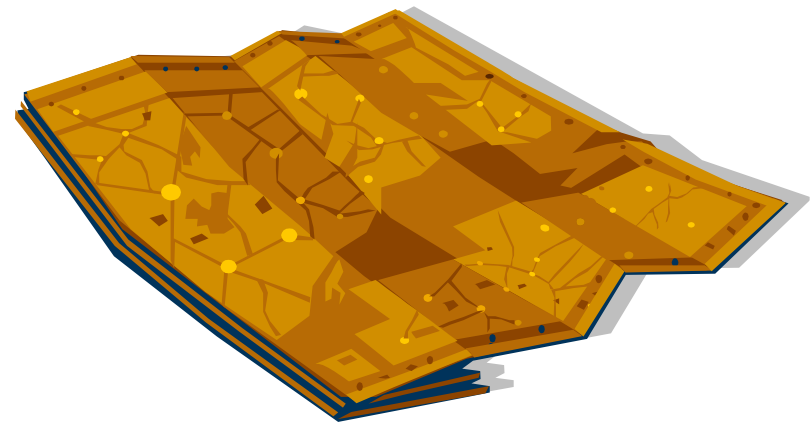
Who to include?

Consider inviting the following:

- Staff providing direct care for the patient at the bedside (RN, CNA)

- Interprofessional Team (pharmacy, PT/OT, MD, QI, SW)

- Patient/family

Careful not to overwhelm patient/family with team…

"…it's good for patients and families to know that we're watching over the patient and are [including them] either to get some feedback or provide some feedback so – that's kind of where we've thought our value is."

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The Interprofessional Necessity

- Multiple points of contact with patient

- Multiple perspectives about etiology and prevention

- Multiple potential root causes

Photo citation: http://ipep.arizona.edu/blog_tags/teamwork

"We all just bring a little different tool or element to problem solving that makes it collectively a better way to solve the problem"

Interprofessional huddles have best chance to capture all of these!

A Two-Stage Huddle Option

Consider a two-stage huddle process to achieve the goal of interprofessional input:

Core Team (1): Bedside huddle that occurs immediately

Coordinating Team (2): Members of inter-professional team (e.g. pharmacist, PT, OT, QI) review fall event report and huddle form within 24 hours
- Provide complementary input to nursing
- Review the event in the context of the system and previous events

Photo citation: http://www.computerweekly.com/news/2240180253/UK-government-launches-cyber-threat-data-sharing-partnership

"[there is] a couple different levels of huddle too, what can we do right now to stop it from happening again, and …
is there a process issue."

When to hold the huddle?

- Bedside huddle should occur immediately
    - <u>Must</u> occur before end of shift

- Interprofessional team huddle ideally within 24 hours

- Time is our enemy
    - Forget important details in a matter of minutes/hours…

"…it is too difficult to get all of the people involved back together after the shift is over."

Where to hold the huddle?

- Ideal = where the fall occurred with the patient/family

- Necessary = a space large enough for the huddle team to openly discuss the event

Photo citation: http://www.skodn.com/hospital-room/hospital-room-novdrtf/

- A space more similar to where the event occurred ensures better recall of circumstance of the event

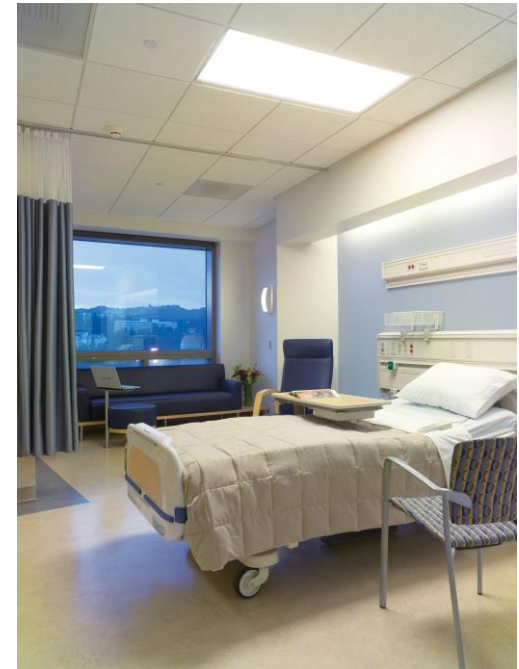 - e.g. another open hospital room similar to patient's room

Who facilitates the huddle?

