Huddle Up for Safer Health Care (HUSH Huddles)

RCVS Knowledge Quality Improvement in Practice Award Champion 2025

Paragon Veterinary Referrals

Introduction

Huddle Up for Safer Care (HUSH) huddles is an innovative team-based approach to improving patient safety, developed within NHS hospitals. After a member of the Paragon Veterinary Referrals Quality Improvement (QI) Team saw the huddles in action, the team adapted the concept to their dispensary processes and reached out to the Improvement Academy[1], a team of clinicians with expertise in improvement science and patient safety for support.

The HUSH huddle concept combines daily team huddles with measuring and celebrating improvements in patient safety. The huddle focuses on preventing medication and dispensing errors by embedding key principles, including involving all members of the clinical and non-clinical teams to identify at-risk patients and agree on actions to mitigate that risk. These short daily huddles to share information and learnings resulted in 10 error-free weeks in five months compared to 10 error-free weeks over the previous 12 months. Additionally, they saw a 10% reduction in total medication errors from August to December 2024 when compared to August to December 2023.

1. Choose a topic relevant to your practice

The topic should be amenable to measurement, commonly encountered and with room for improvement.

a. What topic was chosen?

Reducing medication errors in ward patients.

b. Why was this topic chosen?

During our monthly QI meetings, medication incidents were the most frequently reported and discussed, contributing to 50% of all reported incidents.

We had tried many techniques to reduce this, with limited sustained improvement, and we were also concerned there was under reporting of medication incidents. We began researching novel methods and found the HUSH initiative run by the Improvement Academy.

We decided to focus on inpatient wards to begin with as this was where we struggled to due to the high volume of team members working in the area. We had also struggled to engage the team as they felt disconnected to the solutions.

2. Selection of criteria

Criteria should be easily understood and measured.

a. What criteria was used?

The inclusion criteria included all reported incidents where the:

- Wrong medications had been given to in-patients
- Wrong frequency and/or dose of medications had been given to in-patients
- Wrong medications had been dispensed i.e. label does not match contents.

3. Set a target

Targets should be set using available evidence and agreeing best practices. The first audit will often be an information-gathering exercise, however, targets should be discussed and set.

a. What target was set?

To reduce medication errors from our current rate of 1.9 per week and to have one error free week per month. Specifically, to stop patients with the same name and/or breed receiving each other's medication and to reduce patients receiving medications at incorrect frequencies when prescribed four or more medications.

b. What evidence was used to define the target?

An annual review of VetSafe reports from 2023 revealed that medication incidents are the most common incidents in hospitalised patients in veterinary practice. Specific, measurable, achievable, relevant and time-bound (SMART) goal targets were set based on identifying trends in the ward areas from the reports.

4. Collect data

Identify who needs to collect what data, in what form and how.

a. When was the data collected?

Before introducing the HUSH huddles, 12 months of data was collected and analysed to assess where we were and establish the baseline. Following the commencement of huddles, data was collected and analysed every two months.

b. What data was collected?

The number of medication errors were retrospectively collated from our online reporting platform, Halo. All data was collected anonymously.

c. Who collected the data?

This data was downloaded every two months by a member of the team and shared with the Improvement Academy, who analysed the data and collated it into weekly error reports.

d. How was the data collected?

All Halo reports made by colleagues were downloaded into an Excel spreadsheet. The reports were reviewed and categorised by the QI Team, separating medication incidents into two categories:

- Patient harm
- Near miss.

e. Results:

- The full results can be seen in **appendix 1**.

5. Analyse

Was the standard met? Compare the data with the agreed target and/or benchmarked data if it is available. Note any reasons why targets were not met. These may be varying reasons and can take the discussion from the entire team to identify.

c. Was the target met, if not, why not?

The data collected during the first cycle established the current situation, providing a baseline that we could use to benchmark any improvement against. The data showed that there was an average of 1.9 incidents reported per week, and it took twelve months to achieve ten error free weeks.

