POST-EVENT SAFETY HUDDLES

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

A post-event Safety Huddle is a multidisciplinary team review which takes place as soon as possible after a safety incident or a near miss is detected (ideally before the end of the shift, while the event is still fresh in people's minds).

Post-event Safety Huddles happen after immediate care has been provided to the effected individual and can occur following incidents and events such as:

- A patient fall
- A medication error
- Patient complaint
- Threats to staff safety
- Equipment failure
- Concerning trends arising in IIMS

Purpose of post-event Safety Huddles

Post-event Safety Huddles:

- Uncover the contributing factors leading to the safety event.
- Allow staff to quickly develop plans to prevent a reoccurrence and prevent future harm to patients, families and staff.
- Identify whether the harm or harm risk was related to patient factors, or systems and processes.
- Provide reassurance that something is being done.
- Enhance teamwork and communication ensuring everyone is on the same page.

What do Post-Event Safety Huddles look like?

Post-event Safety Huddles are a safe space encouraging open and honest conversation. They are an opportunity to accept responsibility and learn from errors, and are facilitated by a team leader, such as the nurse in-charge, an experienced clinician, or the Unit Manager.

Including patients and their family or carers

Where appropriate, include the patient and their family and carers as part of the review team. Multiple perspectives exploring why an incident occurred helps teams to understand the factors contributing to the incident. It also promotes a partnership model in developing a sustainable risk mitigation plan.

Answers needed from post-event Safety Huddles

- What was planned?
- What happened?
- What are the gaps?
- Who was affected?
- What did we do to reduce the risk?
- How do you know the risk was reduced?
- Who is accountable for any raised actions?
- Who is responsible for the documentation?
- Have we met the needs of the affected patient or staff member?
- What can we learn?

Always start with an introduction to ensure all participants understand the purpose and process.

The focus is always on processes and not people as safety events are usually symptoms of a larger problem.

About Team Culture and Communication

The CEC's Team Culture and Communication aims to enhance teamwork and communication at the point of care and support clinicians to create the conditions to allow quality and safety improvement to occur.

For further information, please visit
http://www.cec.health.nsw.gov.au

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