- Several options, for example:
  - Nurse assigned the patient
  - Lead/charge nurse
  - Doctor
  - Fall risk reduction team member

Key: Have a person responsible for leading the huddle and completing necessary documentation!

Photo citation: http://www.collegenetwork.com/blog/emerging-nursing-career-clinical-nurse-leader

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Why is a facilitator essential?

- Ensures accountability for
  - calling and conducting the huddle
  - completing documentation
  - implementing agreed upon changes in plan of care
- Ensures all aspects of event reviewed
- Elicits and clarifies multiple versions of story
- Prevents negative attendee behaviors (e.g. blame)
- Facilitates positive attendee behaviors (e.g. open sharing environment)

Photo citation: http://www.strategies.com/blog/wp-content/uploads/2013/11/huddle.jpg

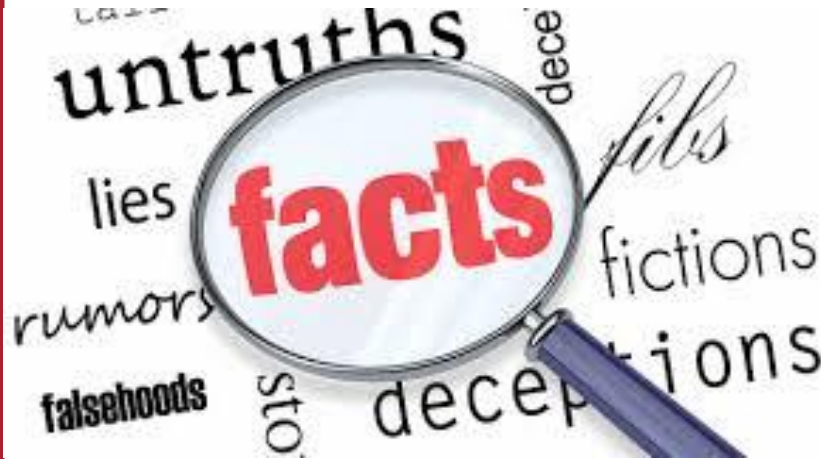# What huddle form to use?

What is a post-fall huddle form?

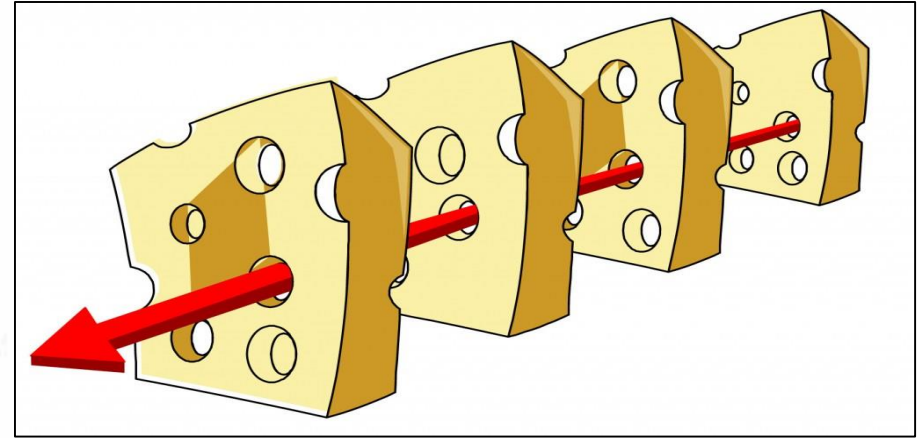Why "yet another" form is helpful?

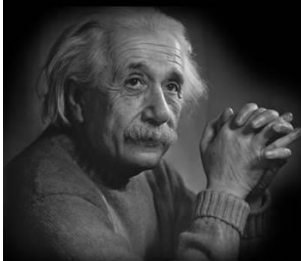Our proposed post-fall huddle form...

Page 1 of Huddle form

If we knew what it was we were doing, it would not be called   a huddle would it?