6. Implement change

What change or intervention will assist in the target being met? Develop an action plan: what has to be done, how and when? Set a time to re-audit.

a. What changes were introduced?

We implemented HUSH huddles and encouraged open discussion of harms and near misses in August 2024. We used Plan, Do, Study, Act (PDSA) cycles to test and adapt our huddles in practice daily.

A daily huddle is scheduled for 7.30am prior to the patient handover to allow us to target as many associates as possible across all teams in order to obtain a cross-disciplinary perspective into how errors occurred and gain proactive suggestions to prevent these same errors in future. This uses a bottom-up approach focussing on the actions and thoughts of the team on the floor caring for the patients, with full support of senior nursing and veterinary leadership.

b. What was the overall action plan?

To create an open, non-judgemental and just culture to improve awareness of the factors that influence medication incidents and reduce these from occurring through accurate reporting and use of HUSH systems.

The HUSH system focused on implementing a daily huddle to celebrate the number of days between medication errors and aim for error free weeks. In addition, a culture survey was carried out in practice. This enabled us to gain valuable insights to how all members of the team perceive the safety, workplace and cooperation culture and how they feel those in management positions contribute or detracts from these areas. The results were explored with the team to develop and put in place strategies to address the identified problems.

c. When was a re-audit planned?

The second audit was planned to take place two months after commencement of HUSH huddles and then repeated every two months thereafter.

7. Re-audit

Repeat steps 4 and 5 to see if changes in step 6 made a difference. If no beneficial change has been observed them implement a new change and repeat the cycle. This cycle can be repeated continuously if needed. Even if the target is not met, the result can be compared with the previous results to see if there is an improvement.

a. When did the re-audit take place?

1st October 2024 after the huddles had been running for two months

b. What data was collected for the re-audit?

The number of medication incidents reported each day of occurrence, including patient harms and near misses.

c. Who collected the data?

All colleagues submit reports, and these are reviewed weekly by the Quality Improvement team. This was then collated by a member of the team and sent to the Improvement Academy for statistical analysis every two months.

d. How was the data collected?

Halo reports are downloaded into an Excel spreadsheet. The reports are reviewed and categorised by the QI Team, separating them into patient harms and near misses.

e. Results:

- The full results can be seen in **appendix 1**.

f. Was the target met, if not, why not?

HUSH huddles were started in August 2024. By October 2024 we had successfully achieved one error free week in every month for three months. A new target of two error free weeks in one month was set after re-auditing. This was achieved within the second audit cycle and by December 2024 we had achieved three error free weeks in that month.

The results chart also shows we achieved 10 error free weeks in the five months since starting the huddles. This is compared to taking 12months to achieve 10 error free weeks prior to huddles.

There has been a 10% overall reduction in number of errors from August 2024 to December 2024, when compared to the same time frame between August 2023 to December 2023.

Reducing the average baseline number of incidents per week from 1.9 requires a consecutive run of 8 weeks below the average. This has not yet been achieved, but the team are confident this will be achieved in 2025 as we continually learn and take actions within huddles to prevent errors.

g. Were any further changes implemented?

The focus of the huddles has changed from the original specific criteria due to the different errors we were encountering. During the second audit cycle it was identified most of the errors were now not occurring in the inpatient wards, instead occurring peri-operatively within a different team. As a result of this finding the surgical and anaesthesia nurses now attend the huddles.

8. Review and reflect

Share your findings and compare your data with other relevant results. This can help to improve compliance.

a. At what stages were the team involved?

Part of the process included a culture survey which involved all members of the team. Communication about the project was sent to the whole team prior to starting. The results of this survey were shared with the whole team in October 2024. At first the HUSH huddles were led by one nurse and the clinical director who introduced the concept to the wards team directly. This was expanded after the first two months to include more of the nursing, veterinary and patient care assistant (PCA) teams.

b. How were the team involved?

