THE CENTER FOR COLLABORATION SCIENCE

UNIVERSITY OF Nebraska Omaha

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

UNMC

Acknowledgement

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

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CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

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

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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. View and reflect upon effective participation, leadership, and facilitation behaviors for post-fall huddles in particular and debriefs in general

What is a Post-Fall Huddle?

A post-fall huddle* 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
- Patient care team (core team)
  - Nursing
  - PT/OT
  - Pharmacy
  - Quality Improvement
  - Providers
- Administration/Management

Photo citation: http://www.forbes.com/sites/meghanbiro/2012/10/22/leaders-go-social-5-ways-to-awesome-community/

*TeamSTEPPS definition of huddle—an ad hoc meeting to regain situation awareness, discuss critical issues, and emerging events

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, cohesion, and trust among bedside personnel (patient care team) in the hospital

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

What does a bad huddle look like?

Two major issues (among others)

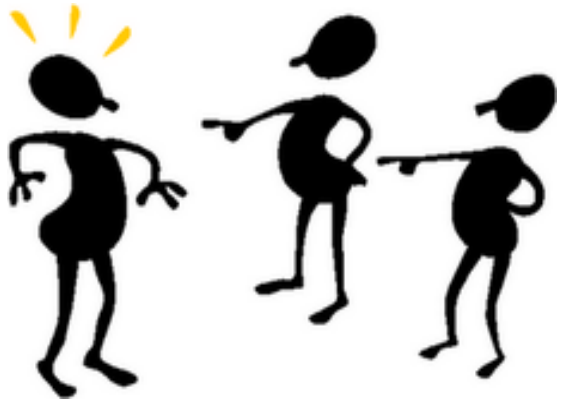


Photo citation: http://3.bp.blogspot.com/-LzXpn_Zdt-I/TcRHbuyIcaI/AAAAAAAADsc/MlSqSLjuehU/s320/blame.jpg

1. Blaming and critical comments

2. Unmanaged challenging/negative personality

Fall Event Timeline

- 1315…finished in room treatment with PT; PT left pt. sitting up in bedside chair with (R) leg extended on foot stool
- 1430…pt. wanted to go to bathroom, he did not use the call light because he didn't think he needed assistance; he attempted to stand from chair and was reaching for wheeled walker when he became lightheaded and fell sustaining a skin tear to right forearm; knee incision intact
- 1430…staff down the hall heard the pt. fall
- 1440…dressing applied to skin tear, ice applied to (R) knee
- 1445…post-fall huddle begins

The “Bad” Huddle

Pause this presentation and follow the link:
https://www.youtube.com/watch?v=tCy0vk5MWW4&feature=youtu.be

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?

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 felt like I could speak freely.	90	75	100
6. It was acknowledged when we did things well.	81	62	100
7. Our successes were praised	75	62	100

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. Talked about what can be learned from the fall.	89	60	100

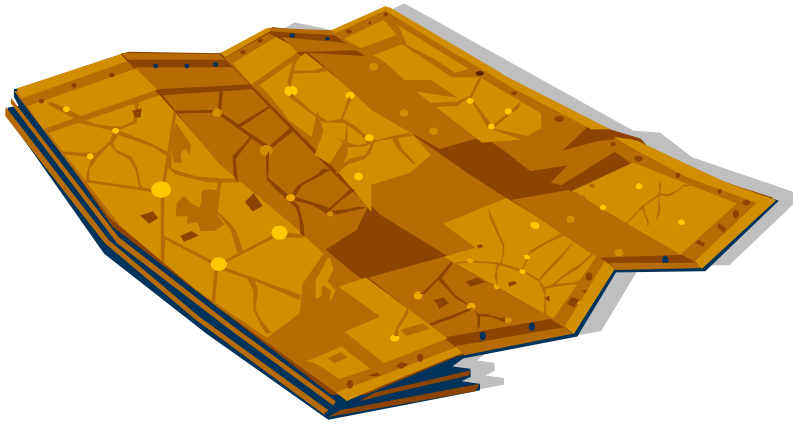
Satisfaction with Huddles	% Agree	Low Hos.	High Hos.
1. I feel satisfied with the way in which my last huddle was conducted.	81	25	100
2. I feel satisfied with the procedures used in my last huddle.	81	25	100
3. I feel satisfied about the way we carried out the activities in my last huddle.	82	25	100
4. I feel satisfied with the things we achieved in my last huddle.	81	25	100

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

What makes for a successful huddle?