Albert Einstein
German Theoretical-Physicist
(1879-1955)

QuoteHD.com

Changes
NEXT EXIT →

Page 2

1.

http://diggerfortruth.wordpress.com/2014/03/25/who/
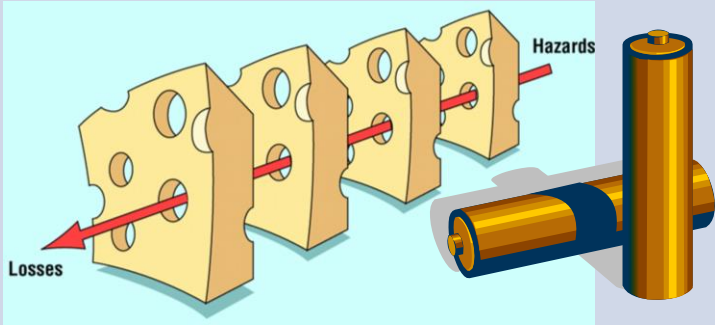
2. What type of fall occurred? CHECK ONE
- ☐ Accidental fall due to environment
- ☐ Anticipated physiological fall due to known risk factors
- ☐ Unanticipated physiological fall due to unpredictable factors
- ☐ Unsure: _____

Fall

↓

Post Fall Huddle

↓

Determine Immediate Cause ← What was different this time?

↓

Immediate Causes

| E.g., Spill on floor Trip over tubing Broken equipment or furniture | E.g., Postural hypotension Weak or impaired gait Loss of balance Confusion Centrally acting medication | E.g., Heart Afttack Seizure Drop Attack |

↓

| Environmental | Known Intrinsic/ Extrinsic Risk Factors | Unknown Sudden condition that cannot be predicted before the first occurance |

Types of Falls

↓

| Accidental Fall | Anticipated Physiological Fall | Unanticipated Physiological Fall |

Unpreventable Falls

Determine Preventability

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Learning Domains

		Actor Interdependence	
		Low	**High**
Process Uncertainty	**Low**	**Task Error**	**Coordination Error**
	High	**Judgment Error**	**System Interaction**

MacPhail LH, & Edmondson AC. Learning domains: The importance of work context in organizational learning from error. In D. A. Hofmann & M. Frese, Errors in Organizations. New York: Routledge; 2011:177-198.

Learning Domains

		Actor Interdependence	
		Low	**High**
Process Uncertainty	**Low**	**Task Execution**: Individuals perform well understood, routine tasks **Task Error Example:** Forget to turn on bed alarm	**Coordination:** Process knowledge high within groups; low between groups **Coordination Error Example:** Information about previous fall not handed off between shifts/departments
	High	**Judgment**: Individuals perform unfamiliar processes that require decision making **Judgment Error Example:** Patient at high fall risk and cognitively impaired left alone in bathroom	**System Interaction:** Multiple people involved in new activity **System Error Example:** No policy/ procedure to regularly replace batteries in newly acquired chair alarms

MacPhail LH, & Edmondson AC. Learning domains: The importance of work context in organizational learning from error. In D. A. Hofmann & M. Frese, Errors in Organizations. New York: Routledge; 2011:177-198.

Cautions on Huddle Forms

Don't get stuck in the checklist

- Probe an issue until the root cause is identified by asking "Why?" multiple times
- Goal is to achieve a "rich" understanding of the situation based on multiple perspectives

Photo citation: http://yourpeoplefirst.com/page16.html

Build in flexibility

- Accommodate unexpected variations
- Don't be afraid of ambiguity

Managing Huddle Attendee Behavior

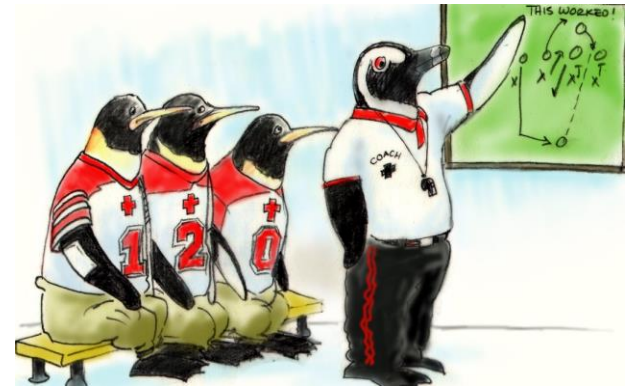| Engage in Positive Behavior	STOP Negative Behavior
• Open and honest sharing • Supportive discussion • Acknowledge good work • Praise successes • Accept responsibility • Identify things to work on	• Blaming • Finger pointing • Overtly critical comments

Huddle Leader Behavior

Engage in positive facilitator techniques

- Allow/encourage EVERYONE to speak

- Ensure concerns are voiced

- Discuss each attendee's role during and in response to the fall

- Discuss what can be learned from the fall

- Agree on processes to be improved in the future

- Give praise/commend for good work

What does a bad huddle look like?