Results of the survey were shared with the whole Paragon Veterinary Referrals team. The wards team have been involved daily in adapting the process from the start and this has now expanded to include the diagnostics, anaesthesia, dispensary and surgery nursing teams. The veterinary team are not always on site and so we have co-opted a medic and surgeon to act as representatives and intermediaries to ensure team discussions are fed back to the vet team. The QI team have also been invited to take part in mentoring sessions.

c. Did the team need any support? How was this given?

Quality and improvement training was provided by the Improvement Academy, including mentor networking sessions, to ensure the huddles and culture were set up effectively for success. A number of the nurses were trained to lead the huddles to ensure they happened daily.

d. What barriers did the project face, and how were they overcome?

Initially the project faced a lack of engagement by most team members. The workplace culture survey carried out by the Improvement Academy and the openly discussed results with the whole team encouraged input and prompted constructive discussions from all team members across different departments. Openly discussing the survey results and

further ways to improve culture helped embed a positive working environment. Following this we had a higher engagement in the huddles across the team. Those that were initially reluctant to participate are now wanting to lead huddles. Additionally, by celebrating the number of days between errors (see appendix 2) and receiving certificates for error free milestones the team strives for longer error free periods.

e. What was the impact of the project?

Upon analysing Halo reports we realised the initial specific errors we targeted had stopped occurring. The medication errors we began to see were "new" ones that had not been previously identified or discussed during the huddles. Once these different errors were addressed in the huddles, we saw a reduction in their occurrence. Each time this happened, we were able to identify additional "new" errors, address them and continue to monitor for re-occurrence.

We found once errors were discussed, they did not seem to reoccur at the same frequency. Instead, other "new" errors peaked until they were similarly addressed. In response to this unexpected outcome, we adapted the focus of the huddles to reflect the current themes of incidents and encouraged involvement from other departments to aid in the reduction of these previously unidentified errors.

Team members are more diligent and are now catching near miss incidents before they reach the patients, reducing patient harms but increasing the numbers of near misses reported. As a result of the open and just discussions that take place during the huddles, information is now voluntarily shared by those who made the error or raised on their behalf if they cannot attend.

f. What surprised you about the project?

The HUSH huddles created a psychologically safe environment for all clinical team members to openly discuss the errors. This has also led to an increase in the proportion of medication incidents reported.

The team will discuss the problem together, contributing ideas to avoid similar errors in the future. Colleagues will now openly voice when they have made a mistake in the huddles with a large group of colleagues, knowing they will get a supportive response. Colleagues report feeling supported by each other and comfortable having open discussions. As a result, we are confident we have reduced the number of errors beyond what the data suggests as we now have a more accurate way of reporting incidents.

g. If this audit was done again, what would be done differently?

We realised on reflection that when we first started the huddles, they were not held at an appropriate time, did not involve the correct personal or follow the correct structure. Our original huddles were reactive and not based on celebrating success. This may have contributed to lack of engagement when we hard launched the HUSH huddles. Having input on from The Improvement Academy when we did the test huddles for dispensary may have helped improve this.

h. How and where were the results shared?

As this is an ongoing audit cycle the results are shared daily during the huddles highlighting how many days since we last had an error. Additionally, every 2 months the Improvement Academy awards certificates to the team to celebrate error free intervals of 7, 14, 21 consecutive days. This is also sent to the entire team though email communication.

i. What consideration has been given for Human Factors?

Encouraging the team to speak up during HUSH huddles has highlighted the contrast between work-as-imagined and work-as-done, particularly when the individual involved in the medication error is able to share the event from their perspective. This has led to the team having a greater appreciation for the messy reality of medication errors occurring, particularly considering the complexity of handling medication, from prescription through to administration. The non-technical skills of the team have been developed through huddle implementation, whilst prioritising psychological safety and closed-loop communication when medication errors are identified.

