SOLUTION: Employee Response to Errors, Defects, and Dissatisfaction (aka "Huddle Up!")

On a "Journey to Excellence", dissatisfaction, errors and near misses will still happen as you continue on your way to zero defects. When dissatisfaction or defects occur, employees must be trained and empowered to provide a front-line response. Everyone (not just leaders) have a role in responding to, and preventing, dissatisfaction and defects.

The first step is recognizing, the next is responding. For starters, everyone should be encouraged to be on the look-out for signs of dissatisfaction or defects. Then, when dissatisfaction or an error/near-miss is detected, a prompt and appropriate response is the important next step.

When a defect is detected (e.g. a wound, an injury of a patient, a med error, a fall), the reason for a huddle is many:

1. Opportunities to identify employee roles related to the defect.
2. Recognize successes and identify errors that came into play.
3. Ensure employees learn from the defect or error to prevent similar events in the future.

Research on post event huddles demonstrates that better huddle attendee and huddle leader behaviors are related to improved satisfaction with huddles. In other words, employees need to give huddles a chance. They cannot be dismissed as "I don't have time for this – obviously, I am busy! My patient just fell!"

Who should be invited to a post-defect/event huddle?

Staff providing direct care for the patient at the bedside (RN, CNA) • Interdisciplinary Team (pharmacy, PT/OT, MD, QI, SW)

The reason for an interdisciplinary post event huddle is:

- Multiple points of contact with patient
- Multiple perspectives about etiology and prevention
- Multiple potential root causes

Some organizations have developed the best practice of a two-step post-event huddle. The first step is a bedside huddle and assessment immediately, usually with the frontline employees caring for the patient. (within moments but must happen prior to close of shift). The interdisciplinary huddle happens later (within 24 hours).

Be careful not to overwhelm the patient/family with the team present. It's good for patients and families to know that we're watching over the patient and are [including them] either to get some feedback or provide some feedback.

Who should lead the huddle?

- Nurse assigned the patient
- Lead/charge nurse
- Doctor
- Fall risk reduction team member

The key to success is to have someone assigned the documentation of the huddle, and to facilitate the huddle.

Why a facilitator?

- Ensures accountability for
    - calling and conducting the huddle
    - completing documentation
    - implementing agreed upon changes in plan of care
- Ensures all aspects of event reviewed
- Elicits and clarifies multiple versions of story
- Prevents negative attendee behaviors (e.g. blame)
- Facilitates positive attendee behaviors (e.g. open sharing of incident)

Specific behaviors of a great huddle facilitator:

- Engage in positive facilitator techniques
- Allow/encourage EVERYONE to speak
- Ensure concerns are voiced
- Discuss each attendee's role during and in response to the fall

- Discuss what can be learned from the fall
- Agree on processes to be improved in the future
- Give praise/commendation for good work

Examples of Huddle Behaviors:

Great Behavior:

- Engage in Positive Behavior
- Open and honest sharing
- Supportive discussion
- Acknowledge good work
- Praise successes
- Accept responsibility
- Identify things to work on

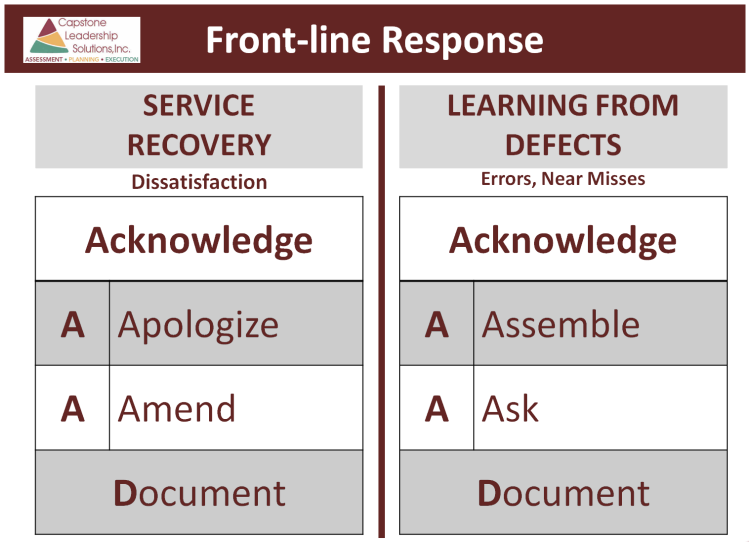
Negative Behavior

- Blaming
- Finger pointing
- Overtly critical comments

A study on post -patient fall huddles to determine if there was a defect at play is found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734353/

The study concluded that incidences of defects (in this instance patient falls) is decreased when a huddle is conducted, post-event.