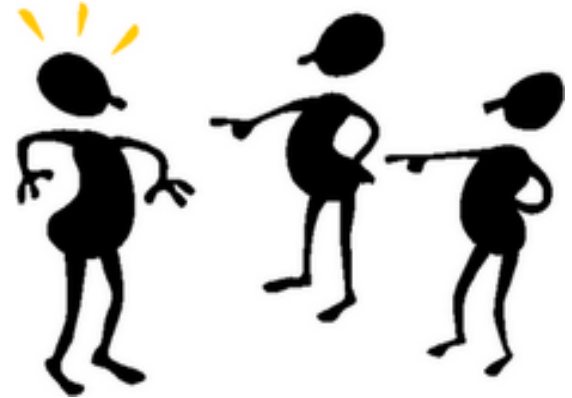Two major issues (among others)

1. Blaming and critical comments

2. Unmanaged challenging/negative personality

Photo citation: http://3.bp.blogspot.com/-LzXpn_Zdt-I/TcRHbuyIcaI/AAAAAAAADsc/MlSqSLjuehU/s320/blame.jpg

Role-play – "Bad" Huddle

What does a good huddle look like?

Three major keys to a successfully managed huddle (among others):

1. Open, safe sharing environment (i.e. turn taking)

2. Thoughtful and focused on processes (i.e. no automatic reacting)

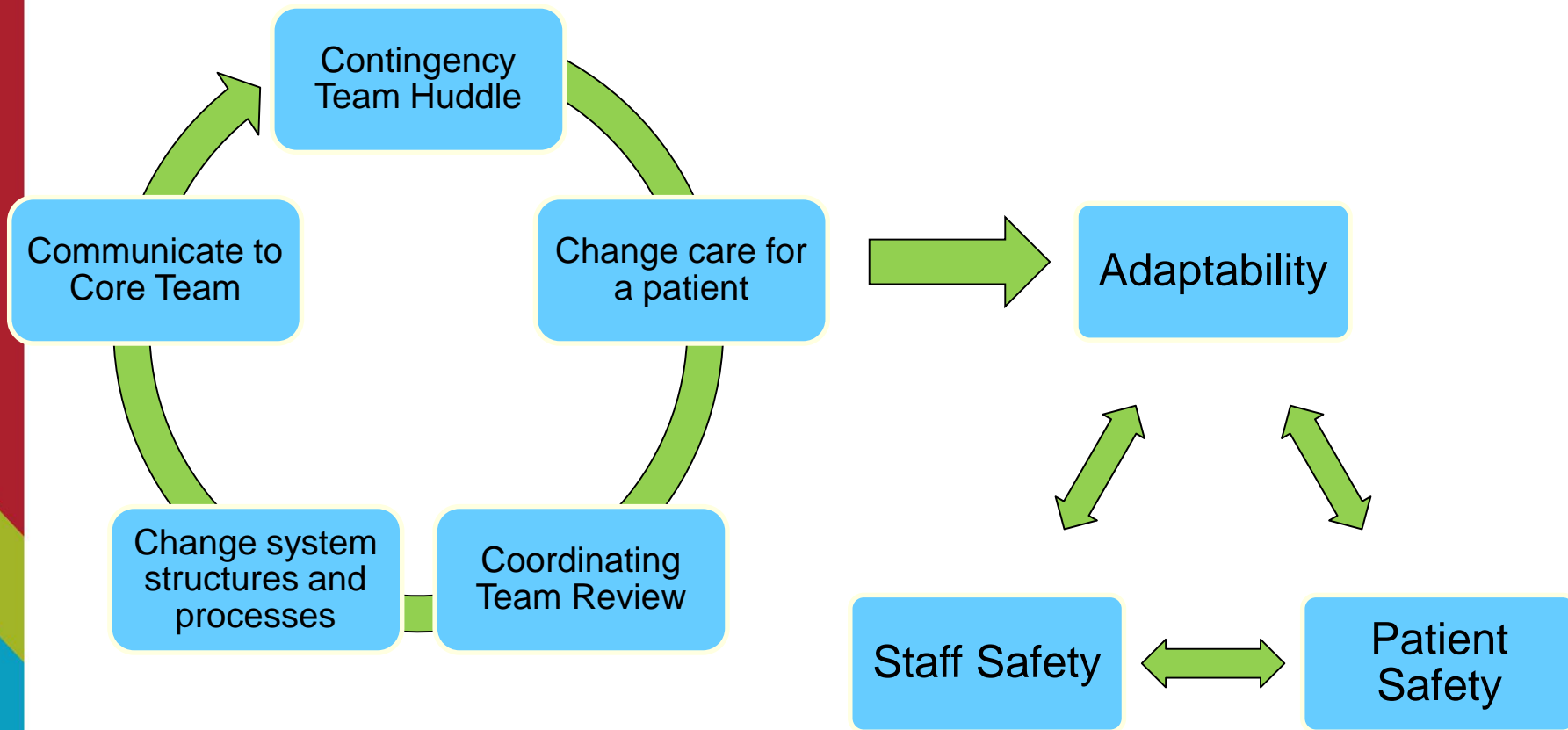3. Learning occurs and is identified

KEEP CALM AND take turns

http://www.keepcalm-o-matic.co.uk/p/keep-calm-and-take-turns/