Appendix 1

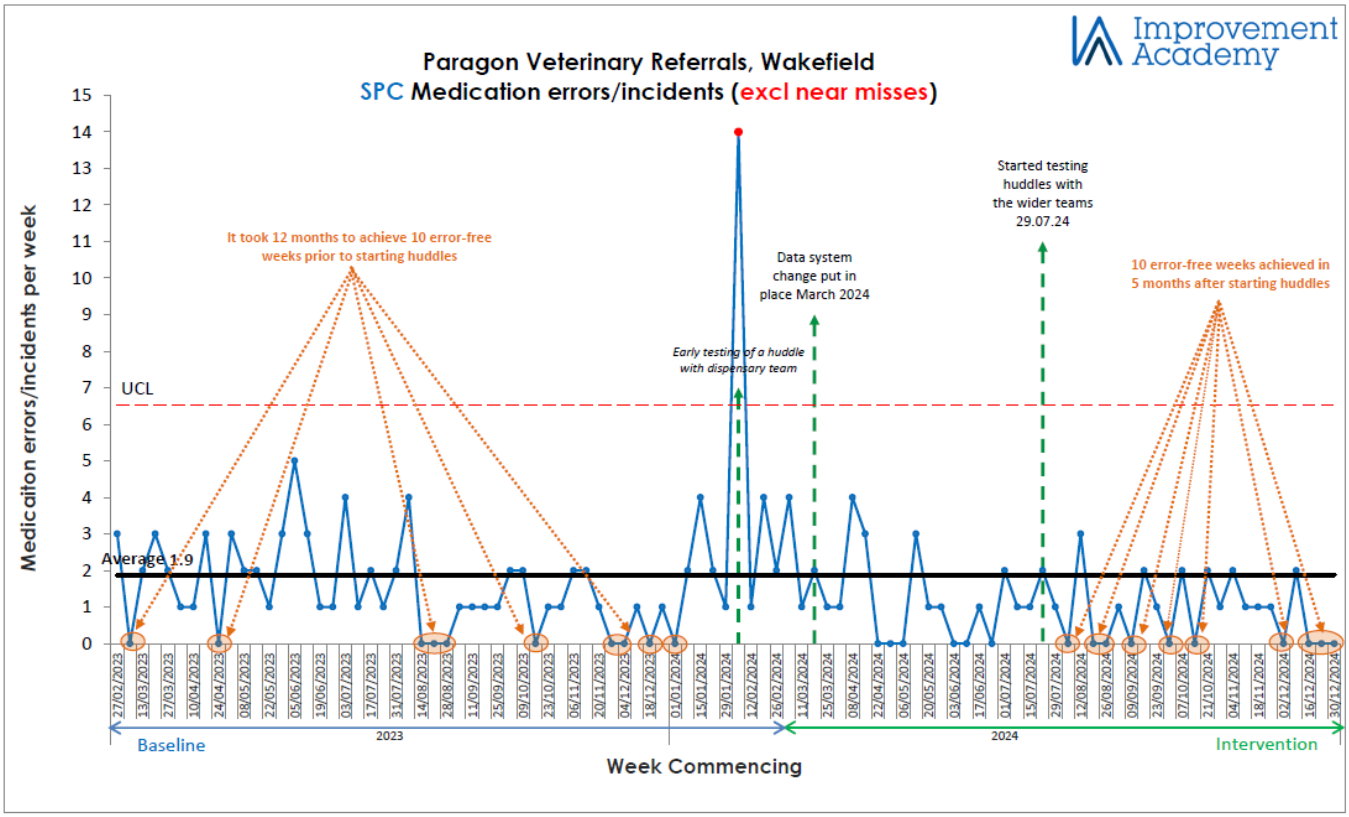

Figure 1: Chart showing the stages of the project and plotting the impact of the interventions over time

