A huddle and a 'druggle' to improve patient safety on the neonatal unit

As part of the Situational Awareness for Everyone initiative, the Leeds Centre for Newborn Care initiated a daily patient safety 'huddle', a brief meeting of the multidisciplinary team aimed at reducing harm and improving safety culture on the neonatal unit. Following on from its success a weekly 'druggle' was introduced to address drug-related patient safety.

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Key points

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1. Improving patient safety is everyone's business.
2. The huddle is a daily safety briefing that opens up communication between the whole multidisciplinary team about patients at risk of deterioration or clinical incident.
3. The druggle is a five minute, once-a-week bite sized teaching session to improve prescribing and reduce medication error.

SAFE (Situational Awareness for Everyone) is a Royal College of Paediatrics and Child Health (RCPCH) initiative that the Leeds Centre for Newborn Care joined in September 2015. The overall aim of the project is to reduce the number of respiratory and cardiac arrests in the paediatric population nationally by improving recognition of avoidable patient deterioration. With a focus on patient safety, the key intervention at Leeds was the roll out of safety huddles, which had proved to be a huge success in Cincinnati Children's Hospital.[1]

Situational awareness is defined as the ability to identify, process and comprehend the critical elements of information concerning the team and wider workplace. More simply, it is about knowing what is going on around you so that you can potentially predict where problems may occur and intervene before they do.

The huddle

The safety huddle should be a daily, brief 5-10 minute meeting of the whole multidisciplinary team (MDT) including medical and nursing staff (**FIGURE 1**). It is helpful to include other team members as they may have information to share with the wider team but no obvious forum to do this, eg ward clerks, psychologists, pharmacists. The hope is that with greater sharing of information, everyone's situational awareness will increase and patient safety will improve.

Prior to starting with SAFE the Leeds Centre for Newborn Care had safety briefings each morning on the neonatal unit (NNU) but these focused specifically on staffing numbers and bed management

FIGURE 1 A multidisciplinary team huddle.

and initially involved just the senior nurses and consultants. The SAFE programme teaches the value of involving the wider MDT and expanding on discussions in a succinct manner. Anything included in the safety huddle has to be relevant to patient safety and potential deterioration and not simply a morning gossip session.

The huddle was audited shortly after starting the SAFE initiative in October 2015. It was found that the safety huddle:

- lacked leadership
- was interrupted by bleeps and other staff
- often started late
- inconsistently covered key topics, eg safeguarding concerns and limitations of treatment agreements.

One of the recommendations that emerged from the audit was to follow a more formal script (**FIGURE 2**), which includes the patients the team was most worried about. This is key as the new NNU at Leeds has over 30 beds including a large newborn surgical area where patients are predominantly managed by the surgical team but which the medical team needs to know of in case there are any deteriorations in condition. At the huddle the patients that are due to go to theatre are highlighted to ensure adequate staffing – specifically epidural-

competent nursing staff – and the necessary intensive care cots.

Infants with known difficult airways are discussed so that everyone is aware of the need to call senior help immediately should there be an accidental extubation. It is also important to be aware of any infants with a tracheostomy.

Safeguarding concerns are mentioned so all team members know brief details. Patients with similar names are highlighted as this has been identified as an area of particular risk on NNUs where many patients simply have the first name 'baby' or are from multiple births and therefore have the same surname.[2]

Clinical incidents from the preceding day are discussed to raise everyone's awareness, as are areas of good practice so team members can learn from them to help improve methodology: reliable, reproducible health care is safer health care.[3]

NNU safety huddle **Date:** **Time:**
Nurse in charge
Consultants
What went well yesterday
Situation report • intensive care • high dependency • surgical • most-worrying patients
Nursing staff, including crash bleep holder
Medical staff
Potential step down patients
Potential discharges
Potential admissions
Patients going to theatre
Patients with a tracheostomy and/or difficult airway
Patients with similar names
Infection control issues and isolations
Social concerns
Yesterday's clinical incidents
Yesterday's accidental extubations
Yesterday's accidental line removals (central/peripheral/drains)

FIGURE 2 The safety huddle script; the script is constantly being developed as other issues often arise.

The 'druggle'

Following on from the successful implementation of the SAFE project, a weekly druggle was introduced to the Leeds NNU in November 2015 so as to improve drug-related patient safety.

West Hertfordshire Hospitals NHS Trust first piloted the druggle as part of its SAFE project in July 2015. The aims of the druggle are to:

- increase communication between pharmacists, the medical team and nursing staff
- educate all staff regarding specific drug-related topics
- enable the team to receive feedback on anonymised errors in real time
- draw attention to areas for improvement
- encourage discussion
- share learning points.

The ward pharmacists present the druggle once a week as part of the daily huddle. The format of the sessions is to start with a 'hot topic'; all members of staff can suggest themes for the hot topic, for example, recent changes to the British National Formulary for Children, antimicrobial prescribing or principles of dose rounding. This is followed by an example of a recent error (eg illegible prescriptions, incorrect dosing) that is discussed among the team, allowing time for education and feedback (**FIGURE 3**).