Several steps and inputs to consider:

1. What is the purpose?
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?



What huddle form to use?

What is a post-fall form?

A two-part form may be most helpful…

Part 1 Facilitator Guide

- ✓ Because people have to learn how to "team"…
- ✓ Come together
- ✓ Generate new ideas
- ✓ Overcome personal conflict and jargon
- ✓ Keep asking "WHY?" until solutions emerge

Edmondson, AC. teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy. San Francisco: Josey-Bass; 2012.

Part 1. Huddle Facilitation Guide

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

Remember: Patients fall because their center of mass is outside their base of support.

During the huddle look for specific answers and continue asking "*why?*" until the root cause is identified.

1. Establish facts:

1.a. Did we know this patient was at risk? ___ YES ___ NO

1.b. Has this patient fallen previously during this stay? ___ YES ___ NO

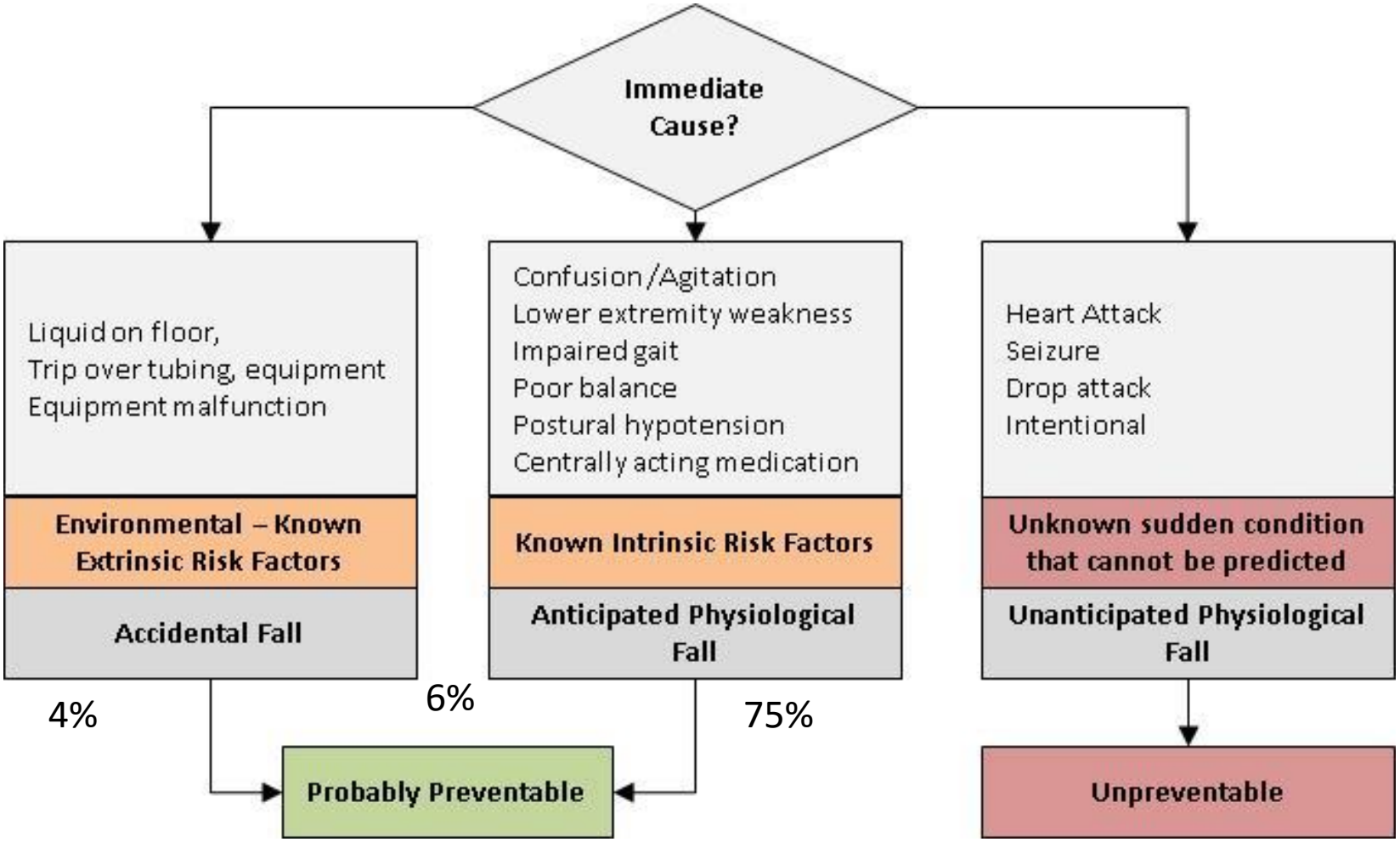
1.c. Is this patient at high risk of injury from a fall? (ABCS)