We suggested AAAD as a response to defects. This approach of a Service Recovery dissatisfaction) with the technique (for errors, near-misses).



method of front-line dissatisfaction and combines the teaching response (for Learning from Defects defects and

Service Recovery: AAAD

*See **Solution for Service Recovery** for more information.

Acknowledge: If dissatisfaction or a complaint is made known to you, recognize it and use it as a chance to perform service recovery. Acknowledge to the patient or family that it is recognized. Example: "I can hear the concern in your voice in regard to the cancellation of your procedure."

Apologize: Sincerely say you are sorry for the person's experience. Use empathy to show concern: "I am so sorry that your procedure will not be done today as planned." Body language is important, such as facing the person, nodding and asking follow-up questions or making clarifying statements.

Amend: If possible, fix the problem immediately or take the issue to the right person as soon as possible. Ask, "What would make this right for you?" Utilize the Service Recovery Toolkit if applicable and deemed appropriate to the situation.

Document: Communicate, including in writing, to those who need to know about the dissatisfaction and the action taken.

Error/Defect/Near-Miss: AAAD

Acknowledge: If an error, defect or near-miss (e.g., incidence or occurrence) is made known to you, acknowledge that it has occurred. As appropriate, this may include informing the patient, such as "As you are aware, your morning dose of your antibiotic was delayed by one hour. The doctor has requested that it be given now and that your next dose be given at 1 p.m. as previously ordered."

Assemble: Gather together a small group (five or less people) who would be helpful in analyzing the defect. Assemble in a place where open discussion can take place. As to not adverse impact the care of patients and operations in the department, the discussion is often limited to a maximum of 15 minutes.

Ask: Facilitate an open discussion utilizing the Learning From Defects questions:

- What happened?
- Why did it happen? (5 Whys technique)
- What prevented it from being worse?
- What can we do to decrease risk and prevent another occurrence?
- With whom shall we share our learning?

Document: Communicate, including in writing, to those who need to know about the error, defect or near miss, utilize the applicable occurrence or incidence reporting format. Follow applicable guidelines for documenting in the patient's medical record.

Best Practice: Acknowledge and Celebrate Near Miss Reporting

A great way to increase the reporting of near miss events is to create a culture that not only analyzes the data generated by current processes but recognizes the value and significance of employee reporting and celebrates it! A Good Catch program that studies all near miss events, recognizes employees who report the events, and transparently creates improvement so these events are not repeated, is best practice.

Consider having your HRO Team or your Employee Engagement Team review each near miss report and score them using this simple rubric:

Score Likert 1-5 with 1 being lower risk and 5 being higher risk

1. Involves or has the potential to involve multiple departments 1 unit/department to 5 or more units/ departments (ex. Pharmacy, ED, med/surg, physicians, OB, clinic, surgery, registration, RT, etc.)
2. Potential for serious harm to patient 1-5
3. Potential to happen again if not reported 1-5
4. Potential to be missed by involved staff 1-5

Each member of the committee (HRO or EE Team) scores each event and send those scores to the chairperson (or delegate) who studies and tabulates the raw numbers and ranks the events (highest possible score - most serious event - was 20). At the next meeting, the team discusses the "winning" event to decide if they could all support recognizing this particular event. Sometimes, rarely, the numbers do not drive the winner totally- the rich discussion does.

Consider a quarterly shout out for the Good Catch program and have a senior leader as well as the HRO or EE team chairperson and the unit manager presenting a simple certificate of appreciation and take a photo.

The event and the employee(s) who reported the “winning” event are recognized in your organization’s newsletter, portal and/or posted in the cafeteria so colleagues can see and learn from the event and congratulate the winner.

The message you are sending to your employees is that reporting near misses is not only encouraged, it is celebrated!