Points to Remember

- Hold Safety Huddles regularly—either at a regularly scheduled time or at the end of a defined part of work, e.g. after morning care is completed. Schedule them at a time that is best for your particular unit and staff.

- Keep meetings brief. Safety Huddles may be accomplished in as little as 15 minutes.

- During the meeting the group asks:
  1. What happened to threaten patient or staff safety?
  2. What should have happened?
  3. What accounted for the difference?
  4. How could the same outcome be avoided the next time?
  5. What is the follow up plan?

  Assign one person to take responsibility for making sure that follow up is done.

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SAFETY HUDDLE

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What is a Safety Huddle?

Safety Huddles are based on After Action Review (AAR), a highly successful method of knowledge transfer that is used in high performing organizations, such as the United States Army. AAR is a method for transferring knowledge a team has learned from doing a task in one setting to the next time that team does the task in different setting (Dixon, 2000). This process moves unique knowledge that an individual holds into a group setting so that the knowledge can be integrated, understood by the whole team and used when individuals face similar circumstances.

Often, knowledge generated in work settings is not shared and therefore not usable. Safety Huddles provide a structured method for making tacit knowledge explicit among team members, thus usable next time a similar situation is faced.

Safety Huddles offer an effective means for learning from both safety mishaps and near misses. It is an informal process in which there are no recriminations, reports are not forwarded to supervisors, and meetings are facilitated locally. In Safety Huddles staff should feel free to share knowledge without fear of embarrassment or recrimination.

Dixon, N. (2000). *Common knowledge: How companies thrive by sharing what they know.* Boston: Harvard Business School Press.

Safety Huddles are compatible with established mechanisms for dealing with errors and near misses such as incident-reporting and root cause analysis. The advantage to a Safety Huddle is that it becomes part of the routine way that a work team goes about its business to maximize patient safety.

When should Safety Huddles be conducted?

Safety Huddles are most successful when held on a regular basis. Either schedule them at the same time every day or after some defined unit of work, e.g. after morning care is completed. The more frequently you conduct them the more comfortable you will become with learning from experience without placing blame. Routine meetings held frequently may be easier to keep brief and highly focused.

Who should attend Safety Huddles?

Everyone involved in direct care should be involved in Safety Huddle meetings. Each person's information and ideas are necessary to get a full picture of what happened and to generate ideas about how to incorporate the learning into future actions. Not attending will suggest that the Safety Huddle results are not a product of everyone involved, and that some members can not contribute to learning from experience.

How long should Safety Huddles last?

Keep the meetings brief. They may be accomplished in as little as 15 minutes. The group asks:

1) What happened to threaten patient or staff safety,
2) What should have happened,
3) What accounted for the difference,
4) How could the same outcome be avoided the next time, and
5) What is the follow-up plan?

Engage in open discussion based on objective facts without blaming individuals.

Should minutes be recorded?

Keep only informal notes, and make them available to other staff if it will help them to avoid patient errors and staff injuries. Do not formalize notes, nor send them to supervisors. Keep in mind that the focus of Safety Huddles is to help the team itself learn from its own experiences. One person should be responsible for making sure that corrective actions were taken.

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