The neonatal pharmacy team completed a baseline prescribing standards audit in February 2016 (after the induction of the new medical team), which was repeated before the doctors rotated in August. The initial audit provided information about common prescribing errors and helped to identify possible hot topics. The most common errors identified were:

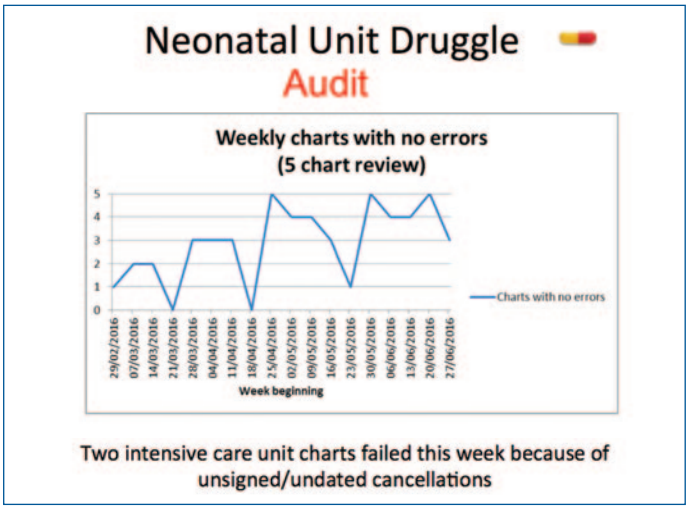
- incorrect transcriptions
- cancellation of prescriptions without a signature and/or date
- medications prescribed 'when required' with no maximum frequency or dosage.

The repeat audit showed great improvements in all of these areas.

Good prescribing practice is celebrated by presenting the results from the weekly audit. To monitor improvement in prescribing safety, a 'zero tolerance' weekly audit of five randomly chosen prescription charts is completed. A chart 'fails' when the first prescribing error or deviation from prescribing standards is identified. These audits have shown continuous improvement; from 20% of prescription charts with no prescribing error to 64% with no errors over a 25-week period.

The druggles have been well received on the NNU. They have encouraged more discussions, allowed the MDT to work together to improve the standard of prescribing, and have proved to be an invaluable tool when implementing new processes. Feedback from staff has included: "I find it really useful, it means that I'm challenging myself and the doctors a lot more, I'm picking up on errors more and I feel that I'm learning something new every week."

The druggles have led to improvements in existing practice; for example, infants' drug charts have now been separated from mothers' drug charts on the postnatal wards following an error that was discussed by the team at a druggle. Similarly, a cholestasis monograph has



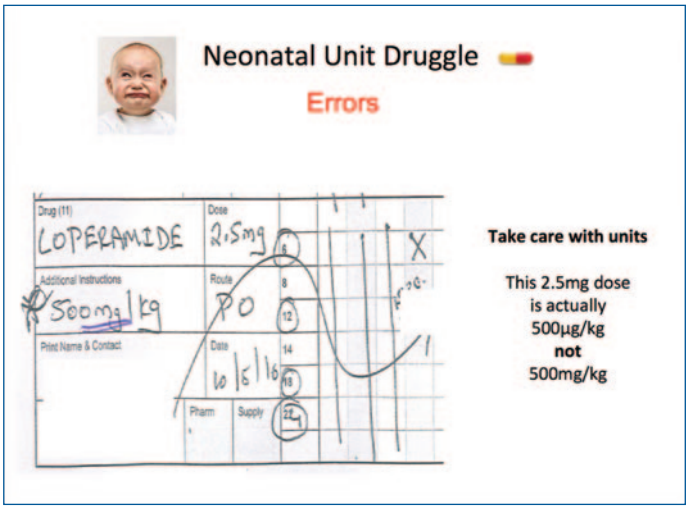


FIGURE 3 Example slides from a druggle presentation.

been developed that details the doses and formulations of common medications required following feedback from a hot topic at a druggle.

The paediatric pharmacy team is in the process of rolling out the druggle to all specialties within Leeds Children's Hospital. It is envisaged that there will be a monthly hospital-wide druggle to communicate topics relevant to all areas to augment the existing weekly druggles that take place within specialties.

Conclusion

The huddle and the druggle are embedded in the morning routine at Leeds NNU. The aim for the future is to build on the enthusiasm for these interventions and to keep refining the process to improve patient safety on the NNU.

References

1. **Goldenhar L.M., Brady P.W., Sutcliffe K.M., Muething S.E.** Huddling for high reliability and situational awareness. *BMJ Qual Saf* 2013;22:899-906.
2. **Gray J.E., Suresh G., Ursprung R. et al.** Patient misidentification in the neonatal intensive care unit: quantification of risk. *Pediatrics* 2006;117:e43-47.
3. **Resar R.K.** Making noncatastrophic health care processes reliable: learning to walk before running in creating high-reliability organizations. *Health Serv Res* 2006;41:1677-689.