Safety huddles: improving patient safety culture.

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Safety Huddles: Improving Patient Safety Culture in Nursing

Introduction

The prevalence of harm to patients in healthcare settings remains a critical global concern, with falls and pressure injuries being the most common yet preventable forms of harm. Various strategies, such as clinical audits, staff training programmes, and standardised protocols, can be employed to address these issues. Among these, safety huddles stand out as a promising approach to further mitigate harm by fostering collaboration and accountability within healthcare teams. This commentary examines how safety huddles can mitigate harm, enhance team dynamics, and advance patient safety culture, emphasising the pivotal role of nursing in these efforts.

What is a safety huddle?

Safety huddles are a brief focused meeting (usually 5 to 15 minutes) where healthcare professionals discuss safety concerns, risks, and strategies to improve patient safety. While these huddles are beneficial across various healthcare settings, they are especially important in nursing, where patient care and safety are paramount. The goal is to ensure all team members are aware of safety issues and aligned in addressing them. During a huddle, the team discusses high-risk patients, incidents or near misses, staffing levels, resource availability, and environmental factors such as equipment or space issues. Critical updates on patient conditions, admissions, transfers, or discharges are also shared. The primary objective is to identify and address risks early, improving patient outcomes and preventing harm.

Pressure injuries and falls in hospital

Pressure injuries (also known as pressure ulcers or bedsores) and falls are significant concerns within hospital settings, impacting patient safety and healthcare quality (Morris and O'Riordan, 2017). In the UK, it is estimated that up to 700,000 people are affected by pressure injuries annually, leading to increased healthcare utilisation and patient discomfort. Studies show that approximately 60,000 individuals die each year due to pressure ulcers, highlighting the severe impact of these injuries globally (AHRQ, 2024). In critical care units, the prevalence of pressure injuries can range from 12% to 32.7%, the highest among all healthcare settings, making effective prevention strategies crucial (Cox et al, 2022).

Falls also represent a major concern; within clinical and hospital settings falls are a significant cause of harm among patients aged 65 and over (Morris and O'Riordan, 2017). The incidence

of falls in hospitals can vary between 1.3 and 8.9 falls per 1,000 patient days, depending on the setting (Lee et al., 2021). These falls can result in severe complications, such as fractures and longer hospital stays, which in turn affect both patient outcomes and the overall cost of healthcare. However, the impact of falls goes beyond physical harm, falls often lead to a loss of independence, increased morbidity, and, in some cases, mortality (Hendrian and Tipton, 2020; Cameron et al., 2018). These injuries, caused by prolonged pressure and shear on the skin and underlying tissues, are particularly prevalent among immobilised or vulnerable patients (Chadboyer et al., 2016). Furthermore, treating pressure injuries imposes a significant financial burden on healthcare systems, costing the NHS more than £1.4 million daily (Guest et al., 2017). Safety huddles help to foster interdisciplinary discussions, enabling teams to address factors contributing to pressure injuries and ensure timely interventions. The introduction of safety huddles provides an opportunity to identify fall risks proactively and implement preventative measures.

Safety huddles are brief, regular meetings where healthcare teams come together to discuss patient safety concerns, share vital information, and coordinate care. Implementing daily safety huddles has proven to improve communication within teams, foster open discussions, and increase situational awareness (Lamming et al., 2021). This enhanced communication ensures that patient safety concerns, including risks for pressure ulcers and falls, are identified and addressed promptly. Additionally, safety huddles provide an opportunity for healthcare staff to collaborate on solutions, creating a culture of safety that leads to better patient outcomes.

Overall, the high incidence and severe consequences of pressure injuries and falls in hospitals emphasise the need for effective safety measures. Safety huddles offer a practical, evidence-based approach to enhancing communication, identifying risks, and improving patient safety outcomes. This approach not only addresses immediate concerns but also contributes to long-term improvements in hospital safety practices.

A catalyst for positive culture change

In response to high-profile care failures, such as those highlighted by the Francis Report (2013), strategies like Incident Reporting Systems (IRs) and SSKIN Bundles have been implemented within the NHS to reduce harm. However, a growing body of research underscores the transformative potential of safety huddles in enhancing team culture and promoting a shared commitment to patient safety. For instance, Rowen et al. (2022) demonstrate how safety huddles encourage collaboration and team building among healthcare professionals, creating a ripple effect of positive cultural change. Buljac-Samardžić

et al. (2021) emphasise that when team members collaborate to address safety concerns, they foster a culture of shared responsibility and mutual accountability. However, for safety huddles to be truly effective, ongoing education is essential. Healthcare practices, technologies, and guidelines are constantly evolving, and continuous education ensures that staff members are equipped with the latest knowledge and skills to address emerging challenges. Without regular training and updates, the effectiveness of safety huddles may diminish over time, as staff may become complacent or miss important changes in best practices. Ongoing education also helps reinforce the importance of patient safety and supports the development of critical thinking skills, enabling healthcare professionals to identify risks more effectively and respond appropriately. Therefore, combining the regular, collaborative nature of safety huddles with continuous education, healthcare organisations can foster a culture of safety, facilitating the exchange of best practices and knowledge (Croke, 2020). This ensures teams are not only motivated to perform at their best but are also well-equipped to meet the ever-changing demands of patient care.

Central role of nursing and education

Nurses comprise of 50% of the global healthcare workforce, positioning them as essential contributors to patient safety initiatives (Vaismoradi et al., 2011). Education is a critical starting point for cultivating the knowledge, attitudes, and skills necessary for safe practice. Nursing students, described by Francis (2013) are the ‘safety leaders of the future,’ and play a vital role in shaping a culture of safety. Integrating patient safety concepts into undergraduate nursing curricula ensures that newly qualified nurses are prepared to deliver evidence-based care while bringing a fresh perspective to the workplace (Murray, 2018). While safety huddles are particularly useful in nursing, safety huddles are valuable in any healthcare setting dedicated to patient safety. However, for nurses, safety huddles serve as an opportunity to actively engage with colleagues, address concerns, and identify immediate safety issues that may require attention. Nurses play a critical role in identifying risks, such as patient falls, medication errors, or potential infections, which can then be addressed in the huddle. Involving all members of the care team, safety huddles encourage open communication, facilitate problem-solving, and help ensure that any safety concerns are promptly addressed.

Incorporating safety huddles into the routine workflow helps to reinforce patient safety as a collective responsibility. These huddles are particularly valuable in dynamic healthcare environments where situations can rapidly change, and teams must be ready to adapt to new information or circumstances. Safety huddles also support a culture of continuous learning, where teams reflect on past incidents, learn from them, and develop strategies to prevent similar issues in the future (McKinnon 2016). Furthermore, they offer a platform for new

nurses, who may feel uncertain in fast-paced environments, to voice concerns and contribute to patient safety discussions, empowering them as safety leaders (Lamming et al 2021). Hence, the widespread adoption of safety huddles, not only in nursing but across all healthcare settings, can significantly contribute to improving patient outcomes and fostering a proactive approach to risk management. As healthcare settings continue to evolve, safety huddles serve as a key component in creating a culture where patient safety remains a top priority and is actively reinforced by all members of the healthcare team.

Conclusion

The integration of safety huddles into nursing practice holds significant potential to reduce patient harm while fostering a collaborative and proactive safety culture. Using safety huddles provides an opportunity to address common risks such as falls and pressure injuries, therefore, safety huddles may be useful for enhancing patient outcomes as well as strengthening team cohesion and accountability. Nurse education, both at the undergraduate level and through continuing professional development, is key to sustaining this practice and ensuring the next generation of nurses are equipped to lead in patient safety.

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