___ Age 85+ ___ Brittle Bones ___ Coagulation ___ Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.	NOTES
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). Ask why multiple times.	
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	
3. Determine underlying root causes of the fall.	**NOTES**
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	
4. Make changes to decrease the risk that this patient will fall or be injured again.	**NOTES**
ASK: How could we have prevented this fall? ☐ Need to consult with physical/occupational therapy about mobility/positioning/seating ☐ Need to consult with pharmacy about medications	
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	
Ask: What patient or system problems need to be communicated to other departments, units or disciplines?	

http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

Part 2. Determine Cause & Type



Part 2. If Preventable, Determine Error Type to Facilitate Learning

		Actor Interdependence	
		Low	**High**
Process Uncertainty	**Low**	**Task Errors:** • Bed alarm not on • TABS alarm not in place • Bed alarm function not checked CNA did not lock w/c brakes • Chair pad not plugged into wall	**Coordination Errors:** • Fall risk and previous fall not communicated to family • Transfer technique not handed off between shifts & disciplines • Order for diuretics to be given at 10:00 p.m.
	High	**Judgment Errors:** • Patient left alone in bathroom • Did not use gait belt Did not take into account sensory deficits • Consider use of sitter sooner • Pt. with COPD fainted while walking after shower	**System Errors:** • No policy/procedure to regularly replace batteries in newly acquired chair alarms • No policy/procedure regarding timing of diuretics

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."

When to hold the huddle?

- Bedside huddle should occur immediately
  - Must 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."

When to hold the huddle?

Always conduct a huddle immediately after a fall?

Consider:

- Nature of the fall
  - Did the patient experience a traumatic injury or death?
  - Did the patient require immediate transfer to surgery or another facility for post-fall care?

- Emotional state
  - Will conducting the huddle elicit primary or secondary post-traumatic stress responses for staff and/or others in the huddle?

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
- 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

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

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

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

Huddle Pocket Card

CAPTURE FALLS:
POST-FALL HUDDLE GUIDE

1. Establish facts... a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient's plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation
    a. Who attended
    b. Type of fall
    c. Type of error

POST-FALL HUDDLE
FACILITATOR TIPS

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the *front line to learn* about why a patient fell – actively listen and be slow to judge)

2. Ask probing questions (e.g., ask "*why?*" until root causes are identified)

3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person's contribution)

4. Give praise and acknowledge good work (e.g., say "thank you" and "nice job" when appropriate)

5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)

Cautions on Huddle Guide

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…the story

Build in flexibility

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

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

Hilligoss, B & Moffatt-Bruce, SD. The limits of checklists: handoff and narrative thinking. BMJ Qual Saf. 2014;23:528-533.

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 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

