SaTH Improvement Hub

The Shrewsbury and Telford Hospital NHS Trust

# Safety Huddles

September 2022

**Rachel Webster/ Ward Managers- Medicine (PRH Wards 6,7,10,11,15,16,17 and RSH Wards 21,22,24,27,28,31,32,35)**

**Abstract:** In order to improve the assurance around Safety Huddles, a standard template was agreed to be trialled for all medicine wards along with the process of recording the huddles.

## SMART Aim

To have standardised, auditable, Safety Huddles taking place each day in clinical areas in order to improve patient safety by September 2022.

## Plan

Across the wards at SaTH there is variation in the use and content of team briefs / safety huddles. The recent CQC inspection highlighted the need for oversight and assurance around the rhythm of the day for the wards. There is a need for ongoing communication regarding workload and concerns within the ward team during the day, plus the opportunity for sharing and cascading information and learning. It was felt that standardisation of Team Brief and Safety Huddles would be an important element of this and help ensure we understand key patient safety concerns following shift changeover.

## Do

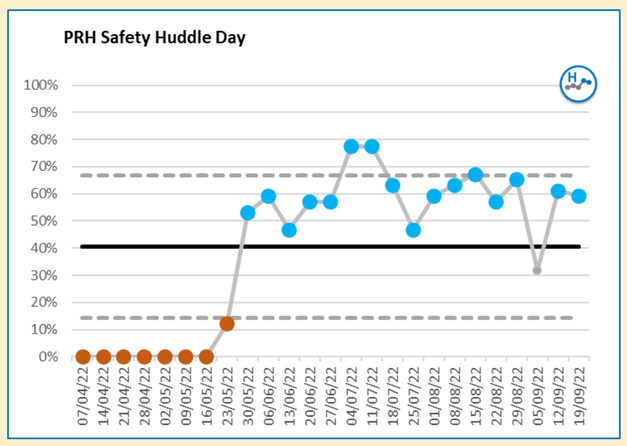
Teams involved within the process engaged to agree a standardised template to test across the medical wards. The team then tested the initial draft to ensure it covered the key communication points.

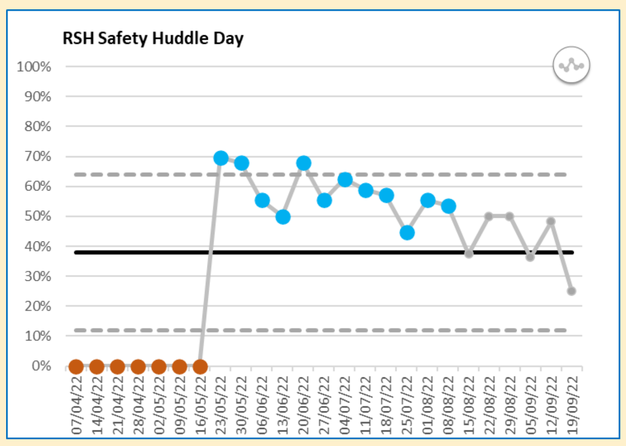
A process flow session was also carried out to understand the variation in ward demands during the day and the purpose and content of each task (such as safety huddle, team brief, handover etc). It was agreed to initially focus on the safety huddle element of the ward processes.

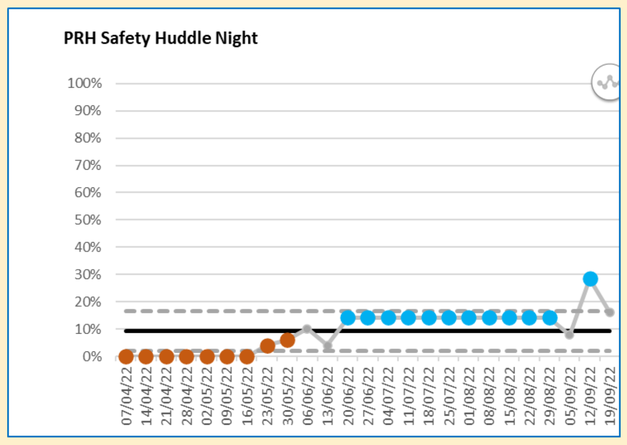
Ward teams carried out the safety huddles both morning and evening and documented this on the standardised template and scanned the document into a central folder for review.

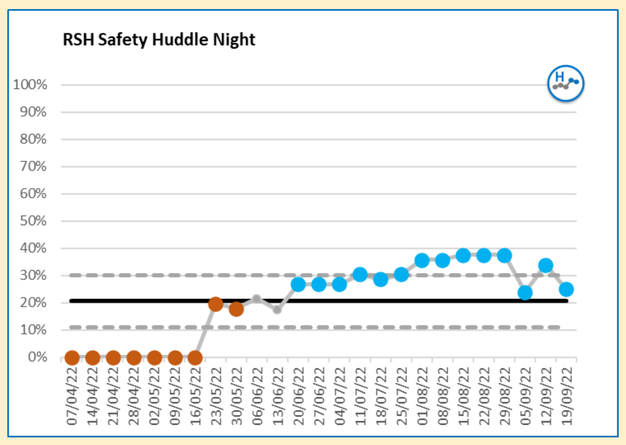
## Study

The numbers of documented safety huddles showed statistically significant improvement during the initial stages of the trial at both PRH and RSH sites. The figures would suggest that further work should be carried out to understand the completion of the safety huddles at night. Is has been difficult to correlate the use of the safety huddle to improved patient outcomes due to the complexity of the patients.




## Act

The next steps for teams will be to ensure the safety huddle process continues, with matron oversight and further development to ensure the right information is being communicated to ensure safety of our patients both day and night.