Implementation of Nursing Safety Huddles During the Change of Shift
HealthSouth Rehabilitation Hospital of Petersburg
Rachel Provau, RN, MSNA, CNO

Background
HealthSouth Petersburg, a freestanding inpatient rehabilitation hospital, has had three expansions from 44 beds, to 53, to 64 beds in November 2013. The hospital is two football fields long and has three units. The building has two long halls and intersecting nursing stations. With the last expansion, it became apparent that the nursing staff felt disconnected and the change-of-shift process was not effective. There was a lack of communication and teamwork.

The nursing leadership group discussed how to implement a change-of-shift safety huddle including a list of items to discuss every time with the off-going supervisor to welcome the oncoming shift and recognize a “great catch” from the off-going shift.

The huddle process was announced during group meetings throughout one week. The entire management team, including the CNO, NM and supervisors, were present the following week for the change of shift process. The staff was surveyed six months after the huddle. The huddle was kept at five to seven minutes consistently.

Methods
Plan: A daily huddle sheet was designed by nursing leadership to include the following: high-risk patients, fall-risk patients, equipment needs, staffing challenges, hospital meetings, “good catches” and recognition of team members from the previous shift. This was done based on a literature review.

Do - Attendance was measured and staff was reminded of the time and place for the huddle. Staff assignments were given after the huddle. The huddle was kept at five to seven minutes consistently.

Check - Fall and acute care transfer statistics were measured prior to the huddle and posted for the staff to see. Staff required less reminding to attend huddle.

Act - Staff automatically congregated in conference room on time. The staff was surveyed six months after the huddle was implemented for quality of experience. Fall and ACT rates, as well as other quality data, are measured prior to the huddle and posted for the staff to see. Staff required less reminding to attend huddle.

The building has two long halls and intersecting nursing stations. With the last expansion, it became apparent that the nursing staff felt disconnected and the change-of-shift process was not effective. There was a lack of communication and teamwork.

The nursing leadership group discussed how to implement a change-of-shift safety huddle including a list of items to discuss every time with the off-going supervisor to welcome the oncoming shift and recognize a “great catch” from the off-going shift.

The huddle process was announced during group meetings throughout one week. The entire management team, including the CNO, NM and supervisors, were present the following week for the change of shift process. The staff was surveyed six months after the huddle. The huddle was kept at five to seven minutes consistently.

Do - Attendance was measured and staff was reminded of the time and place for the huddle. Staff assignments were given after the huddle. The huddle was kept at five to seven minutes consistently.

Check - Fall and acute care transfer statistics were measured prior to the huddle and posted for the staff to see. Staff required less reminding to attend huddle.

Act - Staff automatically congregated in conference room on time. The staff was surveyed six months after the huddle was implemented for quality of experience. Fall and ACT rates, as well as other quality data, are measured prior to the huddle and posted for the staff to see. Staff required less reminding to attend huddle.