Appendix 2

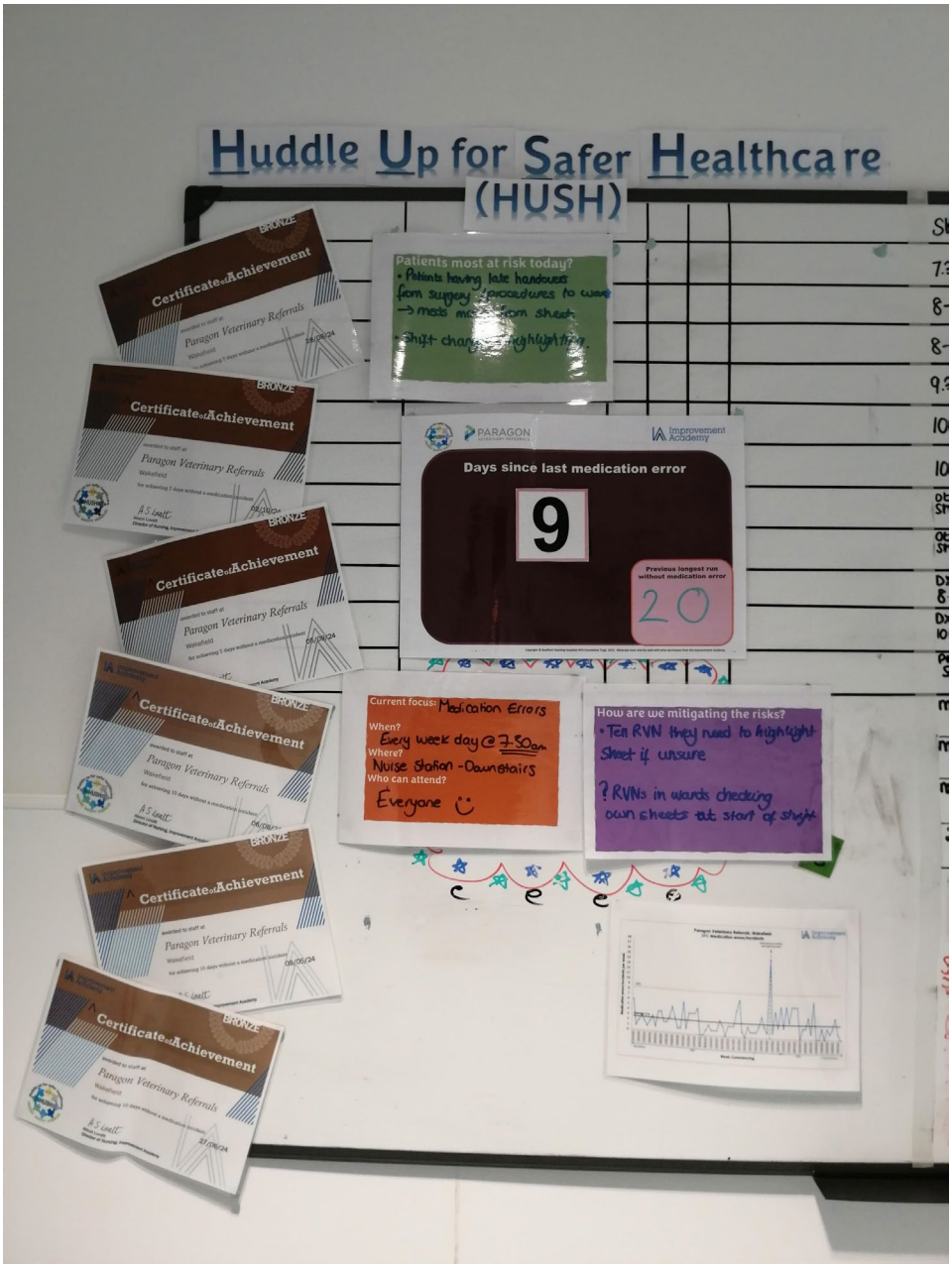

Figure 2: Display of the HUSH huddle board sharing results and "Days Between Medication Errors," alongside milestone certificates used to celebrate achievements.

Summary

Clinical audit is a process for monitoring standards of clinical care to see if it is being carried out in the best way possible, known as best practice.