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

The “Good” Huddle

Pause this presentation and follow the link:
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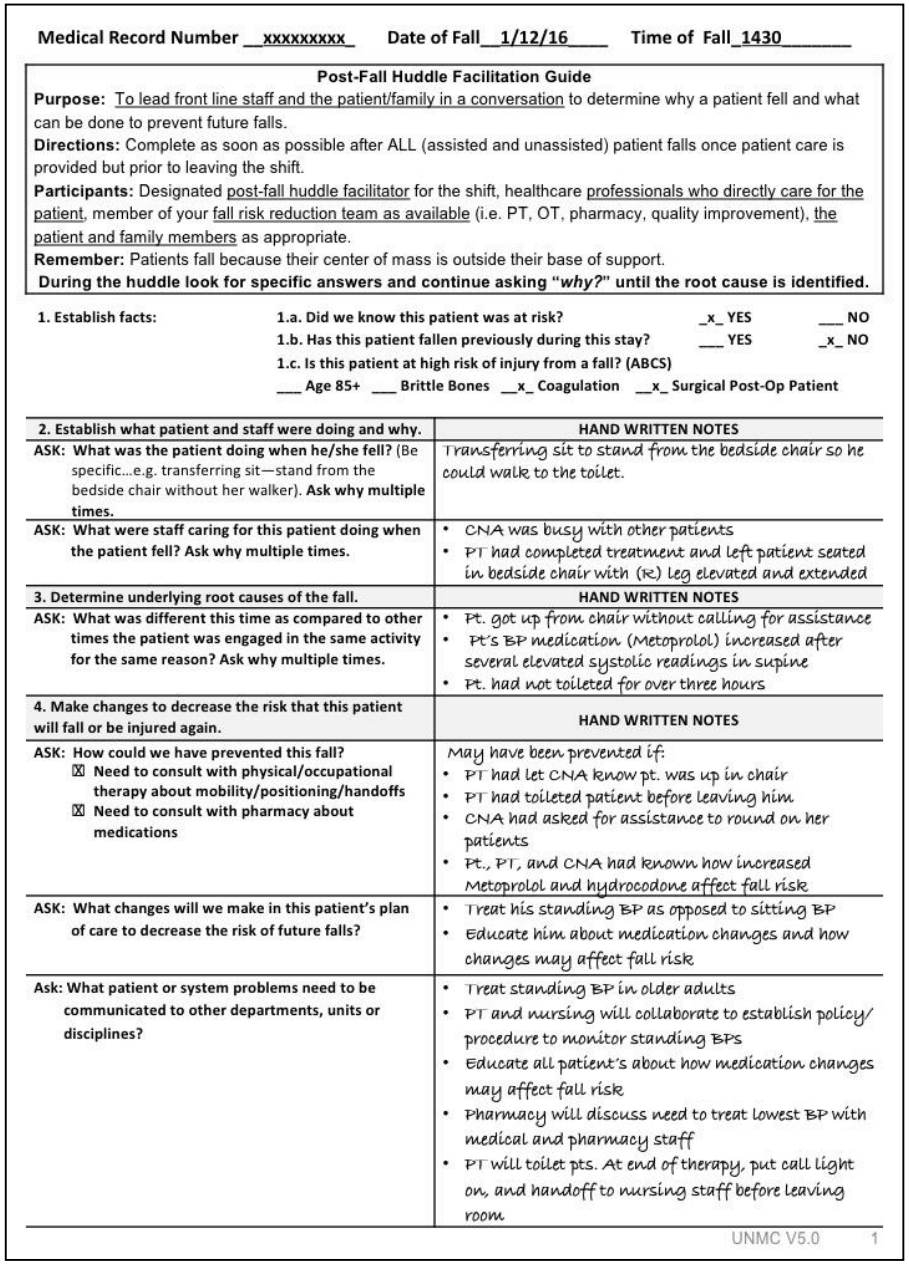

Medical Record Number __xxxxxxxxx_ Date of Fall__1/12/16____ Time of Fall_1430_____

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1. Establish facts:

1.a. Did we know this patient was at risk? _x_ YES ___ NO

1.b. Has this patient fallen previously during this stay? ___ YES _x_ NO

1.c. Is this patient at high risk of injury from a fall? (ABCS)

___ Age 85+ ___ Brittle Bones __x_ Coagulation __x_ Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.	HAND WRITTEN NOTES
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). **Ask why multiple times.**	Transferring sit to stand from the bedside chair so he could walk to the toilet.
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	• CNA was busy with other patients • PT had completed treatment and left patient seated in bedside chair with (R) leg elevated and extended
3. Determine underlying root causes of the fall.	**HAND WRITTEN NOTES**
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	• Pt. got up from chair without calling for assistance • Pt's BP medication (Metoprolol) increased after several elevated systolic readings in supine • Pt. had not toileted for over three hours
4. Make changes to decrease the risk that this patient will fall or be injured again.	**HAND WRITTEN NOTES**
ASK: How could we have prevented this fall? ☒ **Need to consult with physical/occupational therapy about mobility/positioning/handoffs** ☒ **Need to consult with pharmacy about medications**	May have been prevented if: • PT had let CNA know pt. was up in chair • PT had toileted patient before leaving him • CNA had asked for assistance to round on her patients • Pt., PT, and CNA had known how increased Metoprolol and hydrocodone affect fall risk
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	• Treat his standing BP as opposed to sitting BP • Educate him about medication changes and how changes may affect fall risk
Ask: What patient or system problems need to be communicated to other departments, units or disciplines?	• Treat standing BP in older adults • PT and nursing will collaborate to establish policy/ procedure to monitor standing BPs • Educate all patient's about how medication changes may affect fall risk • Pharmacy will discuss need to treat lowest BP with medical and pharmacy staff • PT will toilet pts. At end of therapy, put call light on, and handoff to nursing staff before leaving room

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http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

We need your feedback!

http://www.psdgraphics.com/buttons/round-rating-buttons-psd/

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