Implementation of Unit Based Safety Huddles to Improve the Culture of Safety

PURPOSE
The healthcare organization where the DNP project was conducted has implemented several house wide safety initiatives, including a Daily Operational Brief (DOB) that have resulted in a significant decrease in serious safety events. Despite these efforts, individual unit performance on the Agency for Healthcare Research and Quality (AHRQ) safety survey were below national benchmarks in several domains. The aim of this quality improvement initiative was to implement a unit-based safety huddle on a 20-bed acute care unit for 90 days to improve the perceptions of the unit safety culture.

BACKGROUND
Safety briefings increase safety awareness, improve communication among frontline staff and help organizations improve the overall culture of safety (Cooper & Meara, 2002). In 2005, the Joint Commission reported that communication failures were the leading root cause of all sentinel events.

METHODOLOGY
The Plan, Do, Study Act method (Institute for Healthcare Improvement, 2011) of quality improvement was used for this project. Measurement included AHRQ survey results from 2016 (reported in 2017) and volume of safety reports reported on the unit 90 days prior and 90 days post implementation.

RESULTS
The targeted areas of the AHRQ survey demonstrated improvement. In addition, the rate of safety event reporting on the pilot unit increased from 12.5 reports/1000 patient days to 24.8 reports/1000 patient days in the 90 days post implementation.

IMPLICATIONS
Unit Based Safety Huddles should be implemented across the hospital system to:
- Provide a robust forum for addressing and resolving safety issues/concerns
- Increase safety reporting
- Enhance timely resolution of safety issues/concerns
- Improve safety culture at the unit level