Implementing safety huddles / Improving observational practice

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Aims/Objectives
- To predict and reduce potential harm to patients, address potential self harm, aggression and/or abscondion.
- Improved communication to allow staff to discuss positive risk taking and implement management plans.

Description
The aim was to predict and reduce risk and potential harm to patients; and address potential for self harm, aggression and/or abscondion. This would maximise the quality of the patient care within this 20 bedded Acute Adult admission ward (Mental Health).

The huddle aimed to identify early warning triggers, discuss appropriate person-centred care to allow positive risk taking and daily therapeutic goal setting.

This time was pertinent to highlight and discuss specific management plans with the aim of reducing the number and duration of enhanced observations.

Methodology
We used PDSA (plan, do, study, act) methodology as a small test of change.

Staff completed questionnaires to ascertain understanding and attitudes towards all levels of observational practice.

The nurse in charge scheduled team safety huddles twice a day. We developed and used MOODS as a tool to generate discussion around the following topics:

- Medication / National early warning score (NEWS)
- Observations/legal status
- Ongoing risk management plans
- Deterioration
- Safety plans

Results/Outcomes
- Communication on the ward more inclusive of the wider nursing team, specifically nursing assistants.
- Staff awareness of potential risk situations improved and practice focused on prevention rather than reaction.
- Collective team are now more confident in having group discussions and making decisions around risk while implementing strategies to reduce risk and harm.
- Sense of staff empowerment has been cultivated alongside staff accountability.
- Patients report feeling safer and more involved in decision making regarding their care, in particular their own risk management plans and daily goal setting.

Conclusions
100% of staff believed that the aide memoir had the correct questions to predict and prevent risk and that it improved communication between all ward staff.

References
Janet E Anderson and Naonori Kaodate
Learning from Patient Safety Incidents in Incident Review Meetings: Organisational Factors and Indicators of Analytical Process Effectiveness.

J S Mahoney, T E Ellis G Garland et al.
Supporting a Psychiatric Hospital Culture of Safety.