Role-play – "Good" Huddle

Call to Action/Conclusion

Contingency Team Huddle

Change care for a patient

→ Adaptability

Communicate to Core Team

Change system structures and processes

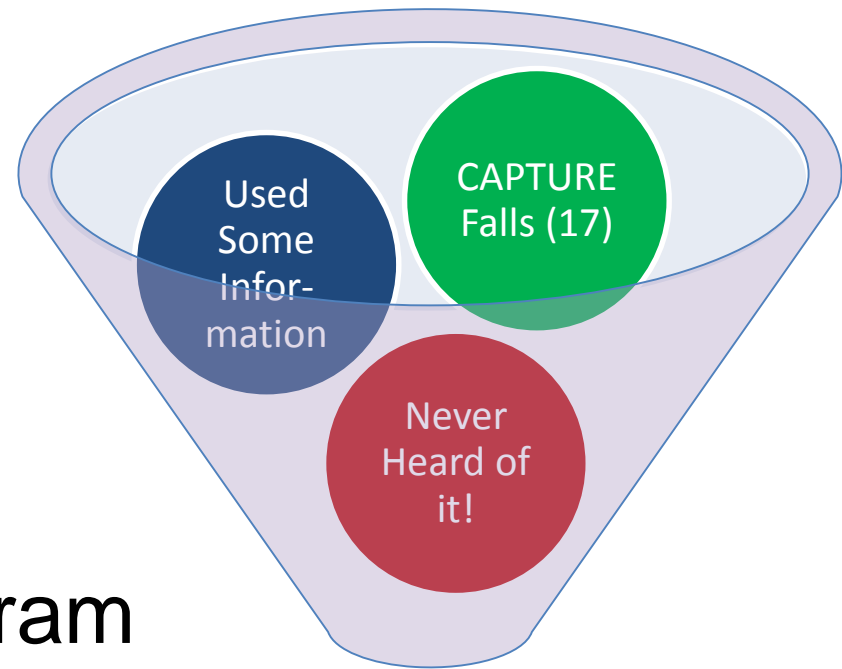Coordinating Team Review

Staff Safety ↔ Patient Safety

"I think all [huddles] are effective in one way or another—
you know you learn something from every one…"

Next Steps

1. Natural Experiment

2. CAH Fall Event Reporting and Benchmarking Program

We Pay For Performance!

http://rangelmd.com/2010/05/how-pay-for-performance-in-medical-practice-wont-work/

Used Some Infor-mation

CAPTURE Falls (17)

Never Heard of it!

Fall Rates?