A clinical audit can be described as a systematic cycle. It involves measuring care against specific criteria, taking action to improve it, if necessary, and monitoring the process to sustain improvement. As the process continues, an even higher level of quality is achieved.

What the clinical audit process is used for

A clinical audit is a measurement process, a starting point for implementing change. It is not a one-off task, but one that is repeated regularly to ensure ongoing engagement and a high standard of care.

It is used:

- ⇒ To check that clinical care meets defined quality standards.
- ⇒ To monitor the changes made to ensure that they are bringing about improvements and to address any shortfalls.

A clinical audit ensures concordance with specific clinical standards and best practices, driving improvements in clinical care. It is the core activity in the implementation of quality improvement.

A clinical audit may be needed because other processes point to areas of concern that require more detailed investigation.

A clinical audit facilitates a detailed collection of data for a robust and repeatable recollection of data at a later stage. This is indicated on the diagram wherein in the 2nd process we can see steps 4, 5 and 6 repeated. The next page will take you through the steps the practice took to put this into practice.

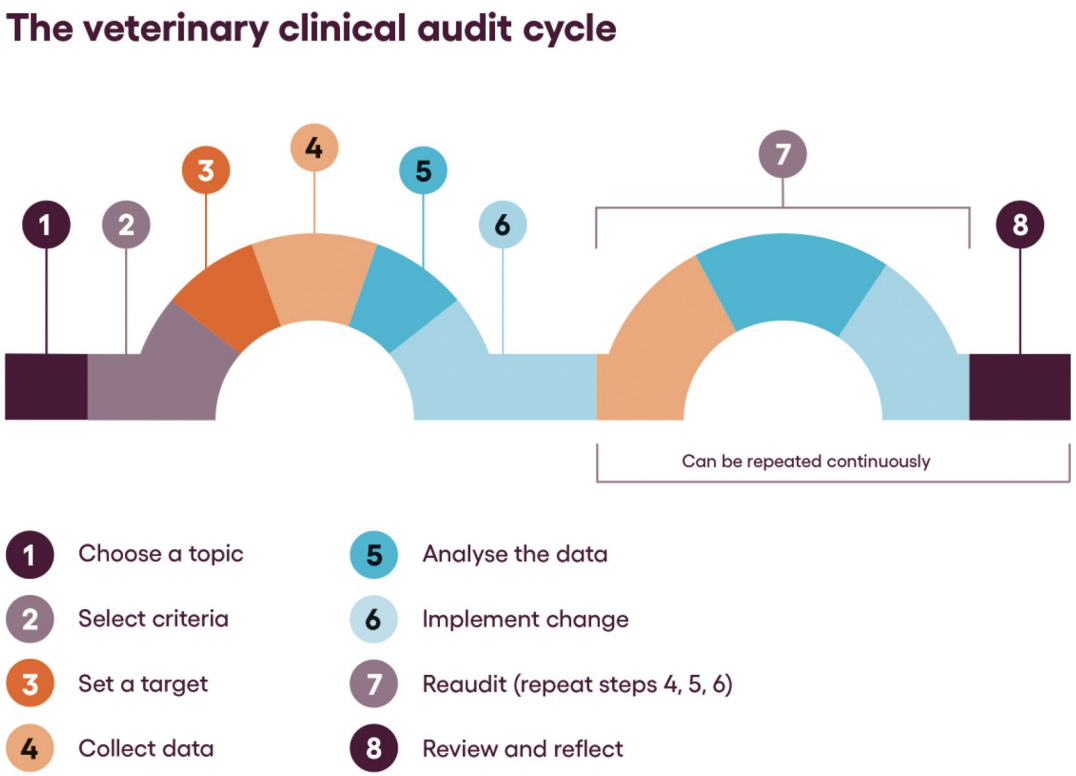

Figure 3: The Veterinary Clinical Audit Cycle by RCVS Knowledge. Available from www.rcvsknowledge.org. Developed by the Royal College of General Practitioners www.rcgp.org.uk/qi-ready

References

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